One of their functions of online mental health communities is the construction of coherent identities for their members based on the various characteristics of different mental health conditions. This paper contains microanalyses of 2 message threads on mental health discussion forums—one concerning depression and the other ‘emetophobia’ (fear of being sick)—which illustrate some of the discursive functions of such forums. Conversation analytic techniques are employed, such as the use of second stories for social support purposes, and the generation of category predicates for building up a set of activities that constitute ‘normality’ in this context. It is argued that these socially situated practices constitute a more important function of online support groups than the mere dissemination of ‘advice’.

Key words: online communities, mental health, conversation analysis, discussion forums, identities

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Mental health communities online

Over the last decade, online support groups have flourished for an enormous range of health and mental health conditions. Those dealing with health have been the subject of quite extensive research (Mo & Coulson, 2008; Owen et al., 2010; Seale, 2006), which has documented the demographic and psychological characteristics of online support group users, and the contents of their discussions. However, despite the very large numbers of online communities organised around mental health issues, relatively little research has been conducted on the nature of support offered (Giles & Newbold, 2011).

While online support plays a role in helping to construct the ‘expert patient’ central to health care modernisation (Fox, Ward & O’Rourke, 2005), it potentially hands greater control to consumers, to an extent that challenges traditional service provider/user relationships (Broom, 2005). In the case of mental health, the empowerment of consumers is not simply a matter of improved access to information and preventative health practices. It also creates a space where health categories and identities can be negotiated, especially where websites are established by service users themselves. The best documented in the literature are those dedicated to eating disorders, where there is a stark contrast between the philosophy of “recovery” sites, often owned by health services or private health companies, and ‘pro-ana’ sites which promote anorexia as a lifestyle choice (Giles, 2006; Lipczynska, 2007; Riley, Rodham & Gavin, 2009).
The emergence of the pro-ana community, which has turned the idea of mental-illness-as-stigma on its head, is an extreme manifestation of the empowering potential of user-led mental health sites. It is not, however, an exception. Another very active community is that dedicated to Asperger’s Syndrome (Clarke & van Amerom, 2007). Sites like Wrong Planet and Aspies For Freedom boast tens of thousands of members, promoting a very positive, often celebratory, image of the condition soon to be subsumed within the general dimension of Autism Spectrum Disorder (American Psychiatric Association, 2010).

Despite the very large numbers of mental health communities online, the phenomenon has received surprisingly little attention away from the pro-ana literature, mostly driven by the fears of parents, health and medical professionals and teachers following sensationalist press coverage (e.g., Paquette, 2002). Nevertheless, a few individual authors have remarked on the potential of the Web for creating “a madness for identity” (Charland, 2004), whereby mental health diagnoses come to operate as subcultural identities, and Bell (2007) has also noted the emergence of “extreme communities” alongside more orthodox uses of the Web for online therapy and information seeking.

It is probably too early to say how these online interactions will affect health care practice since in many cases the participants are young people, often still at school, who may or may not use this material in negotiating emergent adult identities. One of the most striking features of many online mental health communities is the way that members offer informal diagnoses for one another, even creating tools for self-diagnosis (Giles & Newbold, 2011). Since diagnosis is strongly associated with community membership, particularly in the pro-ana community, where it is important for establishing authenticity (Giles, 2006), it has the potential to fuel consumer demand for offline diagnosis by professionals. In a parallel development, psychiatrists have already reported the presentation of clients actively seeking diagnosis for bipolar affective disorder following widespread media coverage of the condition (Chan & Sireling, 2010).

Therefore it is particularly important to examine the way that online mental health communities work to construct their own versions of mental health conditions, since it is here that identity categories are constructed, and their various attributions detailed. One becomes ‘ana’ or ‘aspie’ by virtue of the categories created in situ, and whether one meets the normative criteria established by that community.

**Analysis of online discussion forums**

Increasingly, researchers from social and health sciences are examining the details of online interaction in discussion forums and message boards, those sections of websites where members post messages to each other in “threads” which build up asynchronously into a series of conversational-style turns (Antaki, Ardévol, Núñez & Vayreda, 2005; Stommel & Koole, 2010). It is in these forums where the interactive business of the community gets done, where relationships between members are developed, and identities are negotiated and constructed (Giles, 2006). Of course, there are many different types of online community with interests in mental health, and many sites operate strictly from a biomedical perspective, particularly those set up by health and medical services. Others are set up independently (such as most pro-ana sites), while some are linked to websites with a very broad focus, such as the Experience Project, or Uncommon Knowledge, which provide a variety of forums discussing physical, psychological and social problems.

