SOCIAL SUPPORT AND ANOREXIA RECOVERY ONLINE

By

Allyn Lueders

Submitted to the graduate degree program in Communication Studies and the Graduate Faculty of the University of Kansas in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Chairperson Adrianne Kunkel, Ph.D.

Debra Ford, Ph.D.

Alesia Woszidlo, Ph.D.

Jeffrey A. Hall, Ph.D.

Sonya Satinsky, Ph.D.

Date Defended: July 19, 2013

The Dissertation Committee for Allyn Lueders
certifies that this is the approved version of the following dissertation:

SOCIAL SUPPORT AND ANOREXIA RECOVERY ONLINE

_____
Chairperson Adrianne Kunkel, Ph.D.

Date approved: July 23, 2013

Abstract

An analysis of an online anorexia recovery message board community was used to develop an understanding of how anorexia patients conceptualize the recovery process, what tangential topics they discuss on the message board, if the community has similar characteristics to those previously marked as effective by previous studies (Barak, Boniel-Nissim, & Suler 2008), and how community members deal with stigma. Through discourse analysis, ideologies were identified from the message board postings collected from the website, eating-disorder.supportgroups.com, over a one month period in 2013. Ideologies are "social systems of ideas, values or prescriptions of groups [and] have the function of organizing or legitimating the actions of the group" (van Dijk, 1998, p. 3). The ideologies identified in the current study demonstrate that recovering anorexics understand recovery as a process and discuss tangential topics in an effort to relate to, and connect with, one another. Also, this study provides evidence that the online community of anorexics dealing with recovery is similar to communities deemed effective by prior research (Barak et al., 2008) and that recovering anorexics make use of various stigma management strategies. Theoretical and practical implications are offered in an effort to improve the anorexia recovery process.

Acknowledgements

I could not have completed this project without the extremely generous help of many people. First, I must express my gratitude to my amazing advisor, Dr. Arianne Kunkel. Not only did she have four advisees trying to complete their degrees in the same summer, but her unwavering encouragement and guidance was sometimes the only thing that made me believe that finishing was possible. As long as Dr. Kunkel is at the University of Kansas, I will never hesitate to encourage other interpersonal students to join the department. Thank you for being incredibly patient and supportive, especially when my timetable became much shorter than we originally planned.

As overwhelmingly important as a supportive advisor is to the completion of a dissertation, I am equally indebted to my amazing husband, Ryan. I would never have been able to survive the grueling process of graduate school in general, much less complete such a large project in a limited amount of time without his constant encouragement. Not only did he listen to my frustrations and lament through my struggles, his constant joking and jovial attitude helped me remember that remaining lighthearted is just as important as staying motivated through this process. Thank you for being my strong, funny, hardworking husband, and the best partner in life I could ever hope for. This brief paragraph cannot cover all the ways you have helped me, but thankfully, we have the rest of our lives for me to show my gratitude. It is definitely going to be an adventure!

Though I shared my time at KU with my husband and advisor, it would not have been the same without the great friends I've made here as well. Thank you especially, Jenny Guthrie, Jen Schon, and Jessica Pauly for laughing and screaming with me as only fellow graduate students can do. Your friendship helped me remember that I was not alone, and together we encouraged

each other through the late nights, long papers, and tough exams. I think each of us would not have succeeded without the others, and though I was only able to share an office with one of you, all of you have been so caring, generous, and thoughtful throughout our time together. Thank you all for making KU feel more like a family, and I truly hope we are able to stay in touch for many years to come.

Finally, I must thank my family, who have been influential my entire life. My parents, David and Susan, raised me to believe I could accomplish the great feat of a Ph.D., and to use my skills to honor God. I would never have gotten the job I have if they hadn't raised my sister and I in a Christian home and I can never fully express my gratitude for that. Also, I feel so lucky that I have an amazing aunt and uncle, David and Sheryl, who live close to the campus of my new school. They opened their home to me and Ryan so that we could become comfortable in the area and find a new home, and I appreciate that so much. Thank you for being excited for us, and for helping us get situated in Marshall.

Table of Contents

Abstract iii

Acknowledgements iv

Table of Contents vi

Chapter One: Introduction and Rationale 1
- Pro-Anorexia Movement 2
- Treatment and/or Recovery 3
- Social Support and Recovery 4

Chapter Two: Literature Review 7
- Definitions of Anorexia 7
- Definitions of Treatment 8
- Definitions of Recovery 9
- Online Recovery Communities 10
- Social Support and Support Groups 11
- Stigma and Stigma Management Theory 17

Chapter Three: Method 21
- Data Source 21
- Participants 21
- Data Collection 22
- Data Analysis and Ideologies 23
- Data Analysis and Coding 25

Chapter Four: Results 28
- Definitions of Recovery (RQ1) 28
  - Empowerment is important 29
  - Recovery takes time, but it is worth it 29
  - Take care of yourself, but accept help from others 30
  - You *can* find a good doctor 31
  - You *can* find good counseling and therapy 31
  - It is hard, but be hopeful 33
- Tangential Topics Discussed (RQ2) 34
  - Connections are important 34
  - It is important to stay healthy 35
  - It is okay to express your worries 36
  - Faith is important 37
  - Information is important 37
  - Fun is important 38
- Evidence of Effective Support Provided (RQ3) 39
  - Having a safe place to share and people to listen is important 40
  - Sharing empathy and appreciation is important 43
  - Good advice and information should be valued 44
  - You need to improve knowledge through other people and resources 46

Getting and giving support is important 48
Getting and giving compliments is important 50
Mentioning support directly is appropriate 52
Stigma Management Strategies Used (RQ4) 54
Because of stigma, sometimes you have to avoid situations 55
Sharing with people who understand is helpful 55
Recovering anorexics are better than the others 56
It is not all your fault 56
Your anorexic self is not your true self 57
Chapter Five: Discussion 58
Definitions of Recovery (RQ1) 58
Tangential Topics Discussed (RQ2) 61
Evidence of Effective Support Provided (RQ3) 66
Stigma Management Strategies Used (RQ4) 70
Theoretical Implications 74
Practical Implications 75
Limitations and Future Research 77
Summary and Conclusion 78

References 80

Appendix A: Ana Creed 91

Appendix B: Tables 92
Table 1 – RQ1: Definitions of Recovery 92
Table 2 – RQ2: Tangential Topics Discussed 93
Table 3 – Qualities of Effective Support Communities 94
Table 4 – RQ3: Evidence of Effective Support Provided 95
Table 5 – RQ4: Stigma Management Strategies Used 96

Chapter One: Introduction and Rationale

According to the National Eating Disorders Association (2012), "in the United States, as many as 10 million females and 1 million males are fighting a life and death battle with an eating disorder such as anorexia" (Facts and Statistics, para. 1). Forty-two percent of first- to third-grade girls want to be thinner, and 81% of 10-year-olds are afraid of being fat (TeenHelp, 2012). All of these behaviors and beliefs are indicators of the severe eating disorder, anorexia nervosa. Clearly, the problem of anorexia is widespread and impacts people of all ages.

Anorexia is defined as, "an eating disorder that makes people lose more weight than is considered healthy for their age and height" (United States, 2012). Symptoms include "restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics" (WHO, 2007). Anorexics are often afraid of eating food and/or gaining weight, even when they are already severely underweight (Berkman, Lohr, & Bulik, 2007).

Of all mental disorders, anorexia carries the highest mortality rate (Sullivan, 1995). This disease leads women and men to starve themselves until their heart slows so much that they are near death or lose their lives. Such a pattern of behavior can also lead to pneumonia or renal insufficiency as a result of chronic dehydration. Indeed, "anorexics are dying at a rate of 10% to 20% from complications of starvation or from suicide" (Tomaselli, 2008, para. 5).

Though clearly dangerous, eating disorders are difficult for doctors to diagnose. Many times, those suffering from anorexia are hesitant to come forward and it is possible they do not want treatment (Cooper, 2005). Clinically, the diagnosis process consists of semi-structured interviews that delve into topics related to patients' body image, self-esteem, eating practices, fasting, self-mutilation, and substance abuse (Fichter, Herpertz, Quadflieg, & Herpertz-

Dahlmann, 1998). Answers to these interview questions reflect the degree to which a patient displays symptoms of an eating disorder, which then can lead to diagnosis (Fichter et al., 1998).

Whether or not an anorexic receives an official diagnosis, choices about how to proceed must be made. Two possibilities stand out as potential choices: (1) pro-anorexia or (2) treatment and/or recovery. There are degrees with which a person can subscribe to the tenets of each position, and some may be more committed or involved than others.

Pro-Anorexia Movement

The pro-anorexia movement developed because, despite the morbid consequences involved, not everyone sees anorexia in a negative light. In fact, a sub-culture exists online; that is, "pro-ana," that promotes anorexia as a lifestyle choice. "Pro-anorexics are individuals who consider anorexia a legitimate alternative lifestyle that they choose to have, rather than an illness that they cannot control" (Lyons, Mehl, & Pennebaker, 2006, p. 253). Because this is, unsurprisingly, not a widely held opinion, pro-anorexics have turned to the internet to find others who agree with and support their viewpoint or worldview (Bardone-Cone & Cass, 2006; Fox, Ward, & O'Rourke, 2005). Known as pro-ana groups, visitors can go to such websites to garner tips for how to look like you are eating without ingesting anything or how to add weight on the scale in the form of lead pieces and/or other objects (Haas, Irr, Jennings, & Wagner, 2011; Norris, Boydell, Pinhas, & Katzman, 2006). In fact, Custers and Van den Buick (2009) define pro-anorexia groups as "websites that claim AN [anorexia] is not a disease but a choice of lifestyle" (p. 215).

It is difficult to determine exactly how many pro-ana sites exist because many are shut down when a web host deems the site as harmful to others. For example, one pro-ana site, http://proanalifestyle.blogspot.com/, lists 15 links to other sites that may provide further pro-ana

support. However, though the site was last updated September 18, 2012, only seven of these site links were active. Four of these links were directed to sites hosted by freeweb.com. Currently, the link connects users to a page that says, "We're sorry, this site is frozen. If you are the site owner, please contact our abuse team regarding the status of your website" (Freewebs.com, 2012). There is no way to know when the sites were taken down, but this is a clear example of the fluidity of the internet, and pro-ana sites more specifically. Examples of other, still active, pro-ana sites include: anorexics.net, ceruleanbutterfly.com, houseofthin.com, and proanalifestyle.blogspot.com/.

Treatment and/or Recovery

Anorexics who do not appreciate the "thinspirational" pictures of emaciated individuals that are present on many pro-ana sites, do not believe in the Ana Creed (see Appendix A; http://proanalifestyle.blogspot.com/2007/07/anas-creed.html), and want to be cured from the disease can follow the more widely accepted path and seek recovery. Such a decision may not come easily, and treatment is far from simple. Between deducing the cause for a specific case of anorexia and finding an effective course of action, arriving at a successful treatment is a very difficult process. Over the years, doctors have used different approaches to achieve various goals they feel are makers of success. Agras and Kraemer (1984) note that "the goal of treatment has come to be seen as the restoration of normal body weight, which, in turn, leads to exposure to and experience with normal adolescent or adult social and interpersonal demands" (p. 193). The treatment that Agras and Kraemer (1984) note specifically addresses the anorexic symptoms of lower than normal body weight and social anxiety in everyday situations. Other treatment options address additional symptoms, such as irregular menstruation and low self-esteem.

There are many types of treatment, all of which target anorexia from different angles. A qualitative analysis of eating disorder patients' concept of treatment revealed a specific connection with eating comfortably, having no distorted thinking, obtaining normal weight, experiencing generally healthy functioning, and possessing a positive body image (Darcy et al., 2010). Broadly speaking, these and other forms of treatment can be divided into three categories: (1) medical treatment (hospitalization), (2) behavior therapy, and (3) drug therapy (Agras & Kraemer, 1984).

Regardless of how a person chooses to deal with their disease, an additional consideration of the anorexic's experience is how the stigma of being anorexic affects them. Stigma has traditionally been defined as an identity discrediting mark on someone of questionable moral status (Goffman, 1963; Meisenbach, 2010) and it can clearly be seen that the societal and medical definitions of anorexia as a disease would qualify any of its victims as stigmatized. Further, Smith and Hipper (2010) discuss how the management of a stigmatized label, such as "anorexic," may lead the stigmatized to disclose to confidants, who, in turn, encourage them to hide their stigma. This may provide additional embarrassment and ultimately affect the recovery process.

Social Support and Recovery

Because of the stigma surrounding anorexia, social support through the recovery process is extremely important. Social support has been defined in various ways (Burleson & MacGeorge, 2002) including, "the subjective feeling of belonging, of being accepted, of being loved, of being needed all for oneself and what one can do" (Moss, 1973, p. 273). Providing feelings of want and need, or social support, can have a strong impact on a person's self-worth (Burleson & MacGeorge, 2002). Indeed, one of the main factors leading to recovery, as noted by

participants in an ethnographic study, was the existence of supportive, non-familial relationships (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2002). It is possible that the relationships formed in an online community may include such non-familial relationships. Many times, individuals cannot locate much needed support from offline friends and are pushed to locate and solicit support in online communities (Wright, 1999).

However, the type and nature of support provided in online recovery communities remains unclear. Dias (2003) reports that the majority of prior studies in this area have stemmed almost exclusively from the medical model, seeking causes and treatments for the disease, not considering the individual patient's perspective. It may be that the best way to cope with stigma and fight for recovery is to come to terms with it in online communities or forums, but this is not yet known. Answers to these queries can be best attended to through investigating experiences of individuals who participate in online anorexia recovery communities or forums.

Therefore, through discourse analysis of message board posts of an online anorexia recovery support group, the current research seeks to understand the experience of recovering from anorexia and how online support groups may facilitate this process. Because anorexia patients are notorious for refusing treatment, and treatment methods are so intertwined with cultural and feminist issues (Gremillion, 2003), uncovering patient perspectives on recovery, support, and stigma will be beneficial in strengthening and understanding the complex process of anorexia recovery.

Specifically, this study adds a deeper understanding of the patient's perspective to the literature on anorexia recovery, in hope of making the recovery process more effective. Additionally, by investigating discourse exchanged through an online recovery community, this study bolsters our understandings of online communities and online support. Finally, through an

analysis of stigma-related discourse in an online recovery community, this study adds to our conceptualization of stigma management by proposing that with the affordances of anonymity and invisibility, online communities are effective channels through which stigma can be dealt with and negotiated.

By first taking a broad view of anorexia's history and treatment methods, a picture of the difficulties anorexics experience is presented. Then, exploring how stigma can affect anorexics, even those who are recovering, further illuminates why social support is so crucial to the recovery process and why so many seek such support from an online community. Following this discussion, a detailed description of data collection and discourse analysis procedures is described in relation to each of the research questions posed in this project. Results for each of the research questions are then offered. And, finally, a discussion of the implications of this research is presented, along with ideas for future research and potential limitations of the current study.

Chapter Two: Literature Review

Definitions of Anorexia

Anorexia has been defined in many ways throughout its history. Current definitions range from "a biologically based mental illness that can also cause serious physical health problems" (Alexander & Sangster, 2013, p. 1) to "the direct result of a cultural norm in which women are faced with the idealized image of an underweight, underfed, 'skinny' body" (Baratta, 2011, p. 31). From the medical distinction of "disease" to the social characterization of "stigma," the definition and treatment of anorexia nervosa has long been debated (Haas et al., 2011). In fact, the term 'anorexia nervosa' was first used in 1874 by the physician William Gull, who was desperate to categorize medical symptoms and behaviors that he witnessed, but seemed inexplicable absent a diagnosis (Garrett, 1998). The label and definition of anorexia was therefore part of a strategy by Gull and other physicians to legitimize and categorize symptoms that otherwise seemed unreasonable at the time.

Early on, during Gull's time, anorexia, along with many other forms of female complaints, was considered a form of hysteria (Gremillion, 2003). Since then, three explanatory models of anorexia have become accepted: (1) biomedical, (2) psychological, and (3) social/cultural (Garrett, 1998). Combining these definitions, anorexia can be seen as a psychiatric mental illness that must be situated within cultural and social expectations (Gremillion, 2003).

