A corpus-assisted study of the discourses of infertility in UK blogs, news articles and clinic websites

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For my Dad, Paul Donnelly (29.06.1953 – 14.09.2005)

"Il miglior fabbro"

Acknowledgements

The metaphor of the journey is often used when talking about the PhD process, and it is undoubted that I would have fallen by the wayside several times without my fellow travellers.

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You have all made it a road worth travelling.

Declaration

I hereby declare that this thesis is the product of my own work and has not been submitted in any form for the award of a higher degree elsewhere.

Karen Kinloch. April, 2018

Abstract

Infertility, the inability to have children when this is desirable, is reported to affect 1in 6 couples in the UK. The experience of infertility has become increasingly 'medicalised' (Conrad, 2004) in the context of rapid developments in assisted reproductive technologies, leading Greil et al., (2010) to posit that "the social construction of health and illness is perhaps even more striking in the case of infertility than it is for other conditions". While there is considerable work into the social aspects of infertilty, as yet there is almost no research into the linguistic or discursive representations of infertility, an absence addressed by this thesis, in the research question what are the discourses of infertility?

The combination of corpus linguistics and discourse analysis (CADS) has been fruitfully employed previously in the study of a range of social phenomena (Partington et al., 2013; Baker et al., 2008), including health issues such as depression (Hunt, 2013) and is the approach adopted in this study. Crucial to CADS is the use of comparison, this requirement is met in this thesis by using three text types on the topic of infertility; 1) weblogs written by people experiencing infertility, 2) news reports on the topic of infertility, and 3) fertility clinic websites, all collected in the UK context.

I apply a combination of corpus linguistic methods to identify salient linguistic features, and close reading of these features in context to identify traces of discourses (Sunderland, 2004) around the topic of infertility in the three text types. Unique to the methodology of the thesis is the use of the Patterns tool in the Wordsmith suite to identify repeated collocate patterns around a word of interest and identify features for close analysis.

Through this process of linguistic analysis and contextual reading, four overarching discourses of infertility were identified; 1) the transformative effect of infertility, 2) medicalised (in)fertility, 3) the marketization of reproduction, and 4) parenthood as privilege and imperative. These discourses encompass multiple, intersecting sub-discourses which operate interdiscursively within and across the three text types studied. The increased awareness of these discourses has the potential to improve understanding of practitioners in the field of infertility, especially frontline staff and thus improve the experience of those accessing services. On a societal level, to critically appraise dominate discourses around a condition can be a conduit to challenging those discourses which are problematic.

Contents

Chapter 1 - Introduction

> *"It is only through reading other women's stories that I*
>
> *am able to gain access to parts of my own life narrative."*
>
> (IF024)

This thesis was shaped from the development of two research interests which at first glance may appear incongruous; 1) corpus linguistics (CL), particularly use of CL in discourse studies (Corpus Assisted Discourse Studies, or CADS) and 2) representations of the experience of infertility in the UK at the start of the 21st century. However, as will be apparent throughout the thesis, CADS is a methodological approach well suited to the study of socially problematic phenomena, a category in which I place infertility. Therefore, there are two main aims to the thesis; one methodological, involving appropriate use of corpus assisted discourse studies to study a socio-medical phenomenon, and one topical, the study of the lived experience of infertility as it is discursively constructed in the UK from 2006 to 2012.

In this introduction chapter I explore the motivations which underpin both aspects of this thesis, asking; why study infertility, and why use CADS and in doing so I clarify the choice of research questions, data collection and focus of my analysis. The chapter ends with an overview of the structure of the thesis.

1.1 Aims and motivations

The experience of infertility is unique, comprising as it does both social and medical perspectives, and thus ripe for linguistic attention to those texts which contribute to discourses around this experience.

Through the process of data collection, it became clear that the main goal of this thesis was to examine the ways in which the experience of infertility is manifest in language but also to critique problematic discourses which I identify from linguistic 'traces' (Sunderland 2004, p. 28). Whilst the thesis includes analysis of three text types, it is the lived experience of this condition, articulated in the texts of those who are currently experiencing infertility which is the focus. Although I did not set out with an explicitly emancipatory agenda, my analysis became focused on the people experiencing infertility both in terms of their self-representation and in representation by others, along with the potentially problematic discourses around this position. Thus, my analysis moved from a descriptive mapping of the term *infertility*, to an analysis of the representation of people with infertility and their experiences around the condition. Central to this analysis is the comparison between how infertility is represented by the people who experience it and the media and clinical accounts, considering potential overlap and influence between these three sources of knowledge-making around infertility. Before going further, however, it is useful to spend some time defining the term *infertility* itself.

1.2 Why Infertility?

UK regulators of the fertility industry, the Human Fertilisation and Embryology Authority (HFEA) define infertility for heterosexual couples as those who "haven't conceived for a year …or…have a condition that affects your fertility".[1] It is currently reported that 1 in 6 couples in the UK experience infertility and it is the second most common reason for women aged 20–45 to visit their GP, after pregnancy itself (HFEA). Yet even the attribution and choice of the label of "infertility" is itself potentially problematic and this issue of naming is explored further in Section 2.4.2.

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[1] https://www.hfea.gov.uk/i-am/heterosexual-couples/ retrieved 10/03/17

A striking aspect of infertility, which piqued my interest initially, is its unique position as an issue at the intersection of the social, ethical, personal and medical. In the Report of the Committee of Inquiry into Human Fertilisation and Embryology (Warnock, 1984. Commonly known as the Warnock Report) it was concluded "that infertility is a condition meriting treatment" (p. 10), thereafter enshrining the medicalised status of infertility in the UK. This change in the status of infertility, from a personal problem to be dealt with in the private sphere to a public health issue warranting intervention, maps onto Conrad's (2011, p. 13) description of medicalisation as something which "occurs when previously nonmedical problems become defined (and treated) as medical problems, usually as an illness or disorder.". Indeed, it is stated by Greil et al. (2010, p. 141) that "the social construction of health and illness is perhaps even more striking in the case of infertility than it is for other conditions". Throughout this increasing medicalisation, the representation of the experience of infertility has also shifted, as Bell (2010, p. 634) points out "prior to the development of ARTs, involuntary childlessness was constructed as a disappointing, inevitable act of nature, whereas it is now expected that infertility is something to be overcome.".

As a researcher with an interest in language around potentially problematic or contested terms, infertility was an obvious case for study, as previously there has been a dearth of linguistic research into infertility, a gap which this thesis seeks to rectify.

1.3 Methodological framework and terminology

There is a growing body of work applying corpus linguistics (CL) to the analysis of the representation of social issues, broadly (critical) discourse analysis (Hardt-Mautner, 1995; Baker et al. 2008; Partington, 2012), although there is variation in the type of analysis which is applied to the corpus.

McEnery, Xiao and Tono (2006, p. 4) define a corpus as "a collection of sampled texts, written or spoken, in machine readable form which may be annotated with various forms of linguistic information." and CL as "a methodology with a wide range of applications over many areas and theories of linguistics" (ibid.). One of the benefits of CL is that it allows "researchers to objectively identify widespread patterns of naturally occurring language and rare but telling examples, both of which may be over-looked by a small-scale analysis." (Baker and McEnery, 2005, p. 201).

Whilst there is some debate within CL whether it is a methodological tool or an area of research (Tognini-Bonelli, 2001), I classify CL as a methodology to use in combination with (critical) discourse analysis, theorised by Baker et al. (2008, p. 273) as "a useful methodological synergy".

The use of CL methodology in combination with (critical) discourse analysis is no longer a novelty but a well-established field of research (Baker and McEnery, 2015; Partington, 2012). This methodological combination has been successfully employed to study textual representations of topical issues such as climate change (Grundmann and Krishnamurthy, 2010), refugees and asylum seekers (Baker et al., 2008) and same sex marriage (Bachmann, 2011). Most pertinent to this thesis, this method has also underpinned studies of health issues, such as, eating disorders (Hunt and Harvey, 2015; Lukac, 2011), and obesity (Mulderrig, 2017).

A significant benefit of CL and discourse analysis is the emphasis on comparison to elicit linguistic similarities and differences (Taylor, 2013). As Baker (2010, p. 125) points out '[a] key way that we make sense of things is by casting them in relationship to something else', and this study examines the "relationship" of both language patterns and discourses between three text types.

It is necessary in any study of "discourses" to acknowledge that it is a contentious term with multiple meanings across and within disciplines, (explored further in Section 2.2.4). While in several studies the term *discourse* is sometimes used as a referent for "a stretch of spoken or written language" (Sunderland, 2004, p. 6) I gloss this as text, while use of discourse as a type of institutional communication, for example, news discourse (Hyland, 2013, p. 111), I refer to as a text-type. Instead, in this thesis, drawing on Sunderland's definition of interpretative discourses, discourses are characterised as "ways of seeing the world" (2004, p. 6) but also Foucault's (1972, p. 49) position that "discourses are practices which systematically form the objects of which they speak" I view discourses as both constituted and constitutive of social practice.

This study aims not just to interpret or identify discourses but to examine how they interact inter- and intra-textually, what is sometimes referred to as recontextualization (Bernstein, 1990; Fairclough, 2003) or as intertextuality (Fairclough, 1995). The study of discourses as they are operationalised in different text types is described by Fairclough (2003, p. 51) "a process of recontextualization - a movement from one context to another", as discourses are not just reproduced verbatim in a new context but transformed to "fit" this context. It is the movement and transformation of discourses which is addressed in research question 3 (Section 1.5).

While methodologically my focus is on CL and discourse analysis, ontologically, this thesis is informed by social science perspectives on infertility, particularly Becker's (1997) interpretation of infertility as a life disruption, neoliberalism and reproductive health (Lupton, 2013) and the medicalisation of infertility (Greil et al., 2010).

1.4 Data selection

According to Partington (2010, p. 90), "CADS is also characterised by the compilation of ad hoc specialist corpora...of the discourse type under investigation" and one key

consideration when compiling specialist corpora, rather than using large general corpora such as the British National Corpus (BNC) is the question of what data to include (see Section 2.1.4) Many studies focus on one text type but as mentioned previously, a central premise of CADS is the use of comparison. My aim for this thesis was not to analyse differences in representation of infertility over time (diachronic) or across multiple locales (cross-cultural), although both would be valid and interesting approaches. Instead the aim was to examine discourses of infertility across several contexts, to represent personal, societal and clinical representations of infertility.

With the proliferation of health communication online (Fox, 2005) and developments in the use of the web for corpus linguistics (Mautner, 2005), it was timely to look to the internet as a site for data.

Most previous studies in online health communication (in corpus linguistics at least) have used forum data (Hunt and Harvey, 2015; Semino et al., 2012; Malik and Coulson, 2008) and while these undoubtedly provide a useful insight into illness experiences mediated online, I turned instead to weblogs, or Blogs.

Blogs are generally defined as ''web-based journals in which entries are published in reverse chronological sequence'' (Herring, et al., 2004, p. 1) and are a linguistically unique genre, close to spoken data but also epistolary in nature (Blood, 2004). Blogs also offer a unique source of longitudinal, naturally occurring language data, compared to previous qualitative studies of infertility which were reliant on interview data. It should be noted at this point that it is not the technical affordances (Herring et al., 2004) of blogs which are the focus of this thesis but the language used. While there have been a small number of social science studies into infertility blogs (Strif, 2005; Whitehead, 2013) these have not addressed linguistic aspects of this data.

As there has been an upsurge of fertility related information seeking online (Mariott et al., 2008) it is increasingly likely that individuals who are both digitally and health literate (as is the case with the bloggers) access fertility clinic websites as a source of advice. Clinical websites are not only sources of information but exist to market their services to potential health consumers (Harvey, 2013). Previous work on fertility clinics has mostly looked at compliance with regulation (Huang et al., 2005), or analysis of clinical information (Chan et al., 2014), with little attention paid to social aspects (an exception being Johnson, 2011). Therefore, this thesis provides a timely analysis of the discourses of infertility, and the positioning of both service providers and potential patients, in these clinical texts.

A substantial body of work in discourse studies utilises news data (Fowler, 1991; Richardson, 2007), including the analysis of news media in in the fields of CADS (Partington, 2008, 2010, & 2013) and CL and discourse studies (Baker et al., 2008). News media is of interest for critical discourse analysis as it reflects and reproduces power structures within society (Fairclough, 1995), and acts as a barometer of public opinion.

This interaction between news and public life is summarised by Baker and McEnery (2005, p. 200) as "newspapers, which are widely read on a daily basis, can help to shape/reflect public opinion". The study of health in news media is a burgeoning field and the importance of media in shaping social representations of health has been highlighted (Seale, 2003). The use of news data provides access to dominant accounts of an experience (Baker and McEnery, 2005) and brings to this thesis a means of triangulation between the public and personal accounts of infertility.

The text types selected for comparison in this thesis were chosen to provide insight into the personal experience of infertility, news representation of infertility and clinical

information on infertility treatment, all within a contemporary UK setting, thus my data comprises:

a) weblogs written by UK women experiencing infertility, the BLOG Corpus;

b) articles on infertility in UK national newspapers, the NEWS Corpus;

c) UK fertility clinic websites; the CLINIC Corpus.

1.5 Research questions

Taking a data driven approach, the scope of my overarching research questions is broad, focusing on methods of identifying discourses linguistically, and how the linguistic identification of discourses is comparable across different text types, through reiteration of language patterns.

My research questions do not specify one type of linguistic analysis i.e. metaphor studies or Systemic Functional Linguistics but acknowledge that a range of these may be employed as appropriate following preliminary analysis of my data sets.

Therefore, the following three main research questions will be answered during my thesis;

1) What discourses around infertility are found in newspapers, infertility blogs and clinical websites?

2) How are these discourses linguistically realised through keywords and frequent patterns of language use?

3) How do the discourses of infertility interact across and within the three different text types studied?

In each of the analysis chapters 4 to 7 I also include a subset of questions specific to the aspect of infertility under investigation.

1.6 Structure of the thesis

Following from this introduction chapter, in chapter 2 I explore the relevant literature on corpus linguistics, critical discourse analysis (CDA) and corpus assisted discourse studies (CADS), health communication, particularly online and news texts, and social science perspectives on health and reproduction. In chapter 3 I discuss the development of my research questions, data selection, building and cleaning of my three corpora, and ethical considerations. This chapter also describes my analytical framework, tools for analysis and method which utilises the Patterns tool in Wordsmith Tools.

Chapter 4 is the first of my analysis chapters and begins with a categorisation of the top 100 keywords in each corpus, a justification of the keywords selected for closer analysis, followed by an exemplar analysis of the keyword *infertility*.

In chapters 5 to 7 I present my detailed analysis of keywords across the three corpora, related to identity, embodied, medicalised experience and reproduction respectively.

Finally, in chapter 8 I conclude the thesis with a summary of my research findings, critical reflections on the PhD process, discussion of impact activities which I have carried out and some suggestions for future research.

Chapter 2 - Context and Literature Review

This chapter will address the background literature to my thesis from both methodological and theoretical perspectives, contextualising my work in the fields of corpus linguistics, CDA, CADS and health language and social science approaches to health, particularly reproductive health and infertility.

2.1 Corpus Linguistics, CDA and CADS

2.1.1 Corpus Linguistics

Due to extensive range of corpus linguistic (CL) methodology and applications this section will concentrate mainly on literature which relates directly to building small specialised corpora and analysing them using discourse analytic frameworks. It will, however, address universal issues in CL such as representativeness and sampling, as well as the limitations and challenges presented by corpus use which have relevance to my research.

2.1.2 Why use a corpus?

Although McEnery, Xiao and Tono (2006, p. 4) state that "corpus should always be viewed as a somewhat vague and inclusive term", they also provide a helpful working definition of a corpus as "a collection of sampled texts, written or spoken, in machine readable form which may be annotated with various forms of linguistic information".

The literature in this area posits several key advantages of corpus linguistics as a methodological approach. Firstly, the advantage of using large datasets which, according to Sinclair (1991, p. 4) "allow patterns to emerge providing evidence about language in use which was not previously available". Secondly, these large datasets allow researchers to "find differences that intuition alone cannot" (Tognini-Bonelli, 2001, p. 55) and whilst this move away from intuition to natural language use (Biber et

al., 1998) is commended, it is also worth noting the role of intuition in developing corpus based research questions.

2.1.3 A methodological tool or an end in itself?

Whilst there are a range of views of on corpus usage, it has been suggested that they can be broadly divided into two types of study: 'corpus-based' and 'corpus-driven', (Tognini-Bonelli, 2001). Corpus-based studies generally use a corpus to test existing theories or descriptions, whilst corpus-driven theorists take a more radical approach, rejecting pre-existing theories and focusing on the corpus as evidence (for an overview of this dichotomy see McEnery, Xiao and Tono, 2006, p. 8-11). However, this binary opposition has been criticised as unhelpful (McEnery and Hardie, 2012, p. 143) and I would suggest that a cline from corpus as methodology to corpus as theory as more appropriate. Positioning myself on this cline, I take a classic corpus-driven approach of using keywords to direct my analysis, reflecting the evidence of the corpus (Sinclair, 1991). However, I also engage with pre-existing theoretical frameworks and analytical techniques drawn from the critical linguistic (including but not exclusively CDA) tradition and from medical sociology.

No matter what position a researcher takes within CL, it is necessary to deal with two key issues in research design: corpus design and corpus analysis, which I address below.

2.1.4 Using small specialised corpora

Although my dataset for this study contains over 7 million words, in corpus linguistics this can still be considered a small specialist corpus in comparison to large reference corpora like the British National Corpus (comprising 100 million words). Most of the literature on corpus building is devoted to the compilation of such large, general corpora., However, in the last decade there has been an increase in the creation of (small), specialist corpora (Koester, 2010; Flowerdew, 2004), mainly for use in

language pedagogy (O'Keeffe et al., 2007), Language for Special Purposes (LSP) (Bowker, 2001) and, increasingly, discourse analysis (Baker, 2006; Mautner, 1995). As McEnery, Xiao and Tono (2006, p. 11) point out, "most of the recently published studies of ideology and culture are based on specialized corpora" while Koester (2010, p. 67-71) suggests that the benefits of using specialised corpora include; "a much closer link between the corpus and the contexts in which the texts in the corpus were produced" (p67) as the compiler is also the analyst and the fact that the corpus can be "targeted to reflect contextual features, such as information about the setting, the participants and the purpose of communication" (p69).

With regard to the size of a specialist corpus, McEnery, Xiao and Tono (2006, p. 15) suggest that, "specialized corpora tend to be domain or genre specific" and according to Handford (2010, p257), "the more specialised the genre the smaller the corpus can be", which goes against a common view in CL that bigger is better (Sinclair, 1991). Hunston (2002, p. 26) somewhat pragmatically asserts that "a corpus user makes use of as much data as there is", which is especially true when examining a specific genre or text type in a specialist corpus.

More important than size in most studies is the issue of balance and representativeness in corpus design; how to select the texts (the sampling frame) from a genre/register (population) to provide the most robust evidence of a linguistic or discursive phenomenon.

Hunston (2002, p. 32) draws a distinction between a corpus as a collection of texts and a corpus as a collection of samples of language. In the vast majority of cases specialized corpora fit in the former category, what Tognini-Bonelli (2010, p. 21) describes as a topic corpus – a collection of texts on an event whilst Koester (2010, p. 67) suggests genre/register as a basis for compiling specialized corpora. However, the type of text is

selected (the sampling frame), when it comes to collection, Flowerdew (2005; p78) states that it is "more important to collect complete text types rather than samples to be representative in specialised corpora". Following these suggestions, my specialized corpus includes whole texts selected based on topic (infertility), with sub corpora organised according to genre (blogs, news articles, clinical websites) with the aim advocated by McEnery and Hardie (2012, p. 6) of "reflecting the language as it exists at a given point in time, constructed according to a specific sampling frame."

As McEnery, Xiao & Tono (2006, p. 18) state "There is no objective way to balance a corpus or measure its representativeness" and Hunston, (2002, p. 28) highlights the problem of knowing how representative a sample is without knowing what the character of the 'whole' is. With these constraints on knowledge the focal issue for corpus linguists is the appropriateness or relevance of the corpus to the research question (Hunston, 2002), developing a corpus which will most effectively allow researchers to provide evidence for specific queries.

2.1.5   Alone a corpus can do nothing - analysing corpora

Hunston, (2002, p. 3) makes the point that a corpus cannot do anything alone and it is the use of appropriate software which is necessary for analysis of corpus data. There is currently a large range of available software for corpus analysis, making it possible to sort, search and test hypotheses on large datasets computationally rather than manually. Indeed, it is this software which makes it possible to elicit the language patterning in a corpus which provides the basis for this type of research. This section outlines some types of analysis that corpus tools offer, examining the interplay of computational and intuitive techniques, addressing keywords, concordances and collocational meaning making.

Initial corpus investigations usually examine how often a word or phrase (Scott, 2012) occurs in the text, through frequency lists. While this can provide useful ways in to a textual analysis for sociolinguistic/discourse analytic approaches this approach can only provide what is frequent. Thus, many researchers choose to utilise "keywords" defined by Scott (1997, p. 236) "as a word which occurs with unusual frequency in a given text. This does not mean high frequency but unusual frequency, by comparison with a reference corpus of some kind." This frequency is calculated via statistical tests. For example, a common test used to derive keywords is the log-likelihood test, which returns a p value for each word in the corpus.[2] Whilst a keyword "does not itself constitute an analysis" (Bondi and Scott, 2010; p3) it may be used to facilitate understanding of the main point of a text and as a starting point for further analysis (Harvey, 2013, Baker, 2010), particularly when it is an "aboutness" (Scott, 2012) keyword as opposed to a high frequency grammatical word.

In order to elicit more about the context of a keyword, many studies go on to look at the collocates of these keywords. Based on Firth's assertion (1957, p. 11), that "You shall know a word by the company it keeps" and Halliday's functional grammar, Krishnamurthy (2000, p. 33) suggests that "collocation is among the linguistic concepts which have benefitted most from advances in corpus linguistics". Collocates, described by Scott (2012) as statistically significant co-occurrences (of a word within a text), are frequently used to ascertain patterns of meaning around a word or phrase and can also be utilised as a way of filtering data and providing focus when faced with a large number of keywords as potential search terms. According to Tognini-Bonelli, (2001, p. 128) textual meanings arise from the co-selection of more than one word and this is

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[2] A p value is the probability that we would obtain the results we have observed assuming that the 'null hypothesis' is true. In this case, the null hypothesis is that there is no difference in the frequencies of a particular word in the two text types we are comparing.

particularly useful in unpicking ideologically loaded terms (e.g. Hamilton et al. 2007 on *risk* and Orpin, 2005 on *sleaze*). Both Louw (1993) and Sinclair (1991) strongly support the notion of semantic (discourse) prosody, the "consistent aura of meaning with which a form is imbued by its collocates" (Louw, 1993, p. 157).

Whilst Baker (2006) points out that collocates give the most salient and obvious lexical patterns surrounding a term, there are several criticisms of this methodology including problems of defining what counts as a collocation, how proximal they need to be and how to manage those which are "Not necessarily adjacent or in a specific order" (McEnery and Hardie, 2012, p. 123). McEnery and Hardie (2012, p. 124) also state that a word's collocational patterns are a crucial part of its meaning but point out a divergence of definitions and methodologies for accessing collocations, as while many researchers use statistical software to calculate collocates, there is still some reliance on manual counting and intuition. I would argue that collocates, like keywords, provide the corpus-driven analyst with a way into to the data besides intuition.

Useful as both collocates and frequency list can be for deriving the main points of a text, or patterns of meaning around a node word, as Baker (2010, p. 317) points out, "Lists of words reveal very little on their own, and taken out of context, incorrect conclusions are often reached regarding their usage or meaning". Thus, at this point it can be advisable to turn to concordance analysis which is, according to Baker (2006), where researchers combine qualitative (concordances) and quantitative (keyness) analysis.

By using a software search on a node word of interest (Hunston, 2002, p. 45) concordance lines display a word in its immediate context and can be sorted in numerous ways to "allow us to observe the behaviour of a particular word-form in detail" (Krishnamurthy, 2008). This method is frequently used by researchers

combining CL and critical social research on topics such as discourses of New Labour (Fairclough, 2000), carbon compounds (Koteyko, 2010) and Islam (Baker et al., 2013, p. 118). This approach illustrates the combination of corpus-driven and corpus-based methods (Morley and Bailey, 2009, p. 17) as researcher intuition leads to examination of concordances which prove or disprove the initial hypothesis. One criticism is that concordance lines require manual analysis by the researcher to elicit patterns around a word, which in large datasets may be extremely time consuming and being reliant on researcher interpretation could be censured for lack of objectivity. However, they give a level of fine grained detail which cannot be elicited though other methods.

2.1.6 What a corpus cannot do – the issue of context

Despite the many applications of corpus methodology, the approach has several limitations. For many researchers a corpus can be analysed to provide evidence of linguistic phenomena, however, it cannot alone provide an explanation of this evidence and this must be provided using other methodologies providing a strong justification for mixed methods approaches, such as corpus linguistics and discourse analysis. This criticism is also made by Widdowson (2004) who indicates that a corpus can provide a description of the text not the discourse. However, in highlighting significant linguistic features through corpus analysis this may elicit traces of potential discourses and it is not suggested that the data alone, without intuition or contextual information can reveal discourses (Stubbs, 2001).

Whilst corpora can show what is present in text, as McEnery and Hardie (2012) point out, they cannot provide negative evidence, so in the case of discourse analysis, it is difficult for corpus analysis to reveal much about groups or discourses which are omitted from texts.

It is also still necessary for researchers to provide the context to the text. According to Handford (2010), decontextualisation is a persistent failing of corpus linguistics, however, most of these criticisms are aimed at large, general "mega-corpora. Small specialist corpora go some way to addressing these concerns and as Koester (2010, p. 66) points out the "compiler is analyst which provides a greater degree of familiarity with the texts and context". Although, this can also contribute to the criticism that the researcher lacks objectivity it is possible to address this as a self-reflexive researcher, returning often to the original research questions and critically examining one's own expectations of the data.

2.2 Corpus Linguistics and Critical Discourse Analysis

2.2.1   Combining methods for a robust approach

The desire to address critiques of CDA (Wodak and Meyer, 2009), has led to burgeoning research into the application of quantitative methods, especially the use of Corpus Linguistics (CL) as a complement to qualitative studies, described as a "useful methodological synergy" (Baker et al, 2008, p. 273).

Although still a relatively niche area, since initial studies (Caldas-Coulthard's (1993, 1996) corpus approach to gender representations in written news data, Hardt-Mautner's (1995) seminal paper on combining CL and CDA methodologies looking at concordance lines referring to European integration in the British press and Krishnamurthy's study of the language of racism in 1996) this area has expanded to include a range of methods drawing from several schools of discourse studies.

Much of this work (Baker, 2006; Baker et al., 2008; Orpin, 2005; Partington, 2010) has explicitly sought to tackle Stubbs' (1997) criticisms of CDA for the use of small sets of texts, failure to draw comparison with general language usage and perceived lack of objectivity through applying varied corpus methods to questions more frequently

addressed by CDA. For example, the use of large datasets (corpora) allows "researchers to objectively identify widespread patterns of naturally occurring language and rare but telling examples, both of which may be over-looked by a small-scale analysis." (Baker, 2004, p. 346).

While much of this work is carried out by corpus linguists with an interest in social research (Baker, 2006; Baker and McEnery, 2005; Mautner, 2008), it has also been used by CDA researchers to develop robust and replicable methodologies or enhance diachronic analysis (Mulderrig, 2011). Combining a corpus approach with one or more forms of discourse analysis can be a triangulation technique, providing an alternate framework and 'way in' to the data, strengthening findings. Employing both qualitative and quantitative methodologies is sometimes referred to as methodological triangulation (Marchi and Taylor, 2009, p. 5) whilst using data which includes "a range of text types from a range of sources" (Baker, 2006, p. 36) can facilitate data triangulation.

While interest in this area initially focused on combining CDA frameworks (Fairclough, 2003) with CL methodology, current studies use not just CDA but other "discourse-oriented theories/methodologies" (Baker et al., 2008, p276). Indeed, as Baker et al. (2008, p. 275) point out "corpus based studies may adopt a critical approach, but may not be explicitly informed by CDA theory and/or its traditional methods, or may not aim to contribute to a particular discourse-oriented theory." This multi-method approach also draws on other schools within discourse studies (Sunderland, 2004; Partington, 2008) but all comes under the umbrella of critical social research (Wodak and Meyer, 2009; Fairclough, 2003).

Another key development in corpus approaches to discourse analysis is the CADS school, which rejects the "Critical" aspect of CDA and defines discourse as a text type,

i.e. newspaper discourse refers to the stylistic/linguistic type of text used in printed press (Partington, 2010). CADS aims to uncover "non-obvious meaning, that is, meaning which might not be readily available to naked-eye perusal." (Partington et al., 2013 p. 11) and concentrates on political and media language, due in part to its foundations in political science studies. Although CADS has been criticized for focusing on a limited text type, recent studies have also looked at spoken discourse interaction e.g. news interviews or parliamentary debates as a method of examining institutional discourses (Partington, 2008).

CADS does not require the researcher to take a political standpoint or challenge a specific social issue but rather takes a data-driven approach to identifying discourses around a concept or text type. Although my analysis has methodological commonalities with CADS, I take a more critical, feminist approach to the discourses discussed and align myself to the emancipatory role of the analyst in critical social studies.

2.2.2   Corpora, Discourse and the representation of social groups

Specialist corpora in discourse-based research most often utilise "institutional" data for example, news articles, political documents or speeches that Baker and McEnery (2005, p. 199) suggest are "more likely to be received as hegemonic or widely accepted positions" and provide insights into the discursive construction of institutional entities and identities. This type of data is also utilised to examine power structures (Mulderrig, 2011).

In contrast with the discursive representation of institutional entities such as political parties and mainstream media, other studies examine representations of social groups, who are perceived to be "other", sometimes discriminated against and usually not institutionally powerful, for example, Muslims, (Baker, 2010) gay men (Baker, 2005), businesswomen (Koller, 2004), refugees and asylum seekers (Baker et al., 2008), young

people (Harvey et al., 2007) and the elderly (Mautner, 2007). These groups are infrequently if at all given the opportunity to discursively construct their own identities and are instead used as what Hardt-Mautner (1995) describes as relational constructions to allow powerful groups to position themselves in relation to the "other". Both Baker and McEnery (2005) and Baker (2006) highlight the importance of lexical choices in maintaining discourses and the "incremental effect of discourse" (p. 13). The study of collocations is particularly useful in revealing how social groups are viewed not just in texts and discourses but in society as it provides evidence of "how people are categorized and how categorization does indeed produce social outcomes" (Caldas-Coulthard and Moon, 2010, p. 125).

In this thesis I will explore and compare discursive representations of social actors (Caldas-Coulthard and Moon, 2010) in both institutionally powerful groups (media, politicians and experts) and those who do not traditionally occupy powerful positions (women experiencing infertility).

Related to this is work on the discursive constructions of problematic social terminology which are frequently used but not always clearly defined, such as corruption (Orpin, 2005), political correctness (Johnson et al., 2003), risk, (Hamilton et al., 2007), climate change (Grundmann and Krishnamurthy, 2010) and genomics/genetics (Adolphs et al., 2003, Nerlich at al. 2004). These investigations do not begin with a social problem or social group per se but with socially problematic or contested terminology, such as infertility, which may impact on social groups and power structures.

2.2.3 Criticisms of using corpus approaches to discourse analysis

Although the approach described above has been commended for allowing researchers to deal with much larger datasets than would be possible with CDA manual analysis, it has also been suggested this may lead to loss of context at both a textual and socio-

cultural level (Widdowson, 2004, p. 124). By grouping individual texts together in large data sets there may be a temptation to treat "institutional" texts as a homogenous group not giving full or proper attention to the identity/agenda of the producer, what Fairclough (1993, p. 34) describes as the social conditions of production, which are usually key to CDA. By utilising smaller, specialised corpora of English for Specific Purposes "issues of production and reception can be more easily articulated" (Baker, 2006, p. 180).

As well as the potential loss of social context, the nature of corpus linguistic analysis is in almost all cases based around written texts or written transcriptions of speech (the Nottingham Multimodal Corpus (Adolphs and Carter, 2007) is one notable exception), usually forfeiting visual context, formatting information and metalinguistic data. This is particularly problematic as, as Baker (2006, p. 35) points out "discourses can be embedded within images".

However, it is possible to take an approach to data advocated by Fairclough (2001) for CDA. Moving between close analysis of individual texts and broader analysis of groups of texts it is possible to examine general patterns of certain linguistic features and then the contextual information surrounding these.

A corpus analysis can reveal lexical and grammatical patterning but this does not mean that meaning can automatically be inferred from these patterns, this is reliant on the individual researcher. Whilst Widdowson (2004, p. 124) suggests that "as context cannot be inferred from co-text, this cannot be used as evidence of discourse" this is a theoretical rather than a methodological disagreement as many researchers, including myself, do believe that recurrent co-textual patterns can reveal linguistic traces of potential discourses.

While I believe that corpus approaches are helpful for uncovering discourses, it is necessary to avoid the complacent assumption that quantitative analysis is inherently objective. Thus, it is necessary to be as reflexive as one would when carrying out any form of CDA. This involves being aware that all text selection and analysis is as Baker (2005, p. 36) says mediated by researcher bias and it is crucial to remain aware not just of the context of the data but the context of the research undertaken and the researcher's own background and motivations.

Having referred to *discourse* in this section in terms of its relationship to corpus methods to analysis, it is useful to spend some time defining the term in relationship to its use in this thesis, before moving on to focus on health communication and infertility.

2.2.4 Defining discourse (analysis) and identifying discourses

According to Wodak and Meyer (2009, p. 2) "the notions of text and discourse have been subject to a hugely proliferating number of usages in the social sciences", and they stress the importance for researchers to orient themselves in relation to their definition of these terms.

At the most basic level of description Stubbs (1983, p. 1) classified discourse as "language above the level of the sentence", and beyond this discourse analysis is often described as the study of "language in use" (Potter and Wetherell, 1987). However, a growing number of critical theorists across multiple schools of discourse analysis expand the study of language in use to what Jaworski and Coupland (2006, p. 3) identify as "language use relative to social, political and cultural formations – it is language reflecting social order but also language shaping social order, and shaping individuals' interaction with society". Sunderland (2004, p. 148) provides a helpful distinction between discourse, a linguistic 'text' or 'interaction' and discourses, "ways of seeing the world" and describes the way in which characteristic linguistic 'traces' reoccur

across a range of texts/discourse to constitute these discourses. In Critical Linguistics, (a discipline closely applied to Critical Discourse Analysis) "discourse refers to the social process in which texts are embedded" (Hodge and Kress, 1988, p. 6), and the social construction of meaning through language and other semiotic features is central to the development of (critical) discourse analysis.

Even within the Critical Discourse Analysis (CDA) "school" (following Wodak and Meyer, 2009, p. 3), there is not agreement on single usage of the term discourse, or indeed text, and though many theorists attempt to delimit the terms text (spoken or written), discourse and discourses and the relationship between these categories (Fairclough, 2003; Mills, 2004; Sunderland, 2004; Van Dijk, 1995; Wodak, 2009), this vagueness of terminology is one of the criticisms which is levelled at CDA (Widdowson, 2004, p. 15).

However, many CDA researchers align with Foucault's (1972, p. 49) position that "discourses are practices which systematically form the objects of which they speak" and the Fairclough, Mulderrig and Wodak (1997, p. 258) statement of "discourse as social practice" is widely accepted as a central tenet. Critical Discourse Analysis, according to Fairclough (2009), who situates himself within critical social research, "begins with a social problem" and should "focus upon a social wrong" giving examples such as "immigration, terrorism, globalization or security", which have "significant implications for human wellbeing" (p. 167-8). Wodak and Meyer (2009, p. 2) state that "any social phenomenon lends itself to critical investigation, to be challenged and not taken for granted", taking a less "grand-theory-orientated position" which I find more methodologically useful, taking reproduction and particularly infertility as a social phenomenon.

Another key issue for this type of discourse analysis is the extent to which researchers self-identify as "critical", a position which is challenged by Sunderland (2004) who suggests that all discourse analysis is essentially critical, but does indicate the difference between adopting a critical stance and doing critical discourse analysis.

Within this thesis, I view discourses as a set of co-constructed meanings, and practices (Fairclough, 1992). These meanings can be realised in the use of patterns of language and repeated use of such patterns may indicate trace of a certain discourse (Sunderland, 2004, p. 6). Following Hunston (2002), I take the position that semantic sequences or patterns of language can reinforce meaning, i.e. that patterns and meanings are inextricably linked. Just as there are social and cultural limitations on the discourses we can access, so there are also linguistic limitations, albeit ones which can be subverted and contested to challenge dominant views. Therefore, it is the repeated use of language patterns or traces as a way in to meanings and discourses (Baker, 2006, Sunderland, 2004) which form the analytic basis of this thesis.

2.3 Health Communication

I take as my starting position the statement by Atkins and Harvey (2010, p. 605) that "Language use is centrally important to the way in which we constitute our experiences of health and illness". While I have called this section of my literature review "health communication", it could also be explained as a review of the language of health, or health language in society.

Beginning with Skelton and Hobbs' (1999) work on concordancing and practitioner interaction, much previous work in this field has centred on health "interactions" and the study of health language as an institutional discourse (Sarangi and Roberts, 1999; Sarangi, 2004). A key study by Adolphs et al. (2004) of applied linguistics in healthcare

contexts made the case for the use of corpora to study health interactions. This applied approach has included the study of health language as a complement to evidence-based practice in medicine (Brown, Crawford and Carter, 2006; Crawford, Brown and Harvey, 2014), with a view to informing clinical practice through data driven learning. While this is a valuable endeavour, I feel that there is space for research in health language which is not driven by pedagogic needs of practitioners but the need to critically examine how health is linguistically constructed in a broader social context.

Thus, my interest centres not on language of clinical interaction, or on health promotion campaigns (e.g. Brookes et al., 2016) but on what Fleishmann (1999) calls the "language we drawn upon to present our illness experience". There is considerable previous work on health language in various contexts, such as the communication practices of different groups e.g. adolescents online (Harvey, 2013), and oncology practitioners (Demmen et al., 2015), and it is this systematic analysis health language of groups and texts which inform this thesis.

The following section will focus on work in communicative practices, particularly linguistic preferences, which are used to enact health in different contexts, specifically in the media and online.

2.3.1 Health communication online

According to Hamilton and Chou (2014, p. 8);

> "Online interactions…have afforded researchers new sources of health communication data through which to better understand perceptions, attitudes and behaviours related to health",

and the potential of this source of naturally occurring, health communication data is one of the initial motivations of this thesis. More broadly, this section will cover literature

on the affordances of online health communication and the linguistic and discursive practices used in this context, particularly in the case of infertility.

There has been considerable work in the social sciences on the communicative affordances of creating and accessing health related content on the internet, as "the internet fundamentally shapes our experiences of the everyday, including our experiences of health and illness." (Ziebland and Wyke, 2012, p. 221).

Ziebland and Wyke's (2012) review of the literature on communicative affordances of internet health has highlighted the role of information seeking and building support networks, as well as the use of narrative to manage illness online. These are particularly relevant for the study of the experience of infertility online, both in blogs and clinical websites.

2.3.1.1 Help and information seeking

The internet has become a key source for information on health and illness (Fox, 2006; Lowe et al., 2009) both as a first port of call and to 'supplement health information received from traditional sources' (Pandey et al., 2003, p. 179). The quest for knowledge around infertility is shown to be "an important motivation for fertility related Internet use was seen to be a need for a better understanding of fertility problems" (Haagen at al., 2003, p. 2074).

Conrad at al. (2016, p. 28) foreground the way in which "the internet allows individuals to easily seek experiential knowledge", gaining advice from those who have experience of a condition, rather than medical "experts" and I would argue, blurring the line between seeking knowledge and seeking social support.

Internet health communication is often classified as "helpseeking", cited in the literature as a way to feel "normal" (Harvey et al., 2007; Lowe et al., 2009) and online social support around health is well documented (Fox, 2006). In the case of infertility Hinton

et al. (2010, p. 440) suggest that the internet is an opportunity for niche support, "allowing anonymous, timely, targeted access to the experiences of others".

There have been a considerable number of qualitative studies into user groups accessing support online for potentially stigmatised health problems including mental illness, fibromyalgia, and eating disorders but until recently the linguistic study of online health has been limited, with the Adolescent Health Corpus (Harvey et al., 2007) being a notable exception.

More recently linguistic analysis of online health has focused on forum data including Demmen et al. (2015)'s work on cancer and metaphor, Jaworska's (2017) study of narrative of PND, Anesa and Fage-Butler's (2015) construction of biomedical knowledge, and MacDonald and Woodward-Kron's (2016) representations of bipolar disorder. Although other studies have looked at social media, such as Facebook, (Hunt and Koteyko, 2015) currently blog data is an under-used resource in the study of health language online.

This general trend is mirrored in studies of infertility online, so while there are "high levels of interaction online around reproduction and childbirth" (Song et al., 2012), much of the work on these interactions has focused on qualitative reports of online support seeking (Malik and Coulson, 2008; Malik and Coulson, 2010; Lundin and Elmerstig, 2015).

Two notable exceptions to this preference for forum data are Strif's (2005) work on the performance of infertility on weblogs and Whitehead's (2013) thesis on the negotiation of entitlement to motherhood on infertility blogs. However, both these studies are sociological rather than linguistic, indicating again the dearth of linguistic work on this topic which my thesis will address.

2.3.1.2 Marketing health services online

While the previous section covered literature on information and helpseeking, in this section I review what is in some ways the opposite view, studies into the provision of online information for potential health consumers, the marketing of health service online. These are sites where as Koteyko (2009, p. 115) points out "customers themselves choose to visit the websites as they seek out information about a product or service", an area of considerable interest in the expanding medicalisation and marketisation of health (Conrad and Leiter, 2004). It must be stressed that this is not a review of the literature on health promotion online, rather an appraisal of critical studies into the online marketing of "medicalised" conditions.

Work into the discourse of marketing health online has focused on sites promoting "non-essential" enhancements to health, including hair loss products (Harvey, 2013) nutri-genetic services (Saukko et al., 2010) probiotics (Koteyko, 2009; Koteyko and Nerlich, 2007) and genital cosmetic surgery (Moran and Lee, 2013). A common factor of these sites is that they do not market health as the absence of illness but the augmented self, adhering to neoliberal discourses of healthism[3] (Cheek, 2008) and reliant on the desire to maintain self in accordance with perceptions of normality. This work has also shown a preference for multimodal analysis (Harvey, 2013) with a focus on close analysis of a small sample rather than a large corpus of texts, and as yet corpus methods have not been widely used in this field.

The marketing of health online reinforces the positions that (Fox et al., 2005) label the "expert patient or resisting consumer", creating the subject position of ideal patient who is informed and compliant. For fertility clinic sites this leads to the framing of personal

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[3] In which individuals are constructed as morally responsible for maintaining their health and averting risks to overall well-being.

choice to create the ideal consumers of medical information and thus services (Song et al., 2012).

As an area for study, fertility clinic sites are unique, combining clinical and legislative information, with the selling of services through a range of genres including fora, patient testimonials and infomercials (Johnson, 2012). They have been critiqued by Jain and Barbieri (2005) for being "primarily a form of advertising" and therefore open to abuse. Much of the work on clinical websites is based the US, thus, not directly comparable to the UK contexts, and this body of work is based mainly on studies of information quality (Spencer at al., 2016), adherence to legislature (Chan et al., 2014) and treatment claims (Huang at al., 2005). The few studies on social aspects of clinical websites are limited to ethical critique of barriers to access for same sex or single parents (Johnson, 2012), advertising social egg freezing (Barbey, 2017) and sperm donation (Johnson, 2011), again with little or no work in the UK context.

Recently Wilkinson et al. (2017, p. 6) conducted a study of UK fertility clinic sites and reported "An emphasis on pregnancy was evident, with pregnancy outcomes representing the most common way to report success". Although this gives some helpful context for my data it was not a linguistic analysis and currently there have been no studies of the language of fertility clinics.

2.3.2   Health Communication in the Press

As Lupton, (1999, p. 260) states "For many lay people, the mass media constitute one of the most important sources of information about health and medicine." rendering the media a rich source of data for researchers into the discursive construction of health and illness. While there is a large body of work in media and journalism studies, this review will focus on literature which covers the language of health in the news, specifically the language used to represent health/illness in the press.

Studies into news health coverage shows a preference for reporting of potentially serious illnesses, such as; cancer (Clarke and Everest, 2006; Seale 2001), mental illness (Holland, 2012), neurodegenerative disorders (Brookes at al., 2017; Peel, 2014) and hypertension (Collin and Hughes, 2011). There has also been a significant focus on the representation of population wide health "risks" including; AIDS (Lupton, 1992) obesity (De Brun et al., 2013), and SARS (Wallis and Nerlich, 2005). Common features in the findings of this literature include the framing of responsibility and causation (Brookes et al. 2017), which is usually individual rather than environmental, news values of personalisation and negativity (Bednarek and Caple, 2014) and surveillance medicine (Lupton, 1992).

Particularly pertinent to this thesis is the language of responsibility for health in news texts in which "negative health consequences involve the listing of symptoms or effects from a particular disease left untreated and/or inaction surrounding one's personal health" (Roy, 2008, p. 469). This neoliberal discourse of personal responsibility is prevalent in the study of infertility in the media, foregrounding potential risks of older motherhood (Campbell, 2011), and subsequent engagement with reproductive technologies (Budds, et al., 2013). Indeed, Shaw and Giles (2009, p. 222) found that "much negative discourse is circulated by the media about older mothers, from implied claims of selfishness (older mothers as 'delaying' conception) to violations of the 'natural order'." The negative evaluation of particular subjects in the media can lead to stigmatisation of those who occupy positions outside dominant norms, as Markens (2012, p. 1747) points out "dominant media narratives tend to reproduce conventional understandings of gender, family and motherhood".

However, for critical linguistic research, data which reproduces dominant discourses on a topic can be a valuable barometer of widely held beliefs, and in the case of this thesis a point of comparison with less "powerful" accounts.

2.3.3 Corpus linguistics and health communication

The use of corpus linguistics to study health and illness language can as Harvey (2012, p. 373) points out offer "hitherto undescribed insights" which cannot be accessed through more usual qualitative approaches to health communication. Seale at al. (2006, p. 2577) commend the use of corpus approaches to health language as "an effective substitute for the qualitative thematic analysis based on the coding and retrieval approach used in the majority of qualitative studies of illness experience".

However, early studies in corpus linguistics and health communication tended to focus on practitioner-patient interactions, for example: Skelton and Hobbs (1999) and Adolphs et al. (2004) used conversational analytic techniques rather than (critical) discourse analysis. With an emphasis on clinical communication and related training for practitioners this may be more accurately described as "applied clinical linguistics" (Adolphs et al. 2004).

Although my research is located in corpus approaches to health language, my interests lie in the wider societal implications of language choices rather than the use of corpus analysis as a practitioner teaching tool (Staples, 2015) or to study English for Medical Purposes (Grabowski, 2015).

Focusing on naturally occurring written data, my thesis aims to examine the language by which a condition or illness is discursively constructed. There is a growing body of work in this field, using analysis developed in CL and CDA to study social groups and phenomena, now applied to social problems in the health sphere. One way to achieve

this is to identify and code keywords to examine "their situated use in discourse" (Harvey, 2012. p 370) and so uncover salient topics around a given condition.

My work is at the interface of health online, the lived experience and media representations of a condition and the different discourses drawn upon by different text producers. As such, the corpus analysis of the linguistic manifestation of health issues such as self-harm (Harvey and Brown, 2012), and anorexia and depression (Hunt, 2013) informed data collection for my study as the data includes texts from both practitioners and people experiencing the condition.

While there is a growing accumulation of work on online health communication (such as the study of patient feedback to the NHS by Brookes and Baker, 2017) these studies are usually based on forum data from individuals experiencing a health condition (Harvey, 2012; Hunt and Harvey 2015), and it is rare to find studies of health blogs.

Most pertinent to my thesis, for data selection, is work by Semino et al. (2017), Demmen et al. (2015), and Potts and Semino (2017) which involved purpose built corpora on a topic of interest (end-of-life care in cancer) including blogs from health care professionals. However, the focus of analysis in both cases is on metaphor rather than a broader range of discursive features.

Corpus linguistic studies of the lived experience of an illness are scarce. An analysis of depression in journals of Sylvia Plath, (Demjen, 2014) uses keyword and concordance analysis, and there is some work on fictional portrayal of illness experience (Demjen, 2015; Hunt and Carter, 2012), and on forum data and interviews (Seale et al. 2006). However, I feel corpus methods are underutilised to study the lived experience of illness and one of the goals of my thesis is to address this gap.

While there is considerable work using corpora to study social phenomena in the news, surprisingly there is not a great deal of corpus work on health in the media. Notable

exceptions being work on sleep disorders (Seale et al. 2007), coverage of perceived health crises such as MRSA (Koteyko et al., 2008) or health supplements such as probiotics (Nerlich and Koteyko, 2008).

All of the above studies contain elements which I draw on in this thesis to examine corpus approaches to the discursive construction of health conditions, and to illuminate the case of infertility.

2.4 Infertility

This section provides an overview of infertility from a social perspective, with a focus on the UK context, salient terminology and studies of the representation of infertility in society.

2.4.1 Infertility in the UK

Whilst this study draws broadly on Western literature about the cultural representation of infertility (Adashi, 2000; Greil at al., 2010, DeLacey, 2002), the historical and legislative context will concentrate solely on developments in the UK from 1970s, and the public discourses which surround these developments.

In the UK, infertility is the most common reason why women aged 20–45 see their GP, after pregnancy itself and is estimated to affect one in six/seven couples (HFEA, 2012). There is currently broad acceptance of a biomedical model of infertility, and associated treatment of the condition is no longer considered particularly experimental or controversial by practitioners and publics (Adashi, 2000). However, prior to the 1970s the study of potential treatment for infertility, most commonly glossed as assisted reproductive technologies (ARTs), was viewed as controversial even within the scientific community (Spallone, 1989) with strong ethical concerns voiced by many.

With the stated aim of alleviating infertility in women with blocked or damaged Fallopian tubes, in 1970s, UK based researchers Robert Edwards and Patrick Steptoe (Brinsden et al., 2009) developed a technique for retrieving eggs from women via laparoscopy, fertilising the egg outside of the human body (in vitro) and implanting the egg in the womb in the hope that pregnancy would result. Despite the initial refusal of the Medical Research Council to fund Steptoe and Edwards' work on human conception during 1971 (Johnson, 2010) and amid considerable ethical opposition, in 1978 the first live birth resulted from this technique - Louise Brown, the world's first test tube baby (Spallone, 1989).

With the success of in vitro fertilisation (IVF) as a 'treatment' for damaged fallopian tubes, the medical indications for IVF in other instances of infertility grew rapidly, as did the development of other ARTs. Currently there are treatments for infertility licensed in the UK ranging from artificial insemination (AI) with partner or donor sperm to In Vitro Fertilisation (IVF) and Intra-cytoplasmic Sperm injection (ICSI) with over 50,000 fertility treatments performed each year in UK licensed clinics (HFEA, 2012). The biomedical background to infertility is inextricably linked with legislative issues such as regulation, access and licensing and as reproductive technologies advanced, public demand for ethical and legal regulation increased.

In 1982 the Committee of Inquiry into Human Fertilisation and Embryology (commonly known as the Warnock Inquiry, led by Dame Mary Warnock) was set up "to examine the social, ethical and legal implications of recent and potential developments in the field of human assisted reproduction" (Warnock, 1984, p. iv). The Committee comprised members drawn from the fields of law, theology, medicine, psychology and ethics and considered evidence from 398 external bodies and 695

submissions from the general public. The report of the Committee's findings was delivered in 1984 and became the key text in recent UK history of infertility definition and treatment (Warnock, 1984), instrumental in shaping the hegemonic discourse on fertility since its publication until the present day. The sheer breadth of the scope of this document and the changes enacted in response to it form the bedrock of fertility and embryology regulation in Britain. Albeit with several key changes, the Warnock report provides a framework for many of the current debates in infertility including issues of consent, anonymity, counselling and eligibility in relation to treatments. There were several key findings of the Report (Warnock, 1984), perhaps the most significant in terms of support of the biomedical model is that the Committee "concludes that infertility is a condition meriting treatment" thus cementing the role of medical intervention in addressing infertility. In the terms of reference of the Report these medical treatments included AI, IVF, egg donation, sperm donation and surrogacy.

The Inquiry also addressed issues of parenthood both in terms of the disruptive effect of infertility on life expectations and in the constitution of familial relations, in which case it was recommended that "as a general rule it is better for children to be born into a two-parent family, with both mother and father" (Warnock, 1984, p. 11). Framing debates on the implications of using new reproductive technologies to alleviate infertility, the Report explicitly addressed the delicate balance between private and public morality and the need to consider the best outcome for society and the individuals within that society. The inquiry also examined the position, needs and rights of all "actors" within an infertility environment including parents, donors, children, practitioners and the wider public and expressed criticism of attitudes towards infertility, signalling a need for change.

One of the main remits of the inquiry was to address and formalise regulation of the application of new reproductive technologies. In addition to recommendations for improved data collection and the need for better information on infertility for both public and practitioners, a key outcome of the Report was the expression of an urgent need for a legislative framework for fertility treatments and the related field of embryology, where previously regulation and law was limited or non-existent.

The recommendations for improved regulation of new reproductive technologies resulted in the formation of the Interim Licensing Authority which, in 1985, was established to regulate work on reproductive technology until the introduction of government legislation as per the Report. This was superseded in 1990 by the Human Fertilisation and Embryology Act and the resulting regulatory body, the Human Fertilisation and Embryology Authority (HFEA), in 1991.

Since 1991, the Human Fertilisation and Embryology Authority (HFEA) has licensed and regulated treatment and research centres using eggs, sperm or human embryos and provided "authoritative information for the public, in particular for people seeking treatment, donor-conceived people and donors" (HFEA, 2012). The HFEA also plays a key role in consultation on and formation of public policy relating to reproductive technologies. The Human Fertilisation and Embryology Act 1990 has been supplemented by several additional legislative instruments including regulations on the use and storage of embryos and gametes and the treatment of donor information, including the right to anonymity. The most recent and significant changes, however, resulted from a review of the 1990 Act and subsequent amendments to this Act which

came into force in 2009-2010. These amendments provided significant changes to the 1990 Act, particularly in the definition of "parenthood", specifically;

> "requiring that clinics take account of "the welfare of the child" when providing fertility treatment, and removing the previous requirement that they also take account of the child's "need for a father", allowing for the recognition of both partners in a same-sex relationship as legal parents of children conceived through the use of donated sperm, eggs or embryos and enabling people in same sex relationships and unmarried couples to apply for an order allowing for them to be treated as the parents of a child born using a surrogate". (HFEA, 2008[4])

Providing a reversal of the Warnock definition of parents as a heterosexual couple, these amendments theoretically open up avenues of medical intervention for same sex couples and single women who are experiencing infertility without the requisite two years of unprotected heterosexual intercourse previously used to define infertility.

Whilst the HFEA provide a regulatory policy framework for the treatment of infertility, the guidelines on best practice in the treatment of "people who have problems getting pregnant" and the clinical provision of ARTs are developed by the National Institute for Clinical Excellence (NICE), a division of the National Health Service in the UK. NICE provides peer reviewed, evidence-based guidance for clinicians and (potential) patients on the most effective ways to diagnose, treat and prevent disease and ill health and care quality standards. The current NICE guidelines on infertility, published in 2013, provide best practice information "on the care of people in the reproductive age group who perceive problems in conceiving" (NICE, CG156) i.e. those who present for treatment to their GP with concerns about their fertility. Guidance is provided on a range

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[4] http://hfeaarchive.uksouth.cloudapp.azure.com/www.hfea.gov.uk/134.html

of clinical issues relating to infertility including, initial lifestyle advice to presenting patients, definition of infertility, types of treatment for infertility, eligibility for treatment on NHS and costing models and algorithms. This advice also forms the basis for advice provided by the NHS.

2.4.2   Infertility – what's in a name?

The Oxford English Dictionary (OED, 2012) defines infertility as "the quality or condition of being infertile" with further investigation, infertile is glossed as "not fertile", with fertile as "bearing or producing in abundance; fruitful, prolific" thus infertility is by its very nature defined by that which it is not.

This act of labelling a concept so heavily defined by absence whilst still loaded with meaning is a key problem of (in)fertility studies. The multidisciplinary nature of this subject, encompassing medicine, gynaecology, embryology, sociology, psychology, philosophy, law, ethics and even literature, and even lack of an agreed definition within disciplines (Gurunath et al., 2011), results in a range of sometimes contradictory definitions of infertility.

There is also significant variation within the literature on chronological, geographical and cultural bases, thus even the decision to use the term "infertility" can only be reached after examination of this potential lexicon. Many terms in gynaecological and psychological literature are imbued with medical connotations, such as subfecundity (Greil et al., 2010), involuntary infecundity (Schmidt and Munster, 1995), and sterility, used as direct referents to a 'patient', whilst sociological and anthropological studies tend to embrace more subjective, experiential terminology such as "difficulty conceiving a child" (Allison, 2011), "having an experience with infertility" (White et al., 2006), and "having fertility issues" (British Infertility Counselling Association,

2011). Consistent to the whole lexicon, however, is a marker of abnormality, the absence of that which is 'normally' present.

With a variety of possible social and biomedical definitions possible, many studies elucidate a distinction between what Letherby (2002, p. 278) describes as "the difference between the biological condition of 'infertility' and the social experience of 'involuntarily childlessness'".

Biomedical studies of infertility, understandably, embrace guidelines from national or international regulatory bodies, such as the World Health Organization (WHO), which label infertility as a "disease" or from professional bodies, for example the American Society for Reproductive Medicine (ASRM) website states that,

> "Infertility is the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery".[5]

In most cases these biomedical guidelines also give a time period after which a person or couple is deemed to be experiencing infertility, in most cases after one to two years of regular sexual intercourse using no contraception there has been no pregnancy (WHO, 2012) and this key concept of 'time' is one I shall return to.

However, social scientists studying 'infertility' or more often 'involuntary childlessness' are critical of the delimiting nature of these definitions, pointing to the range of possible circumstances under which a person may experience 'infertility' (Letherby, 2002) including but not limited to, an inability to conceive, an inability to carry child to term, inability to have further children (secondary infertility), those who cannot have children for social or economic reasons and those parenting non biological

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[5] http://www.reproductivefacts.org/topics/topics-index/infertility/

children. Even women who have children or go on to have children may still identify with the 'label' infertile (DeLacey, 2002; Throsby, 2004). Many social scientists expressed a preference for the term involuntarily childless, (Thompson, 2006; Earle and Letherby, 2003; Johansson and Berg, 2005, Becker, 2000) which while gaining acceptance in academic writing is confined to this area and rarely found in accounts of the lived experience, although this could be read as an indictment of the limited positions offered.

One of the strongest themes of both biomedical and social accounts of 'infertility' is the negotiation and self-definition of 'infertile' or experiencing 'infertility', with both categories as malleable and dynamic rather than fixed what Greil et al., (1988, p. 175) describe as "the consensual process of becoming infertile". In later work, Greil et al., (2010, p. 141) go on to posit:

> "Infertility is best understood as a socially constructed process whereby individuals come to define their ability to have children as a problem, to define the nature of that problem and to construct an appropriate course of action."