We treat online mental health forums as “communities of practice” (Stommel & Koole, 2010; Wenger, 1998) in that they are constituted by the activities of their members rather than membership per se. For example, the home page of a website might tell us about the broad aims and purpose of the site (e.g. a support group for people with depression), but it is only on entering the discussion forum that one is able to understand the nature of the community itself. The variety of forum topics tells us
what interests the community; the level of activity on each forum (and on each individual thread) tells us yet more.

The sheer complexity of mental health online makes it important to scrutinise each forum in its context, although even there it is difficult to say that any given site set up by service users will follow a particular philosophical stance on the condition concerned. Each eating disorder website, for example, has its own unique agenda concerning the nature of anorexia, its position on pro-ana, whether it encourages members to “recover” through medical or therapeutic means, and even the sort of talk permitted on the site. For instance, Stommel and Wyke (2010) report on a site where forum moderators actually substitute an alternative (German) phrase whenever a member posts the term “pro-ana” in a message. Other sites have their own, sometimes brutal, ways of enforcing local norms on novice members, rounding on “newbies” who fail to use the appropriate language and forcing them out of discussions with gratuitous abuse (“dumb bitch,” “please die”; Brotsky & Giles, 2007).

In this paper, we draw on insights developed within discursive psychology (DP), conversation analysis (CA) and membership categorisation analysis (MCA) in order to analyse two threads that illustrate broader patterns of interaction in online mental health forums. There is a small but growing literature using methods from discursive psychology and conversation analysis to explore interaction in online community discussion forums on topics such as celiac disease (Veen, te Molder, Gremmen & van Woerkum, 2010), eating disorder (Wyke & Stommel, 2010), self-harm (Smithson et al., 2011), suicide (Horne & Wiggins, 2009), and bipolar disorder (Vayreda & Antaki, 2009). These authors have identified conversation analysis and related methods as appropriate for the microanalysis of exchanges on discussion forums because of their likeness to conversation (see Antaki et al., 2005 for an extended discussion of this). Although some limitations of the method have been identified, notably the speed with which online turns can be taken so that the exchanges do not always follow a linear sequence (Smithson et al, 2011), researchers have found a number of CA concepts useful in examining the interaction presented in message “threads” (sequences of messages posted asynchronously).

We use MCA as our main analytic tool since this is ideally suited to the construction of identity through the study of categories and category-relevant information. There has been some debate in the recent literature as to the compatibility of MCA with CA in that the latter seems to have neglected the study of categories in the interests of a focus on the sequential structure of conversation. However Housley and Fitzgerald (2002, 2009) argue that, through the use of sequential analysis one can explore how categories are used to make moral attributions, returning to Sacks’s classic example of “The baby cried. The mommy picked it up” (Sacks, 1972) as suggesting that, not only are baby and mommy bound as discursive objects into the category of family by this particular sequence, but their sequential order implies that the mother has a moral obligation to pick the baby up. MCA is, therefore, compatible with a sequentially-orientated microanalysis of conversational data.

MCA has been applied by researchers interested in social identity processes, such as the way in which speakers use category labels and associated activities to reproduce “normative gendered practices” (Stokoe, 2004, p.119), and how media reports used psychological categories to account for the activities of a mass murderer (Rapley, McCarthy, & McHoul, 2003). One of the key differences between CA and MCA lies in the extent to which the analyst can orientate to the broader social context within which the interaction is situated. This is important for the current research, since we aim to draw a clear distinction between the study of mental health per se and the study of mental health online. These are not merely discussions between people with depression; they are discussions evolving on a website organised around the category “depression.” The online context is crucial to the understanding of the interactional processes and identity work involved.

Of particular interest is the way that novel categories and their predicates can be worked up in an online context in order to create “revolutionary” categories that are owned and managed by minority
groups, deriving from Sacks’s (1979) study of “hotrodders,” young people constructing their own identities and the preferred activities associated with them. This kind of category work is prevalent in the pro-ana community (Giles, 2006) and other mental health online forums, whereby ‘symptoms’ and other typical characteristics of mental health conditions function as predicates, or “category-bound activities” (Schegloff, 2007) in order to construct identity norms for the community.