Many believe that anorexia is a mental disorder having to do with low self-esteem, the need for attention, and/or a desire for control (Tozzi et al., 2002). However, starving oneself and exercising obsessively can lead to medical complications that have life or death consequences (Bulik, Sullivan, & Kendler, 2000; Mancini, Daini, & Caruana, 2010). It is because of this

pairing of psychological and medial issues that the best treatment for anorexia is hard to determine. Doctors must decide whether treatment should focus on returning patients to a healthy weight or helping them deal with their psychological issues (Rich, 2006). For example, should a patient be prescribed drugs, sent to counseling, or both?

Rich (2006) reports that a number of varying constructs have been used to describe anorexia, including "medicalization," which Conrad (1992) defines as "a process by which nonmedical problems become defined and treated as medical problems" (p. 209). This ambivalent explanation demonstrates how difficult defining anorexia has been. Others ascribe more social meaning to anorexia. For example, some social scientists and feminists take anorexia to be a reflection of "Western cultural preoccupations or to patriarchy," while others in the pro-anorexia community see anorexia as a form of control and self-expression (Fox et al., 2005, p. 944).

Definitions of Treatment

Different definitions of anorexia are echoed by the different methods of treatment. Kinoy (2001) points out that doctors, clinicians, and researchers have been studying anorexia for many years, and the best understanding developed so far is that the disease is multi-dimensional, and thus so is its treatment. Because of this fact, there is a growing understanding that the best course for treatment may be multi-faceted and interdisciplinary (Kinoy, 2001). In this type of comprehensive treatment approach, it is essential that the most up to date treatment guidelines be followed, that evidenced-based care is administered, and that the treatment itself is cost-effective (Kaplan, 2002).

Considering all options, it seems that for many years there were three main categories into which treatment was separated: (1) medical treatment, (2) behavior therapy, and (3) drug

therapy (Agras & Kraemer, 1984; Gore, Vander Wal, & Thelen, 2001; Kinoy, 2001). Because doctors and researchers have discovered that every case stems from a different cause and/or every patient understands the disease differently (Williams, Watts, & Wade, 2011), a new multi-disciplinary course of treatment is now viewed as most effective (Baratta, 2011). If one patient is driven to anorexia because of severe self-hatred and another has turned to anorexia because of familial abuse, the same treatment is not likely to be effective in both cases. For example, Goldkopf-Woodtke (2001) reports that a combination of individual therapy, group therapy, nutritional counseling, medical observation, and anti-depressants was successful for her personal recovery. Further, anorexia is commonly a life-long struggle, and various stimuli can trigger a patient to slip back into harmful behaviors throughout the lifecycle (Zipfel, Lowe, Reas, Deter, & Herzog, 2000). Because such a large variety of events can be triggering and a patient can struggle with any facet of the disease at any time, Goldkopf-Woodtke (2001) reports that trying to separate types of treatment (nutritional, medical, therapeutic) is often futile. In fact, Goldkopf-Woodtke (2001) explains, "A patient needs them all [treatment] at the same time" (p. 167).

Definitions of Recovery

Regardless of what causes an individual to enter recovery or where he or she gets the most helpful support, it is difficult to determine when an individual is in recovery in the first place because the word "recovery" has a different meaning for seemingly every stakeholder. Indeed, researchers, therapists, and doctors have thus far been unable to decide on one, singular definition for recovery. Levenkron (1982), for example, describes anorexia as "an attachment to a sadistic, imaginary mother, invented to fill a nurturing vacuum" (p. 16). He then goes on to say that the only way to recover from anorexia is to achieve separation from that parent (Levenkron,

1982). While other therapists speak of an attachment to the disease and longing for attention from the parents as a struggle with anorexic recovery (e.g., Anderson, 1985), not all see parental separation as the end goal.

Other definitions of recovery include a wide variety of benchmarks patients must reach, including an appropriate body weight, daily caloric intake, and motivation to change (Darcy et al., 2010). For example, in their systematic review of eating disorder literature, Berkman et al. (2007) defined a patient in recovery as "above the 85% IBW [ideal body weight] cutoff, had no menstrual disturbances, reported no binging or purging behavior, and free from any other eating or body image disturbance" (p. 298). However, the fact that anorexia has both physical and mental dimensions makes defining recovery even more difficult (Ellin, 2011). For example, recurrence of menstruation is an easy sign of recovery to assess, but a mental level of self-acceptance or self-esteem is not. Perhaps recovery is reached when patients are no longer tempted to return to dangerous habits, such as restricted eating or over-exercising, to achieve comfort (Goldkopf-Woodtke, 2001; Gremillion, 2003). Some studies have attempted to define recovery in terms of the patient's perspective (e.g., Darcy et al., 2010; Keller, Rosenthal, & Rosenthal, 2005), yet none have accessed online recovery communities to see how recovery is defined in these communities, or even what leads someone to recovery in the first place.

Online Recovery Communities

The exact cause for change that pushes someone towards recovery is different for every anorexic individual. But because people have been dealing with this disease for so long, some catalysts have been identified. Tozzi et al. (2002) report that the etiology of anorexia stems from socio-cultural, family, and individual characteristics. So too do the causes for recovery. Specifically, Tozzi et al. (2002) found that supportive relationships, supportive friendships, and

maturing out of the disease were the most common factors related to recovery for the participants in their study.

Finding relationships that will be helpful and supportive through anorexic recovery is not easy, however. In fact, Smith and Hipper (2010) report that one of the common ways confidants suggest for coping with a stigma, like anorexia, is to hide it. Keeping a stigma from others could possibly assist in escaping ridicule and other negative consequences. Unfortunately, it is not an altogether healthy way of coping and does not suggest to the stigmatized that they are being understood. Instead, such a suggestion can cause the stigmatized to believe that their confidant is ashamed and/or embarrassed by their condition, which is also unhelpful (Smith & Hipper, 2010).

Because of such complications, many people suffering from anorexia become involved in online communities. Some of these communities are pro-anorexia and support unhealthy habits such as over-exercising and starving oneself, while other sites focus exclusively on healthy habits for recovery wherein they emphasize turning away from eating disorder habits and attempting to move beyond self-harm. These recovery sites also attempt to offer care, concern, and encouragement to community members as they go through the recovery process. Therefore, this study addresses the following research question:

RQ1: How is the anorexia recovery process discussed in online anorexia recovery communities?

Social Support and Support Groups

As mentioned above, seeking social support is a principle reason for visiting or participating in an online community. Social support has been approached in many ways (Burleson, Albrecht, Goldsmith, & Sarason, 1994) by various scholars (Barnes & Duck, 1994;

Burleson & MacGeorge, 2002), but overall can be described as a feeling of belonging and acceptance. Many different approaches to conceptualizing social support have been previously outlined by the authors noted above, but Dakof and Taylor (1990) offer a particularly useful typology by distinguishing between tangible, emotional, and informational support. Dakof and Taylor's (1990) categorization was selected for use in this study because it focused on the experiences of cancer patients who face a serious health risk. Further, the support typology they used (i.e., tangible, emotional, and informational) might be akin to those struggling with anorexia that face a different serious health risk (Spake, 2003). From the data collected in Dakof and Taylor's (1990) investigation, tangible support was categorized as support that "provided practical assistance" (p. 82). Emotional support was described as "being physically present and expressing concern, empathy, or affection" (Dakof & Taylor, 1990, p. 82). Finally, informational support was succinctly described as support that "provides useful information" (Dakof & Taylor, 1990, p. 82).

It is important that support groups, such as an online anorexia recovery community, provide tangible, emotional, and informational support effectively if they are to avoid negative outcomes (Cline, 1999). Members of support groups have common goals such as "sharing information, offering and receiving emotional support, reducing stress build-up" (Alexander, Peterson, & Hollingshead, 2003, p. 308) and the fulfillment of such expectations can lead to a successful experience. The idea behind most support groups is that people with similar problems and needs are comforted when coming together to share personal histories, listen to, and learn from others (Dennis, Kunkel, & Keyton, 2008; Yalom, 1985). But a support group cannot be effective without also providing social support or "responsiveness to another's needs" (Cutrona, 1996, p. 10).

Many people seek social support and support groups online because the internet allows access to many additional friendships and connections (Wright, 1999, 2000). Offline, it is sometimes difficult to find the right support group for a unique aliment, or one that is conveniently located, and this can leave some without sufficient support. Specifically, variables that limit social support include restricted mobility, alienation, fixed income, and/or a small geographical community (Wright, 2000). The internet affords individuals a chance to communicate with others who share their experience, no matter how unique, and no matter how distant their geographical location. Therefore, many who seek support but who cannot find it within their face-to-face relationships are quick to seek connections online because of the ease of access.

Because of the wide variety and convenience, the popularity of online support groups has greatly increased in recent years and the number of these groups is estimated to be in the hundreds of thousands worldwide (Barak, Boniel-Nissim, & Suler, 2008). These groups allow participants to "engage in supportive interaction through bulletin boards, chat rooms, listserves and individual e-mail exchanges" (Wright & Bell, 2003, p. 40). Through such communication, members are able to establish a great number of weak tie connections that would have been completely unavailable to them without the reach of the internet (Wright & Bell, 2003). Baym (1993) further explains that topics discussed in an online community do not necessarily have to relate to the community's main purpose to contribute to the feeling of connection. For example, in the soap opera fan community she studied, Baym (1993) discovered that some members found it more enticing to discuss tangential topics, rather than the soap opera that was central to the fan community. Similarly, the conversations included in an anorexia recovery community do not necessarily have to be related to anorexia or recovery to add to patients' feelings of support.

Therefore, to ascertain the extent to which extraneous topics are discussed in online anorexia communities, this study addresses the following research question:

RQ2: To what degree do participants in an online anorexia community discuss topics other than stigma, support, and recovery?

Regardless of the topic of discussion, making such connections in online support communities allows members to feel a sense of community and reject feelings of isolation (Eichhorn, 2008). In a study of an online support group for individuals who have some sort of disability, Braithwaite, Waldron, and Finn (1999) note, "Knowing they are part of a larger cultural group can help people with disabilities adjust, provide a base of knowledge and political action, and decrease feelings of isolation or alienation for individual participants" (p. 128). Because this sense of community can be found without leaving one's own residence, it is a major benefit to online support groups.

Reduced social risk is another benefit to online support, because the cover of anonymity lowers any social risk that could be incurred when seeking or giving support over the internet (Wright, 2000). Similarly, many online support groups are text-based and therefore provide not only anonymity, but invisibility as well. As Barak et al. (2008) note, "Group members do not have to worry about how they look or sound" (p. 1871) and this is particularly comforting for those with an ailment that affects physical appearance, like anorexia. If anonymous, support group members could potentially pass each other on the street without being confronted with any shared secrets or being judged by something as simple as a glance (Wright, 2000). If invisible, there is no need to awkwardly avoid eye contact when discussing a sensitive subject; text communication offers a built in opportunity to avoid eye contact (Barak et al., 2008). For these

and other reasons, online social support has been an enticing venue for many, and especially those who suffer from a stigmatized or specialized problem, like anorexia (Eichhorn, 2008).

Online support groups are not only convenient and protected by anonymity; it has also been found that they can provide effective support for community members. For example, Wright (1999) posted an online survey on the bulletin board of 24 online support groups for various illnesses and found that the amount of time participants spent communicating with others in the group was directly related to the size of their support network and satisfaction they received from the online support group (Wright, 1999). Additionally, by coding 1,175 message board posts using a modified version of the coding scheme set forth by Cutrona and Suhr (1992), Braithwaite et al. (1999) found that the text-based nature of an online support group provided unique forms of supportive communication. Sharing poetry and thoughtful prose was a common practice in the support community these scholars analyzed, and it became especially clear that members with communication-related disabilities benefitted from the asynchronous and invisibility affordances of computer-mediated communication (Braithwaite et al., 1999; Eichhorn, 2008).

It is likely that anorexics have difficulty receiving support from offline contacts that cannot or will not understand their situation. Therefore, many anorexics rush to an online community to fill this void. However, it is not yet clear exactly what types of support anorexics are receiving online that are most helpful when working through recovery. Past studies have reported participants' complaints about being pushed into recovery (Darcy et al., 2010) or recovery being too medicalized (Rich, 2006). Clearly, these examples highlight the extremely complex nature of providing successful support. Yet, it appears that successful support is achieved on certain occasions, as online community members appear satisfied with their online

experiences, noting the sites' motivational attention to the good and positive parts of recovery (Keller et al., 2005).

Many studies have failed to find empirical evidence to support the claim that support provided in an online community is effective. However, Barak et al. (2008) distinguish between support groups and therapy groups, and insist that one does not have the same purpose as the other. In fact, Barak et al. (2008) note that "taking part in an online support group does not aim at effectiveness in terms of distress-related outcomes; rather its objective should be seen in terms of affording general emotional relief and an elevated sense of control – two essential components of personal empowerment" (p. 1879). These authors suggest that while therapy groups are focused on producing clinical results that relate to a specific illness or disease, support groups are more concerned with empowering participants and helping them feel capable of making the clinical changes encouraged during therapy. In fact, (online) support groups could very well offer a complementary form of support to that found in therapy groups (Eysenbach, Powell, Englesakis, Rizco, & Stern, 2004).

Through a review of both quantitative and qualitative studies that analyze the effectiveness of online support groups, Barak et al. (2008) identified factors of a successful online support group. These factors include an opportunity to: express thoughts through writing, express emotions, gather information and improve knowledge, develop interpersonal relationships, and cultivate better decision-making skills. Together, these attributes assist participants in generating a personal sense of empowerment (Barak et al., 2008). Uncovering how these specific qualities create a supportive environment for recovering anorexics in the community analyzed in this study will be helpful in assisting other anorexia recovery websites. Therefore, this study addresses the following research question:

RQ3: Does the online support group offer components essential to an effective online anorexia recovery group based on the findings of Barak et al. (2008), and how are those evident?

Stigma and Stigma Management Theory

Unfortunately, locating and creating an effective support community is not the only struggle set before anorexics. In addition, pursuing an extremely thin figure sets anorexics up to be ridiculed and ostracized by those around them. Further, even if those suffering from anorexia recognize their problems and decide to enter recovery, cruel stigmatization from others (even loved ones) can encourage a return to dangerous habits. Clearly, an individual suffering from this disease can, at any point, be stigmatized, and this is another large part of the experience of a person recovering from anorexia.

Stigma can be defined as a social process through which meanings are exchanged (Bos, Pryor, Reeder, & Stutterheim, 2013; Deacon, 2006; Joffe, 1999). Specifically, pointing to the need for a more comprehensive understanding of stigma related to HIV and other illnesses, Deacon (2006) developed an explicit description of how stigma influences our perceptions of illnesses and those suffering from them. Because anorexia is considered a disorder, according to the Diagnostic and Statistical Manual (DSM, American Psychiatric Association, 1994), Deacon's (2006) definition of health-related stigma is utilized in this research. Accordingly, Deacon (2006) defines a health-related stigma as a social process in which:

> (i) illness is constructed as preventable or controllable, (ii) immoral behaviors causing the illness are identified, (iii) these behaviors are associated with carriers of illness in other groups, drawing on existing constructions of the other, (iv) certain people are thus

> blamed for their own illness, and (v) status loss is projected onto the 'other,' which may or may not result in a disadvantage for them. (p. 421)

Health-related and other stigmas can generally be divided into four categories (Pryor & Reeder, 2011) and each serves a distinct function (Bos et al., 2013). The four categories that Pryor and Reeder (2011) separate stigma into include: (1) public stigma, (2) self-stigma, (3) stigma by association, and (4) structural stigma. Public stigma involves the cognitive, affective, and behavioral reactions of people who stigmatize, or the perceivers. Self-stigma stems from an awareness of public stigma and addresses the social and psychological impact that being stigmatized can have. Stigma by association refers to reactions to people who are associated with a stigmatized person. Finally, structural stigma is present when a stigmatized status is perpetuated or legitimized by society (Pryor & Reeder, 2011).