As there is not a single pathology of infertility, rather an absence of a desired state, a cline of 'infertility' develops from initial concerns over the ability to conceive, to the seeking of (often medical solutions), to one of several possible outcomes (Clarke, Martin-Matthews and Matthews, 2006). Thus, individuals negotiate where to position themselves on this cline and this may change according to external factors (costs, health, relationship, alternative outcomes, conception) and internal factors (rejection of medical intervention, acceptance of childfree living).

By adopting this dynamic, self-reflexive model, studies of infertility place the 'self' at the centre of defining 'infertility', a position which I shall also adopt as currently, this term is most frequently used and therefore most likely to be identified with by those experiencing this condition.

2.4.3   Assisted reproductive technologies

One of the most problematic dimensions of defining terms in this area is the near universal conflation of 'infertility' with the use of assisted reproductive technologies, such as donor insemination and in-vitro fertilisation. Many studies are censorious of the 'medicalisation' of what was, until recently, viewed as a social condition (Becker and Nachtigall, 1992; Becker, 2000; Greil et al., 2010; Thompson, 2006) and point to the development of this dominant medical model as concomitant with the development of assisted reproductive technologies (ARTs) from 1970s onwards.

Conrad (2007, p. 13) posits that "medicalization occurs when previously nonmedical problems become defined (and treated) as medical problems, usually as an illness or disorder", thus the experience of this "problem" is socially constructed to necessitate clinical/medical solutions. This is of relevance to infertility as according to Greil et al. (2010, p. 141) "the social construction of health and illness is perhaps even more striking in the case of infertility than it is for other conditions".

The relationship between infertility and ARTs also contributes to a model in which women/couples are deemed infertile when they seek, and crucially meet the appropriate criteria for medical approaches to infertility, thus there are many studies into the commencement (Becker, 2000; Bunting and Boivin, 2007) and cessation (DeLacey, 2002; Throsby, 2004) of fertility treatment and the psychosocial effects of this.

According to Brown (1995), diagnosis is a key aspect of medicalisation and in the case of infertility diagnosis represents the time and location where medical professionals and other parties determine the existence and legitimacy of a condition.

Sangster and Lawson (2014, p. 493) identified a biomedical model of infertility caused by delayed childbearing, p. resented as a women's issue and "As such, it may be difficult for them to respond to infertility in any way but by the pursuit of medical interventions". In summary "Infertility is dominated by medical discourses associated with abnormality, treatment and cure" (Gillespie, 2000, p. 225). However, "treatments do not target the etiologic factors of infertility; instead, they circumvent those factors in an attempt to achieve the desired outcome, a biological child" (Sandelowski, 1990, p. 477).

Despite the reservations voiced about medical models of infertility, most studies in this area recruit respondents from a population who are already seeking advice or treatment for their concerns about fertility (Ulrich and Wetherall, 2000; Malik and Coulson, 2008) and thus data is almost exclusively drawn from those who have chosen to position themselves within this biomedical sphere (Greil at al., 2010). Indeed, some researchers have undertaken ethnographic studies within fertility clinics in order to uncover hidden discourses and elicit 'other' voices in the clinical environment (Becker, 2000; Thompson, 2006).

The dual issues of treatment seeking as self-definition and data collection via clinical settings leave researchers limited options in contesting the normalisation of ARTs as a standard response to infertility. However, this does not necessarily devalue further study of how the hegemonic medical model of infertility is both constructed and contested (Thompson, 2006).

While medicalisation is not necessarily a negative process, potentially more problematic is the marketization of infertility as "Health care and health are increasingly

commodified" (Mooney, 2012, p. 398). This is problematic for the experience of infertility as Conrad and Leiter (2004, p. 168) point out "Consumers who wish to have biological children are drawn to technological solutions to infertility".

Much of the early feminist, critical literature on infertility is centred on debates around, and condemnation of, ARTs, positioning women as 'dupes', passive and agentless in the face of patriarchal technology acting upon the female body (Corea, 1985; Spallone, 1989) or of ARTs answering a 'desperate' need for a child (Franklin, 1997). However, later studies have suggested that the act of engaging with reproductive technologies can be emancipatory, engendering a feeling of control with positive effects (DeLacey, 2002; Earle and Letherby, 2007, Silva and Machado, 2011).

2.4.4   Infertility – parenthood, disruption and stigma

Several recurring themes emerging within social scientific literature on infertility broadly classified as; identity/self, parenthood, life course/life crisis, public perceptions and stigma.

As mentioned when problematising definitions of infertility, many studies take the position that the ability to reproduce is integral to satisfactory construction of self and that a disruption to the standard reproductive trajectory causes a serious disruption to one's identity (Clarke, Martin-Matthews and Matthews, 2006; Earle and Letherby, 2007; Greil et al., 2010). Considerable work has been done on how those who experience infertility, particularly women, chose alternative life narratives and identity construction as a way of negotiating this disruption (Ulrich and Wetherall, 2000; DeLacey, 2002), and this is particularly the case for those who fall outside of heteronormative discourses of family relationships and reproduction (Nordqvist, 2008).

The pronatalist ideology underpinning many cultural beliefs and values around gender roles and parenting perpetuates the notion that "motherhood is the defining element of true womanhood" (Parry, 2005, p. 338) and social conceptions of motherhood have long constructed the role of mother as universal, stable, and natural among women, amounting to a "motherhood mandate" (Russo, 1976, p. 143).

Most studies of infertility initially assume what Bunting and Boivin (2007, p. 1662) describes as the "near universal desire to become a parent", a reasonable assumption in the study of those who are seeking help to realise this desire. Very few studies contest the hegemonic positioning of parenthood as an essential part of selfhood. However, some do seek out those who have attained this through unconventional means including conception via ARTs (Letherby, 2002) and the effect this has on the construction of biological identity.

Although I have construed this hegemonic position as the ideal of parenthood, the majority of studies into infertility, particularly the psychosocial aspects, focus on women and constructions of motherhood (Franklin, 1997; Becker, 2000; Throsby, 2004; Earle and Letherby, 2007). Despite medical literature focusing on the treatment of couples, and heteronormative presentations of the nuclear family as a successful outcome of ARTs, most studies into provision of ARTs and patient responses thereof are focused on the female experience (Becker, 2000, Thompson, 2006). There are a limited range of studies into male perspectives on infertility and its effect on masculine identity (Gannon et al., 2004; Malik and Coulson, 2008). However, the majority of studies which do not focus solely on women examine gender differences in responses to infertility (Greil et al., 1988; Slade et al., 2007; Throsby and Gill, 2004) generally comparing reactions within individual couples, looking at the relational effect of infertility as well as broader societal responses. It was found that whilst levels of distress

within couples do not generally differ according to gender (Greil et al, 2010) the likelihood of disclosure to social networks was higher in female respondents, even when this is correlated with higher levels of reported distress (Steuber and Solomon, 2011). The inability to biologically reproduce is frequently presented as a life crisis, almost universally deemed to be responsible for increased levels of personal and relational distress as described above. The responses to infertility described are often analogous to those related to other serious disruptions to expected life narratives, particularly serious health issues (Becker, 1997). Whilst in some cases infertility is the result of a primary medical condition, in many cases it remains unexplained. However, the hegemonic discourse of health and illness holds across cases, whatever the reason for an infertility diagnosis (Becker and Nachtigall, 1992; Throsby, 2003; Greil et al., 2010). This is in part related to the conflation of infertility and medical responses in the form of ARTs. However, it is also suggested that the use of a medical discourse to present infertility is helpful to those who experience it "by lending medical legitimacy to their failure to conceive" (Becker and Nachtigall, 1992, p. 456) and legitimising the helpseeking model (Malik and Coulson, 2008b). The public perception of infertility as a medical condition which can legitimately be treated is only one strand to the complex public discourses of infertility which those involved in fertility issue whether as patient or practitioner must negotiate. Studies have shown a fear of public stigmatization informs many experiences of infertility (Allison, 2011; Gannon at al., 2004; Slade et al., 2007), with fears over inability to live up to normative representations of femininity and masculinity. However, there is little evidence of negative public responses to those who are experiencing infertility (Adashi, 2000), despite concerns over policy issues such as costs and the improper use of ARTs (Campbell, 2011). This suggests that it is

wider hegemonic gender positions and power relations which are being brought into play in discourses on fertility and reproduction.

This chapter has drawn together the main literature around both methodological and topical aspects of the thesis, namely corpus-linguistics and the experience of infertility. As discussed above, the methodology of this thesis is supported by a substantial body of work in combining corpus linguistics and discourse analysis as applied to social issues. However as stated in section 2.3.3 there is still comparatively limited research into discourses of health and illness using corpus methodology. I would argue that the affordances of this method, using specialist data sets and providing an evidence based approach to a topic is particularly suited to the study of health discourse.

Infertility as a social phenomenon is much studied in fields such as medical sociology, anthropology and health psychology and this has informed the context of my thesis, especially work on the lived experience of infertility and its disruption to life course and identity (Letherby, 1999; Becker, 2000).

There has however been limited research into the linguistic manifestations of infertility and one of the primary aims of this thesis is to address this gap.

The four analysis chapters (4-7) will utilise the corpus-assisted methods described, to explore the lived experience of infertility, informed by the social science literature described above.

The following chapter will set out the methodology of the thesis including data collection and analysis procedures.

Chapter 3 - Data and Methodology

3.1 Introduction

The rationale for my data selection initially appeared simple: to compile a corpus of texts from different genres all addressing the topic of my thesis, infertility. In reality, the process was more complex, as my choice of both data and analytical methods went through a series of iterations before it settled into its final form.

In this chapter I detail some of the methodological choices I faced, relating to data collection, ethical concerns and how to combine corpus linguistics and discourse analysis in the most rigorous and meaningful way for my particular data set and research questions. I provide a justification for the novel approach of using the Patterns tools for corpus-assisted discourse analysis and set out the step by step process of analysis which underpins chapters 4-8. I do not discuss theoretical concerns around corpus linguistics and corpus-assisted discourse analysis as these have been critiqued in detail in Sections 2.1 and 2.2 in my literature review.

3.2 Data collection

3.2.1   Introduction

Following the statement by Partington (2008, p. 189) that "CADS is also typically characterised by the compilation of ad hoc specialised corpora" my methodology begins with the creation of such "specialised corpora" on the topic of infertility in a UK setting. Rather than collecting one large corpus, a key feature of this thesis is data triangulation (Patton, 1999) provided by looking at three different text types all focussed on the same topic, infertility. As Denzin (2012, p. 82) points out "The use of multiple methods, or triangulation, reflects an attempt to secure an in-depth understanding of the

phenomenon in question." Rather than claiming that this method provides greater objectivity, it instead provides complementarity, enriching the findings from each perspective by comparison with others and it was this complementarity which drove my choice of data.

An initial question arose during data collection of the choice of terminology around labels for "infertility". Many academic papers in the social sciences use the term *involuntary childlessness* (Malik and Coulson, 2013; Letherby, 2002). However, none of the personal accounts included this term. Equally, medical journals use a range of clinical terms including *subfertility*, and *subfecundity* (King, 2003) which again did not reflect individual accounts. From reading personal accounts along with HFEA, NICE and WHO definitions, *infertility* and *infertile* are the terms which I use both to describe the condition and as search terms in compiling the corpora.

While building one's own corpus is an excellent way of creating a snapshot of a specific topic/text type at a moment in time it is not without challenges. Alongside the issue of search terminology, the use of small specialist corpora also requires a large input of researcher time both in collecting the data and in preparing it for use with the appropriate software. This process will be described in the following section.

Addressing the size of a specialist corpus, McEnery, Xiao and Tono (2006, p. 15) suggest that, "specialized corpora tend to be domain or genre specific" and according to Handford (2010, p. 260), "the more specialised the genre the smaller the corpus can be", which goes against the commonly held view in CL that bigger is better (Sinclair, 1991). Hunston (2002, p. 27) makes the pragmatic assertion that "a corpus user makes use of as much data as there is", which is especially true when examining a specific genre or text type in a specialist corpus and the approach I have taken. For discussion of the datasets chosen see Section 1.4 in the Introduction.

3.2.2   Collecting the BLOG Corpus

I follow the working definition of blogs provided by Herring et al. (2004, p. 1) "Blogs are frequently updated websites in which messages are posted in reverse chronological sequence, typically by a single author." In the case of the blogs I collected the "single author" is a person (woman) who self-defines as infertile and who is writing in the UK from the period 2005 to 2011. This time period was used for pragmatic reasons of data which met the criteria for my study being available from 2005 until data collection ended in 2011.

The use of blogs for linguistic research, particularly in the field of health and help-seeking is discussed in my review of literature on health communication (2.3) so in this section I focus more on the collection of blog texts.

Although they provided the richest and most unique insights, the blogs were the most problematic data set to collect, both in terms of ethical and practical considerations. I first used specialised blog search engines with the search terms "infertility" and "infertile". There are many blogs on infertility although a large majority are not written by people in the UK and thus are not suitable in the context of this study. It became clear that to locate a dataset of UK-only blogs it would be necessary to include geographically specific terminology including NHS, GP and UK. From these search terms an initial set of 8 blogs were returned and checked for location – this could usually be elicited from a blogger's "profile" or "About Me" section.

From this point I used a quasi-snowball sampling methodology, checking the "blogrolls" of the initial 8 websites to elicit further blogs from the infertility blogging community in the UK, giving me a final total of 31 sites. All the blogs selected were publicly available, non-password protected and written over a period of at least 6 months, with at least 3 entries per month.

At this point I made contact, where possible, with the bloggers whose work I intended to use asking for consent. (For further discussion of ethics see section 3.4) This reduced the dataset to 25 blogs.

I collected the blogs using the specialist web crawling software HTTrack[6] which allows websites to be downloaded and a "mirror" of the site saved for offline retrieval. The sites were saved as .htm files then converted to .txt files to allow them to be readable by corpus software. HTTrack also enabled the exclusion of media file types such as .wav and .mp3 as these would not be used in this thesis.

Both automated and manual cleaning of the texts was necessary to remove boilerplate and create metadata headers (which will be excluded from corpus software analysis) of the month and author of each text. The blogs were then saved by author, year and month (see Figure 3.1 below). All blogs were anonymised and given an identification code meaning only I could access identifying data i.e. the blogsite from the code.

Contextual information was saved separately and included (where it was possible to ascertain it) the gender, relationship, location, age, reproductive status at last recorded blog post and treatment history of each blogger. All the blogs were written by women aged 25-45, 24 out of 25 of them were in heterosexual relationships, while one was single but identified as heterosexual, all had accessed treatment from Assisted Conception Units which ranged from initial consultation and investigation to IVF. Only one blogger had previously had a child (see APPENDIX I for full table of contextual information).

When collecting the blog data, I made the decision not to down-sample from larger sets but dealt with possible skewing by looking at distribution patterns across the keywords and search terms. Thus, exclusions were made when it was clear that a term was only

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[6] https://www.httrack.com/ HTtrack is a free software offline browser (Retrieved 5/3/2017)

used by a single blogger and therefore indicative of their idiolect rather than general patterns of use.
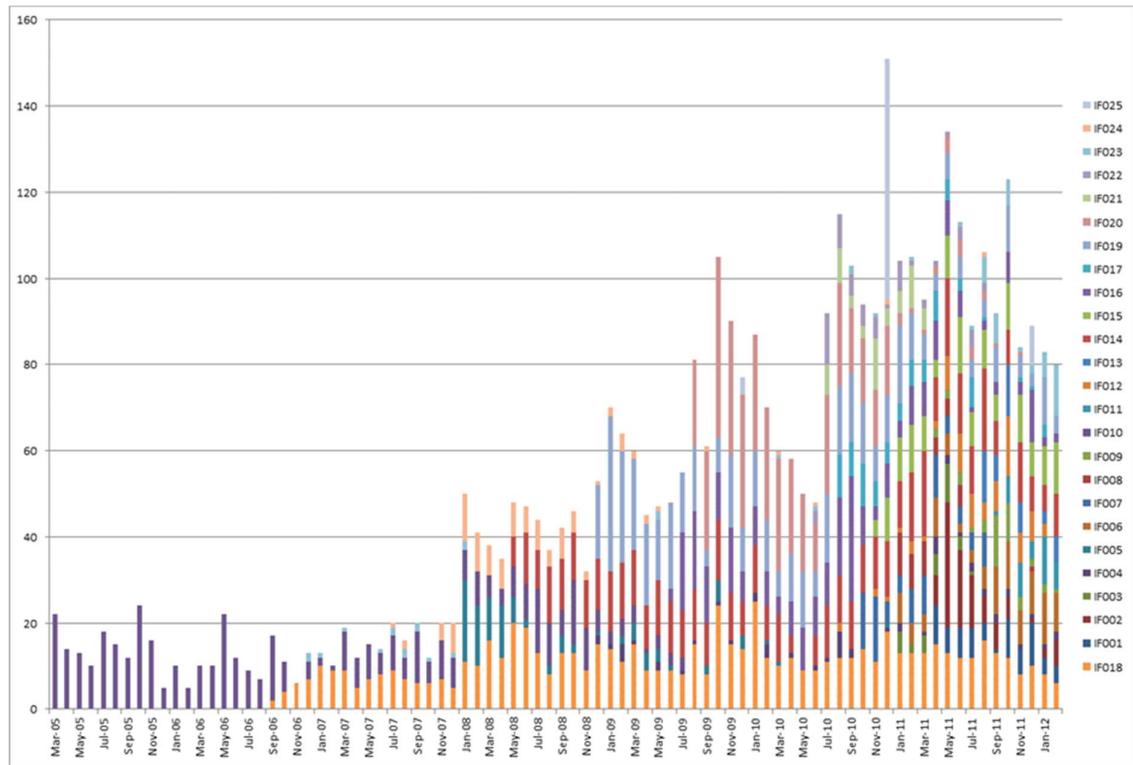
Figure 3.1 *Distribution of BLOG corpus by author, month and year*

3.2.3   Collecting the NEWS Corpus

The NEWS Corpus, once issues of search terms were resolved, was a relatively straightforward process, informed by many previous CL studies of news data (e.g. Jaworska and Krishnamurthy, 2012; Baker et al., 2008; Taylor and Marchi, 2009).

Data for this corpus was retrieved using NexisUK[7], an online, searchable archive of full text news articles from around the world. This allowed articles to be collected and downloaded in electronically readable form as .txt files for ease of processing. However, it is not possible to view these articles in their original context via this database or to view any images which accompanied them. As this corpus was intended to provide a

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[7] https://www.nexis.com/

broad overview of the construction of infertility, the search parameters were set to retrieve all articles including the terms *infertile* or *infertility* in all UK national newspapers written within a six-year period from 1 January 2006 – 31 December 2011, resulting in articles from 16 source publications including Sunday editions (see Figure 3.2). Data collection was led by the blogs; indeed, this is the case for my analysis and the timeframe for the NEWS Corpus mirrored the time period for the BLOG Corpus. I manually removed articles which appeared in multiple editions of the same newspaper but duplicate articles across publications were left in as Taylor (2013, p. 82) points out "the duplicate articles published in the different newspapers were important because they can tell us something about messages being delivered and endorsed". I also manually removed articles which were not written about the UK setting, which only had a single mention of infertility or were referring to infertility in non-human species.
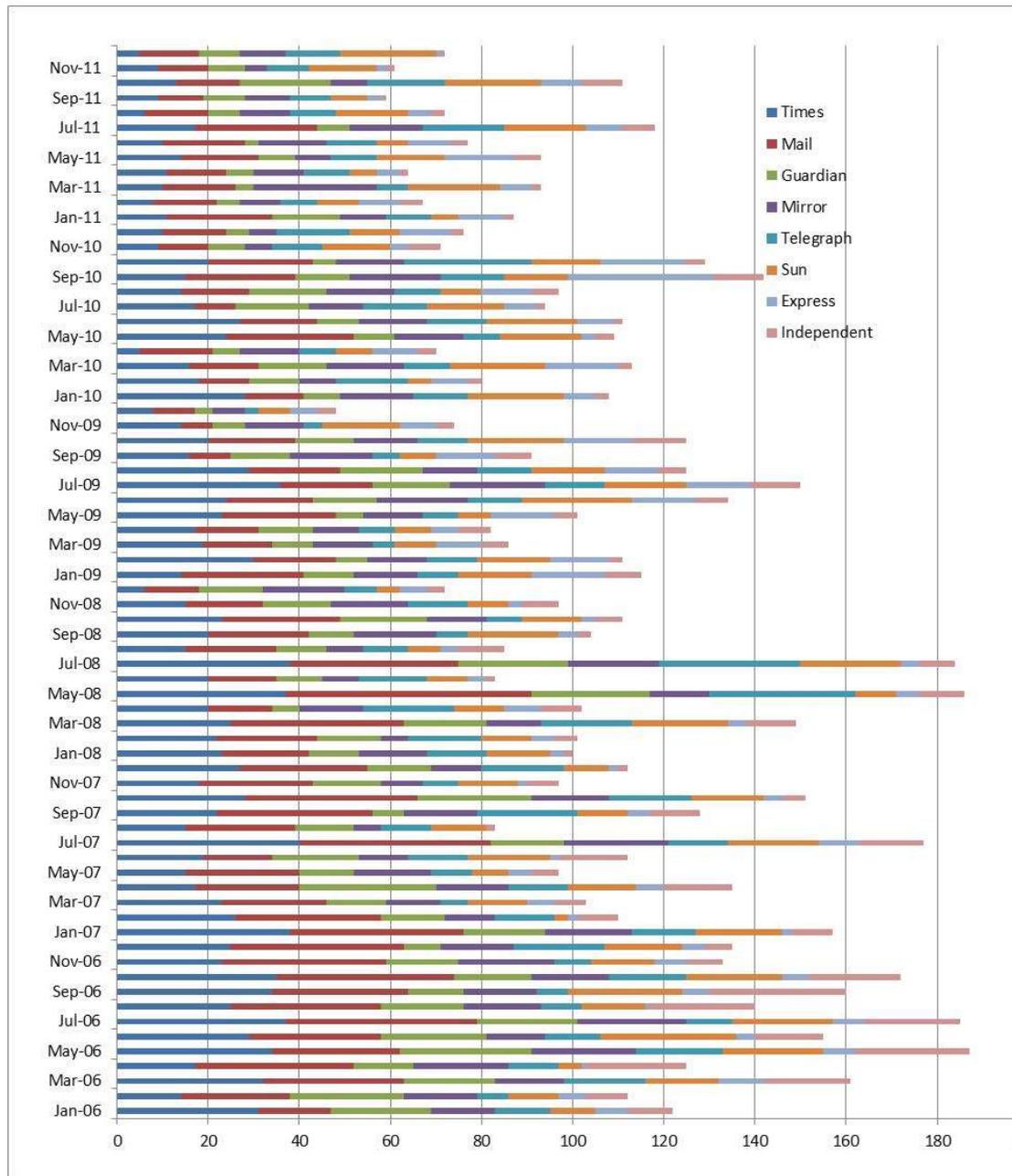
Figure 3.2 Distribution of NEWS Corpus by month, year and publication

3.2.4   Collecting the CLINIC Corpus

The CLINIC Corpus contains texts from 44 UK websites on infertility collected in February 2012. These sites were sourced from the Human Fertilisation and Embryology Authority (HFEA) UK "find a clinic" web search (see Figure 3.3 below), which patients

in the UK are directed to as a way to locate a treatment centre in their area, providing a link to the clinic's website and statistics.

Figure 3.3 An example of the HFEA clinic search (retrieved in 2011)

Forty-three UK fertility clinic websites were found via this search, all of which treat both private and NHS patients. This corpus also includes the generic NHS advice site on infertility but not the HFEA website as this is a regulatory body rather than a front-line service provider engaging with people who experience infertility.

The collection of websites followed the same methodology as the BLOG corpus (section 3.2.2) using HTTrack to collect whole sites, and convert them to .txt files which were then prepared for analysis by removing boilerplate and adding headers.

3.2.5   Overview of data collected

The total texts and words in each corpus are shown in Table 3.1 below.

Corpus	Words	Texts
BLOG	1,604,725	4207
NEWS	5,259,717	8039
CLINIC	768,178	447

Table 3.1 Total words and texts by corpus

3.2.6 Choosing a reference corpus

As Partington (2008, p. 101) points out "it is only possible to both uncover and evaluate the particular features of a discourse type by comparing it with others." In this thesis rather than comparing each of the three corpora to the other two (i.e. compare BLOG with CLINIC & NEWS) all the corpora are compared individually to the same reference corpus. This method of comparison elicits not just the lexical differences between the corpora but also the similarities (for more on this see section 3.3 on keywords).

Ideally a reference corpus should be of an appropriate language and text type for comparison, large enough in comparison with the chosen corpora, however when Scott (2010, p. 86) went "in search of a bad reference corpus" he concluded that comparing different texts against randomly selected reference corpora of varying sizes "very much the same keywords are generated whatever the RC used." (ibid).

Considering that my data is authored by 21st century British English writers, ideally, my reference corpus should also consist of written texts in British English. Although the British National Corpus is often a popular choice, the data is from the early 1990s. Also, the inclusion of computer mediated communication from the 2000s in my study corpora meant that the UK WebAsCorpus[8] (hereafter UKWaC) contained more similar text types than the BNC. The full UKWaC in its 2-billion-word entirety was so large as to make processing restrictively slow, so a 10 million word, downsampled, representative, subset was used. This was kindly provided by UKWaC. The corpus contains web pages that end in a .uk extension, indicating that they (are likely to) have be authored by a British person. The pages were collected using medium-frequency words from the BNC as seed words (words used in search algorithms to identify candidate texts for inclusion).

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[8] http://clic.cimec.unitn.it/marco/publications/lrec2008/lrec08-ukwac.pdf

3.3 Ethical considerations

The ethical protocol for this study was developed in accordance with the Association of Internet Researchers Ethics Guidelines (2002) and ethical approval was sought and granted by the Lancaster University Ethics Committee. The main ethical consideration in this study is the potentially sensitive nature of data collected from blogs on infertility. However, all blogs selected as potential data are fully accessible to the public via the web. Ethics research in this area provides a framework to ascertain whether the intent of the blogger is public or private interaction and suggests where blogs are fully searchable, non-password protected and have a comment function that this is intended as a public text (AOIR, 2012). Bloggers were contacted via email and given the opportunity to remove their data from the study prior to data collection (following the protocol used by King, 2009). No bloggers actively withdrew from the study, however 5 blogs changed their security settings from public to password protected and I chose to remove these from the study, as I no longer felt them to be public domain from an ethical viewpoint.

In addition to the consent procedure, I followed several precautionary principles when using the BLOG Corpus data: all demographic information is stored separately from the textual data; all identifying language including names of people, places and clinics were redacted from quotes used in publication; all quotes in publications are anonymised and I do not, and will not, reproduce the URLs of the blogs I gather data from.

Due to the public nature of the blogs I am aware that using extended quotes from the blogs in presentations and publications could be identifying and I attempt to mitigate against this by limiting the quotes used in public presentations or using aggregated quotes (all quotes in thesis are in full and as found in original text). Whilst it may be possible to identify some blogs due to the time between the data collection and

completion of this thesis now only 2 are active, 23 are dormant or have been taken down.

3.4 Analytical framework:

My analytical approach is essentially mixed methods drawing on a tradition combining Corpus Linguistics and (Critical) Discourse Analysis dating from the seminal paper by Hardt-Mautner (1995). The approach to analysis is most markedly influenced by work from Baker et al. (2008) and the Corpus-Assisted Discourse Studies of the Siena/Bologna group (Partington, 2003) (see section 2.2 in the Literature Review for further discussion of this approach).

Two key aspects to my research are inspired by Baker at al. (2008). Firstly, that I am carrying out "context based research" (ibid: 283) and secondly that

> "researchers ought to carry out background research and form hypotheses in advance of doing corpus-assisted analysis, rather than approaching the corpus from a naive position" (ibid: 284).

In practice, while only 3 sets of data were collected for analysis, this was informed by a range of texts about infertility, the Warnock Report (1984), information provided by the Human Fertilisation and Embryology Authority, and discussions with clinicians, counsellors and patients within an infertility clinic. This process was not linear but rather iterative over the period of my PhD candidature as further information was gathered which caused me to reflect on and in some cases, alter the direction of my analysis. For example, discussions with patients and practitioners foregrounded clinical encounters leading to an extended discussion of the term *clinic* in the Medicalisation chapter, rather than a small subsection of a planned chapter on social actors.

My research is also situated within critical studies of health language (for further discussion of this see section 2.3).

3.4.1 Discourses

Rather than explore in detail the considerable academic debate into the definition of discourse(s), which I have discussed in the literature review section 2.2.4, I will instead provide a working definition of the terminology as it will be used in this thesis.

Broadly following Sunderland (2004) my analysis seeks to interpretatively identify discourses through the examination of repeated linguistic patterns, while acknowledging that "There is no finite set of discourses; discourses are not bounded and not even visible; they are historical and transient; they are continually produced and reproduced." (p 3).

The definitions shown in Table 3.2 are used throughout the thesis, to disambiguate the repeated use of the term discourse.

Term	Definition
Discourse	A 'way of looking at the world' or constructing a version of reality which is realised by use of a collection of linguistic features (often repetitively) linked to social practices which they describe. I have named each Discourse based on the main ways it constructs a reality of infertility.
Discourses of infertility	Discourses which specifically relate to the ways that infertility is understood or represented.
Overarching discourse	A discourse which draws on multiple sub-discourses and exemplifies a major component of the way in which the experience of infertility is understood and is found across multiple contexts and linked to several keywords.
Sub-discourse	A significant and repeated way that infertility is described which contributes to an overarching discourse but is not necessarily found across all text types or is linked to multiple keywords.
Normative discourses	Discourses which support normalised views or practices – and tend to be taken for granted e.g. heteronormative reproduction.
Dominant discourse	Discourses that are most frequently drawn on and/or are associated with powerful social actors.
Minority discourse	Less frequently drawn-on discourses, confined to particular text producers, and thus less likely to be associated with powerful social actors

Alternative discourses	Discourses which do not actively contest other discourses but provide a different view to another discourse.
Contesting discourses	Discourses which actively and/or consciously oppose another discourse
Discourse marker	A word used to structure the flow of spoken or written discourse e.g. well, oh

Table 3.2 Definitions of discourse and discourses

3.5 Tools for Corpus-assisted discourse analysis

Hunston, (2002, p. 3) makes the point that a corpus cannot do anything on its own and it is the use of appropriate software which is necessary for analysis of corpus data. My software of choice for this thesis is Wordsmith Tools (Scott, 2008) Version 5, "an integrated suite of programs for looking at how words behave in texts."[9] At the time I began my analysis Wordsmith was the most popular corpus analysis tool, one I| had used in previous work (Donnelly, 2007), and one which allowed a greater functionality than, for example, AntConc (Anthony, 2005) or Sketch Engine (Kilgariff, 2004). As my analysis came to be based on the use of the Patterns tool in Wordsmith, a function not available in the other corpus software, this proved to be a good choice. The following sub sections give information about the corpus analysis procedures available in WordSmith 5.

3.5.1 Wordlist Tool

The Wordlist Tool is in some respects the simplest of the suite of tools, used to compile a list of all words which occur in a corpus to then be sorted by various parameters (i.e. frequency, alphabetically). While some corpus-based studies of discourse use a Word Lists as an analysis tool in its own right (Baker, 2012, p. 101) it is more frequently used as a route to the creation of Keyword Lists.

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[9] As this quote is taken from online documentation that accompanies WordSmith Tools, no page numbers are given for Scott (2016).

3.5.2 Keywords Tool

According to the author of the Wordsmith Tools, Scott, (2016) "Key words are those whose frequency is unusually high in comparison with some norm" and "provide a useful way to characterise a text or a genre." Keywords are generated by comparing two Wordsmith derived word-lists, one from the study corpus, the other from the reference corpus, working on the assumption that the smaller (study) corpus is the focus of interest for characterisation.

The keywords in this thesis were calculated using Log Likelihood tests on each word with a cut-off points as follows: p value of 0.00001, minimum frequency = 10, minimum % of text =10%.[10] These cut-off points ensured that I did not spend time focussing on keywords that were very infrequent or only occurred in a small, unrepresentative number of texts in my corpora.

3.5.3 Concord Tool

The Concord Tool allows the researcher to look more closely at certain words in context, by finding all the examples of a search word in a text or set of texts. Through looking at repeated examples of the context of the word it becomes possible to analyse patterns of usage, and elicit potential patterns of meaning. The Concord Tool can be used to calculate the collocates of a word, clusters (or n-grams), concordance lines, frequency patterns of collocates and the distribution (plot) of a word across texts. One novel aspect of my thesis is the use of frequent collocate "patterns" to examine the possible meanings and prosody around my search terms. Although this is my focus, I also use concordances and distribution plots to recheck my intuitions from the Patterns and to check whether patterns are representative or skewed by overuse in a given text.

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[10] Log-likelihood tests are a form of hypothesis testing which indicate the amount of confidence that we can claim that a word is actually a keyword (e.g. that there is a frequency difference between its occurrence in two corpora). The test does not indicate how strong the difference is likely to be.

According to McEnery, Xiao and Tono (2006, p. 147), concordances "allow us to observe the behaviour of a particular word-form in detail". In their most simple form they show a list of all the occurrences of the search word in the chosen corpus, with a predetermined number of characters of text around it, thus they are also known as keywords in context (KWIC).

Software such as Wordsmith Tools allows lines to be resorted by a given number of words to the left or right of the search word to enable the researcher to see lexical patterns more clearly. It is also possible to set a limit for generation of a random selection of concordance lines, which is helpful when dealing with high frequency search terms. Selected concordances can be exported to spreadsheet and QSR packages for coding or a limited amount of annotation can be carried out in the Wordsmith Tools software itself. I analysed the concordances following Sinclair's (2003, p. xvii) principle of examining a set of lines (for example 30), followed by the next set until the analyst is satisfied they have accounted for the full range of possible meanings around the search term. In the case of large numbers of concordances being generated around a search term, I used Wordsmith to randomly generate a reduced sample of up to 200 lines, again following Sinclair's (ibid) assertion that "It is unwise, though understandable, to try to examine each and every instance when the numbers are more than a hundred or two.".

3.5.4 Collocation

Scott (2016) defines collocates as "the words which occur in the neighbourhood of your search word" and following Firth's (1957, p. 11) maxim that "you shall know a word by the company it keeps", collocates "can be useful in revealing how meaning is

acquired through repeated uses of language, as certain concepts become inextricably linked over time" (Baker 2014: 13).

Using Wordsmith Tools, it is possible to calculate the relationship between a search word and its collocates using a range of statistical tests which indicate either the strength of relationship (Mutual Information) or the confidence level of the relationship (Log likelihood). The top collocates in a Mutual Information calculation will be those with the strongest relationship to a word i.e. those which most often co-occur close to the word and do not occur far away from it, these are often low frequency words. In contrast, using the Log Likelihood measure tends to reveal high-frequency words as collocates.

3.5.5   Patterns

One issue of using a high frequency measure to calculate collocates is that this is likely to elicit lots of "grammatical" or "closed class" words and without looking at the position of them in relation to the search word it is difficult to ascertain possible meaning and prosody. Using the Patterns tool is an excellent way to look at the frequency of the lexical and grammatical words in their most frequent positions, i.e. as lexical chunks. As Scott (2016) states "The effect is to make the most frequent items in the neighbourhood of the search word "float up" to the top. Like collocation, this helps you to see lexical patterns in the concordance" (see Figure 3.4 below for a screenshot example of the Patterns tool).

Concord
File   Edit   View   Compute   Settings   Windows   Help

N	L5	L4	L3	L2	L1	Centre	R1	R2	R3	R4	R5
1	THE	THE	TO	TO	THE	FERTILITY	CLINIC	AND	THE	THE	THE
2	TO	TO	THE	OF	MY		TREATMENT	I	I	AND	I
3	A	A	AND	AT	OF		MONITOR	AT	A	I	TO
4	I	I	APPOINTMENT	THE	A		AUTHORITY	FOR	TO	TO	THAT
5	OF	OF	A	WITH	ON		IS	THE	IT	IS	A
6	AND	AND	I	FOR	AND		TREATMENTS	IS	IS	ME	IT
7	FOR	IN	IN	AND	FOR		FRIEND	ON	FOR	A	OF
8	IT	BE	MY	ON	TO		ISSUES	TO	THAT	OF	AND
9	MY	WE	OF	FROM	OUR		PROBLEMS	BUT	OUR	IT	HAVE
10	HAVE	AS	FOR	MY	WITH		AND	IN	AND	MY	ME
11	THIS	HAVE	WHO	ABOUT	YOUR		CHARTING	ARE	OF	ON	NOT
12	ONE	HAD	WITH	USING	THEIR		UNIT	THIS	IT'S	THAT	WE
13	US	AN	REFERRAL	OVER	IN		SPECIALIST	WE	HAVE	YOU	IS
14	YOU	IT	NOT	ALL	THROUGH		DOCTOR	SO	YOU	HAVE	BUT
15	WAS	WAS	ABOUT	THAT	ABOUT		STUFF	TODAY	UP	WAS	IN
16	ABOUT	THIS	BEEN	SEE	FELLOW		SHOW	OF	IN	SO	HOSPITAL
17	IN	THAT	BE	OUR	BIG		CHART	THAT	WE	BE	ARE
18	WE	MY	GO	BY	OWN		NURSE	AS	THIS	FOR	FOR
19	THAT	IS	US	THROUGH	HAVING		FIGHTERS	A	ME	WE	WAS
20	WHO	OUR	AN	A	THAT		CLINICS	WEBSITE	HAD	FIRST	AN
21	BEEN	ON	ANY	IS	HIGH		FRIENDS	WILL	AT	US	SO
22	IS	BEEN	LIKE	IN	LOW		I	WHO	MY	I'M	ON
23	AS		REFERRED	GOING	PEAK		INVESTIGATIONS	WHICH	ON	ARE	AT
24	OUR		ARE	YEARS	THIS		DOC	HAVE	SO	JUST	WITH
25				GREAT			SIGNS	MY	THEY	THIS	YOU
26				SORT			BALL	IT	WILL	LOCAL	AS
27				UP			STRUGGLES	HAS	IF		MY
28							DRUGS	ROLLING			MORE
29								OR			
30								I'VE			
31								WAS			
32								STILL			

concordance | collocates | plot | patterns | clusters | filenames | follow up | source text | notes

32   Type-in   .... and they'd give me fertility treatment, the three ....

Figure 3.4 Screen shot of pattern tool in Wordsmith Tools.

Figure 3.4 shows the collocates of the word *fertility* in each position from L5 to R5, five places to the left and right of the search word. These collocates are shown in each column in terms of their frequency in that position, for example; *my* is the second most frequent L1 collocate of *fertility*.

3.6 Stages of analysis:

Whilst a key aim of the thesis was to triangulate findings through the comparison of different corpora, a question of equal importance was eliciting the frequently backgrounded voices of those who experienced infertility through the analysis of the BLOG Corpus. The thesis does not claim to provide an objective view of discourses around infertility (if such a thing is even possible) but to look at dominant ways of viewing infertility in comparison with more personal, potentially contesting views.

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This balance was achieved both through the selection of keywords and through returning to and reflecting upon the analysis considering new learning about the experience of infertility gained through engagement with the texts and with the individuals I spoke with during my public engagement project.

Other scholars (Marchi, 2009; Baker, 2006) have previously described this mixed methods approach as a "funnelling" with a broad approach taken at the beginning in collecting texts which form the corpus, narrowing to focus on chosen linguistic features elicited through corpus software tools, and ultimately leading to a close critical analysis of these selected features.

Although I align to a certain extent with this description, the stages of my analysis more closely resembled an hourglass or gyroscope, a time turner (see Figure 3.5) beginning with a broad social and textual range, narrowing to close reading of central linguistic features and then opening out again to engage with the wider context. Whilst doing so the findings were influenced through the multiple axes of three different text types.

Figure 3.5 *Time Turner*

Prior to using any corpus analysis tools, the first stage of my analysis (as discussed in section 3.3) was the development and execution of my data collection strategy. Once

the data was collected and cleaned the first step was to use Wordsmith Tools to create Wordlists and subsequently Keyword Lists for all three of the corpora as, what Baker (2006, p. 126) describes as, a "way in" to the text. (I discuss keywords in more detail in section 4.1).

To obtain enough keywords to make valid generalisations about the language used around infertility in these text types but few enough for the scope of a doctoral thesis my cut off for Keywords was 100 (provided there were this many generated for each corpus). One of the issues of Keywords is the large number of proper nouns that the technique elicits, which may characterise a text but are not necessarily discursively interesting and the large number of function words which do not carry any particular "semantic load" (Mautner, 2010; p127). Therefore, I created a stoplist[11] of terms to be excluded from both Wordlist and Key Word analysis which included: determiners, pronouns, auxiliary verbs, prepositions, adverbial particles, coordinators and subordinators, as well as any proper nouns which only occurred in one text. (For the full stoplist see APPENDIX II). Although the stoplist words are not included as keywords or search words they will be discussed where appropriate in patterns around lexical keywords.

These exclusions created a list of 100 "lexical" words for each corpus which were "key" and likely to be in Biber et al.'s (1999, p. 55) term "the main carriers of meaning".

As Baker (2004, p. 350) states "it is essential to realise that a keyword list only provides the researcher with language patterns which must be interpreted to answer specific research questions." This is the point where the methodological pendulum swings from more quantitative, automated analysis to more qualitative, inductive work as I grouped

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[11] Stoplists are lists of words which analysts decide not to include in analysis for various reasons e.g. to exclude common function words like *the*, *of*, *was*, *is* and *it*. The stop list consists of a plain text file which specifies all the words you wish to ignore. If it is activated, the words in it will not be included in a word list (Scott, 2016).

the Keywords manually into semantic sets (Partington, 2008) guided by my research questions. This approach is closer to corpus-driven work (Tognini-Bonelli, 2011) allowing themes to develop from study of the data rather than around a preconceived hypothesis.

I initially sorted the keywords into thematic sets using disambiguation to ensure that words were placed in the most relevant category. This involved reading a sample of concordances of potentially ambiguous words and categorising them according to their most frequent use in the context of my data. An example of this is the word *sex* which could refer to either sexual intercourse or biological sex. In my data it was used most frequently in the context of sexual intercourse in the BLOG Corpus but as a biological label in the CLINIC Corpus and was categorised accordingly in my table of keywords. Although I did not have a specific hypothesis about what discourses of infertility may be found, the study of contextual material did lead me to develop several thematic groups of interest and salience; Identity, Medicalisation and Reproduction which the keywords were then gathered under (see Chapter 4). It is important to stress that these themes were developed after the initial keyword analysis and derived from the data in addition to the contextual material rather than me forcing data into ill-fitting thematic boxes. The development of these thematic groups derived from initial categorisation of keywords which were more specific and descriptive such as "medical actors" or "body parts". From these descriptive categories and after several iterations, the three overarching themes (and basis for my chapters) were developed to include each group of keywords.

After this thematic sort the next step was a closer reading of the concordances of selected keywords from each "group". As the lived experience of infertility was my main area of interest, I concentrated on features which were significant by their presence

or absence in the BLOG corpus, in comparison with the other two corpora (see Table 4.2 in Section 4.2.1).

Many scholars (e.g. Mautner, 2008; Baker et al., 2008; Orpin, 2005) have utilised lists of collocates to uncover meanings around a node word and my initial intuition was to follow this path using the Collocation feature of Wordsmith Tools. However, it quickly became apparent that the size and multiplicity of my corpora made the study of concordances for a list of collocates relating to every node word in every corpus was beyond the scope of this PhD thesis unless I was willing to do a very broad but shallow study. This additional stage of analysis also ran the risk of "mission creep" and a method which retained focus on lexical and grammatical features salient to discourses of infertility was necessary.

While keywords analysis focuses on specific features, studies looking at concordance lines can also reveal repeated patterns of lexical and semantic usage (Baker, 2006; O'Halloran, 2009). As Stubbs (2001, p. 215) states "Repeated patterns show that evaluative meanings are not merely personal and idiosyncratic, but widely shared in a discourse community. A word, phrase or construction may trigger a cultural stereotype."

The necessary focus was achieved by using the Patterns tool in the Wordsmith suite, which shows collocates (words adjacent to the search word), organised in terms of frequency within each column. That is, the top word in each column is the word most frequently found in that position (Scott, 2016). This provided a way to look at a manageable number of collocation and colligational patterns around my search words whilst I could still be confident that there was a meaningful relationship with a collocate. This is not dissimilar to looking at concordance lines for repeated patterns (Sinclair, 1991; Stubbs, 2001) around a node word. The Patterns tool is a way in to the most

frequent of these for any given word with the added advantage that it shows not just the most frequent collocates but the most frequent lexical chunks (for an exemplar of this see Section 4.3). The most frequent lexical chunks (in the top 10 lines of the Patterns tool, three places to the left and right of the search word) became the focus of my analysis. These highly frequent patterns were then examined in context, in concordance lines and repeated patterns of meaning were noted as potentially indicative of discourses around this keyword, in the context of infertility. Rather than the traditional method following Sinclair (1991) of examining a page of concordances with the linguistic context limited to a single line I exported the concordances from Wordsmith into an Excel spreadsheet. This allowed me to include longer textual examples and gave space to make detailed notes on possible discourses for each set of concordances. I have used these examples to illustrate the analysis and illustrate the complexity of the discursive construction of infertility and justify the interpretations I made in the analytic process. In the final analysis, I identified and "named" discourses and sub-discourses around each pattern, which were further refined with reference to my contextual data about infertility in the UK and charted the similarities and differences of these discourses across and within the corpora.

As discussed in section 2.2.4 the identifying and naming of discourses is potentially problematic, particularly with regard to issues of reliability and replicability. In this thesis, sub-discourses were identified using manual coding of extended concordance lines for each keyword studied, as described above. The names for these sub-discourses were selected in one of two ways, in the first instance, names were developed from contextual reading around infertility in the social science literature, for example the concept of life disruption (Becker, 1999). The second method drew on language used by the text producers themselves, when the text used encapsulated a

particular aspect of the experience, for example "more than the sum of my lady parts" in the BLOG Corpus and "social eggs freezers" in the NEWS Corpus.

While the identification of sub-discourses was based on analysis of repeated linguistic patterns, this parameters for this process can vary across corpora. In a very large corpus of, for example, news texts more examples would be required in order to claim a set of repeated patterns of lexis and meaning constituted a dominant discourse. In contrast, for smaller corpora such as the blog corpus then fewer examples would be needed. It is also important to acknowledge that potentially contesting or minority discourses may have fewer examples but still be noteworthy when mapping the discursive construction of a topic. Bearing in mind the need for reflective and context dependent practice I developed the following three criteria when coding my concordances lines for sub-discourses.

1) Must be identified in over 10% of concordances lines (over 30% to be a dominant discourse)

2) Must use a clearly defined naming strategy drawing on theoretical framework or reflecting the language of the text producer

3) When revisited by the researcher must be internally consistent.

Following these criteria allowed the flexibility to work with multiple sized corpora while still maintaining a rigorous approach.

Model of stages of analysis:

Following Partington (2008) and Baker et al. (2008), I developed a step by step model (see Figure 3.2) of my methodology which remains constant throughout chapters 4-8, especially the iterative process between linguistic analysis and context.

Study of context including media, legislative and academic texts

Data collection (Selection and building of corpus)

Create wordlists and keyword lists

Selection of keywords

Thematic categorisation of keywords

Pattern and concordance analysis of selected keywords

Identification of patterns of meaning indicative of discourses

Map similarities and differences of patterns and discourses around infertility

Figure 3.6 Model of methodological steps

In summary, my method embraces a comparative approach founded on previous work by Baker (2006), Partington (2008) and Marchi and Taylor (2013), however in doing so I utilise a previously under-used tool in the Wordsmith suite, the Patterns tool. The process of analysis was not a straight forward one but was both iterative and interpretative, as Teubert points out (2015, p. 427);

> "But it is also true that no purely statistical analysis of language patterns can reveal meaning. Statistics are vital, but only as a heuristic procedure. Biased as it is, it is only interpretation that can express what a word or a longer text segment means in a given context"

So, while the statistical affordances of corpus linguistic tools helped to focus the words selected for study, the process of identifying and mapping discourses was more qualitative in nature.

This methodology will be exemplified in Chapter 4 where I undertake a sample analysis of the term *infertility*, following the stages described in Figure 3.6 which will then be replicated for each of my search terms in Chapters 5-7

Chapter 4 - Keywords

4.1 Introduction

In this thesis, keywords are used as an initial "way in" (Baker, 2006) to the data and offer the opportunity to explore salient topics within each corpus for closer analysis using collocation, colligation and concordancing. Furthermore, comparison of keywords in each corpus can point to the lexical and semantic gaps in a corpus, to identify absences as well as presences (Scott, 1995).

Using Wordsmith Tools 5[12] (Scott, 2008) the three sub-corpora were compared to a 10 million word sample of the UK Web as Corpus (UKWaC) (see section 3.4.1 for discussion of the choice of reference corpus) to elicit the 100 keywords with the highest keyness scores (derived by their log-likelihood values).[13] My research questions (RQs) aim to identify discourses in texts on infertility. These discourses, and sub-discourses will be identified through the keywords in texts on infertility which are organised into thematic categories, the patterns around selected keywords from each category and, crucially, how these keywords, patterns and discourses vary across different text types. With an equal number of keywords taken from the three corpora it was possible to build a pattern of presences and absences in each semantic field, for example a high number of mental processes were found in the BLOG Corpus but not in the NEWS or CLINIC Corpora.[14] As my focus for analysis is lexical keywords, indicating lexical choices, I derived a stop list of (mainly grammatical) terms which was applied during the keyword analysis.

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[12] See Method Section 3.4 for an explanation of the chosen software for corpus analysis.

[13] Using the top *n* of any list of keywords rather than a particular keyness cut off value can be problematic for comparability, but as the corpora were of varying sizes it was unrealistic to set a cut off based on a minimum keyness score. If I had, for example, selected all keywords with a log likelihood score of at least 50 there would have been a high number of keywords from the NEWS Corpus and comparatively few from the BLOG Corpus, so this method would not have met the needs of my particular research questions.

[14] All the keywords selected for analysis in the thesis exceeded a minimum log likelihood value of 15.3.

The top 100 keywords (post stop list[15]) for each corpus were grouped into thematic categories (Table 4.1) which have salience for the topic of infertility[16]. During this process disambiguation was carried out by checking a sample of 100 concordance lines of that term to ensure that each word was included in the most appropriate category for its use in each context. For example, the word *couple* is typically a quantification term in the BLOG corpora but a social actor in the NEWS and CLINIC corpora

4.2 Keywords by category

In undertaking the categorisation of the keywords, it became clear that the categories which emerged (which could be referred to as 2nd level themes) could be further grouped into overarching themes (1st level themes), around which the analysis chapters of the thesis are structured, namely; identity, the embodied and medical experience, and outcomes and expectations. This part of my methodology was not in place prior to data collection, rather it was an inductive process led by the types of thematic categories and the lexis within them. It is worth stating at this point that any one of the themes would have provided enough material for a thesis, however gains in depth would have been at the expense of broader comparative analysis. The choice I made to include such a wide range of categories and keywords was to best demonstrate the way in which discourses are not fixed but are mutable across keywords, patterns and text types. These themes and categories and the keywords within them are shown in full in Table 4.1.

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[15] A keyword list was derived with no stopwords and checked manually for grammatical terms or term related to the particular format such as "reblog" in the blog corpora. These terms were added to the stoplist and another keyword list was derived. This process was repeated until all grammatical and style specific terms were eliminated from the keyword list when the stoplist was applied.

[16] A full list of top 100 keywords in order of keyness can be found in APPENDIX IV – Top 100 keywords from all corpora

Theme	Category	BLOGS	NEWS	CLINIC
IDENTITY	***Relational actors***	I, me, she, myself, we, DH, husband, couple, him, hubby, friends, mother	she, women, I, couples, woman, they, mother, mothers, men, he, husband, parents, me, family, mum, father, woman's, male, daughter, women's, Britain's, girls	couples, women, male, partner, we, woman, you, she, couple
	Emotion and Cognition	know, feel, think, feeling, thought, felt, lovely, good, bad, pretty, excited, tears, knew, hope, chance, want, wanted, sure	wanted	
EMBODIED AND MEDICAL EXPERIENCE	***Medical Actors***	nurse, doctor, clinic	doctors, donor, HFEA (Human Fertilisation Embryology), Dr, NHS, clinic, clinics, patients, hospital	clinic, clinics, donor, donors, patient, patients, HFEA, consultant, nurse, GP, embryologist, NHS, hospital
	Clinical processes	IVF, cycle, cycles, TTC, IUI, Clomid, AF, progesterone, HSG, scan, appointment, test, injections	IVF, treatment, conceive, reproductive, frozen, implanted, fertilisation, abortion, medical, pill, drugs	appointment, fertility, IVF, ICSI, cycle, cycles, fertilisation, freezing, frozen, donation, transfer, ovulation, IUI, reproductive, insemination, assisted, conception, conceive, stimulation, fertilised, donated, implantation, surrogacy, conceiving, ultrasound, counselling, scan, scans, treatment, injection, procedure, gynaecology, consultation, test, drugs, screening, medical, clinical
	Bodily parts and experiences	uterus, ovary, follicles, womb, pain, bleeding, blood, cramps, pill, pee, blood	blood, womb, ovaries, ovarian, cells, hormones, disease, healthy, cells	ovaries, ovary, ovarian, uterus, womb, fallopian tubes, follicle(s), endometriosis, blood, hormone
REPRODUCTION	***Reproductive experiences***	trying, infertile, infertility, fertility, pregnancy, miscarriage, sex, pregnant, ovulation,	pregnant, risk, chance, chances, infertility, sex, infertile, fertility, pregnancy, pregnancies, born, childless, motherhood, menopause,	success, chance, rates pregnancy, pregnant, miscarriage, birth, born,
	Reproductive actors	sperm, egg, eggs, baby, embryo, embryos,	sperm, eggs, embryos, baby, babies, birth, births, children, twins,	babies, sperm, eggs, embryos, baby, semen, blastocyst.
	Time	day, never, morning, weeks, wait, days, tomorrow, time, yesterday, today, waiting, months, night, weekend, started, moment, birthday	age, year, years, yesterday, months, weeks, never,	age

Table 4.1 Keywords organised by theme and lexical category

Theme One: Identity

The central focus of my research is the representation of the identity of women experiencing infertility, thus the Identity theme comprises two categories of keywords relating to this, which I have labelled *relational actors* and *emotion and cognition*. In the analysis chapter following this one, relational actors are further divided into those representing the woman experiencing infertility[17] (the self) denoted through pronouns and the partners of the woman (significant others). This theme encompasses the representation of self, the representation of others and the representation of mental or emotional processes, giving insight into the multiple, possible subject positions around infertility and how they are negotiated. Although originally included in what became the Identity Theme (originally labelled *Social Actors*), I subsequently moved the *Medical Actors* category to the Embodied and Medical Experience Theme. Perhaps unsurprisingly, given the focus of news texts on human interest (Conley and Lamble, 2006) the NEWS Corpus contained the widest range of social actor words of the 3 corpora. Whilst all corpora contain a range of terms for self and (possible) partner, only the NEWS and BLOG corpora contain repronormative terms such as *husband* and *hubby* as top 100 keywords. The texts in the CLINIC corpus, following the guidelines of Human Fertilisation and Embryology Authority (HFEA), refer to *couple* or *partner*, not precluding the option of same sex couples or individuals seeking assisted conception, thus legislature, as well as normative discourses, shapes these lexical choices. Although not a keyword, *husband* does occur in the CLINIC corpus but only in patient testimonials.

In the BLOG corpus, the texts contain a greater frequency of pronouns which indicate a first-person account typical of this genre and the lexis of *emotion and cognition*.

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[17] The self in these cases is a woman as all the bloggers are women and this thesis is seeking to explore particularly the female experience of infertility.

Whilst this may be stylistically predictable, further collocational and concordance analysis will elicit from these frequent terms the nuances of the lived experience of infertility.

Theme Two: Embodied and Medical Experience

The largest group of keywords belong to the theme of Embodied and Medical experience, which is relatively unsurprising given the inclusion of the clinical websites and the dominant discourse of infertility as a medical condition (Greil et al., 2011). This theme presented a challenge in terms of putting the large semantic groups of bodily processes and parts and medical terms into meaningful categories. Using the embodied experience of infertility as my focus, I selected the labels *medical actors* as those who act upon the infertile body, *body parts and experiences* as those terms which refer to non-medical processes which are nonetheless part of the embodied experience and finally, *clinical processes* for those actions carried out by medical actors on the infertile body. The BLOG Corpus and CLINIC Corpus keywords for this section included a large quantity of acronyms and subject specific medical lexis, such as *ICSI* (Intracytoplasmic sperm injection), and *TTC* (trying to conceive) which required careful checking of concordances lines to ensure they were correctly categorised. In contrast, the NEWS Corpus keywords include more general lexis of health and medicine i.e. *hospital* and *disease*.

Theme Three: Reproduction

The final theme is centred on the reproductive experience in light of infertility and how this is linguistically negotiated. Here the analysis is focused on the reproductive actors and experiences categories, exploring the representation of the actors (*baby*, *eggs*) and experiences of the reproductive life-course (*pregnant*).

There was an additional category of Time which did not fit well into any of the overarching themes, yet appeared throughout the analysis to be intrinsic to the lived experience of infertility. Rather than disregard the lexical items in this category altogether they will be discussed as they occur in the context of other search words across the three themes which comprise my main three analysis chapters.

4.2.1 Keywords for further analysis

As discussed at the start of section 4.2, the process of grouping keywords and then selecting the most salient for analysis was a reiterative process. The keywords from Theme One: Identity, were chosen for their potential insights into the representation of self individually and in relation to others. In Theme Two: Medical and Embodied experience, I make the distinction between the clinical experience of infertility and the experience of the infertile body. In Theme Three: Reproduction Through the Lens of Infertility, my selections map the (ideal) reproductive process from gametes to baby, via pregnancy examining this process when disrupted by infertility. The keywords for each chapter are shown in below.

CHAPTER	BLOG	NEWS	CLINIC
5. IDENTITY	I, H, OH, DH, hubby, husband, know/think, feel	she, husband, know/think, feel	you, partner, know/think, feel
6. MEDICALISED AND EMBODIED EXPERIENCE	doctor, nurse, clinic, ovary/ovaries	doctor, nurse, clinic, ovary/ovaries	doctor, nurse, clinic, ovary/ovaries
7. REPRODUCTION	egg, baby, pregnant	egg, baby, pregnant	egg, baby, pregnant

Table 4.2 Keywords for analysis by chapter and corpus

It is worth noting at this point that I initially explored several other keywords but these were excluded from my final thesis on the grounds of either uneven distribution of the KW (for example, *uterus* only occurred in one BLOG Corpus texts), repetition of

findings from other keywords (*IVF* was markedly similar to *infertility treatment* in terms of its lexical and discursive patterns and as I discuss the keyword *infertility* in section 4.3 below, there was no need to detail the analysis of IVF), or words which were not the most salient to those experiencing infertility, the bloggers (for example, *risk,* while potentially interesting, was not key in the BLOG Corpus).