Data collection and analysis
The data in this study are taken from a large corpus collected from online mental health communities visited during the month of November, 2008. These sites were identified following an open search using various DSM-IV-related terms such as bipolar, Asperger(‘s), and schizophrenia, links from more general health and medical Web sites, and additional links from previously visited sites.

The original aim of the search was to identify sites that qualified as “user led”—in other words, sites that were not owned or established by mental health professionals (for example, if the front page did not include links, advertisements, or any other material placed by professional health or medical services). In practice, this turned out to be difficult because many apparently user-led sites had indirect connections to therapeutic or even medical sites. However, we generally discounted sites that had explicit connections to the medical or health professions, such as those nested within the UK’s National Health Service, or hosted by private health care companies.

A database of forums was compiled on the remaining sites, in which issues around identity, or the nature of a particular mental health condition, were debated. Usernames were removed for purposes of anonymity, leaving only the content of the messages. Data were grouped according to broad themes of members’ interaction: the threads in this paper were taken from a theme we called “typical behaviours” where members worked interactively to construct a set of predicates that defined their particular membership category. Often this work consisted of an explicit attempt to normalise a particular behaviour or experience within the context of the condition: for example, in thread A below the first poster asks “is rage a normal effect of depression?” Other members are then expected to establish whether indeed rage can be included as a *bona fide* symptom of depression, either through authoritative claims (e.g., DSM criteria) or through personal experience (I have depression and I also have rage). This way, a community establishes a set of predicates around a particular category.

Thread A
The first thread I wish to discuss here is taken from www.depressiontribe.com, a member of a network of online support communities based in California called *Webtribes* (other communities include addiction, OCD, and nonmental health conditions such as HIV/AIDS). On 10 August 2011, the community contained 397 separate support groups (biggest categories “activities,” “health, wellness, fitness,” “music,” and “family and home”) and 31,374 separate blogs. Since the research timeframe ended, access to the forum has become restricted to members and is password-protected.

The thread concerned was initiated on 17 October 2008 and is entitled ‘Is rage normal?’ As in Stommel and Koole (2010), we present an overview of the thread as a participation framework whose six members are coded according to their order of participation, so that A1 is the member who provides the opening posting (OP), A2 the first response, and so on. The sequence of postings is as follows:

1 A1: opening posting, addressing forum (17/10)
2 A2: response to 1, addressing forum (17/10)
3 A3: response to 1, addressing forum (18/10)
This thread follows a typical forum format, similar in structure to those reported by other studies focusing at the level of the message thread (e.g. Stommel & Koole, 2010). A1’s opening post (see Excerpt 1 below) is an open appeal to the forum for two questions: ‘is rage a normal effect of depression?’ and ‘is it just me?’ It is not until A5 that A1 is addressed directly. A2 (Excerpt 2) posts a very general comment about rage that is directed at nobody in particular. A4 (Excerpt 3) posts a more detailed message, but it is a first person narrative that addresses no other member. It is not until A5’s direct address (Excerpt 4) that A1 responds (Excerpt 5), although her first response is to direct a brief supportive message to A4 before directing a more extended narrative, along with an expression of gratitude, to A5.

Excerpt 1—(posting 1)¹

1 Hello . . . I just signed up to this site. I was wondering . . . is rage a normal effect of depression? I’ve always had a quick temper, but it seems multiplied with depression.
2 The tiniest little thing will suddenly set me off, like dropping something, or the store being out of an item, or pushing the wrong button on the remote.
3 Plus, when one thing happens, I’ll notice tons more throughout the day, and they’ll build up in my head until I could just cry with frustration, and end up slamming doors & cursing a lot. Is this just me?

A1’s opening post (OP) shares much in common with OPs in the recent literature on message threads, particularly those dealing with psychological distress. It is a ‘news announcement,’ intensified with an extreme case formulation (‘the tiniest little thing will set me off’), with a life narrative and a request for help (Vayreda & Antaki, 2009). Its open, casual style (‘I was wondering’) invites others to respond, especially the disclosure that the poster is new to the site, thereby encouraging established community members to share their experience and display their wisdom.

The category work in this posting, as in many mental health subforums (see Giles & Newbold, 2011), concerns the attachment of a predicate on to the category around which the forum is organised—in this case depression. It involves the OP proposing a predicate (here, ‘rage’), and inviting established members to assess its credentials as a normative feature of the category. This enables members to build up ‘knowledge’ about a category so that category and predicate become normatively connected (Stommel & Koole, 2010).