All types of stigmas function in specific ways that can impact social structures and interactions. One of these functions is enforcing social norms, or keeping people in line (Bos et al., 2013). Also, Bos et al. (2013) suggest that stigma can function as a way to avoid disease or keep people away. A final way in which stigma can function is as exploitation and domination, or keeping people down (Bos et al., 2013). Using stigma to exploit or dominate the stigmatized was also highlighted by Shoham (1970), who describes a model of stigmatization that provides reasons an individual might be the victim of a stigma. He terms one of those reasons "somebody to look down upon" and this could be the driving force behind anorexia stigma (Shoham, 1970, p. 108). Another possibility is, in Deacon's (2006) framework, when an illness (like anorexia) is judged to be preventable, immoral behavior of the stigmatized is identified as the cause and people are looked down upon because of their illness.

In the United States particularly, society is obsessed with being attractive and thin, as well as obtaining the proper weight (Spake, 2003). Shoham (1970) explains that a society filled with tension can lead to excessive ambition and inner anxiety over the stressor. When an achievement-based society does not achieve the set goals and reach high status, the common tendency is to lower the status of the stigmatized (Shoham, 1970). This explains anorexia stigma quite clearly. It is a hard battle to always maintain the ideal physique and pressures to do so are pervasive. When a person is unable to meet goals they have set, they direct attention to individuals of lower status, as Shoham (1970) describes, and thus increase their stigma. As in the case of anorexia, people who struggle with their own weight look down upon anorexics and feel power through shunning them (Shoham, 1970).

Dealing with stigma, no matter what the cause or type, is always difficult. Bos et al. (2013) have theorized and identified strategies of stigma management that are either problem-focused or emotion-focused. Problem-focused strategies include "selective disclosure, compensating during social situations, avoiding situations where stigmatization is likely, affiliating with others who share the same condition, seeking social support, and activism" (Bos et al., 2013, p. 3). These strategies can be used to target the self, the situation, or others. Additionally, Bos et al. (2013) provide emotion-focused strategies for dealing with stigma that can be used to regulate negative emotion. These include downward social comparison, external attributions for the behavior of others, positive reappraisal of the experiences of stigmatization, distraction, and detaching oneself from the stigmatized identity (Bos et al., 2013).

Whether using problem- or emotion-focused stigma-management strategies, it is a hard task to endeavor alone. As previously discussed, many anorexics do not receive helpful support from their friends and families, and therefore feel compelled to go online in search of others who

understand them. Many times, this leads people to anorexia recovery communities where other anorexics share their experiences and relate to one another on a deeper level (Haas et al., 2010). One key component of the supportive communication anorexics are searching for may be a way to deal with the stigmatization they experience day to day.

As Meisenbach (2010) notes, "The need to enhance individuals' management of stigmatization stems from the range of negative outcomes linked to stigma, such as devalued social identities, prejudice, stereotyping, discrimination, and neglect" (p. 269). Some maintenance behaviors used to deal with stigma are more successful than others and the desire to see how others have coped may be a natural reaction. Indeed, "stigma attitudes encourage the sharing of stigma messages with others in a network, which may, subsequently, bond in-group members" (Smith, 2007, p. 462). For these reasons, it is plausible that stigma is being managed in anorexia recovery communities, but research has yet to examine how this is being done, and its efficacy. Therefore, this study addresses one final research question:

RQ4: How is the anorexia stigma understood, managed, and negotiated in online anorexia recovery communities?

Chapter Three: Method

Data Source

In an attempt to understand the complexities of living with an eating disorder and attempting recovery, message board postings from an online anorexia recovery website were collected. First, message board posts provided fruitful data because, as Stern (2000) argues, "the medium of internet forums, weblogs and home pages offers a powerful arena for self-disclosure and self-expression messages" (p. 30). Specifically, messages were collected from the message board eating-disorder.supportgroups.com. Supportgroups.com is:

> an online support group community that has over 220 online support groups. [The] goal is to bring people together around life's challenges by providing concise, up-to-date information and a meeting place for individuals, their friends and families, and professionals who offer pathways to help. (supportgroups.com/how-this-site-works)

The page directed at eating disorder support (i.e., eating-disorder.supportgroups.com) is listed as a top support group on supportgroups.com and has 1,840 registered members who have contributed 53,654 posts as of December 2, 2012. However, it is possible to access the site and read others' posts without registering as a member of this specific support group. Therefore, it is unclear exactly how many people read this message board. Logging in is required to write a post or comment on the message board, but a valid e-mail address is all that is required to register, and there is no fee.

Participants

For this project, participants were considered anyone who posts on the supportgroups.com eating disorder message board. Each post has a screen name attached to it, which is likely not the poster's real name, and therefore anonymity is ensured. Though an e-mail

address is required for login, it is not attached to an individual post, which further protects anonymity. It is up to individual members if they choose to disclose their real names or provide additional contact information.

Data Collection

Following Ranung's (2012) online study of young men and eating disorders, message board postings for the current research study were collected from eating-disorder.supportgroups.com over a one-month period (i.e., February 1, 2013 to February 29, 2013), yielding 125 pages of single-spaced text. When someone comments on a previously posted message on this message board, that message is returned to the front of the message board, causing posts made prior to February 1, 2013 to be present in the data collected for this study.

In her study, Ranung (2012) read discussion board threads and extracted themes to analyze the functions and services of an online support community. Virtual ethnography was also used to generally map out the site before a thematic analysis was conducted on the messages posted by members of the site. Virtual ethnography, according to Ranung (2012), involves the researcher gaining an understanding of the context, and the overall research situation or site, through participation and the continual collection of data. Virtual ethnography was not used in the current study, but Ranung's (2012) data collection methods were followed closely.

Unfortunately, extant research on anorexia online support groups examining online message board posts does not provide a standard period of data collection from which to draw. For instance, Gavin, Rodham, and Poyer (2008) collected data from one website for three days, while Lukac (2011) studied nine different blogs for three weeks, and Dias (2003) analyzed multiple sites over a two-year period.

Because of the lack of consistency, I had to make an informed decision about how much discourse to analyze from the online forum. After examining several studies, I decided to follow Ranung's (2012) example because the frequency of posts in the website she studied seem to align with the site studied in the current project in the following way: eating-disorder.supportgroups.com had 1,840 registered members and 53,654 total posts as of December 2, 2012, which translates to roughly 29 messages per member. The site studied by Ranung (2012) had 1,126 registered members and 28,045 total messages at the time of study. This translates to roughly 24 messages per member, which is similar to the 29 messages per member on the site studied in the current project. Additionally, with similar data and data collection parameters, Ranung (2012) successfully used qualitative analysis to arrive at conclusions. Thus, Ranung's (2012) methodological procedures were followed closely in the current study. Furthermore, in keeping with additional previous research, this study adopted an unobtrusive, passive data collection method (Gavin et al., 2008; Winzelberg, 1997). Site users were not informed of the research to avoid an interruption of the natural process of posting and replying in the community. In addition, all posts, and subsequent comments, were reformatted into a Word document and separated by a line for ease of coding.

Data Analysis and Ideologies

Collecting and discursively analyzing message board posts from this eating disorder support site assisted in answering this study's four research questions. As Lindlof and Taylor (2002) state, "of particular interest to communication researchers is the role of discourse and other symbolic forms in the way in which conflictive issues are understood by participants and audiences" (p. 73). Discourse analysis is particularly applicable for this study because its aim is to examine how recovering anorexics in an online community see the world, as well as the

ideologies inherent in these understandings. Specifically, this study queries how the anorexia process is discussed and defined in online recovery communities (RQ1), whether tangential topics are discussed by community members (RQ2), what community members see as effective recovery (RQ3), and how stigma is dealt with and managed (RQ4).

Because discourse analysis is seen as an expression of participant ideologies (van Dijk, 1995), I searched for ideologies in the data in order to answer the first and second research questions (RQ1 and RQ2). Specifically, ideologies are defined as "social systems of ideas, values or prescriptions of groups [and] have the function of organizing or legitimating the actions of the group" (van Dijk, 1998, p. 3). Further, van Dijk (2003) indicates that these ideologies can be seen as "enacted, reproduced, and resisted through talk and text" (p. 353). Thus, for van Dijk (1998; 2003), searching for and identifying ideologies is the purpose of discourse analysis.

So, for example, drawing from van Dijk (1998; 2003), in order to answer the first research question (RQ1) posed in this study, which concerns how the anorexia recovery process is discussed in the online recovery community, actual mentions of *recovery* in the online support group were considered and recurrent themes or key words were seen as shaping a possible ideology. Likewise, to answer the second research question (RQ2) posed in this study, which examines whether individuals discuss tangential topics not directly related to the anorexia recovery process, all references to peripheral topics were attended to, as well as the perceived importance placed on these tangential topics (e.g., "*the most important*," "*the best idea*"), in order to illuminate a potential ideology.

Next, categories provided for an effective support community by Barak et al. (2008) were searched for in the online community that was studied for this project in an effort to answer the third research question (RQ3), which is focused on the level of success for an online support

community. Specifically, Barak et al. (2008) identified an opportunity to express thoughts through writing, express emotions, gather information, improve knowledge, develop interpersonal relationships, and cultivate better decision-making skills as six markers of successful online support communities. According to Barak et al. (2008), if these requirements were met, the community is considered effective.

Finally, answers to the fourth research question (RQ4), which investigates how participants negotiate the stigma surrounding anorexia, were sought through data addressing stigmatizing situations, or other negative attention participants receive because of their anorexia. Relevant data was compared to the categories of stigma management set forth by Bos et al. (2013) to determine if problem- or emotion-focused strategies seem most effective, or if there is another aspect to stigma management involved. For example, if self-disclosure and/or compensation are common strategies discussed, it is clear that problem-focused strategies are in use. If downward social comparison and/or positive reappraisal are evident, then clearly emotion-focused management strategies are chosen. On the other hand, if the stigma management strategies did not match with those proposed by Bos et al. (2013), additional strategies were highlighted through analysis.

Data Analysis and Coding

I began coding by reading through the texts gathered from message board posts multiple times to become familiar with the data. Then, initial line-by-line coding was completed, wherein I described the content of each passage in each post (Meisenbach, 2010). The coding process continued as I developed a list of recurrent themes across the message board posts. For example, during line-by-line coding, all topics of discussion that are tangential to anorexia, recovery, or stigma were highlighted, as were discussions related specifically to anorexia recovery. This data

was saved for later consideration in answering RQ1 and RQ2. Additionally, line-by-line coding drew attention to evidence of effective online support groups (according to Barak et al., 2008) and stigma management strategies used in this group, which were matched with categories set forth by Bos et al. (2013). Each identified tangential topic, discussion of recovery, statement of effectiveness, or stigma management strategy was given a preliminary descriptive code. Phrases containing multiple points of interest were occasionally assigned more than one code. For example, a statement such as "I love being able to write out my thoughts here and really express my feelings" was coded as evidence of an effective community (RQ3) and a stigma management strategy (RQ4).

After completing this preliminary stage of coding, coding re-commenced, starting at the beginning. After multiple passes through the data, preliminary codes were collapsed into categories. In order for two codes to be combined into a category, they had to be expressive of a definition of recovery (RQ1), an ideology, or an "ideal, value or prescription" of the group (RQ2; van Dijk, 1998, p. 3; that is, "people recovering from anorexia value talking about movies"), a quality of effective support communities (RQ3; that is, "you guys have the best information"), or stigma management strategy (RQ4; that is, "if I know it's going to feel weird, I just don't go").

Once this initial list was generated, I re-examined it multiple times. My coding process involved multiple iterations as a coding scheme developed. These descriptions and themes became conceptual categories that were later combined into overall themes or ideologies through axial coding procedures (Charmaz, 2006). For two categories to qualify for the same theme, they had to be evidence of the same ideology, the same reason the community is effective, or the same stigma management strategy. Overall, this revision process allowed for the development of

more concise categories (Miles & Huberman, 1994). These final themes are considered representative of the data and provide answers to the four research questions guiding this study.

Chapter Four: Results

This study was guided by four research questions. The first research question (RQ1) was focused on how members of an online anorexia recovery community talked about or discussed recovery. The second research question (RQ2) was concerned with the tangential topics, or topics other than stigma, support, and anorexia recovery, that were discussed by members of an online anorexia community. The third research question (RQ3) assessed whether the online support group offered the components essential to an effective online anorexia recovery group based on the findings of Barak et al. (2008). Finally, the fourth research question (RQ4) investigated stigma management strategies discussed on the message board and compared them with strategies identified by Bos et al. (2013).

After analyzing the message board posts on the anorexia recovery site eating-disorder.supportgroups.com, it is clear that not only is recovery discussed in specific ways, but other topics are discussed on this online community as well. Additionally, there is evidence of Barak et al.'s (2008) criteria for an effective support community, and of the stigma management strategies discussed by Bos et al. (2013). Specific codes, categories, and ideologies are discussed below.

Definitions of Recovery (RQ1)

The first research question addressed in this study was focused on how members of an online anorexia recovery community talked about or discussed recovery. Overall, there were six ideologies identified from this online community members' discussion of recovery, including: (1) empowerment is important, (2) recovery takes time, but it is worth it, (3) take care of yourself, but accept help from others, (4) you *can* find a good doctor, (5) you *can* find good counseling and therapy, and (6) it is hard, but be hopeful. Ideologies, as identified by van Dijk

(1998) are "social systems of ideas, values or prescriptions of groups [and] have the function of organizing or legitimating the actions of the group" (p. 3). By analyzing the ideologies presented in reference to anorexia recovery, it becomes possible to develop an understanding inherent in the message board posts examined in the current study.

Empowerment is important. The first ideology highlighted is the importance of empowerment. The theme from which this ideology stems is actions and behaviors online community members feel they can do for their own recovery. Categories contributing to this theme include the basic needs for a person to start and continue or follow through with recovery. Community members often suggested ways other members can successfully start and continue their recovery. For example, subcategories such as "get help," "get better," "stay motivated," "work hard" contributed to both the categories of "start" and "continue." Community members referenced "*my getting help*" and "*I went to counseling*" when speaking of the ownership taken over their recovery. Further, statements such as, "*I stopped*" and "*I am capable of feeding myself*" contributed to the impression that members take control of their own improvement.

In terms of continuance, comments such as "*stay motivated*" and "*have a plan*" display how important it is to keep moving forward once recovery is started. In fact, several posts reiterated the importance that community members "*work hard*" and "*move forward*." Therefore, the overarching ideology of empowerment was apparent in the online community. All subcategories were derived from the line-by-line stage of coding, and taken directly from the message board posts. For examples, see Table 1.

Recovery takes time, but it is worth it. A second ideology present in this online community's discussion of recovery is that recovery is worth it, but not a speedy process. This ideology stems from the theme of recovery being a process that takes time. Comments such as

"*feeling better takes time*" were often shared and emphasized the idea that recovery does not happen quickly. Categories contributing to this ideology include "not an instant fix," "will work eventually," and "have to start somewhere." Community members often made comments that seemed to be directed at encouraging others to remain steadfast and committed to the process. One specific subcategory that contributed to this ideal is "feeling better takes time." Community members made comments like, "*in therapy for three years*," and, "*took months, not days*" to convey this sentiment. Other subcategories that are relevant include "taking the first step" and "healing continues." Posts such as, "*starting to heal*" and "*the first step*" emphasize the importance of the beginning of recovery. For examples, see Table 1.

Take care of yourself, but accept help from others. Third, an additional ideology stemming from discussion of recovery in an online community is that you should take care of yourself, but accept help from others as well. The overarching theme informing this ideology is actions and behaviors online community members feel they can do that are helpful. Community members listed many different concepts as helpful in message board posts, but these codes could generally be divided into help coming "from myself" and "from others." For example, help "from myself" would be something members could do for themselves, like reduce stress and set goals. Posts to the message boards such as "*get my energy up*" and "*building up vitamin wise*" contributed to the subcategory "healthy behavior," which is also something members could accomplish alone.

In contrast, some of the things considered helpful in this support community included other people. Indeed, help "from others" consisted of getting "social support from friends and family" and "getting professional help." Community members suggested that things such as, "*reaching out*" and "*telling my family*" helped them on the road to recovery. In addition,

members provided testimony of the beneficial experiences of "*being in counseling*" and "*going to a psychologist*." Such comments suggest that seeking help "from others" is a worthwhile endeavor. For examples, see Table 1.