4.3 Analysis of the keyword *infertility.*

As discussed in my introduction, the aims of this thesis are twofold; to investigate how patterns of language can be used to reinforce and contest discourses around a certain topic and the application of this to reveal discourses of the lived experience of infertility. This chapter will serve both as a methodological example and seek to answer the two research questions:

I. What linguistic patterns are found around the keyword *infertility*?

II. What does analysis of these patterns uncover about discourses of the lived experience of infertility?

While the previous section detailed the thematic patterns of the top 100 keywords in my data, in this section I explore one of the top 100 keywords present in all corpora, *infertility.* This word was chosen because as the focus of the thesis and a high-ranking keyword in all my corpora, it serves as a salient starting point for the analysis of my corpora. In addition, it functions as an exemplar of the methodology which will be used throughout the thesis, particularly my innovative use of the Patterns function in Wordsmith Tools concordancer. By looking at the discursive patterns of *infertility,* and the patterns of the keywords around it, I can begin to build taxonomy of the discourses around infertility which transect text types and highlight some of the different language choices by which these discourses are constructed. Table 4.3 shows the frequency of *infertility* across the corpora.

INFERTILITY (keyword rank)	Raw Frequency	Relative frequency (PMW)
BLOG Corpus (45)	839	507
NEWS Corpus (22)	3788	671
CLINIC Corpus (12)	1535	1998

Table 4.3 Raw and relative frequency of the keyword *infertility* across corpora

4.3.1 Infertility in the BLOG corpus

Throughout the thesis the BLOG corpus will be the starting point for analysis as the site which is most germane to the lived experience of infertility. Therefore, the other two corpora, NEWS and CLINIC are used to provide context for, and comparison with, two salient sites of communicative practices around infertility, clinical texts and media texts. Table 4.4 shows the Wordsmith-derived Patterns for the search term *infertility*, this feature is used to elicit the most frequent collocational patterns around a word (for a full explanation of this tool see section in the Methodology chapter.) As stated above, I limited my investigation to those terms in the L3-R3 window, as these positions were most likely to form lexical/grammatical "chunks" with *infertility*. The Patterns were exported from Wordsmith into Excel as shown in the format of Table 4.4 below. As Wordsmith does not distinguish between upper and lower case letters when calculating patterns, all the tables of Patterns throughout the thesis will be in upper case, to preserve the original look of the data.

L3	L2	L1	Centre	R1	R2	R3
THE	OF	OF	INFERTILITY	AND	I	THE
TO	GREAT	WITH		IS	A	A
A	STRUGGLING	THE		I	THE	I
IS	ABOUT	ABOUT		HAS	AND	TO
AND	THE	MY		CLINIC	NOT	THAT
I	TO	OUR		IT	LOSS	IS
HAVE	IN	UNEXPLAINED		BUT	IS	ME
OF	WITH	AND		THE	IN	IT
IN	THAT	THAT		IN	ARE	ARE
ARE	A	AN		BLOGS	TO	HAVE

Table 4.4 Top 10 patterns around *infertility* in the BLOG Corpus

Rather than using a list of collocates which may occur in any position, usually within 5 words left or right of the search term, the Patterns tool allows access to a range of collocates around a word. This aids the selection of potentially salient chunks of language for further analysis through close reading of concordance lines. It is important at this point to note that when selecting the patterns for closer analysis, certain terms, such as *great* in the L2 position (n=18), were not prioritised if they were only used by a single writer e.g.

> *The nurse at the Great Big Infertility Clinic recommended that I do two separate*
>
> *injections.* (IF024)[18]

While such cases can be interesting in terms of telling us something about personal choices or individual experiences, they are not usually representative of more general ways of discussing infertility. I do refer to rare cases occasionally if they illustrate an interesting perspective but have tried to focus more on the typical patterns in the corpora. In the case of the BLOG Corpus patterns around *infertility* there was only one such case which is described above. Concordance analysis of the patterns shown in Table 4.5 was employed to ensure sufficient cotext to identify linguistic features of the discourses around infertility. Most patterns in Table 4.4 are grammatical rather than lexical terms, except for *loss, clinic, unexplained* and *struggling*, all of which initially indicate a negative and medical prosody for infertility. Table 4.5 includes the patterns which were selected for close reading of concordances lines, and ultimately, in the identification of possible discourses.

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[18] Each blogger was assigned a code comprising IF, followed by three digits, for example IF001. For a list of the bloggers codes and demographic details please see APPENDIX I.

Pattern	Example from concordances (BLOGID)	Frequency
NOUN *of infertility*	The descent into the world of infertility is incremental. (IF018)	94
infertility is COMPLEMENT	Infertility is a seriously isolating experience (IF002)	70
VERB *with infertility*	Chances are, you know someone who is struggling with infertility. (IF025)	64
PRONOUN *infertility*	This is yet another experience that my infertility has robbed me. (IF005)	72
infertility and	I suppose that infertility and loss makes second-guessers of us all. (IF016)	91
Unexplained infertility	The options are a hormonal imbalance, something internal with my plumbing that's as yet undetected, or the delightful "unexplained infertility". (IF005)	29

Table 4.5 Patterns for analysis - *infertility* in BLOG Corpus

4.3.2 Overview of patterns around *infertility*

One of the most frequent and striking collocates of *infertility* which occurred at the top of the patterns table was *of* in the L1 position. Examination of the concordances of this pattern showed that the L2 position contained a noun, which expressed an experience of infertility and that while these nouns cross a range of semantic categories the prosody is broadly negative. Following categorisation developed in work by Teubert (2007) (reflecting on Sinclair 1991), the examples found in the concordances show a strong preference (84% of concordances) for metaphorical use, particularly the effect of infertility on both the psyche and body of the writer.

> *I know we all know the scars of infertility will be there forever (IF010)*

The pattern *infertility is* COMPLEMENT is used to define potential meanings of infertility for the bloggers, both literally and metaphorically circumscribing the experience, and constructing infertility as an actor within these narratives as seen in the example below.

> *Infertility is a heart-wrenching, faith-questioning, relationship-testing, life-altering experience. (IF006)*

Concordances around this pattern also show how people writing about infertility can be "eager for medicalisation" (Becker and Nachtigall, 1992), seeking a diagnosis as an explanatory and legitimising action.

> *It's not a 'lifestyle choice' as infertility is a disease of the reproductive system*
> *(IF004)*

The majority (67%) of verbs in the VERB *with infertility* concordances are verbs of action taken by bloggers against the effects of infertility, portrayed as a constant battle which can subsume the rest of their existence.

> *When you are struggling with infertility, it is very difficult not to let those*
> *feelings of hopelessness and despair seep into other areas of your life.* (IF024).

The use of the active construction *struggle/cope/deal with* are more frequent (50%) than more reactive constructions such as *suffering with* (0.5%) suggesting bloggers position themselves as actively seeking to retain control.

> *People suffering with infertility issues are already stressed enough and they*
> *add to it. (IF004)*

In all three examples *suffering with infertility* is used as a descriptor of others rather than the bloggers themselves, which supports the idea that this is something to be rejected in favour of a more active approach.

In work by Hunt (2013) the construction *the condition* (in this case an eating disorder) was suggested as a way of distancing the writer from the condition and depersonalising the experience. Thus, the construction *my|our infertility* indicates linguistic expression of connection rather than disconnection, perhaps as a way of actively taking back control and ownership of the condition.

> *I seem to have reached some sort of impasse where I have accepted my infertility*
> *and it can go fuck itself. (IF005)*

The presence of the connector *and* linking *infertility* with other (negative) topics can be used to reinforce the negative prosody of *infertility*. In the BLOG Corpus, this is particularly relevant in the experience of loss and miscarriage which are expressed linguistically in a variety of ways (comprising 40% of concordances) as seen in the examples below.

> *I suppose that infertility and loss makes second-guessers of us all.* (IF016)

> *Although infertility and pregnancy loss have taken us to some pretty dark places, and have at times stretched our relationship almost to breaking point, we weathered that storm.* (IF024)

The experience of infertility is not "just" the inability to conceive which is referenced in the medical definitions but often a repeating cycle of pregnancy and loss (see Chapter 7 for further discussion).

Through the concordance analysis of these patterns in the BLOG Corpus, several discourses emerge as dominant, namely: the transformative nature of infertility, journeying through infertile space and time, and seeking medicalisation which will be explored and exemplified in the next section.

4.3.3   Discourses of infertility in the BLOG Corpus

4.3.3.1 The transformative nature of infertility

A dominant framing of infertility is as a violent and active force acting on the person, which bloggers have little or no control over, with far reaching consequences for the view of self and life-course expectations.

> *Infertility is a horrible, soul-destroying thing (IF020)*

> *Infertility is a heart-wrenching, faith-questioning, relationship-testing, life-altering experience. (IF006)*

I have always been proud of the fact that I haven't given into my infertility and

let it beat me. (IF025)

Bloggers employ creative metaphors as the experience of infertility is represented as a physical force working against the person experiencing it.

It's like the manacle keeping me chained to the side of the juggernaut of

infertility and loss, forcing me to run with it, dragging me when I fall. (IF018)

When I received mine (poor AMH results), I was devastated, it was probably the

straw that broke me on my infertility journey if I'm honest. (IF011)

Even when describing the emotional experience infertility is described in physical, visceral terms.

Not having a furry companion has made the loneliness of infertility bite even

harder (IF005)

It was at that point that I decided that maybe they might actually be able to

grasp something of the impact of infertility. (IF024)

The repetitious nature of loss and struggle experienced may explain the depth of damage and the level of transformation which is felt by those experiencing infertility when compared to other negative experiences.

Infertility is, indeed, a very painful struggle. The pain is similar to the grief over

losing a loved one, but it is unique because it is a recurring grief. (IF006)

Perhaps society should take a look at itself, and acknowledge those losses, that

they are real, distressing and immense, and then perhaps those who suffer the

indignity of infertility and miscarriage would get the support they need. (IF017)

Indeed, these repeated hurts are described in their ongoing effects using physical metaphors for emotional/psychological impacts.

Flesh heals but I know that the pain of infertility does not. (IF005)

I know we all know the scars of infertility will be there forever. (IF010)

My experience of infertility has had a profound effect on the way I feel about pregnancy (IF024)

To summarise, in the discourse exemplified above, the transformative effect of infertility is perceived as destructive, visceral, all-consuming and viewed as permanent regardless of the outcome of the individual.

4.3.3.2 In infertile space and time

Another dominant discourse is the representation of infertility as not just an experience but a virtual space and time which is occupied and travelled through by the bloggers. As in the transformative experience section, the repetitive, chronic nature of infertility is a key issue for individuals experiencing it.

Bloggers draw on geographical/chronological metaphors of the infertile experience as a space to travel through, describing a journey or quest through this space over which they have limited control.

As I fell further and further down the rabbit hole of infertility, I felt increasingly isolated. (IF024)

They have not been through the minefield of infertility. (IF002)

After spending over two years navigating through the murky, choppy waters of infertility the sea has now become like a mill pond with no sights or sounds or anything of note. (IF014)

This space is marked by unwillingness to occupy it and a deviation from their expected life course. Bloggers reproduce cultural and textual knowledge to creatively explore this space.

Where they have progressed smoothly down the road to parenthood, we somehow took a wrong turn and found ourselves on the lonely and inhospitable path marked 'infertility'. (IF024)

I've considered - at some length - staging a protest by using Facebook to describe my own progress through the hell of infertility. (IF005)

Both chronological and geographical metaphors highlight the liminal nature of infertility, where people are neither childless or parents but are travelling in space/time between these two identities.

It will be tough but also worth it if we can end this journey of infertility if we achieve our goal of having a child, our own child. (IF004)

We were circling our own orbits of infertility: on a break after failed IVF for one, hoping for success in my IUI and the third still woefully unexplained and unmedicated. (IF014)

Another geographical aspect of infertility is the community a person experiencing infertility occupies, a community inherently defined by the shared experience of the condition as outside this safe space there is the fear of stigma and misunderstanding.

*It dawned on me this weekend that with blogging it means everyone following this, in real life, or in my infertility world, everyone knows EVERY step, there is no hiding. (*IF017)

To some of the smug fertiles, our infertility has become the elephant in the room - they will go to any lengths to avoid mentioning it. (IF024)

The discourse of infertile space and time constructs infertility as a disruption to the expected life-course, and exemplifies how this can contribute to the stigmatising and othering nature of involuntary childlessness.

4.3.3.3 Pursuing medicalisation

While the social sciences, feminist technoscience studies (Britt, 2001, Rowland 1992), often take a critical position on the medicalisation of infertility, and critique the development of medical technology as a driver for this, this ignores the potentially positive role of engagement with medical technology for people with infertility (Thompson, 2006).

The repeated assertion by bloggers that infertility is a medical as well as social experience indicates their keenness to place it within the biomedical framework to both justify and explain their fertility problems.

> *Infertility is a diagnosable medical problem that must be treated by a Doctor.* (IF006)

> *XXX implies that as infertility is not life threatening, it is not as important as "real" medical problems.* (IF003)

> *Afterall, the NHS is meant to be all about health and infertility is a HEALTH problem. Also, the people who smoke, take illegal drugs, drink a lot of alcohol/binge drink all get treatment free on NHS for their problems which they self-inflicted, yet no one bats an eyelid?* (IF004)

The bloggers position themselves as unwillingly experiencing a medical condition, distancing them from potential stigma, and contesting the dominant media discourse of infertility as a lifestyle choice (Sangster and Lawson, 2014) resulting from irresponsible or deviant behaviours. (see sections 4.3.6 and 7.3.1 for discussion of this discourse).

Engagement with treatment can be viewed as a progression, and a way of regaining an element of control and hope during the infertility experience.

> *We had just got our infertility diagnosis. In some ways it was more hopeful as we were going to do something.* (IF012)

So lucky to live in the tiny part of the world in the tiny part of human history where something can be done about our infertility. (IF015)

This time I felt supported rather than processed. She decided that at 34, and after three miscarriages in quick succession, I ought to be referred to one of the expert facilities for investigation to see if there may be an underlying cause for my infertility. (IF023)

Legitimising infertility as a medical issue warranting treatment potentially lessens the stigma and blame which is felt by the bloggers. However, it also heightens a sense of injustice when medical technology cannot provide resolution.

I say that perhaps my infertility is not unexplained! I wonder why there has not been more research into this (IF001)

As a result I have no funding even though I have a legitimate medical issue that has led to my infertility in the first place. (IF002)

Accessing a diagnosis and treatment is framed as part of the struggle against infertility which characterises the bloggers' representations of the condition. In this framing, *unexplained infertility* poses a further problem to managing infertility through medicalisation and the bloggers negotiate this by challenging its legitimacy as a diagnosis.

We were diagnosed with 'unexplained infertility' which accounts for around 20% of all infertility cases. While on one hand it was great to know we had no obvious problems it also meant that they still didn't know the problem and likely never would, therefore it couldn't be treated. (IF008)

After our diagnosis of so-called 'unexplained' infertility (male factor) and the suggested treatment of Donor Insemination, we weren't happy. (IF005)

4.3.3.4 Summary

The discourses of *infertility* in the BLOG corpus represent both the term and the condition as a site of tension. The transformative nature of the experience acts upon the sense of self and can become a point of definition, regardless of desire for this to be the case. The person experiencing infertility is shown to operate outside of expected norms, particularly life course expectations, which can lead to feelings of isolation, stigma and blame. The chronic nature of the experience can partly explain the level of impact as seen in the example below and this will be explored further in Chapter 5.

> *Over the past six years, my infertility has become - for better or worse - part of*
> *who I am.* (IF024)

The blog texts frame the lack of control which is felt and ways in which this is managed linguistically, including humour and creative metaphors. The bloggers' description of engaging with medical treatment for infertility indicates a need to legitimise the experience and the self by labelling it as a medical condition, yet they risk becoming disempowered by this medicalisation and the compulsion to continue medical engagement.

The following section will explore the news media construction of infertility and examine the ways in which the experience of infertility in the UK is represented by the media.

4.3.4   Infertility in the NEWS Corpus

The term *infertility* occurs 3788 times (671 PMW) in the NEWS Corpus and has a keyword ranking of 22. The analysis which follows will cover the most frequent Patterns around the term, shown in Table 4.6 and how the meanings imbued in them can function as markers of particular discourses of *infertility*.

L3	L2	L1	Centre	R1	R2	R3
THE	OF	OF	INFERTILITY	AND	UK	THE
A	TO	TO		NETWORK	THE	AND
OF	CAN	AND		TREATMENT	A	SAID
CAN	LEAD	MALE		IS	AND	A
AND	THE	CAUSE		IN	IN	OF
TO	AND	THE		THE	TO	TO
WHICH	FOR	FOR		PROBLEMS	IS	IN
COUPLES	RISK	WITH		BUT	WOMEN	IS
IN	WITH	UNEXPLAINED		OR	BE	THAT
THAT	CAUSE	ON		CAN	OF	BE

Table 4.6 L3-R3 patterns around *infertility in* the NEWS Corpus

As with the BLOG Corpus above, there are cases in the NEWS Corpus where a collocation does not indicate a general semantic pattern around infertility but which is part of a proper noun. In the NEWS Corpus patterns of *infertility*, the L1 collocate *network* refers to a key stakeholder group, Infertility Network UK (299 occurrences), whose representatives are often quoted by the media for a patient perspective.

This noun phrase accounts in part for the frequency of the collocation construction *of infertility* as the construction *spokesperson of Infertility Network UK* accounts for 69 occurrences of this pattern.

> *Clare Brown, chief executive of Infertility Network UK, said "continual research" was needed to ensure "treatment is safe for couples and potential children". (Guardian, October 26, 2006)*

This group are framed as experts and patient advocates, in contrast to "real life" testimonials of people experiencing infertility.

Table 4.7 shows the patterns selected for closer concordance analysis.

Pattern	Example from concordances	Frequency
NOUN *of infertility*	Many women who leave it until their forties will suffer the heartbreak of infertility. (The Independent, December 31, 2006)	538
infertility and	Obesity takes up to nine years off a person's lifespan, and raises the risk of a host of health problems including some cancers, diabetes, heart disease, stroke, infertility and depression. (Daily Mail, May 15, 2008)	365
to infertility	The cases of chlamydia, which can lead to infertility, doubled in the first six months of last year. (The Mirror, January 24, 2007)	246
infertility treatment	The issue is whether or not women who have chosen to go it alone, or lesbians, should have equal access to infertility treatment. (The Guardian, March 27, 2008)	196
cause infertility	SOME STIs can seem symptomless yet cause infertility if untreated. (The Sun, October 6, 2011)	165
male infertility	Figures included in the league table also reveal a trend of rising male infertility across Europe. (The Guardian, June 22, 2006)	181
unexplained infertility	FOR much of her life, Wendy Neilson, 58, a social worker, struggled to accept the unexplained infertility that left her unable to have children of her own. (Daily Mail, April 20, 2007)	83

Table 4.7 Patterns for analysis - *infertility* in NEWS Corpus

4.3.5   Overview of patterns around *infertility*

Infertility in the NEWS corpus has a negative semantic prosody, framed as a threat to both physical and psychological wellbeing. The high frequency of *infertility treatment* indicates a biomedical discourse (Greil et al,. 2010) and this is further supported by the inclusion of *infertility* in lists of medical conditions around the pattern *infertility and.* The pattern *infertility treatment* is framed in terms of access, with reference to costs, location and eligibility, and the problematizing of limited access lends treatment itself a more positive prosody as something, if not desirable, then necessary in the majority (58%) of examples.

> *Couples desperate to have a baby still face a postcode lottery to obtain infertility treatment on the NHS.* (Guardian, August 30, 2006)

In 67% of the concordances of *infertility and* it is grouped with other serious medical conditions most frequently including cancer, heart attack, stroke and miscarriage.

> *However, if it's allowed to progress untreated, the disorder can also lead to the bone-thinning disease osteoporosis, infertility and a raised risk of bowel cancer.*
>
> (The Mirror, September 2, 2008)

By combining infertility with a list of other serious health conditions, the NEWS texts place it firmly in the biomedical realm, and raise the seriousness of the threat of infertility which is discussed below. This threat is in over 70% of cases the object of another medical disorder, further reinforcing the medicalised discourse of infertility. However, closer examination of these concordances also reveals examples of "lifestyle" blaming, where infertility is the outcome of deviance from social norms, including sexual behaviour, drug use and disordered eating.

> *The drugs also generate increased risk of heart attack, stroke, infertility and some forms of cancer.* (The Times August 7, 2006)

In the patterns NOUN *of infertility*, *cause infertility*, *to infertility* and *can CAUSE word[19] infertility*, infertility is positioned as an object of threat and a potential negative outcome. In 34% of the concordances of NOUN *of infertility*, the noun is part of the semantic set of causality (*cause of* (n=70), *risk of* (n=68), *causes of* (n=46)) with infertility as the object and therefore outcome.

The subjects in these cases vary from medical conditions such as *Polycystic Ovary Syndrome (PCOS)* and *Endometriosis*.

> *POLYCYSTIC ovary syndrome is one of the leading causes of infertility in women.* (Daily Mail, November 26, 2006)

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[19] The term "cause word" is taken from Mcenery and Xiao (2006) and refers to either the word CAUSE or phrasal verbs which share this semantic set.

However, it also encompasses behavioural or so called "lifestyle" factors such as alcohol and smoking;

> *Smoking is one of the major causes of infertility in both men and women.* (The Independent on Sunday, June 18, 2006).

In another 17% of these concordances, the word in the NOUN position describes a negative property of infertility such as *pain*, *misery* and *stress*, contributing to the negative prosody and reinforcing the sense of threat.

In the pattern *to infertility* (where *infertility* is not followed by *treatment*) the preceding clause is attributive, for example, *lead to* (n=99), *linked to* (n=25) and *leading to* (n=19) and the subject of the clauses most frequently (sexually transmitted) medical conditions.

The pattern *cause infertility* follows a similar pattern and carries a similar prosody but with the inclusion of other medical conditions such as endometriosis.

An important aspect of cause word patterns is the inclusion of a modal of possibility such as *can*[20] or *may*, also found in previous work on negative prosody around the term *cause* (Stubbs, 1995; McEnery and Xiao, 2006; Dam-Jensen and Zethsen, 2007). In these patterns the negative outcome is glossed as a possibility but without any measure of likelihood given, thus the threat is present but its extent is uncertain.

With non-human actors in the subject position of the above clauses, further concordance analysis was carried out to discover the social actors linked to infertility. Consideration of wider co-text was sometimes required to elicit these, for example:

> *Women who eat a diet high in trans fats are more likely to develop a womb condition that can cause infertility, researchers say.* (The Daily Telegraph, March 24, 2010)

---

[20] CAN is also one of the top 10 most frequent terms in the pattern table but has not been included for individual analysis as 90% of examples are covered by the inclusion of other patterns such as *cause* and *lead to* with the variation as a result of less common attributive clauses such as *result in.*

In 22% of cases the human actor was omitted, and the behaviour or medical condition become the actors, as in the two examples below.

> *It is bizarre when smoking is one of the most important causes of infertility problems and the first thing a GP would advise is to quit*. (Independent on Sunday, June 18, 2006)

> *Gonorrhoea affects genitals, anus, rectum and throat and can cause infertility.* (The Mirror, June 16, 2009)

In common with the BLOGs *unexplained* frequently (n=83) precedes *infertility* in the NEWS Corpus and carries the unusual meaning of a diagnosis which is not a diagnosis. This adds a further dimension to the lack of control over infertility as it is not only an invisible illness (Conrad, 1987) but an unexplained one. While people experiencing infertility can actively seek to engage with a diagnosis as an explanatory mechanism and a way of regaining control, unexplained infertility does not function in this way and can potentially lead to further frustration.

> *So we fell into the category of "unexplained infertility" - a complete anti-climax!* (The Mirror, July 1, 2006)

The term *male infertility* originates in clinical literature (Jequier, 2011). Its high frequency in the NEWS Corpus is interesting because it functions as the marked term, assuming the non-marked form of female infertility and draws on related expectations about masculinity, gender and infertility (Barnes, 2014). Further analysis of the concordances of *male infertility* reveals a strong medical and scientific prosody with only 3 out of 181 examples relating to the emotional aspects of male infertility. In many of these concordances the focus is on scientific or technological approaches seeking to address male infertility. It is framed as a public health risk to be addressed, and rather

than blaming individual behaviour the term collectivises and distances individual men from the diagnosis.

> *Research indicates that male infertility is a growing problem.* (The Times, January 4, 2006)

> *'Male infertility is a growing problem and no one knows why. We'll be able to study the effects of pollution and nutrition in the lab.'* (Daily Mail, July 8, 2009)

Despite the prevalence of male infertility as a diagnosis, the female body is usually the site which is acted upon regardless of male or female factor diagnosis, and infertility is situated as a female domain. This will be explored further in Chapter 5 section 3.3.1 keywords categorised as significant others).

4.3.6   Discourses of Infertility in the NEWS Corpus

4.3.6.1 Infertility as a threat

The patterns NOUN *of infertility*, *cause infertility*, *to infertility* and *can CAUSE WORD infertility* all frame the threat of infertility as a potential negative outcome, where the threat is not a certainty but lies within the possibility of terms such as *linked to, can lead to* and *can cause.* In these cases, uncertainty is used to create a semantic prosody of peril.

> *Health experts have even expressed fears that wearing heels excessively can lead to infertility.* (Daily Mail, April 1, 2008)

> *This is the first time trans fats have been linked to infertility. They are already known to clog arteries, raising the risk of heart attacks and strokes.* (The Mirror, January 20, 2007)

> *Excess production of free radicals in the semen reduces sperm count and has been linked to infertility* (Daily Telegraph, February 11, 2008)

The threat of infertility is heightened by the medicalised framing; either as part of a collection of serious medical conditions, or as the result of another medical diagnosis;

> *About one UK woman in ten has polycystic ovary syndrome (PCOS). It results in enlarged ovaries and multiple cysts, a common cause of infertility.* (The Times, May 12, 2007)
>
> *Endometriosis causes infertility and is incurable.* (The Express, March 24, 2010)
>
> *An early diagnosis is vital, as apart from osteoporosis, coeliac disease can raise the risk of bowel cancer and cause infertility problems* (Daily Mail, January 19, 2010)

Crucially, while there are instances of individual stories about infertility in the NEWS texts it is represented as a threat not just to the individual but to society as a whole. This is most apparent in the concordances which reference rising infertility, particularly male infertility, as a public health threat;

> *Doctors fear that infertility may be becoming more of a male than a female problem, with fertility clinics treating more and more cases of male infertility.* (Daily Mail, July 30, 2007)
>
> *Last night one of Britain's leading fertility doctors blamed obesity for increasing levels of infertility across the nation.* (Daily Telegraph, February 1, 2008)

The construction of infertility as a public health threat is reinforced and intensified through links to other health panics which received a high amount of media coverage, such as obesity (De Brun et al., 2013; Lupton, 2013).

4.3.6.2 Reproductive responsibility and blame

While it initially appears that the news texts position medical conditions as causes of infertility, closer reading of concordances uncovered the blaming of individuals who

succumb to these conditions through their behaviour. A highly frequent example of this is infertility resulting from sexually transmitted diseases such as chlamydia, which account for 85% of concordances of *can cause infertility;*

> *Now it appears chlamydia, which can cause infertility, has exploded among women previously reckoned to be low risk.* (The Sun, July 11, 2006)

However, blame is not directly placed on individuals but on groups, who engage in behaviours which can be seen as socially undesirable, such as unprotected sex:

> *The startling rise in cases of the infection, which can lead to infertility and ectopic pregnancies, has alarmed health professionals, who blame increased casual and unprotected sex among young people.* (The Independent, July 2, 2006)

This can also be linguistically constructed as potential causation between behaviour, and infertility, in cases where the behaviour is not named but implied through shared knowledge of sexually transmitted infections.

> *But the discovery suggests that the prevalence of the disease may be contributing to infertility across an entire generation of young adults.* (The Times, October 15, 2007)

In the neoliberal climate of taking personal accountability for health (Lupton, 1995), infertility is characterised as the responsibility of individuals both to act upon advice about improving fertility and avoid behaviours which are contrary to socially sanctioned norms (such as being obese, smoking, drinking, having unprotected sex or delaying parenthood). This is presented through advisory messages which seek to manage this behaviour and reinforce these social norms as "common knowledge".

> *If you are diagnosed with polycystic ovaries, a common cause of infertility, losing weight is now the first line of management.* (The Sun, July 5, 2006)

We all know that being overweight can cause infertility and that smoking harms

not just mother, but baby too and affects fertility. (The Mirror, March 4, 2009)

Despite the focus on increasing rates of male infertility, responsibility for infertility is

framed as a female domain in the majority of NEWS corpus texts (68% of concordances

of the NEWS patterns of infertility). This can partly be explained by the

disproportionate focus of assisted reproductive technologies on the female body, even

in cases of male factor infertility (Throsby and Gill, 2004). It nonetheless places the

female body in a position to be judged and blamed against gendered norms of maternal

behaviour (Becker and Nachtigall, 1982; Johnson and Fledder-Johanssen, 2013).

4.3.6.3 Deserving parenthood

An aspect of infertility which links to threat and blame is the issue of who is entitled to

be a parent. In the NEWS Corpus this is presented in terms of socially sanctioned access

to treatment and the representation of infertility as lifestyle choice, brought about by

breaking norms around bodily behaviour, particularly procreative norms.

Access to infertility treatment, is problematized, on the one hand 75% of concordances

of fertility treatment advocating fair and timely access ("the right to a child" encoded

in the Warnock Report, 1984).

Couples seeking infertility treatment in some parts of Scotland are having to

wait up to three years longer than those in other areas, it was revealed

yesterday. (The Times, October 21, 2009)

Couples desperate to have a baby still face a postcode lottery to obtain infertility

treatment on the NHS, with help for all in some areas but for only a few in others,

experts say today. (The Guardian, July 20, 2006)

On the other hand, some texts advocate limiting access to treatment to those who meet

the criteria and thus earn the right to try. Meeting the criteria for treatment is most

commonly framed as adhering to guidance around weight loss, smoking cessation and sexual behaviour;

> *If we can afford to provide some infertility treatment then it should go to those who are best able to benefit. If that excludes obese women on sound medical grounds, so be it.* (The Times, September 1, 2006)

This draws on the language of blame and responsibility described above, in which by the threat of infertility is used to manage behaviour seen as socially deviant, such as obesity.

Ideals around reproduction, particularly with regards to maternal age and relationship status, feed into normative criteria for parenthood, framing these older mothers as problematic parents.

> *Today's report, from the American Society for Reproductive Medicine's meeting in New Orleans, that older mothers may be increasing the risk of infertility in their daughters by delaying childbirth.* (The Independent, October 25, 2006)
>
> *Women who choose motherhood at a later age also run much greater health risks for themselves and their baby. Over the age of 35, the possibility of infertility rises, and for those who become pregnant there are greater chances of miscarriage or complications during pregnancy or labour.* (Daily Mail, May 26, 2010).

The NEWS Corpus discourse is primarily a moralising discourse with notions of blame, responsibility, and deserving parenthood all contributing to this prosody.

4.3.6.4 Summary

In contrast to the personal experience represented in the BLOG Corpus, analysis of the NEWS Corpus data reveals the emphasis placed on the intersection of the social and medical aspects of infertility. Constructions of infertility in the NEWS Corpus

foreground dominant biomedical discourses. However, this also draws on other socio-medical moralising discourses such as the obesity crisis, (Lupton and Petersen, 1996) and the neoliberal culture of personal responsibility and blame (Lupton, 1995). Thus, infertility is seen as both a personal medical condition and a public health crisis. The news media construction of infertility also perpetuates shared norms of behaviour and beliefs around reproduction and parenthood.

When the dominant framing is of infertility as an individual responsibility and a social ill, it can be problematic for those who identify as infertile to manage to avoid self-blaming and feelings of stigma or to reject the negative media evaluation and stigmatisation. Bloggers seek to contest this blame and shame through the legitimacy of a medical diagnosis, and by distancing themselves from people who have "deserved" their infertility through their behaviour, yet this can serve to reinforce normative ideas of deserving parenthood.

4.3.7   Infertility in the CLINIC Corpus

The CLINIC Corpus, unsurprisingly given the subject matter, shows the highest frequency of the term *infertility.* As shown in Table 4.8 below, it shares many of the collocational patterns of infertility in the BLOG and NEWS corpora. However, the texts share the personal aspects of the BLOG Corpus and the biomedical and aetiological aspects which are found in the NEWS Corpus.

L3	L2	L1	Centre	R1	R2	R3
THE	OF	OF	INFERTILITY	AND	THE	THE
OF	MALE	MALE		TREATMENT	IS	AND
TO	CAUSE	UNEXPLAINED		IS	AND	A
AND	CAUSES	FOR		NETWORK	UK	TO
CAUSE	THE	FACTOR		IN	A	IS
A	TREATMENT	IN		THE	IN	ARE
IN	AND	AND		PROBLEMS	TO	TREATMENT
IS	FOR	THE		COUNSELLING	ARE	BE
FOR	TO	WITH		CAN	CAN	OF
ALL	WITH	TO		TREATMENTS	FOR	AS

Table 4.8 Top 10 patterns around *infertility* in the CLINIC Corpus

As with previous corpora the main collocational patterns of infertility are grammatical rather than lexical with exceptions being *male* as a frequent modifier and medical terms such as *treatment(s)* and *counselling* as shown in Table 4.9. The lexis in this corpus is likely to draw on national guidelines around communicating treatment options set by HFEA and NICE, which may mean less stylistic variation than in the other corpora. While the term *infertility and* is included in the concordance analysis for the NEWS Corpus in the CLINIC Corpus it does not take the form of medical listing but as a conjunction of two clauses.

Pattern	Example from concordances	Frequency
of infertility	Anovulation is the commonest cause of infertility and the easiest to treat. (AGO[21])	276
infertility is	Infertility is a common problem. (STJ)	103
infertility treatment	What are my infertility treatment options for endometriosis? (MAN)	144
male infertility	Although male infertility is commonly associated with impotence, many infertile men have perfectly normal sexual relationships. (MID)	113
unexplained infertility	In a proportion of couples we cannot find an obvious cause for their subfertility and this is termed "unexplained infertility". (RUH)	71

Table 4.9 Patterns for analysis *infertility* in CLINIC Corpus

4.3.8   Overview of patterns around infertility in the CLINIC Corpus

Concordance analysis of the most frequent pattern around infertility in the NEWS corpus, *of infertility*, revealed a broader range of lexis than was found either in the BLOG or NEWS corpus where main prosodies were the experience and causation respectively. Although *cause/causes of* infertility account for 96 occurrences in the pattern *of infertility,* in contrast with the NEWS corpus the strongest prosody is around identification and treatment of such causes (aetiology), not on placing blame and responsibility on groups or individuals;

---

[21] Each clinic was given a three letter code derived from the clinic name which is used when quoting the text. A full list of these codes can be found in APPENDIX III.

In order to determine the cause of infertility and the subsequent planning of the

treatment cycle, the doctor will carry out a series of investigations. (IVF)

There are numerous tests used to discover the various causes of infertility.

(CRE).

The drive to categorise and thus address reasons for infertility can also be found in lexis

of typology which precedes the pattern *of infertility*: *cases* (n=11), *range* (n=10), *forms*

(n=8), *types* (n=6).

Another unique aspect of the CLINIC corpus is the foregrounding of infertility being

acted upon in the patterns *diagnosis|treatment of infertility* (n=31)

[ANONYMISED] has one of the world's most experienced donation teams

dedicated to the treatment of infertility. (CAR)

Infertility treatment is represented within the model of patient choice (65% of

concordances), another aspect of the neoliberal discourse of personal responsibility for

health (Mooney, 2009), with potential consumers of infertility services positioned as

knowledgeable collaborators in treatment decisions.

We offer confidential private consultations to help you decide the best and safest

infertility treatment available. (SPI)

So the advice is, quite rightly, to make sure that both you and your partner are

in the best health you can be before you embark on any infertility treatment.

(MAN)

We have monthly open evenings so anyone thinking about infertility treatment

can come and meet us face-to-face and ask as many questions as you can. (MID)

Additionally, infertility treatment is positioned as something which is sought as part of

a solution to the threat of infertility with the clinic as the conduit to the solution.

> *We have one aim - to offer the highest standards of patient care and comfort for couples and individuals seeking infertility treatment.* (NUR)

The pattern *infertility is* also foregrounds aetiology (54% of concordances), as seen in the patterns above, and recontextualised in the BLOG Corpus as legitimising strategy placing infertility within the biomedical model.

> *Infertility is most commonly caused by problems with ovulation (the monthly release of an egg).* (NHS)
>
> *Infertility is an illness and people have the right to try.* (IVF)
>
> *With professional help infertility can often be treated and infertility is no one's fault.* (ORI)

The pattern *infertility is* is used to highlight the clinic's awareness of the social and emotional aspects of infertility albeit less frequently (in 20% of occurrences).

> *Infertility is difficult for many couples to contend with* (HER)
>
> *Independent counselling offers couples and individuals an opportunity to explore and discuss in a safe and supportive environment the effect their infertility is having on their lives and relationship.* (SHR)

The clinical definitions of infertility appear to actively contest apportioning blame for infertility, focusing rather than the potential solutions which they offer and while blame is backgrounded, explanatory models are foregrounded.

Although the pattern *male infertility* could use the marked term for blaming (e.g. female infertility is unmarked as *infertility*), the concordances actually use the explanatory model with treatment of male infertility framed as a technological goal.

> *Since it was introduced in the mid-1990s, intracytoplasmic sperm injection (ICSI) has revolutionised the treatment of male infertility.* (LON)

Abnormal semen (the fluid containing sperm that is ejaculated during sex) is the

most common cause of male infertility. (NHS)

Male infertility, like *unexplained infertility*, is represented as a clinical challenge rather than an insurmountable obstacle.

In just under 20% of couples no definite cause will be found, even after complete

investigation. These couples are said to have unexplained infertility but can, of

course, still be treated. (BRI)

As noted earlier, the term *unexplained infertility* is possibly unique as a diagnosis which is an absence of diagnosis and is reliant on the accepted definition of infertility as a failure to conceive after a given time.

It is often the first treatment to be recommended when couples have unexplained

infertility, that is, no medical reason why they cannot get pregnant. (MAN)

The uncertainty of this definition can be utilised by clinics to encourage continued engagement with treatment and to manage expectations around infertility diagnosis and treatment.

4.3.9   Discourses of infertility in the CLINIC Corpus

4.3.9.1 Normalising the threat of infertility

While infertility is still framed as undesirable in the CLINIC Corpus, instead of an insurmountable obstacle it is represented as both commonplace, thus normalising the condition, and treatable, presenting a clinical solution to the threat. In the patterns x *of infertility* and *infertility is* lexis such as *frequent* and *common*, foreground the normality of the experience of infertility. As a rhetorical strategy in normalising infertility, the clinics quantify infertility as a common public health issue in the UK.

The causes of infertility vary between individuals, but ultimately result in a couple's inability to conceive a child. Infertility is not wholly uncommon, with 1 in 6 to 1 in 7 couples in the UK affected. (SPI)

Primary infertility is an extremely common problem, affecting more than one in seven couples attempting their first pregnancy. (CMF)

Infertility is very common; in fact, about one in six couples experience some problems in achieving pregnancy. (ORI)

The clinics position themselves as providers of reassurance that this "common" problem can be resolved. This potentially has a destigmatising effect and is thus positive for people experiencing infertility. However, by normalising infertility, and related treatment the clinics are better able to pursue their agenda as suppliers of these services.

Anovulation is the commonest cause of infertility and the easiest to treat. (AGO)

Some guides to the possible causes of infertility and possible treatments are technical and full of medical jargon. [ANONYMISED] *quick guide to infertility and some of its causes is written in everyday language to help you understand the issues.* (ORI)

4.3.9.2 Medical solutions and expertise

While in the previous section the normalisation of infertility was foregrounded, clinic texts also highlight their expertise in the field as a potential solution to the problem of infertility. Thus, the condition becomes a target for clinical experts to act upon using a model of investigation, diagnosis, treatment.

Tests involve a detailed analysis of sperm count and quality, which allow us to diagnose the probable cause of infertility and recommend expert advice without delay. (CRE)

GPs will refer couples with fertility issues to the relevant hospital where checks such as hormone tests will be undertaken to try and identify the cause of infertility. The couple will then be able to have treatment at a specialist fertility clinic. (BOU)

Although the primary focus in these examples is expertise and medical authority, the investigation-diagnosis-solution model also draws on a neo-liberal discourse of personal choice and responsibility. In the examples below, the addressee of the website, the person experiencing infertility, is represented as empowered to make "responsible" choices through the expert knowledge provided by the clinic.

Learn about the causes of infertility, our ever widening range of treatment options and what you can do to increase your chances of success. (BRI)

We also offer you the opportunity to have a personal 10-minute one-on-one chat with Professor [ANONYMISED], which is extremely useful in helping you make an informed decision on infertility treatment. (CRE)

In using the second person pronoun *you* the examples above employ an aspect of synthetic personalisation (Fairclough, 1992), constructing potential consumers as wanting to equip themselves with knowledge of infertility and possible treatments in order to gain from the clinical expertise on offer.

4.3.9.3 Managing reproductive expectations

While clinics seek to normalise infertility, and offer solutions through infertility treatment, the clinic texts also indicate a management of expectations through lexis of hedging and modality. This is particularly true in the case of *unexplained infertility* and *infertility treatment*.

Couples or women with unexplained infertility who haven't had success with other fertility treatments may have success with IVF. (NHS)

Unexplained infertility means, literally, that the cause of infertility is not known; about 22% of couples fit into this category. Some of these patients will eventually achieve a pregnancy naturally but many will not. (SPI)

The fertility doctor will give guidance on at what point treatment has more to offer than continuing to try naturally for a pregnancy. Unexplained infertility can be managed in several ways and is often the reason for considering IVF. (ABE)

The management of expectations can be viewed as a positive for people experiencing infertility, indeed clinics are legally bound to indicate the likely success of treatment for the full range of diagnoses. However, the modality used retains the possibility of solution to the problem of infertility and this is foregrounded to encourage consumers to view intervention as a necessary step to pregnancy.

The CLINIC Corpus discourses of infertility position the ideal reader and thus consumer of their services, promoting personal responsibility to achieve the desired reproductive outcomes and providing the solutions to enable them to do so. Thompson (2006) presents an ethnographic view of the fertility clinic with patients as consumers and this view is born out in the examples above. The prevalence of the term *couple* or *couples* indicates a heteronormative view of the ideal clinical consumer and the addressee of clinical texts.

4.3.9.4 Summary

The aim of the clinic is to manage the perceived needs and expectations of consumers of their service. The language of the clinic seeks to reassure both of the commonality of the experience of infertility and yet the availability of individualised medical solutions. Modality is used to manage expectations and if one is being cynical, absolve the clinic of responsibility for solving the problem of infertility.

4.4 Conclusion

When looking at the patterns around infertility it is immediately clear that the lexis of the BLOG Corpus stands apart from the NEWS and CLINIC Corpora, which show more convergence both in patterns and discourses.

Descriptions of infertility are most frequently found in the patterns *x of infertility* and *infertility is* as well as the less frequent *modifier infertility* where the modifier includes *male*, and *unexplained*.

Further descriptive work is done through the pattern *infertility and* which links the condition with other undesirable features. These features include infertility and loss in the case of the BLOG Corpus, infertility and other medical conditions in the NEWS Corpus, while the CLINIC corpus combines both loss and comorbidity. Thus, the bloggers focus on the personal experience, of harm, while the NEWS and CLINIC corpora frame it in public health terms.

In the NEWS and CLINIC corpora, patterns relating to the aetiology of infertility in the forms *risk|cause of infertility* and *lead to infertility* are frequent, in contrast to the BLOG corpus where they are very infrequent. Again, this foregrounds the medicalised perspective, and the use of infertility as a threatened outcome in the moralising discourse perpetuated in the NEWS Corpus. News text producers can thus recontexualise clinical lexis or report clinical findings to support their evaluative stance with an "expert view".

Further reinforcing the medical perspective of infertility both NEWS and CLINIC patterns include solutions to the condition in the patterns *infertility treatment*, and *infertility counselling*. These patterns are not frequent in the BLOG corpus, however, bloggers on a specific topic need not modify the word treatment with infertility as this is the focus of their experience and shared understanding.

A particularly interesting pattern due to the way it functions in two different semantic sets is *with infertility.* One the one hand it is used in BLOG and NEWS Corpus to give agency to the person managing the condition i.e. *struggling with infertility*. Yet, in the NEWS and CLINIC corpora the pattern *with infertility* is also preceded by a noun designating the person who is experiencing infertility, a common construction in medical lexis, using the pattern person with condition to foreground personhood over diagnosis. The pattern person with condition is as mentioned above used to destigmatise and de-medicalise the experience. However, the bloggers appear to actively seek to engage with infertility as the pattern *my|our infertility*, indicating ownership of the condition is only a top pattern in the BLOG Corpus.

What is perhaps most interesting about the discourses developed from these patterns is the intersection of the personal and the social, as the personal impact is detailed by bloggers, while infertility is framed as both a public health and personal threat in the NEWS Corpus especially.

Medical treatment is problematized in the NEWS and BLOG but it is apparent that medicalisation surrounds the management of infertility and will impact on the experience of it, even if an individual rejects the medical pathway.

What is also clear is that infertility is fundamentally a breakdown of expectations, personal, social and bodily, which is felt by the individual, recontextualised in the media and reinforced through the clinics.

The identification of sub-discourses around the term *infertility*, led to the development of the overarching discourses of infertility, however these were not fully realised until analysis and identification of sub-discourses for all keywords were completed.

Table 4.10 below shows the organisation of the sub-discourses from this chapter into the overarching discourses which were identified across the thesis.

BLOG CORPUS   NEWS CORPUS   CLINIC CORPUS

OVERARCHING DISCOURSES

	Transformative effect of infertility	Medicalised (in)fertility	Marketization of reproduction	Parenthood - imperative and privilege
SUB-DISCOURSES	Infertility acting on the self	Pursuing medicalisation	Medical solutions and expertise	Infertility as threat
	In infertile space and time	Normalising the threat of infertility	Managing expectations	Responsibility and blaming
				Deserving parenthood

Table 4.10 Discourses and sub-discourses identified for keyword infertility

The Table 4.10 above shows the distribution of sub-discourses across the overarching discourses for each text type, and this will be replicated in the conclusions of each analysis chapter in the thesis.

Chapter 5 - Infertile Identities: The representation of self and others

5.1 Introduction

> *"Whatever is silenced will clamor to be heard, though silently."*
>
> (Margaret Atwood. The Handmaid's Tale, 1985)

Social science research into the experience of infertility foregrounds its effect on identity in multiple ways, encompassing gender (Cunningham, 2013), biographical disruption (Throsby, 2004; Letherby, 2009) and normative constructions of motherhood (Thompson, 2006). At the centre of experiences of infertility is the desire to achieve an identity: motherhood, and the inability to do so, which is problematic for one's sense of self and for the sense of existing within a pronatalist society (Parry, 2005).

Looking at representations of infertile identity, in this chapter I address the following research question:

> How do 'personal' texts, such as infertility blogs, support or contest 'medical' and 'media' representations of the lived experience of infertility?

Within the context of this question the scope of this chapter covers representations of identities around infertility, concentrating the analysis on two sub questions:

a) How are women represented in relation to the experience of infertility in personal blogs, news and online clinical texts?

b) How do these representations affect the management of identity by women who experience infertility?

Personal narratives are compared with collective narratives and societal norms of reproduction as I explore how women experiencing infertility manage their identity linguistically.

In order to address my research questions, in this chapter I look at the multiple, possible identities for women who experience infertility. My initial focus (in section 5.2) is on the construction of identity in light of infertility, looking at self-representations in the BLOG Corpus and representations of women who experience infertility in the NEWS and CLINIC Corpora through the use of pronouns. In the second analysis section (5.3) my focus turns to the (male) partners of infertile women, though my main interest here is how these women are represented relationally, as a key facet of identity is "who people are to each other" (Benwell and Stokoe, 2006: p6). In the final analysis section (5.4) I turn my attention to the mental/emotional processes of women experiencing infertility in patterns around verbs of cognition and emotion. All the search words selected for concordance analysis are top 100 key words in at least the BLOG corpus (as this is the data which shapes the analytic focus for the thesis) and can be found in the *social actors* or *feelings and emotion* themes of the Keyword table (see Table 4.1).[22] Table 5.1 shows the search words which will be used in the three analysis sections in this chapter.

Category (section)	BLOGS	NEWS	CLINIC
Infertile selves (5.2)	I	she	you
Significant Others (5.3)	DH, hubby, husband, OH	husband	partner
Feelings and emotions (5.4)	know, think, feel	know, think, feel	know, think, feel

Table 5.1 Search terms for each section of this chapter

As the BLOG corpus is written by heterosexual women it is inevitable that the analysis in this chapter is viewed through the lens of a heteronormative female experience of infertility, and I address this in my discussion on possible further work (chapter 8).

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[22] Although clinical actors such as *nurse* and *Dr* are also key across the corpora they will be discussed in the next chapter on the embodied, medicalised experience of infertility.

5.2 The self and infertility

5.2.1 Introduction

Pennebaker (2013) views pronouns as central to the language of the self, whilst Vaughan and Clancy (2014) describe them as "linguistic proxies for identity". The top two lexical keywords for the BLOG corpus were, perhaps unsurprisingly *I* and *me*. Therefore, the focus for this section is the use of pronouns in self-representation as "personal pronouns play a crucial role in the construction of social identities and social relations" (Hardt-Mautner, 1995).

It is worth noting that in the BLOG and NEWS corpora personal pronouns occupy high positions on the keyword list, yet this is not the case for the CLINIC corpus, indicating genre differences e.g. the CLINIC corpus is written in a more impersonal voice.

5.2.2 I in the BLOG corpus

Due to the autobiographical nature of the blogs there are an extremely high number of occurrences of *I* in this corpus (58,768 in total), too frequent to examine in a conventional concordance analysis. The Patterns tool was used to produce a table of the most frequent patterns around the search word *I* (see below Table 5.2).

N	L3	L2	L1	Centre	R1	R2	R3
1	THE	THE	AND	I	AM	TO	TO
2	I	AND	THAT		HAVE	A	THE
3	TO	I	WHEN		WAS	THE	A
4	A	OF	BUT		HAD	I	I
5	AND	TO	SO		DON'T	HAVE	AND
6	OF	A	AS		THINK	THAT	IT
7	MY	THIS	IF		KNOW	IT	THAT
8	IN	ME	BECAUSE		CAN	NOT	MY
9	IT	MY	WHAT		WILL	MY	IN
10	ON	SO	TIME		DO	BE	ON

Table 5.2 Top 10 patterns around *I* in the BLOG Corpus

As shown in table 5.2, the most frequent pattern of R1 collocation around I is *I AM*. Due to its high frequency, and the fact that *I AM + NOUN PHRASE* functions as a statement of being rather than doing and is therefore a useful example of what Benwell and Stokoe (2006:98) call "identity deixis", I chose to focus on *I AM* as the search term for this section (see Table 5.3).

N	L3	L2	L1	Centre	R1	R2	R3
1	THE	THE	AND	I AM	NOT	TO	I
2	I	AND	THAT		A	A	TO
3	TO	I	BUT		SO	I	AND
4	A	TO	SO		GOING	AND	THE
5	AND	OF	AS		STILL	THE	A
6	OF	MY	BECAUSE		NOW	THAT	MY
7	IS	IS	NOW		FEELING	IN	THAT
8	MY	SO	IF		VERY	OF	FOR
9	IN	THIS	WHEN		ON	MY	OF
10	FOR	A	WHICH		IN	ON	THIS

Table 5.3 Top 10 Patterns for *I am* in the BLOG Corpus

As there are 5215 occurrences of *I AM* in the BLOG corpus, I further refined my analysis to the patterns in Table 5.4.

Pattern	Concordance example	Frequency
I am NOUN PHRASE	I am a walking encyclopaedia. (IF018)	n=231
I am not NOUN PHRASE	I am not good at waiting for things. (IF012)	n=92

Table 5.4 *I am* - patterns for analysis in the BLOG Corpus

In doing so, I capture positive and negative identification phrases as well as the ongoing process of identification and, importantly, dis-identification with a range of possible selves (Goffman, 1990). In this section I address only statements about states of being rather than statements of emotion as this is covered in section 5.4. This reduced the concordances to a large but still manageable set of 725 which were coded using inductive methodology into the following 3 sub-discourses: 1) more than the sum of my lady parts, 2) the medicalised, monitored self, and 3) the disrupted self.

An important and perhaps underexplored aspect of the experience of infertility is the negotiation of a multiplicity of selves, unrelated to the infertile self, in order to manage identity. This is most visible in the sub-discourse of "more than the sum of my lady parts" discussed below.

5.2.2.1 More than the sum of my lady parts

Although the blogs are written primarily from a subject position of the "infertile" self, 41% of the concordances of *I am* include identities which are unrelated to the writers' reproductive potential. They also include opportunities for exploration of comedic and confessional identities.

These "other" selves include positive personal and professional characteristics as seen in the examples below:

> *I am a decorating whiz.* (IF017)
>
> *I am a geek. I actually like cataloguing and classifying* (IF018)
>
> *I am a research assistant at a large London teaching hospital.* (IF016)
>
> *I am a Veterinary Surgeon and work extremely* long hours (IF019)

One of the most unique and revealing ways to manage identity work in the infertility blogging community is the use of self-mockery, often showing a self-consciously comedic element, which confirms users as part of the blogosphere (Herring et al., 2004). Although these examples are written in a self-deprecating tone, there is also a sense that the roles performed here are those which the bloggers are happy and comfortable with, part of an ongoing narrative of self (Woodward, 2002) which is woven to deliberately elicit amusement and approval.

> *When I was younger I was somewhat of a nerd. I know that's hard for you all to believe now that I am dazzling fashion-conscious blonde girlie!* (IF025)
>
> *I am a Morning Person the same way Silvio Berlusconi is a feminist.* (IF018)

> *I am a bit of a technocripple but I can't believe that I have created this little*
>
> *diary.* (IF002)

They also include a confessional element, encouraged by the perceived anonymity of CMC but again these "confessions" are narrated to prompt amusement rather than derogation from their readers.

These statements of identity, separate from, or in addition to the infertile self may be an active attempt to challenge to the feeling described thus.

> *In my head I know that I am more than just the sum of my lady-parts. But in my*
>
> *heart? I feel pointless*. (IF014)

5.2.2.2 **The medicalised self**

A diagnosis of infertility is the point at which individuals frequently begin to identify themselves in relation to the medical model, of particular note is the emphasis used in the capitalisation below to indicate how the blogger rejects infertility as a state (*HAVE*) and instead conceptualises it as an identity (*I AM*).

> *And that's why it's right that at the moment I define myself in a new way. I don't*
>
> *HAVE infertility. I AM infertile.* (IF009)

In over 30% of concordances of *I am* the bloggers self-refer in terms of the medicalised self but the use of quotation marks in the examples below suggests these are the words of medics which the bloggers themselves may not choose to identify with.

> *I am described as "a 28-year-old, nulliparous lady".* (IF019)
>
> *At 38 I know that I am a 'geriatric mother'* (IF023)

Over time the lexicon of the bloggers reflects increased engagement with the medicalised model of infertility, particularly in the positioning of the self in terms of clinic time. In 12% of concordances the bloggers use clinical acronyms to describe their reproductive status in the phrase *I am*.

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So I wanted to avoid that this time, we waited for as long as we could and tested

just one day before our OTD, today I am 10dp3dt (10 days past a 3 day transfer,

so 13dpo (13 days past ovulation/egg collection). (IF007)

Today I am 6DPO (6 days past ovulation) and this morning I saw a temperature

dip. (IF015)

The concordances analysed show an acute awareness of both time and age in normative

reproductive terms, and concordance lines of *I am* related to age account for 28% of the

total, acknowledging the central role of this in accessing medicalised reproduction.

Also, I am 34. I am running out of time. If I was 24, hell, yes, as many 'see what

you can do in your own bed' cycles as I liked. (IF018)

Today is exactly one month since I started to properly bleed (floods rather than

spots) and exactly 6 months until I am 42 and no longer eligible for IVF in this

country. (IF016)

In Scotland I am the age to qualify for having free NHS treatment as it's 23-39.

(IF007)

These examples also reflect the categorisations imposed by clinical eligibility

requirements, which leads to further self-monitoring.

5.2.2.3 Disrupted expectations of self

In contrast with the comedic tone of the previous examples, in 30% of the *I am* and *I

am not* concordances from the BLOG Corpus, infertility is revealed as acting upon the

self in a negative way exemplified below;

Where has xxx gone? I feel like an empty shell. I am depressed, I am moody, I

am grumpy, I am down, I am not myself (IF025)

To hell with weekly blood tests. To hell with sex. I want the summer off, to get

my head together and remember who I am, and I want a holiday. (IF005)

The examples above express an apparent separation of the "actual" self and the "infertile" self, possibly as a way of managing the way in which the lived experience of infertility negatively disrupts expectations of an identity which includes reproduction. The infertile self is experienced in conflict with the expectation of the writer and perceived societal expectations.

> *I am childless not by choice, I have no say in the matter and I am being treated like a 'cold hearted career woman'.* (IF002)

> *I am not normal. I haven't got the luxury of choosing when I start my family.* (IF025)

> *I am not the person I meant to be, and I still have to get up every morning and be this other, lesser, human being and pretend I like it.* (IF021)

The unoccupied subject position of mother is one which is problematic for those experiencing infertility and this gap between expectation and reality results in the problem of how to enact a non-parenting identity.

> *As I said to DH last night, if I don't get pregnant, all I am is an unemployed woman who can't have children (or a woman in a job she hates who can't have children).* (IF010)

> *I am contemplating how I am going to live my life without a family and imagine I will be the crazy rabbit lady at the end of the street.* (IF025)

In this acknowledgement of a self which the bloggers do not like or wish to accept, there are examples in which the undesirable infertile self is one which may or may not exist once their infertility is resolved, demonstrating a sense of multiple and fluid identities (Benwell and Stokoe, 2008).

> *I hate being that woman, but I am, intrinsically, her until this nightmare is over.* (IF010)

I am also beginning to confront the fact that childlessness remains a very real

possibility. I know that I will be forever scarred by infertility. (IF024)

The examples from blog texts show how multiple identities are negotiated to mediate

the transformative effect of infertility and the shift in identity necessitated by it as the

writers seek the desired position of mother.

5.2.3 SHE in the NEWS Corpus

The word *she* is the highest keyword in the NEWS corpus (occurring 28,000 times) and

is used here as a comparator for *I* in the BLOG Corpus. For the sake of equivalence, the

pattern *pronoun + present tense To BE* is my chosen search term, with top 10 Patterns

shown in Table 5.5, although it is only the fourth most frequent R1 collocate of *SHE* in

the NEWS (*was*, *says* and *said* are the top 3).

N	L3	L2	L1	Centre	R1	R2	R3
1	THE	THE	THAT	SHE IS	A	TO	TO
2	TO	AND	AND		NOW	A	THE
3	A	HER	BUT		NOT	THE	AND
4	HER	TO	IF		THE	AND	A
5	AND	A	BECAUSE		ALSO	HER	OF
6	IS	OF	SAYS		STILL	OF	HAVE
7	OF	SHE	WHEN		IN	IN	HER
8	SHE	IS	AS		PREGNANT	WITH	SHE
9	IN	IN	NOW		AT	BY	WITH
10	NOT	HOW	HER		EXPECTING	THAT	FOR

Table 5.5 Top 10 patterns around *she is* in the NEWS corpus

From 1768 concordances retrieved from the search term *she is* there are 370 examples

where the referent of *she* is not a woman with experience of infertility, these are not

selected for analysis, instead all the concordances which did refer to women

experiencing fertility were analysed. Therefore there is no table of particular patterns of

analysis in this section. In the majority (90%) of examples these are women who have

130

engaged with ARTs, demonstrating the conflation of infertility with treatment seeking as the societal norm in this context.