Excerpt 2—(posting 2)

1 It’s hard to say what’s normal. I’ve always been pretty pissed off in general. I think it just means you’re paying attention in a f***ed up world.
Excerpt 3—(posting 4)

1. I have felt angry for years. It would build and build until I would explode.
2. What right did my cousin have to touch me there when I was under 5.
4. There have of course been numerous other reasons for my rages but those are the
5. major pointers that I still cannot get over. I hate them for what they did and can
6. never forgive or forget.

The first three responses in the thread follow A1 in addressing nobody in particular (so we can only say that they address the forum as a whole). A2 and A3 (not shown here) give rather impersonal responses that answer neither of A1’s queries and are, not surprisingly, ignored by A1 when she finally replies. A4’s post is also a first person narrative but does at least draw a sympathetic response from A1 (albeit as part of a double posting the bulk of which is addressed to A5). A4 certainly orientates to the category predicate, throwing in a final angry emoticon as if to underline the vehemence of her “rages.”

These three responses are examples of what Smithson et al. (2011, p. 495) call “minimal turns . . . posts without a clear request or activity, and without anything specific to respond to.” Such postings run the risk of “freezing” a thread, by halting activity on it (perhaps for good). However at this point A5 steps into the breach (Excerpt 4) by contributing a post that does finally address A1. This does not happen immediately. A5 begins in the style of the previous posters, with a first person narrative, but in line 7 she produces a second person singular pronoun that orientates the post firmly towards A1. The remainder of the post is liberally sprinkled with “yous” and “yourselfs,” marking it out as a personal message that clearly answers A1’s questions. It is therefore not surprising that it is this post that finally prompts a reply from A1, albeit a day later.

Excerpt 4—(posting 5)

1. Irritability is a symptom for many people suffering from depression. I experience
2. irritability.
3. Irritability is also a symptom in bipolar. I don’t know really know how to
4. distinguish them.
5. I have experienced rage too.
6. Another thing that I think it could be part of is Borderline Personality Disorder.
7. So you should get diagnosed by a psychiatrist or psychologist - being honest about
8. yourself to get the best diagnosis.
9. Probably at the bottom of it lies the thing that we never learned impulse control as
10. little ones. However you can learn how to manage your rage and temper but of
11. course you need also to have your depression treated.
12. I have found meds good.
13. To learn to manage rage, you need to do a lot of work on yourself because its
14. really a tool box you need and the ability to find a different attitude towards the
15. things that are setting you off. Often people who experience rage or irritability are
16. easily dissappointed when their (unrealistic) expectations are not met. Anyway its
17. not just you but you should try to work on it with the help of professionals. it will
A5’s post also contains some important categorical work. Not only does it, like the previous post, reinforce the attachment of rage to depression, but introduces a new predicate—irritability—and two new categories, ‘bipolar’ and ‘Borderline Personality Disorder,’ which are suggested as candidate categories for the predicates of rage and irritability. This is typical of category work in mental health forums, where community members are often engaged in the process of self- and other-diagnosis (Giles & Newbold, 2011). By making these inferences, A5 is effectively saying that she herself could be bipolar (since irritability attaches bipolar disorder), that A1 could have Borderline Personality Disorder (since rage attaches to that too), and, by implication, that all three diagnoses are possible (for either of them). While “comorbidity”—the existence of two or more diagnoses in the same individual—is a frequent phenomenon in mental health practice, it threatens the acquisition of a coherent online identity such as “bipolar” or “aspie.”

While A5 has diagnostic suggestions to offer A1, she nevertheless delegates the real diagnostic business to professionals (line 7). This starts off a series of blunt instructions that are typical of the sort of ‘advice’ offered to new community members by established members (see also Vayreda & Antaki, 2009). A1 should ‘get diagnosed’; needs to have her ‘depression treated’; needs to ‘do a lot of work’ on herself; should ‘try to work on it with . . . professionals’. Such obligations risk being ignored, the existing literature argues, because online forums are really about sharing experience rather than seeking information (after all, the advice to see a psychiatrist or psychologist is hardly unexpected from a forum about depression).