You *can* find a good doctor. A fourth ideology found in these online community message board posts is that recovering anorexics are capable of finding a doctor good who is good for them. The main theme fueling this ideology is the characteristics of doctors and therapists. Categories contributing to this theme are "good" and "bad" characteristics. Qualities that community members considered important to "good" doctors included "helpful" and "approachable." Community members labeled their doctors as people who "*can work with you*," and are "*respect[ful] of my dosing suggestions*." In this way, "approachable" appeared to be a sought-after characteristic of a "good" doctor.

Conversely, the "bad" category consisted of one subcategory, which was "negatives." There were not many negatively-valenced comments used to describe doctors, though some were quite pointed. For example, some community members called their doctors "*useless*," "*wrong*," and "*chicken*." Other characteristics that community members deemed negative in relation to doctors is when they "*disagree with one another*" and "*talk in medical terms*." However, the overarching impression of doctors in this online recovery community is that they are positive, helpful additions to a recovery team. For examples, see Table 1.

You *can* find good counseling and therapy. The fifth ideology is the same as the fourth, but focuses on counseling and therapy instead of doctors specifically. The main theme that formed this ideology was the characteristics of counseling and therapy. Like the fourth theme, the categories that contributed to this theme were "good" and "bad" characteristics. In addition, characteristics that community members identified as positive about doctors were

similar to what they liked about counseling and therapy. Specifically, community members professed that counseling is "*helpful*," "*unique*," and "*challenging*."

Community members discussed counseling and therapy in various ways. Some called it "*private*," "*plentiful*," and "*safe*." Other members made more explicit references to counseling being helpful through comments such as, counseling "*helps you work through*" and that it "*works miracles for some*." In addition, "unique" characteristics of counseling were displayed when members discussed it as something to "*shop for*," "*find*," or "*look for*." It was clear that community members valued a specific choice of the most appropriate counseling for an individual; however, it was also clear that the same counselor was not necessarily right for everyone.

Finally, "challenging" contributed to the "good" category because it was sometimes discussed with positive valence, though it was also sometimes described as "*hard to get*" or even "*something to make it thru*." Community members discussed that counselors "*challenged me to get better*" and he "*pushed me*" through the process. While it might not be an easy journey, counseling/therapy was still deemed helpful in these ways. However, there are some negative components included in this category as well. For example, many community members complained that counseling is not affordable, or "*costs too much*." It was also discussed that counseling is something "*to quit*" when the situation becomes too difficult, but this decision was not supported by other community members.

Finally, the "bad" category regarding characteristics of counseling and therapy consisted of one subcategory, which was "offensive." Interestingly, there were not many negative descriptions of this aspect of recovery, and all codes and subcategories that made up the "bad" category are from one post from one member about one incident of therapy. At the meeting in

question, the doctor told this community member, an older woman, that anorexia is a "*teenager disease*" and that she should "*just grow out of it*." Other community members were shocked at this news and called this therapist "*offensive*" and "*wrong*." Though a powerful story, this incident only amounted to a small portion of all comments regarding the overall view of counseling and therapy. For examples, see Table 1.

It is hard, but be hopeful. One final ideology was derived from the theme of counseling/therapy present in this study's data. "It is hard, but be hopeful" is the ideology stemming from the theme, "characteristics of recovery" and/or "endurance." Indeed, a majority of all message board posts on this online recovery community were, in some way, directed at recovery. Categories that supported this theme include "it's not easy," "not always personal," and "it works." Comments representative of the subcategory "difficult" include discussing recovery as "*something to get past*," "*something to survive*," and that it is "*still a challenge*." Also supporting this subcategory are statements that recovery is "*hard*," "*really hard*," and "*not easy*."

Despite such a level of difficulty, many community members also talked about recovery as something that is "necessary" and deserves constant "forward progress." Comments that supported the "necessary" subcategory include remarks of desperation like, "*I really need help*." Also, comments regarding "forward progress" include "*edging a little closer*," and "*reaching out again*." Taken together, these subcategories suggest a sense of urgency and reinforce the ideology that recovery is hard, but community members should remain hopeful. For examples, see Table 1.

Tangential Topics Discussed (RQ2)

The second research question investigated in the current study was in relation to any seemingly tangential topics discussed on the online anorexia recovery community. Specifically, did community members discuss anything besides anorexia recovery, support, or stigma? The answer to this question is yes; many additional topics were discussed and they support further ideologies present in this community. Overall, there were six ideologies identified from community members' discussions of tangential topics, including: (1) connections are important, (2) it is important to stay healthy, (3) it is okay to express your worries, (4) faith is important, (5) information is important, and (6) fun is important. These ideologies are discussed in more detail below.

Connections are important. The first ideology stemming from tangential topics discussed is that in anorexia recovery, personal connections are important. Indeed, one of the main tangential topics incorporated into message board posts was an emphasis on the personal connections of the community members. These connections came in the form of people and things, which were the categories that informed this theme. Many types of "people" were discussed in this community, including "family," "significant others," and "friends." Indeed, community members discussed seemingly every member of their families, including, "*Mother*," "*Dad*," "*children*," "*brother*," "*sister*," and "*grandmother*." Family related topics were also discussed, such as "*marriage*" and "*parenting skills*." Family members were not the only source of personal connections, however. Significant others like "*boyfriend*" were also frequently mentioned. Finally, people that community members labeled as "*friends*" were often incorporated into discussions in this online community.

"People" were only one of the ways that community members talked about connections in their lives. Other "things" assisted with connection, including "pets" and "residence." Specifically, in a discussion of things that are comforting to those recovering from anorexia, many members began discussing their "pets." Dogs and some cats were credited for "*always being there*" and "*know[ing] when I'm upset*." One cat was described as lying next to the laptop a community member was using to contribute to the message board as she typed. Pets were not the only "things" referenced as comforting, however. Referring to a location where community members sit to contribute to the message board was one way they incorporated residences into the discussion. Also, many members mentioned "*home*" as a place involved in their recovery. For examples, see Table 2.

It is important to stay healthy. A second ideology that can be seen from data collected from this community is that staying healthy is important during anorexia recovery. The overarching theme of tangential topics discussed that constitute this ideology are "healthy habits." There were many ways that community members discussed staying healthy, including "food," "medicine," and "exercise." "Food" that members mentioned included "fruit" and "other," which was in reference to "*granola bars, crackers,*" and other snacks. Eating such foods was often suggested to other community members as something that would help them feel better. Similarly, "medicine" was also talked about as something that makes community members feel better. This category consisted of subcategories "general" and "specific." In the same way, the "exercise" category was made of subcategories "general" and "specific." For both of these categories, the subcategory "specific" was in reference to a medicine or exercise mentioned by name (e.g. "*Xanax*" or "*push-ups*"). For examples, see Table 2.

It is okay to express your worries. The next ideology inherent in the data collected for the current study is that it is acceptable to express worries in this community. The theme of tangential topics that supports this ideology was that of additional worries. The members of this online community worried about many things that are not specific to anorexia recovery, and the ideology. Types of worries discussed included "physical worries," "emotional/mental worries," "medical worries," and "external worries."

First, the category "physical worries" was made up of the subcategories "abuse" and "side effects." Topics mentioned such as "*sexual assault*" and "*losing a lot more hair*" were exemplary of this category.[1] Next, the "emotional/mental worries" category was informed by the subcategories "abuse," "trust," and "complicating disorders." Members discussed experiences with "*emotional abuse*" and other emotional/mental problems like "*PTSD*" and "*depression*." Again, emotional abuse was talked about frequently, giving the impression that many community members have experienced this problem.

The "medical worries" category consisted of subcategories "specific medicines" and "hospital." Community members talked about their experiences with medicines such as "*Xanax*" and "*morphine*" as part of their recovery. Also, a few members wanted to share their experiences about visiting the hospital and the "*E-room*." Hospital visits were described as a relatively common experience for most community members, though not always a voluntary choice. A final set of worries discussed in this online community included "external worries." Things external to recovery that were discussed on the message board included "media," "others' opinions," and "money."

[1] Sexual and physical abuse was brought up many more times in message board discussions than was any other anorexia complication.

In these tangential discussions, community members took issue with a very wide variety of topics. The members were especially aware of the pressure felt by the media and "*supermodels on tv*" to be extremely thin. Also, members worried about insurance and medical expenses, as well as other financial problems. In addition, there was a lengthy discussion in the posts wherein community members lamented the lack of education provided to warn middle and high school students about the dangers of anorexia. Finally, community members expressed stress they feel from work and college. For examples, see Table 2.

Faith is important. An additional ideology present in the message board data collected for the current study is that faith is an important component to anorexia recovery. Indeed, the theme of faith was often present in the members' posts. This theme included the categories "authority figures" and "actions." The "authority figures" category involved mentions of "God" and other "church leaders," which was in reference to leaders from varying faiths. Additionally, the "actions" category was made up of "prayer" and "saying mantras." Members offered to pray for each other in an effort to offer support and comfort. "*Pm [private message] me if you want me to pray for you*" was commonly offered after a community member explained a particular struggle. For examples, see Table 2.

Information is important. The next ideology displayed is that that having information is important to anorexia recovery. The theme present in this study's data that supports this ideology includes additional resources community members often consult. The resource theme was highlighted by two categories, "experts" and "accessible." The "experts" that community members mentioned were "philosophers," "practioners," and "classes." Specifically, one theory that a community member used to explain an experience was "*Friedemann Schulz von Thun's four ears*." Also, another member referenced Emile Durkheim's work as helpful to her.

Not all resources were scholarly, however. In fact, the "accessible" category incorporated information that community members can easily understand such as "print media" and "websites." The "print media" mentioned in this community was often a book that someone found inspirational like, "'*The Laughing Heart' by Charles Bukowski*." Also, newspaper articles that community members found relevant to the discussion were mentioned. Other references suggested in this community were websites members found helpful. Www.mediationoasis.com and Ehow.com were suggested to other community members. Also, one community member commented that the Facebook pages of the "National Eating Disorders" association and "Strong is pretty" are "*informative and inspirational*." For examples, see Table 2.

Fun is important. A final ideology demonstrated on this anorexia recovery online support community is that it is important to try to have fun while recovering from anorexia. This theme consisted of four categories, including "entertainment," "light-hearted," "activities," and "engaging." Things discussed related to "entertainment" included "music" and "movies." Community members mentioned specific artists "*Florence and the Machine*" and specific actors like "*Demi Levato*." The "light-hearted" category was informed by the subcategories "e-cards" and "humor." Discussions of "*comedians*" and "*laughter*" give the impression that community members are enjoying life. Similarly, the category of "activities" shows that members discuss "exercise" and "sex" as enjoyable. Finally, the "engaging" category was made up of "face-to-face" interactions community members have, such as "dating," and "online" interactions, like the online anorexia recovery community studied for this project. For examples, see Table 2.

Evidence of Effective Support Provided (RQ3)

In addition to examining how recovery was discussed in this online anorexia recovery community and the tangential topics mentioned therein, the current study was also interested in whether or not the forum constituted an effective support group. In order to determine whether the site was providing effective support, categories from Barak et al. (2008) were attended to and compared with the current study's data. These categories were identified through a review of the traits extant research has shown that effective online support communities have in common (Barak et al., 2008). The categories include: an opportunity to express thoughts through writing, express emotions, gather information, improve knowledge, develop interpersonal relationships, and cultivate better decision-making skills. These categories were used to determine if successful support was being provided in the community found at eating-disorder.supportgroups.com.

When applying these categories to the data analyzed in the online community, it was clear that some were fulfilled; however, others were not. While Barak et al. (2008) suggested a total of six categories, only four were represented in this study's data. There was nothing included in the message board posts that explicitly qualified as community members developing interpersonal relationships or cultivating better decision-making skills. However, two additional forms of support not included in Barak et al.'s (2008) typology were evident. Specifically, emotional support and esteem support were both identified in many posts. In addition, it was clear in members' posts that members considered direct mentions of support to be helpful. By analyzing how these categories were employed, their efficacy became clear, as did the ideologies expressed through their use. See Table 3 for a comparison of categories in Barak et al. (2008) and the findings of this study.

The following paragraphs highlight the ideologies present in this community that were reflective of an effective support group, including: (1) having a safe place to share and people to listen is important, (2) sharing empathy and appreciation is important, (3) good advice and information should be valued, (4) you need to improve knowledge through other people and resources, (5) getting and giving support is important, (6) getting and giving compliments is important, and (7) mentioning support directly is appropriate.

Having a safe place to share and people to listen is important. The first ideology present in the current study that points to the effectiveness of this community is that members feel having a safe place to share their thoughts, and people to listen, is important. The theme supporting this ideology follows Barak et al.'s (2008) characteristic of effective online communities that stipulates members' need to "express thoughts through writing." In fact, one common reason people join an online support group, regardless of the issue, is that they feel isolated or have no one else to talk to about their problems (Wright, 1999). Anorexia recovery communities are accessed many times for this reason; offline contacts do not understand the issue or do not want to be involved (Wright, 1999). Therefore, it was quite apparent that members took advantage of the opportunity to express thoughts via writing message board posts. Further, expressing thoughts through writing has been shown to be therapeutic by other researchers as well (Pennebaker, 1997). The overarching ideology behind community members' need to tell their stories and express their thoughts in the online community is that it is very important, and sometimes rare, to have a safe place to share thoughts and have people listen. Multiple categories contributed to this ideology, including the need for a place to talk, someone to talk with, and a place that is safe and accepting.

Something for which many community members expressed gratitude was that they had a place to talk. Though interacting through a message board community that allows members to literally type out their comments to others, community members repeatedly described their interactions as "*talk*." The interchanging of talking and writing in these descriptions is a clear example of the mixed modality of online communication. Certain characteristics of online communication are akin to writing (Baron, 1998; 2008; Baym, 2010). These include that the text is addressed to the recipient, it can easily be edited, and that interactants are separate when the message is transmitted. On the other hand, online communication also shares many characteristics with speech. Online communicators often use phonetic spelling, turn taking is involved, and rapid topic change often occurs (Baron, 1998; 2008; Baym, 2010). For these reasons, it is not surprising that when describing their interactions in the message board community, members described it as talking, rather than writing. However, because posting to the message board entails many characteristics of writing, members also experience the benefits of expressing their thoughts through writing.

Aside from enjoying the benefit of writing our their thoughts, community members also mentioned how comforting it is to have a safe place to talk, which suggests that other places may not be as safe as an anonymous online community. Additionally, community members discussed that being able to express thoughts in the online community was surprisingly helpful and/or beneficial. One member specifically commented, "*I didn't realize I had these things to express*." Another said, "*I never expected to share so much as I have online*."

Also, community members expressed in the message board posts that they appreciate that this online anorexia recovery community provided someone to talk with. Despite the fact that message board posts and responses are a form of asynchronous communication (Braithwaite et

al., 1999), comments made by community members give the impression they provide someone with whom it is possible to talk. Specifically, important qualities of people community members could talk with were that they are available, understanding, and open. Comments that suggested members are available to talk to each other include, "*I'm here if you want to talk*," "*you can talk to me if that would help*," and "*if you need support, feel free to message me*." Sending private messages between community members was also recommended many times. The abbreviation "*pm*" was used as jargon to signify a private message among members of the site.

Besides just being available, community members also valued that those with whom they could talk were understanding and open. One post identified the benefit of understanding plainly by saying, "*On SG [supportgroups.com], we reached out and found people with similar values and experiences*." Other comments expressing this quality included very direct comments like, "*I understand*" and "*I totally know what you mean*." When community members expressed their appreciation for others being open, it was often in the form of thanking others for sharing. "*Thanks to everyone who has contributed their thoughts and views*." Also, one member explained altruistic reasons for posting on the site, "*I hope it helps you to hear from others on this*." Clearly, both the value of expressing thoughts and having those thoughts "heard" by others is evident.