The texts of the NEWS Corpus as a whole represent societal norms around reproduction and position women in relation to norms of age, lifestyle choices and engagement with treatment. All the concordance lines in this section support a predominantly pronatalist position but only within the context of normative reproduction, as any deviance from this norm was a case for critique.

5.2.3.1 Aging mothers as a cautionary tale

The most commonly subverted reproductive norm is the category of older mother, women who reproduce past the age at which they are expected to do so, and who are unable to do so without the use of ARTs. Sixty per cent of concordances referred to the age of the women who were experiencing infertility and drew on the discourse of aging mothers as a cautionary tale. There are two features of this sub-discourse, extraordinary examples of aging mothers and the generalised threat of age related infertility. The examples of the first aspect, extraordinary cases, focused on just three women who were labelled "Britain's oldest mother" Patricia Rashbrook in 2006 (30%), Sue Tollofson in 2010 (8%) and Elizabeth Adeney in 2009 (3%). The women labelled thus were constructed as selfish and foolish individuals, figures for ridicule and a cautionary tale warning against delayed reproduction.

> *Dr Rashbrook - who is, of all things, a child psychiatrist – has gone to extraordinary lengths to conceive a child who will still be at school when she is 80. That must be seen as satisfying her desires, not putting her unborn child's interest first*. (The Daily Telegraph, May 5, 2006)
>
> *Most parents would hope to give at least 30 loving years to their offspring.*

> *What kind of fool thinks she is entitled to have a 66-year age gap?* (Daily Mail,*
>
> June 3, 2009)

A particularly interesting aspect of the reporting of older mothers who are critiqued for the flaunting of what is constructed as their inappropriate fecundity, "showing off their bump".

> *BRITAIN'S oldest mum-to-be proudly showed off her bump yesterday. Beaming*
>
> *child psychiatrist Patricia Rashbrook 62, said she is "delighted" after splashing*
>
> *out on fertility treatment with an Italian medic.* (The Express, May 5, 2006)
>
> *WITH her sizeable bump on show, this is Elizabeth Adeney Britain's oldest*
>
> *mothertobe. At 66, she is four years older than the previous record holder.*
>
> (Daily Mail, May 16, 2009)

The older mothers in the examples above are represented as cautionary tales against late reproduction. In addition to this, the possible age-related decline in fertility is framed as a public concern of which women should be more aware, encouraging adherence to reproductive norms and monitoring the reproductive self.

> *Too many young women who think it will be fine to wait until they're in their*
>
> *late 30s to try for a baby. In fact a woman is half as fertile at 35 as she is at 25,*
>
> *and half as fertile again at 40. (Guardian, 2006)*
>
> *ONE in three women is still single by the time she is 35, according to a new*
>
> *survey. It's a significant proportion, and alongside the fact that one in five*
>
> *women has not had a baby by the age of 40, a picture emerges of a generation*
>
> *playing Russian roulette with their fertility.* (Daily Mail, April 12, 2007)
>
> *Tony Rutherford, chair of the British Fertility Society, said: "If a woman leaves*
>
> *it late, by which I mean 36, she is taking a gamble.* (The Observer, August 9,
>
> 2009)

In the examples above and below, women are framed as irresponsible and unrealistic in their expectations of age related infertility and potential treatment options. In the second example above, being single is implied to be part of the problem of women who play 'Russian roulette' with the infertility – acting as a warning to women who do not take a traditional heteronormative route through life. The use of gambling metaphors and the term *reality check* in the example below imply not just obliviousness but wilful ignorance.

> *She is now 41. After four rounds of IVF - three full cycles and one where she had a frozen embryo implanted - she is up against a reality check.* (The Sunday Telegraph, June 8, 2008)

> *She is part of an epidemic of older women who think they can get away with defying biological laws that have held good for thousands of years.* (Daily Mail, July 17, 2009)

The representation of age related infertility and delayed motherhood metaphorically as an *epidemic* affecting a generation of women creates a moral panic around aging women who want to be mothers. The use of the individual examples shown at the start of the section is extrapolated to the depiction of a societal problem.

5.2.3.2 Earning parenthood

Ways in which women can earn the right to motherhood are myriad in the NEWS Corpus, via engagement with technology, compliance with lifestyle/societal norms and through legislature.

In the examples below, the right to have a child is a contested concept within a framework of socially sanctioned reproduction based on age, weight and "lifestyle" choices.

To their delight she became pregnant first time and is due to give birth in
October. But she is adamant that weight guidelines for NHS fertility treatment
are unfair. (Daily Mail, August 31, 2006)

Dr Rashbrook would not have been treated in the UK, where the authorities
consider she is too old. (The Guardian, May 4, 2006)

The right to (try to have) a child is also constructed in terms of legal endeavours and in the examples below draws on ideas of genetic relatedness, and gametes as commodities.

The woman claims she is entitled to have them implanted as her husband signed
his consent to the procedure in 2002. (The Sun, February 5, 2009)

What lies at the very core of this case is Miss Evans's desire to become a mother,
but to become a mother to children that are genetically hers. She is not alone in
this quest. (Daily Telegraph, March 13, 2006)

As in the examples of aging mothers, women claiming their right to a child are in some cases positioned as entitled and negatively evaluated. Language like 'But she is adamant that' and 'claims she is entitled' appear to give a voice to the women in these news stories but at the same time raise questions about the credibility of these women's views. However, the desire to participate in the gold standard of reproduction is understood as a shared value.

5.2.3.3 A baby at any cost

While the examples above show women who have successfully pursued motherhood, women who have not are represented as desperate to do so at any cost which even in a pronatalist society is also negatively evaluated.

A WOMAN of 54 is so desperate to have a baby she is advertising on busy
London buses for an egg donor. (Mirror, March 5, 2007)

> *She is desperate to have children and if they had stayed together they might*
>
> *have.* (The Sun, April 13, 2007)

Again, in the second example above, the phrase 'and if they had stayed together' keys in to the previously seen representation of women who pay the price of not being in a heteronormative relationship.

Reporting of the individual experience of infertility also includes accounts of celebrity mothers, who are often placed at the intersection of the categories of aging and desperation. And whilst desperation for a child is negatively evaluated, there are also examples in the NEWS Corpus in which women who (desperately) keep trying to have a child are lauded for their determination to achieve motherhood "at last".

> *AFTER suffering 18 miscarriages, Angie Baker hardly dared hope that her 19th*
>
> *pregnancy would be successful. But thanks to pioneering treatment, she is a*
>
> *mother at last.* (Daily Mail, February 19, 2010)
>
> *CUDDLING her twin babies, Stacy Bodle just can't stop smiling - after years of*
>
> *heartbreak and tragedy, she is finally a mum. And the 30-year-old married*
>
> *businesswoman owes it all to a pioneering fertility "recipe" of eggs and soya*
>
> *beans* (The Mirror, May 2, 2011)

In the NEWS Corpus the overarching message is of socially sanctioned reproduction. Whilst motherhood is represented as a normative aspect of female identity to be pursued and earned (sometimes at a high price) those who try too hard or do so outside of reproductive norms are negatively evaluated. The sub-discourses of aging mothers, the right to a child and desperation do not stand alone but, in most examples, they intersect with each other.

5.2.4   YOU in the CLINIC Corpus

As a third and final triangulation of PRONOUN BE, in the CLINIC Corpus the node

chosen for analysis is *you are,* with the top 10 patterns shown in Table 5.6. Here, it is

important to note that *you* is only in 86th position in the CLINIC keyword list, and

several actor keywords are higher, including *patients* (15th), *couples (*18th) and *women*

(21st). I take the view from these terms and from examining the concordances of *you*

are that the hypothetical addressee of *you* on the clinical sites, and potential consumer

of clinical services, is a woman in a couple experiencing infertility and

seeking/receiving medical treatment.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	THE	IF	YOU ARE	NOT	TO	TO
2	THE	TREATMENT	THAT		INTERESTED	IN	YOUR
3	YOUR	HOW	WHEN		A	THE	A
4	OF	YOU	WHETHER		HAVING	FOR	YOU
5	FOR	TO	AND		CONSIDERING	A	THE
6	A	IMPORTANT	YOUNGER		ABOUT	OR	HAVE
7	EGG	ENSURE	TREATMENT		USING	YOUR	TREATMENT
8	IS	SO	BEFORE		UNABLE	ABOUT	OF
9	YOU	OUT	FERTILE		FULLY	AND	AND
10	AND	IS	AS		THE	OF	OR

Table 5.6 Top 10 Patterns of *you are* in the CLINIC Corpus

The high frequency of the conditional *if* in the L1 position initially constructs the

addressee as potential consumer which is reinforced by the high frequency of mental

process referents such as *interested* or *considering* in the R1 position. Thus, the ideal

consumer of clinical services is engaged in information seeking, part of the neoliberal

discourses of choice and personal responsibility in health care (Jones, 2013).

Of the 634 concordance lines of *you are,* 229 refer to individuals who may be

experiencing infertility (the others refer to potential gamete donors) Concordances

about potential egg and sperm donors were excluded from this selection unless specific

reference was made to them engaging in egg/embryo sharing arrangements as part of fertility treatment.

Within these examples the most salient sub-discourses of identity are the suitability of parents (53%), and potential consumer (27%).

5.2.4.1 Suitable parents

On closer examination of these concordance lines it was clear that the construction of normative parenthood as determined by age/weight/lifestyle choices are present when looking at infertility identity on clinical sites. Women addressed by the sites are encouraged to assess and manage themselves in terms of these clinical categorisations for appropriate reproduction, particularly around weight.

> *It is therefore essential that you achieve a normal weight if you are to give yourself a chance of pregnancy* (NEW)
>
> *An important step in becoming pregnant is ensuring that you are healthy, which you can do by making simple lifestyle changes.* (NHS)
>
> *Certain health authorities will not offer NHS funding if you are overweight (NEW)*

As well as suitability based on (maternal) lifestyle choices the clinic texts warn that older women may be outside of normal reproductive boundaries, thus reducing their chance of achieving the desired identity of mother.

> *This could be particularly important if you are an older woman, over the age of 37, looking to have IVF treatment. Success rates in older women are already reduced due age and egg quality* (MFC)
>
> *Female fertility diminishes with age, so if you are using your own eggs, on average, the younger you are the higher your chances of success* (SLC)

The foregrounding of aging mothers, age related infertility and fertility planning which occurs in NEWS Corpus texts is replicated and even magnified in the CLINIC Corpus texts, although the moral evaluation and representation of such women as ignorant and entitled found in the NEWS Corpus does not appear in the CLINC Corpus. But it is apparent that the fertility clinic sites offering (the chance to pay for) "fertility MOTs" are key advocates of these messages.

> *This is a series of simple tests, for both men and women, which will give you an idea of how fertile you are and if you do have any problems which may make it difficult for you to conceive naturally.* (MFC)
>
> *If you are over 30, we recommend that you see a doctor for a checkup as soon as you decide to start trying to conceive* (BRI)

Despite the inclusive tone and content on the clinic texts, as previously discussed, the sub-discourse of the suitability of a person to be a parent based on notions of socially sanctioned reproduction is problematic. In the case of clinics this also manifests as issues of access based on economic and medical criteria. This sub-discourse is similar to earning parenthood and the right to a child found in the NEWS Corpora. Within these examples, people are labelled in terms of their eligibility for funding (in some cases related to the age/weight criteria mentioned above) and their medical "suitability".

> *The initial consultation will determine whether you are a suitable candidate for IUI.* (HEF)
>
> *To access funded fertility treatment, the first step is to see your GP to establish whether or not you are eligible for NHS funding and if treatment is funded for at our Centre. (SPC)*

5.2.4.2 Potential Consumers

The fact that the clinic is seeking to provide (for payment) a service casts the potential infertility patient in the role of consumer who needs the services of the clinic. The examples below show how personalised address and the assumption of shared knowledge is used to position the clinic in a positive light as "helper", giving informed patients a choice of services; (this will be explored further in section 6.2)

> *To help those who are not eligible, we provide a fee-paying service and details of the costs are given below (NEW)*
>
> *Perhaps you are already on the road of investigation and you are fed up with the repeated tests and lengthy waits for appointments, then our one stop service will give you a rapid answer to your fertility questions. (HEF)*
>
> *When you first come to the hospital for treatment you are always apprehensive and it can be very daunting. The courtyard helps to make you feel more at home (UCHW)*

Potential consumers of the clinic websites are encouraged to normalise both the experience of infertility and the desire to seek treatment through the phrase *you are not alone* (n=18).

> *You are not alone. Around one in six couples in the western world have fertility problems and require some kind of treatment. (BIR)*
>
> *You are not alone. Problems with conceiving a child are much more common than you may realise. (CARE)*
>
> *It is estimated that at least one in six couples in the UK encounter difficulties when trying to conceive, it is therefore not surprising that you are not alone when questioning your ability to conceive. (HEF)*

The use of *you* in the CLINIC Corpus reinforces an empathetic mode of address, building a relationship with potential consumers what Fairclough (1997) describes as synthetic personalisation. Thus, the clinic constructs a community of people who have fertility issues, minimising stigma and encouraging the addressee to engage with this clinical community.

5.3 Self and significant others

5.3.1 Introduction

A key aspect of identity work is the way we construct the self in relation to others. In this section I shift focus from the representation of self to what I have termed "significant others". All the bloggers in this study describe themselves as in a heterosexual relationship (at least at the point of writing) and these "significant others" form some of the key social actors across all corpora, albeit glossed in differing ways. Other studies in this field have examined the impact of infertility on intimate relationships (Letherby, 1998), the role of emotion work for relationships which experience infertility (Exley and Letherby, 2001) and the gendered nature of the experience of infertility (Earle and Letherby, 2003). As the focus in this chapter is on the identity of women who experience infertility, this section will not deal specifically with male subject positions but how (heterosexual) relationships are negotiated in light of infertility and female identity is negotiated in relation to others.

5.3.2 Husband (and variations) in the BLOG Corpus

In the initial analysis of keywords several terms denoting a partner/spouse were found to be key in the blogs including *OH* (other half)*, H* (husband), *DH* (dear/darling husband)*, Hubby* and *Husband*, the first three being well-known spousal acronyms in

the blogosphere (see Table 5.7). In three of the blog texts there is an explicit acknowledgement of the place for nicknames and acronyms in the fertility blogosphere.

DH – DickHead (IF015)

The husband (still no nick-name, especially after we decided that 'Nuts', while amusing, was just a tad too obscene) (IF018)

The Husband (Yes, this nickname isn't just an affectation for my blog I do actually call him The Husband a lot, and he calls me The Wife - I know if it makes you want to puke think how I feel, I have to deal with it on a daily basis) (IF014).

Word	# of blogs	# of occurrences
OH	4	84
H	10	1987
DH	8	702
Hubby	6	253
Husband	24	924

Table 5.7 Frequency of search terms for heterosexual partner in the BLOG Corpus

5.3.2.1 Dispersion issues and disambiguation

Within the blog corpus the terminology used for naming their partner varies from blogger to blogger as shown in Table 5.7, with *husband* being used by the most bloggers, despite not being the most frequent term. Due to the individual styles and preferences of bloggers, all the node words in the table vary considerably in their dispersion. The analysis of *OH* requires some disambiguation as it is most frequently as the discourse marker, "*Oh, despite everything, I do love the NHS.*" (IF014) or phrasal idiom *"OH God, how badly I wanted to be pregnant again"* (IF018). Of the 84 occurrences when it is used to refer to a partner, this is restricted in 69 cases to a single blogger, so it is not well-dispersed but more of an idiosyncratic choice. The term *H* is problematic as it can be a substitute for the name of an individual, not necessarily a spouse and is used in 1800 cases by just 2 bloggers. *Husband* is also used in the phrase

"her husband" in 101 lines and this form is excluded from the concordance analysis in this section. Similarly, the term *the husband* is used 280 times out of a total 329 by one blogger. Bearing these issues of dispersion in mind I treat these terms as a semantic set and look at patterns common to the set (see Table 5.8). Hereafter these will be collectively referred to as OTHERS.

N	L3	L2	L1	Centre	R1	R2	R3
1	THE	AND	MY	H	AND	I	TO
2	I	I	THE	HUSBAND	IS	TO	THE
3	AND	TO	AND	DH	HAS	THE	A
4	TO	THE	WITH	HUBBY	WAS	ME	AND
5	A	WITH	HER	OH	HAD	A	HAVE
6	OF	MY	TO		TO	HE	ARE
7	MY	THAT	MR		I	HIS	I
8	IN	FOR	THAT		WHO	NOT	HAD
9	IT	THIS	FOR		FOR	AND	ME

Table 5.8 Top 10 patterns around *OTHERS* in the BLOG Corpus

The two most frequent patterns around OTHERS are relational, namely, *OTHER and I* (502 occurrences), and *My OTHER* (410 occurrences) and it is these patterns which are the nodes for the concordances lines in this section, see Table 5.9 for examples

Pattern	Concordance example	Frequency
OTHER and I	*And H and I are both chromosomally normal, you see.* (IF018)	502
my OTHER	*I did bring up the possibility of my DH making love to a cup and he didn't seem overly impressed.* (IF019)	410

Table 5.9 OTHERS patterns for analysis in the BLOG Corpus

162 occurrences of the concordances for *my OTHER* contain the pattern *my OTHER and I* and these duplicates have been removed from the analysis.

A key question for this stage of the analysis is: when the blogger must adopt an "infertile" identity, what impact does this have on her identity as wife/partner considering society's heteronormative, pronatal expectations?

5.3.2.2 Infertility as a female domain (men in supporting role)

Numerous studies (Becker, 2000; Greil et al., 1988; Slade et al., 2007) highlight the importance of social support from partners during the experience of infertility and this is fundamental to the representation of male partners in the blog corpus. While it is clear that fertility treatment is still perceived by many as a woman's province, support of both a practical and emotional nature is expected by the bloggers of the male partner, although not necessarily as something which is given willingly. Almost 1 in 5 cases (19%) of the concordance lines of OTHER relate to some aspect of spousal support.

One of the crucial aspects of the "support role" detailed above is the need for the lived experience of infertility to be a joint one, particularly when that experience becomes medicalised through engagement with ARTs. As Throsby (2002) states "the IVF process is profoundly gendered, both in terms of bodily intervention and in the distribution of labour in the implementation of treatment", and this problematic division of the physical aspect of infertility is expressed in many of the blog texts.

> *My husband had the easy part of this whilst I faced some nasty testing*. (IF008)
>
> *Still getting my husband to inject not ready to do it myself! In a way, I rather like how he is involved with it.* (IF001)

However, the management work (Exley and Letherby, 2001; Throsby, 2002) of infertility on both a practical and emotional level is often done by the female partner (Letherby, 1998), and to subvert this gendered expectation can be seen as a challenge.

> *I don't doubt that as a woman, I feel it more acutely. After all, it's my body, my hormones, my biological clock. But my husband has feelings about this too. He also wants to have children and sometimes I forget that.* (IF022)
>
> *My darling husband looked devastated. He tried to hide it, bless him, but I could see it in his eyes* (IF015)

> *My husband struggled in his own way, and from little things he said I knew he felt as bad as I did.* (IF020)

The need for support from the other party can indicate the stigmatised and sometimes isolated position women who are experiencing infertility occupy in society.

> *G is my husband and my lifeline - he doesn't judge me when I am a weeping mess* (IF025)

> *But I sadly don't have anyone but my DH.* (IF019)

5.3.2.3 Disrupting the reproductive biography

The sense of female responsibility for infertility is something which has been well documented in studies (Cousineau and Domar, 2007; Throsby, 2002; Earle, 1999) on the psychological impact of the condition, especially when the choice is made to engage with reproductive technologies and this complex intersection of guilt and blame is explicit in many of the blog texts. The experience of infertility can be construed as a biographical disruption (Hudson et al. 2015) and this manifests in the examples below to a disruption of the expected life-course of the couple relationship.

In the previous section on self and identity (Section 5.2.2) I discussed the problematic subject position of women who are experiencing infertility being defined by what they are not - mothers - and this appears to be extended to the subject position of their partners.

> *And I want, possibly more than anything else, to make my husband a dad.* (IF022)

> *I actually hate Father's Day more because it reminds me of what I can't give my husband* (IF002)

Many of the bloggers express self-blame for failing their partners and this has severe implications for their expectations of their relationship.

I honestly don't understand why my husband doesn't just leave me for someone who can give him a child. (IF005)

My biggest fear is that I have let my husband down: that I have, in some way, failed him because it is my fault that we are in this position. (IF021)

However, there are also (fewer) examples of the male partner feeling that they too have reproductively failed.

My DH admitted that he feels it's all his fault that we can't get pregnant and that if the treatment doesn't work he think's we'll split up (IF009)

Some bloggers even express relief at the fact their partners are also seen as jointly responsible for their infertility reducing the felt stigma (Goffman, 1973) of the female partner.

My DH also has to have his sperm tested which is good. I am pleased the Dr suggested this as we all know it's not always the women's fault for not conceiving (IF019)

5.3.2.4 Disrupted intimacies

Due to the perceived anonymity of the internet many of the blogs detail very intimate aspects of their relationship, including the impact of infertility on their sexual experience and identity and this is one of the most frequent subjects in the OTHER concordances (occurring in 34% of concordance lines).

The bloggers highlight how sex can become a prescribed activity, to take place on certain days or not according to ovulation or medication, rather than a pleasure.

I'm fed up of knowing what day of my cycle I'm on and I'm really fed up of having sex with my husband when I don't particularly feel like it (IF017)

My DH is exhausted and sick of sex and I have a big bruise on the inside of my thigh!! I am wondering if we are having enough sex though. (IF019)

And best of all, hubby and I don't have to have sex again this cycle! I am

disproportionately pleased about this; as, I would wager, is he. (IF005)

H and I have been dutifully making the beast with two backs for days and days

on end (IF018)

Some bloggers overtly challenge this view of sex, driven perhaps by the need to

emphasise that the relationship is still one of sexual attraction and their relational

identity is not dependent on their fertility.

Believe me, the husband and I have conjugalled with the best of them (IF014)

My husband and I haven't stopped making love since we found out that we're

infertile. (IF020)

5.3.3 Husband in the NEWS Corpus

Husband is a key word in the NEWS Corpus (position 43; 2644 occurrences) and used

as search term for the "significant other" in this section, it is worth noting at this point

that *partner* is not in the top 100 keywords and the heteronormative term is the preferred

one.

N	L3	L2	L1	Centre	R1	R2	R3
1	SHE	AND	HER	HUSBAND	AND	I	A
2	AND	HER	MY		IS	A	THE
3	WITH	WITH	YOUR		WAS	THE	TO
4	HER	A	THE		WHO	AND	AND
5	OF	TO	AND		HAD	TO	IN
6	TO	THAT	A		JOHN	HAD	I
7	I	FROM	SECOND		THE	HER	HAVE
8	THE	MY	WITH		IN	IN	WAS
9	A	BUT	EX		I	WAS	THEIR
10	IS	OF	FIRST		HAS	IS	OF

Table 5.10 Top 10 Patterns around *husband* in the NEWS Corpus

Exemplified in Table 5.10 and Table 5.11, the top patterns in the NEWS Corpus mirror

those in the BLOG Corpus; *possessive pronoun husband* or *husband and I*. On closer

examination of the concordances lines I found *husband and I* (104 occurrences) occurs

exclusively after the word *my* so is not looked at as a separate set.

Pattern	Concordance example	Frequency
her husband	*Sharon, 42, from Ratoath, and her husband started trying for a family after they married, when she was 31.* (The Sunday Times, September 27, 2009)	983
my husband	*Eventually my husband agreed we should try IVF and I finally gave birth to my much-wanted child a few months ago after two failed attempts.* (The Mirror, June 12, 2009	550
husband and I	*My husband and I have been trying for a baby for more than a year and recently, after tests, have found out that he's infertile.* (The Sunday Telegraph, August 1, 2010)	133

Table 5.11 Husband – patterns for analysis in the NEWS Corpus

The NEWS Corpus concordances of *husband* exemplify dominant sub-discourses of

infertility including the disruption of the expected reproductive life course, as manifest

in a heterosexual relationship and the role of earned, socially sanctioned, parenthood.

5.3.3.1 Disrupting the reproductive biography

The most frequent category (25%) in the concordances lines of POSSESSIVE

PRONOUN *husband* contain a discursive construction of the spousal relationship like

the examples found in the BLOG Corpus, of partners working towards an expected life

plan. This reproductive biography follows a narrative of meeting an appropriate partner,

planning to get pregnant, trying for a baby, and failing to conceive necessitating medical

intervention (thus the disruption occurs).

> *I'd do anything to get better as I've been married for three years and my husband*
>
> *and I have just decided we want to start a family.* (The Mirror, January 2, 2008)
>
> *When I met my husband, Lee, he knew I'd had fertility problems in the past but*
>
> *we still wanted to try, hoping that we'd be lucky together.* (The Sun, June 5,*
>
> 2007)

WHEN Jo Hill and her husband John started trying for a family they assumed it would be straightforward. However when Jo, then 33, hadn't fallen pregnant after six months they sought medical advice. (The Express, June 7, 2011)

The protagonists (woman + husband) in this narrative of fertility work together to achieve the expected biography: meeting a partner, having a child and becoming a family, and deviation from this is represented as a life course disruption (Becker, 1984). Lexis like *hoped*, and *imagined* are manifestations of this disruption.

Happily married at 34, I hoped that becoming pregnant wouldn't be too difficult. My husband was older - 54 - but his sperm had a track record: he already had children from previous marriages. (Sunday Times, December 21, 2008)

I had always imagined that I would be a mum. One day. I had always imagined that my husband - the love of my life - and I would have kids together. (Independent, July 4, 2006)

In the examples below, the blame for this life disruption is placed on the age of the woman and age-related decline in fertility, engaging with the dominant discourses of aging mothers and deserving parenthood and acting as a cautionary tale (see section 5.2.2).

Like most women I thought I'd have two or three children by the end of my 20s. But my husband Andrew and I didn't start trying for a baby until I was 34. (Express, June 2, 2011)

Not until I was 38 and actually started 'trying' to conceive did I realise how difficult it was. I met John, my husband, in March 1999 when I was 34. (Daily Mail, March 28, 2007)

But after meeting her husband, David, at the age of 41, she decided it was time

to start a family - only to be told their chances of having a baby were slim. (The

Sun, August 6, 2009)

Looking at the examples of individual and relational identity around infertility, age and

timing are key in the NEWS Corpus representations of both couples and women within

society.

5.3.3.2 Earning parenthood

As found in the analysis of individuals in the NEWS Corpus (section 5.2.2 on page

130), in this corpus articles on couples experiencing infertility often describe such them

in terms of the length of time they have been trying to conceive, or how much they have

spent on treatment, drawing on a sub-discourse of earning parenthood, whereby the high

costs of time, money and personal suffering form part of a narrative relating to the

success of the woman to become pregnant.

She, too, turned to IVF for help; the five-year struggle cost her and her husband

£20,000 before she finally fell pregnant . . . naturally. (Daily Mail, December

16, 2011)

She and her husband had endured 13 failed IVF cycles, two miscarriages and

an ectopic pregnancy before having the procedure. (The Mirror, September 2,

2009)

'This is the best feeling in the world, this is worth all the agony, all the tears, all

the upset.' Her husband, a 31-year- old teacher, is just as pleased. 'It's a good

feeling being a father, having seen our daughters come into the world,' (Daily

Mail, April 6, 2006)

This sub-discourse contributes to the erroneous idea that if a couple tries long and hard enough they will somehow get the outcome they desire (and have earned through personal suffering) and this connects to the sub-discourse of keep trying.

> *AFTER three failed IVF attempts, Niki Cotsen and her husband Jason have not given up their dream of a pregnancy that will bring them their own baby*. (The Sun, May 1, 2007)

Although earning parenthood is lauded and framed as an appropriate reaction to infertility, within these examples, those who try *too* hard are constructed as desperate, (echoing Letherby's work in 1999) and overly invested both emotionally and economically, going beyond the bounds of socially acceptable efforts to have a child. It is also interesting to note that in these examples desperation for a child is not solely a female province but shared equally in these partnerships, reinforcing the normative position of the nuclear family.

> *Yasmina, 34, and her husband Aldwin, a 53-year-old risk management consultant, were so desperate for a baby that they've spent £60,000 on fertility treatment.* (Daily Mail, January 9, 2007)

> *"But would-be parents are desperate and will try and pay for anything when they don't know how much is absolutely necessary." For Sian Buchanan and her husband Tony, 46, the need for a baby turned into rounds of tests, treatment and IVF cycles that took them to the depths of despair.* (Mirror, June 21, 2011)

> *Exhausted by years of infertility, wrung emotionally dry by miscarriage, my husband and I decided we would give surrogacy - hiring a woman to bear our child - one try. It was a desperate measure*. (Sunday Times, December 21, 2008)

Whilst the examples above account for the majority (70%) of concordances around *husband* in the NEWS Corpus and can be considered the dominant discourses, there are

also minority discourses around procreative power (8%) and those who reject the earned parenthood model and make the choice to stop treatment (2%).

5.3.3.3 More to life – when to stop

Unique to the NEWS corpus are the representations of people who have gone beyond infertility to living child-free (none of the bloggers have reached this point) as this experience is described with a mixture of relief and regret, and offers an alternative (Sunderland, 2004, p. 102) to the sub-discourse of parenthood at any cost.

> *Four years after the treatment ended, she says: "My husband and I are still dealing with it. I have had to reinvent myself. I didn't know what my identity was after we had finished.* (Times, July 19, 2008)

> *I have recently decided not to try another round of IVF. My husband and I have a great life, and at 38 I feel physically, emotionally and spiritually better than ever.* (Times, October 24, 2010)

> *After 15 years of unsuccessful fertility treatments, the time had come to face up to the heartbreaking truth - I would never become a mum. Altogether, my husband and I had spent a staggering EUR22,000 on what? Nothing, except year after year of false hope and heartache.* (Mirror, January 22, 2007)

The discourses described above both reflect and support societal norms around reproduction, namely that having children is desirable and worth the investment of time, money and emotion work. Infertility is presented as a disruption to the expectation of the heteronormative narrative of meet, marry and have a child, and while it is presented as a "couple" problem, the male partner is represented as an addendum to an inherently female domain.

5.3.4 Partner in the CLINIC corpus

Partner is the only term for OTHER which is in top 100 KWs in the clinic corpus, with 678 occurrences (in comparison *husband* occurs 149 times and *wife* 43). This lexical choice derives from the legal language of assisted conception and the use of a more gender-neutral terminology in legislature. While the use of *partner* may initially appear to be a challenge to heteronormative discourses (Warner, 1999), opening the possibility of same sex partnerships, in the study of the concordances it is clear that it indicates a male partner of a female recipient of fertility treatment. The top 10 patterns for *partner* in the CLINIC Corpus can be found in Table 5.12 below.

N	L3	L2	L1	Centre	R1	R2	R3
1	YOU	THE	YOUR	PARTNER	AND	A	TO
2	OF	AND	MALE		TO	THE	A
3	TO	WITH	FEMALE		IS	TO	THE
4	WITH	OR	MY		HAS	BE	SPERM
5	AND	A	HER		WILL	HAVE	IS
6	FOR	FROM	A		OR	NOT	WILL
7	WHERE	PARTNER	THEIR		SPERM	ALSO	AND
8	FROM	IF	THE		IF	SPERM	ARE
9	IF	TO	HIS		S	IS	DONOR
10	SPERM	OF	TO		MAY	DONOR	BE

Table 5.12 Top 10 Patterns around *partne*r in the CLINIC Corpus

This section shows the complex interaction between people seeking fertility treatment and the clinic, and how roles of male/female partners are negotiated and mediated through clinical reproductive interventions.

Pattern	Concordance example	Frequency
your partner	*Are you and your partner unable to make love on a regular basis?* (LON)	207
male/female partner	*On the day of egg collection the male partner, if applicable, will be asked to produce a semen sample.* (SPI)	143/62

Table 5.13 *Partner* – patterns for analysis in the CLINIC Corpus

While the phrase *your partner* uses personal address, building a relationship between addresses and clinic, the gender marked examples of *partner* (see Table 5.13 for examples) can have the opposite distancing effect as the individual tends to be reduced to their reproductive role.

5.3.4.1 Infertility as a female domain

In 88% of the concordance lines *your partner* is explicitly represented as male, through reference to the partner's sperm/semen or other markers of male reproduction, thus the ideal/default addressee of the clinical websites would appear to be a woman in a heterosexual relationship seeking information on fertility treatment.

> *Your partner will be required to produce a semen sample* (CRE)
>
> *Perhaps the test shows your partner has a low sperm count* (MFC)
>
> *Has your partner ever had mumps? Does your partner have difficulty making love? Does your partner have problems ejaculating?* (LWC)[23]

The pattern *male partner* is also more frequent than *female partner* with the woman foregrounded in the clinical experience of infertility and the male cast in the supporting role.

> *The woman receiving treatment, and her husband or male partner being treated with her* (CRG)
>
> *The female partner will have a physical examination and in some cases the male partner may also be examined.* (ORI)

In the example below the male partner can be further backgrounded and positioned as an optional extra whilst the female partner is the patient and the site for clinical intervention.

---

[23] Mumps can cause lowered fertility in men.

The male partner is encouraged to accompany the patient during the procedure.

(HAE)

Your partner is welcome to attend all appointments, and we encourage them to do so. As a minimum, he must attend the first doctor's appointment, and again on the day of the egg collection. (IDC)

The only exceptions to this pattern are all found on a site dedicated to andrology (male reproductive medicine) where the pattern is reversed.

We are able to refer your partner to a Gynaecologist if she would also like to undergo some initial tests. (AND)

*Our health professionals will then make recommendations on how to optimise your sperm quality to maximise chances of a successful pregnancy with your partner. (*AND)

The idea of fertility as inherently female, and the backgrounding of men in terms of infertility, is problematic for men as well as women. While it can lead to women shouldering the emotion and physical load of the fertility treatment, it can also side-line and further stigmatize the issue of male infertility. (See Chapter 4 on *infertility* as a keyword for further discussion). It is also reinforced by the representation of the female body as a site of reproductive problems and medicalised reproduction, discussed further in chapter 6.

5.3.4.2 Beyond reproductive (hetero)norms

The absence of a male partner, in the case of treatment for either same sex couples or single women, is marked in 5% of the concordance lines and overtly distinguished from a clinical diagnosis of infertility of male infertility.

There are many reasons why couples need to use donor sperm, such as a risk of passing on a severe inherited disease, or the male partner simply not producing

any sperm at all. Donor sperm is also used to help same-sex couples and single

women achieve pregnancy. (MFC)

(DI) uses sperm from a known or unknown donor to help women become

pregnant, and can be used in instances of male infertility, or when there is no

male partner. (SPI)

These are patients whose only 'cause'(sic) of infertility is the lack of a male

partner; success rates are very high. (LWC)

This can lead to women who are not in heterosexual relationships feeling marginalised, with circumstantial rather than medical infertility (Johnson, 2012). As discussed above, the dominant subject position for fertility clinic service users is a heterosexual couple, where the woman is the key addressee, so the absence of a male partner is viewed as a minority issue[24].

Donor IVF involves the use of sperm from a donor rather than the male partner.

It is available for couples where no sperm are available from the male. (SHR)

Who needs donated sperm? There are couples that can't have a baby because

the male partner is unable to produce any sperm, or sperm of high enough

quality to allow it to be used in infertility treatment. (CAR)

The CLINIC Corpus highlights the role of "others" in addition to the potential parents, reflecting the reality of treatment options. According to the HFEA[25] 10% of fresh IVF cycles in 2013 used gamete donation in the form of sperm, egg or embryo and in the clinical websites the role of this type of genetic *other* is highlighted when talking about partners and significant others. In purely reproductive terms a donor gamete has equivalence with a partner gamete.

---

[24] This is actually borne out by HFEA data. Less than 10% of patients presenting for DI or IVF cycles in 2013 were registered as same sex or single women.
[25] http://www.hfea.gov.uk/docs/Egg_and_sperm_donation_in_the_UK_2012-2013.pdf (retrieved 29.11.2016)

IVF is where your eggs are retrieved and fertilised in a laboratory with semen

from your partner or a sperm donor (MFC)

The baby is therefore the genetic child of the male partner and the egg donor

*but any pregnancy is carried by the patient. (*SHR)

Efforts are made to minimise and perhaps naturalise the presence of this genetic other by matching the characteristics of the partner to create visibly normalised families. However, this in itself can be read as evidence of a reproductive hierarchy where the ideal is to create your own genetically related offspring or to disguise when this is not the case. Thus, there is an imperative to meet norms of the reproductive biography (see sections 5.3.2.3 and 5.3.3.1) in which two individuals (from the same ethnic background) meet and reproduce. This potentially has the effect of stigmatising the use of donor gametes unless this is done in a way which occludes any deviance from these reproductive norms.

We will try to match the physical characteristics of the male partner. If you are

single, or in a same sex relationship, we will use your own, or your partner's

characteristics. (AGO)

As far as possible we use sperm from a donor who has the same physical

characteristics as any male partner, e.g. race, skin, hair and eye colour.

In addition to the genetic other, the clinic and clinical staff can also function as a third partner mediating the reproductive relationship as a usually private encounter is moved into the public space of the clinic. (This is covered in more depth in Medical Actors Section 6.2).

The clinical concordances of *partner* foreground the role of societal expectations and the impact that the communicative practices of the clinic have on subject positions available for women experiencing infertility.

5.4 Mental processes

5.4.1 Introduction

In the following section the focus is on two verbs of cognition and affect (what Biber (1999) describes as private verbs[26]), *know,* and *feel* (see Table 5.14 for frequency data). Although they are only keywords in the BLOG Corpus, they are integral to identity construction, and as indicators of stance[27].

	BLOG (PMW)	NEWS (PMW)	CLINIC (PMW)
KNOW	2569	784	527
FEEL	1483	428	410

Table 5.14 Normalised frequencies (per million words) of *know* and *feel* across corpora

Initial study of the patterns around these verbs reveals the most frequent lexical chunks are *pronoun + VERB + that* or the form *pronoun + VERB + pronoun* (*that* is elided between verb and pronoun in this case). In Adolphs' (2013) work on spoken data she suggests that the form *I + VERB OF COGNITION + that* is a way of reporting mental processes, which may account for the frequency of this form in the BLOG Corpus (as this genre more closely resembles spoken than written linguistic norms) and in the NEWS Corpus through reported speech.

As well as studying these verbs for indications of the types of mental and emotional processes which are represented in texts on infertility, I will also address whether the similarity in constructions which are found across the three corpora are accompanied by semantic similarities.

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[26] Biber et al. (1999) also identify *that*-clauses being used for reporting mental states and processes.

[27] The keyword *think* was also examined initially but as it showed almost identical patterns to know it was not included in the thesis to avoid repetition and avoid an overlong section.

5.4.2 Know in the BLOG Corpus

The role of emotion work in infertility has been noted in several studies and this analysis looks at how this is enacted in the language of the BLOG Corpus.

N	L3	L2	L1	Centre	R1	R2	R3
1	I	I	I	KNOW	THAT	I	I
2	AND	AND	DON'T		WHAT	TO	IS
3	TO	WE	YOU		I	THE	TO
4	THE	YOU	TO		HOW	IS	THE
5	BUT	LET	DIDN'T		THE	IT	A
6	SO	DO	ALL		IF	YOU	ARE
7	YOU	BUT	WE		IT	A	WAS
8	THAT	WANT	NOT		IT'S	MY	DO
9	OF	YES	ME		THIS	THAT	BE
10	MY	THAT	DO		ABOUT	NOT	IT

Table 5.15 Top 10 patterns of *know* in the BLOG Corpus

The most frequent patterns (see Table 5.15) around *know* which form the basis of the concordance analysis are positive and negative statements of the verb namely: I *know that*, *I know I* and *don't know* and statements of collective cognition *you know,* and *all know* (Examples given in *Table 5.16*). Due to the similarity in form (and function) of *I know that* and *I know I* these chunks will be analysed together.

Pattern	Concordance example	Frequency
I know that/I know I	*I know that IUI is better than nothing but still - hoping, hoping, hoping…* (IF016)	220
don't know	*I don't know why I was so convinced, as my uterus is certainly not in good shape at the moment, but there we go.* (IF017)	578
you know	*You know the myth, once you are on the waiting list for IVF you miraculously get pregnant and no longer need IVF!* (IF019)	550
all know	*So we all know the deal. The way to get pregnant is to just relax.* (IF014)	92

Table 5.16 Know- patterns for analysis in the BLOG Corpus

While conventionally *know* may be assumed to be a cognitive rather than emotion verb, in these cases the object of the concordance is emotional knowledge.

5.4.2.1 Negotiating expectations

The primary function (60%) of the pattern *I know that* is the negotiation of the gap between what is seen as logical and a visceral emotional reaction. It takes on the prosody of a (sometimes unspoken) *but* following the statement of what is known. The examples below show how bloggers address the disconnection between what is viewed as a sensible, rational course of action and the actual lived experience.

> *I know that he would never leave me but in my darkest moments I wonder if I should leave him to live his dreams.* (IF021)
>
> *My fantasies really are running amok, aren't they? I know that, yet every month I do the calculation, and every month I mourn that lost birthday* (IF010)
>
> *When you add in the fact that I just feel so bloody sad most of the time - I know that sounds pathetic, but there it is* (IF005)

These concordances of *I know that* also show the negotiation of feelings in relation to perceived societal expectations and obligations of how they should be behaving, whilst managing their inability to live up to these expectations.

> *I'm not dying or anything, and I know that I should be grateful for what I do have. But I want this too.* (IF017)
>
> *I know that turning into a hermit is the least painful option but the option that I can least afford to take.* (IF024)
>
> *I hate feeling like this as I know I should be enjoying my pregnancy, and I am for the most part, but just can't help feeling like this at the moment* (IF006)

The examples below show how this form also takes a confessional, self-critical prosody in the examples of this form, expressed as an apology for deviating from perceived

obligations and expectations. At the same time it shows the emotion work being carried out, working towards an acceptance that the difficultly of this experience is real and valid and potentially not something an individual can help.

> *I know he's desperately sick of it too, and I know that we should be kinder to each other to help ourselves through this. But it's hard when it feels like you're the only two people in it.* (IF005)
>
> *I know I am going to regret being so anal about things and am asking for a failure but this is all I can think about.* (IF019)
>
> *Yes, I know I have to accept all of this. But it is hard and sad and unfair.* (IF016)

5.4.2.2 Doubting the self

When looking at the concordances of *don't know* only 39 out of 417 examples (9%) refer to factual forms of knowing. These are all related to bodily and medical knowledge in the context of self-monitoring.

> *It's CD19 and I don't know where I am in my cycle or where my body is at* (IF014)

The most frequent (131 occurrences - 31%) function of *don't know* does not relate to a lack of factual knowledge but the internal processing of self-doubt about the writer's capability to manage the experience of infertility.

> *I don't know how we are going to bear this because this is so hard* (IF016)
>
> *My heart feels a little bit broken right now and I don't know how to make the hurt go away.* (IF025)
>
> *All I know is that my mind is working overtime and I don't know what I want, other than a baby and that doesn't look likely for ages now* (IF019)

These examples of self-doubt also demonstrate a breakdown of the sense of self, replicating the transformative effect of infertility found in section 5.2.1.

*I have lost me and I don't know where she is or how to find her. (*IF021)

Right now I just feel like I've fallen apart and I don't know how to put myself back together again. (IF012)

While the examples above refer to the present situation, in 72 (17%) other examples of *don't know* concordance lines the writers indicate uncertainty about the future, and the ability of themselves to continue the management of their infertility.

I don't know where we go from here, fertility-wise. (IF017)

I don't know how much longer I can keep putting myself through this. (IF024)

It is starting to become an abstract concept, being pregnant. I don't know what I would do if I ever got there, and I have increasingly little faith that I will get there. (IF010)

5.4.2.3 Expert patients, insider knowledge

As well the presentation of individual mental processes, the patterns *you know* and *all know* indicate in-group shared knowledge of those who have experienced infertility. In the case of *you know* the dispersion is skewed somewhat as it is most prevalent in the blog of a speaker of Irish English (294/519 cases) as a discourse marker.

Doctor Google, however, is a little coy about symptoms and recovery times and, you know, quite important things like that. (IF018)

However, in 25% of the concordances of *you know* it also functions as a marker of collective knowledge about one another and the "insider" view of the experience of infertility.

Most of you know how long we fought for this moment, and I love our baby so much already. (IF006)

And you know what our discussions always come round to in the end (IF020)

I am sure a lot of you know how I feel with your multiple injections each day.

(IF019)

The pattern a*ll know* occurs less extensively (n = 48 in 13/25 blogs) but again it signals collective knowledge about the negative experience of infertility.

We all know that fertility treatment is expensive (IF009)

We all know the scars of infertility will be there forever (IF010)

I guess you all know how I am feeling right now. (IF019)

This pattern is also used to indicate previous disclosure amongst the group and intimate shared knowledge.

As you all know when it comes to egg collection I do not fare well. (IF0125)

We all know my track history of IVF failure. (IF020)

And you all know how hopeful I was about this cycle, having got pregnant last time. (IF010)

The language of self-knowledge in the BLOG Corpus can have multiple functions. It appears to serve a therapeutic purpose as bloggers manage complex feelings through the expression of such feelings. It also suggests that the infertility blogosphere is a safe space to express negative experiences and gain understanding, balancing intimacy and shared experience with anonymity and catharsis.

5.4.3   Feel in the BLOG Corpus

The analysis of the keyword *feel* provides an interesting contrast to the analysis of *know*, as it contrasts the discursive patterns around an emotional process as opposed to a cognitive process.

N	L3	L2	L1	Centre	R1	R2	R3
1	I	I	I	FEEL	LIKE	I	I
2	AND	AND	ME		A	AND	AND
3	THAT	MADE	TO		THAT	TO	THE
4	IT	MAKE	DON'T		THE	A	TO
5	BUT	MAKES	YOU		BETTER	BIT	OF
6	TO	HOW	AND		SO	THAT	THAT
7	THE	THAT	DIDN'T		I	FOR	ABOUT
8	HOW	BUT	JUST		VERY	ABOUT	IT
9	THIS	IT	STILL		ABOUT	IT	BETTER
10	IS	MAKING	DO		AS	THE	IS

Table 5.17 Top 10 patterns of *feel* in the BLOG Corpus

As shown in the pattern in Table 5.17, the frequency of patterns including the lemma
MAKE PRONOUN *feel* indicate a more passive role as the blogger is acted upon by
external forces. The pattern *I feel like* indicates both a description of feelings and the
possibility of figurative language, particularly simile. It is these patterns, plus the pattern
feel INTENSIFYING ADVERB, to indicate strength of emotion, which will be used for
close analysis (see Table 5.18).

Pattern	Concordance example	Frequency
MAKE PRONOUN feel	*Googling "unexplained infertility" made me feel better.* (IF001)	279
I feel like	*I feel like we are barely coping with this anymore, as a couple and as individuals.* (IF005)	144
feel INTENSIFYING ADVERB	*I feel very frustrated with my body, and very worn out by the worry and the upsetness.* (IF010)	127

Table 5.18 *Feel* – patterns for analysis in the BLOG Corpus

The patterns analysed combine figurative language, the potentially passive positioning
of people experiencing infertility and the intensity of emotion experienced.

5.4.3.1 Travelling through infertile space and time

This sub-discourse constructs infertility in spatiotemporal terms, to figuratively explore the "infertility journey" particularly the distance to the desired state of parenthood from the current position of infertility.

> *I feel like I need to make myself stronger because I may be only at the beginning of a very long journey (IF025)*
>
> *We're no closer to having a baby than we were a year ago; I know it's a silly way of thinking about it but I just feel so far behind. (IF012)*
>
> *I feel like I am getting further away from my dream of a baby.* (IF019)

The journey metaphor is also used to express the uncertainty and lack of control which can be a feature of infertility.

> *So, today I feel like I am back on the road again, where that roads goes I don't know and what it will bring might be positive or not. (IF021)*
>
> *I feel like my journey is more of a freefall where I move so quickly from stage to stage and never have a chance to feel comfortable at any level. (IF018)*

This lack of control is also discursively constructed in descriptions of infertility as a liminal experience, related to the lack of movement seen in the previous examples.

> *I feel like we've been living in limbo for the past five years.* (IF024)
>
> *Right now I feel like I am living my very own Icelandic Volcano eruption - I am stuck in limbo and have no-way to get out of here* (IF025)
>
> *I feel like in the last three years I have just been treading water.* (IF014)

A potentially positive aspect of the infertile space is when it is occupied by other people who are experiencing infertility, again figurative spatial and journey language is used to create a shared space for people experiencing infertility.

Googling "unexplained infertility" made me feel better. I found lots of posts on

forums from women in the same boat having the same thoughts. (IF001)

The experiences other women share within the book made me feel like perhaps

I wasn't lost in the wilderness all alone. (IF016)

Every story I hear makes me feel a little bit less alone in this journey. (IF020)

5.4.3.2 **The broken self**

In 38% of the concordances of I feel like, it is used figuratively, in some cases drawing on the metaphor of the mechanistic body, the self as a machine which is broken and is acted upon (for further discussion of this see Chapter 6.3) and the body as a vessel which is brittle, damaged or empty.

I feel like a broken packing-case. (IF018)

I feel like an empty shell. (IF020)

It hurts so much that I feel like I am going to shatter into shards. (IF016)

The experience of both diagnosis and treatment of infertility are felt viscerally, and again in terms of the body and therefore self which is damaged.

But I don't think I can do this emotionally. I feel like I could break. (IF025)

I just feel so broken and so bloody useless. (IF010)

This IVF cycle and the stress of 2010 has made me feel weak (IF007)

The person experiencing infertility describes the inability to get pregnant as an agent acting upon the person who is under attack, placing themselves in a passive position.

I am a young looking late 30 year old, getting pregnant was on my mind not the

menopause. It made me feel like a failure as a woman, old, unattractive, useless

and all sorts of other negative things. (IF011)

This afternoon I feel like I have been bombarded with the things that make me

feel the worst, (IF021)

Infertility has made me feel a failure - as a woman, as a wife, but also as a

*daughter. (*IF024)

5.4.3.3 Keep trying and act positive

The concordances around the pattern MAKE *me feel* also passivize the writer and in 109 examples the outcome of this is negative, in comparison with 61 examples of positive feelings. Unsurprisingly, the main cause attributed to making the writer feel negative is the experience of infertility, as it disrupts the expected life trajectory, or interactions with others which are about fertility.

A few have told me 'never give up'. That statement makes me feel bad. Makes

me feel like we have not done everything possible to get our baby. (IF019)

Actively attempting to make oneself feel better could perhaps be seen as part of the neoliberal discourse of personal responsibility.

The spotting stopped and I decided to think positively as I thought that thinking

negatively would not make me feel any better. (IF001)

So when I remembered that planning always makes me feel better, that's what

I did (IF007)

This also functions as a potential way of regaining control.

I am willing to try anything if it helps or makes me feel like it's helping. (IF025)

It's basically because I feel like I have to do SOMETHING. I can't leave any

stone unturned, and I must do whatever it takes to get pregnant. (IF010)

One means of doing this is through engagement with treatment.

I'm onto daily injections this time to try and control my OV a bit more, so

although I like doing them because I feel like I'm doing something I'm not

looking forward to doing it every single day. (IF001)

I am to go back next week for my first treatment, but at the moment feel very

positive at having taken this step. (IF024)

This provides an alternative discourse to the othering discourse of those who experience

infertility (see section 7.3.1) and a way of resisting the potential stigma of infertility.

5.4.4 Know in the NEWS Corpus

In the NEWS Corpus in order to delimit the broad range of things which are known,

and people who know to a manageable scope for this thesis I will concentrate on the

question: what are the discourses of knowledge around infertility in the news?

N	L3	L2	L1	Centre	R1	R2	R3
1	I	I	I	KNOW	THAT	THE	THE
2	BUT	WE	TO		WHAT	TO	OF
3	THE	AND	DON'T		HOW	I	IS
4	AND	DO	YOU		THE	THEY	ARE
5	WE	YOU	WE		IF	IT	IT
6	A	WANT	DIDN'T		ABOUT	IS	TO
7	TO	BUT	NOT		IT	ABOUT	I
8	YOU	DID	THEY		I	THAT	HAVE
9	THAT	RIGHT	NEVER		THEY	YOU	WAS
10	SHE	NEED	ALL		WHO	ARE	A

Table 5.19 Top 10 patterns of *know* in the NEWS Corpus

The analysis in this section will focus on the reporting of knowledge (about fertility) in

the NEWS Corpus, which is foregrounded in the common terms of reporting

what/how/who which occupy the R1 position (see Table 5.19). The negatives *don't* and

didn't most frequently co-occur with the pattern *know what*, (N=213) (to indicate lack

of knowledge about action) and *know how* whereas *know that* more frequently (N=500)

co-occurs with a statement of positive knowledge.

Pattern	Concordance example	Frequency
I know that	I know that when Freya is 10 I'll be 67 and I do wonder how she will feel, but we'll cross that bridge when we come to it (The Sunday Telegraph, March 23, 2008)	112
we know that	we know that some NHS boards do provide infertility services to same-sex couples. (The Express, November 2, 2009)	84

Table 5.20 Know – patterns for analysis in the NEWS Corpus

Although the pronoun preceding the search term varies between plural and singular (see Table 5.20), even when reporting individual knowledge this is framed in terms of collective expectations.

5.4.4.1 A baby at any cost

The sub-discourse of "a baby at any cost", shows the emotional and financial burden which people are willing to accept to have a child (also discussed in section 5.2.3.3.) These concept of emotional and financial costs are often intertwined, as seen in the examples below.

> *I understand that some women have an overriding desire to have a baby and I know that for some women, it would be by any means necessary.* (The Mirror, February 8, 2011)

> *I know that for some couples, undergoing IVF can be so stressful it spells the end of their relationship.* (Daily Mail, June 8, 2010)

> *Going through treatment for infertility is very stressful and we know that one of the key concerns for patients is how much it will cost.* (The Times, January 10, 2008)

In the news representation of the costs involved with fertility treatment, when this treatment results in a positive outcome it is glossed as being worth the cost, potentially reinforcing discourses of medicalised reproduction and marketized reproduction

Despite everything, we know that we are the lucky ones. IVF took its toll on us, as well as on everyone around us, but Daisy is truly a miracle. (Sunday Telegraph, November 27, 2011)

They know that without egg freezing they would be childless, but they emphasise that they did not set out to use the technique. (The Guardian, March 4, 2006)

In this sub-discourse the potentially high cost of infertility is communicated through examples of shared expert knowledge and individual testimonials, acknowledging but also justifying this cost.

5.4.4.2 Leaving it too late

The second most frequent sub-discourse was one of "leaving it too late" (39% of cases), as there is an assumption of shared knowledge about age-related infertility, coupling the repronormative idea that women desire children with judgement on those who leave it too late. This sub-discourse is reinforced through 3 perspectives – expert, experiential and evaluative which all draw on the construction of knowledge around age related (in)fertility.

The expert voice is used to state medical knowledge about when to procreate.

"We know that 10 years before menopause women are much less fertile, and five years before, many are infertile. (The Express, May 26, 2009)

"I need to know that they know that by the time they're in their late 30s the chance of any of those eggs turning into a live birth is very low. (The Guardian, March 4, 2006)

This is then reinforced by individual's testimonials which draw on the knowledge stated by "experts" showing acceptance the danger of "time running out".

I'm 33 in a few weeks and I know that time is running out if I want a family. (Daily Mail, February 20, 2006)

However, I know that your fertility drops at 35, so I wanted to be tested because knowledge gives you the choice, and I'd hate to leave it too late. (The Mirror, September 3, 2009)

The individual acceptance and recontextualisation of this sub-discourse is then also translated into societal knowledge about older motherhood, which shows a similar discursive construction to the aging mothers as cautionary tale sub-discourse (see section 5.2.3.1).

We know that the older the woman is when she has a baby, the higher the health risk, so paying for more older women to get pregnant seems reckless. (The Mirror, June 29, 2010)

We know that much of this childlessness is involuntary or, at least, unconsidered, the consequence of infertility, a lack of opportunity or leaving it too late. (The Observer, June 14, 2009)

The reporting of collective knowledge about infertility is supplemented by individual experiences through personal interest stories and the combination of expert and experiential statements about infertility are used to reinforce dominant social discourses of infertility such as the marketization of infertility (section 8.2.4) and deserving parenthood (section 4.3.6.3).

5.4.5   Feel in the NEWS Corpus

Unlike the verbs of cognition, as a verb of emotion most of the *feel* concordances comprise personal interest stories, describing the feelings associated with individual experiences of infertility.

N	L3	L2	L1	Centre	R1	R2	R3
1	AND	I	I	FEEL	LIKE	AND	THE
2	I	MADE	TO		THAT	ABOUT	AND
3	BUT	AND	YOU		THE	TO	I
4	HOW	MAKE	ME		SO	THE	TO
5	IT	MAKES	THEY		A	I	A
6	THE	HOW	DON'T		AS	A	OF
7	TO	YOU	DIDN'T		THEY	FOR	HAVE
8	THAT	BUT	WE		VERY	IF	IS
9	A	IT	AND		I	THAT	IT
10	OF	WE	CAN		IT	IT	THAT

Table 5.21 Top 10 patterns of *feel* in the NEWS Corpus

The patterns in the NEWS Corpus are similar to the BLOG Corpus with the use of potential figurative language (*I feel like)* and the passivisation of the person who is the object of the verb *feel* (see Table 5.21).

The most frequent patterns in the NEWS Corpus mirrors the BLOG Corpus: *pronoun + feel like* (N= 211) and *made/make/makes +pronoun + feel* (N=265) and these have been selected as patterns for analysis, shown in Table 5.22.

Pattern	Concordance example	Frequency
MAKE PRONOUN feel	Tana says fertility treatment made her feel a "failure". (Sun, September 12, 2006)	265
feel like	Having a child after such an incredible struggle really does feel like the greatest gift ever. (Express, December 22, 2009)	211

Table 5.22 Feel – patterns for analysis in the NEWS Corpus

The concordances of the patterns in Table 5.22 include a range of positive and negative experiences, from an account of someone feeling like they were the luckiest person alive (when they successfully conceived), through to a depiction of failing as a woman (due to inability to conceive).

5.4.5.1 Happy endings

The examples of this sub-discourse are exclusively voiced by individuals who provide an emotive narrative of happy endings providing with a resolution to a chronic experience of infertility and loss.

> *To have lost three babies - and then have three - makes me feel like the luckiest mum in the world.* (Mirror, November 28, 2006)
>
> *I started having acupuncture and hypnosis, both of which made me feel much more relaxed, calm and positive. After a third cycle of IVF, my daughter, Daisy, who is now one, was conceived.* (Times, 2010)
>
> *After much soul-searching, I tried IVF and I am now six months pregnant. I feel like the luckiest woman in the world.* (Guardian, December 18, 2008)

The happy endings sub-discourse is interwoven with the sub-discourses of "keep trying" (section 5.4.3.3) and "a baby at any cost" (section 5.4.4.1).

> *After what we went through it doesn't matter what he cost because we feel like we have won the lottery," Jennifer beams. "We never gave up on our dream and finally it came true.* (The Mirror, January 18, 2011)
>
> *"When I look at Serenity and Owen I feel like pinching myself," says Jessica.*
>
> *"After so much heartbreak, and so many years trying and failing to have a baby, I still can't believe how lucky I've been.* (Sunday Mirror, July 13, 2008)

Within the happy endings examples, the reinforcement of the sub-discourse of baby as goal elides the voices of those who do not or cannot engage with the necessary intervention to attain this.