Excerpt 5—(postings 6 and 7)

1 A4: Well, there goes my rage again. Those jacka**es had NO right, and I truly
2 hope the universe finds a good way to make them suffer for it.
3 A5: I did find it helpful, thank you. I’m already on meds. I talked to my doctor
4 about insomnia and yakking all the time, and he diagnosed me with ‘a touch of
5 bipolar’. The drug Seroquel takes care of both pretty well; it shuts my brain up,
6 which also lets me fall asleep. (Doc said he told the drug reps how it knocks me
7 out at night and they said it’s not supposed to. Drugs have never done what they’re
8 ‘supposed to’ in me, though. We don’t know why.)
9 Anyway, not too long after that, my depression came back, (I was diagnosed in
10 grade school, but it comes and goes, in several year blocks) and he just upped my
11 Seroquel dose to handle that, too. (Cool that one drug treats three different things.)
12 It’s still not doing as much as I’d hoped, and I’m cleared to up the dosage, but I’m
13 hesitant. The fibromyalgia already makes me tired all day, and if I up the dosage
14 of a drug that already knocks me out, I don’t know if I’ll ever truly wake up!

A1’s response to A5 (Extract 6, posting 7) further develops the diagnosis talk. On this occasion it is the anecdote about ‘my doctor’ (line 3) that references the category “bipolar,” although this is indirectly called up by the predicates “yakking” and “insomnia” (understood here as being inconsistent with a simple diagnosis of depression). The doctor’s glib expression “touch of bipolar” (evoking the notion of a viral infection) is part of a chain of references to pharmacological treatments (“meds”) that have agency ascribed to them: They “shut up” her “brain,” “knock” her “out,” behave inappropriately,
confound medical expertise, and, despite their capricious nature, are “cool” in that they have multiple purposes (if not efficacy).

This particular posting is surprising because it contrasts so markedly with A1’s OP, in which she is ‘just signed up’ and merely ‘wondering’ about the rage/depression connection. A5’s diagnostic talk and series of instructions, rather than simply being ignored, have prised open a Pandora’s box of revelations about a long history of depression (A1 was “diagnosed in grade school” but is clearly well into adulthood now since it has recurred “in several year blocks”), pharmacological treatment and its varied effects, and even (line 13) the invocation of a further predicate for association with depression, fibromyalgia (chronic muscle pain). This is introduced as an incontestable predicate (“the fibromyalgia”) as if its connection to depression is, unlike rage, not a matter for debate. So by the end of the message thread we learn that A1 is, far from a greenhorn web surfer just wondering whether she might have depression, a long-time psychiatric service user with a concomitant level of expertise. In the light of this new information her opening post appears almost devious in its lack of disclosure.

As observed by Smithson et al. (2011), requests for help or advice are often a way of gaining membership of a group, even if the advice could easily be looked up, or has an obvious answer. This is clearly the case in thread A. A1’s initial request seems authentic enough until we reach the end of the thread and discover her life story. So what could be her motive in starting the thread? From an MCA perspective, it is most likely explained by the online forum’s role in building up shared knowledge. By the end of the thread it is successfully established (in this community, at least) that rage is indeed a “normal” effect of depression—category and predicate are normatively connected—and that A1 can be reassured that her behaviour is consistent with community expectations. This successful outcome is signalled by her opening flourish in posting 6 (“there goes my rage again”).

Thread B

The second thread presented in this analysis illustrates similar categorical work but in the context of a more supportive community. It is taken from No More Panic (nomorepanic.co.uk), a British-based site funded by volunteers, whose stated purpose is to “provide information to sufferers and carers of people with Panic, Anxiety, Phobias, and Obsessive Compulsive Disorders.” It is a much smaller concern than Depression Tribe, although on 14 August 2011 it claimed 24,352 members and the forum contained over 88,019 threads.

Thread B, initiated on 22 August 2008, is entitled “Emetophobic . . . and scared,” and contains 10 exchanges over the period of five days.

1 B1: opening posting, addressing forum (22/08)
2 B2: response to 1, addressing B1 (22/08)
3 B3: response to 1, addressing B1 (24/08)
4 B1: response to 2 & 3, addressing B2 & B3 (24/08)
5 B4: response to 1, addressing forum (25/08)
6 B5: response to 1, addressing B1 (26/08)
7 B1: response to 5 & 6, addressing B4 & B5 (27/08)
8 B3: response to 7, addressing B1 (27/08)
9 B1: response to 8, addressing B3 (27/08)
10 B3: response to 9, addressing B1 (28/08)

From the overview of the thread, we can see the difference from thread A in that most posts have a direct addressee other than the OP, which follows the standard thread convention of addressing the forum generally. Unlike the responses to A1’s OP, all the other messages in the thread are addressed
directly to B1 with the exception of posting 5, and the interaction is much richer and more positive as a result: so much so, in fact, that we are unable to include more than a few excerpts here.