The quality of openness was considered above as a component of the category, "someone to talk with." In this way, openness by others is an important quality of an effective online support community. However, the ability for community members themselves to be open is considered as a component of the category, "an accepting [and safe] place." Because they felt free to express opinions, members of the community repeatedly expressed appreciation for the feeling of acceptance. While often calling the community "*a safe place to talk*," many expressed

thanks when members shared. "*Thanks for opening up, Shiney!*" Additionally, one community member showed appreciation through loyalty by saying, "*Since I joined this site, I'll never abandon it*."

Another way in which community members displayed appreciation of the safe place to talk were comments about the lack of judgment on the site. Community members labeled the website "*a place to vent without judgment*" and "*a place where if a person wants to express what they're feeling, they can*." Also, when discussing the controversial topic of suicide being selfish, one member commented, "*it's ok if you don't agree with me. I am not here to judge*." Finally, confessions such as "*I have never told ANYONE*" (emphasis in original) are evidence that members felt they truly could be open. For examples, see Table 4.

Sharing empathy and appreciation is important. A second ideology represented in this community is that expressing compassion towards, and appreciation for, others in the community is an important component of anorexia recovery. The theme supporting this ideology is another of Barak et al.'s (2008) criteria for an effective support community, which is ability members feel to "express emotions." Expressing emotion was a common practice on this online anorexia recovery community. Two categories derived from message board discussions informed this ideology, "sharing" and "compassion."

One way in which the importance of sharing was expressed is through showing relief after disclosing. The comment, "*I had to get this off my chest*" is demonstrative of relief felt by community members. In addition, other posts such as "*I just wanted to share this*" and "*I felt like getting something out*" add to this sense of necessity community members felt to share their emotions.

Though all types of sharing were important in this community, one specific emotion that was often shared is compassion. An important characteristic of online recovery communities is that they consist of others who share a similar experience (Wright, 2000). Therefore, the phrases, "*I'm sorry*" and "*I understand*" were often included in message board posts. In conveying how sorry they truly are for the various maladies of others, community members used phrases such as, "*I'm so so sorry you're feeling so incredibly unwell*" and "*Sorry to hear about the depression being so bad*." Equally prevalent as expressions of how sorry community members felt were expressions of how much they understand. Assurances similar to "*I know how you feel and I understand*" were commonly used to express understanding in this community. For examples, see Table 4.

Good advice and information should be valued. A third ideology connected to this community's effectiveness is that good advice and information is important during the anorexia recovery process. The theme supporting this ideology is "gather information," which is also drawn from Barak et al. (2008). Whereas the ability to express thoughts through writing and express emotions are outwardly focused qualities of an effective online support community, the ability to gather information from others is a more inwardly focused sign that an online support community is effective (Barak et al., 2008). Gathering information was a prevalent practice in the online community and is therefore reflective of an important ideology. Specifically, attempts to gather information by community members reflected an ideology that good advice and information are important in the anorexia recovery process and thus should be valued.

Indeed, characteristics of advice sought after and given in this online community include the receipt of good, solid advice about specific topics. Several members made comments such as, "*that's good advice*," confirming not only the quality of advice given, but how necessary it

seemed. One community member gave worth to a specific offer of advice by saying, "*That's something I should take to heart*." Also, members commented on the importance of available advice by both looking for and offering advice that is easily accessible. Perhaps the comment most representative of community members looking for attainable advice is, "*I'm here because I live in a small town so there is no real help available there*." In contrast, making support accessible to others was a very common practice. With message board posts such as "*I'm available all day every day*" and "*I'll offer my advice and support to anyone who needs it*," the feeling of available support permeated this online support group.

Finally, it was important, on this site, that advice be not only good and readily available, but specific as well. From specific artists and songs that are inspirational (e.g., "*Listen to Florence and the Machine*") to warnings against specific behavioral choices (e.g., "*Trust me when I say you'll regret it eventually*), specific advice abounded in this online anorexia support community. Perhaps the comment most indicative of how important specific advice is in this community reads, "*Don't even think about trying it. It is sooo much harder to resist once you have seen where it goes. I'm begging you – never start*."

Though occasionally in the form of serious warnings, advice was not the only type of information gathered in the online community. Additionally, specific information regarding healthy food and professional and/or official topics was also seen as important. Specifically, examples of healthy food were often given and/or sought. Items like water, milk, fruit, and crackers were listed as helpful and nutritious. Some posters went even further and shared specific information about healthy food: "*Anything in a wrapper is highly processed*" and "*Fake, highly processed food is addictive*." Along with sharing their own advice and information, community members often recommended seeking information through professional or other

official means. Getting "*checked out by your doctor*" was suggested whenever members had questions about the current status of their health. Specific websites, such as www.mediateionoasis.com were recommended, as was simply searching for more information. In a discussion of the best way to start recovery, one community member suggested to another to try to detox: "*Your liver is probably very toxic and needs a rest. So, educate yourself about healing your liver*." For examples, see Table 4.

You need to improve knowledge through other people and resources. A fourth ideology present in this community is that recovering anorexics need to improve knowledge through learning from other people and accessing resources. The theme supporting this ideology is "improve knowledge" and is a sign of a successful online community, which is a final characteristic of effective support groups highlighted by Barak et al. (2008). Message board posts consistently displayed that community members wanted to improve their knowledge generally from other community members, but they also wanted specific details.

In terms of learning from others, the improved knowledge came in personal and impersonal forms. For example, comments such as, "*I am sure I can learn from you*" and "*I have learned from you*" are indicative of the sentiment that other community members would be helpful in improving knowledge in a personal way. Also, some pieces of information were specifically attributed to community members, as this comment explains, "*this book was recommended to me by an SG [supportgroups.com] friend*."

Not all information was presented in a personal way, however. Occasionally, community members dispensed information in an impersonal way. Stand-alone statements such as, "*any question or concern?*" gave the impression that they might not be directed towards any one particular individual. Another such statement was, "*learned that a long time ago*." Both of these

statements are evidence of community members attempting to improve their own knowledge, or the knowledge of others. Despite such positive motivation, they still do not appear personalized or focused on a specific individual.

In addition, members in this community sometimes traded very specific knowledge in terms of healthy habits and additional sources that could be consulted. Information on healthy habits permeated message board discussions. Many comments such as, "*add more fruits to your diet*" and "*swimming is one of the best exercises*" served as reminders to maintain a healthy lifestyle though the recovery process. Other comments like, "*when we do not eat, our body lets us know by feeling funny*" and "*think of what it will do to your mental health*" acted as warnings against negative behavior that often accompanies anorexia.

Importantly, community members did not claim to know everything. An additional form of specificity used to improve knowledge was the many sources mentioned in this recovery community. Some sources named were directed at medical information. One community member in particular said, "*A couple of great websites: drberg.com and thepowertostop.com*" in an effort to spread information. Also, the book "*Beyond Codependency*" was a suggested source for helpful medical information. Additionally, some suggested information that was less medical and more focused on motivation for healing. One poster suggested that members check out "*a good little book aimed at helping the more gentle spirits*." Similarly, another mentioned, "*If you're on Facebook, I find these pages to be informative and inspirational: National Eating Disorder and strong is pretty*." Clearly, motivational information and medical information were treated as equally important on this online anorexia recovery community.

The list of characteristics of an effective online support community provided by Barak et al. (2008) proved very useful in determining the efficacy of this online community. However,

additional factors discovered in message board posts collected must also be attended to. Further comments not yet considered in this analysis were specific statements of social support. For examples, see Table 4.

Getting and giving support is important. An additional ideology present in the data collected for this study is that getting and giving support is important during anorexic recovery. Specifically, the first type of support identified in the message board posts was emotional support. Dakof and Taylor (1990) set forth a definition of emotional support: "being physically present and/or expressing concern, empathy, or affection" (p. 82). Clearly, communicating through an online support community negates the chance that community members will be able to provide emotional support by being physically present with other community members. Thankfully, the remaining components of this definition are very helpful, as evidence of concern, empathy, and affection was plentiful on this anorexia recovery community message board.

As Dakof and Taylor (1990) outline, concern was a primary component of emotional support. Community members indicated that they were available for others in need and expressed direct worry for others as a way to demonstrate concern. Statements such as, "*I'm here if you ever want to talk*" and "*If you need help, remember everyone here*" are representative of community members providing emotional support by being available and showing concern. Also, community members frequently revealed that they were worried for others with posts on the discussion board. Comments such as, "*I'm worried about you*" plainly expressed that members were worried about, and concerned for, one another. Other posts, like, "*talk to a friend*" and "*it'll be okay*" more implicitly suggest that community members are worried for one another.

Another component of emotional support, according to Dakof and Taylor (1990), is empathy. As emotional support, empathy was expressed as understanding and similarity. Comments such as "*people here truly understand*" and "*I know how you feel and I understand*" convey how important it is that other community members know that others can relate and understand. Some community members wanted to be more clear about how much the understanding means, with comments like, "*Feels so good knowing there are people on here who *really* understand* (emphasis in original)" and "*having someone who understands would be great*."

The other way in which empathy was shown in this online community was expressions of similarity. Community members mentioned things like, "*I feel the exact same way*" often in message board discussions. Further, other comments such as, "*we have a very similar story*" and "*I've had the same battles*" are also informative. These comments confirm that highlighting similarity is a way in which community members expressed emotional support.

A final component of emotional support is affection (Dakof & Taylor, 1990). In this online community, affection was expressed for other, specific community members, as well as for the online community as a whole, in some message board posts. One method that community members utilized to demonstrate affection is through statements of their importance. Saying things like, "*this is about you*" to others in crisis spread the feeling of self-importance. Also, comments such as, "*we have to be kind to ourselves first*" indirectly imply that the receiver should consider him- or herself important. Similarly, community members expressed affection by confirming that the members of the community are not only important, but also authentic. Statements including, "*Feel how caring and sincere this place is*" and "*It amazes me how kind*

people are on here as opposed to the real world" are evidence of community members creating a site comprised of authentic and important people.

Because members felt so important and authentic within this online community, many commented on the meaningfulness of the support. Members frequently recounted their appreciation for "*a kind word and a helping hand*" by expressing "*thanks to everyone who has supported me here!*" Others remarked that, "*you have many friends on here*" and wished community members well by saying, "*I hope this time is going by positively for you*." As a final example of how meaningful support was shared in this online community, one member commented, "*Without SupportGroups [supportgroups.com], I would be in a very dark and desolate place*." For examples, see Table 4.

Getting and giving compliments is important. Similar to the ideology highlighting the importance of getting and giving support, another ideology present is that getting and giving compliments is important in anorexia recovery. Thus, a second type of support identified in the message board posts of this online community included instances of esteem support. According to Cooke, Rossmann, McCubbin, and Patterson (1988), esteem support is "information which leads you to believe that you are valued and respected for who and what you are and what you do" (p. 212). In this online anorexia recovery community, esteem support was evident in community members' discussions that success is achievable, appreciation for the quality of support, and compliments provided to other members.

First, the sentiment that success is achievable is a component of esteem support as defined by Cooke et al. (1988) because it aligns with the idea that what community members are doing (i.e., trying to recover from anorexia) is respectable. This ideal was present through community members wishing each other good luck, sending each other positive affirmations, and

providing warnings to keep in mind. Specifically, esteem support came through wishes of good luck such as, "*I'm rooting for you!*" and "*best of luck*." Further, often after community members shared their story of struggling with anorexia, other members would respond in similar ways, but directed their comments specifically at one member. For example, "*Good luck, Fran!*" Other times, well wishes were more generalized to the entire site: "*Best of luck and strength everyone!*"

In addition to wishing good luck, community members often exchanged positive affirmations with each other. Similar to well wishes, some of the affirmations were directed at the entire online community. For example, "*We can all do this!*" is an encouragement of strength for everyone in the community. On the other hand, some affirmations were in direct response to one post, like, "*Seeing someone else so resolute helps me*" and "*you can do it*." Other forms of esteem support present in these affirmations include, "*I'm sure you will get to your goal*" and "*you will come out of this stronger*." All of these examples point to the sentiment that community members are respected for who they are and what they do (Cooke et al., 1988).

A final way that community members ensured one another that success is achievable was not quite as overt as the others. Specifically, these comments provided warnings to community members. In essence, these warnings signified that while success is achievable, there are pitfalls that need to be avoided. For example, one member warned, "*YOU CAN NOT TRICK YOUR BODY!!*" (emphasis in original) during a discussion of eating restrictions. Still another individual claimed, "*It's not that easy*." Through these warnings, community members again conveyed that others are respected for who they are, and therefore provided with esteem support.

Another way in which community members provided each other with esteem support is through showing appreciation. Appreciation was shared both for the people who provided support, as well as the information they shared. Blatant comments such as, "*Appreciation for all*

that you do here" made the meaning obvious – community members appreciate what others do for them. Other expressions of gratitude were slightly less obvious, but very common. Comments like, "*thanks guys, you are awesome!*" and "*Thanks so much*" were commonly added at the end of an advice or support exchange. Also, appreciation was shared for specific advice in comments like, "*Thank you! That is very powerful!*" In this way, esteem support was provided through validating the advice and the advice giver.

A final way esteem support was provided is through compliments exchanged on the message boards. Some of the compliments were directed at a community member's worth. For example, "*You made me feel so good about myself today*" communicates that it was the other community members who are given credit for another's good mood, thereby showing their value. Another community member shared, "*what is truly important is what is on the inside that counts [sic]*." Esteem support is definitely being exchanged though placing such value on another community member's "insides." Some compliments were about outward appearance, however. For example, "*You're beautiful – learn to believe it*." It is possible that compliments about a member's outward appearance have additional meaning in an anorexia recovery support group. For examples, see Table 4.

Mentioning support directly is appropriate. Though emotional and esteem support accounted for a great number of message board posts, it was not an exhaustive categorization. In fact, a final ideology related to the effectiveness of the community analyzed for the current study is that "mentioning support directly is appropriate" and community members should not feel ashamed. The theme supporting this ideology is "direct mentions of support." Indeed, many additional comments made on this online community's message board are direct, overt mentions of "support." Support is discussed in this online community in a variety of ways, including the

getting and giving of support. First, getting support was described in many forms, such as looking for and accepting support. Comments like, "*I really need help* ☹" and "*looking for support*" are clearly expressing a desire for getting support. Other comments, like, "*I'm always looking for people to make friends with*" are slightly less direct, yet still indicative of support seeking.

Seeking support is slightly different than accepting support, though the two are closely linked. Statements such as "*good job letting us support you*" may be indicative of an overall feeling that accepting support can sometimes be difficult. A final way that seeking support was evidenced in this online anorexia recovery community was in the appreciation community members expressed. For example, posts like, "*I know I wouldn't be here without all the encouraging words and support here*" exemplify how much getting support from this community means to members.

In contrast to getting support, giving support was also deemed important in this online community. Offering support often came through overt comments such as, "*Here is me, offering support*," "*I offer everyone my advice and support*," and, "*I hope I can be a source of support*." Other comments were not quite as overt. For example, "*Here to lend a hand to whoever needs to be heard or talked to*" implies support but does not say it outright. However, with all of these statements taken together, a clear ideology of the importance of getting and giving support in this online community is formed. Further, often times getting support was connected with giving support, through comments such as, "*We want to support other people and be supported*." For examples, see Table 4.

Stigma Management Strategies Used (RQ4)

The final research question (RQ4) considered in this study assessed how stigma is understood, managed, and negotiated by members of the online anorexia recovery community. To assist in answering this question, categories of stigma management set forth by Bos et al. (2013) were applied to collected data. The first cluster of stigma management strategies suggested by Bos et al. (2013) is focused on the specific stigmatized problem – the reason for the stigma. Problem-focused stigma management strategies can be used to target the self, the situation, or others. These strategies include selective self-disclosure, compensating during social situations, avoiding stigmatizing situations, affiliating with others afflicted with the same stigma, seeking support, and activism (Bos et al., 2013). The second cluster of stigma management strategies drawn from Bos et al. (2013) focuses on the emotions a stigmatized problem causes. Emotion-focused strategies are used to manage negative emotion caused by stigma. These strategies include downward social comparison, external attributions for the behavior of others, positive reappraisal of the stigma experience, distraction, and detaching from the stigmatized identity (Bos et al., 2013). By analyzing which stigma management strategies were chosen by online community members in this study, it becomes clear whether problem-focused or emotion-focused management strategies are deemed the most useful for managing stigma, as well as what ideologies support these choices. Overall, there were five ideologies identified from community members' discussions of stigma, including: (1) because of stigma, sometimes you have to avoid situations, (2) sharing with people who understand is helpful, (3) recovering anorexics are better than the others, (4) it is not all your fault, and (5) your anorexic self is not your real self.