5.4.5.2 Negative effects of medicalised reproduction

In contrast the positioning of IVF as a potential resolution to infertility in the happy ending sub-discourse, when the concordance lines of *made me feel* refer to negative

feelings, the agent of negative processes is IVF rather than a specific diagnosis of infertility itself. This indicates possible resistance to medicalised reproduction as the dominant discourse is to have a family "naturally" but it also demonstrates the contradictory nature of NEWS Corpus framing of IVF where pronatalism is encouraged but medical intervention to achieve it is framed as deviant.

> *From injecting dye into my womb to check for blockages, to the frequent ultrasounds to see if drugs had motivated any eggs to develop - made me feel like a piece of meat.* (The Sun, June 1, 2006)
>
> *In order to ripen enough eggs for IVF I had to inject myself with hormones every day," she explains, "but the drugs gave me mood swings and made me feel sick and bloated. I grew to dread the needle every day.* (Mirror, 2010)
>
> *When I turned 42 I was running out of emotional energy and IVF had begun to feel like a punishment.* (Sunday Telegraph, June 15, 2008)

This sub-discourse encompasses aspects of medicalised reproduction and repronormativity, including narratives which contest the use of reproductive technologies.

5.4.5.3 Disrupting the reproductive biography

While this sub-discourse, to an extent supports the medicalisation of infertility and the use of IVF and other ARTs as a solution to mend the broken reproductive self, this is also linked to a feeling of failure when individuals do not meet expected reproductive outcomes.

> *The idea of using another woman's eggs made me feel such a failure* (Mirror, December 26, 2006)
>
> *So we had in-vitro fertilisation, which made me feel like a complete failure.* (Express, September 11, 2006)

The stigmatising effect of this reproductive disruption draws on repronormative ideals that the purpose of women is to reproduce and to fail to do so is a failure of feminine identity.

> *MY partner and I had IVF, which failed. Now I don't feel like a woman and it's putting a terrible strain on our relationship.* (The Sun, December 2, 2006)
>
> *I feel like an utter failure. I have failed to do the one thing that even the most uneducated, unimaginative woman, sane or insane, can accomplish. I've failed to have a child.* (Daily Mail, August 24, 2011)

The NEWS Corpus texts draw heavily on individual experiences in order to reinforce wider societal discourses of disrupted reproduction, including the negative evaluation of medical intervention and aging mothers.

5.4.6   Know in the CLINIC Corpus

The word *know* is less frequent (per million words) in the CLINIC Corpus, compared to the BLOG and NEWS Corpora. It is rarely used to describe affect or evaluation but instead tend to be used to present information in terms of expert knowledge, with less personal testimony.[28]

The collocation *to know* is not a frequent pattern in the BLOG or NEWS corpora but is the most frequent in the clinic, which when co-occurring with the verbs *need* and *want* in the L2 position (see Table 5.23) indicates knowledge as desirable or necessary.

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[28] Concordance lines relating to the feelings of egg and sperm donors have been excluded as they do not represent the experience of infertility which is the focus of this thesis.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	LET	TO	KNOW	THAT	THE	OF
2	AND	WANT	WE		IF	YOU	ARE
3	YOU	NEED	YOU		HOW	THEY	WOULD
4	WE	IF	THEY		THE	TO	IS
5	THE	GET	US		WHAT	WE	HAVE
6	I	YOU	I		ABOUT	MANY	THE
7	IS	AND	NOT		MORE	ABOUT	YOU
8	FOR	DO	WILL		WHETHER	I	WE
9	HOW	WILL	WHO		A	IT	TO
10	DONOR	BECAUSE	DON'T		WHICH	LUCKY	I

Table 5.23 Top 10 patterns of *know* in the CLINIC Corpus

In common with the BLOG and NEWS Corpora the pattern *we know* and *you know* as markers of shared knowledge are high frequency patterns in the CLINIC Corpus and it is these patterns which are selected for analysis in this section.

Pattern	Concordance example	Frequency
to know	*We want you to know we're here for you.* (CAR)	117
we know/ you know	*Then you know you've done all you can before the medical profession helps you.* (NHS)	49/49

Table 5.24 Know – patterns for analysis in the CLINIC Corpus

In the concordances of the patterns in Table 5.24, knowledge is constructed positively both on an individual and shared level. The sub-discourse of expert patient, draws on both medicalised and marketised reproduction discourses supporting engagement with medical technology as an informed consumer. In the empathy and expertise sub-discourse, the clinics represent their knowledge of both personal and technological aspects of infertility foregrounding their capability to market their services.

5.4.6.1 Expert patients

In the concordances of *to know* potential patients are constructed as self-aware and fertility-aware, and encouraged to engage with clinical services to optimise this, drawing on the sub-discourse of "expert patients".

> *Women are increasingly encouraged to know abovarian reserve* (MFS)
>
> *Getting to know your menstrual cycle and particularly the signs that you are ovulating is becoming a popular method of speeding up conception through monitoring* (CRE)
>
> *A visit to the gynaecology specialist would help them to know if they had any fertility compromising problems.* (GYN)

The clinic texts use this idealised informed patient model to construct a set of assumed knowledge by which they can provide reassurance and demonstrate empathy, as a form of relationship building.

> *It can be hard to know which clinic could be best for you, especially when many claim that only they can help you get pregnant.* (MFC)
>
> *And with around 80 per cent of couples pay for their IVF treatment, they need to know which clinic(s) offer the best hope of a successful pregnancy.* (ORI)
>
> *Clearly if you are planning to undergo fertility treatment, you want to know that the clinic you have chosen has a good track record of success.* (WES)

5.4.6.2 Empathy and expertise

Both *we know* and *you know* are markers of collective knowledge which in 80% of cases is knowledge on the part of the clinic, while the remaining 20% refers to patient knowledge. As previously shown in the concordance lines above, this assumed shared knowledge is used as a form of relationship building and empathy with potential clients by acknowledging the difficulties of people who experience infertility. In doing so the

language mirrors that of personal narratives e.g. by referencing the disruptive effect of infertility (section 4.3.3.1).

> *We know that from the moment you experience problems with fertility, it can be a challenging and stressful time.* (BRCM)
>
> *We know how difficult it can be, so we try to look after your emotional as well as your physical needs.* (CAR)
>
> *At xxx, we know full well that IVF and infertility treatment is an emotional rollercoaster.* (MFS)

We know is also used display expert knowledge on the part of the clinic, which may in turn encourage the ideal, well-informed patient, often using specific medical lexicon.

> *If the embryos reach the blastocyst stage, there is an increased chance of pregnancy as we know these embryos have reached a further stage of development.* (IVFD)
>
> *This is an important question, since we know that the chance of success from treatment is partly dependent on the receptivity of the endometrium* (COMP)
>
> *We always like to do our own testing because we know it's thorough and does more than just count the number of sperm.* (MFS)

Patient experiences are testimonial in style, those who have a positive experience and attribute it to the clinic (and also to luck or fate in a similar style to the BLOG Corpus and personal interest stories in the NEWS Corpus).

> *Despite the convoluted route, we know that we are some of the lucky ones. We have two beautiful daughters who wouldn't be here today without the help of the xxx Clinic.* (OXF)
>
> *We were very lucky to have our baby after just a single cycle of treatment - we know that other couples aren't so fortunate.* (MFS)

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Without your clinic and staff we know that we would not have xxx in our lives.

(BRI)

Although the concordance lines of *know* indicate an ideal of the expert clinic and well-informed patient, within the patient stories conception/parenthood is constructed as luck, albeit luck that they engaged with a particular clinic. In positioning themselves as experts, the clinic discourse is also positioning an ideal patient; one who is informed, self-monitoring and able to make appropriate choices. Patient success stories are thus constructed as resulting from engagement with clinical services, relationship building to make patients feel cared for – about the experience as much as about results - which is borne out in Chapter 6.

5.4.7   Feel in the CLINIC Corpus

There are relatively few occurrences of *feel* in the CLINIC Corpus (n=315) and of those 82 % are found in patient testimonials, most frequently including the pattern *you feel* (see Table 5.25)

N	L3	L2	L1	Centre	R1	R2	R3
1	AND	MADE	YOU	FEEL	THAT	TO	TO
2	TO	IF	I		FREE	AND	AND
3	HOW	YOU	TO		LIKE	THE	CONTACT
4	THE	HOW	WE		IT	A	AT
5	YOU	MAKE	PLEASE[29]		ABOUT	IS	THAT
6	OR	BUT	MAY		A	THEY	A
7	ABOUT	WE	US		THE	NEED	IS
8	I	THAT	ME		SO	IT	HAVE
9		MAKES	THEY		MORE	ABOUT	WITH
10		AND	AND		AT	ARE	ARE

Table 5.25 Top 10 patterns of *feel* in the CLINIC corpus

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[29] *N.B. please feel free* accounts for 40/315 concordance lines and are part of standard messages on the contacts and health warning pages of clinical websites.

In this corpus again the most frequent pattern was MAKE WORD *feel*, and in the majority of cases (63%) the agent of these feelings was the clinic. It was clear from initial analysis of the concordances around this pattern and the pattern PRONOUN *feel* (see Table 5.26 for examples) that *feel* is a verb most associated with patients rather than clinical staff or clinics.

Pattern	Concordance example	Frequency
PRONOUN feel	Words cannot express the gratitude that we feel towards the clinic and its staff. (BRI)	101
MAKE WORD feel	Right from our very first visit we felt you all cared and did your up most (on every visit) to make us feel comfortable at such a sensitive time. (ORI)	43

Table 5.26 Feel – patterns for analysis in the CLINIC Corpus

In the concordances analysed the clinic was represented as a place of solace, as well as medical interventions for infertility. This sub-discourse and the sub-discourse of happy endings, which was also identified in these concordances, are mutually reinforcing in which the clinic provides both support and solutions.

5.4.7.1 Clinic as solace

In the patterns of MAKE WORD *feel*, a strong discourse around what the clinic can do to improve the feelings of patients was foregrounded through testimonials.

> *Throughout our treatment, we were made to feel special and everyone seemed genuinely concerned with our situation.* (BRI)
>
> *Every single member of staff made me feel most welcome and at home*. (LON)
>
> *The surroundings make it feel less clinical because it's so nice* (BOU)

Interestingly the emphasis is on feeling relaxed and supported which picks up on the folk myth around infertility of "relax and it will happen" (Boivin et al, 2011).

5.4.7.2 Happy Endings

These concordances show the language of testimony, containing stories of gratefulness to clinics due to experience as well as outcome.

> *We feel the professionalism and positive approach of the staff we met at xxx can only have helped us to achieve a successful embryo implantation.* (BRI)

In the infrequent occurrences of *PRONOUN feel* where *PRONOUN* is the clinic and not the patient this is used to give staff testimonials of positive clinical experiences.

> *I feel proud and privileged to be a part of the team and to continue helping patients towards realising their dreams of having a baby*. (MID)

> *"Nothing compares to the joy that you feel to see a couple coming back to the clinic holding close a baby, they may have come to believe they would never have.* (BOU)

> *We feel passionate about helping our patients fulfil their aim of having a child.* (BAR)

The examples of this sub-discourse also employ the metaphor of infertility is a journey, in which the destination is reached through the assistance of the clinic. The successful outcome is attributed both to parental luck, perseverance and to the fertility treatment, in the form of patient testimonials of luck seen below.

> *"You never realise how long your IVF journey can be until you get to the end." But we feel incredibly lucky to have two children."* (BOU)

> *We feel so lucky and proud to have our beautiful son and will always be thankful to xxx for this* (MFS)

> *My beautiful girl and boy bring me joy every day and I feel extremely blessed to have them in my life.* (BRI)

These personal narratives can give an idealised view of the experience of infertility. While they do acknowledge the difficulty of conception, they result in the desired outcome of a baby, parenthood in light of infertility is presented as a miraculous outcome achieved by clinical intervention. The fact that clinics are part of a market providing fertility services to potential consumers mean the only voices heard are positive ones, which provides a sharp contrast to the wider range of representations of the mental and emotional processes which can result from infertility found in the BLOG Corpus.

5.5 Chapter Summary

The aim of this chapter was to explore the discourses around identity in light of infertility through analysis of subjects and their mental actions and the way in which these discourses were recontexualised across the three corpora. Some sub-discourses were explicitly identified in multiple corpora (e.g. happy endings), whilst in other cases complementary sub-discourses were found (e.g. earning parenthood, a baby at any cost and keep trying), and even where sub-discourses were identified they could be either adopted or contested in the process of recontextulisation of an overarching discourse (e.g. medicalised infertility). The sub-discourses identified and their relationships to each other and to the overarching discourses (discussed in Chapter 4) are shown in Figure 5.1 below. The lines indicate how a sub-discourse forms part of one or more over-arching discourse, while the colours of the boxes indicate which Corpus the sub-discourse was found in. Where a sub-discourse occurred in two of corpora, the box contains two colours.
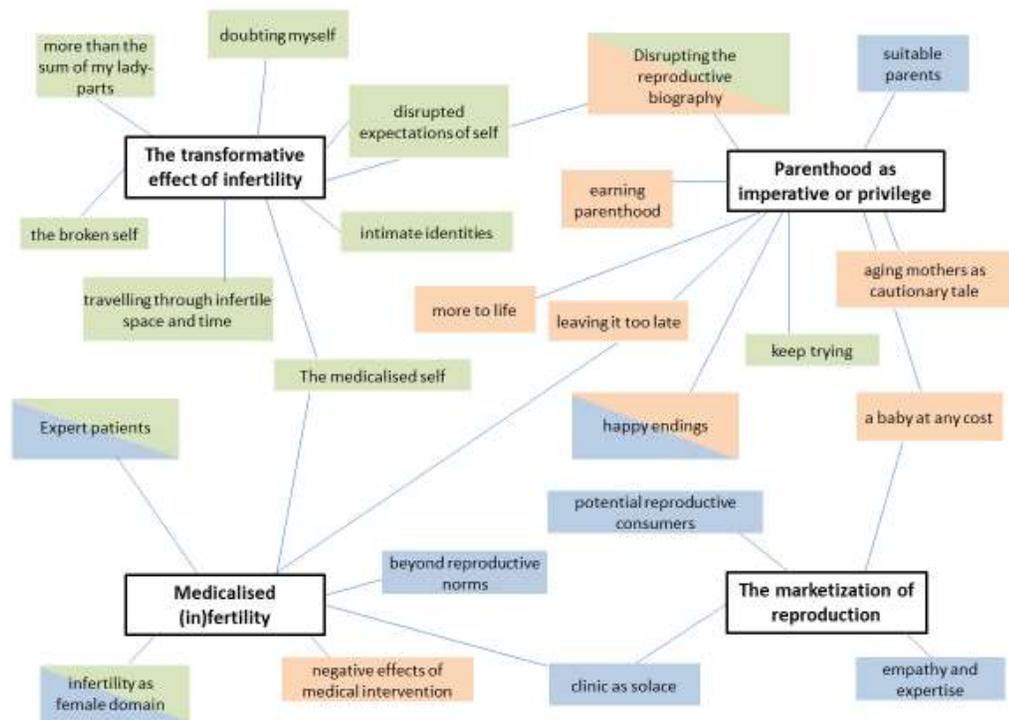
Figure 5.1 The relationship between overarching and sub-discourses around Identity keywords in all 3 corpora.

As seen in Figure 5.1 and 5.27 it is rare for sub-discourses to stand alone, rather they intersect with one another and across overarching discourses.

	OVERARCHING DISCOURSES			
	Transformative effect of infertility	**Medicalised (in)fertility**	**Marketization of reproduction**	**Parenthood - imperative and privilege**
SUB-DISCOURSES	more than the sum of my lady-parts	the medicalised self	potential reproductive consumers	keep trying
	disrupted expectations of self	infertility as female domain	clinic as solace	aging mothers as cautionary tale
	effect on intimate identities	expert patients	empathy and expertise	suitable parents
	doubting the self	beyond reproductive norms	a baby at any cost	earning parenthood
	the broken self	more to life		leaving it too late
	travelling through infertile space and time	negative effects of medical intervention		happy endings
	disrupting the relationship biography			

Table 5.27 Overarching discourses and sub-discourses around identity

Whilst it is helpful to identify the discursive practices around identity, it is necessary to look in more depth at the way in which they are accessed by different users and their potential meaning for individuals experiencing infertility.

The discourses around the transformative effect of infertility cluster mainly in the BLOG Corpus and relate to the disruption which an experience or diagnosis of infertility has upon identity, particularly the self. However, these sub-discourses also intersect with the discourse of parenthood as imperative or privilege, as this contextualises the expectations of individuals with regards to the reproductive biography. The sub-discourses of parenthood (most frequently found in the NEWS Corpus) mediate the actions and identities of those who are suitable to become parents. In turn, the discourse of parenthood as imperative or privilege is interconnected with both the marketization and medicalisation of reproduction. In, for example, the aging mothers discourse, those

who fulfil socially sanctioned norms are given access to (medicalised) reproduction, whilst those who do not are excluded. However, the discourse of the marketization of reproduction was not identified in the analysis of the BLOG Corpus, where the focus was far more on the emotional and medical experience of infertility. Both NEWS and CLINIC concordances did contain evidence of this discourse, framing individuals who experience infertility as potential consumers and the CLINIC as providers of expertise and solace.

The discourse of medicalised reproduction is closely linked with marketization as discussed in the previous chapter but also with the transformative effect as individual identities shift to encompass the position of expert patients and the medicalised self.

The issues around identity and infertility within this chapter can be summarised in terms of expectations, disruptions and negotiations to the sense of self. Societal expectations include an imperative to parent, within sanctioned norms particularly related to age, and it is expected that this will form a part of the repronormative life course and identity, particularly for women. Thus, this identity for both individual and couples is transformed by infertility and the subsequent treatment, which requires negotiation of possible selves, including medicalised self, expert patient, new intimacies and consumers of reproductive services.

Chapter 6 - The medicalised and embodied experience of infertility

6.1 Introduction

> *"I used to think of my body as an instrument, of pleasure, or a*
>
> *means of transportation, or an implement for the*
>
> *accomplishment of my will."*

(Margaret Atwood. The Handmaid's Tale, 1985)

In this chapter I explore the medicalised and embodied experience of infertility from the perspective of those who experience infertility and the social and clinical contexts they must negotiate. As Silva and Machado (2008, p. 4) point out

> "Medical diagnosis of infertility represents a fertile location for observing many of the social conflicts within the context of medicine, as the social construction of infertility begins at the time when medical professionals and other parties determine the existence and legitimacy of this condition."

In my data, all the bloggers in the BLOG Corpus have received a diagnosis of infertility and engaged with fertility treatment. As seen in Chapter 4, news texts often conflate infertility with medicalisation through assisted reproductive technologies and clinical texts necessarily view infertility from the biomedical perspective.

The main research questions addressed in this chapter are:

I.   What are the linguistic patterns around medical and bodily actors and spaces?

II.   What discourses can be inferred from the patterns around these actors, spaces and bodies and what implications does this have for the lived experience of infertility?

Question I can be answered in part by looking at the keywords. The category of bodily actors encompasses not just medical professionals, but also institutions, the clinic, and

the bodily parts, organs and processes of reproduction. Given the intensely medicalised experience of infertility, words related to health, medicine and the body account for the highest proportion of keywords in all three corpora. This thesis has neither the space nor intent to fully examine the clinical language of infertility but rather focuses on the subjects who occupy these clinical spaces and how they act upon the body.

6.2 Medical actors

Previous work on the linguistic construction of medical actors has often focused on interactional discourse in clinical settings (Candlin and Candlin, 2003). In this chapter, I look at the range of ways in which nurses, doctors and clinics are represented in texts about infertility and what implications this has for people who experience infertility. In the same way "significant others" were analysed in relation to the female partner, medical actors are viewed through the prism of who they are and how they interact with people with infertility.

Although *nurse* and *doctor* are keywords in the BLOG corpus, the only social actor which is key across the three corpora is *clinic*, a spatial, non-human actor (see Table 6.1). The key role of medical actors is as gatekeepers and conduits to treatment and thus the experience of infertility must be mediated through these medical professionals. The language of this experience shows verbal rather than physical processes.

	BLOGS		NEWS		CLINIC	
	Raw Frequency	Per million words	Raw Frequency	Per million words	Raw Frequency	Per million words
NURSE	559	338	482	85	496	646
DOCTOR	676	409	2029	389	318	414
CLINIC	713	431	580	103	2233	2907

Table 6.1 Raw frequency and frequency per million words for *nurse, doctor* and *clinic*, across corpora

The keywords *nurse* and *doctor* follow similar patterns in all the corpora and will be grouped together for analysis, with a focus on how they are modified and what actions they are represented as taking part in. As they will be treated together, when describing the patterns which relate to both groups the label HCP (health care practitioner) will be used for brevity.

6.2.1 Nurse and Doctor in the BLOG Corpus

In the BLOG Corpus *nurse* is a keyword since in the majority of clinical interactions within the fertility clinic a nurse will be present. Nurses in this setting specialise in reproductive techniques and are likely to carry out procedures including but not limited to egg retrieval, scanning and injecting medication. Studying the concordance patterns around the term *nurse* uncovers how they are described in terms of patient expectation and what they do (and who they are doing it to). Further analysis shows the implications of this for people experiencing infertility. Table 6.2 and 6.3 respectively show the top 10 patterns around the terms *nurse* and *doctor* within the BLOG Corpus. In the BLOG Corpus *doctor* is a keyword (occurring 676 times) and shows similar high frequency patterns to those found in the nurse patterns.

N	L3	L2	L1	Centre	R1	R2	R3
1	I	THE	THE	NURSE	WHO	ME	ME
2	THE	AND	A		PERFECT	THE	TO
3	TO	WITH	AND		WAS	TO	THE
4	AND	A	NICE		TO	I	AND
5	A	TO	FERTILITY		SAID	MY	MY
6	IT	THAT	TO		CHEERY	A	I
7	WAS	WAS	NEW		I	WAS	IN
8	OF	OF	AUSSIE		AND	AND	WAS
9	WITH	AS	ANOTHER		HAD	TIME	A
10	APPOINTMENT	BY	MY		CAME	IN	WITH

Table 6.2. Top 10 patterns for *nurse* in the BLOG Corpus

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	THE	THE	DOCTOR	WHO	THE	THE
2	THE	TO	A		AND	I	TO
3	I	WITH	MY		WAS	THAT	ME
4	AND	A	SENIOR		I	A	AND
5	WITH	AND	FRENCH		SAID	ME	I
6	WENT	SEE	FERTILITY		TO	TO	A
7	WAS	WHEN	YOUR		IS	WAS	THAT
8	IT	THAT	MISTER		HAS	IT	IT
9	MY	BY	NEW		HAD	HAD	WAS
10	APPOINTMENT	WHAT	GYNAE		TOLD	SHE	MY

Table 6.3 Top 10 patterns for *doctor* in the BLOG Corpus

In the patterns of *nurse* the L1 and R1 collocates show how they are modified through adjectives such as *nice* (N=12), *cheery* (N=18) and *perfect* (N=25), although both *cheery* and *perfect* are part of pseudonyms which one blogger (IF020) gives to the nursing staff.

> *The head nurse is my favourite nurse…We'll call her Nurse Perfect.* (IF020)

Further descriptive examples can be elicited through the pattern *the [adjective] nurse,* again focusing on personality traits and communication skills.

> *The nicest nurse there called and I went through a few things with her* (IF003)
>
> *Had the crabby nurse again today and this time she didn't even tell hubby to*
>
> *come through for the scan.* (IF009)

These descriptions indicate expectations of nurses not relating to their competence but to more holistic nursing skills and their role in providing support.

In contrast, the modifiers of *doctor* relate to their medical specialism such as *gynae*, *fertility* and *senior*. Again the modifiers are skewed by the use of nicknames including *Mister Doctor* which tend to be only used by one blogger.

> *I have managed, whooping with triumph, to extract an appointment with*
>
> *dismissive Mister Doctor from the clutches of the NHS.* (IF018)

Despite these differences, the patterns for both *doctor* and *nurse* show a marked similarity, with personal pronouns *I, me* and *my,* verbal processes *said* and *told,* and the pronoun *who* amongst the most frequent collocates in both sets. Both *nurse* and *doctor* are also occasionally modified by their nationality (*French*, *Aussie*).

Interestingly, the possessive pronoun *my* is far more frequent when modifying *doctor*, perhaps indicating continuity of care at a consultant level which is not the case in nursing. This is also supported by the more frequent use of *another/new* when modifying *nurse*.

Retaining the central focus of the study as the person experiencing infertility the patterns selected are communicative acts with doctors; *doctor said/told*, the personal relationship with physicians through possessive pronouns; *my/your doctor* and the doctor acting upon patient through the construction *doctor VERB PHRASE me*.

Pattern	Concordance example	Frequency
doctor/nurse who	*I chatted with the nurse who relieved me of some nine vials of blood yesterday* (IF005)	45/52
my doctor/nurse	*I should not really been peeing on any sticks untill Friday, thats the day my doctor told me to do it.* (IF019)	46/5
doctor/nurse VERB PHRASE me	*The nice nurse helped me do my Chlamydia test and talked me through all the other steps.* (IF013)	42/65
doctor said/told	*The doctor said she was going to examine me.* (IF005)	19/12
nurse said	*The nurse said in her experience, only perfect cycles work.* (IF020)	19
with WORD doctor/nurse	*I called the hospital yesterday and explained I wanted the results and to book an appointment with the doctor.* (IF014)	26/27

Table 6.4 Doctor/nurse -patterns for analysis in BLOG Corpus

When analysing the concordances of the patterns in Table 6.4 there is an amount of overlap between the patterns i.e. *doctor who* and *my doctor* frequently precede verbal processes in the patterns *doctor said* and *doctor told me*. Due to this overlap, and the relatively small number of concordances for each pattern, the concordance analysis was

carried out on all of the patterns together, with note taken if a particular discourse was only found in the presence of an individual pattern. Three main sub-discourses were identified in the concordance lines of the patterns for analysis shown in Table 6.4: acting on the person, gatekeepers and guides, and Doctor knows best?

6.2.1.1 Medics do things to me

The pattern *doctor/nurse who* is followed by a verb phrase (VP) describing the process the actors are undertaking. The VP which follows *who* in these cases also shows the nurse acting upon the blogger, reiterating the passive position of the infertility patient. The actions of the practitioners are also manifest in the pattern nurse/doctor VERB *me, and nurse/doctor* WORD VERB *me* (n=65) with the blogger in the object position. In descriptions of physical actions on the person, it is most frequently nurses who are acting, in contrast with doctor who is more likely to be the subject of a verbal verb phrase such as *told*.

The concordances of these patterns show HCPs acting upon the body both internally (injections, egg collections) and externally (scans), in the case of nurses they are literally at the sharp end.

> *Nurse Perfect gave me a Cetrotide injection to prevent me ovulating too early and took an armful of blood* (IF020)
>
> *I chatted with the nurse who relieved me of some nine vials of blood yesterday morning* (IF005)
>
> *Now we get to the clinic and it is the doctor who did my 1st and 3rd EC's where as you may recall I ended up in agony.* (IF025)

Although the processes are described in visceral terms and can indicate a level of pain, it is not necessarily the case that acting on the body is a negative experience; it can also be viewed as an act of care.

In the concordances of *nurse who* an ambivalent view of nurses unfolds, as *nurse* is represented as acting on the body in unpleasant ways but this can be mitigated by good communication and perceived kindness despite physical discomfort.

> *The nurse who took my blood was indifferent to my concerns when I asked her why I was having an unscheduled blood test and whether there was a problem.* (IF014)

> *The nurse who held my hand was soooo lovely and nice - she cracked jokes and made me totally at ease even though I had my ladybits out for all to see!* (IF025)

> *The nurse who did the injection was really nice, and when she injected the drugs it was a lot less painful than the last one.* (IF009)

Although it occurs less frequently in the concordances of *doctor who*, doctors are also positioned as acting upon the body, particularly in the monitoring of the body and the role of this in accessing treatment.

> *I assumed the position and awkwardly exchanged handshakes with a new doctor who was already inspecting my lady-bits.* (IF016)

> *Today the doctor who scanned me and the nurses who took my bloods all commented on how bloated I must be feeling* (IF020)

In acting on the person doctors and nurses are responsible for monitoring the body, and thus the person, both of which are expected to behave in appropriate ways. In the examples below, the verbal process verb phrases carry more power than even potentially unpleasant physical processes.

> *The nurse who scanned me actually had the gall to tell me off for having "too full" a bladder.* (IF005)

The nurse scanned me then said that I had 2 14mm follicles and 2 11mm follicles, and because they weren't big enough she wasn't willing to book me in. (IF009)

The doctor who did that scan got shirty with me for weeping and being unable to discuss whether I wanted a D&C or not less than three minutes after she'd told me my precious, precious baby was dead. (IF018)

As the body is monitored and acted upon, it is often the communicative processes which are fundamental to the descriptions of this experience, verbally acting upon the person and in this both doctor and nurse hold power.

6.2.1.2 Medics as gatekeepers

In 40% of the concordances, *doctor* is positioned as a powerful actor who controls access to fertility treatment and therefore the potential for reproduction, the gatekeeper. The *nurse* is also shown as a gatekeeper in 20% of the concordances, through administering drugs, giving out information or as a route to other clinicians.

In the examples below bloggers describe the negotiation of the clinical encounter to access their desired outcome, as both nurses and doctors hold information, and the ability to refer to the next stage of treatment which must be negotiated by patients.

Anyway, we have our appointment a week Tuesday with the original doctor who started the fertility ball rolling for us. (IF005)

So I asked for a printout and the doctor said he'd call the hospital, find out why it was such a long wait to give a sample last time and see if he could sneak him in a bit quicker. (IF015)

I still have to go for a blood test, but I got the nurse to let me go in tomorrow instead of Friday. (IF010)

In particular, verbal processes signpost the role of health care professionals as guide and gatekeeper, possessing the authoritative voice of the clinic.

> *Together the husband and I sat like obedient school children, wide-eyed and quiet as the Doctor told us what the next steps were.* (IF014)

> *The nurse also told me that I 'wasn't allowed ANY physical contact with my partner between now and the HSG'* (IF014)

In these verb phrases there is the expectation of obedience on the part of the patient, contributing to the passive position occupied by people seeking medical intervention for infertility. This occupation of the passive position reinforces traditional power dynamics between doctors and patients, and indicates that clinicians act on patients not just bodily but verbally.

6.2.1.3 Doctor knows best?

As described in the previous section, in 50% of examples doctors are characterised as holding power as they gate-keep access to further medical interventions, and this power is manifest in the language of the bloggers, even when it is being contested. Doctors hold a high level of agency over the bodies and lives of others, as the relationship is negotiated and they become *my doctor* this implies a social contract in which they can act upon their patient. As with nurses the process of negotiating with clinical actors is based on communicative acts, even in the construction *doctor VERB PHRASE me* the process is in 70% of cases a verbal process. The verbal processes carried out by doctors indicate an illocutionary force acting on the patient.

> *My doctor has told me I should start trying for a baby and that is what I am doing.* (IF019)

> *After much pushing the doctor said I could come in on Thursday if I really wanted to, but I'd have to come in on Friday as well* (IF010)

However, 30% of the concordances of the pattern *my doctor* show bloggers either actively or retrospectively expressing reservations about the power and perceived expertise of clinicians.

> *I waited when the doctor told me to go away because it was normal not to have periods for 6 months (total bollocks- sic)* (IF012)
>
> *And this from the same doctor who, in March, confidently predicted I'd have IVF in late Spring - not realising the next available appointment was in June.* (IF014)

In a small number of the concordances (n=4) the bloggers turn to one another for assistance in negotiating with doctors, trusting experiential knowledge from the blogosphere over medical expertise, constructing those who have been through infertility as "expert patients".

> *I need to work out exactly what I should be asking my Doctor about. And you guys did all the hard work for me last time I asked, so I'm going to lean on you again* (IF014)
>
> *You are officially Cleverer Than My Doctor, or, It Takes One (adenomyosis sufferer) To Know One).* (IF018)
>
> *I think I want a HSG to see if my tubes are blocked, if so I can then justify having a laparoscopy etc. I don't know if I can really demand this from my doctor or not?* (IF019)

In all of the three sub-discourses described above, medical interactions are viewed as communicative acts, in which information is power. However, power is something to be negotiated amongst patients and clinicians. While the blogger is most frequently in the passive position as the object of clinicians' actions, they are by no means powerless, showing themselves willing to question advice and treatment protocols. In neoliberal

approaches to health, it is viewed as positive and indeed necessary to be an "informed patient" as a way of maintaining autonomy. However, in the case of infertility this can be potentially damaging as comparison with other treatment pathways is problematic due to the individualised nature of the condition. In the examples above, the medical encounter is judged on the calibre of the communicative act, and not necessarily a clinical outcome, emphasising the importance of an individual's experience in a clinical setting.

6.2.2 Nurse and Doctor in NEWS Corpus

In the NEWS Corpus *nurse* is not a keyword and 90% of the relatively few cases of *nurse* do not actually relate to infertility. For example, the L1 collocate *former* is due to reporting around Nadine Dorries in stories about her campaigning to change the abortion law, and being described as a former nurse. These examples also include nurses who are fertility patients. The term *fertility nurse* only accounts for 8 examples. Instead in the news the main medical actors are doctors and clinics that are represented as the locus of power and expertise rather than the day to day experience of infertility which can be accessed through the bloggers accounts. Thus while the patterns table is included for completeness (Table 6.5) no further concordance analysis will be done.

N	L3	L2	L1	Centre	R1	R2	R3
1	A	A	A	NURSE	WHO	THE	THE
2	THE	AND	THE		AND	ME	AT
3	AND	THE	FORMER		AT	A	A
4	TO	AS	OR		SAID	HER	IN
5	SHE	DOCTOR	PRACTICE		TO	SHE	I
6	MP	WITH	TO		THE	AT	ME
7	WAS	WHEN	NURSERY		FROM	I	WAS
8	BY	TO	CARDIAC		FOR	TO	THAT
9	YOUR	WAS	FERTILITY		I	WAS	BRITISH
10	OF	BY	SPECIALIST		SPECIALIST	IN	TO

Table 6.5 Top 10 patterns of *nurse* in the NEWS Corpus

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	TO	THE	DOCTOR	AND	THE	THE
2	A	A	A		WHO	A	TO
3	THE	THE	FERTILITY		SAID	ME	A
4	AND	SEE	YOUR		TOLD	TO	I
5	WENT	AS	MY		TO	I	WAS
6	MOST	BY	HER		IN	IT	THAT
7	BY	TOP	IVF		FOR	TARANISSI	AND
8	OF	AND	THEIR		WAS	THAT	IT
9	I	WITH	ONE		HAS	YOU	OF
10	BRITAIN'S	WHEN	OUR		IS	HER	YOU

Table 6.6 Top 10 patterns of *doctor* in the NEWS Corpus

The keyword *doctor* in the NEWS Corpus shows similar patterns (Table 6.6) to in the BLOG Corpus and the patterns for further concordances analysis include *doctor said/told* (n=154), *doctor* VERB *me* (*me* as subject position of person experiencing infertility) (n= 88) and *doctor* pre-modified by possessive pronouns (n=212) indicating a relationship with the doctor in question.

Pattern	Concordance example	Frequency
fertility/IVF doctor	*A PRIVATE fertility doctor pressed women into having expensive and unnecessary treatments, the General Medical Council heard yesterday*. (The Daily Telegraph, March 2, 2006)	169/54
doctor said/told	*Her doctor told her she has fertility problems and must not delay if she wants children.* (The Sun, January 3, 2007)	84/70
doctor VERB PHRASE me	*My doctor told me I'd never conceive naturally.* (The Mirror, July 19, 2011)	73
POSSESSIVE PRONOUN doctor	*The NHS recommends that, after trying and failing to get pregnant for a year, you should see your doctor.* (The Guardian, May 7, 2010)	291

Table 6.7 Doctor – patterns for analysis in the NEWS Corpus

The representation of doctors in the sphere of infertility is of a powerful group, particularly in accessing fertility treatment. However, this power is presented as

ambiguous and open to abuse. The sub-discourses around the terms *fertility doctor* and *IVF doctor* uses lexis of controversy and risk as seen in the examples below.

6.2.2.1 Controversial fertility doctors

While 74% of the concordances of *fertility doctor* relate to their success, with modifiers such as *top, successful, leading* and *eminent,* the counterpoint to this is the reporting of failures and corruption even at the highest levels of the profession, found in 60% of examples.

> *BRITAIN'S top fertility doctor failed to run basic checks on a patient who was so ill she was later admitted to intensive care, a disciplinary hearing was told yesterday.* (The Sun, October 1, 2008)

> *AN EMINENT fertility doctor whose private company was paid £630,000 to treat a backlog of his own NHS patients is at the centre of a fresh row over his role with a controversial Chinese IVF clinic.* (Mail on Sunday, January 30, 2011)

Whilst described in light of their success, the *fertility doctor* is also glossed in terms of controversy and rebellion as exemplified below.

> *Mohamed Taranissi, the controversial fertility doctor who has the highest success rate in the UK, has been told by the regulator that he is not a fit person to have legal responsibility for his clinic.* (The Guardian, July 24, 2007)

> *It is thought she and Mr Farrant paid maverick fertility doctor Severino Antinori up to £50,000 to make her Britain's oldest mum.* (The Sun, May 4, 2006)

Doctors are presented as acting outside reproductive norms, for example, without the usual reproductive age limits, with those who provide and access fertility services as potentially deviant. There is an implication of success corrupting, particularly in

financial terms. This is linked to the marketization of the fertility sector and the consumerist discourse which has developed around ARTs. While there is evidence that bloggers contest medical power in the discourse of Doctor knows best?, this discourse of medical controversy and corruption is unique to the NEWS Corpus and could be viewed as a cautionary tale and in opposition to the discourse of a child at any cost.

6.2.2.2 Medics as gatekeepers

As in the BLOG Corpus, doctors, both fertility specialists and GPs, are presented as gatekeepers to accessing reproductive services. In 50% of concordances of POSSESSIVE PRONOUN *doctor*, the doctor is shown as a first step to diagnosis or referral from which people can move towards the subject position of experiencing infertility. Making contact, usually in the form of *see* POSSESSIVE PRONOUN *doctor,* is the conduit to a potential diagnosis of infertility and subsequent interventions.

> *If you've been trying for a year (six months if you're over 35) and haven't become*
>
> *pregnant, see your doctor for tests to check for potential underlying causes.* (The
>
> Mirror, August 17, 2006)
>
> *After a year had passed and nothing had happened, I went to see my doctor. He*
>
> *referred for fertility tests*. (Daily Mail, March 15, 2007)

The potential patients in these narratives are not shown as necessarily seeking treatment but as seeking diagnosis and in doing so they move to occupy the role of person experiencing infertility, mirroring the work on Frank (1987) and Sontag (1984) on the "sick role". In this discourse medical interaction is characterised as a potential solution to the problem of infertility, this problem/solution model will be further explored in Section 6.3 on the representation of the clinic.

6.2.2.3 Diagnosis reifies infertility

As mentioned in the previous section, the power of doctors, in part, lies in their ability to make a diagnosis and thus allow the person who is diagnosed to occupy a particular subject position, and access the medicalised space. In over 70% of the patterns *doctor said* and *doctor told* there encompasses both a speech act and the illocutionary force of the act, which in the examples below show an act of judgement on the object's reproductive ability.

> *'Eventually, when I was 45, the doctor said that if we really wanted to have children, we should think about adopting.* (Daily Mail, June 10, 2006)
>
> *The doctor told me I would need fertility treatment if I wanted to have a child.* (The Sun, December 14, 2006)
>
> *After the third cycle, the doctor told us that we were unlikely to conceive.* (Sunday Times, July 23, 2006)

The discourse of diagnosis as a reification of infertility is a key moment in the transformation of the person from trying to get pregnant to "infertile". Whilst it is described as a communicative act it actually goes far beyond the verbal and places individuals in the category of infertile, again reinforcing medical power over individuals (who engage with the dominant biomedical model of infertility).

The three sub-discourses discussed in this section, demonstrate the intersection of power and controversy in the representation of doctors, especially fertility doctors. The controversy around these medics may contribute to a discourse of deviant reproduction, which then reflects on those who engage with fertility treatment and may also account for the cynicism expressed by bloggers in the sub-discourse of *Doctor knows best?*

6.2.3   Nurse and Doctor in the CLINIC Corpus

The role of *nurse* and *doctor* in clinic website texts contributes to the process of positioning not just medical staff but individuals as potential patients. Thus, in the CLINIC Corpus texts it is apparent that the presentation of *doctor* or *nurse* begins with the management of patient expectations of the fertility clinic, and the building of a relationship between potential consumer and the clinical service provider.

The patterns around *nurse* in the CLINIC Corpus in Table 6.8 show a focus on the presentation of expertise and formal role titles such as *fertility nurse specialist*. In addition nurses are positioned as named contacts in the "meet the staff" section of clinical sites, selling the expertise of the individuals who work for them.

	L3	L2	L1	Centre	R1	R2	R3
1	AS	A	FERTILITY	NURSE	SPECIALIST	AND	AND
2	THE	THE	A		MANAGER	AT	THE
3	AND	WITH	THE		SPECIALISTS	THE	TO
4	A	AND	STAFF		AND	TRACEY	LEWIS
5	OF	MFS	YOUR		CO	IN	A
6	WITH	AS	INCLUDES		WILL	ORDINATOR	MFS
7	TO	OUR	OR		IN	TO	GODWIN
8	MFS	TO	INFERTILITY		ASSISTANT	SARAH	JOINED
9	DOCTOR	SENIOR	DOCTOR		LED	WILL	CLINICAL
10	OUR	OF	CLINICAL		OR	MANDY	YOU

Table 6.8 Top 10 patterns of *nurse* in the CLINIC Corpus

	L3	L2	L1	Centre	R1	R2	R3
1	TO	WITH	THE	DOCTOR	WILL	THE	THE
2	THE	BY	A		IN	DISCUSS	AND
3	WITH	A	YOUR		OR	YOUR	A
4	BY	SEE	FERTILITY		TO	YOU	NURSE
5	CONSULTATION	THE	OR		AND	A	YOUR
6	YOUR	AS	IVF		AT	WILL	PLACE
7	YOU	AND	FAMILY		WHO	ANY	TO
8	SHOULD	TO	HOSPITAL		BOOK	FERTILITY	IN
9	A	NURSE	REFERRING		MAY	ALSO	OF
10	QUALIFYING	AN			NURSE	IN	HAVE

Table 6.9 Top 10 patterns of *doctor* in the CLINIC Corpus

Compared to *nurse, doctor* (shown in Table 6.9) is a relatively infrequent form (n=318, where nurse n=496) in the CLINIC Corpus, as these texts tend to use more specific terms such as *consultant* and *GP* or name an individual.

Both *doctor* and *nurse* have the modal verb of certainty *will* as a right collocate, setting out guidance and expectations around the actions of clinical staff.

Pattern	Concordance example	Frequency
your doctor/nurse	*Your doctor may also suggest you try blastocyst transfer if you have produced good quality embryos in a previous IVF cycle but they failed to implant in the womb.* (COM)	48/8
doctor/nurse will	*Soon after transfer a nurse will visit you and explain the next steps, but you will be able to go home soon after.* (CAR)	37/20
doctor/nurse WORD will	*Following the initial consultation you will meet a specialist fertility nurse who will talk you through your treatment plan.* (LON)	6/12

Table 6.10 Doctor/Nurse -patterns for analysis in the CLINIC Corpus

Through the analysis of the patterns in Table 6.10, two striking sub-discourses around the representation of doctors and nurses emerged, as mangers of the patient pathway and as clinical educators.

6.2.3.1 Managing the patient pathway

The management of diagnosis and treatment positions the doctor (and, less frequently, the nurse) as an expert in collaboration with potential patients. When describing an initial encounter with a medic, the language of the CLINIC Corpus foregrounds expectations how this diagnosis and treatment will be managed in the figurative lexis of the "journey" or "pathway". As found in 64% of concordances of *doctor will,* exemplified below, there is agreement of a care pathway, guided by the expertise of the clinician. In the examples, this guidance is realised in the language of management, particularly the use of the verbs *plan* and *review*.

When you attend your first consultation, one of our doctors will complete a review of your medical history. The doctor will also answer any questions you have. (CAR)

The fertility doctor will give guidance on at what point treatment has more to offer than continuing to try naturally for a pregnancy. (ABE)

When planning treatment, the doctor will carry out tests to diagnose the cause and then plan appropriate treatment. (IVF)

While the examples above foreground the managerial expertise of the clinician, the doctor in these encounters is also shown in a collaborative role, drawing on expectations of the well-informed consumer of medical services and thus constructing the ideal "patient/customer" discussed in chapter 5.

There are different options and you can decide which is most appropriate with your doctor. (LON)

Your doctor will discuss the most effective options for you (AND)

The doctor will also explain what is involved in the treatment, what the chances of success are and the risks of treatment. (COM)

The positioning of the clinician as a guide to treatment options also necessitates the lay person taking individual responsibility, and making choices which potentially require them to become expert patients. This links to the "clinicians as educators" sub-discourse, described in the following section.

6.2.3.2 Clinical educators – making the expert patient

Both nurse and doctor fulfil the role of educators, and in doing so set up the subject position of educated patient for people engaging with fertility clinics. There are two particular aspects to this role, information giving (60% of concordances), and demonstrating clinical processes (30% concordances), which in 20% of cases occur

together. Manifest in verbal processes which indicate both education and dialogue (e.g. *explain*, *discuss*), the discourse of clinician as educator constructs the expectation that patients wish to be informed, are capable of understanding and wish to act upon this information.

> *Your nurse or Consultant will explain PESA, TESA and TESE in detail with you. (BEN)*
>
> *Our infertility nurse practitioner will discuss the circumstances of the treatment and why it may have been unsuccessful. (UCH)*

The expectation of action following education is most noticeable in the discussion of "lifestyle factors", in which the compliance of the potential patient is assumed.

> *Male fertility can be affected by various lifestyle factors and the fertility nurse specialist will discuss these with you and offer advice on how to maximise your fertility (CAR)*
>
> *Your nurse will discuss what options are available to support you in making changes in for instance diet or smoking (COM)*

Unique to the role of *nurse* in the CLINIC Corpus is the process of educating individuals to act on their own bodies, through the self-administration of the medication used in fertility treatment. The language used in the examples below reflects the pedagogic process through the verbs demonstrate and teach.

> *You can contact the Centre to arrange an appropriate time to meet a Nurse Coordinator who will go through the procedure step by step, and demonstrate how to self-inject the drugs to be used (HAE)*
>
> *This makes the injections very easy to do. The nurse will teach you how to administer the injections when you are ready to start them. (IVD)*

The nurse will demonstrate the injection technique and discuss the scheduling

of treatment. (ABE)

The expectation of patients to engage with this clinical education, and be willing to act upon their own person, requires the implicit acceptance of the medicalised approach to infertility and the role of the expert patient within it.

Whilst in the BLOG Corpus nurses are positioned as acting (sometimes painfully) on the body, doctors and nurses in the CLINIC Corpus are primarily positioned as verbal actors, and the medicalised experience of infertility is thus enacted through the communicative as well as bodily acts. Experiences with doctors and nurses are described in detail with a sense of bloggers evaluating these interactions, sometimes framing their interactions as powerful/powerless where obedience is expected (referencing the Doctor knows Best? sub-discourse).

In the NEWS and CLINIC Corpora the processes around infertility treatment are represented as less visceral and more dialogic, therefore acting on the body is positioned as a collaborative process, facilitated by nurses but with the willing participation of women who are experiencing infertility. This collaborative process, particularly in the CLINIC Corpus, contrasts with the representation of clinicians acting upon the person and gatekeeping which was found in the BLOG Corpus, although there is an expectation of compliance due to the power differential between consumers and providers of medical intervention.

6.3 Medical space

The clinic in the context of infertility is both a physical space and an actor. It is a unique space and experience and operates differently to usual clinical interactions, in a state of transition and liminality (Cunningham, 2014). In Allan's (2007, p. 133) study of British women seeking fertility treatment she describes "attending the clinic in the hope that an

answer would be found to their infertility through medical interventions" and views the clinic as a site for negotiation of the uncertain experience of infertility. The clinic is a space where the "infertile" identity is most apparent, and indicates a transition from "real" life (Cunningham, 2014).

The following analysis looks at the role of clinic in the experience of infertility, both as a location and an agent, and the implications for those who engage with the clinic and the medicalised aspects of infertility.

6.3.1 Clinic in the BLOG Corpus

In the BLOG Corpus the patterns around the search term *clinic* indicate it as a spatial entity through the prepositions *to the*, *at the*, *from the* (Table 6.11). Thus, the clinic is a place to go. The L1 modifiers of *clinic* show the clinic as a possession (*my*) and a site of specialism (*fertility/infertility*), with less frequent left collocates *call* and *called* in which the clinic is the object of a communicative act.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	THE	THE	CLINIC	AND	THE	THE
2	AT	AT	FERTILITY		TO	I	TO
3	I	TO	MY		IS	A	AND
4	THE	FROM	XXXX		FOR	TO	I
5	BACK	THAT	NEW		I	MY	A
6	AND	BIG	OLD		ON	HAD	ME
7	GREAT	A	INFERTILITY		HAS	AND	MY
8	CALL	CALLED	A		IN	THAT	FOR
9	APPOINTMENT	IN	THIS		THIS	THEY	IN
10	WITH	AND	IVF		AT	ME	HAVE

Table 6.11 Top 10 patterns of *clinic* in the BLOG Corpus

It is necessary at this point to note patterns which are not evenly dispersed across the BLOG Corpus and therefore will not be used for concordance analysis.

The term "great big infertility clinic" accounts for all instances of *big* in the L2 position and 18 out of 20 of the instances of *infertility clinic* and is a naming strategy used by

only one individual. Similarly, XXXX refers to the anonymization code used by one blogger who gives the name of their clinic. It is also notable at this point that *fertility clinic* is the preferred term when compared to *infertility clinic*, emphasising the positive, and reinforcing the clinic as a solution. The term which indicates absence (infertility) is in contrast dis-preferred as potentially negative.

Pattern	Concordance example	Frequency
my clinic	*My clinic has me injecting and suppositing myself even after embryo transfer.* (IF014)	86
fertility clinic	*When I went to the fertility clinic, I was told I shouldn't be drinking at all.* (IF001)	98
at DETERMINER clinic	*we arrived at the clinic this morning completely in the dark as to what awaited us* (IF007)	149

Table 6.12 *Clinic - Patterns for concordance analysis in the BLOG Corpus*

Taking the position that the clinic is the locus of the medicalised infertility experience, in this section, concordances of the patterns (shown in Table 6.12) *at* DETERMINER *clinic* (location), *my clinic* (possession)*,* and *fertility clinic* (specialism) are used as a way in to the blogger's negotiation of this experience.

My analysis of the concordances lines around these patterns identified three sub-discourses which are drawn on in the representation of the clinic; clinic as portal to parenthood, living on clinic time, clinical versus lay expertise.

6.3.1.1 Clinic as a portal to parenthood

In the patterns *fertility clinic* and *at DETERMINER/NOUN clinic*, engagement with the specialist fertility services either through referral or appointment is acknowledged and welcomed as a progression towards achieving the goal of parenthood.

> *We get the best letter ever - one with our first fertility clinic appointment printed*
>
> *on it* (IF006)

> *The doctor conceded there may be a problem and referred me to specialist fertility clinic in hospital.* (IF014)

> *We do have a little bit of progress though, in that we have now been referred to the fertility clinic at the local hospital, to have our 'subfertility' investigated.* (IF012)

At the same time the desire not to engage with clinic treatment and to have a baby "naturally" is acknowledged, as is the difficulty of these conflicting emotions and the ambivalence felt towards the clinical experience.

> *Well, we went to the hospital yesterday - our referral to the fertility clinic. It still feels really weird saying things like that.* (IF015)

> *Finally admit that you might have a problem and arrange an appointment at a fertility clinic. Wait a month or so for that, and fail to conceive another baby while you're waiting.* (IF020)

> *We're jumping back on the roller coaster today with our first appointment at XXXX clinic.* (IF020)

Engagement with the clinic and thus with a diagnosis of infertility is a point of emotional ambiguity and transition for people who find themselves unable to conceive. This discourse fulfils a similar function to the point of diagnosis as the reification of infertility as a point in which the position occupied by an individual is confirmed through medical intervention. It is also the point at which people experiencing infertility move into what I describe as clinic time which is explored in the next section.

6.3.1.2 Living in clinic time

The representations of reproduction, whether assisted or "natural" include accounts of waiting and counting, days and cycles (Ettore, 2002; Sevon, 2005). In the patterns of *at* DETERMINER *clinic* and *my clinic* in the BLOG Corpus the temporal aspect is key. In

the examples below the bloggers adopt the medicalised lexicon used by their clinic in respect of measuring time (CD1, OTD). This is both a demonstration of their adherence to the schedule of the clinic and the development of lay expertise. While the bloggers indicate compliance, in common with the "Doctor knows best?" sub-discourse, they also voice desire to contest the strictures of the clinic, and rely on lay expertise of the infertility blogosphere.

> *If AF arrives after noon, my clinic counts CD1 as the following day, so as AF turned up yesterday afternoon, today is CD1.* (IF020)

> *I did not want to test today, I loved being PUPO, but my clinic told me today was my OTD.* (IF019)

> *So when should I test? My clinic won't take any notice until a test 16 days after transfer.* (IF014)

The time between clinic visits and the inaction which characterises this time contributes to the liminal experience of medicalised infertility as time is measured in medical actions or interactions.

> *We're in a state of utter limbo between now and the fertility clinic a week tomorrow.* (IF005)

> *Christmas is just going to be another tough kid-oriented nightmare to get through before we can present ourselves back at the clinic next spring.* (IF015)

The time spent at the clinic represents a time of action as opposed to the enforced inaction of the time between visits.

6.3.1.3 Clinical versus lay expertise

The bloggers' references to the pattern *my clinic* also reveals the information gathering and sharing which takes place in the infertility blogosphere, with the assumed aim of maximising their chances of success. As they become more embedded in clinical

practices they demonstrate their expertise and seek reassurance among their community.

> *To swab or not to swab! My clinic didn't send me any alcohol swabs but every video I've watched mentions it and so Twitter to the rescue, everyone is using them* (IF007)

> *No one mentioned this at the clinic so I don't know if there is scientific proof but I've seen it on several different sites - any experts out there?* (IF014)

The process of becoming an expert patient and accessing what is perceived as the best treatment can lead to a negative representation of the clinic in which individuals have to drive the treatment process in the light of clinical caution. As seen in the examples below, this leads to demands on individuals to develop expertise and on clinics who manage this potentially conflicted situation.

> *My clinic has suggested that I have immune testing before next cycle. I am very happy about this as I was going to push for this* (IF014)

> *They are so bloody conservative at this clinic, it's not true. It makes me glad I am so proactive about my treatment.* (IF010)

The gathering of clinical evidence and the development of expertise shows similarities to the "Doctor knows best?" sub-discourse. Thus individuals are required to strike a balance between compliance with neoliberal demands to be an expert patient and the lack of control which can be felt in this liminal, clinical space.

In the representation of the clinic, bloggers explore the conflicts of its role as a necessary conduit to treatment which at the same time is treated with a level of mistrust, and a potential mismatch between expectations and experience. The examples of the bloggers' negotiation of the clinic, in this analysis, chart the progress of their experience

and knowledge becoming increasingly "medicalised" as they inhabit and engage with the temporal-spatial clinic.

6.3.2 Clinic in the NEWS Corpus

In the NEWS Corpus, *clinic* occupies a problematic position as both a site of technological and biomedical expertise and also as a space focused on moneymaking and controversial practices. As shown in Table 6.13, in this corpus the characteristics of *clinic* are most frequently marked through location: *London* (n=76), as a possession; *his* (n=116), *Sims* (n=27), *Taranissi's* (n=25), and specialisation; *fertility* (n=577) and *IVF* (n=157) *private clinic* (n=76). Like the BLOG Corpus patterns, prepositions such as; *at, to* and *in* dominate the left hand collocates.

It should be noted that the pattern *London Women's Clinic* is the name of a particular clinic and accounts for all of the 77 out of 100 occurrences of *women's clinic*, thus the exclusion of this as a search term for concordance analysis.

N	L3	L2	L1	Centre	R1	R2	R3
1	THE	THE	THE	CLINIC	IN	THE	THE
2	AT	A	FERTILITY		AND	A	TO
3	TO	AT	A		THE	TO	A
4	A	TO	IVF		HAS	LONDON	WAS
5	OF	LONDON	HIS		TO	THAT	IN
6	IN	AN	LONDON		FOR	SHE	AND
7	FROM	IN	PRIVATE		AT	WAS	OF
8	AND	FROM	WOMEN'S		IS	IT	IS
9	FOR	OF	HEALTH		WHERE	HAS	THAT
10	TREATMENT	THAT	SIMS		THAT	HARLEY	SAID
11	BY	HIS	TARANISSI'S		SAID	IN	FOR

Table 6.13 Top 10 patterns of *clinic* in the NEWS Corpus

To maintain focus on those experiencing infertility, I made the decision not to use the L1 collocates of *his*, and *Taranissi's* to analyse the individuals who own/run clinics in the following section. Instead I examine the discourses around *fertility clinic* and *private clinic* (see Table 6.14) to uncover the intersection of the medical and commercial

aspects which drivers of the infertility experience. These patterns also capture the prepositional phrases used to locate the clinic.

Pattern	Concordance example	Frequency
fertility clinic	*Every time the couple arrived back at the fertility clinic for more treatment, even their doctors would urge them to quit.* (Daily Mail, September 8, 2010)	577
private clinic	*Desperate Andrew and Vicki Case turned to a private clinic after she failed to conceive naturally.* (Mirror, 6 May 2010)	76

Table 6.14 Clinic - patterns for analysis in the NEWS Corpus

The concordance lines of *fertility clinic* provide evidence of their contested status; at once pushing ethical and legal boundaries, market driven and error prone, in the sub-discourse, Clinical controversy, whilst at the same time at the forefront of scientific developments and providers of technological hope in the sub-discourse, The infertility marketplace.

6.3.2.1 Clinical controversy

The majority (63%) of the concordances for the pattern *fertility clinic* show them at the centre of some form of controversy, either on the part of those staffing the clinic or those accessing their services. These controversies centre on appropriate access to reproductive services or practices which are on the boundary of current ethical and legal guidelines.

> *The Ukranian fertility clinic where the UK's oldest mother-to-be is thought to have had IVF said yesterday that it regularly treats British women.* (Daily Mail, May 18, 2009)

> *A Los Angeles fertility clinic is offering to design a baby to the parents' exact requirements.* (The Sunday Telegraph, March 1, 2009)

THE doctor behind the Los Angeles fertility clinic proposing to design the world's first "trait baby" has said he has helped Irish couples select the gender of their child. (The Sunday Times, March 8, 2009)

In the examples above the otherness of the fertility clinic is reinforced by the foregrounding of the foreign location or of the explicit description of actions outside the current UK legislature. However, the Badlands of deviant reproduction are not restricted to non-UK settings. In addition to promoting "irresponsible" parenting, clinical controversies also take the form of reproductive errors.