B1 opens her OP (Excerpt 6) in quite a different style to A1. Although she is a “new member” (this is indicated directly beneath her username) she does not make a tentative introduction nor does she withhold any information about her history. Instead she details her history of service use (lines 11–16), including her pharmacological and therapeutic treatment, provides a (very) recent anecdote (“I just got back home”) and twice lists a set of coping resources, or props (“black zippy top,” “newspaper, mints, tissues) that she uses to manage her “condition.” It seems reasonable to suppose that the amount and quality of the responses she receives are attributable to the open nature of her disclosure, coupled with the fact that she makes a more explicit request for help than A1 (“please help me with any advice or information”) along with a more general request (line 17) for fellow sufferers of emetophobia (fear of vomiting) to “get in touch.”

Excerpt 6—(posting 1)

1 I have recently found out what ‘Emetophobia’ is and that this is what my condition is called. It is a real shock to the system and I am now even more scared of it.
2 I just got back home after literally picking up my handbag and racing out of a restaurant where I had been with my fiance and a mutual friend because I began to panic and started to feel nauseaus. I always thought I was a complete and utter freak because of the nauseaus feeling and the absolute terror - even that doesn’t explain how scary it is - of being ill in public. I can’t even really say the ‘s’ word. It is too terrifying.
3 I always carry around my black zippy top and a newspaper so that if, on the off chance, I am ill, at least I will be ill on those.
4 My GP prescribed me some propranolol and domperidone - to help with the symptoms of anxiety and also to stop me feeling nauseaus or being ill. These really do make a difference, and I am also getting CBT to help me get out more because the fear of being ill has massively restrained my life.
5 My therapist seems to think that I need a lot more therapy after the 8 sessions of CBT are finished because I have a lot of ‘unresolved issues’ to work out and sort out.
6 I just hoped that anyone else out there who has this would get in touch . . . I don’t know much about the condition, all I know is that I have a ridiculous number of things that I do to help myself . . . carry mints in all my pockets, the zippy top and newspaper which I already mentioned, tissues in my bag, etc etc etc
7 Please help me with any advice or information, I would really appreciate it so much.
8 Right now I just feel like cr*p and a total, crying, waste of space. I don’t understand how this happened or why.

The category work in this posting is also somewhat different from thread A, because part of the task facing B1 is to establish emetophobia as a valid category in its own right. In thread A there was no need to establish depression as a valid category since the entire community was devoted to it, but here the community has a much broader remit than this one specific phobia. B1 orientates straight away to its relative obscurity, admitting that she has only “recently found out” about it and that it provides a name for “my condition.” However this seems slightly curious given her history of service use, the fact that she is receiving CBT (cognitive behavioural therapy) to combat “the fear of being ill.” One can
only assume that the health professionals who have worked with her have not used the term, or that B1’s use of “recently” is relative and dates back to the start of her service use. Either way, subsequent speakers do not problematise these issues.

B2’s response is typical of successful postings in mental health forums in that it directly addresses B1, assures her that she is “in no way ‘abnormal,’” and that she herself, along with “a lot of” other people, also suffers from “this condition.” It thereby fulfils the primary function of online forum support, by providing empathy, a reassurance of the normative nature of the behaviour (as far as the community is concerned), along with a disclosure of similar experience. As requested in the OP, B2 also offers advice: Not only should CBT help, but will “teach” her (line 4) about anxiety, and “get to the root causes” (line 7) of her phobia. She also offers a further suggestion, that of “EFT” (emotion focused therapy) that she herself has undergone and found helpful. Note that B1 does not refer to EFT in her subsequent posts (although she does describe some of the uses of her CBT), again suggesting that the advice is less well received than the shared experiences: She begins her reply (posting 4) by saying “it is nice . . . that I am not the only one here who has this condition.”