Because of stigma, sometimes you have to avoid situations. The first ideology discussed on the message board in terms of stigma management is that sometimes, because of stigma, anorexics are forced to avoid certain situations. This is a problem-focused strategy, as identified by Bos et al. (2013). The theme supporting this ideology is "avoiding stigmatizing situations." Community members discussed avoiding specific people, or avoiding behaviors while in public in an effort to manage stigma. Specific people were reportedly avoided many times because they made community members uncomfortable. Specifically, one member posted, "*I've been avoiding most of the mean people and ignoring the rest*." Community members also discussed using this avoidance strategy because they were feeling scared or insecure. One member said, "*I'm scared people will know who I really am*." Another community member similarly remarked, "*If I don't feel skinny/pretty enough, then I avoid being around others*."

Avoiding specific people was not the only way avoidance was discussed in this community. Sometimes, avoiding the enactment of certain behaviors was enough to help to manage stigma. For example, one community member described feeling "*the constant need to hide my eating habits*." Another, when describing her changed behavior in public, said that sometimes disordered behaviors are "*difficult to get away with*." For examples, see Table 5.

Sharing with people who understand is helpful. A second ideology present in the message board data collected for the current study is that throughout anorexia recovery, sharing thoughts and emotions with others who understand is very helpful. The theme supporting this ideology is "affiliating with afflicted others" and is that final problem-focused stigma management strategy explicitly discussed on this message board. Specifically, one community member admitted, "*I'm here because it's hard for me to connect and reach others while I [am] away at school*." Another remarked, "*Since I joined this site, I'll never abandon it*." Clearly,

community members value the ability to discuss their stigma issues with others, and this is an effective management strategy. For examples, see Table 5.

Recovering anorexics are better than the others. A third ideology present in the message board posts collected for the current study is that community members believe those recovering from anorexia are better than others who have not struggled like they have. The theme supporting this ideology was "downward comparison" which was an emotion-focused strategy outlined by Bos et al. (2013). This strategy was used in one specific way by many community members and included members comparing themselves to "other girls." For example, comments such as, "*you are worth far more than those other girls*" exemplify the tactic of downward comparison in that they lift community members up by insulting others. Another commenter's post, "*just because other girls are thinner than you (or you think they're thinner than you) doesn't mean they're better than you*" highlights the fact that downward comparison can function with or without an accurate assessment of others. The ideology present here is that recovering anorexics are better than others. For examples, see Table 5.

It is not all your fault. Another ideology dealing with stigma management in this online recovery community is that recovering anorexics are not completely to blame for their problems. The theme supporting this ideology is "external attributions," which is an emotion-focused stigma management strategy (Bos et al., 2013). External attributions were used in regards to current problems and the outcomes they produce. First, in regards to blaming current problems on external factors, one community member remarked, "*Now as a result of the trauma of living with him and my own separate issues, I've been diagnosed with PTSD*." Similarly, another member confessed attributing problems to a less personal cause by saying, "*The media put the idea into your head that everyone who is normal should look and act just like the supermodels on*

tv."

Additionally, community members used external attribution strategies to attribute blame for outcomes of their disorder. One community member recounted the events of her difficulties with constipation and a trip to the emergency room in this way: "*The doctors and paramedics were all laughing about it. That's when I decided to end it*." From these examples, an ideology of the online anorexia recovery support community is clear. Community members do not feel that their anorexia is their own fault. For examples, see Table 5.

Your anorexic self is not your true self. A final ideology regarding stigma management strategies used in this online community is community members' anorexic selves are not their true selves. The theme supporting this ideology is "detaching" oneself from the stigmatized identity. Use of this strategy was evidenced by community members insisting to others that they "*be the real you*." Comments such as "*Don't try and be like other girls, try to be like yourself*" confirmed an ideology present in the community: Your anorexic self is not your real self. Another poster offered similar advice by saying, "*Accept yourself on the inside, then you'll be able to accept yourself on the outside as well*." This and other message board posts confirm that community members try to detach themselves from their anorexic identity. For examples, see Table 5.

Chapter Five: Discussion

The purpose of this study was to develop an understanding of the difficulties those living with anorexia experience while attempting recovery. To accomplish this goal, posts on an anorexia recovery online community were analyzed to see how recovering anorexics talk about recovery and other tangential topics. Additionally, this study compared traits of effective support communities identified by extant research (Barak et al., 2008) to attributes described by participants of the community studied in this research. Finally, evidence of how those recovering from anorexia discuss and utilize stigma management strategies was identified in the message board posts and compared to the strategies presented by Bos et al. (2013).

Results indicated that ideologies have been formed in this community and guide members' understandings and values regarding recovery, tangential topics, the community itself, and stigma management. These ideologies, or the ideas and values inherent in a group that help to organize its actions (van Dijk, 1998), shed light on how recovering anorexics understand the recovery process and all of its relevant dimensions. Illuminating the implications of such ideologies will not only build a deeper understanding of these complicated factors, but also allow comparison to previous findings and the ability to formulate theoretical and practical applications. The following discussion aligns with each research question guiding this study.

Definitions of Recovery (RQ1)

The first research question this study sought to answer was how the anorexia recovery process is discussed in an online anorexia recovery community. Extant research has revealed that anorexia is a complex disease, and those in the medical community have not reached consensus as to the causes and proper treatment measures (Alexander & Sangster, 2013; Baratta, 2011; Haas et al., 2011). Indeed, stakeholders as diverse as doctors, parents of those suffering,

and the patients themselves all seem to define and talk about anorexia recovery differently (Gremillion, 2003; Koski, 2013).

While doctors and therapists have the opportunity to express their opinions about how anorexia should be defined and treated through publication, this study sought to uncover how patients themselves discuss anorexia. In fact, after analyzing the message board posts in an online anorexia recovery community, it appears that defining what anorexia is, and which treatment is best, was not a huge priority for these community members. Instead, discussions on this message board focused on dealing with the process of recovery, the best ways of facilitating and nourishing relationships with others, and how to go about maintaining self-esteem. Occasionally, members offered warnings to other members against disordered eating habits or other harmful behaviors. However, in the data collected for the current study, precise definitions of anorexia were never mentioned. This ambivalence regarding a singular definition for anorexia recovery is echoed in a similar study of women with anorexia (Darcy et al., 2010). Though Darcy et al. (2010) used a face-to-face interview methodology, findings of the current study align with those of Darcy et al. (2010) in that recovery had many meanings, and for some participants, no definition at all.

Therefore, it is not surprising that participants did not talk about a singular definition of anorexia recovery. Instead, an analysis of how community members *discuss* anorexia and the recovery process proves more explanatory. The ideologies identified through the posts on the message board regarding recovery revealed that community members have a fairly clear picture of what is involved in recovering from anorexia. Specifically, they indicated that recovery is a difficult process that can work, but requires patients to be empowered and seek help from professionals.

Overall, it was clear from the message boards that community members understand anorexia recovery as a process that can be very difficult and takes time, but can ultimately produce positive results. Therefore, it seems that community members do not strive for a singular end goal that signifies recovery. Rather, members of this online support community value continued positive change, as well as an understanding that one bad day does not signify a departure from recovery, but a "*pot hole along the way*." This finding suggests that an online or offline anorexia recovery community needs to treat recovery as a *process* and not set up specific benchmarks that members need to achieve to be "recovered." For example, achieving a specific caloric intake may help an anorexic with recovery in the short-term, but addressing the potentially life-long process of recovery is essential for any long-term success.

Besides considering recovery to be a process that can be successful, members of this online community also described anorexia recovery as something that requires patients to be empowered and to take ownership of their recovery. Further, members of this community encouraged each other to accept help and advice from others around them. Some members discussed getting help from their family and friends. Others accepted help from doctors and therapists, and described this help as extremely fruitful. These findings are also similar to what extant research has found regarding recovery (e.g. Darcy et al., 2010; Tozzi et al., 2002). In fact, this study impacts our theoretical understanding of anorexia recovery in that it provides additional evidence that successful recovery combines motivation of the patient and outside help from caring others and doctors/therapists.

The juxtaposition of a community ideology that encourages members to accept responsibility for their own recovery, with a second ideology that encourages them to accept help from others, reiterates the complexity of recovering from this disease. Current findings suggest

that though they may find it difficult, some recovering anorexics do see accepting help from others as beneficial and necessary to their recovery. Therefore, a practical implication stemming from these results is that anyone trying to help someone recovering from anorexia who is resistant to going to therapy or seeing a counselor should know that interacting with others who are also going through the recovery process may yield a positive influence.

Tangential Topics Discussed (RQ2)

To answer the second research question, this study sought to uncover other tangential topics that were discussed in this message board community, apart from stigma, support, or recovery. Extant research (Baym, 1993) has indicated that in online communities, tangential topics are often introduced into the conversation and used as a way to create and support relationships. In this study, members of the online community discussed many topics extraneous to anorexia recovery, and the ideologies created through these discussions provide evidence that while recovering from anorexia, community members value other things than recovery alone. Specifically, community members placed importance on being connected in life, feeling free to express worries, staying healthy, staying informed, and having fun. Though these topics may seem inherently connected to recovery, because this study employed discourse analysis to identify discussions separate from stigma, support, and recovery, these topics were identified as tangential.

Results revealed that community members often mentioned connections in their lives, including people, pets, and places they live. Admittedly, instances when connections were mentioned were not always positive. Especially when referencing family members, particularly parents, community members often lamented about difficult situations they endured while growing up (e.g., physical and emotional abuse, drug dependency). However, many other

references to personal connections related to close family members or friends were discussed in extremely positive ways such as fond memories or current events. These statements confirm that maintaining relationships is considered helpful and important to recovering anorexics.

Along with other people, members were also connected to pets they own and places where they live. Community members often disclosed having a dog or cat on the message board, and others would respond in kind. Posters were able to find similarity and common ground through the shared experience of having pets. Also, the ability to care for those pets seemed to provide community members with a sense of satisfaction and purpose. During a discussion of what helps community members carry on, one said, "*I have a dog, and 4 cats (too many, I know, but that's another story). If it were not for my fur-babies, I would not be here. Who would take care of them?*" In fact, many members referenced their "*fur-babies*" and how important they are in their lives. Similarly, "*home*" and other places community members lived were referenced, many times as an important piece in the anorexia recovery puzzle.

The finding that members of the online anorexia community believe that it is important to stay connected to people and places in their lives suggests that recovering from anorexia may not be entirely different from recovering from other mental illnesses, especially regarding the isolation and confusion it brings, as well as the need for supportive family and friends (Alexander & Sangster, 2013; Bradshaw, Armour, & Roseborough, 2007). Indeed, some research (e.g., Alexander & Sangster, 2013) indicates that anorexia is considered by many to be a form of mental disorder. Additionally, members of the online community made references to anorexia as mental illness in comments such as, "*Sometimes the people closest to you find mental illness hard to accept*." Bradshaw et al. (2007) report connection with the community and connection with family and friends, as two essential ingredients to recovering from mental

illness. And, as noted, these themes were echoed in the current data. Therefore, it seems that treating anorexia as similar to other mental illnesses may be a successful road to recovery.

People and places with which community members remained connected were not the only tangential topics discussed in this message board community. Additionally, an important ideology evidenced is that it is acceptable for community members to share their worries on the site. Members' worries about physical and emotional abuse outweighed worries about trust and self-esteem, though those were shared as well. The prevalence with which these worries were shared suggests that the experience of abuse is closely tied with that of anorexia. Thus far, doctors and/or therapists have not identified a singular cause that leads someone to an eating disorder (Berkman et al., 2007). However, it is thought by some that uncontrollable factors in life, like being abused, may cause the afflicted to strain for control of at least one thing in life (Ellin, 2011). Many in this situation turn to manipulating their diet, which can quickly transform into an eating disorder (Baratta, 2011; Ellin, 2011). Perhaps this study's finding of a co-occurrence of anorexia concerns, coupled with physical and emotional abuse concerns, provides further evidence that the two are inextricably linked.

Extant research concerning mental illness and abuse has primarily focused on substance abuse in patients, not their experiences with physical or emotional abuse (e.g., Drake, Brunette, Mueser, & McHugo, 2004; Finfgeld, 2000). One study highlighted the benefits of having an online self-help community for those with mental illness hosted by a mental health professional (Hsiung, 2000), yet this study also focused on drug and alcohol abuse, not patients' experience with physical or emotional abuse. Therefore, a suggestion for future research stemming from the current study is to investigate how physical and emotional abuse affect patients with anorexia and other mental illnesses. Further, the link between physical/emotional abuse and anorexia

presented in the current study suggests a possible practical implication that any approach to anorexia treatment should include attention to complicating factors and psychological counseling for current or past abuse.

Besides staying connected to others and expressing worries, another topic that was prevalent in community members' posts were strategies and techniques for staying healthy. Given that recovering from anorexia was the overarching topic of this online community, discovering that members also discussed staying healthy seems slightly contradictive given their (past) unhealthy habits. If they had stayed healthy in the first place, they would not need this online community. However, it is possible that community members find common ground in the fact that they have all engaged in dangerous, unhealthy behaviors and are now all wishing to move forward with healthy choices. If that is the case, it is understandable that community members want to trade tips for healthy eating and exercising. It could also be that knowing the results of living out anorexia behaviors makes community members all the more intentional about staying healthy in the future.

Though many discussions of healthy habits present in this online community were simply innocuous suggestions, others were direct warnings against unhealthy choices and careful suggestions of how to avoid falling back into unhealthy behavior. Specifically, when some community members admitted their difficulties with healthy habits, others would rush to provide advice and tips to help them move forward. For example, one community member shared:

> *im feeling so sick. i often do cuz of my depression. i hate food. i often feel dizzy or sick just threw up. shaking, not from cold, just shaking. help. my head hurts, inside not out. my thoughts hurt. my heart hurts [sic].*

Nineteen replies quickly came from other members, all suggesting different ways to cope with such difficulties. One in particular exemplifies the type of healthy suggestions provided in this online anorexia recovery community: "*I had a recovery routine - I would start by sipping water, once that was ok I would sip gatorade. Next was chicken soup and then later jello.*" In this way, it is clear that by discussing the importance of staying healthy, community members keep each other on track and suggest ways to be successful. These findings further indicate that because community members are familiar with the difficult struggles of anorexia recovery, they do not want anyone to slip back into old habits.

This echoes the sentiment present in Bos et al.'s (2013) study that affiliating with others afflicted by the same disease is a useful way to manage difficulties and stigma. Indeed, members of this online community seemed to value and learn from the experiences of others, while simultaneously holding each other accountable. It is likely that the context of the online community analyzed for the current study has a large impact on this level of accountability and shared understanding. In fact, an expressed purpose of any community connected with supportgroups.com is to "help yourself while helping others." Therefore, such uplifting encouragement is to be expected from this community.

In addition to talking about staying healthy, the final tangential topics discussed on this message board highlight the importance of staying informed and having fun. Indeed, community members discussed specific ways to gather information, as well as ways that they could have fun. Placing importance on how and where to get information in an online recovery community is not surprising; community members have a specific goal to achieve, but do not necessarily have the professional expertise to achieve it alone. Therefore, members often shared resources they have found to be helpful with others who might benefit.

Less expected was that community members also discussed the importance of having fun through the recovery process. The ideology stemming from the inclusion of these tangential topics is that having fun remains important, despite the horrible circumstances community members might currently be experiencing. Possibly because recovering from anorexia is not a linear process with a clear, distinct finish line, keeping a lighthearted attitude whenever possible seems vitally important. By mentioning things they find enjoyable (e.g., specific music and movies) and introducing tangential topics to distract from the gravity of other discussions, members tried to help others by offering strategies so they could continue enjoying life.