A solicitor representing a couple whose last chance of having another child was destroyed after a mix-up at an NHS fertility clinic meant their final embryo was implanted in another woman by mistake said there had been other "near misses". (The Guardian June 15, 2009)

AN IVF blunder in an Irish fertility clinic has left EIGHT white families with mixed-race children, it was revealed yesterday. (Sunday Mirror, June 14, 2009)

A MARRIED white couple are suing a fertility clinic after the wife gave birth to a black baby. (Daily Star, March 23, 2007)

Not only does this present the actions of such clinics as controversial but it foregrounds the primacy of "natural" reproduction, where individuals have children who are evidently biologically related to them (see also "beyond reproductive norms" Section 5.3.4.2). This also mirrors discourses around egg donation found in Chapter 7.

The reporting of these "controversies" echoes the reporting of fertility doctors as outside the UK and outside the law and operating at the periphery of ethical boundaries.

6.3.2.2 The infertility marketplace

This sub-discourse, focused on the highly lucrative market for fertility treatment and access to treatment in a combined public/private health system is found in concordances

of both *fertility clinic* and *private clinic*. In the NEWS Corpus the discourse of marketized reproduction is realised through reporting of the high price that people are willing to pay in order to become parents and marketized practices, such as egg sharing programmes, "league tables", consumer reviews of clinics and even a lottery to "win" a chance at treatment.

> *Patients often pay several visits to a fertility clinic before they undergo in vitro fertilisation, which can be a costly and time consuming process* (The Sunday Times, October 12, 2008)
>
> *Bigger clinics in Barcelona and Valencia charge more but the total cost, including flights and accommodation, is rarely higher than the bill from a private clinic in Britain. Some even offer deals - a lump sum for three cycles.* (The Observer, January 15, 2006)
>
> *What price, though, a raffle ticket with a human egg as first prize? The whole stunt is to drum up custom for a London fertility clinic.* (The Express, March 16, 2010)

Linking to the sub-discourse of clinical controversy described above, clinics are framed as financially motivated to the point of unethical behaviour and the concept of making money from infertility as morally dubious and undesirable.

> *A FERTILITY clinic run by Britain's richest doctor offered unproven and potentially dangerous therapies to a reporter posing as a woman seeking IVF, it was claimed today*. (Daily Mail, January 15, 2007)
>
> *When an infertile couple approaches a private clinic, the doctor who diagnoses their problems and suggests treatments has a direct stake in the outcome of his advice. The more pricey the tests and therapies he orders, the more his business will profit financially.* (The Times, April 1, 2006)

The discourse of the infertility market in the news is potentially self-contradictory. Whilst private practices are condemned as unethical and profit driven, in the examples below, access to treatment on NHS is presented as limited, unreliable and potentially less successful. Thus those engaging with the market are effectively damned if they do (pay) and damned if they don't.

> *The parents-to-be opted for a small, private clinic as "there was the potential of a big wait on the NHS"* (Independent on Sunday, July 30, 2006)
>
> *We were let down by the NHS, which forced us to pay the private clinic prices.* (The Sun, June 5, 2007)
>
> *For Sian, there was no hesitation when an NHS fertility consultant advised them to go to a private clinic rather than wait for their free cycle.* (The Mirror, June 21, 2011)

The market is also driven by people experiencing infertility that are framed as willing to pay any price in order to fulfil their desire for a child, thus entering the fertility market is an imperative not an option.

> *One attempt costs around £3,000 at a private clinic. "We didn't keep track of the money," says Laura. "It was too scary. But I would have given up everything for a child."* (Independent on Sunday, March 12, 2006)
>
> *Because of Hertforshire's non-funding of IVF, we had no choice but to go straight to a private clinic.* (The Sun, June 3, 2006 Saturday)

In the NEWS Corpus the fertility clinic it is represented as a problematic and possibly aberrant locale. However, we should remember that the drive for newsworthiness, particularly reference to something negative (Galtung and Ruge, 1965), encourages the proliferation of tales of individual error and controversy (Bednarek and Caple, 2012). These exceptional tales, with their overarching focus on fertility clinics as an (unethical)

industry, potentially promote the mistrust of medical professionals which are found in the blogs. They also contribute to a moral panic around fertility clinics and fertility treatment as a site of reproductive deviance which is potentially stigmatising for those who choose to engage with their services.

6.3.3 Clinic in the CLINIC Corpus

The analysis in this section focuses on both the self-representation of the clinic and the potential subject positions this offers to those experiencing infertility and seeking treatment. The clinic website is likely to be the first point of contact for potential customers and as such is an essential marketing tool for the clinic services. Legally, information supplied must comply with HFEA policy, which restricts some of the language used by clinics in these texts. However, they play a considerable role in the selection of clinics by people seeking fertility treatment (Hawkins, 2014).

N	L3	L2	L1	Centre	R1	R2	R3
1	THE	AT	THE	CLINIC	IN	THE	THE
2	AT	THE	FERTILITY		AND	A	TO
3	TO	BOURN	HALL		IS	TO	A
4	A	LONDON	WOMEN'S		HAS	YOU	OF
5	OF	A	IVF		FOR	IS	IS
6	IN	TO	OUR		TO	AND	IN
7	TREATMENT	LISTER	A		AT	IN	AND
8	AND	OF	INFERTILITY		WILL	FERTILITY	FOR
9	OUR	FIRST	YOUR		THE	BE	YOU
10	FROM	IN	ANOTHER		WE	HAVE	UK

Table 6.15 Top 10 patterns of *clinic* in the CLINIC Corpus

This section will cover how fertility clinics position themselves and their services, and the communicative practices which are used to appeal to potential consumers of these services. Looking at the patterns found in *Table 6.15*, the most frequent patterns around clinic are accounted for as part of the name of an individual clinic e.g. Bourn Hall Clinic, London Women's Clinic, Lister Fertility Clinic Thus, the highly frequency of *clinic* in

this corpus is due in part to the repetition of the clinic name as a marketing strategy, reinforcing the brand in the mind of potential consumers (McQuarrie & Mick 1996). The pattern *IVF clinic* (n=58) is most frequently seen in the pattern *first IVF clinic* and used to refer to Bourn Hall, in all but 5 cases. However, the term *fertility clinic* (n=260) (preferred to *infertility clinic* (n=24) in these texts) is used in a more general sense and thus is the chosen term for concordance analysis (see *Table 6.16*).

Pattern	Concordance example	Frequency
fertility clinic	*The couple will then be able to have treatment at a specialist fertility clinic.* (BOU)	260
at the clinic	*As you can imagine, each of us at the Clinic has a part to play in delivering this service to you.* (SEF)	101
our/your clinic	*As our clinic has changed and grown, we have become a world leader in reproductive and genetic healthcare.* (CRG)	42/18

Table 6.16 *Clinic – patterns for analysis in the CLINIC Corpus*

In addition to *fertility clinic*, the phrase *at the clinic* is included as a search term to provide comparison to the representation of clinic as location found in the BLOG Corpus. As exemplified in the patterns of *our/your clinic* the clinical website genre also utilises two potential text producers, clinical information writers, and the creators of patient testimonials.

The following analysis section shows the most common sub-discourses of the clinic, which are utilised to construct the clinic as a spatial entity, the potential expert patient and the role of clinical expertise in the baby quest.

6.3.3.1 Marketing the clinical space

The representation of clinical space in the CLINIC Corpus is part of a multifaceted marketing of the clinic, with a focus on the location and facilities of the clinic drawing on a discourse more commonly found in tourism texts.

The clinic website serves both as an introduction and threshold to the clinical space and as the two examples below show, this is framed from the start as both technologically advanced and user friendly,

> *A leading Manchester fertility clinic has launched a new online service which allows people to seek free fertility advice anonymously from their team of experts.* (MAN)
>
> *When we relaunched the MFS website in 2005 we aimed to make it the most useful and current website of any fertility clinic in the UK - and even the world.* (MID)

The language in the examples below foregrounds the appeal of the clinic's physical environment, both in the descriptive text which is reminiscent of tourism or estate agency and in the use of testimonials from previous patients. The marketing of the clinical space is just one aspect of the positive framing of the experience, moving from a medical register to one more reflective of leisure pursuits.

> *Bourn Hall itself is a Jacobean manor house with the addition of a purpose built modern fertility clinic during the 1980s. There is ample free parking and 22 acres of park land giving a feeling of a country estate* (BOU)
>
> *Our clinic is based within a friendly, small private hospital, in a leafy suburb of Woking.* (SUR)
>
> *A lovely place with a very serene and relaxing atmosphere. I feel I am well cared for when at the clinic.* (WES)

The marketing of the space involves foregrounding the open nature of the clinic to possible patients. The personal mode of address, particularly the collective pronouns *we* and *you* in the examples below, highlights the linguistic choices used to construct a relationship with prospective consumers and encourage them into the clinical space.

217

From the moment we welcome you for your first consultation at our fertility

clinic in Manchester, you'll find your experience with us is designed to be as

comfortable, and stress-free, as possible. (MAN)

We hold regular open evenings at the clinic once a month…Drinks and nibbles

are provided and you will be shown round the centre by one of our staff. (AGO)

We understand that empathy is more powerful than sympathy and having the

right information is the key to putting your mind at rest. So we hold open

evenings at the clinic for couples contemplating treatment. (BEN)

6.3.3.2 Expert patients, reproductive choice

The linguistic choices in the clinic texts, centred on discussion and information seeking,

promote the ideal of an informed consumer selecting the best choice of service. In the

texts below there is a clear presupposition of engagement with medical treatment; and

the choice not to do so is understandably elided in the clinic texts.

Once you have discussed your infertility problems and determined their possible

causes the next step is choosing the best fertility clinic for you. (CRE)

Then ring up the fertility clinic and ask for brochures or information, or visit

the clinics website. (MAN)

As seen in the discourse of marketing the clinical space, the process of engagement with

the fertility clinic as a series of informed choices, draws on promotional language which

is more usually seen in discourses around tourism (Jaworska, 2017) or selective

education (Drew, 2013). In particular, the neoliberal discourses of individualism and

making an informed consumer choice are located in the lexis of these concordances.

Choosing a fertility clinic can be quite a daunting task. There are so many

questions to be asked, so many things to consider that it can be difficult to know

where to start. Ultimately, your choice will be down to how you feel about a

clinic when you visit for the first time. (WES)

The London Women's Clinic is often described as the fertility clinic of choice

for single women and same sex couples (LON)

Your fertility clinic should help you learn more about IVF and come to the

decision that's right for you. (NHS)

Even the NHS site, which is not a commercial entity, in the example above draws on

the discourse of the informed consumer of fertility services.

6.3.3.3 **Clinical selling points**

Another frequent aspect of the discursive construction of the fertility clinic is the

foregrounding of experience, as clinic sites highlight their track record and length of

establishment as well as other marks of validation. This is similar in lexis to the

foregrounding of expertise around clinical staff, seen in section 6.2.3 above and used to

reinforce a sense of quality assurance.

The ARGC has for many years been the most successful IVF clinic in the

country. (ARG)

The level of success is phrased within the quantification of babies and families - as will

be seen in chapter 7, these are the gold-standard outcomes of fertility treatment. The

clinics represent themselves as causal actors in the following concordances which typify

this phenomenon.

MFS is the Midlands longest established fertility clinic and will soon celebrate

the birth of the 3000th baby born as a result of treatment at its Aldridge and

Wolverhampton units. (MID)

IVF and Fertility Clinic Wessex Fertility has helped hundreds of couples

become families over the last 24 years. (WES)

Over 10,000 babies have been born following treatment at the clinic and over 4 million babies have been born worldwide. (BOU)

In addition to the quantification rhetoric around clinical success, the clinics emphasize unique scientific expertise or access to technology as in this competitive market each requires a unique selling point (USP). This is particularly prominent in the lexis of the licensing and use of new technologies.

Manchester Fertility Clinic becomes first in region to use new 'EmbryoGlue' (MAN)

While more than 400 babies have been born from IVM worldwide, the Oxford Fertility Clinic is the only British centre licensed to perform it. (CRE)

Due to the success of the trial, in early 2011, IBSA also selected MFS as the only UK fertility clinic for a clinical trial of new formulation Merional. (MID)

The promotion of the facilities, technologies and expertise of the clinics intersects with the "expert patient" sub-discourse (section 5.4.2.3), as it presents a range of choices to be made for the best possible chance of successful treatment.

While the sub-discourses drawn on to represent the *clinic* in the CLINIC Corpus show a degree of variation, they are all ultimately utilised in the marketing of clinical services, through neoliberal discourses of choice and patient expertise.

6.3.3.4 Summary

The discourses around the clinic bring together concepts of expertise, marketization, and spatiotemporal nature of infertility. The location of expertise is negotiated between the bloggers and the clinic. Whilst the bloggers indicate compliance with clinical expertise they also enact resistance. In contrast, the clinics assume the willingness and capability of potential clients to make informed choices which collude with the dominant biomedical framing of infertility. The promotional campaigns around patient

choice and expertise are difficult for people experiencing infertility to resist and it is evident that this subject position is adopted in the BLOG Corpus texts. The becoming of the expert patient is another aspect of the overarching transformational effect of infertility, as is the occupation of clinical space. Entry to this clinical space is framed as desirable and to seek diagnosis through clinical interaction is to enter the sphere of medicalisation. Whilst the discourse of controversy and deviant reproduction is dominant in the NEWS Corpus, this does not form a part of either BLOG or CLINIC corpora, however, there is no evidence that it is actively contested either. Rather the texts in the CLINIC Corpus foreground expertise and reliability to counteract mistrust.

6.4 The medicalised body

Whilst the previous sections have covered the actors and locations of medicalisation a final aspect of this to be covered in the chapter is the medicalised (female) body. As Fleishman (1999, p. 24) points out "When one suffers from a serious illness, the affected organ or body part is never just a body part. It carries multiple layers of culturally-determined associative meaning." There is considerable work in medical sociology on the role of the female reproductive body as a site for technological experimentation (Franklin, 1997), patriarchal interference (Martin, 1989), and as a site of potential aberration (Ettore, 2012). There were several keywords elicited which related to the female body including *womb*, *uterus* and *ovaries*, it is the latter which are the focus of analysis in this chapter[30] as the term which is most frequent and most evenly dispersed across the BLOG Corpus. Ovaries are, as seen below, the reproductive organ which is perceived as most "active" as it is the process of ovulation which initiates the opportunity for reproduction.

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[30] It should be noted that while *ovaries* are the search term for this analysis, initial concordance readings for the search term *womb* revealed markedly similar patterns.

In the social sciences ovaries are found to be framed in terms of ovarian reserve and aging maternity through the trope of the "biological clock" (Friese et al. 2006) as the whole body is pathologised in light of ovarian dysfunction. Thus female reproductive organs are indicative of the success or failure of enacting feminine identity. According to Allan (2007), fertility patients are symbolically divided into body parts to be investigated, as their bodies are treated as objects to be acted upon. Most women can live in ignorance of their ovaries until reproduction/conception doesn't happen (Thompson, 2006). However, in the realm of infertility, attention is focused on the reproductive parts of the process, including the ovaries (Throsby, 2004).

6.4.1   Analysis of the keyword ovary/ovaries

Ovaries are central to the reproductive experience, through egg production and regulation of female sex hormones. As the value of women is frequently conflated with their reproductive capacities, (Throsby and Gill 2003) the disruption of these capacities is another problem to be negotiated in the experience of infertility. The process of ovulation, and therefore the ovaries, is the locus of the reproductive cycle, to be monitored and acted upon in the course of trying to conceive. A disorder of the ovaries, Polycystic Ovary Syndrome (PCOS) is listed as one of the causes of infertility and in the BLOG Corpus 12 of the 25 bloggers have some form of ovarian disease.

In all three corpora (see Table 6.17) *ovaries* is a top 100 keyword and *ovary* is a top 100 keyword in both the BLOG and CLINIC Corpora.

Corpus	Ovary (raw/pmw/rank)	Ovaries (raw/pmw rank)
BLOG	325 (197) 57	253 (153) 79
NEWS	475(84) 122	1225 (217) 68
CLINIC	216 (281) 96	624 (812) 28

Table 6.17 Frequency and keyness of ovary/ovaries in all corpora

In the CLINIC Corpus the keyness of *ovaries* is influenced by the frequent usage of the medical term Polycystic Ovaries.

6.4.2 Ovary/Ovaries in the BLOG Corpus

The patterns of *ovary/ovaries* in the BLOG Corpus (Table 6.18) indicate an unusually intimate awareness of the internal organs, even down to location in the body (*left/right ovary*). Through the highly frequent left collocation with *my* and *your* are glossed as possessions whilst the L1 collocate *polycystic* is a modifier which indicates a dignosis of PCOS.

> *I was concerned so went to a doctor, she diagnosed polycystic ovaries (PCOS).*
>
> (IF014)

N	L3	L2	L1	Centre	R1	R2	R3
1	ON	MY	MY	OVARY	AND	THE	TO
2	TO	THE	LEFT	OVARIES	I	A	THE
3	I	ON	RIGHT		IS	HAVE	AND
4	IN	OF	THE		ARE	AND	I
5	MY	AND	POLYCYSTIC		THE	I	A
6	AND	THAT	ONE		TO	TO	ON
7	THAT	A	YOUR		WAS	IT	OF
8	OF	IN	AN		BUT	WAS	BEEN
9	BUT	HAVE	BOTH		IN	NOT	HAVE
10	HAVE	SUPPRESS	EACH		WHICH	IS	IS

Table 6.18 Top 10 patterns of *ovary/ovaries* in the BLOG Corpus

After initial concordance analysis of the modifiers of *ovary/ovaries*, the most fruitful analysis arose in the patterns of *ovary/ovaries* preceded by a possessive pronoun and the patterns of *ovary/ovaries* preceded by determiner (see Table 6.19 for examples).

Pattern	Concordance example	Frequency
my ovary	*There is also a slight issue that my ovaries have not been particularly cooperative of late.* (IF014)	148
my WORD ovary	*I feel quite protective over my right ovary now, poor thing!* (IF007)	98
my WORD WORD ovary	*My sodding lazy eggs could be withering away inside my sodding lazy ovary, week by week.* (IF018)	14
the WORD ovary	*The cyst last month was on the right ovary, indicating that I should probably be ovulating from the left one this month.* (IF020)	40
the ovary	*I start with Gonal F injections to stimulate the ovaries again to produce (hopefully lots of) eggs.* (IF007)	51

Table 6.19 Ovary/ovaries – patterns for analysis in the BLOG Corpus

The initial comparison of *my ovary* with *the ovary* was to elicit whether there is a depersonalising effect when using the determiner as opposed to possessive pronoun and whilst there is a slight tendency of the use of a determiner in more medical contexts and pronoun in more personal contexts, this was by no means universal. Across both patterns both biomedical and personalising discourses were employed in the lexis around ovaries.

6.4.2.1 Personified ovaries

In 60% of concordances of the search patterns in *my* as a left collocate of *ovary* the writers engage in the personification of the ovaries, through addressing and describing the ovaries as "persons" who play an active role in the reproductive process and ascribe a level of agency to these organs. Humourous references are used to manage what can be a senstive and stigmatising process.

> *I battled to coax my aging ovaries into producing the one decent egg I needed*
>
> (IF020)

Clearly my right ovary is going for the mid-term performance turnaround, while my left is still skulking in the "could do better" corner. (IF010)

The relationship people experiencing infertility have with their ovaries is complex due to the consciousness that the ovary needs to perform in order for pregnancy to occur which is manifest in frustration, yet a sense of protectiveness over the body. It is also worth noting the personalisation in the first and second examples extends to imply sentience on the part of the ovary, as the addressee.

And what have you done? Eff all. Yes, you had many teeny follicles, but, my dear ovary, you are the cystic that is poly, and you always have many teeny follicles (IF018)

And probably also a lot of talking to my right ovary to try to persuade it to pull its finger out and start growing those follicles. (IF019)

Sadly the right-hand ovary is the incompetent one but perhaps it has been shocked into action after watching the sea of dye whoosh past last week. (IF005)

The act of personification could be read as an act of distancing the self from the "blame" for infertility, and in the second and third examples below, this distancing is extended by the figurative representation of ovaries as recalcitrant children.

My ovaries are on their last legs. (IF024)

The sonographer could tell straight away that my ovaries weren't playing nicely.(IF016)

My left ovary is truly sulky and refusing to oblige me with anything (IF014)

6.4.2.2 Bodily monitoring

In the second most frequent sub-discourse, the relationship of women and their ovaries is mediated through the monitoring of the body for signs of the potential for reproduction i.e. ovarian function and ovulation, as scanning of the ovaries is an integral

part of assisted reproduction. This surveillance of reproduction is internal and reliant on biotechnology, unlike monitoring of symptoms and behaviours, creating an uncommon intimacy with usually obscured body parts.

> *My uterus was the right shape and size and all that, and my ovaries showed lots of baby follicles (at least ten on each).* (IF017)

> *I've just been for my first scan. I have a 10mm follicle on the left ovary and another 10mm and two 14mms on the right* (IF020)

> *The dildo cam revealed that three of the follicles on my right ovary had grown to 19mm, 14mm and 13mm respectively* (IF024)

In addition to biomedically enacted monitoring, fertility treatment can result in a hightened sensitivity to the internal functioning of the body, as the bloggers engage in a ritualistic checking for potential positive or negative signs of ovulation.

> *I felt no cramps or anything around the ovaries so thought that the follies had stopped growing.*(IF001)

> *With every twinge, I visualised the follicles appearing on my ovaries. I imagined them growing to a good size.* (IF024)

> *The bloating has continued this evening, tummy feels quite weird really, firm in some places, like my ovaries might burst, I hope there are a lot of eggies waiting* (IF007)

6.4.2.3 The reproductive body as machine

While the monitoring of the body encourages intimacy with body parts, 40 of the concordances draw on a biomechanistic discourse (Mattingly, 2011) of the body with ovaries glossed as broken, dysfunctional parts of the whole, distancing them from the person (fulfilling a similar function to personalisation). This discourse is characterised by biomedical lexicon and/or mechanical verbs, such as *switched on* and *reset*.

He and I both now agree that my left ovary does not appear to be functioning as it should (IF024)

I feel better in myself since my ovaries have been switched back on (IF001)

I am cycling, my ovaries have kicked back into gear and I will get my baby. (IF019)

The biomechanistic approach presents the dysfunctional part being acted upon in the hope of repair, through biomedical technologies of reproduction.

There are several ovarian stimulation medication protocols that are used to "pump up" the ovaries to make sufficient follicles and eggs (IF025)

The pill has indeed as I mentioned reset the ovary (IF018)

I inject myself with Pregnyl (to get my ovaries ready to release the eggs) at midnight tonight (IF014)

The representation of ovaries and the relationship women experiencing infertility have with their reproductive organs is marked by contrasts. At once personal and intimate, yet also biomedical and surveyed, the ovaries are given agency through their personification yet passively acted upon and monitored through clinical agents.

6.4.3   Ovary/Ovaries in the NEWS Corpus

The representation of *ovary/ovaries* in the news is firmly in the biomedical sphere, and whilst the words are preceded by personal pronouns (see Table 6.20), they are also the subject of medical lexicon to a degree which is not found in the BLOG Corpus.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	OF	THE	OVARIES	AND	THE	THE
2	EGGS	IN	POLYCYSTIC	OVARY	TO	PRODUCE	AND
3	THE	FROM	HER		SYNDROME	A	EGGS
4	OF	STIMULATE	THEIR		ARE	AND	TO
5	IN	A	MY		WHICH	IN	A
6	FROM	WITH	YOUR		TRANSPLANT	TO	MORE
7	THAT	ON	AN		THE	PCOS	IN
8	WOMEN	THE	WOMAN'S		REMOVED	IS	OF
9	DIAGNOSED	HER	OF		OF	I	HER
10	CYSTS	HAVE	AND		WERE	REMOVED	THAT

Table 6.20 Top 10 patterns for ovary/ovaries in the NEWS Corpus

The collocations to the left of *ovary/ovaries* show the most common co-occurrence is with a pronoun of possession, the concordances of these collocational patterns will be used to explore the relationship between women and their ovaries. In comparison with the BLOG corpus ovaries are not pre-modified by descriptive terms, with the exception of *polycystic*. The right collocates *transplant* and *remove* and the terms *polycystic* and *syndrome* indicate the biomedical prosody of the reporting of ovaries as a problematic site to be managed, however, this will not be covered in great detail as the focus of the thesis is infertility, not related medical conditions such as PCOS

Pattern	Concordance example	Frequency
her ovary	*At 27, her ovaries stopped working.* (Daily Mail, November 15, 2008)	186
their ovary	*IVF is more successful in younger women, who have more egg cells in their ovaries.* (Daily Telegraph, July 18, 2011)	104
my ovary	*Amazingly, it did the trick - tests showed my ovary was ovulating.* (Mirror, February 17, 2006)	92
your ovaries	*Your ovaries aren't releasing eggs.* (The Sun, June 1, 2006)	44

Table 6.21 Ovary/ovaries – patterns for analysis in the BLOG Corpus

Ovaries are again the locus for reproduction, without functioning ovaries women are forced to negotiate the identity of the problematic, dysfunctional female body

(Shildrick, 1997). The patterns for analysis exemplified in Table 6.21 are focused on eliciting the experience of the possessors of the body parts in question.

6.4.3.1 Dysfunctional female bodies

In a third of the concordances of the patterns PERSONAL PRONOUN *ovary/ovaries* the representation of the dysfunctional female body draws on biomechanistic ideas of the failed and broken body; in this case ovaries are a broken part of the machine which controls reproduction. When these parts are broken this in turn can be problematic for the female reproductive identity.

> *Mrs Butscher had been diagnosed as being infertile 12 years ago and was told her ovaries were not working properly.* (Independent, November 15, 2008)
>
> *"My ovaries weren't working normally, my egg supply was diminishing and the quality was poor."* (Guardian, August 23, 2010)

The dysfunctional body is often linked to the aging body as ovaries which are no longer functional are seen as representative of inner failure despite outward appearances, and therefore condemnatory of women who "fail" to reproduce at the socially sanctioned age.

> *As a woman's ovaries run out of eggs in her 30s and 40s, production therefore has to be stepped up to encourage more eggs.* (The Daily Telegraph, October 25, 2010)
>
> *"But I think it's vital that women recognise - even though, in their late thirties and forties, they look and feel so young - their ovaries may be past their sell-by date."* (Independent on Sunday, December 31, 2006)
>
> *Fertility reduces rapidly after the age of 35 and very sharply after the age of 40 - mainly as a result of the reduction in the quality of eggs remaining in her ovaries.* (Sun, July 15, 2008)

The female body parts in the examples above are figuratively described in terms of commodities of which production has slowed or which are "past their sell by date". This is further explored in the section on eggs (see section 7.3).

In contrast to the negative evaluation of age-related infertility as socially undesirable, medical causes of ovarian issues, and related infertility, are presented as deserving cases for biotechnological intervention in order to maintain the "motherhood mandate" (Russo, 1986).

> *Endometriosis had affected my ovaries and Fallopian tubes. The only option now was IVF.* (Daily Mail, November 16, 2006)

> *Medical tests revealed cysts on my ovaries and I was distraught. They prescribed a fertility-boosting drug and two years later I finally got pregnant.* (Mirror, 2007)

> *Other women may have lost the use of their ovaries due to disease, surgery or the treatment of cancer.* (Mirror, 2009)

6.4.3.2 Acting on the ovaries

Advances in biotechnology mean that monitoring and labelling bodily dysfunction is a normalised process, thus encouraging women to self-monitor as part of neo-liberal discourses of health and personal responsibility to maintain a functional body.

> *Fertility researchers have unveiled a test which will tell women how many eggs they have left in their ovaries compared with the average for their age group.* (Guardian, January 26, 2006)

> *I have a pelvic ultrasound scan to assess the health of my ovaries and womb.* (Sunday Times, October 12, 2008)

The normalisation of bodily monitoring and taking responsibility for one's own health in relation to fertility intersects with the idea of acting on the body, engaging with

biomedical procedures on the ovaries to achieve reproductive goals. This results in representations of women acting on themselves, in an unusually medicalised situation of medical intervention which will result in the previously healthy recipient experiencing feelings of ill-health.

> *They could make another attempt, with Deborah taking powerful drugs to stimulate her ovaries*. (The Daily Telegraph, June 15, 2009)
>
> *I'll have to self-inject (inject myself?! Outsource! Outsource!), and have my ovaries punctured to extract the eggs*. (Times on Sunday, October 12, 2008)
>
> *The process was gruesome," she says. "My ovaries grew to the size of grapefruits.* (Mirror, September 27, 2007)

Although medical treatment for infertility is normalised in dominant discourses, including in the media, the language around this suggests mechanical processes in which the body is acted upon for example the verbs "drilling" and "harvested" seen below.

> *Catherine was injected daily by her husband with drugs to stimulate her ovaries and 11 of her eggs were harvested.* (Daily Mail, June 13, 2009)
>
> *When Shaw decided she wanted to have children she had keyhole surgery, known as ovarian drilling, to encourage her ovaries to release eggs.* (Times, June 8, 2010)
>
> *Among women having the standard in vitro fertilisation treatment - where high doses of drugs "kick-start" their ovaries - abnormalities were found in five out of seven embryos.* (Sunday Telegraph, January 21, 2007)

The ovaries could become a site for women to be acted upon as passive recipients of medical treatment. However, media accounts of this action represent women as complicit and eager for this process, despite the negative descriptions of the experience.

Medical action on the body is viewed as an appropriate response to the mediate the dysfunctional female body described in the previous section. This response is borne out in blog accounts as bloggers seek to act upon their own "recalcitrant ovaries" (IF018).

6.4.3.3 Privileging genetics

Although less prevalent than the previous two discourses, accounting for only 10% of the concordances overall, ovaries are indicative of reproductive potential, and the chance to have a child "naturally" i.e. one who is genetically related to the mother and/or carried in her womb.

> *Natallie, 34, is now engaged to another man but unable to conceive naturally -*
> *her ovaries were removed in 2001 when they were found to be pre-cancerous.*
> (Mail on Sunday, April 9, 200)
>
> *There was zero chance of conceiving a baby naturally because, while my ovaries*
> *were still working, my womb was next to useless.* (Mirror, April 29, 2010)
>
> *Her chances of bearing a child carrying her genes would have ended with the*
> *removal of her ovaries.* (Guardian, March 9, 2006)

As this is represented as the most socially desirable outcome and privileges genetic relatedness (Becker at al., 2005) it potentially stigmatises those who experience infertility and drives the continued desire to engage with medical treatment in order to achieve this goal.

6.4.4   Ovary/Ovaries in the CLINIC Corpus

As shown in Table 6.22 perhaps predictably in a set of clinical texts, ovaries are a site to be acted on and the CLINIC Corpus shows similar patterns (co-occurrence with forms of the lemma STIMULATE) to the NEWS Corpus, suggesting that this biomedical discourse is partially recontextualised between these two text types. While a medical diagnostic term *polycystic* as an L1 collocate occurs 121 times as part of noun phrase

Polycystic Ovary Syndrome, overtly medical terms such as *removal* and *transplant* as not present in the top 10 CLINIC patterns.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	OF	THE	OVARIES	AND	PRODUCE	TO
2	FOLLICLES	IN	POLYCYSTIC	OVARY	TO	THE	EGGS
3	EGGS	STIMULATE	YOUR		SYNDROME	PCOS	THE
4	STIMULATION	FROM	HER		ARE	A	A
5	WOMEN	WITH	AND		THE	IS	BE
6	THE	ON	THEIR		WHICH	TO	AND
7	FALLOPIAN	BY	WHOSE		IS	STIMULATED	WITH
8	AND	AND	UTERUS		OR	ARE	IN
9	RELEASED	HAVE	BOTH		HAVE	NOT	OF
10	PRODUCED	WITHIN	OF		THIS	AND	AN

Table 6.22 Top 10 patterns of Ovary/ovaries in the CLINIC Corpus

There is less variation in the CLINIC Corpus language around ovaries as the texts are dominated by explanations of what happens to the ovaries during fertility treatment and infertility caused by ovarian issues.

Pattern	Concordance example	Frequency
the ovaries	*For this treatment the ovaries are stimulated to produce several eggs.* (NHS)	422
her ovaries	*The female will be given fertility drugs to stimulate her ovaries.* (BRI)	83
your ovaries	*you will be put on a course of drugs to make your ovaries work overtime.* (LON)	78

Table 6.23 Ovary/ovaries – patterns for analysis in the CLINIC Corpus

Around the search terms in this corpus (see Table 6.23) the sub-discourses found included are of agents "acting on the ovaries" (and eliding the person) and the "reproductive body as machine".

6.4.4.1 Acting on the ovaries

The most frequent L1 collocate of *ovary/ovaries* is *the* (n=422), and the most frequent form is the plural (n=292). The use of the determiner instead of the possessive pronoun found in the BLOG Corpus has the effect of distancing the ovaries from a woman's body and thus distancing the body from the processes carried out on the ovaries. This

use of a depersonalising scientific register provides an interesting contrast with the more informal address of the clinic seen in section 6.3.3.1 (Marketing the clinical space) and 5.2.4.25.4.6.2 (Empathy and expertise).

> *The ultrasound probe is introduced into the vagina, the ovaries are visualised and then an aspiration needle (attached to the probe) is passed through the top of the vagina into the follicles*. (IVF)

> *For this treatment the ovaries are stimulated to produce several eggs which are recovered using ultrasound guidance*. (HAM)

Even where the ovaries in question are preceded by a possessive pronoun the language of action on the ovaries depersonalises the experience through, for example, references to *the female* or *the woman.*

> *The woman takes fertility medication to encourage her ovaries to produce more eggs than normal.* (NHS)

> *The female partner takes fertility drugs to stimulate her ovaries so that several eggs can be collected* (LON)

In the example above the woman is at least the agent, while in the following example *the female* is the subject of medical intervention by a (deleted) agent.

> *The female will be given fertility drugs to stimulate her ovaries to develop several mature eggs for fertilisation* (CRG)

As well as the detached third person address here, the use of *female* as opposed to *woman* has a further distancing effect, removing explicit reference to the fact that person is being discussed, but instead labelling her just in terms of her gender.

Further depersonalisation occurs as the passive voice is used and the woman is omitted with the ovaries becoming the subject of action by the unnamed actor.

> *It will then be a daily stimulation injection dose to stimulate your ovaries to*
>
> *produce more than one egg.* (BRIS)
>
> *Fertility drugs are used to stimulate your ovaries, thus maximising the number*
>
> *of eggs you produce.* (CAR)

The way in which women who experience fertility treatment are acted upon in order to act upon their ovaries may explain the intimate relationship between the two shown in the BLOG Corpus texts, yet in the lexicon of the CLINIC Corpus women are removed from the process. While both BLOG and CLINIC Corpus texts show a separation of ovaries and self, the contrast between the humorous and personal way this is manifested in the BLOG Corpus and the impersonal lexicon of the CLINIC Corpus is marked.

6.4.4.2 The reproductive body as machine

In common with the findings from the BLOG and NEWS corpora, the ovaries are framed by a bio-mechanistic discourse of triggering/stimulating the "faulty" body part into appropriate reproductive action.

> *Premature ovarian failure, where your ovaries stop working before you are 40*
>
> *is another reason for female infertility.* (CAR)
>
> *Improve the function of the ovaries to produce higher quality eggs.* (CRG)
>
> *Your own hormone production is temporarily switched off and your ovaries are*
>
> *stimulated to produce more eggs than usual.* (BIR)

The glossing of ovarian failure/function can be problematic for women as the failure of the part can lead to the pathologisation of the whole self. However, it can also be a positive discourse, as if the faulty part can be "mended" then it can act as a potential solution to the problem presented by infertility and as discussed previously (chapter 2) a biomedical discourse can be adopted by "patients" to combat potential stigmatisation.

6.5 Chapter Summary

Despite the title of the chapter the discourses and sub-discourses around medical and embodied aspects of infertility are not confined to "The medicalisation of reproduction" but instead reflect the complexity of discourse around this experience.

As shown in Figure 6.1, the sub-discourses identified around medical actors, medical space and the medicalised body intersect across the four overarching discourses and across corpora (see Section 5.5 for information regarding the interpretation of this kind of figure).
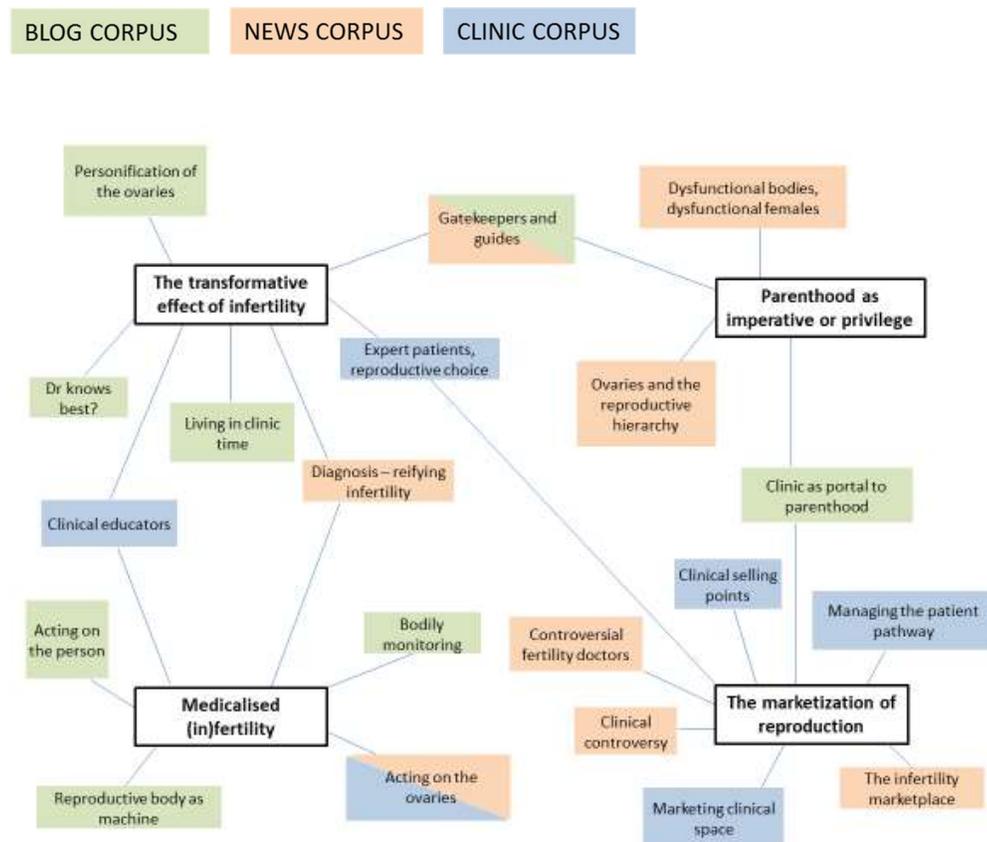
Figure 6.1 The relationship between overarching and sub-discourses around medical and bodily keywords in all 3 corpora.

	OVERARCHING DISCOURSES			
	Transformative effect of infertility	**Medicalisation of fertility**	**Marketization of reproduction**	**Parenthood - imperative and privilege**
	Dr knows best?	medics do things to me	clinic as portal to parenthood	medics as gatekeepers
	personified ovaries	bodily monitoring	the infertility marketplace	clinic as portal to parenthood
	living on clinic time	the reproductive body as machine	controversial fertility doctors	dysfunctional female bodies
SUB-DISCOURSES	diagnosis reifies infertility	medics as gatekeepers	clinical controversy	ovaries and the reproductive hierarchy
	expert patient reproductive choice	diagnosis reifies infertility	marketing clinical space	
		acting on the ovaries	expert patients reproductive choice	
		clinical educators	managing the patient pathway	
			clinic selling points	

Table 6.24 The overarching and sub-discourses of medical actors, space and bodies.

As seen in Table 6.24 it is possible for sub-discourses to be part of more than one overarching discourse, for example "Expert patients, reproductive choice" encompasses the transformation to expert patient for people experiencing infertility and engaging with clinical services, and the marketization of these services. Similarly, the sub-discourse of "Gatekeepers and guides" are part of the medicalisation of infertility, while simultaneously reinforcing the discourse of "Parenthood as imperative and privilege".

Unsurprisingly the CLINIC Corpus texts foreground the marketing of the clinic, spatially, medically and experientially, mainly found in the discourse of "The marketization of reproduction". While bloggers draw on the sub-discourse of "expert

patients" they also use this position as "expert patients" to critique clinical services and information, in the sub-discourse "Dr knows best?".

In contrast to the "The marketization of reproduction" discourse in the CLINIC and BLOG texts which comprises sub-discourses of service provision and expertise, the NEWS texts focus on sub-discourses of controversy around fertility service providers. Although the focus in this chapter is on clinical actors, who are usually more powerful than patients, the personal aspect of the medicalised experience is provided by the analysis of ovaries. The ovaries exemplify a transformation of the relationship between a woman and her body (parts) as they experience infertility, and as substitute for the woman, functioning both intimately and as a distancing device. The ovaries are used to negotiate a woman's relationship with her "dysfunctional" reproductive body, both in the BLOG sub-discourse of "personalisation of the ovaries" and in the NEWS sub-discourse of "Ovaries and the reproductive hierarchy". They are also used to embody the imperative to achieve reproductive normality, or the ability to "pass" (Goffman, 1968) as such and avoid potential stigma. The sub-discourses "acting on the ovaries" and "the reproductive body as machine" draw on broader bio-mechanistic models of the body which can be "mended" through medical intervention (Walker, 2012).

In medicalising infertility, the options for people experiencing it can become limited to a range of patient subject positions but this does not mean that they passively accept these roles or that the roles themselves are passive. The experience of medicalisation and engaging with medical intervention is not a state but a process of becoming as a person is transformed not just by infertility but by the acceptance of the medical model of infertility through the "clinic as portal to parenthood".

Chapter 7 - Reproduction through the lens of infertility

Each month I watch for blood, fearfully, for when it comes

it means failure. I have failed once again to fulfil the

expectations of others, which have become my own.

(Margaret Atwood. The Handmaid's Tale, 1985)

This final analysis chapter addresses the experience of reproduction in the context of the experience of infertility. Following the previous chapter on the medical and embodied experience, this chapter's analysis concerns reproductive subjects and outcomes. The structure of the chapter deliberately follows the narrative of the standard reproductive "journey" foregrounding the difference in experience for people seeking reproduction in light of infertility. This chapter focuses on reproductive process and parts from gametes (*egg*), through the state of being *pregnant*, to the final desired outcome of a *baby*.

The experience of, and awareness of, the process of reproducing is fundamentally different for people who experience infertility than those who do not. As previously discussed, infertility creates a deviation from standard expectations and a disruption to the usual life course. From the point of diagnosis, the reproductive cycle becomes monitored and medicalised; those experiencing infertility necessarily foreground clinical and scientific aspects of the reproductive process. This chapter looks at how this different knowledge and experience is manifest in language choices.

The representation of childbearing as an expected life event, and thus infertility as a disruption to the anticipated reproductive life course, has featured strongly in previous work on the social constructions of infertility (Earle, 2014; Earle and Letherby, 2007; Becker, 1999) and it is within this framework that my findings are positioned. Reproduction after infertility is framed within social, cultural and medical norms and

this chapter will investigate the language of these norms through the following research questions;

I.   What are the keyword patterns around reproductive actors (*egg*, *baby*) and events (*pregnant*) in texts on infertility?

II. How do these patterns reveal the discursive construction of reproduction in the context of infertility?

The keywords selected reflect the reproductive process: the first section on the keywords, *egg* explores the representation of female gametes in discourses of infertility, the second section looks at language around the keyword *pregnant,* examining the liminal state between infertility and having a child. In the final section, I look at the keyword *baby* as the desired outcome of those who struggle to conceive. The analysis in each section will focus on the lived experience of reproduction in light of infertility and the otherness of this experience when compared with expectations of having a child.

7.1 Gametes – the start of the story

The representation of human gametes occupies a unique position in the literature on social aspects of fertility, as social actors, according to Martin (1992, p. 415) "the cell has taken over as the personification of life", while for Lie (2012, p. 480) "the cells reappear as detachable, usable entities".

Gametes are also part of what is referred to as the medical market (Markens, 2012) where medicalisation meets commercialisation. Reproductive technologies involving eggs and sperm, such as IVF and ICSI, are described by Emily Martin (1991) as a scientific fairy tale, adhering to traditional femininities and masculinities to tell the story of ARTs (Assisted Reproductive Technologies). Due to the nature of my data, this chapter will look at the representation of gametes in heterosexual relationships as opposed to same sex/single woman using ARTs, and how heteronormative gender

identities are negotiated in light of faulty reproductive body parts resolved by donation of gametes or ARTs.

It is also worth noting at this point that UK legislature removing the right to anonymity for gamete donors came into force in 2005 leading to reports of a shortage of donors and reinforcing the perception of oocytes (cells in ovaries) as commodities.

7.2 Analysis of the keyword egg(s)

Many patients undergoing fertility treatment view the production of sufficient eggs as an early successful step in IVF (Haimes and Taylor, 2009), thus eggs are both a countable entity and a measure of potential reproductive success, what Parry (2005) describes as the potentiality of life.

There is also a gendered aspect to the presentation of gametes (Martin, 1991) as men can keep producing sperm whereas women have a finite number of eggs, contributing to the discourse of the time (eggs) running out and the ticking of the biological clock (Friese et al., 2006).

The health, or otherwise of gametes, can be a statement on the health of the body, or person producing the gametes, whilst the need for donor gametes is also problematic as it deviates from the norm of a genetic relationship between parent and child.

Both *egg* and *eggs* are top 100 keywords in all three corpora, although relatively most frequent in the CLINIC Corpus as seen in Table 7.1.

	Egg		Eggs	
	Raw Frequency	Per million words	Raw Frequency	Per million words
BLOG	571	345	528	319
NEWS	3414	604	6235	1104
CLINIC	3344	4353	2585	3365

Table 7.1. Frequency of *egg/eggs* across corpora

Both singular and plural forms will be analysed together in this section as the patterns tool allows for dominant patterns around each form to be elicited.

7.2.1 Egg(s) in the BLOG Corpus

As seen in Table 7.2 the most common patterns around the keywords *egg* and *eggs* are related to possession (*my eggs*, *donor eggs*), value (*quality*) and processes in which they are involved (*collection*, *retrieval* and *sharing*).

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	OF	THE	EGG	COLLECTION	THE	THE
2	THE	THE	MY	EGGS	AND	AND	AND
3	OF	A	OF		I	I	I
4	I	AND	DONOR		IN	SPERM	BE
5	AND	TO	AN		RETRIEVAL	IS	IS
6	WITH	FOR	FOR		WHITE	ON	HAVE
7	WE	HAD	AND		QUALITY	TO	A
8	NOT	IN	NO		SHARING	A	SPERM
9	THAT	WITH	AFTER		TO	BE	TO
10	QUALITY	HAVE	QUALITY		ARE	IN	AS

Table 7.2 Top 10 patterns for *eggs(s)* in the BLOG Corpus

The intersection of possession and value, as well as the type of processes which eggs are part of, indicate a possible presentation of eggs as a commodity, the medical market described above. The frequency of the term *quality* shows the potential for judgements of gametes and potentially of individuals. The singular form *my egg* is most frequently part of the phrase *my egg collection*/*retrieval* rather than a description of an individual egg, whilst the pattern *my eggs* is most frequently followed by a complement describing the eggs. *Donor eggs* were mentioned infrequently as this was an option which was not espoused by any of the bloggers at the time of data collection

The patterns selected for analysis focus on the nominalised processes of *egg collection*/retrieval, the characteristics of *egg(s)* as realised through *my eggs* and NOUN *of eggs* and *quality* as a collocate of *egg* in both L1 and R1 positions. Concordance line examples and frequencies for these patterns are shown in Table 7.3 below.

Pattern	Concordance example	Frequency
my eggs	*my eggs must be on their last legs by now* (IF010)	108
egg collection	*I trigger tonight for egg collection on Wednesday.* (IF020)	190
egg retrieval	*For those of you use to IVF speak I am currently 8dp5dt and 13days past egg retrieval.* (IF014)	28
NOUN of eggs	*I start with Gonal F injections to stimulate the ovaries again to produce (hopefully lots of) eggs.* (IF022)	55
donor eggs	*I'm not ready for donor eggs.* (IF010)	38
egg quality/quality eggs	*The consultant was also concerned about egg quality in view of the pregnancy losses.* (IF016)	21/19

Table 7.3 *Egg(s)* – patterns for analysis in the BLOG Corpus

From close analysis of the concordance lines of these patterns I identified three sub-discourses of eggs as part of the experience of infertility; "eggs as goods", "the personification of gametes", and "reaping rewards" (related to the egg collection process). These are explored and exemplified below.

7.2.1.1 Eggs as goods

Eggs are represented in terms of commodity in the patterns *my eggs*, *NOUN of eggs* and *egg quality/quality eggs*. Both quantity and quality are potential areas for judgement of self and despite the apparent separation of self from gametes it is clear that individuals feel that (positive and negative) judgements about the quality of their eggs are a judgement on their person.

> *It's not that my eggs have hard shells, but just that they're really poor quality.*
>
> *So that made me feel good about myself.* (IF020)
>
> *The doctor was very complimentary about my egg quality and overall health.*
>
> (IF014)

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In terms of egg quantity, high numbers indicate an increased level of hope, while a decrease in eggs is viewed as a cause for concern, and this is expressed with phrases such as *running out of* or *reserve* which characterise eggs in terms of supplies.

> *Dr Candour feels that I am not running out of eggs any time soon.* (IF010)
>
> *Every month is another month closer to the inevitable time when I'm going to run out of eggs altogether.* (IF014)
>
> *I have a good reserve of eggs and am not going through premature menopause.* (IF005)

Further developing the idea of eggs as supplies, four of the bloggers figuratively describe their eggs as foodstuffs, using dark humour in referencing the trope of eggs as a finite supply and recontextualising this metaphor in their own writing.

> *Is this an indication that my eggs are in fact past their sell by date?* (IF024)
>
> *Meanwhile, my egg cupboard is almost bare.* (IF020)
>
> *If I respond appropriately my eggs will be ripe for the plucking* (IF014)
>
> *Also, sad that even H gets that I'm 36 and my remaining eggs are going stale.* (IF018)

Although donor eggs are often represented as commodities in dominant discourses of infertility, in the BLOG Corpus they are framed as less desirable than "natural" routes to pregnancy, prioritising the genetic aspect of family.

> *No donor eggs, no adoption. We'll try naturally.* (IF010)

7.2.1.2 Personification of gametes

A particularly interesting theme which occurred frequently (68%) in the pattern *my egg* and *my eggs* was the relationship between women and their eggs, with the bloggers assigning human agency and qualities to gametes (reinforcing the sub-discourse of personified ovaries 6.4.2.1). In the examples below this may function as a humorous

device to distance the experience and outcomes of infertility from the individual, particularly in cases of age-related decline in fertility.

> *The odds for us are not high - my eggs are too old, and DH's sperm are too thin on the ground, too lazy and too misshapen.* (IF020)

> *The day I turned 35 - when, if the media are to be believed, my eggs were busy staging a Wako-style mass suicide*. (IF014)

This personification is developed further as the relationship between egg and sperm is glossed in terms of a (heterosexual) couple creating a family or a normative ideal of male chivalry.

> *I just hope my egg found its way through my crap just about patent tube and DH's sperm are treating her well* (IF019)

> *If the sperm are decent sorts, mix them with my eggs…the idea being that by morning several sprightly embryos will be jostling the sides of the petri dish in their eagerness to become kids.* (IF005)

The egg is assigned agency for its role in the reproductive process which is outside of the individual's control. This may be a way of distancing from self-blaming for fertility problems.

7.2.1.3 Reaping rewards, egg collection

The process of *egg collection* (n=190) is described using the nominalised form accessing a more formal, medical register and drawing on the discourse of the clinic. However, the clinical term *egg retrieval* (n=28) is considerably less frequent indicating a combination of formal register with less formal lexicon used by the "expert" patient. The two terms herald a scheduled event rather than a clinical process and is perhaps glossed as a red-letter day due to it being one of the few external manifestations of internal processes.

The way things are looking just now I will have 4 to 6 follicles ripe for the plucking when the egg collection comes round. (IF014)

The dreaded egg collection, or "harvesting". (IF007)

Egg collection (sometimes referred to as the acronym *ec or EC*) is seen as an event to be welcomed as it is another step closer to the potential outcome of a child. However, there is a marked contrast between anticipation and fear particularly of the process and what it will entail.

So today was the big egg collection (ec) day! (IF025)

Can't quite believe I'm this far into it. I can't deny it's started to feel a bit scary now I'm being monitored and egg collection is so close. (IF022)

I am a month away from EC and don't even start DR injections till tomorrow, but I am really bricking it about egg collection. (IF001)

Descriptions of egg retrieval as a painful and intrusive process are shared within the infertility blogosphere, yet it is also described as "worth it" drawing on the recurring discourse of earning parenthood through personal travail.

Just back from my egg retrieval. Am in a lot of pain but worth it as got 16 eggs! (IF019)

And if I thought that the plan for a frozen cycle meant that I'd have an easy go of it directly after egg collection I was sorely mistaken (and I use the word 'sorely' advisedly). (IF014)

The representation of *egg(s)* in the BLOG Corpus shows the intimate and often personified relationship between individuals and their gametes and whilst eggs are framed within norms of commodified reproduction their intrinsic value is related to their potential to fulfil the bloggers' desire to create a family.

7.2.2 Egg(s) in the NEWS Corpus

A key factor influencing the representation of eggs in the NEWS Corpus is the proliferation of reproductive technology and subsequent legislation which occurred during the period of data collection (see for Section 2.4.1 for details of UK context)[31]. The development of the use of donor gametes and the change in law to remove anonymity around this were important topics in this period and this is reflected by the frequent forms of the lemma DONATE found in Table 7.4. While the majority of news texts which mention eggs relate to technological advances, nonetheless these are relevant to the lived experience of infertility as they demonstrate the norms of socially acceptable reproduction and evaluation of engagement with these technologies.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	OF	THE	EGGS	AND	THE	THE
2	THE	TO	OF	EGG	TO	SPERM	TO
3	OF	A	THEIR		DONATION	A	A
4	AND	SPERM	AN		ARE	IN	IN
5	A	THE	DONOR		IN	AND	AND
6	WOMEN	FOR	HER		FROM	BE	IS
7	USING	USING	AND		FREEZING	IS	OF
8	IN	INTO	HUMAN		FOR	ARE	BE
9	FROM	WITH	DONATED		DONORS	TO	FOR
10	WITH	FROM	MY		OR	FOR	IT

Table 7.4 Top 10 patterns for *eggs(s)* in the NEWS Corpus

The following section examines the representation of the patterns *donor eggs* and *egg donors*, contrasting them with *their, her* and *my eggs* as shown in Table 7.5. As in the previous section on the BLOG corpus, the prepositional phrase *of eggs* will be analysed, particularly focusing on the nouns which precede it. The pattern *donor eggs* will also

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[31] A central piece of legislation related to rules around egg donation. Therefore texts in the NEWS Corpus relating to women who donate eggs but do not identify as infertile are excluded.

be the subject of analysis as it is central to the representation of experience of infertility in the NEWS Corpus.

Pattern	Concordance example	Frequency
donor egg/s	*As she had been through the menopause she needed donor eggs and was pumped full of fertility drugs in the £30,000 treatment.* (The Sun, July 16, 2009)	399
egg donors	*A recent change in the law, which removed the right to anonymity for egg donors, had also led to a fall in the number of eggs available to women.* (Daily Telegraph, *June 30, 2009)*	271
of eggs	*The clinic can guarantee a steady supply of eggs because it is allowed to pay donors £ 700 a time.* (The Times, January 29, 2006)	605
their eggs	*OLDER professional women are freezing their eggs as they wait for their soulmate, say experts.* (The Mirror, June 29, 2010)	492
her eggs	*Storing her eggs is her insurance policy against the future.* (Daily Mail, June 1, 2007)	355
my eggs	*The way I see it is that, if I freeze my eggs, it extends my shelf-life.* (The Times, September 21, 2008)	186

Table 7.5 *Egg(s)* – patterns for analysis in the NEWS Corpus

The dominant sub-discourses of *eggs* in the NEWS Corpus intersect around ideas of commodification of reproductive parts and processes, and their role in age related infertility.

7.2.2.1 Commodified reproduction

A recurrent sub-discourse found in the NEWS Corpus shows both eggs and egg donors as commodities in the patterns *of eggs*, *donor egg* and *egg donor*. Egg donation and the need for donor eggs is presented as a moral/ethical issue of exploitation, critical of privilege, blaming of older women and stigmatising those who are perceived as necessitating this practice. In concordances of the pattern *of eggs* 48% relate to the quantity, or otherwise of eggs (the second most frequent semantic pattern is the quality

of eggs). In terms of quantity the shortage of eggs is presented as crisis with their value increasing due to scarcity.

> *There is a severe shortage of donor eggs in the UK.* (The Mirror, October 10, 2011)

> *Weeks's case, which highlights the extreme difficulty of obtaining donor eggs, has renewed calls for donors to be paid.* (The Sunday Times, June 29, 2008)

> *'There is a serious lack of availability of egg donors and this is an issue which is not being addressed.* (Daily Mail, July 8, 2006)

The representation of this as a crisis reinforces the discourse of desperation around infertility (Letherby, 1999).

> *It's awful to be needing donor eggs in the first place. Not to be able to have a family because your eggs are no good is devastating. Women needing eggs is a very common problem.* (The Guardian, August 23, 2010)

> *Like a growing number of British and Irish women who cannot conceive naturally, she had to travel to Eastern Europe to receive a donor egg.* (Daily Mail, July 20, 2006)

Egg donation in these patterns is presented as a solution to the "problem" of the shortage of eggs, albeit one which is framed as ethically problematic.

7.2.2.2 Youth as reproductive commodity

Related to the commodification of reproduction is the problematizing of age-related infertility creating further demand for donor gametes and thus commodifying youth. The news texts highlight age-related decline in egg quality and quantity presenting eggs as a measureable commodity which is in short supply for older women. Note how in the first example below the phrase *don't like* is used rather dismissively to evaluate women over the age of 35. The brief wording style implies a general dislike of such women,

rather than say a phrase such as "We don't like *to use the eggs of* women over the age of 35".

> "We *don't like women over the age of 35," says a fertility expert at Midland Fertility Services (MFS). Harsh! "There's an instant decline after that age in the quality of eggs.* (The Times, October 12ᵗʰ, 2008)
>
> *Once you move into your 30s your fertility declines quite rapidly. And the number of eggs available in the ovaries and the quality of those eggs reduces therefore the chances of conceiving are reduced.* (The Mirror, December 7, 2011)

Thus a link is created between aging mothers and the creation of a market for donor eggs, as seen in the following example:

> *In Britain, more than 20 babies a year are being born to women over 50 following IVF treatment with donor eggs harvested from much younger women.*
> (The Guardian, June 3, 2006)

In this example, and throughout this discourse, younger women's eggs are represented as an agricultural product, reiterating the reaping rewards sub-discourse in the BLOG Corpus (Section 7.2.1).

7.2.2.3 Social egg freezers

The process of freezing eggs or ovarian tissue for fertility preservation was originally developed for individuals undergoing medical treatment which would impact their fertility. However, since 2007 it has been possible to access this service without specific medical reasons to do so.

> *WOMEN will soon be able to freeze their eggs, allowing them to postpone motherhood and have a healthy baby when they choose.* (The Telegraph, September 3, 2007)

The increased use of these techniques for so-called social reasons has led to a negative discourse surrounding "social egg freezers", a trope which is specific to the NEWS Corpus.

> *In May, Lucy - 34 and single - took the radical decision of freezing her eggs to let her conceive in future when she finds a long-term partner. She is one of a new generation of thirty-something "social" egg freezers determined to secure their shot at motherhood.* (The Sun, July 15, 2008)

This discourse accounts for 45% of *their eggs* concordances, 10% of *her eggs* concordances and 12% of *my eggs* concordances in the NEWS Corpus (the remainder relate to egg donation and will not be included in the scope of this section as this has been explored above).