Excerpt 7—(posting 2)

1 B1,
2 What you’re experiencing is in no way ‘abnormal’. A lot of people suffer from this
3 condition (including me) - see a couple of other recent threads in this group.
4 I think the CBT should help you. It will teach you that what you are feeling are the
5 effects of anxiety (which can make you dizzy and nauseous) rather than that you are
6 about to be sick.
7 Therapy should get to the root causes of why you are so afraid of being sick in public
8 (for me I threw up, unexpectedly, on a school coach trip when I was nine).
9 I’ve also had some EFT therapy which has helped to take the sting
10 out of a few issues.

The second response, from B3 (Excerpt 8), is very similar to the first, in that it reassures B1 that she is “not alone,” that she also carries a prop (a plastic bag, line 5), and offers advice in as much as she recommends the forum itself as helpful, underlying its value by explaining how she feels ‘so abnormal’ and yet the forum allows her to interact with people in a similar situation and, perhaps most importantly of all, to “air her woes” (line 9).

Excerpt 8—(posting 3)

1 Hi there,
2 Firstly can I say you are not alone.
3 I have had this for a long time and my fear started when was ill in a cinema and the
4 reaction of the people in the same screen drove me to fear of others.
5 I carry a plastic bag with me all the time. But I have nausea all the time and I am so
6 frightened it will lead to vomiting (worst word in the world).
7 I feel so abnormal and yet from being on this site just a few days I am in contact with
8 numerous people in a simialar situation. It lessens a level of anxiety for me when I
9 can air my woes with someone that can understand me.
These last two excerpts demonstrate an important feature of online mental health forums—the use of second stories. The phenomenon of second stories was first described by Sacks (1992, p. 260) as a device used in gatherings such as the meetings of Alcoholics Anonymous (AA) where members are encouraged to tell their personal stories as a way of “[coming] to see that we’re all in the same boat.” He contrasted this with the kind of troubles telling interaction in therapy, where the therapist is not expected to respond by disclosing a similar experience to the client.

Arminen (2004) has since further developed Sacks’s initial ideas by studying AA meetings directly in order to examine the components of second stories. He argues that one of the key features of second stories is the way speakers “echo” previous stories by referring to, and elaborating, features of earlier stories. This enables speakers to demonstrate understanding (because those features resonate with their own experiences) and support, because subsequent speakers are able to use those features to offer explanations for the problem, a different interpretation, and/or maybe a solution.

We can see evidence of this echoing taking place in B3’s posting in excerpt 8. Firstly she echoes B2’s story by presenting her own “root cause” in lines 3 and 4 (being “ill” in a cinema). This reinforces B2’s claim that one of the goals of therapy is to help B1 understand (or even “teach”) her about the origins of her fear. This way, it helps to establish emetophobia as a condition that is learned (rather than inherited) and therefore treatable. B3 also echoes B1’s OP by referring to the plastic bag that she carries “with me all the time,” thereby reassuring that B1 that use of such props is not only normative but helpful. A third echo comes from her reference to the word vomiting as “the worst word in the world” (line 6), reflecting B1’s disclosure that she “can’t . . . say the ‘s’ word” (Excerpt 6, line 7). Again this achieves the effect of reinforcing her earlier point that B1 is “not alone” because she, and others, have similar experiences and ways of coping with them.

By replying earlier in the thread than A1, a relationship is struck up with the other members of the community and this results in a series of exchanges, notably between B1 and B3 at the end of the thread, where the tables are effectively turned, and it is B1 who ends up giving advice and support to B3.

**Excerpt 9—(posting 8)**

1 . . . today and yesterday has been hell. I was sick badly for about six hours and my dad
2 (being an Environmental Health Officer) thinks I could have poisoned myself.
3 I am so drained and I am dreading leaving the house . . .
4 I am frighteend to go to sleep in case it comes back as well . . .

**Excerpt 10—(posting 9)**

1 Oh my goodness, you poor thing {{{HUG}}}) I really feel for you, I know how
2 completely awful it is . . .
3 Just know that you WILL feel better in the very near future
4 and that night-time is usually the worst time . . .
5 I really hope you managed to get some sleep and are feeling a lot better. You will get
6 through this!
Excerpt 11—(posting 10)

1 Hi
2 Had some sleep, feel a bit more refreshed and focused.
3 My dad rang me to say he has been dealing with cases of salmonella in the last few
4 days.. I havent had as bad as those hes been in touch with . . .