Taken together, data referencing tangential topics discussed in this online anorexia recovery community support Baym's (1993) assertion that tangential topics are involved in online community members' conversations. Dennis et al. (2008) also uncovered similar findings when studying a face-to-face support group for breast cancer. While the women were all there to support one another and offer suggestions for how to deal with breast cancer, it was equally important for the group members to talk about issues unrelated to the disease, like things going on in the community (e.g., basketball) or upcoming events (e.g., holidays). Indeed, discussing tangential topics is a way to form connections between members (Baron, 1998; Baym, 1993; Dennis et al., 2008). Further, members' connection with one another is similar to Barak et al.'s (2008) assertion that interpersonal relationships are created and nourished in an effective online support community.

Evidence of Effective Support Provided (RQ3)

Discussions of recovery and tangential topics on this message board would not be meaningful if there were no qualities that other studies have found to be effective, which was the third research question assessed in this study. Thankfully, by comparing characteristics of this

community with those of communities that have proven successful (Barak et al., 2008), it is clear that the online community studied has qualities that match with those listed as effective or useful by extant research in many ways. In fact, because community members described the ability to express themselves on the message board, gather information, and receive and provide support, it seems that this community includes qualities that Barak et al. (2008) list as effective. For example, one community member said, "*I have found that people seem to get the support they need on here.*"

One main reason this online support community matches with qualities others have found useful (Barak et al., 2008) is that members were able to express themselves to others who have had shared their same experiences. As mentioned above, members of this online community seemed to benefit from the mixed modality of online communication, and feel that they have others to "talk" to, though they are actually writing out their thoughts on the message board (Baron, 1998, 2008; Baym, 2010). In addition to valuing the ability to share thoughts, members also expressed how important it was to have someone to listen to those thoughts. Statements such as, "*There are lots of people here who truly understand and know how important it is to have a safe place to talk!!*" demonstrate how important community members feel it is to be able to express their thoughts, and have people there to listen. Findings that community members placed so much importance on having a safe place to talk and were so thankful for someone to talk to, point to another potential side effect of anorexia: loneliness or isolation (Baratta, 2011; Bulik et al., 2000). This again suggests that, in addition to the physical aspects of anorexia recovery, a psychological and emotional component is also necessary.

Not only did community members benefit by expressing their thoughts to others with similar experiences, they also benefitted by the very act of writing out their thoughts and

emotions in this online community. In fact, expressing oneself through writing has been shown to provide many physiological and psychological benefits (Pennebaker, 1990, 1997; Pennebaker & Graybeal, 2001). While conducting an experiment regarding how therapeutic writing effects the immune system, Pennebaker (1990) found that "people who wrote about their deepest thoughts and feelings surrounding traumatic experiences evidenced heightened immune function compared with those who wrote about superficial topics" (p. 37). Because of such promising results, this methodology has successfully been applied as a tool to help patients cope with traumatic experiences and eating disorders (Brown & Heimberg, 2001; Frayne & Wade, 2006). Specifically, Brown and Heimberg's (2001) study demonstrated that after writing a personalized description of the trauma, victims of rape showed lower levels of dysphoria, social anxiety, and post-traumatic stress disorder. In addition, therapeutic writing has been shown to reduce the occurrence of eating disorder symptoms for patients suffering with anorexia and bulimia (East, Startup, Roberts, & Schmidt, 2010; Frayne & Wade, 2006).

While specific cause and effect data was not collected for the current study, results presented regarding characteristics of this community align with extant research on the benefits of writing for eating disorder patients. Members of this online community clearly appreciated having a place where they could express their problems through writing, and seemed to gain satisfaction and a sense of comfort through sharing their thoughts with others. Further, this study adds to our understanding of the mixed modality of online communities (Baron, 1998), as evidenced by community members' description of their interactions as talk, rather than writing or typing. Previous research has not investigated the effects of this mixed modality in online communities and future research could address whether community members see their discussions as talk because of the level of intimacy or self-disclosure involved.

Similarly, the idea of mixed modality is again relevant in that these results demonstrate the benefits of therapeutic writing can also be found with typing. Previous research shows that talking into a tape recorder has similar benefits to writing (or talking) out one's thoughts (Pennebaker, 1990, 1997). Results of the current study further suggest that typing a post to an online community can also be considered therapeutic thereby enhancing community traits that prior research (Barak et al., 2008) has found to be effective.

Another way that this online recovery community was similar to communities that prior studies have marked as effective is through the many ways community members were able to increase their knowledge of anorexia recovery by participating on the site. Community members traded information amongst themselves by sharing sources they had previously found useful. In the many discussions in which such practices occurred, it was clear how much they appreciated being able to talk with others who shared similar experiences. Sharing of information became more than just a trading of facts; it was a way to relate to, and connect with, other members.

A final way this support community is similar to those marked as effective by previous research (Wright, 1999) is that social support was abundantly present throughout the data. By providing support to one another, community members received the benefits of support giving and receiving. Emotional and esteem support were consistently exchanged between members, and everyone seemed to value and appreciate the support. Seeing actual evidence of requested and provided support again suggests that the online community studied in the current study may have elements of an effective support community, when compared to extant research (Barak et al., 2008).

These findings align with Wright's (1999, 2000) assertions that social support does not need to be exchanged face-to-face to be impactful. This is especially meaningful and important

for the anorexic that does not live in an area with available support nearby. Similarly, many anorexics are resistant to public engagements or have difficulty leaving their places of residence (Berkman et al., 2007). Therefore, online communities, like the one examined in the current study, are often the best option for many in need of support.

Stigma Management Strategies Used (RQ4)

The final research question addressed in this research attended to stigma management strategies discussed in this message board community. Managing stigma is a relevant component of recovering from anorexia because, as extant research has shown, anorexics suffer from specific stigmas that are different than those applied to patients afflicted with other mental illnesses (Crisafulli, Thompson-Brenner, Franko, Eddy, & Herzog, 2010; Stewart, Keel, & Schiavo, 2005). For example, when compared with a healthy individual, a person with asthma and a person with schizophrenia, participants in Stewart et al.'s (2005) study reported that a person with anorexia is the most to blame for his or her problems. Thus, data from Stewart et al. (2005) reflects a self-attribution and responsibility stigma associated with anorexia, but not other afflictions. Similarly, Crisafulli et al. (2010) demonstrated that participants who were shown a video explaining the causes of anorexia from a cultural standpoint stigmatized and blamed those with anorexia more so than participants who received a biological explanation of the disease. Such results highlight that misunderstandings surrounding anorexia feed into its stigmatization, further causing anorexics to struggle with stigma in unique ways.

For the present analysis, strategies discussed by community members were compared to the successful stigma management approaches outlined by Bos et al. (2013). In total, five management strategies were overtly discussed in the message board posts. Those strategies included: (1) avoiding stigmatizing situations, (2) affiliating with other afflicted individuals, (3)

downward comparison, (4) external attribution, and (5) detachment from the stigmatized identity. Bos et al. (2013) separated strategies into problem-focused and emotion-focused categories based on their emphasis.

The first problem-focused strategy directly referenced in this online community was avoiding stigmatizing situations. Community members discussed avoiding certain people to hide their stigmatized condition and changing their anorexic behaviors in public to avoid scrutiny. Avoiding select situations is especially pertinent for anorexics trying to avoid stigmatization because the enactment of anorexic practices almost always results in a recognizable change in physical appearance (Stewart et al., 2005). It is difficult, though not impossible, for anorexics to hide their condition when in public. Therefore, avoiding certain public situations is a natural choice to manage stigma, as has been noted in prior research (e.g., Rich, 2006). A second problem-focused strategy openly discussed was affiliating with other afflicted individuals. In this way, members expressed appreciation for others who truly understand their predicament. These strategies are considered problem-focused because they deal directly with the problem of displaying anorexic behaviors in public. Inevitably, questions and scrutiny arise whenever a stigmatized identity is enacted and the individual needs to find a way to manage these difficulties.

Aside from problem-focused strategies, community members also utilized emotion-focused strategies. Members openly used the downward comparison strategy by instructing others to not compare themselves to "*other girls*" and always believe they are just as good, or better, than "*the rest*." Also, events were often explained on the message board by using external attributions, which is another emotion-focused strategy highlighted by Bos et al. (2013). Many community members often blamed their problems on outside factors like physical abuse and bad

parenting. Indeed, external attributions were used to manage stigma in an effort to separate oneself from the stigmatized behaviors and ensuing emotional stress.

In this way, the current study extends applications of attribution theory as community members used external attributions to explain their anorexia and manage their stigma. For example, by blaming physical and/or emotional abuse for their eating disorder, community members attributed their anorexia to outside factors and not themselves. Prior studies have revealed that recovering from disordered eating is inherently linked to attributions used by patients to explain their disorder (Niederdeppe, Shapiro, & Porticella, 2011; Watt, Sharp, & Atkins, 2002). Specifically, Watt et al. (2002) found that many anorexics struggle with overly attributing their difficulties to internal causes and therefore have trouble with recovery because they blame themselves and do not feel worthy of recovery. The findings of the current study are in contrast to those of Watt et al. (2002) in that members of this online community used external attributions to understand and deal with their anorexia. Perhaps this is because these community members are already in the process of recovery and have reached a state where external attributions allow them to forgive themselves and move toward recovery, as previous studies have indicated (e.g., Crisafulli et al., 2010).

A final emotion-focused strategy explicitly mentioned was detaching from the stigmatized identity. Community members discussed how important it is to "*be the real you,*" which gives the impression that one's anorexic self is not their real self. Detaching from the stigmatized identity is a way to separate from any negative consequences arising from stigmatized behaviors (Bos et al., 2013). By doing this, recovering anorexics were able to continue moving forward and not be distracted by scrutiny from others. Anorexics are not the only individuals that engage in self-harming behaviors who seek to detach themselves from their

stigmatized identity. Specifically, those who engage in self-cutting frequently use this same stigma management strategy while engaging in negative behaviors (Hodgson, 2004). In her study of self-cutters, Hodgson (2004) reported that cutters detach themselves from their identity and are able to conceal the effects from others because they are no longer bothered by the consequences. The participants in her study no longer felt that the body they were cutting was their real self (Hodgson, 2004). In a more positive, yet similar way, anorexics that detach themselves from their disorder in an effort to manage stigma also do not feel that their disordered self is their real self. They are therefore able to separate themselves from the consequences of their choices and work towards recovery (Rich, 2006).

Not all of the stigma management strategies used in this community were discussed overtly in message board posts, however; some were inherent in the online community itself. In fact, three additional problem-focused strategies were implicitly involved in this online recovery community. First, one problem-focused way to handle stigma was through selective self-disclosure (Bos et al., 2013). Many message board posts were just that – community members sharing their personal story of anorexia recovery. However, because of the asynchronicity of online communities, members were able to be intentional and selective about everything they disclosed (Braithwaite et al., 1999). Therefore, posting to this message board can be seen as similar to effective ways for community members to manage stigma mentioned in prior studies.

A second problem-focused stigma management strategy implicitly employed was affiliating with others who are afflicted with the same stigma. While this affiliation was discussed overtly as well, the very act of joining this anorexia recovery community provides a way to stay in contact with others recovering from anorexia. Members often discussed how thankful they were to have people to talk to who understand their predicament. Additionally,

visitors to the website who are recovering anorexics could receive benefits of this stigma management strategy even if they did not ever contribute to the message board.

A final problem-focused stigma management strategy used implicitly in this community was seeking (and providing) social support. Simply joining a support group is a way to manage stigma because one has the potential to receive social support without even asking for it (Bos et al., 2013). Community members received support vicariously through other members and the questions they asked. Also, members were able to feel connected to each other through the similar experiences they shared on the message board. Members of the online recovery community often openly requested support, but the implicit, habitual exchange of support happening in the community was another way members managed their stigma.

Theoretical Implications

Besides confirming that social support can be delivered in an online context as extant research has revealed (e.g., Wright, 2000, 2003) and that stigma is managed through strategies similar to those suggested previously (Bos et al., 2013), this study's findings contribute to our understanding of the definition of anorexia, characteristics of an effective online support community, and how attribution theory can be practically applied in the case of anorexia. First, though many definitions of anorexia exist in the literature (e.g., Alexander & Sangster, 2013; Garrett, 1998), it is an emerging trend to understand the disease as multi-faceted, with a variety of instigating causes (Darcy et al., 2010). Findings of the current study, that recovery should be defined as a difficult process that can be successful, but requires patients to be empowered and seek help from professionals, echoes the need for a broad definition of anorexia that encompasses a wide array of experiences. Additionally, discussions on the message board

highlighted a need for anorexia recovery to include attention to psychological and emotional difficulties that may contribute to anorexic tendencies, such as physical and emotional abuse.

An additional theoretical contribution coming from the current study is related to qualities of an online support community that extant research has shown to be effective. Barak et al. (2008) provide six characteristics of other communities previously deemed effective and the community analyzed in the current study aligned with four of those. However, three additional characteristics could be added to further Barak et al.'s (2008) findings. Specifically, the provision of emotional and esteem support, as well as permission to directly mention support in the community without chastisement can be added as characteristics that may be effective in an online support community, as is suggested by previous studies (e.g., Wright, 2000).

A final theoretical contribution of the current study is an expanded conceptualization of attribution theory. Attribution theory seeks to explain how certain people understand the cause of events and the motivations involved (Heider, 1958; Weiner, 1986). As mentioned above, attribution theory has been linked to anorexia both in how patients understand their own disease (Watt et al., 2002) and how they manage stigma (Crisafulli et al., 2010). Findings from the current investigation further demonstrate the complex relationship between anorexia and attribution theory.

Practical Implications

Along with implications for theory, the findings of the current study also have practical implications. Specifically, this study's findings uncover suggestions for counselors and therapists trying to assist in anorexic recovery, as well as for anorexics themselves who are seeking recovery. In terms of how counselors and therapists could possibly make anorexia recovery more successful for patients, comments on the message board community suggest that

many who are suffering from anorexia are also suffering (or have suffered from) physical and/or emotional abuse. Therefore, an important component of any anorexia treatment program should include attention to psychological difficulties patients may be experiencing alongside their struggles with anorexia. Evidence of a comorbidity of eating disorders and depression already exists (Barretta & Barretta, 2013) which suggests that extraneous issues, like depression and abuse, need to be attended to during anorexia recovery. Treatment to address these issues could come in many forms, but a number of community members who expressed experiencing multiple problems concurrently, and extant research (Barretta & Barretta, 2013), suggests that a comprehensive treatment program will not be complete without attention to comorbid issues suffered by patients.

Also, because members in the online community were so insistent that recovery is a *process*, this study's findings suggest that setting specific benchmarks for recovery may not be an effective strategy for all anorexics. The data from this study points to the fact that some anorexics may take comfort in the idea that recovering from anorexia can be a long process with highs, lows, and occasional set-backs, but that they can still be successful. Therefore, counselors, therapists, doctors, and loved ones (or caring others) should seek to understand how an anorexic thinks about and understands recovery as much as possible to determine which tactic will be most effective. Some may respond to benchmarks positively and see them as motivational. Others, like members of the community in this study, are likely to be frustrated by benchmarks and will not respond well to this form of treatment.

A final suggestion this study provides for counselors and therapists, as well as loved ones and caring others, of individuals recovering from anorexia is that they need an environment in which they feel safe to express themselves. In fact, one of the characteristics of this online

community that members appreciated most was that it provided a safe place for them to talk with others who truly understand their situation. They made comments such as, "*There are some people here who . . . know how important it is to have a safe place to talk*" which suggests that such a place is hard to find. Therefore, counselors, therapists, and caring others should work to create a safe environment wherein recovering anorexics feel like they can express themselves openly.

Limitations and Future Research

First, the data analyzed in this study is limited by the fact that further probing into participants' perspectives was not possible. Indeed, because of the anonymous nature of message board communities, additional contact for interviews outside the message board was not feasible without soliciting further personal information from participants. Additionally, it was the perception of the researcher, and her advisors, that probing into the details of patients' struggles with anorexia could trigger a negative and dangerous response. Therefore, future inquiries might look to populations within a treatment center for potential interviews where, if participants were negatively triggered, help would be immediately available.