> *But some healthy women pay to have their eggs frozen while in their 20s and 30s as an insurance policy, in case they have not settled into a relationship before their fertility begins to decline at the age of 35.* (The Guardian, October 18, 2007)

> *By which time it might be too late. I need to put my fertility on ice, before it runs out on me. So I'm having my eggs frozen.* (The Times, 12th October 2008)

These examples show the how reproduction is further commodified as something which can be stored for later or a valuable asset to be insured. Critiques of women who chose to follow this path draw on the "selfish career women" trope.

> *SOARING numbers of women are putting their careers before motherhood by freezing their eggs.* (Daily Mail, May 3, 2008)

> *HELEN BARNES, a British canoeist and 2012 Olympic hopeful, is to freeze her eggs with the aim of defying her ticking biological clock, it was reported last week.* (The Express, 5th October 2008)

> *IT HAS been hailed as "liberation for women", but now the country's leading fertility experts are to express serious moral and medical doubts about women freezing their eggs to suit their lifestyles and aspirations.* (The Observer, February 1, 2009)

The discourse of social egg freezers is absent in the BLOG and CLINIC Corpora, and in reality a limited number of women use this process annually (816 in 2014 (HFEA, 2014)), however the media highlights this practice and frames it as an increasing social problem.

Eggs thus become a site of ethical and social tension which goes beyond body parts, or creating a family, to a moral panic about the shortage of eggs as a threat to fertility and society. This moral evaluation includes judgements on technology, deviant reproduction and ageing women who want a career and/or do not follow heteronormative dictats. There is a focus on science, bioethics and research but these become enmeshed with personal responsibility for women, stigma and the veneration of youth in relation to reproduction. This may provide further explanation for the separation of eggs and self, seen in the BLOG Corpus examples, to avoid the judgemental discourse about eggs (and the women around them) in dominant media representations.

7.2.3   Egg(s) in the CLINIC Corpus

As shown in Table 7.6 the lexis of the clinic focuses on biotechnical processes involving eggs, such as *collection*, *sharing, freezing,* and *donation*, which are framed as services provided by clinics. The use of the nominalised forms serves to distance or elide individuals from clinical processes such as *collection* and *donation*. As with the NEWS Corpus gamete donation is a highly frequent topic with 2 positions in the top 10 L1 and R1 patterns as forms of the verb lemma DONATE, while *donor(s)* appears three times.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	OF	THE	EGG	COLLECTION	THE	THE
2	THE	TO	AN	EGGS	AND	AND	AND
3	OF	THE	OF		SHARING	SPERM	TO
4	AND	SPERM	DONOR		DONATION	IS	IS
5	EGG	FOR	YOUR		ARE	A	A
6	TREATMENT	A	AND		FREEZING	PROGRAMME	BE
7	A	USING	DONATED		TO	EMBRYOS	IN
8	WHO	AND	THEIR		OR	TO	ARE
9	SPERM	WITH	OWN		DONOR	BE	EGG
10	FROM	INTO	FOR		DONORS	ARE	FOR

Table 7.6 Top 10 patterns for eggs(s) in the CLINIC Corpus

The selected search patterns which follow relate to people experiencing infertility *your eggs their eggs* and *own eggs* (see Table 7.7 for examples). As stated above, *donor eggs* and *egg donation/sharing* are also an intrinsic part of the representation of infertility and these patterns will also be explored.

Pattern	Concordance example	Frequency
egg sharing	*Egg sharing meant we could get on with treatment straight away," recall*s [NAME] (MID)	345
egg donation	*We were advised that maybe egg donation was the route for us in view of my age.* (CAR)	325
your eggs	*Freezing your eggs is complex.* (CRE)	170
their eggs	*Their chances of getting pregnant naturally reduces, because their eggs decline in quality.* (MAN)	131
own eggs	*Women are increasingly finding that they are not ready for a family during the years when their own eggs are of an optimal quality*. (SEF)	113
donor eggs	*[NAME] was diagnosed with a premature menopause and had no viable eggs, but [CLINIC] enabled the [NAME] to conceive their two children with donor eggs*. (BOU)	279
egg collection	*The egg collection is performed in the same way as a standard IVF collection.* (OXF)	504

Table 7.7 *Egg(s)* – patterns for analysis in the CLINIC Corpus

The pattern *of eggs* shows little variation from the previous two sections with the most common prosody being of quantity (number, shortage, supply) of both eggs and egg donors, and value related to scarcity. The role of eggs as commodities is explored in the concordance analysis of the patterns *own eggs, donor eggs* and *egg sharing* and so the concordance lines around *of eggs* will not be expanded upon in this section.

The term *egg collection* (504 occurrences) is procedural – a nominalised phrase which omits the subject (the person who performs the collection) and the indirect object (the woman whose eggs are collected), instead focussing on just the direct object (the egg). This serves to place the focus on the egg itself, grammatically hiding the social actors associated with it (the clinicians and the donor herself) and helping to construct the egg as a 'product'. In similar ways the phrases *egg sharing* (345 occurrences) and *egg donation* (325 occurrences) are glossed as clinical services.

7.2.3.1 Privileging genetic links

The privileged position of one's own gametes is central to discourses of assisted reproduction. The desirable state is to reproduce using one's *own* eggs, having genetically related offspring so as to be publicly identifiable as genetically related to their child (Wong, 2017) as discussed previously in the sub-discourse "Beyond reproductive (hetero)norms" in section 5.3.4.2. In the CLINIC Corpus the chance of achieving this desirable state is shown as less likely as women age.

> *30% of women will end up at 40 involuntarily childless and IVF success rates for women over 40 using their own eggs are very low.* (MAN)

> *Female fertility diminishes with age, so if you are using your own eggs, on average, the younger you are the higher your chances of success.* (SPI)

However, the inability of women to reproduce can be mitigated through medical intervention and matching recipients and donors can also be a way of obscuring

deviation from reproductive norms – embracing the idea of "passing" as genetically related (Wong, 2017; Becker et al., 2005).

> *Egg donation is most commonly used when the patient is unable to produce her own eggs. This type of infertility is often associated with older maternal age, when the ovary's store of follicles is beginning to run out*. (LON)

> *At this stage you will be matched with a recipient and your cycle will be coordinated by our egg donation team.* (SPI)

The link between the use of donor eggs (less reproductively desirable) and increased maternal age (less socially desirable) as evidenced in the clinic texts can be read as a way of stigmatising those who do not follow conventional routes to reproduction.

One way of mitigating this is the use of egg freezing which is framed as a possible way of maintaining the valuable genetic link to one's offspring:

> *Freezing your eggs at an early reproductive age can help to preserve your fertility and maximise your chances of a future pregnancy if you should experience fertility problems in the future.* (CAR)

In contrast to the negative representation in the NEWS Corpus of social egg freezers, in the CLINIC corpus this is presented as a way of managing the reproductive life course.

7.2.3.2 The gift of hope or the sale of gametes

In the patterns *egg donation, egg sharing* and *own eggs,* women who cannot use "their own eggs" are represented as potential recipients of the "gift" of eggs, while those who can are steered towards egg sharing/donation programmes as a way to make IVF financially accessible,

> *Egg-sharing is an IVF treatment which brings together women having conventional IVF (the sharer) with those unable to produce their own eggs (the recipient). Egg-sharing enables these two groups of women to help one another*

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- egg-sharers receive free IVF treatment, while recipients receive the eggs they

need for IVF. (LWH)

If you are 35 or under and able to produce healthy eggs but want to freeze your

eggs, with our egg-sharing service, you could donate some eggs to a potential

mother in need of them. (LON)

Egg-sharing/donation is a commercial facility provided by the clinics, yet this practice is represented as altruistic and empathetic, glossed as an act to help others who are also seeking reproductive assistance. While *egg collection* was shown above to be a grammatically agentless process these practices use a more personal lexis.

Catherine also agreed to donate half her eggs to a woman who was unable to

produce her own eggs, so allowing another couple the chance to conceive.

(MID)

If a woman is unable to produce her own eggs, an egg from another woman can

help her to have a baby. (BIR)

There are many women who have thought about donating their eggs to help

other women to have children. Egg donation gives hope to women who

previously thought they would be unable to have children. (RUH)

The examples above position egg donors and clinics as facilitators of reproduction for those experiencing infertility. They also reinforce the discourse of eggs as commodities or possessions to be traded.

7.2.3.3 A package of reproductive services

As with the examples from the NEWS Corpus, the CLINIC Corpus concordances of *donor eggs, egg donation* and *egg sharing* also reflect the discourse of commodified gametes, at a further remove, in marketing the reproductive services which they provide.

Bio technical advances in the storage of gametes are promoted as part of a package of potential reproductive services, as exemplified below.

> *Egg freezing can also be carried out in conjunction with the egg-sharing programme, which enables women under 35 who are freezing eggs to donate eggs to the egg-sharing programme in order to receive discounted treatment.* (LWC)

> *Egg sharing and 'Freeze and Share' provide further solutions for a growing number of patients.* (BRI)

Gametes are commodified both through their representation as vehicles of hope to those who wish to have a family and as objects in the provision of reproductive services. However, there is little mention in the CLINIC Corpus of the complex bioethical debates around this or related psychosocial issues, such as the exploitation of donors and the privileging of genetic relatedness which are seen in the NEWS Corpus and BLOG Corpus.

7.2.4 Summary

Across all the corpora a dominant sub-discourse of eggs as commodities/possessions is found, as part of the medicalisation and marketization of reproduction, albeit realised in a variety of ways. For bloggers the emphasis is on the quality and quantity of their personal supply of eggs and the monitoring of these while in the news and clinic corpora the focus is on donation, indeed, none of the bloggers discuss sharing or donating their eggs, only their disquiet about the possible need to use donor eggs. The personalisation of their eggs in the BLOG Corpus texts draws on the use of dark humour to manage a problematic situation as seen in the section 5.2 on identity and in this section the state of their eggs is intertwined with their reproductive identity. The discourse of social egg freezing is unique to the NEWS Corpus, forming part of a moral panic around deviant

reproduction, which is sharply contrasted by the normalisation of these services in the CLINIC marketing of egg freezing and sharing.

7.3 Analysis of the keyword pregnant

Pregnant is a top 100 keyword in all three corpora and a high frequency term, as seen in Table 7.8. Pregnancy is one of the outcomes by which treatment success is measured (HFEA, 2014) and can be read as the embodiment of visualised success for people experiencing infertility.

	Pregnant	
	Raw Frequency	Per million words
BLOG	2416	1461
NEWS	5214	923
CLINIC	706	919

Table 7.8 Raw and normalised frequencies of *pregnant* in all three corpora

For those desiring children, *pregnant* is a looked-for state, in contrast with unexpected conceptions which are framed as accidental or undesirable (Beynon-Jones, 2013) thus pregnancy is particularly anticipated and commended in the infertility community. For those unable to conceive, becoming pregnant can be seen as a restoration to a natural order (Becker, 2000) and also a transitional state to be moved through in expectation of the desired outcome of a baby (Cunningham, 2014).

However, being pregnant is also constructed as a state of risk and tension, wherein bodies are surveyed and potentially problematic decisions made (Lupton, 2004) and characterised by high levels of uncertainty, even without the complication of previous sub-fecundity (Ross, 2016). As, Hammer and Burton- Jeangros (2013, p. 56) point out "the experience of pregnancy is currently driven by the development of surveillance medicine focused on the monitoring of a wide range of risks" which requires those desiring or experiencing pregnancy to manage these potential risks.

In the analysis below I compare linguistic patterns around the term *pregnant* in the three different corpora. The concordances of selected patterns will be closely analysed to shed light on interpretations of the discursive construction of *pregnant* (in light of infertility).

7.3.1 Pregnant in the BLOG Corpus

Pregnant is the third highest keyword in the BLOG corpus, and as getting pregnant can be seen as a resolution to infertility, whilst the process of doing so becomes a central facet of the life of a woman who cannot conceive (Letherby, 2009). As seen in Table 7.9 the most frequent L1 collocates of *pregnant* relate to the process of becoming and being pregnant or, crucially, not pregnant. Thus being pregnant is something to be strived for, and this is reinforced by the L3 collocate *trying*.

N	L3	L2	L1	Centre	R1	R2	R3
1	I	TO	GET	PREGNANT	AND	I	I
2	THAT	I	WAS		I	THE	THE
3	IF	SHE	BE		WITH	AND	A
4	TRYING	I'M	GETTING		AGAIN	A	TO
5	AND	OF	NOT		BUT	HAVE	AND
6	TO	NOT	GOT		WOMEN	MY	NOT
7	WE	AND	BEING		FOR	NOT	IT
8	WHEN	WHO	WEEKS		THE	WAS	MY
9	YOU	AM	IS		AT	IT	HAVE
10	OF	YOU	AM		THIS	THAT	WAS

Table 7.9 Top 10 patterns of *pregnant* in the BLOG Corpus

The patterns selected for close concordance analysis in the BLOG Corpus shown in Table 7.10 explore the meanings made around the pursuit of getting pregnant and the potential failure to do so, in light of normative expectations around reproduction.

Pattern	Example from concordances	Frequency
get pregnant	I know you hear about women who suddenly get pregnant without medical intervention (IF024)	537
getting pregnant	I am trying consciously to keep doing things that will occupy my mind other than babies and getting pregnant. (IF025)	150
got pregnant	If I had got pregnant straight away, we would have a newborn by now (IF012)	121
not pregnant	I could sit here and cry all evening but it will not change a thing.... I still am not pregnant. (IF019)	141
pregnant women/ she [BE] pregnant	Cuddly Dads are the last straw, for me, even worse than smug pregnant women patting their bumps. (IF018)	177/52

Table 7.10 Patterns for analysis of *pregnant* in the BLOG Corpus

Close reading of these concordance lines resulted in the identification of three main sub-discourses which are drawn on by the bloggers; the liminal or uncertain state of "pregnant", the othering of this state for people who experience infertility and the balancing of uncertainty with the need to maintain hope.

7.3.1.1 Getting pregnant is no guarantee of a baby

A common lay definition of infertility is the inability to get pregnant, thus (being) *pregnant* is positioned as a desirable goal and a resolution. Patterns including forms of the verb lemma GET to the left of *pregnant* are highly frequent in the BLOG Corpus. As the examples show, for bloggers getting pregnant is only the first stage, without which it is not possible to move onto the next stage. However, it is not seen as a guarantee of a baby or indeed as a resolution to infertility, thus the writer occupies a liminal state, a discourse which is found in 27% of concordances around *pregnant*.

> *I'm more scared of us not getting pregnant than I am of getting pregnant and miscarrying again. Perhaps because getting pregnant is the first hurdle, perhaps because it's the hurdle we've always fallen at before.* (IF010)

As those few people who know keep telling me, it's great news that I got pregnant at all; the clomid worked for us so it's bound to work again soon; we're still young and have plenty of time. (IF012)

Even when pregnant, for people who have experienced infertility the fear and anxiety that the pregnancy will not end in a healthy baby is present, adding to the uncertainty of the state.

It is very unlikely that I will get pregnant and, as I know now, getting pregnant is no guarantee of a baby anyway. (IF012)

We managed to get pregnant (twice!), we managed that bit, but the baby died. (IF017)

For the bloggers experiencing infertility, pregnancy is framed as an ambivalent outcome, with such awareness of potential loss that they retain their identification as "not a mother" until birth and potentially beyond.

7.3.1.2 Othering the experience of pregnancy

A frequent sub-discourse among bloggers (found in 45% of concordances of pregnant) is the contrast between expectations of reproduction and the individual lived experience of infertility. Two examples shown below highlight the comparison between the "fertile" experience of having a child with the "infertile" experience.

I think the whole IF thing is so difficult because we are in a minority and most of society have no problem getting pregnant at all. (IF001)

I almost can't imagine conception from the perspective of a fertile, just being able to decide one day "I think I want a baby" and within a few months knowing it is there; finding out you are already several weeks pregnant without even

> *knowing; getting excited at the prospect of getting pregnant and then having all your dreams fulfilled instantly.* (IF003)

The emphasis which the experience of infertility gives to the fertile/infertile identity is writ large in the process of identification according to one's inability to get pregnant, note the somewhat reductive functionalisation (van Leeuwen, 2008, p. 54) of any woman who can get pregnant as *a fertile* in the above example – they are not assigned any other characteristics such as gender e.g. (*fertile women*).

This sense of being outside reproductive norms is underlined by the visible presence of pregnant women, increasing the othering of women who are not and potentially cannot become pregnant.

> *This message is for pregnant women-Just being around you is painful for your infertile friends. Seeing your belly grow is a constant reminder of what your infertile friend cannot have*. (IF006)
>
> *Just to say that even in Rome I could not escape from the many pregnant women rubbing their bumps in my face!* (IF019)

In 80% of the concordances of *got pregnant* the pregnant actor is not the blogger but another person as the writers explore the hypothetical possibility of getting pregnant and making comparisons with others who get pregnant. These examples also include common beliefs, manifest as fertility folk tales, about the ease with which others can get pregnant, despite infertility.

> *Do you remember that couple you met at our barbeque in the summer? Well, they were trying for ages, IVF and everything, then when they gave up and stopped they got pregnant naturally ...* (IF014)

I have a friend who also has PCOS[32] and she got pregnant on her first try when she came off the pill - maybe your first try after the treatment will be similar? (IF003)

She also told me about her friend who got pregnant as soon as she started the application process for adoption, and her other friend who got pregnant naturally after a failed IVF. (IF020)

Part of the discourse of the othered experience of fertility is the gap between expected life course and the disrupted one of someone experiencing infertility. Across the concordances of *get pregnant* and *not pregnant* this disruption accounts for 30% of examples.

I mourned for the way I wanted things to be. I mourned for our large family and I mourned for the romance of getting pregnant naturally. (IF011)

I never thought I'd be 39 and not pregnant. Life wasn't supposed to be this way. (IF010)

I had naively imagined that I would get married, get pregnant and have a baby. After all, isn't this what the story books tell us my Fellow Fertility Fighters? (IF023)

These expectations are also framed by common knowledge about reproduction which is produced from an early age, describing what women are taught to expect about fertility.

At school we are taught, if you EVER have sex without protection YOU WILL get pregnant straight away and it will ruin your life forever. (IF001)

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[32] Polycystic ovary syndrome (PCOS) is a condition that affects how a woman's ovaries work. See Glossary for further details.

It is drummed into you while you're young that having unprotected sex = getting

pregnant, but what they never tell you is that for some people it isn't as straight

forward as all that. (IF009)

Although less frequent (only 5% of examples) this construction of knowledge and expectations around infertility reflects Bunting and Boivin's (2006) findings that there is a lack of fertility awareness among young women, particularly the potential for infertility leading to a high level of disruption when this occurs.

7.3.1.3 Monitoring the potentially pregnant body

Particularly prevalent in the concordances of *not pregnant,* bodily evidence in the form of physical symptoms of impending menstruation or potential pregnancy symptoms is scrutinised in the tension between hope and certainty. Being possibly pregnant is a valuable state for bloggers as it maintains hope. However, this can also lead to higher levels of disappointment if the hope of a positive outcome does not come to pass.

Of course, this probably just means that I'm not pregnant, but I'm hanging on to

optimism while there's still time. (IF010)

My boobs are sore, I've got really bad cramps and I keep feeling nauseous. Is it

not enough that I'm not pregnant? Why does my stupid body have to keep

playing tricks on me and getting my hopes up? (IF012)

In monitoring for signs of hope, via the symptoms of being pregnant, bloggers engage in a combination of bodily monitoring and fatalism.

I am not pregnant. I don't know quite why I'm so surprised about this, but I am.

I was convinced yesterday that I was. (IF007)

On the other hand I don't have any symptoms of NOT being pregnant. I'm not

bleeding, not spotting at all any more and haven't done since last Thursday.

(IF010)

The state of uncertainty is relieved by a negative pregnancy test, which provides concrete but unwelcome knowledge. The capitalisation of Not Pregnant below mirrors the pregnancy test result, replicating and confirming the "official status".

> *And then the answer came up: "Not Pregnant". The box has been opened, and there's no more in-between stage.* (IF020)
>
> *The digital ones are worst - there's something so nasty and final about reading the words "Not pregnant", and you can't exactly hold them up to the light in the hope the "Not" will vanish.* (IF005)

The construction of *pregnant* for infertility bloggers establishes their othered position around this state as even if they get pregnant the experience is fundamentally different to that of "fertiles". While being pregnant is a desirable condition, it is one which necessitates continual monitoring and adjustment in the examples from the BLOG Corpus, due to the potential not to become or remain pregnant.

7.3.2 Pregnant in the NEWS Corpus

Previous work on pregnant women and pregnancy in the news media has foregrounded the morality discourses around pregnancy (Lupton, 2004), and how the media operationalise societal expectations around who achieves the status of being pregnant and the means by which they do so to evaluate social actors (Letherby, 2009; Beynon-Jones, 2013).

From the patterns in Table 7.11, it is clear that in the NEWS Corpus *pregnant* is a goal to be achieved, through L1 forms of the verb lemma GET but is also a transformed state of being both as a modifier of *women* and an object of forms of the lemma BECOME. The L3 collocates *chance* and *chances* reinforce the prosody of both desirability and effort around the term *pregnant*. As in the BLOG Corpus patterns for analysis, the term *pregnant* functions as a modifier of *women* and signposts this as a group for attention.

N	L3	L2	L1	Centre	R1	R2	R3
1	I	TO	GET	PREGNANT	WITH	THE	THE
2	WHEN	I	WAS		AND	A	A
3	CHANCES	SHE	GETTING		WOMEN	WAS	TO
4	WAS	OF	BECOME		I	I	I
5	SHE	WHO	BECAME		BUT	HER	WAS
6	THAT	NOT	GOT		THE	AND	AND
7	OF	CAN'T	BECOMING		IN	TO	FIRST
8	TRYING	AND	MONTHS		AGAIN	IN	IS
9	YOU	WOMEN	FELL		AFTER	SHE	SHE
10	CHANCE	THEY	WEEKS		SHE	WITH	HAVE

Table 7.11 Top 10 patterns of *pregnant* in the NEWS Corpus

Although it is part of a much wider discourse of pregnancy and motherhood in the media, my analysis focuses on *pregnant* as a part of the experience and representation of infertility. The more general discourses of pregnancy in the NEWS are useful as a broader context to this work but close analysis of these are not within the scope of this thesis. In close analysis of the patterns shown in Table 7.12, most attention will be given to the intersections between expectations of becoming *pregnant* and the lived experience of infertility.

Pregnant is a state to be attained, in discourses of infertility this attainment is usually framed as the result of unusual efforts, either over a long period of time or through repeated medical intervention. The extraordinary nature of becoming pregnant in light of infertility is precisely why it receives media attention.

Pattern	Example from concordances	Frequency
to get pregnant	When I was 29 I was referred to hospital because I'd been trying to get pregnant for two years. (the Mirror, October 26, 2010)	560
pregnant after	The unnamed retired Spanish university professor became pregnant after receiving fertility treatment in Latin America. (Sunday Express, December 31, 2006)	140
pregnant with	Caroline says she'll tell William the truth about her using a sperm donor to fall pregnant with him. (The Sun, October 27, 2009)	400
pregnant women	STORES will be forced to display signs warning pregnant women they must not drink in a major crackdown on alcohol abuse. (Daily Mail, May 14, 2009)	261
become/became/ becoming pregnant	Before I had finally become pregnant I had told myself that I would be happy with just one child, that I'd be incredibly lucky to have one, in fact. (The Times, October 22, 2011)	494
fell pregnant	We had two tries of IVF and on the third go, I fell pregnant with twins! (The Sun, July 27, 2006)	160
Chance(s) WORD WORD pregnant	BEING too thin can be even more damaging to a woman's chances of getting pregnant than being obese, research suggests. (Daily Telegraph, October 21, 2011)	132/84

Table 7.12 Patterns for analysis of *pregnant* in the NEWS Corpus

An important distinction in the patterns around *pregnant* is the different levels of agency shown for the act of getting pregnant, from *trying to get pregnant* to *became pregnant* to *fell pregnant*. These patterns either include women actively working to be pregnant or, in contrast, seeking to become pregnant through accident or providence. The contradictions around the moral judgement on those who "choose" to reproduce outside societal norms and the pronatal imperative to "try" to get pregnant leads to moral judgements on who deserves to become pregnant.

7.3.2.1 Non-normative reproduction

One of the most dominant discourses in the NEWS Corpus was the presentation of deviance from reproductive norms as a response to infertility, for example

controversial use of reproductive technologies, older mothers, or having a multiple

pregnancy and associated negative evaluation.

In 60% of the concordances of the pattern *pregnant after*, the state of pregnancy is the

result of reproductive technologies which are framed as risky or controversial, with the

women in question represented as socially problematic and categorised accordingly.

> *She sparked a huge controversy when she became pregnant after having fertility*
>
> *treatment from a controversial Italian IVF doctor.* (The Mirror, May 16, 2009)
>
> *Bousada became pregnant after repeated visits to a fertility clinic in Los*
>
> *Angeles, where she lied about her age.* (The Guardian, July 16, 2009)
>
> *The unemployed single mother became pregnant after having fertility treatment*
>
> *- despite already having six children conceived in the same way.* (The Express,
>
> February 13, 2009)

In the examples above the controversial framing of doctor and clinic discussed in

chapter 6 is drawn upon to imply negative evaluation of a pregnancy which results from

interaction with these controversial actors. The phrase *pregnant with* is most frequently

linked to an account of an unusual pregnancy (for example a multiple pregnancy) or an

unusual method of becoming pregnant.

> *The authority says the women are burdening the NHS by becoming pregnant*
>
> *with more than one baby.* (Sunday Times, February 8, 2009)
>
> *I can't believe that on the same night I took Viagra, I fell pregnant with twins.*
>
> (Daily Mail, November 13, 2006)
>
> *One UK consultant recently saw a woman who had been treated abroad who*
>
> *was five months pregnant with five babies*. (The Guardian, November 6, 2010)

The patterns *become/becoming/became pregnant* present an interesting contrast as the majority of concordances (64%) point to some form of non-normative reproduction, and yet the language pattern carries a lack of agency, in which pregnancy is something which happens to a person.

> *Mrs Seigenberg had two eggs implanted and to the couple's amazement, she immediately became pregnant with identical twin boys and a girl.* (The Mirror, April 19, 2011)
>
> *A 41-year-old British woman gave birth to a baby boy, Oliver, after becoming pregnant using a fertilisation method enabling scientists to screen her eggs without freezing embryos.* (Daily Express, September 2, 2009)
>
> *Experts have expressed concerns about the health impacts of the rapid rise of career women becoming pregnant in later life.* (Daily Mail, April 21, 2006)

7.3.2.2 Keep trying (to get pregnant)

The patterns with a high level of active engagement with becoming pregnant are found around VERB *to get pregnant* (n=556) where VERB is *trying/tried/try* n=209; *fail/failed* n=54; *struggle* n=18. The patterns *pregnant after* and *pregnant with* also exemplify this in concordances describing pregnancy after a long period of trying or medical intervention.

The personal interest news stories of people trying for long periods of time to conceive can reinforce common values of "good things come to those who wait" and "if at first you don't succeed, try, try again". These stories also include unconventional "treatment" for fertility problems, potentially challenging the medical mode but also contributing to common myths around fertility referenced as problematic by the bloggers.

A WOMAN who spent six years trying to get pregnant has finally given birth after her white witch mum gave her a fertility bracelet. (The Sun, May 14, 2010)

When she became pregnant after ten sessions (of acupuncture) Katie and James could hardly believe it. (The Sun, May 24, 2006)

I am a very positive person, and for five years of trying to get pregnant, I remained positive. (The Observer, October 25, 2009)

Although repeated engagement with medical intervention is part of the dominant discourse of keep trying, in the patterns *trying to get*, *fail to get* and *struggle to get pregnant*, there is also a less frequent framing (20%) where this repeated effort is queried and potentially negatively evaluated.

The HFEA plans to publish figures showing the cumulative success rate for two or more cycles of treatment, to help those who fail to get pregnant at the first attempt decide whether it is worth continuing. (The Independent, June 6, 2007)

Katy has been trying to get pregnant since she was 36. She is now 41. After four rounds of IVF - three full cycles and one where she had a frozen embryo implanted - she is up against a reality check. (The Sunday Telegraph, June 8, 2008)

The intersections of the sub-discourses described above are complex and potentially contradictory as in some cases repeated efforts to try to conceive are encouraged, with exemplars of these efforts resulting in pregnancy, yet ongoing engagement with ARTs is framed as problematic and potentially unsuccessful. While becoming pregnant is a still presented as a goal to be achieved, in the NEWS Corpus the routes to attain this are represented more ambivalently than in the BLOG Corpus.

7.3.3 Pregnant in the CLINIC Corpus

The inability to "get pregnant" (when that is desirable) is the clinical definition of infertility (WHO, 2009[33]), and is therefore key to identifying with the condition and diagnosis. A crucial aspect of the clinical patterns around *pregnant* shown in Table 7.13 is the range of possibilities they encompass for describing the process of conceiving, both in the lemmas of GET and BECOME to the left of *pregnant*, and modifiers such as *difficulty* (L2) and *naturally* (R1).

N	L3	L2	L1	Centre	R1	R2	R3
1	CHANCE	TO	GET	PREGNANT	AND	THE	A
2	TRYING	OF	GETTING		AFTER	A	THE
3	IF	I	BECOME		WITH	TO	FIRST
4	HELP	SHE	BECOMING		BUT	IS	TO
5	CHANCES	YOU	WAS		AT	YOU	OF
6	YOU	NOT	BECAME		FOR	TIME	TIME
7	THAT	WHO	BE		NATURALLY	THIS	YEARS
8	I	DIFFICULTY	GOT		IT	WAS	I
9	AND	WOMEN	FELL		IN	IT	AND
10	WHO	AND	WEEKS		AGAIN	AND	THAT

Table 7.13 Top 10 patterns of *pregnant* in the CLINIC Corpus

The concordance lines studied will not just focus on the meanings of *pregnant* in the CLINIC Corpus but the potential subject positions that can be accessed by people experiencing infertility and seeking clinical advice. The patterns which make up the search term for these concordances are shown in Table 7.14.

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[33] http://www.who.int/reproductivehealth/publications/infertility/art_terminology2/en/

Pattern	Example from concordances	Frequency
get/become pregnant	In June 2006, after trying to get pregnant for more than two years, they visited MFS for their first appointment. (MID)	198/60
became/got/fell pregnant	Incredibly it worked and I fell pregnant with twin girls. (SPI)	22/18/17
getting/becoming pregnant	There are many reasons why you might be having difficulty getting pregnant. (GLAS)	108/40
help [WORD] [WORD] pregnant	Donor insemination (DI) uses sperm from a known or unknown donor to help women become pregnant. (LON)	26
pregnant after	Amazingly I became pregnant after the first cycle and nine months later I had a fantastic water birth. (BOU)	29

Table 7.14 Patterns for analysis of *pregnant* in the CLINIC Corpus

In the CLINIC Corpus getting pregnant is presented as a process of attainment and not getting pregnant as an obstacle to be actively overcome through clinical intervention. Pregnant as an outcome is found in the patterns *pregnant after* and *pregnant with* in descriptions of successful outcomes following engagement with fertility treatment.

The CLINIC texts position themselves as potential sites of resolution for those who cannot get pregnant and this is seen in the L1 patterns of the past perfect verbs; *became (n=22), got (n=18),* and *fell (n=17)* which feature frequently in testimonials of clinical success.

7.3.3.1 Problem/solution explanation for infertility

The concordances of *pregnant* in the CLINIC Corpus show a dominant discourse of getting pregnant as a problem to which the clinic can provide a solution, via medical treatment or lifestyle advice. This discourse is most frequent in progressive verb patterns such as *getting* or *becoming pregnant*.

> *We see many couples at Manchester Fertility Service who need help getting*
>
> *pregnant again.* (MAN)

Problems with becoming pregnant are a cause of heartbreak for many people, individuals as well as couples. But we are here to help. (LWH)

As seen in Chapter 4, clinic texts present infertility as a commonplace (e.g. *many couples* and *many people* in the above examples) problem to which the solution is clinical intervention. The clinic is positioned as helper to achieve the idealised process of becoming pregnant.

The use of lexis such as *difficulty* preceding the pattern *getting* or *becoming pregnant* which then refers to collective subjects (couples or people) rather than individuals contributes to the representation of infertility as a societal problem to be solved.

15% of all couples wanting to have a baby will have difficulty getting pregnant (SHR)

The explanations for these problems either draw on either biomedical explanations or personal responsibility.

There are many reasons why you might be having difficulty getting pregnant but broadly speaking they are due to problems of ovulation and egg quality, problems of sperm quality, problems with the Fallopian tubes or a combination of these factors. (GCR)

Many women with endometriosis have difficulty in becoming pregnant. (AGO)

The biomedical model encourages engagement with diagnostic testing to find explanations for infertility. In contrast, a minority discourse (less than 5%) of "personal responsibility" explanations foreground individual efforts around "lifestyle changes" to meet the goal of pregnancy.

There are lots of ways to improve fertility and your chances of getting pregnant. Some of them relate to lifestyle changes such as stopping smoking, eating healthily, weight control and reducing alcohol intake. (LON)

> *An important step in becoming pregnant is ensuring that you are healthy, which*
>
> *you can do by making simple lifestyle changes.* (NHS)

The biomedical approach as a dominant model of infertility can be seen across all three corpora but is only presented as an unproblematic solution in the CLINIC Corpus.

7.3.3.2 Happy endings, resolving infertility

While the discourses above are focused around the process of getting pregnant and constitute the dominant discourses of the clinic, the discourse of pregnant as a resolution to the problematic state of infertility is also dominant in the CLINIC Corpus. This is most frequently realised in patient testimonials or "real life stories" with past tense verbs (*became, was, got, fell*) as L1 collocates of *pregnant* used to report incidence of individual success.

> *"But I got pregnant first time and everything went fine."* (BOU)
>
> *Within a month of commencing IVF treatment at our Centre Amy fell pregnant-*
>
> *all she required was just one embryo transfer* (BEN)
>
> *In April of 2003, after just one course of the drug, I became pregnant. Much to*
>
> *our delight, we finally had a daughter.* (OXF)

The use of the passivizing *fell/got pregnant* in the context of assisted conception draws on narratives of accidental/surprise pregnancy, particularly around the term *fell*, which are also seen in the NEWS Corpus (section 7.3.2) and applies them in a clinical discourse, perhaps as a normalizing rhetoric.

Despite this, getting pregnant is not always presented as a straightforward resolution to infertility, rather it is something to be achieved after repeated medical intervention as seen in the pattern *pregnant after.*

> *On average, most women become pregnant after three cycles of IVF, a total cost*
>
> *of nearly £12,000.* (WES)

Sant got pregnant after a further three cycles of natural-cycle IVF. (CRE)

The juxtaposition of first time success stories with the reality of how long it can take for fertility treatment to be successful shows an attempt to balance an appeal to potential consumers of fertility services with the legal and ethical requirement to realistic information about chances of success.

7.3.3.3 Summary

All three corpora construct the term *pregnant* both as a process of attainment and effort, and a desired outcome. The lexis around the term shows substantial similarities, particularly in common phrasal verbs such as; *getting pregnant*, *fell pregnant* and *trying to get pregnant*. The state of being pregnant is represented as one to be achieved through repeated efforts, medical interventions, and changes to lifestyle, framed as a personal goal in the BLOG and NEWS Corpora and as a problem to be solved in the CLINIC Corpus. Although becoming pregnant is undoubtedly looked-for, it is also framed as a risky and uncertain state by bloggers and news text producers and thus potentially problematic.

7.4 Analysis of the keyword baby

While *pregnant* is characterised as both a state and an outcome, the most frequent framing is as a point of transition in the journey from infertility to having a child. In contrast, the lexis around the keyword *baby* shows the representation of an entity and an outcome which is the objective of the intermediate state of *pregnant*. In part due to reproductive and screening technologies the *baby* which is being represented can be pre or post-natal (in the womb or in the arms) and can occupy a range of possible subject positions. As Harraway (1993) points out, new technologies which make visualisation and thus representation of the foetus possible, changes the point at which gametes become a baby, in the view of those observing the foetus, both parents and clinicians.

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Thus the personhood of the *baby* can be realised at multiple points from (pre)conception to after birth through the lens of the observer.

The *baby* in these texts can in fact be a hypothetical entity, one which is part of the desired life course but is not yet reified. In Moulder's (2009) study of pregnancy loss, the need for foetal or hypothetical persons to be incorporated into what she refers to as the family narrative is crucial to sense making. Thus the outcome *baby* is part of an idealised and normalised narrative of what it means to be or to have a family, a state which is particularly stark for those who cannot attain this goal and thus identify as infertile. As seen in the table below *baby* is highly frequent across all corpora, thus essential to any analysis of the experience of infertility.

	Baby	
	Raw Frequency	Per million words
BLOG	2100	1270
NEWS	8344	1477
CLINIC	1263	1644

Table 7.15 Frequency of *baby* across all corpora

7.4.1 Baby in the BLOG Corpus

In the BLOG Corpus, as seen in Table 7.16, the keyword *baby* is represented both as a possession, through possessive pronouns *my, our, her*, and the lemma HAVE, and as a goal, through the verbs *trying* and *want*.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	HAVE	A	BABY	AND	I	THE
2	I	FOR	THE		I	THE	I
3	OF	A	MY		IS	AND	A
4	AND	HAVING	OUR		IN	A	AND
5	TRYING	OF	HER		BUT	BE	OF
6	A	THE	THIS		WAS	IN	HAVE
7	HAVE	HAD	NEW		AT	MY	TO
8	THE	WANT	AND		MAKING	IS	THAT
9	YOU	AND	THAT		THAT	HAVE	WAS
10	THAT	WITH	OF		THE	ON	IS

Table 7.16 Top 10 patterns for *baby* in the BLOG Corpus

Although the determiner *a* is the most frequent L1 collocate of *baby*, as previously mentioned it functions most frequently as part of phrases such as *have a baby* and *having a baby,* and *trying for a baby.*

In contrast, the determiner *the* is not part of a similar phrasal pattern, instead *the baby* is used in 80% of cases to refer to the baby in utero. In these cases, *the baby* could be conceptualised as a step towards *my baby* but actually having a child in arms is not yet fully realised, so *the baby* is not yet possessed. However, on close reading, the pattern *the baby* is used to refer to the babies of others as well as the baby in utero, and in these examples, can be seen to function as a distancing device from the fertile other (see section 7.2.1 above) who can have babies more easily.

The phrases *have/having a baby* show baby as an outcome, although for many bloggers this still remains a hypothetical, future goal.

The desire for a baby is most clearly realised in the patterns *want a baby* and *for a baby* as bloggers linguistically describe and negotiate this longing.

The effort which goes into fulfilling this longing is seen in the concordances of *trying for a baby* and *baby making*, where baby is the outcome of prolonged endeavour and sex is about procreation not recreation. As shown in Table 7.17 these frequent patterns will be used for concordance analysis in the following section.

Pattern	Example from concordances	Frequency
the baby	I kept hoping that by the time she had the baby I would be pregnant. (IF014)	293
my/our baby	I am managing, I would do anything for us to get our baby. (IF019)	106/78
have/having a baby	The real killer is that at the end of all this waiting and hoping and praying, there is absolutely no guarantee that we'll have a baby - by whatever means. (IF020)	182/73
for a baby	It's like we've been given a chance to really try for a baby in the year we'd planned to. (IF015)	146
want a baby	I want a baby. I don't want this. (IF017)	47
baby making	That is, assuming I don't get pregnant in the meantime (ovulating now + sex = baby making). Right? (IF022)	41

Table 7.17 Patterns for analysis of *baby* in the BLOG Corpus

7.4.1.1 Discourses around baby in the BLOG Corpus

From the analysis of these pattern concordances the following three interwoven sub-discourses were identified as indicative of the ways bloggers discursively construct the term *baby*; the imagined family, disrupted expectations and, earning parenthood (I'd do anything for a baby).

7.4.1.2 The imagined family

A dominant discourse in the concordances of *baby* is the visualisation of the idealised family which will be created with the addition of a baby which is particularly frequent (85%) in the concordances of POSSESSIVE PRONOUN *baby*. As seen in the examples below this visualisation can go from the vague to the extraordinarily specific.

I sing this, sometimes, in my head to the vague non-entity that I pray will one day be my baby. (IF005)

I visualise transforming that second bedroom into the perfect nursery for our baby - it's got a thick, warm carpet, a cosy little crib, shelves filled with Beatrix

Potter books and teddy bears, and a comfy rocking chair where I'd cuddle my baby all day if I could. (IF022)

The thought of the face of our baby at their first birthday party seemed quite real back then. (IF010)

Visualising the end goal and including the theoretical baby in a family narrative are both ways to maintain momentum through infertility and related treatment. As seen in the example below the formation of the word *embabies* embodies the view of embryos as a part of the imagined family from the moment of creation.

*I'm going to take a deep breath, dig into my reserves and see this thing through with as much strength and dignity as I can find. And who knows? I might even end up with my baby...(*IF022)

And that's about it. We're both so excited and can't wait to make our baby. We're not looking forwards to the process, but we're fixed on the end goal right now. (IF015)

I am positive one of those five little embabies is our baby. They feel so close. It's weird to think that they are in a dish in Oxford being looked after. (IF025)

The telling of the (future) family narrative as a way of maintaining hope can also be read as a part of a broader (problematic) discourse of health which entreats patients to think positive (Sontag, 1991).

Despite the role of positive thinking and visualisation in negotiating the idea of having a baby when experiencing infertility, as shown below, the inability to do so is a severe disruption to life-course expectations (Becker, 1999).

7.4.1.3 Disrupted expectations

As part of the expected life course "having a baby" is a normalised part of the narrative. In the concordance lines this is borne out by the evident disbelief bloggers show at this expectation not being fulfilled as motherhood is such a normative role for women.

> *As a girl, you think that having a baby is just something that will happen, it's what we are created for at the end of the day* (IF025)
>
> *I have been TTC [34]for over 3 years now. I can not believe it has been this long. I can not believe we are no closer to having a baby, no closer to having a family.*
> (IF019)

The dominant message here is that the experience of infertility deviates from how things "should be" according to both personal and societal norms. This discourse is also characterised by figurative language of temporal and geographical distance from the ideal.

> *We're no closer to having a baby than we were a year ago; I know it's a silly way of thinking about it but I just feel so far behind. This isn't where I'm meant to be right now; this isn't how my life is supposed to be*. (IF012)
>
> *We have also had this weird thing that every time we get close to having a baby someone else gets pregnant and then their pregnancy is OK and ours goes wrong. In my less rational and more emotional moments I may have commented that other people keep nicking our spot in the baby queue and it's NOT FAIR!*
> (IF011)

As Whitehead (2013) found in her study of infertility blogs, there is a sense of entitlement to parenthood which is compromised and disturbed by the experience of infertility.

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[34] TTC is an acronym for trying to conceive.

7.4.1.4 Earning parenthood – I'd do anything

In the concordances of *for a baby* and *want a baby* the discourse of entitlement to parenthood intersects with how the bloggers perceive the efforts to earn this entitlement. The most frequent pattern (45%) in this set of concordances is *trying for a baby,* and in these examples repeated efforts to have a child and the length of time spent trying is foregrounded through the heightened awareness bloggers demonstrate of the time they have spent.

> *When I was two years into this role I was preparing to get hitched, and thinking that we'd start trying for a baby in about six months. That was three years ago and I am still in a state of limbo*. (IF014)
>
> *My period came yesterday - marking August 2008 out as the 28th month since we started trying for a baby.* (IF005)
>
> *We've been trying for a baby for 11 months today. I really want us to manage it this month as if we don't we're guaranteed to have passed the 12 months mark before we get a positive result.* (IF015)

This can lead to bloggers engaging with a moralising discourse, (12% of concordances) around trying hard enough, making "lifestyle" changes and thus becoming deserving of a baby, recontextualised from media and medical discourse exemplified in the NEWS and CLINIC Corpus later in this section.

> *Wanting to try for a baby is one of the main reasons I decided to lose weight.* (IF006)
>
> *I don't drink much at all these days while we are trying for a baby.* (IF013)

In the examples of the concordances of *for a baby* and *baby making* below it becomes apparent that some bloggers privilege the desire for a baby over other aspects of their

life, including potentially their relationship (as seen in Section 5.3 Significant Others), in pursuit of this all-consuming goal.

I am desperate for a baby. I want a baby more than anything in the world. I really want to have a family with my DH. (IF019)

I'm missing my life waiting for a baby that may never come. (IF012)

In particular, the concordances of *baby making* show a self-reflexive approach to these efforts, positioning themselves as serious and committed and thus deserving.

I felt as though I needed to demonstrate my commitment by going for the first opportunity I possibly could – putting baby-making first above all else, regardless of how difficult that might be at the time. (IF020)

No one would bother to take these (pre-conception vitamins) unless they were serious about the whole baby making business. (IF014)

Even when pregnant with a baby there is a sense of unease or caution as it is a process over which the bloggers do not have control. Where the baby is the end goal of a process of earning parenthood, it is potentially problematic for people experiencing infertility to accept that whatever steps they take they may not be able to have a baby.

7.4.2 Baby in the NEWS Corpus

In common with the representations of *baby* found in the BLOG Corpus, in the NEWS Corpus the keyword *baby* is also framed as an objective. Although it is central to the personal interest stories which dominate news coverage of infertility the baby itself is not the person of interest but the object of potential parents who are foregrounded in these stories.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	HAVE	A	BABY	AND	THE	THE
2	TRYING	FOR	THE		IS	A	A
3	OF	HAVING	MY		WAS	IN	TO
4	THE	A	ANOTHER		BUT	I	IN
5	AND	OF	HER		IN	WAS	AND
6	A	THE	FIRST		FOR	IS	WAS
7	HAVE	TO	TUBE		THE	BORN	I
8	FIRST	HAD	HEALTHY		I	AND	IS
9	I	WITH	AND		TO	TO	OF
10	FOR	TEST	THEIR		AT	BE	SHE

Table 7.18 Top 10 patterns for *baby* in the NEWS corpus

The patterns around *baby* in the NEWS Corpus (see Table 7.18) are broadly similar to those in the BLOG Corpus. Left collocates include possessive pronouns *my, her* and *their*, phrasal verbs *having a baby* and *trying for a baby* and the premodifying adjectives *test-tube* and *first.*

However the patterns for analysis in the NEWS (see Table 7.19) include the modifier *healthy* which is not present in the BLOG, and may indicate texts which draw on the discourse of reproductive hierarchy.

Pattern	Example from concordances	Frequency
for [WORD] baby	They had been married three years and had been trying for a baby without success. (The Sun, July 26, 2007)	738
to have a baby	SHE grew up longing to have a baby one day, but believing it would be impossible. (Daily Mail, December 28, 2009)	584
healthy baby	I remind myself that it's a small price to pay for a healthy baby in the future, but I'm feeling sorry for myself. (The Times, September 24, 2011)	143
another baby	We would like to try for another baby one day, and I will go back on the diet as I'm sure that losing the weight helped me to conceive. (The Mirror, April 4, 2007)	183
test tube baby	It is estimated that every primary school now has at least one "test-tube baby". (The Independent, June 22, 2006)	145

Table 7.19 Patterns for analysis of *baby* in the NEWS Corpus

In the NEWS Corpus a baby is the focus of a quest in which people experiencing infertility are willing to explore all possible interverntions to reach the outcome. At the same time efforts to have a child are surrounded by social norms of reproduction and it becomes clear that there is a reproductive hierarchy in which certain babies, conceived in particular circumstances and at particular times are more socially valid. By extension of this then certain potential parents are valued according to these norms of baby making. Two main sub-discourses were identified in the concordances of *baby*, one which focuses mainly on the individual experiences and one which encompasses wider social norms of reproduction: baby quest, and making and breaking reproductive norms.

7.4.2.1 Baby Quest

In the patterns *for a baby* and *to have a baby* the NEWS texts frame infertile women as willing to do anything for a child, drawing on "discourses of desperation" as seen by Letherby (1999). The NEWS Corpus examples foreground the baby quest as part of life and identity of people who experience infertility.

> *The overwhelming desire for a baby means that 90 per cent of women are willing to sacrifice almost anything in order to fund fertility treatment, a survey has found.* (The Express, September 7, 2010)

> *I understand that some women have an overriding desire to have a baby and I know that for some women, it would be by any means necessary.* (The Mirror, February 8, 2011)

Whilst there are examples in the BLOG texts of those who state that they are willing to do anything to have a child, the presentation of this overwhelming desire potentially passivizes those who experience infertility by situating them as objects of their desire for a child.

In stories of people who are willing to have a baby at any cost, these costs are presented in financial, emotional, medical and relational terms, but most frequently related to repeated medical interventions.

> *One in six UK couples is infertile and many who are desperate for a baby will try anything to conceive, some having as many as seven cycles of IVF.* (Sunday Times, September 27, 2009)

> *Along with her husband Lee, a 32-year-old builder, she has spent more than £50,000 and 16 years of her life having IVF in a desperate attempt to have a baby.* (The Sun, June 5, 2007)

> *Demand is steadily increasing - currently one in six couples have infertility problems and that is expected to rise, and many of these couples will pay almost anything for a baby.* (Guardian, January 15, 2007)

To reinforce the sense of a quest for a baby the news texts draw on journey metaphors in order to illustrate how far potential parents are willing to go.

> *THE fascinating insight into the world of IVF tonight reveals how far some couples will go to have a baby.* (The Sun, December 18, 2006)

> *In our desire for a baby, I had lurched from drugs to intrauterine insemination, from hormone injections to alternative therapies.* (The Independent, July 4, 2006)

This quest is also framed in time-critical terms, with women who attempt to have a child beyond the age of 30 (or in some cases 35) portrayed as having left it too late to "try for a baby" with success being dependent on adhering to appropriate social and biological timings.

By waiting until their late thirties and beyond to try for a baby they risk leaving

it too late because fertility treatment can never make up for lost time. (The Mail,

July 18, 2011)

When Louise hit 30 she was desperate to have a baby with or without a partner.

(Daily Mail, February 4, 2006)

Retired zoologist Jenny, 72, has spent 20 years trying to have a baby through

IVF at fertility clinics overseas. (The Sun, July 23, 2009)

This discourse reinforces the negative evaluation of older mothers seen in previous

chapters as well as the trope of the biological clock running out of time.

The discourse of the baby quest appears contradictory as the negative evaluation of

those who are desperate and willing to do anything is subtle but present while these

texts also stress the imperative to keep trying and maintain hope.

7.4.2.2 Making and breaking reproductive norms

Fairclough (2003) states that news texts seek to promote and sustain social norms, and

in the context of news texts on infertility this includes normalcy around reproduction,

family and kinship. The examples below show how these reproductive norms are

realised in the concordances of three modifiers of *baby*: *another baby*, *healthy baby* and

test-tube baby and how these norms are achieved through the "abnormal" process of

ARTs.

In the BLOG Corpus the idealised family is visualised to include the hypothetical baby.

In the NEWS Corpus this goes a step further and despite the efforts to have one child,

having *another baby* (n=140) is presented as completing the family.

I still dream of holding another baby but time is running out for us, and there

are a lot more risks now I am 41. (The Mirror, November 27, 2009)

In their appeal the woman wrote: "We are a 35-year-old couple with one child and desperately seeking to complete our family with another baby. (The Express, July 4, 2010)

I knew I wanted to give her another baby to complete her family. (Daily Mail, August 14, 2008)

The ultimate successful outcome in reproduction is the *healthy baby,* and in 53% of the concordance lines of this term it is framed as a goal by "experts" such as fertility specialists and regulators.

When patients come to us, most of all they want a healthy baby, and our aim is to maximise the likelihood of this. (Times, May 13, 2011)

We are working to promote the birth of a single healthy baby as the best outcome of fertility treatment. (Daily Mail, November 10, 2010)

Whilst a healthy baby is seen as a pinnacle of reproductive norms, women are shown in 31% of concordance lines as having the opportunity to achieve this reproductive goal through less normative methods.

For the first time, women can have their high quality young eggs harvested and frozen to produce a healthy baby when they want. (The Mirror, September 25, 2007)

A HEALTHY baby has been born from an embryo frozen for almost 20 years – a scientific breakthrough that may give women the chance to put off starting families until much later in life. (Sunday Times, October 10, 2010)

The tension between the goal of a "normal, healthy baby" and using new technologies to achieve this is also seen in the concordances around *test tube baby.* Whilst this is presented as a scientific breakthrough and conduit to a baby for those experiencing infertility it is also reported in scare quotes. The explanation for the high frequency of

this term is the story of Louise Brown, the first UK test tube baby, who gave birth in 2007 (she is referred to in 108/137 of concordances of *test tube baby*). Although this is presented as a personal interest story, it is simultaneously used to frame and evaluate the normalisation of reproductive technologies, particularly IVF.

> *Louise Brown, the first test-tube baby in the world, has given birth to a child of her own. The boy - named Cameron - was conceived naturally and without IVF.* (The Independent on Sunday, January 14, 2007)

> *Around 8,500 of the 640,000 babies born in the UK each year are ART-conceived and it is estimated that every primary school now has at least one "test-tube" baby.* (The Independent, June 22, 2006)

In the examples above the test-tube baby is othered when juxtaposed with a baby conceived "naturally" and although IVF is no longer seen as a new reproductive technology it is still framed as transgressive, risky and mistrusted.

> *For while three decades have passed since the first test-tube baby was born in Britain, doubts persist about its long-term safety.* (The Daily Mail, June 18, 2007)

The NEWS Corpus discourse around *baby* recontextualises clinical discourse of ARTs and the importance of having a healthy baby while still maintaining the reproductive hierarchy, through subtle negative evaluation of reproductive technologies as controversial and problematic.

7.4.3 Baby in the CLINIC Corpus

The ultimate goal of the fertility clinic is to assist in the creation of the "take home baby" and through this measure clinical success is appraised (Wilkinson et a., 2017). A baby is the primary outcome (or product) through which the clinic markets its services,

and the representation of this outcome is positioned to appeal to potential consumers, people experiencing infertility.

In the patterns Table 7.20 the collocates of *baby* show some patterns also found in the BLOG and NEWS patterns, the phrasal verbs *having a baby* and *trying for a baby* and clinical descriptors *test tube baby* and *healthy baby*.

N	L3	L2	L1	Centre	R1	R2	R3
1	TO	FOR	A	BABY	AND	THE	THE
2	OF	HAVE	THE		BORN	A	A
3	TRYING	HAVING	FIRST		FOR	TO	AND
4	THE	OF	TUBE		WAS	AFTER	IN
5	FIRST	A	YOUR		IN	IN	TO
6	AND	TEST	OUR		IS	BORN	TREATMENT
7	HAVE	THE	HEALTHY		WITH	FROM	OF
8	WITH	OUR	IVF		OR	WAS	WAS
9	TRY	FIRST	THEIR		BUT	IS	BORN
10	A	TO	MFS		WE	AND	YEARS

Table 7.20 Top 10 patterns of *baby* in the CLINIC corpus

The key difference from both BLOG and NEWS Corpora is the inclusion of the terms *first* (as L1-L3 collocates, although this is an L3 collocate in NEWS) and *born* (as R1-R3 collocates) used in the reporting of clinical success. These converging and diverging patterns (as shown in Table 7.21) will form the focus of the analysis in this section.

Pattern	Example from concordances	Frequency
for a baby	We can help by giving you peace of mind when actively trying for a baby. (HER)	131
the baby	The scan aims to determine the growth and health of the baby. (LON)	150
have [WORD] baby	Complete Fertility Centre Southampton offers personally tailored consultations, tests and a full range of assisted conception treatments to help you have a baby. (SOU)	131
healthy baby	Leading a healthy lifestyle is important when you're trying to make sure your body is fertile and able to create a healthy baby. (CRE)	27
test tube baby	In lay-man's terms this is known as the "Test Tube Baby" technique. (CRG)	41
first [OPTIONAL WORDS x2] baby	The first ICSI baby was born in 1992. (STJ)	117
baby [OPTIONAL WORDS x 2] born	When baby Mia was born to Essex couple Lisa and Matthew Lawry in July they called her their "little miracle," because she was born against all the odds. (BOU)	97

Table 7.21 Patterns for analysis of *baby* in the CLINIC Corpus

From the patterns analysed, I identified two sub-discourses which were also found in the other corpora: monitoring the possible baby and baby quest. However, the CLINIC Corpus also included a unique sub-discourse: society's infertility journey.

7.4.3.1 Monitoring the possible baby

The term *the baby*, as in the BLOG Corpus, is preferred and used to name a hypothetical foetal entity which exists but is not yet possessed (Ross, 2016). This creates a level of distancing from potential medical problems and medical procedures in contrast with *your baby* which has only 33 occurrences. However, this foregrounds the potential loss of this foetal entity and thus increases a sense of uncertainty around the outcome of baby.

> *A miscarriage is defined as a pregnancy which ends naturally before the baby (called a fetus) can survive outside the womb*. (AGO)

Once we'd had the first scan which confirmed a single healthy heartbeat, I was more worried than ever that we might lose the baby. (MID)

I was anxious throughout the whole nine months, especially after I had a bleed at 10 weeks and thought I was losing the baby. (MAN)

Additional scanning and monitoring is encouraged which can address uncertainty and offer hope as for many scanning make real the foetal entity and potential baby.[35]

Early Pregnancy Scans can determine the actual due date of the baby, brain and spinal cord development, growth and the likelihood of any birth defects. (CRE)

So their world came crashing down when she went for her 12 week ante-natal scan and the sonographer confirmed the baby had failed to develop after about eight weeks. (MID)

This potential for *the baby* not to become a child found in these examples from the CLINIC Corpus echoes the attitude in the BLOGs that pregnancy is just the first step towards having a baby, in this case the embryonic "baby" is one step towards having a family. The distancing strategy of using *the* baby rather than *your baby* may be a way of managing the fear of the negative outcome. The foregrounding of possible loss can be framed as clinics encouraging pregnant women to engage with prenatal monitoring as a way of purchasing certainty.

As well as sexing the baby we can also give you details of the ongoing health and wellbeing of the baby and give you some pictures to take away. (LON)

4D scanning simply means that these life-like pictures can be seen to move in real time so the activity of the baby inside your womb can be studied. (CRE)

In these examples the clinic balances the possibility of a negative outcome with technological management of this uncertainty.

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[35] *Scan* is also a keyword in BLOG and CLINIC Corpora.

7.4.3.2 Baby quest

The concordance patterns *for a baby* and *have a baby* show the efforts which both individuals and clinics put into achieving the outcome of having a baby. This discourse is based on a narrative around the quest for a baby in which trying, over a period of time, with the clinic in helper role, results (in the clinic testimonials) in a child.

> *After eight years of trying for a baby, we finally had our precious girls.* (BOU)

In the examples of *have a baby* concordance lines below, the clinic is presented in a helper role, facilitating women/couples in their quest. This is potentially problematic as fertility treatment success rates are not guaranteed. Indeed the success rate in 2014 ranged from 32.2% to 1.9% depending on the age of the patient (HFEA, 2014).

> *The good news today is that almost all known causes are amenable to treatment and that most women can be helped by fertility treatment to have a baby*. (LON)
>
> *xxx offers personally tailored consultations, tests and a full range of assisted conception treatments to help you have a baby*. (COM)
>
> *We are dedicated to helping couples and women have a baby as safely and naturally as possible even when other clinics have turned them away and fertility drugs have failed. (*CRE)

Patient testimonials which include the pattern *have a baby* can been interpreted as a justification of both medical intervention and the impetus to keep trying.