Excerpts 9–11 are taken from the last three postings, by which point the thread has effectively developed into a private exchange between B1 and B3. Unlike speakers at an AA meeting, forum members have the capacity to break off and continue the discussion between themselves, and here it seems that these two members have ceased to even consider the forum audience as a whole in their postings. In posting 8 (not included here) B3 echoes material from B1’s response to B4 and B5 (posting 7) and this has the effect of drawing B1 back to her, by offering sympathetic support (even a virtual hug) and some words of encouragement and motivation (‘you WILL feel better’; ‘you will get through this’). Clearly appreciated, B3 responds the next day and provides a more positive anecdote about her dad (who features frequently in her accounts, positively and negatively).

It is interesting to note that at this point the thread freezes, never to be resumed. Clearly one of the key functions of online forums is to provide personal information and advice but in a way that it can be used by other members. Here, B1’s contribution may ultimately have been too personal: In offering very general motivational support to an individual member, it serves to extinguish the interest other members have in the thread, and the conversation draws to a close.

Discussion and Conclusions

The analyses reported in this paper have, we hope, demonstrated the usefulness of conversation analysis and related techniques for exploring interaction in online mental health forums. Specifically, we have demonstrated the ways in which forums work to achieve a set of category predicates around what might be considered ‘normal’ within a community that enables members to validate their credentials for community membership. We have also contributed further evidence of the way that forums operate to reassure new members that they meet community norms, particularly through the use of second stories. Consistent with recent literature on various types of health-related online forums, our analyses reflect Smithson et al’s (2011, p. 498) claim that “a prime function of the activity” on such sites, rather than simple online information-seeking, can be defined as “connecting, developing relationships, ‘just being there’ for someone who is struggling.”

The two message threads analysed here are intended to serve a largely illustrative purpose in that they reflect patterns observed throughout a larger corpus of data collected from various online mental health community forums. It could be argued that our corpus is too heterogeneous to be useful, and that indeed a more systematic analysis of different sites relating to different mental health conditions would need to be conducted in order to establish whether forums are used differently by a) different communities, and b) different types of forum within the same community. Naturally, such an analysis would constitute an important contribution to the literature, but we hope that this microanalysis is a valuable early step in charting the territory.

There is, however, a danger in pressing too hard for a research project that breaks mental health communities down by “disorder,” in that by doing so, one simply reproduces an essentialist approach. For example, one might say that our depression forum example produces less positive interaction than our emetophobia example because of the ‘nature’ of depression. While such a claim might be
quantifiably testable, it was not our original aim to simply reproduce categories by conducting separate analyses per condition. At the same time, our use of conventional search terms such as ‘depression’ may well have caused us to miss fringe communities eschewing DSM categories, so we cannot pretend to be fully inclusive.

What intrinsic value might the analysis of online forums have for mental health care? Firstly, we have identified some strategies here that might enable service users to get more out of online resources for managing distress. For example, addressing forum members individually and echoing previous posts are both strategies that could be mobilised to generate more effective online communication. Secondly, it is important for professionals to appreciate the amount of identity work that gets done in online communities, and the kind of baggage that clients may bring to their relationships with health care services.

It is important also to appreciate what cannot be inferred directly from online data: Forums do not offer us a unique insight into depression discourse per se, and they certainly do not provide evidence of ‘beliefs’ or cognitions of people with depression. Treating forums as short cuts to ‘hard-to-reach’ research participants is a practice to be avoided at all costs. Bearing this in mind, future research should seek to contextualise its aims and findings: For example, one can chart and analyse the evolution of the online eating disorders community so that ‘pro-ana’ becomes a historical/cultural phenomenon rather than a series of websites on which people with anorexia occasionally post. This requires something of a reappraisal by clinicians and academics working in mental health, away from individuals (clients, with existential problems and clinical diagnoses) towards communities. If the mental health professions are unable or unwilling to take such a step, the study of online communities then becomes a matter for CMC researchers and social scientists alone, with an accompanying shift in the way we understand ‘mental health’ in relation to personal identity and the relationship between the individual and society.

In addition, these analyses contribute to building up a literature on the application of conversation analysis and related techniques to online forum data more generally. Only time will tell is this a valid project in its own right: whether forums are to continue to provide such rich (and accessible) data for analysis, or whether they may in time mutate into something even more like conversation. There are obvious limits to the application of tools derived from the study of real time, synchronous communication, but these will need more elaborate discussion elsewhere.

Note

1 For reasons of authenticity, all excerpts are presented in their original format, with spellings uncorrected.

References


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