> *We are both now 44 and were given just one chance, it is amazing to have a baby, it is a miracle that we are sitting with our baby right now.* (BRIS)
>
> *We were beginning to think that we would never have a baby of our own as we had also tried other fertility treatments and alternative medicine such as acupuncture and reflexology*. (BRID)

The final part of the narrative is realised in the concordances of *baby born* in which the birth of a child is framed as a happy ending which reflects personal and clinical success.

> *When baby Mia was born to Essex couple Lisa and Matthew Lawry in July they called her their "little miracle," because she was born against all the odds.* (BOU)
>
> *Ellie is also the 2500th baby born after treatment at MFS. What an excellent milestone to confirm at the end of the year*. (MID)
>
> *xxx who celebrates her first birthday today is the 1000th baby to be born as a result of IVF treatment by xxx Fertility.* (WES)

The baby quest sub-discourse is recontextualised in the BLOG Corpus in the sub-discourse earning parenthood, particularly through repeated engagement with medical technologies and is also found in the NEWS Corpus as described in section 7.4.2.

7.4.3.3 Society's infertility journey

As seen in the NEWS Corpus texts on infertility, it is not only a personal experience but reflects broader societal experiences of the rapid technological and ethical developments around fertility and associated treatment. In contrast with more critical NEWS representations, the CLINIC texts promote reproductive technologies as beneficial social development and encourage acceptance of "test tube" babies as a normalised outcome of these technologies.

In concordances of *test tube baby* and *first x baby* it is possible to see the framing of IVF becoming more socially and medically normalised since the first test tube baby. In the examples of *first X baby* below this progress of normalisation is described as a forward trajectory through time and space, indicating a recontextulisation of journey metaphors which are often found in texts on infertility and in healthcare communication more generally.

Fertility treatment and IVF in particular have become so much part of everyday life that it's sometimes quite easy to forget that it is only just over thirty years since the birth of the first 'test tube baby'. (BRI)

Since the first test tube baby, Louise Brown, was delivered in 1978, fertility treatment has come a long way and has helped to deliver over 1 million babies worldwide. It is now used as the primary treatment for a wide range of fertility problems. (OXF)

Involvement at the initial stages of the UK's assisted reproductive journey is framed by clinics as a measure of their success and validity, as is continued involvement in cutting edge technological advances.

The world's first "test-tube baby"" clinic, will expand its assisted conception service. (BOU)

We have helped many thousands of couples to become parents since our involvement in that first IVF baby. (CAR)

The CRGH and UCL Centre for PGD have set many UK firsts in the field of PGD, the first baby conceived to be free of the BRCA-1 breast cancer gene, the first baby born to be free of retinoblastoma. (CRG)

This framing of both long term and recent involvement with technological advances in reproductive technology reinforce the biomedical model, and clinic as solutions to infertility.

In all three corpora, the language around *baby* frames it as an objective to be possessed and in the case of the CLINICs a measure of clinical success. Both the BLOG and NEWS Corpora include sub-discourses of earning parenthood and the quest for a baby, and the NEWS texts in particularly paint a sensationalist picture of the lengths people will go to in order to have a child. In contrast in the CLINIC Corpus the negative

experience of infertility can be minimised through terms such as *trouble getting pregnant* and *help to have a baby.*

While the baby as objective is idealised in the baby quest sub-discourse, and the biomedical model of reproduction prevails in pursuing this objective, it is also "othered" through marked forms such as *test tube baby* and *baby after* followed by fertility treatment which point toward a non-standard conception.

7.5 Chapter Summary

The linguistic patterns and sub-discourse identified in this chapter frame reproduction as a project and process to overcome infertility. It is possible to observe, when tracking patterns from the keywords *egg*, via *pregnant*, to *baby* that all three include desired outcomes for people experiencing infertility – having "healthy" eggs, being pregnant and having a baby. These sub-discourses and their overarching discourses across the corpora are shown in Figure 7.1 and Table 7.22 below.
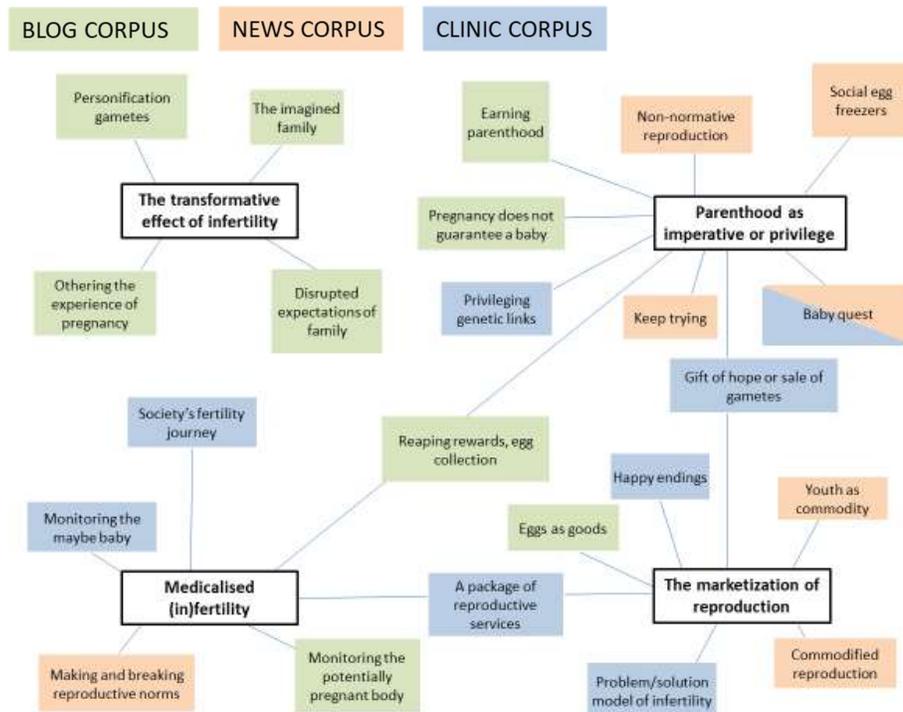
Figure 7.1 Relationships between sub-discourses and overarching discourses around reproduction keywords.

OVERARCHING DISCOURSES

	Transformative effect of infertility	Medicalised (in)fertility	Marketization of reproduction	Parenthood - imperative and privilege
SUB-DISCOURSES	personification of gametes	monitoring the potentially pregnant body	eggs as goods	reaping rewards, egg collection
	othering the experience of pregnancy	reaping rewards, egg collection	commodified reproduction	earning parenthood
	disrupted expectations of family	making and breaking reproductive norms	youth as commodity	pregnancy does not guarantee a baby
	the imagined family	a package of reproductive services	gift of hope or sale of gametes	social egg freezers
		monitoring the maybe baby	a package of reproductive services	keep trying
		society's infertility journey	problem/solution model of infertility	non-normative reproduction
			happy endings	baby quest
				privileging genetic links
				gift of hope or sale of gametes

Table 7.22 The sub-discourses and overarching discourses around keywords of reproduction.

In discursive terms the sub-discourses identified generally adhere to the dominant biomedical framing of infertility and assisted reproduction, and this has become a normalised and encouraged response for people who are unable to conceive.

As seen in previous chapters, in this chapter, the BLOG Corpus sub-discourses mostly correspond to the overarching discourse "The transformative effect of infertility" and the CLINIC sub-discourses are mostly within the overarching discourses of medicalisation and marketization. The greatest spread of sub-discourses across corpora is those which draw on the overarching "parenthood as imperative or privilege discourse". The sub-discourses within this category are somewhat contradictory. On

one hand individuals are encouraged to maintain efforts to "earn" parenthood in baby quest, keep trying and reaping rewards in the BLOG and CLINIC examples thus maintaining the imperative to parenthood. On the other, continued engagement with medical intervention is framed as problematic, particularly in the NEWS Corpus sub-discourse of "non-normative reproduction".

When repeated efforts to become parents do not equate with the desired outcome, the bloggers sub-discourse that "pregnancy does not guarantee a baby" is at odds with expectations around reproduction and the imagined family. This dissonance suggests that their experience of infertility has a transformative effect on expectations and beliefs.

As in previous chapters, the discourses of medicalised and marketised reproduction are mainly found in the CLINIC Corpus sub-discourses. However, the imperative to bodily monitoring is also manifest in the BLOG Corpus, potentially because of their interactions with clinical discourses. This is found both in the monitoring of the potentially pregnant self but also in the sub discourses of "monitoring of the maybe baby" (in utero), and as part of the "baby quest". In these cases, the discourses of medicalised and marketized reproduction intersect with the imperative to parenthood.

Clinics strive to present a more normalised picture of infertility which can be addressed through medical intervention, yet it is these very interventions which are marked as other, or non-normative in NEWS and BLOG Corpus texts.

The "marketization of reproduction" is particularly striking in this chapter as it becomes clear that in providing fertility treatment clinics are not just offering medical intervention but are selling the means to maintain both cultural and individual expectations around the family. As reproductive services are framed by CLINIC, and to a lesser degree NEWS texts, as a route to the resolution of infertility, it is apparent in

the BLOG texts that even when engaging with fertility treatment individuals have experienced a significant degree of disruption to their beliefs about having a family and in doing so may be irrevocably changed. Whilst a baby may be a resolution to the inability to get pregnant, it may not be a cure for infertility.

Chapter 8 - Conclusions

8.1 Introduction

In this concluding chapter I address my main findings, namely the discourses of infertility I identified in my three corpora and the interrelatedness of these discourses across and within the texts studied. This chapter also includes critical reflections on the methodological aspect of this thesis and the application of corpus-assisted discourse studies to the study of a contested condition such as infertility. I then discuss potential further applications of this approach. Finally, I reflect on how my position as a researcher developed throughout the course of the thesis, also considering the effect of impact activities on my work.

8.2 Summary of research findings

8.2.1 Answer to RQs

To draw together my findings, I return to my research questions:

1) What discourses around infertility are found in newspapers, infertility blogs and clinical websites?

2) How are these discourses linguistically realised through keywords and frequent patterns of language use?

3) How do the discourses of infertility interact across and within the three different text types studied?

In each of my analysis chapters I have provided detailed analysis of the linguistic patterning around each of the keywords studied, to address question 2, and to repeat each of these findings would not be practicable or illuminating. Therefore, my conclusion chapter will focus mainly on my first and third questions, relating to the

discourses that were interpreted from the patterns studied and how they interact with one another across the three text types.

While my initial goal was to identify discourses of infertility across text types, I had not anticipated the abundance of possible discourses such rich data would inspire. In order to do justice to the multiple discursive constructions around infertility, I categorised and named each potential "discourse". However, it became clear that these were in fact sub-discourses, parts of overarching discourses which occurred repeatedly but were manifest in different contexts and with different linguistic patterns.

As discussed in Section 3.6 of my methodology, the naming and identification of discourses can be problematic and in order to address this I adhered to certain parameters when analysing my data. While the sub-discourses I identified could best be described as "dominant" within a particular text type, the actual number of concordances lines coded for each sub-discourse varied quite considerably, depending on the number of instances of a linguistic pattern in each corpus. When identifying the overarching discourses discussed in the following section, I returned to my list of sub-discourses and coded each named sub-discourse according to an overarching theme which I documented throughout my analysis. Although the naming of sub-discourses was an iterative process over the course of the thesis, it was only possible to satisfactorily identify overarching discourses once the analysis of all my chosen keywords was complete.

The four overarching discourses which I derived from the sub-discourses in each chapter are named as: Medicalised (in)Fertility, the Marketization of Reproduction, the Transformative Effect of Infertility and Parenthood as imperative or privilege. Some sub-discourses could not be confined to one overarching discourse, for example, the "happy endings" sub-discourse, present in both NEWS and CLINIC texts, was

categorised both as a part of the discourse of marketized infertility and the discourse of

parenthood as privilege and imperative (see Table 8.1 for full list of discourses and sub-

discourses).

	OVERARCHING DISCOURSES			
	Transformative effect of infertility	**Medicalised (in)fertility**	**Marketization of reproduction**	**Parenthood - imperative and privilege**
	infertility acting on the self	pursuing medicalisation	clinic as portal to parenthood	medics as gatekeepers
	in infertile space and time	reaping rewards, egg collection	eggs as goods	clinic as portal to parenthood
	more than the sum of my lady-parts	the medicalised self	a baby at any cost	keep trying
	disrupted expectations of self	bodily monitoring	the infertility marketplace	reaping rewards, egg collection
	effect on intimate identities	the reproductive body as machine	controversial fertility doctors	pregnancy does not guarantee a baby
	doubting the self	medics do things to me	clinical controversy	earning parenthood
	the broken self	monitoring the potentially pregnant body	commodified reproduction	infertility as threat
SUB-DISCOURSES	travelling through infertile space and time	medics as gatekeepers	youth as commodity	responsibility and blaming
	Dr knows best?	diagnosis-reification of infertility	potential reproductive consumers	deserving parenthood
	living on clinic time	negative effects of medical intervention	clinic as solace	aging mothers as cautionary tale
	personified ovaries	making and breaking reproductive norms	empathy and expertise	suitable parents
	personification of gametes	acting on the ovaries	managing the patient pathway	earning parenthood
	othering the experience of pregnancy	normalising the threat of infertility	marketing clinical space	leaving it too late
	disrupted expectations of family	beyond reproductive norms	expert patients reproductive choice	dysfunctional female bodies
	the imagined family	clinical educators	clinic selling points	social egg freezers
	disrupting the relationship biography	a package of reproductive services	medical solutions and expertise	ovaries and genetic privilege
	more to life	monitoring the maybe baby	managing expectations	keep trying
	diagnosis reifies infertility	society's infertility journey	gift of hope or sale of gametes	non-normative reproduction
	expert patient reproductive choice	infertility as female domain	a package of reproductive services	baby quest
		expert patients	problem/solution model of infertility	happy endings
			happy endings	privileging genetic links
				gift of hope or sale of gametes

Table 8.1 Overarching and sub-discourses of infertility across all corpora and search terms

BLOG CORPUS   NEWS CORPUS   CLINIC CORPUS

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The following sections will deal with each of the overarching discourses and their interrelated sub-discourses, and their implications for the lived experience of infertility.

8.2.2 Transformative effect of infertility

"Just as I carry the physical scars from both a laparoscopy and, now, a c-section so too do I carry with me the emotional scars associated with a six-year struggle to conceive and carry to term a child." (IF024)

One of the key findings of this thesis is the transformative effect which infertility has on the lives of those who experience it, and the multiplicity of contexts in which this impact is felt. This discourse is most frequently drawn on in the BLOG Corpus, while in the NEWS Corpus infertility is instead presented as a social rather than individual problem (infertility as threat and social egg freezers) or in terms of resolution (happy endings, more to life), and in the CLINIC Corpus as a temporary barrier to be overcome (problem solution model of infertility).

However, the BLOG data suggests that the experience of infertility brings about the same fundamental changes as does any other serious life disruption (Becker, 2000).

The first context I address is the effect of infertility on the self, which manifests both in negotiating individual identities and in relationships with others. There are multiple sub-discourses which indicate a breach of the expectations of selfhood, including "doubting the self", "the broken self" and "infertility acting in the self", all of which are found in the BLOG Corpus. Despite the transformative effect on the self, the bloggers also indicate the desire to maintain "other" selves even when identifying as infertile, exemplified in the sub-discourse "more than the sum of my lady parts".

As well as disruption to the individual identity of the (female) bloggers, infertility is framed as a disturbance to the expected heterosexual relationship trajectory and the

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functioning of an intimate relationship. Again, this is mainly found in the BLOG Corpus. However, the sub-discourse of "disrupting the relationship biography" was also identified in the NEWS Corpus, perhaps unsurprisingly as the dominant discourse in the news is likely to be both heteronormative and repronormative.

An interaction between disrupted expectations of self and the repronormative life course is realised in the sub-discourses of "disrupted expectations of the family", "the othered experience of pregnancy" and "the imagined family" which are characterised by deviation from the expected narrative of "boy meets girl, boy and girl get married and have a baby".

Although the effect on identity and relationships is foregrounded in this discourse it also encompasses the transformative effect on an individual's body and the perception of that body particularly found in the "personification of gametes and ovaries" sub-discourses. It is possible that this separation of body and self serves as a protective stance, distancing the sense of self from bodily disappointment found in the experience of infertility.

This discourse of transformation intersects with the medicalisation of infertility, as the body and its parts are acted upon but also as individuals develop their experiential knowledge (expert patients) and challenge medical authority (Dr knows best?) in the BLOG Corpus. The language of the clinic is espoused by the bloggers to affirm their role as expert patients, indeed many bloggers engage with the internet to deliberately expand their knowledge of infertility and this may account for the high levels of health literacy among this group.

The transformative impact of engaging with reproductive medicine extends to a temporal/spatial change for individuals who move into previously unfamiliar clinical

territory in which one operates in clinic time ("occupying clinic time", "infertile space and time").

What draws together all the sub-discourses which contribute to the "transformative effect of infertility" is the breakdown of expectations of self, relationship, family, and body. The expectation of some element of control over self, which is dominant in neoliberal norms of health and the body, is necessarily damaged in the lived experience of infertility. The transformative effect of the infertility is cumulative, disruption of initial expectations is repeated through the testing and diagnostic process and through subsequent treatment cycles in a metamorphosis to being an infertile woman.

8.2.3   Medicalised infertility

"We know now, categorically, that any baby we might have will not be conceived in our home, in our bed, as a result of a natural act of love. Instead our child will be conceived in a petri dish in a clinic and replaced in my womb by a catheter." (IF005)

This section addresses how the discourses in this category contribute to the medicalisation of infertility, returning to Bell (2010) who defines this process as "its (infertility's) treatment as a pathological condition rather than a natural or social one" and the implications of this for the lived experience.

The contributory sub-discourses in this category (see table 8.1) foreground the primacy of medicine in the experience of infertility, and its conflation with assisted reproductive technologies such as IVF. What is particularly interesting is the amount of medicalisation sub-discourses which are drawn on in the BLOG Corpus when it could reasonably be expected that the CLINIC Corpus would contribute most to the discourses of medicalisation. The fact that descriptions of the lived experience foreground

discourses of medicalisation suggests that, for these bloggers at least, infertility is an intensely medicalised experience.

The foregrounding of biomedical solutions to fertility problems is particularly apparent in the BLOG Corpus sub-discourse "pursuing medicalisation" and in the NEWS Corpus "diagnosis - the reification of infertility". In both discourses engagement with medicalisation is seen as the start of the process which may alleviate infertility, and validation of the infertile self can be found in this engagement.

However, reliance on biotechnology to address infertility leaves little space for alternative subjectivities and this is apparent in the range of subject positions found in these texts. These subjects are either clinicians, as seen in the "gatekeepers or guides" and "clinical educators" sub-discourses or potential patients, exemplified in "expert patients". As Nettleton, Burrows, and O'Malley (2005) argue, some people "do not necessarily want to be 'empowered' or become 'experts' in illness or disease, and all the responsibility that this might confer" (p. 974).

There is also a gendered aspect to this discourse as the subjects of medical intervention are primarily framed as female, and while this is most explicit in "infertility as a female domain" it is also apparent in the sub-discourses of medical intervention on the female body to address infertility.

The sub-discourses of medicalisation reinforce how once an individual identifies as (possibly) infertile the bodily experience becomes medicalised, both in how the body is treated and how the body is perceived. In this process observing the body becomes crucial, both in anticipation of becoming pregnant and the foetal entity within the pregnant body, as seen in "bodily monitoring", "monitoring the potentially pregnant body" and "monitoring the maybe baby" (Lupton, 2014b).

However, the body is not just acted on in terms of visualisation but physically as it becomes a site of intervention. This can include the whole self as seen in the BLOG sub-discourse of "acting on the body" or particular reproductive sites as seen in "reaping rewards" and "acting on the ovaries" present in both BLOG and CLINIC texts. This encouragement both to pursue medical intervention and to monitor the problematic body draws on neoliberal discourses of self-management (Giddens, 1991) and self-monitoring (Lupton, 2014).

It appears from the sub-discourses encompassed by the discourse of "the medicalisation of infertility" there is little to challenge or critique the overall effect of medicalisation. In the BLOG Corpus and NEWS Corpus there is negative feedback on specific clinical encounters but this is not generalised to the whole concept.

Whilst assisted reproductive technologies can be framed as deviant, as in the NEWS sub-discourse of "breaking reproductive norms", it is also possible to view engagement with medical technology as a desire to maintain societal norms to reproduce, and to comply with the norm of medicalised infertility which is dominant in the UK. Thus, this acceptance of the dominant discourse is in part an acceptance of neoliberal ideals of an informed individual taking responsibility to maintain bodily norms, in this case to reproduce.

The CLINIC Corpus sub-discourse of "Society's infertility journey" illustrates the ways in which infertility as a medical condition, and the subsequent biomedical advances have been normalised in the UK over the past 40 years. I would argue that this acceptance of assisted reproductive technologies can be positive for people experiencing infertility, certainly it is preferable to the NEWS sub-discourse of "breaking reproductive norms" in terms of minimising stigma.

Indeed, it can be seen in the BLOG Corpus that medicalisation has the potential to play an explanatory role for managing stigma and uncertainty around infertility, for example, if the body is seen as a machine then an individual cannot be blamed for its failure.

8.2.4 Marketization of reproduction

We've been TTC for 28 months, so in that time it's cost us roughly £560 for vitamins alone!!! It just goes to show, even when you are lucky enough to have NHS funding, the financial cost of treatment is actually pretty substantial. (IF009)

In the UK, in theory and under NICE guidelines (NICE CG156, 2017), treatment for infertility is provided by the National Health Service. However, many people do not qualify for IVF under ever more stringent NHS criteria[36], and with diminishing resources, some Care Commissioning Groups do not provide funding for fertility treatment. If people do meet criteria there are often long waiting lists for treatment. These factors contribute to the unique position of infertility as a condition which is acknowledged as meriting medical treatment, yet as this treatment may not be freely available, individuals are positioned as potential consumers in the market for reproductive services. Therefore, if individuals are experiencing infertility as potential consumers, clinical service providers are necessarily selling their services, and this section focuses on the discursive construction of this marketization of reproduction.

This overarching discourse contains a multiplicity of sub-discourses which can broadly be divided into three aspects of the marketized reproduction: managerial (e.g. managing the patient pathway, problem/solution model of infertility) commodification (Mooney, 2012) (e.g. the infertility marketplace, marketing the clinical space, youth as

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[36] These include; being a healthy weight (BMI range 19-30), not smoking, not having children from this or any previous relationships, being within specific age ranges (some CCGs will only fund women under 35 years old) (https://www.nhs.uk/chq/Pages/889.aspx?CategoryID=54. Retrieved 2017).

commodity) and the less frequent, commercial controversy (e.g. controversial clinics and controversial fertility doctors).

Most examples of this discourse are found in the CLINIC or NEWS corpora, and the bloggers are less likely to engage with it. However, there is evidence that this discourse influences the blogger's view of reproductive parts and processes as something which can, potentially, be purchased in sub-discourses: "eggs as goods" and "clinic as portal to parenthood". In these BLOG Corpus sub-discourses, similarities are seen with the discourse of medicalised infertility, that engagement with the reproductive market is a necessary step to attain the desired goal of parenthood.

The commodification of the parts and processes which are involved in assisted reproduction is a central facet of this discourse. In the CLINIC Corpus in particular, medical solutions are marketed to mitigate the problem of infertility. Clinics position themselves as a site where these solutions can be provided, emphasising the positive aspects of both the experience in "clinic space" and outcome "happy endings", thus it is not the treatment itself which is marketed in many cases but the end product.

The testimonial accounts of clinic success (e.g. happy endings, clinic as solace) use the narrative of "real life" success to show the pursuit of the idealised goal of creating a family, ideally a genetically related family. The drive to commodify the idealised family extends to treatment and gametes being marketed with the assurance that families who use donor gametes can "pass" (Goffman, 1978) as related. This aspect of the marketization discourse intersects with "Parenthood as privilege or imperative" with reproduction framed as something which can be earned or even bought.

Although the examples in the CLINIC discourse normalise the sale of reproductive services, in a set of sub-discourses unique to the NEWS Corpus the commodification of reproductive treatment is problematized as unethical and risky, due to unscrupulous

doctors and clinics keen to maximise profits in "controversial fertility doctors" and "controversial fertility clinics".

The more managerial aspects of marketized reproduction foreground clinical expertise in managing potential patients' route to parenthood, through the complex area of possible treatments and outcomes, particularly in "managing the patient pathway" and "managing expectations".

In the CLINIC Corpus texts, it is clear that there is a tension between managing expectations, and the regulatory imperative to do this while "selling" a product. This is particularly problematic in the UK context where it is less common for treatment to incur a cost than in other settings which have been studied such as the USA. This tension is also present for individuals who experience infertility who occupy positions both as patients yet as customers, encouraging the neoliberal ideal of the savvy consumer of medical services. Personal tensions are shown around the marketization of reproduction, as for individuals the imperative to engage with technologies is strong but the physical, emotional, and monetary costs of this can be prohibitively high.

8.2.5 Parenthood as imperative or privilege?

We deserve a baby. We'd be good parents. We can do this. (IF005)

This discourse is perhaps the most complex to elucidate, encompassing the tension between the desire for parenthood, the social imperative to reproduce and the social sanctioning of those who are deemed unsuitable for reproduction. This section focuses on the sub-discourses of the cultural norms and moral discourses around attaining parenthood, particularly in light of infertility.

In this thesis, both social and individual drives to reproduce are accepted as dominant discourses of reproduction. In the discourse of "Parenthood as privilege or imperative",

the drive to reproduce is not questioned, however, the extent to which people will pursue this drive and whether they should be permitted to do so is constructed as potentially problematic. Therefore, the discussion of this discourse is centred on identifying the norms of reproduction, and the groups of individuals and their reproductive bodies which are being evaluated.

As stated previously one dominant discourse of reproduction is the imperative to reproduce (Wilkinson et al., 2015). In this discourse individuals are encouraged to persevere to attain the goal of parenthood, which is particularly seen in the sub-discourses of "reaping rewards", and "keep trying". In addition, parenthood is indicated to be a worthwhile goal as demonstrated by the presence of the "baby quest" and "happy endings" sub-discourses in the NEWS and CLINIC Corpora, reinforcing the imperative to keep trying which pervades texts on infertility.

In these sub-discourses it is apparent that parenthood is represented as something to be earned, both through perseverance and by adhering to social and moral codes of deserving parenthood. It is this aspect of earning parenthood which raises questions of who deserves parenthood, and who does not. Infertility, or non-parenthood, is employed as a moral threat which is particularly focused on one group; women who delay reproduction. The negative evaluation of women who are framed as flouting reproductive norms of when one should have a child are widespread and dominant in the NEWS Corpus, found in sub-discourses of "leaving it too late", "aging mothers as cautionary tale", and "social egg freezers". Moral aspects of health are often stratified with middle-class bodies idealised yet in the dominant discourses of infertility, a middle-class group of (career) women delaying motherhood, are almost uniquely positioned as the immoral, irresponsible other.

In contrast BLOG Corpus texts do not draw on these sub-discourses around aging and deserving parenthood. However, they do engage with discourse of "earning parenthood". For bloggers and, to a lesser extent, clinics, parenthood is represented as something which is earned through adherence to "lifestyle" mandates such as being a healthy weight, not smoking and not drinking alcohol.

While the imperative to parent (for those meet the appropriate norms) is dominant, the type of parenthood which is attained is also under evaluation. In this discourse the best way to attain parenthood is the most "natural" and involves least intervention. The gold standard of reproduction privileges genetic relatedness (e.g. privileging genetic links) and in doing so represents the functioning body as the body which has the means to reproduce its genes (ovaries and genetic privilege). Those who do not have a functioning reproductive body are thus framed as less functional individuals, and potentially less deserving of parenthood.

While all three corpora include sub-discourses of parenthood as a privilege to be earned, there is variation across corpora. The NEWS corpus has the most representation of potentially undeserving parents (leaving it too late), contrasting with those who have earned the privilege through repeated efforts (keep trying). Through their adherence to neoliberal health imperatives, the bloggers in the main self-identify as entitled to parenthood (Whitehead, 2013), but are not necessarily certain of attaining the privilege (pregnancy does not guarantee a baby). Parenthood as privilege is least prevalent in CLINIC Corpus texts which are less engaged with moral discourses and more concerned with encouraging the reproductive imperative and promoting clinical services, despite potential restrictions on who can access treatment for infertility.

8.2.6 Interdiscursivity and problematic discourses

This thesis is underpinned by my understanding of interdiscursivity as a process of recontextualization in which discourses interact across, and within, the three different text types. I also adopt Sunderland's (2004) model of damaging discourses, although I use the term "problematic" discourses in my discussion of these.

This section will explore the interplay of discourses across text types, their interaction with wider socio-cultural representations of infertility, and how these discourses may be problematic for people who experience infertility.

In my analysis I found surprisingly little evidence of contesting discourses, although one exception is the BLOG sub-discourse "more than the sum of my lady parts", which contests the homogenising NEWS representation of women who experience infertility as aging and desperate. Similarly, the bloggers "Dr knows best?" sub-discourse contests discourses of clinical expertise. However, in doing so the bloggers still engage with expert patient discourse dominant in the medicalisation of infertility.

While CLINIC sub-discourses of medical expertise do not actively acknowledge and contest the NEWS Corpus sub-discourses of "controversial doctors" and "controversial clinics", they do foreground clinical responsibility and validity in contrast to this.

The fact that there is little to contest medicalisation or marketisation or the imperative to parent suggests that these discourses are so dominant that there is little to challenge them in any "mainstream" accounts. While bloggers draw on the discourse of medicalised infertility, this may be a result of the fact that all bloggers had engaged with medical treatment for infertility and thus accept the biomedical model of infertility. This does not mean that the medicalisation of infertility is unproblematic. As an "outsider" to the experience of infertility I was troubled by this discourse, as in many cases medical intervention does not address infertility yet has a sustained and severe impact on the

body of the individual. My disquiet with broad acceptance of the discourse of medicalised infertility is not a judgement on the bloggers who draw on this discourse but on the process of the medicalisation of infertility, and specifically its intersection with marketized reproduction.

My interaction with health care practitioners assured me of the benevolence of individuals who staff infertility clinics. However, the evidence in the CLINIC Corpora of the extent of the commodification of assisted reproduction was in my view problematic. The sharp contrast between the BLOG Corpus sub-discourse of travelling through infertile space and time, and the CLINIC Corpus sub-discourse of marketing the clinical space reinforced a disparity between the experience of infertile individuals and its representation by clinics.

The transformative effect of infertility is not a passivizing of people who experience it but rather an insight and an acknowledgement of the comprehensive impact of infertility. The transformation which is undergone is ultimately a deviation from expectations of heteronormative parenthood and it is the effects of such expectations which are most problematic.

The discourse of parent as privilege and imperative is problematic precisely because of the interrelatedness of the two concepts. If parenting is an imperative, as sub-discourses such as "infertility as threat" imply, to then frame it as a privilege only to be earned by the deserving (earning parenthood, suitable parents) is to limit the appropriateness of reproduction to those who are deemed suitable parents. This juxtaposition points to the presence of which Ginsberg and Repp (1996) term as "stratified reproduction" in which "some categories of people are empowered to nurture and reproduce, while others are disempowered" (p3).

This discourse of parenthood as privilege interacts with the marketized reproduction discourse as this privilege can be attained, at the right price through engagement with the consumption of reproductive services. These discourses also intersect with the medicalised (in)fertility discourse which similarly offers the hope of parenthood, in this case through compliance with neoliberal health principles such as personal responsibility and self-monitoring.

I found the extent to which women were negatively evaluated through the neoliberal lens of personal responsibility for health in NEWS Corpus to be unsettling, if not wholly surprising. The sub-discourse of leaving it too late is a trope which has been commented on in previous studies of infertility in the media (Campbell, 2011; Budds et al., 2013), and the discursive patterns in this study reaffirm this finding. While aging mothers are repeatedly critiqued in the news coverage, maternal age is comparatively downplayed in the CLINIC and BLOG Corpora, indeed the demographic data of the bloggers does not point to age as a substantive factor for these participants.

As seen above, a striking aspect of my analysis was the level of tension and contradiction present in the negotiation of infertility. As the personal becomes a public health issue this is ultimately problematic for people experiencing infertility as individual distress is compounded by social judgement.

8.3   Critical reflections

8.3.1   Methodological reflections.

As much as this thesis considered discourses of infertility, it was also an exploration of the ways to best approach multiple data sets of varying styles and sizes. Attempts to employ the more conventional method used in Corpus Assisted Discourse Studies of looking at a small number of collocates around a small number of keywords to test a

hypothesis about a language feature or social issue showed that this was not sufficient for the complexity of this data.

While the intention was always to use keywords as "a way in" (Baker, 2006), what emerged from these keywords was based on qualitative categorisation and the development of these categories was a reiterative process of looking at the keyword data and considering them in the context of the research questions and contextual information. These categories then led the selection of data for closer analysis. Analysis using the Patterns tool in Wordsmith elicited a broad range of both grammatical and lexical collocates for potential analysis. The use of this tool helped to elicit units of meaning, but unlike using 2 or 3-word clusters (n-grams) these units were flexible across a span of 5 places to the left and right of the search term. This allowed for the exploration of frequent patterns which included a particular part of speech, for example VERB one place to the left of the pronoun *me*, but did not restrict the pattern to an individual word within the part of speech. The flexibility of using the Patterns tool to analyse units of meaning and the reiterative data-led approach were both key to the method developed in this thesis.

While looking at the social construction of a particular condition was a key focus of the thesis, the approach was closer to a critical realist position in that text producers, and indeed individuals in the world are limited in the potential meanings and subjectivities they can draw on. This may be constrained stylistically or culturally but my belief is that these constraints can also be recognised linguistically, as language patterns are inextricably linked with meaning. By looking at how the meaning made through certain patterns varied (or not) within and across text types, this thesis identifies how meanings can be recontextualised or contested, even within the same patterns. Through analysis

of the patterns around a range of keywords, it has also made clear how a range of linguistic patterns draw on and reproduce a particular discursive repertoire.

It also became clear in the development of my method that when looking at multiple data sets it can become necessary to accept a focus on one particular text type/text producer which most reflects the interests of the researcher. This is in part due to the sheer volume of data which results from multiple datasets, generating any number of potential avenues for analysis but rendering it impossible to cover these in an appropriate level of detail to elicit meaningful findings. Although it has been argued that quantitative corpus approaches can give some level of "subjectivity", the subsequent choices of what analyses to pursue are more aligned with qualitative methodology. In this case my interest in the lived experience of infertility led to a focus on the ways in which the negotiation of identity, embodiment and reproduction are represented in relation to people experiencing infertility. While all the data sets received the same level of detailed analysis, this analysis was guided to a certain extent by the findings from the BLOG Corpus with the other corpora being used as complementary data in order to provide additional consideration of context for identifying and understanding the discourses used by the bloggers.

8.3.2   Originality of research

The originality of the work in this thesis can be summarised in three key points; its position as the first (and at the time of writing *only*), comparative study of the language around infertility; the use of data triangulation to carry out not just a study of the differences between two or more text types but also the similarities; and the use of the Patterns tool for the identification of linguistic patterns in corpus-assisted discourse analysis.

As discussed in Chapter 2, a substantial body of work in the social sciences addresses the experience of infertility, some of which identifies particular discourses around infertility such as "discourses of desperation (Letherby, 1999) and IVF as lottery (De Lacey, 2002). However, even work which addresses textual encoding of the experience, for example blogs (Whitehead, 2013), does not make use of specifically linguistic analysis. The original idea for this thesis was born partly of a desire to address this deficiency in close linguistic analysis as a way to identify discourses of infertility.

The second original aspect of this work came about in relationship to the first, the need not just to analyse discourses of infertility in one text type but to compare how these discourses interact across a range of two or more text types. The use of comparison is a cornerstone of the CADS approach, as Partington (2008, p. 98) states "it is only possible to uncover and evaluate the particular features of a discourse type by comparing it with others". While several studies have used comparison of, for example, articles from broadsheet and tabloid newspapers, diachronic or cross linguistic comparison, thus far corpus-assisted analysis of multiple text types has been limited (Jaworska and Kinloch, 2017). Taking texts from multiple perspectives, in this case personal, media and clinical, on a problematic topic, can illuminate the way in which language, and thus discourses, is utilised by this range of text producers.

The abundance of data which results from comparing three text types on a topic necessitates a strategy to focus the analysis on a manageable but salient set of linguistic features. While my initial research question was broad, simply "what are the discourses around infertility in these text types?", using the Patterns tool to examine repeated linguistic collections gave a unique way in to identifying discourses. This was particularly the case when use of the Patterns tool revealed the unexpected meaning of a perhaps commonplace construction, for example the use of *I know I* in the BLOG

Corpus was used to justify and self-reflect on experiences of infertility. In this case it could be expected that the verb *know* is a purely cognitive process yet in the text showed a far more complex use, closer to an emotional process.

While the previous example is an unexpected finding, what Partington (2008, p. 97) describes as "non-obvious meaning" there were also cases where the linguistic patterns found did not just confirm my expectations but surpassed them. One such case was the transparent commodification/commercialisation of reproduction found in the language around gametes, in which the representation of eggs as goods was dominant to an unexpected extent.

The most unique aspect of my thesis is, for me, the awareness it has given into the lived experience of infertility. Without detailed analysis of repeated patterns of language in these texts I feel assured that intriguing insights such as the way women are "personifying the ovaries" would not have been uncovered.

8.3.3 Learning points

Perhaps unsurprisingly when developing a new approach to a familiar methodology, the main learning points of the thesis were methodological, things which in hindsight would have improved either the quality of the research or the burden on the researcher.

When beginning a study, particularly PhD research, the temptations to "do it all" or 'collect as much data as possible" are strong. However, in retrospect the amount of data I had was at times overwhelming and in future research my desire for inclusion will be tempered by the need to balance the corpora. In the case of this study I could possibly have included fewer NEWS texts, as a representative subsample may have been equally effective, and the potential for using down-sampling for news corpora has

been explored in other studies of CADS (Baker and Levon, 2015; Gabrielatos et al. 2012).

In a similar vein, it would have been beneficial at an earlier stage to accept that it is not possible to examine every potentially interesting keyword in great detail. The focus for my thesis became clearer when I made the choice to justify the patterns for analysis I selected and retain a realistic scope for the thesis. The thesis does not contain all the interesting analytic paths I explored but it does contain the analysis most relevant to the lived experience of infertility across text types.

As mentioned previously the method for this study of using the Patterns tool, rather than the standard approach of using collocates or concordance analyses of selected terms, emerged from testing a method from previous work and this being unsatisfactory. While much successful work in Corpus Assisted Discourse Studies focuses on collocations of key terms the stylistic differences between my corpora meant that this was not a satisfactory approach. The collocates either revealed only closed-class grammatical words (using log-likelihood) or very unusual lexical words (using MI) and the range of these was so great that it was near impossible to select terms for closer analysis without a significant amount of "mission creep" from the research question. While it would have been preferable in some ways to replicate tried and tested methods from other studies I discovered that the key driver of my method had to be its appropriateness towards answering the RQs.

8.3.4 Reflexivity

In carrying out this analysis and writing the thesis I have tried to adhere to Baxter's (2003, p. 245) commitment to be "continuously explicit and questioning about the values and assumptions made by discourse analysis." And I am aware that the

discourses identified are both a product of societal influences and of personal influences.

When deciding to what extent it was appropriate to frame infertility within the dominant biomedical and pro-natal models, the choices made in this thesis are located in my own cultural norms, in which infertility is inherently medicalised (Greil et al., 2010) and parenthood is both socially and individually desirable (Bell, 2010). This does not infer the medicalisation of infertility or the imperative to parent are accepted wholeheartedly either by me as a researcher or in the accounts of the lived experience. However, it does reflect the social reality of infertility in the UK in the early 21st Century.

This acceptance of the biomedical model directed my data collection towards bloggers who identified as infertile by (self) diagnosis and engagement with medical treatment. It also led to the collection of data from clinical sites, and perhaps most importantly, to me orientating to the field of critical health studies, chiefly studies around reproduction and the female body.

While this is methodologically a study of linguistics and language patterns, ontologically it draws on social science disciplines in which critical health studies are most frequently situated, medical sociology and medical anthropology. Work by Thompson (2006), Becker (2000) and Letherby (2008, 2000) informed my view of infertility not as a fixed condition but as a fluid and variable experience. These writings also foregrounded an awareness of the problematic nature of situating infertility in the clinical space, both societally and individually. Letherby (2002) particularly problematizes identity in light of involuntarily childlessness and from the start piqued my interest in the identity work bloggers were doing in my dataset.

Due to my personal experience during the thesis as I moved from someone who was childfree by choice to the mother of a young baby, my perspective inevitably changed.

I developed a more acute awareness of how the pregnant body becomes a site of societal monitoring and evaluation, developing experiential knowledge in addition to my academic knowledge. I also became more intensely aware of the griefs and losses which were experienced by bloggers throughout the trajectory of their infertility.

It is impossible to take the researcher out of the thesis and this work developed from my perspective of a feminist, health linguist. While using quantitative methods to develop my initial keywords, from that point onwards the thesis was more a qualitative work and the choices made are inherently bound with my subjectivities.

8.4 Impact

8.4.1 Impact activities

During my PhD I won funding from the Faculty of Arts and Social Science at Lancaster University to carry out public engagement work based on my initial thesis findings. This funding allowed me to develop a programme of work which initially comprised focus groups in three UK cities with people who had experience of infertility whether personal or professional. These events gave me the opportunity to gain feedback from key stakeholders in the infertility community encouraging me to cast a critical eye on my research. I found that public engagement was a useful way of identifying the value of different research questions that I had initially set. These focus groups led to engagement with the communication team at the Human Fertilisation and Embryology Authority (where I acted as an advisor on a new website), the British Fertility Society (where I gave input on patient advice leaflets), the British Infertility Counsellors Association (where I wrote for their newsletter), Northern Fertility Nurses Study Group (I presented at their annual conference) and writing for the Bionews website. The feedback from this public engagement led directly to following my intuition that the BLOG Corpus should be my focus of the study, and that the voices of individual

experience is something to be valued. These focus groups also encouraged me to develop further work on the specific conditions which can lead to infertility and work with same-sex or single parents who are seeking fertility treatment.

8.4.2 Practical applications and guidance for text producers

While it is desirable to use the critical findings of my thesis in order to improve communication around infertility it is necessary to acknowledge the problematic nature of being highly critical of those you are potentially working with, in my case fertility clinics and their websites. While I would criticise in the strongest terms the marketization of reproduction and the role clinics play in sustaining and developing this market, it is unlikely that the clinical text producers would respond positively to these critiques. However as part of a broader social critique, this aspect of my findings could be raised with patient groups and lobbyists in their field of infertility. The linguistic evidence has the potential to contribute to the evidence base regarding the over-commercialisation of reproductive technologies seen in the recent debates on the marketing of treatment add-ons by the fertility industry[37].

In analysing news coverage of infertility, it was helpful to consider the balance between responsible reporting of potential health problems with the sensationalisation of such stories. For journalists and news editors I would suggest that it is important to report on potential health issues, indeed the BLOG Corpus texts point out that there is a dearth of acknowledgement of fertility issues both in education and in the media. Therefore I would support the idea that it is acceptable to raise the issue of potential deviation from expectations of fertility, for example, a potential for age related decline in fertility.

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[37] https://www.bionews.org.uk/page_95956

However, reporting of medical "facts" i.e. age related decrease in fertility should not be used to negatively evaluate those who have children later and writers should reject unimaginative stereotypes of aging, selfish, career women when reporting stories of age related infertility.

Sensationalist reporting on women who engage with reproductive technologies over the "natural" age of reproduction skews public perceptions of age related infertility and may diminish awareness of the reality of a decrease in fertility in peri-menopausal women. In a similar vein I would urge news text producers to limit unhelpful tropes such as "social egg freezers" as they do not realistically reflect the tiny proportion of people who actually engage in assisted reproduction with frozen eggs and embryos and they perpetuate harmful stereotypes around women and reproductive choice.

Whilst it is possible to critique powerful text producers such as clinical and news sites, in the case of the bloggers it doesn't feel ethical or appropriate to critique writing which is after all an account of an individual's lived experience. I would however encourage people experiencing infertility to critically appraise the texts they receive, particularly those produced by fertility clinics, and hope that my research would provide a timely reminder that these are commercial entities, not just providers of health services.

8.5 Suggestions for future research

From the point of data collection, I was conscious of the heteronormative bias to my study. This was not a deliberate choice, rather it was driven by a dearth of data, as at the point of collection there were no blogs by same-sex couples or single women seeking fertility treatment in the UK. A replication of my study which included these participants would better reflect the current experience of infertility, I would also be interested to see if their experience is medicalised to the same extent in the case of what is sometimes referred to as "social" reasons for infertility.

From my discussion with infertility counsellors I feel it would be timely to use the language of people experiencing infertility as a way in to psychological responses to the experience. Indeed, my goal for future projects would include more participatory research, with co-production with stakeholder groups from the start.

A key interest developed from this thesis is the use of this method with other contested (and potentially invisible) conditions which occupy that problematic space between the social and the medical, for example, Attention Deficit and Hyperactivity Disorder and Chronic Fatigue Syndrome. In collaboration with colleagues at Reading University I have successfully applied this method to the study of another condition which also focuses on norms of motherhood and femininity, postnatal Depression. This study confirmed my intuition of this method as a route to uncovering discursive constructions of socially problematic conditions.

Although I previously stated that more data was not necessarily better I also see the importance in testing my assertion that naturally occurring language data gives a different (and richer) perspective than elicited data such as interviews. Therefore a final further study would use this method to compare discourses on a particular condition in elicited data with naturally occurring language data.

8.6   Concluding remarks

One of the driving forces of this thesis was the desire to "hear" the voices of those who are often backgrounded, the people who are experiencing a condition. In comparing blogs with two more traditionally powerful, and therefore "heard" accounts from media and medical sources I gained a perspective on the language of the lived experience unique in a field of study most used to data elicited from questionnaires or interviews. For me the key to the PhD is not the patterns found, or the semantic construction of infertility but the use of these as a window on the lived experience. It must be

acknowledged that the view from this window is of the language of these bloggers and care has been taken not to assume they speak for all who experience infertility. Yet it does provide a comprehensive analysis of a given community of discursive practices and as an outsider to this community I previously underestimated the emotional impact of infertility. Infertility is as transformative as bereavement but not publicly acknowledged as such. Instead it is framed as an issue of personal responsibility for health and an opportunity for the consumption of services. It is hoped that my thesis will encourage alternative ways of thinking about infertility, which will foreground those who experience it.

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APPENDIX I – Additional information for BLOG Corpus

	Relationship status	status as at last post	used ART	reason for IF	current age if known
IF001	married	pregnant	IVF	unexplained	30
IF002	married	diagnostic testing	No	Turner Syndrome	31
IF003	engaged	pregnant	drugs	PCOS	28
IF004	married	diagnostic testing	No	male factor	29
IF005	married	gave birth	IVF	unexplained	31
IF006	married	gave birth	drugs	PCOS	25
IF007	married	medical intervention	IVF/ICSI	unexplained	33
IF008	married	gave birth - twins	IVF	unexplained	u/k
IF009	married	medical intervention	IUI	male factor	30
IF010	married	completed family (becomes parenting blog)	IVF	endometriosis/male factor	45
IF011	married	medical intervention	IVF	unexplained	39
IF012	married	pregnant	drugs	PCOS	27
IF013	cohabiting	referred to clinic	No	endometriosis	29
IF014	married	referred to clinic	IVF	endometrial hyperplasia	36
IF015	married	referred to clinic	No	male factor	u/k
IF016	single	living childfree	IUI/IVF	unexplained	42
IF017	married	referred to clinic	IVF	gynae problems	29
IF018	married	referred to clinic	drugs	PCOS	37
IF019	married	referred to clinic	IVF	endometriosis	27
IF020	married	pregnant	ICSI	male factor	38
IF021	married	pursuing adoption	drugs	unexplained	u/k
IF022	married	pregnant	IVF	unexplained	38
IF023	married	gave birth	IVF	unexplained	u/k
IF024	married	gave birth	IVF	unexplained	40
IF025	married	referred to clinic	IVF	unexplained	32

APPENDIX II - STOPLIST

MONDAY	IS	THEN
TUESDAY	AM	THE
WEDNESDAY	ARE	THAT
THURSDAY	WAS	THIS
FRIDAY	WERE	THERE
SATURDAY	WE'RE	THAN
SUNDAY	THEY'RE	WHAT
LABELS	BE	WHO
PERMALINK	BEING	WHICH
TRACKBACK	BEEN	WHERE
REBLOG	ISN'T	WHEN
COMMENTS	WASN'T	HOW
POST	DO	OFF
TXT	DID	ON
ITEM	DOES	OUT
MFS	DOESN'T	AT
BOURN	DIDN'T	TO
POB	DON'T	A
SPRINGS	DOING	THING
SATSUMA	DONE	SOMETHING
KAREN	I'VE	JUST
NIC	HAD	THAT'S
OVER	HAVE	ABOUT
UNDER	HAVING	OF
UP	HAS	YES
		NO

APPENDIX III - List of clinic codes

	CODE	IDENTIFIER
1	ABD	Aberdeen Fertility Clinic
2	AGO	Agora Clinic
3	AND	Andrology solutions
4	ARG	Assisted Reproduction and Gynaecology Centre
5	BAR	Bart's and the London
6	BEN	Benenden Fertility Centre
7	BIR	Birmingham IVF
8	BOU	Bourn Hall
17	BRI	The Bridge
9	BRS	Bristol IVF
10	CAD	Cardiff and the Vale
11	CAR	Care Fertility
12	CMF	Central Manchester Foundation Trust
13	COM	Complete Fertility
14	CRE	Create Health
15	CRG	Centre for Reproductive and Gynaecological Health
16	CRW	Centre for Reproduction & Gynaecology Wales
18	DIR	IVF Direct
19	GYN	Gynaecology and Reproduction Centre
20	HAE	Herts and Essex
21	HAM	IVF Hammersmith
22	LEE	Leeds Reproductive Medicine
23	LEI	Leicester Fertility Centre
24	LIS	Lister Fertility
25	LIV	NHS live well
26	LON	London Women's Centre
27	LWH	London Women's Hospital
28	MAN	Manchester Fertility
29	MID	Midland Fertility
30	NEW	Newcastle Hospitals
31	NHS	NHS
32	NUR	Nurture
33	ORI	Origin Fertility Care
34	OXF	Oxford Fertility Unit
35	RUH	Royal University Hospitals
36	SEF	South East Fertility Clinic
37	SHR	Shropshire IVF
38	SPI	Spire Health Care
39	SPL	Spire London
40	STJ	St Jude Clinic
41	SUR	Surrey IVF
42	UCH	University Hospitals Coventry and Warwick
43	WES	Wessex Fertility

APPENDIX IV – Top 100 keywords from all corpora

	BLOG		NEWS		CLINIC	
	Keyword	Keyness	Keyword	Keyness	Keyword	Keyness
1	I	102245.6	SHE	30804.4	SPERM	26678.3
2	ME	23630.34	WOMEN	27771.3	FERTILITY	25875.8
3	PREGNANT	8678.06	FERTILITY	27457.7	TREATMENT	25580.2
4	SHE	7830.89	IVF	21105.8	IVF	20898.1
5	IVF	7166.07	SPERM	16592.4	EGG	16779.1
6	KNOW	5567.38	TREATMENT	13372.3	EGGS	12769.8
7	BABY	5076.41	BABY	13245.4	EMBRYOS	10698.9
8	CYCLE	5028.53	EGGS	12490.9	DONOR	10280.6
9	MYSELF	4273.35	I	12327.1	PREGNANCY	10227.9
10	FEEL	4217.23	EMBRYOS	10681.7	EMBRYO	9198.64
11	H	3972.72	PREGNANT	10243.4	INFERTILITY	9123.96
12	THINK	3823.02	COUPLES	8575.46	CLINIC	8164.53
13	CLINIC	3757.57	BABIES	8300.56	PATIENTS	7621.38
14	PREGNANCY	3612.77	INFERTILITY	8286.9	ICSI	7276.16
15	INFERTILITY	3292.43	BIRTH	7940.71	CYCLE	6648.62
16	WE	3192.26	PREGNANCY	7673.74	COUPLES	6073.82
17	SCAN	3068.37	CHILD	7269.62	WOMEN	5633.17
18	DAY	2955.37	CENT	6976.48	HFEA	5034.27
19	OH	2823.64	CHILDREN	6856.67	FERTILISATION	3986.8
20	MORNING	2796.94	WOMAN	6846.87	BABY	3887.5
21	FERTILITY	2642.96	SEX	6569.14	DONORS	3753.33
22	FEELING	2579.81	CANCER	6415.59	FREEZING	3740.24
23	APPOINTMENT	2510.16	EGG	6317.29	FROZEN	3677.78
24	DH	2452.47	CLINIC	5956.56	SEMEN	3430.96
25	TRYING	2276.38	CLINICS	5478.24	DONATION	3303.62
26	OVULATION	2174.23	THEY	5372.63	OVARIES	3200.86
27	HUSBAND	2071.01	DOCTORS	5230.36	TREATMENTS	3197.25
28	WEEKS	2064.85	INFERTILE	5196.01	TRANSFER	3174.69
29	NOW	2062.99	DONOR	5160.32	OVARIAN	3085.91
30	WAIT	1952.75	MOTHER	5056.44	TESTS	3080.18
31	DAYS	1926.9	EMBRYO	4844.19	ULTRASOUND	3035.09
32	WEEK	1921.32	MEN	4835.24	PREGNANT	2984.01
33	WANT	1862.56	BORN	4773.78	OVULATION	2935.85
34	TOMORROW	1843.27	ABORTION	4402.8	IUI	2915.2
35	TIME	1833.79	HUMAN	4250.68	REPRODUCTIVE	2902.9
36	YESTERDAY	1790.25	CELLS	4196.03	UTERUS	2863.38
37	WAITING	1728.08	PER	3989.26	COUNSELLING	2773.26
38	HOPE	1715.15	HE	3987.76	INSEMINATION	2718.81
39	SPERM	1618.65	CONCEIVE	3914.07	SCAN	2711.87
40	EGG	1549.47	FERTILISATION	3842.28	CONCEPTION	2698.81
41	THOUGHT	1529.28	HFEA	3732.24	PATIENT	2585.12
42	FELT	1512.76	AGE	3730.76	CONCEIVE	2511.86
43	STARTED	1489.17	HUSBAND	3542.1	HORMONE	2471.52
44	COUPLE	1460.99	WOMB	3532.43	WOMB	2446.21
45	MISCARRIAGE	1441.93	EMBRYOLOGY	3528.81	BLASTOCYST	2424.51
46	EGGS	1433.51	DONORS	3463.33	CLINICS	2192.23

47	TTC	1424.95	TWINS	3443.45	CYCLES	2176.47
48	PAIN	1420.98	MOTHERS	3366.27	FALLOPIAN	2150.41
49	UTERUS	1412.82	ME	3337.9	MALE	2140.97
50	MONTHS	1395.65	COUPLE	3029.62	EMBRYOLOGY	2060.55
51	EMBRYOS	1395.55	PARENTS	3028.75	TUBES	2013.69
52	MONTH	1377.95	MEDICAL	3018.45	SUCCESS	1979.07
53	TODAY	1356.57	PATIENTS	2968.1	TEST	1974.27
54	CLOMID	1341.2	REPRODUCTIVE	2966.66	ASSISTED	1948.7
55	TEST	1310.87	DR	2956.3	DRUGS	1943.1
56	BLEEDING	1299.05	SCIENTISTS	2949.47	MEDICAL	1891.41
57	OVARY	1262.07	FAMILY	2949.4	MISCARRIAGE	1879.93
58	IUI	1260.68	POUNDS	2923.82	INJECTION	1805.24
59	INFERTILE	1240.32	PILL	2863.8	PROCEDURE	1794.01
60	BAD	1230.28	BIRTHS	2847.23	BABIES	1776.45
61	PRETTY	1225.12	RISK	2842.24	BIRTH	1706.68
62	BABIES	1214.52	MUM	2824.38	BORN	1706.45
63	FOLLICLES	1182.96	YEARS	2769.46	PARTNER	1706.21
64	NEVER	1171.58	LIFE	2760.5	CHANCE	1696.11
65	CYCLES	1161.48	HOSPITAL	2745.74	APPOINTMENT	1687.27
66	HIM	1137.91	OVARIES	2535.21	FOLLICLES	1631.59
67	HAPPY	1133.59	FATHER	2428.79	CLINICAL	1613.61
68	BLOOD	1132.42	WOMAN'S	2401.87	GENETIC	1603.76
69	WOMB	1127.74	STEM	2394.61	CONSULTANT	1603
70	OVULATE	1113.46	MALE	2387.93	WE	1588.31
71	NIGHT	1105.65	YESTERDAY	2367.71	HOSPITAL	1585.97
72	OVULATED	1101.13	HORMONE	2334.39	WOMAN	1564.6
73	WEEKEND	1083.44	CONCEIVED	2309.27	BLOOD	1547.49
74	EMBRYO	1066.17	HEALTHY	2297.25	NURSE	1540.32
75	NURSE	1057.84	BLOOD	2255.5	STIMULATION	1520.48
76	BLOODY	1035.52	GENETIC	2218.34	FOLLICLE	1497.58
77	AF	1028.03	NHS	2198.75	RATES	1462.75
78	DOCTOR	1019.9	FROZEN	2184	GP	1443.71
79	CRAMPS	1014.35	DISEASE	2145.7	SCREENING	1443.17
80	HUBBY	995.28	CHANCES	2095.45	FERTILISED	1421.65
81	PILL	986.03	NEVER	2069.6	DONATED	1406.28
82	PROGESTERONE	979.94	HORMONES	2018.54	EMBRYOLOGIST	1380.37
83	PEE	975.98	PREGNANCIES	2018.05	FSH	1353.86
84	MOMENT	969.94	DAUGHTER	1987.01	YOU	1321.28
85	FRIENDS	932.54	WEEKS	1953.28	SCANS	1320.2
86	WANTED	930.81	DRUGS	1952.78	LABORATORY	1307.7
87	INJECTIONS	916.46	DOCTOR	1911.71	IMPLANTATION	1291.96
88	OVARIES	884.33	OVARIAN	1899.27	TWINS	1281.98
89	EXCITED	878.1	WOMEN'S	1875.88	SURROGACY	1281.3
90	SEX	873.04	MENOPAUSE	1853.34	UTERINE	1253.68
91	TEARS	852.16	IMPLANTED	1851.3	AGE	1229.93
92	MOTHER	845.07	BRITAIN'S	1849.35	NHS	1205.96
93	BIRTHDAY	841.8	WANTED	1841.73	GYNAECOLOGY	1199.77
94	FRIEND	838	MONTHS	1837.92	CONSULTATION	1167.57
95	FSH	832.11	YEAR	1823.94	CONCEIVING	1166.61
96	HSG	830.48	MOTHERHOOD	1788.96	OVARY	1151.96
97	WOMAN	812.71	CHANCE	1785.24	SHE	1148.84

98	THINKING	804.83	CHILDLESS	1780.54	COUPLE	1147.99
99	KNEW	798.83	GIRLS	1746.11	ENDOMETREOSIS	1133.33
100	MUM	792.7	TREATMENTS	1719.49	SURGICAL	1127.11