Further, as with any research conducted online, it is important to remember that the anonymity of an online message board obscures any possible certainty of community members' identity. Though it seems that many people contributed, with various screen names and profile photos present on the message board, it is possible that one individual posted under multiple screen names. Similarly, though the message board analyzed for the current study had 1,840 registered members at the point of analysis, it is likely that many do not post to the community, and only read others' posts. In addition, some may have joined the community at one time, but have since become uninvolved. Because of this, it is unclear exactly how many people received

the posted messages, or how many were affected by the discussions. This uncertainty makes it impossible to quantify the exact efficacy of the online support community studied. Future inquiries could measure the impact of participating in an online support community, in addition to other treatment options, to ascertain the effects of anonymous support for the anorexia recovery process.

Two final suggestions for future research encourage further investigation into the role of online, anonymous support in anorexia recovery. Specifically, the role of computer-mediated support groups could be assessed and compared with treatment programs that do not include this component. Questions such as whether people feel more free to ask for help in an anonymous context, such as an online message board, and if this enables faster recovery, deserve careful attention if this information can aid in patients' successful recovery. Similarly, an additional study could query whether or not all anorexia treatment programs should include an online component.

Summary and Conclusion

By investigating messages posted in the online anorexia recovery community eating-disorder.supportgroups.com, this study sought to gain an understanding of the experiences of those recovering from anorexia. The results of the current study indicate that recovering anorexics understand that recovery is a process that takes time, but that they can be successful if the proper effort and time is put into recovering. Also, community members discussed many tangential topics on this message board that serve to form ideologies in the community. These ideologies demonstrate that members of the community believe it is important to stay connected to the people and places surrounding them and to remain healthy. Ideologies also suggest that, in

this community, members should feel free to discuss their worries and how faith supports them while gathering information and remaining lighthearted.

In addition, it was confirmed that the community analyzed for the current project shares many characteristics with "effective" online support communities by comparing it to characteristics of other effective support communities (Barak et al., 2008). The data also revealed that stigma management strategies used by community members were consistent with strategies suggested by Bos et al. (2013). Finally, results indicated that recovering anorexics discuss both problem- and emotion-focused strategies for managing the stigma involved with anorexia.

Taken together, these results suggest what many already know – anorexia is a complex disease that is instigated and manifests differently for each patient. It is encouraging that new research on anorexia continues to be published, including new perspectives on what is or is not helpful treatment and support (e.g., Barretta & Barretta, 2013; Koski, 2013; Vandereycken & Vreckem, 2013), but a panacea has yet to be found. Therefore, final recommendations stemming from the current study are that treatment should be as individualized as possible, as should social support. The members of the community analyzed for the current project enjoyed many similar features in the support they received, but were also very specific about what they wanted. Though individualized support and treatment may be more expensive and time-consuming, it seems that if recovery can be achieved, resulting in a happy and healthy life for those suffering from anorexia, no price is too high.

References

Agras, W. S., & Kraemer, H. C. (1984). The treatment of anorexia nervosa: Do different treatments have different outcomes? *Research publications - Association for Research in Nervous and Mental Disease, 62*, 193-207.

Alexander, J., & Sangster, C. (2013). *Ed says U said: Eating disorder translator*. London: Jessica Kingsley.

Alexander, S. C., Peterson, J. L., & Hollingshead, B. (2003). Help is at your keyboard: Support groups on the Internet. In L. R. Frey (Ed.), *Group communication in context: Studies of bona fide groups* (2nd ed., pp. 309-334). Mahwah, NJ: Erlbaum.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. New York: American Psychiatric Association.

Anderson, A. E. (1985). *Practical comprehensive treatment of anorexia nervosa and bulimia*. Baltimore, MD: Johns Hopkins University Press.

Barak, A., Boniel-Nissim, M., & Suler J. (2008). Fostering empowerment in online support groups. *Computers in Human Behavior, 24*, 1867-1883.

Baratta, M. (2011). *Skinny revisited: Rethinking anorexia nervosa and its treatment*. Washington DC: NASW Press.

Barretta, N., & Barretta, P. F. (2013). Using hypnosis and metaphor in the treatment in comorbid depression and eating disorders. In M. D. Yapko (Ed.), *Hypnosis and treating depression: Applications in clinical practice* (pp. 163-187). New York: Taylor & Francis.

Barnes, M. K., & Duck, S. (1994). Everyday supportive contexts for social support. In B. R. Burleson, T. L. Albrecht, & I. G. Sarason (Eds.), *Communication of social support* (pp. 175-194). Thousand Oaks, CA: Sage.

Bardone-Cone, A. M., & Cass, K. M. (2006). Investigating the impact of pro-anorexia websites: a pilot study. *European Eating Disorders Review, 14*, 256-262.

Baron, N. (1998) Letters by phone or speech by other means: the linguistics of email. *Language and Communication, 18*, 133-170.

Baron, N. (2008). *Always on: Language in an online and mobile world*. New York: Oxford University Press.

Baym, N. K. (1993). Interpreting soap operas and creating community: Inside a computer-mediated fan culture. *Journal of Folklore Research, 30*, 143-176.

Baym, N. K. (2010). *Personal connections in the digital age*. Cambridge, MA: Polity.

Berkman, N. D., Lohr, K. N., & Bulik, C. M. (2007). Outcomes of eating disorders: A systematic review of the literature. *International Journal of Eating Disorders, 40*, 293–309.

Bippus, A. M. (2003). Humor motives, qualities, and reactions in recalled conflict episodes. *Western Journal of Communication, 67*, 13–27.

Bos, A. E. R., Pryor, J. D., Reeder, G. D., & Sarah E., S. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology, 35*, 1-9.

Bradshaw, W., Armour, M. P., & Roseborough, D. (2007). Finding a place in the world: The experience of recovery from severe mental illness. *Qualitative Social Work, 6*, 27-47.

Braithwaite, D. O., Waldron, V. R., & Finn, J. (1999). Communication of social support in computer-mediated groups for people with disabilities. *Health Communication, 11*, 123-151.

Brown, E. J., & Heimberg, R. G. (2001). Effects of writing about rape: Evaluating Pennebaker's paradigm with a severe trauma. *Journal of Traumatic Stress, 14*, 781-790.

Bulik, C. M., Sullivan, P. F., & Kendler, K. S. (2000). An empirical study of the classification of eating disorders. *American Journal of Psychiatry, 157*, 886-895.

Burleson, B. R., & MacGeorge, E. L. (2002). Supportive communication. In M. L. Knapp & J. A. Daly (Eds.), *Handbook of interpersonal communication* (pp. 374-424). Thousand Oaks, CA: Sage.

Burleson, B. R., Albrecht, T. L., Goldsmith, D. J., & Sarason, I. G. (1994). The communication of social support. In B. R. Burleson, T. L. Albrecht, & I. G. Sarason (Eds.), *Communication of social support* (pp. xi-xxx). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Cline, R. J. (1999). Communication within social support groups. In L. R. Frey, D. S. Gouran, & M. S. Poole (Eds.), *Handbook of group communication theory and research* (pp. 516 –538). Thousand Oaks, CA: Sage.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209–232.

Cooke, B. D., Rossmann, M. M., McCubbin, H. I., & Patterson, J. M. (1988). Examining the definition and assessment of social support: A resource for individuals and families. *Family Relations, 37*, 211-216.

Cooper, M. J. (2005). Cognitive theory in anorexia nervosa and bulimia nervosa: Progress, development and future directions. *Clinical Psychology Review, 25*, 511-531.

Crisafulli, M. A., Thompson-Brenner, H., Franko, D. L., Eddy, K. T., & Herzog D. B. (2010). Stigmatization of anorexia nervosa: Characteristics and response to intervention. *Journal of Social and Clinical Psychology, 29*, 759-770.

Cutrona, C. E., & Suhr, J. A. (1992). Controllability of stressful events and satisfaction with spouse support behaviors. *Communication Research, 19*, 154-174.

Custers, K., & Buick, J. V. d. (2009). Viewership of pro-anorexia websites in seventh, ninth and eleventh graders. *European Eating Disorders Review, 17*, 214-219.

Cutrona, C. E. (1996). *Social support in couples*. Thousand Oaks, CA: Sage.

Dakof, G. A., & Taylor, S. E. (1990). Victims' perceptions of social support: What is helpful from whom? *Journal of Personality and Social Psychology, 58*, 80-89.

Darcy, A. M., Katz, S., Fitzpatrick, K. K., Forsberg, S., Utzinger, L., & Lock, J. (2010). All better? How former anorexia nervosa patients define recovery and engaged in treatment. *European Eating Disorder Review, 18*, 260-270.

Deacon, H. (2006). Towards a sustainable theory of health-related stigma: Lessons from the HIV/AIDS literature. *Journal of Community & Applied Social Psychology, 16*, 418-425.

Dennis, M. R., Kunkel, A., & Keyton, J. (2008). Problematic integration theory, appraisal theory, and the Bosom Buddies breast cancer support group. *Journal of Applied Communication Research, 36*, 415-436.

Drake, R. E., Mueser, K. T., Brunette, M. F., & McHugo, G. J. (2004). A review of treatments for people with severe mental illness and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*, 360-374.

Dias, K. (2003). The ana sanctuary: Women's pro-anorexia narratives in cyberspace. *Journal of International Women's Studies, 4*, 31-45.

East, P. Startup, H. Roberts, C., & Schmidt, U. (2010). Expressive writing and eating disorder features: A preliminary trial in a student sample of the impact of three writing tasks on eating disorder symptoms and associated cognitive, affective and interpersonal factors. *European Eating Disorder Review, 18,* 180-196.

Eichhorn, K. C. (2008). Soliciting and providing social support over the internet: An investigation of online eating disorder support groups. *Journal of Computer-Mediated Communication, 14,* 67-78.

Ellin, A. (2011, April 25). In fighting anorexia, recovery is illusive. *The New York Times*, pp. D5.

Fichter, M. M., Herpertz, S., Quadflieg, N., & Herpertz-Dahlmann, B. (1998). Structured Interview for Anorexic and Bulimic Disorders for DSM-IV and ICD-10: Updated (3rd ed.). *International Journal of Eating Disorders, 24*, 227-249.

Finfegld, D. L. (2000). Therapeutic groups online: The good, the bad, and the unknown. *Issues in Mental Health Nursing, 21,* 241-255.

Fox, N., Ward, K., & O'Rourke, A. (2005). Pro-anorexia, weight-loss drugs and the internet: An 'anti-recovery' explanatory model of anorexia. *Sociology of Health & Illness, 27,* 944-971.

Frayne, A., & Wade, T. D. (2006). A comparison of written emotional expression and planning with respect to bulimic symptoms and associated psychopathology. *European Eating Disorder Review, 14,* 329-340.

Freewebs.com (2012). Oops! Retrieved from http://www.freewebs.com/worthless_one/

Garrett, C. (1998). *Beyond anorexia: Narrative, spirituality and recovery*. Cambridge, UK: Cambridge University Press.

Gavin, J., Rodham, K., & Poyer, H. (2008). The presentation of 'pro-anorexia' in online group interactions. *Qualitative Health Research, 18*, 325–333.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Goldkopf-Woodtke, M. (2001). Recovery. In B. P. Kinoy (Ed.), *Eating disorders: New directions in treatment and recovery* (2nd ed., pp. 159-177). New York: Columbia Press.

Gore, S. A., Vander Wal, J. S., & Thelen, M. H. Treatment of eating disorders in children and adolescents. In J. K. Thompson, & L. Smolak (Eds.), *Body image, eating disorders and obesity in youth: Assessment, prevention and treatment* (pp. 293-312). New York: Taylor & Francis.

Gremillion, H. (2003). *Feeding anorexia: Gender and power at a treatment center*. Durham, NC: Duke Press.

Haas, S. M., Irr, M. E., Jennings, N. A., Wagner, L. M. (2011). Communicating thin: A grounded model of online negative enabling support groups in the pro-anorexia movement. *New Media & Society, 13*, 40-57.

Heider, F. (1958). The psychology of interpersonal relations. New York: Wiley.

Hsiung, R. L. (2000). The best of both worlds: Online self-help group hosted by a mental health professional. *CyberPsychology & Behavior, 3*, 335-350.

Hodgson, S. (2004). Cutting through the silence: A sociological construction of self-injury. *Sociological Inquiry, 74*, 162–179.

Joffe, H. (1999). *Risk and 'the other.'* Cambridge, MA: Cambridge University Press.

Kaplan, A. S. (2002). Psychological treatments for anorexia nervosa a review of published studies and promising new directions. *Canadian Journal of Psychiatry, 47*, 235-243.

Keller, S., Rosenthal, L., & Rosenthal, P. (2005, May). *A comparison of pro-anorexia and treatment web sites: A look at the health belief and stages of change models online*. Paper presented at the meeting of International Communication Association conference, New York.

Kinoy, B. P. (Ed.). (2001). *Eating disorders: New directions in treatment and recovery* (2nd ed.). New York: Columbia.

Koski, J. P. (2013). 'I'm just a walking eating disorder': The mobilization and construction of a collective illness identity in eating disorder support groups. *Sociology of Health & Illness, xx*, 1-16.

Levenkron, S. (1982). *Treating and overcoming anorexia nervosa*. New York: Charles Scribner's Sons.

Lindlof, T. R., & Taylor, B. C. (2002). *Qualitative communication research methods* (2nd ed.). Thousand Oaks, CA: Sage.

Lukac, M. (2011). *Down to the bone: A corpus-based critical discourse analysis of pro-eating disorder blogs.* Zadar, Croatia: University of Zadar.

Lyons, E. J., Mehl, M. R., & Pennebaker, J. W. (2006). Pro-anorexics and recovering anorexics differ in their linguistic Internet self-presentation. *Journal of Psychosomatic Research, 60*, 253-256.

MacGeorge, E. L. (2001). Support providers' interaction goals: The influence of attributions and emotions. *Communication Monographs, 68,* 28–48.

Mancini, A., Daini, S., & Caruana, L. (Eds.). (2010). *Anorexia nervosa: A multi-disciplinary approach from biology to philosophy*. New York: Nova Science.

Manusov, V., & Spitzberg, B. (2008). Attribution theory. In L. Baxter & D. Braithwaite (Eds.), *Engaging theories in interpersonal communication: Multiple perspectives* (pp. 37-49). Thousand Oaks, CA: Sage.

Meisenbach, R. J. (2010). Stigma management communication: A theory and agenda for applied research on how individuals manage moments of stigmatized identity. *Journal of Applied Communication Research, 38,* 268-292.

Miles, M., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Moss, E. (1973). *Illness, immunity and social interaction*. New York: John Wiley.

National Eating Disorders Association. (2012). Facts and statistics. Retrieved from http://www.nationaleatingdisorders.org/information-resources/general-information.php#facts-statistics

Niederdeppe, J., Shapiro, M. A., & Porticella, N. (2011). Attributions of responsibility for obesity: Narrative communication reduces reactive counter-arguing among liberals. *Human Communication Research, 37,* 295-323.

Norris, M. L., Boydell, K. M., Pinhas, L., & Katzman, D. K. (2006). Ana and the internet: A review of pro-anorexia websites. *International Journal of Eating Disorders, 39,* 443-447.

Pennebaker, J. W. (1990). *Opening up: The healing power of expressing emotions.* New York: Guilford.

Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science, 8,* 162–166.

Pennebaker, J. W., & Graybeal, A. (2001). Patterns of natural language use: Disclosure, personality, and social integration. *Current Directions, 10,* 90–93.

Pryor, J. B., & Reeder, G. D. (2011). HIV-related stigma. In J. C. Hall, B. J. Hall, & C. J. Cockerell (Eds.), *HIV/AIDS in the Post-HAART Era: manifestations, treatment, and Epidemiology* (pp. 790–806). Shelton, CT: PMPH-USA.

Ranung, M. (2012). *Boy you thinspire me*. Huddinge, Sweden: Sodertorn University Press.

Rich, E. (2006). Anorexic dis(connection): Managing anorexia as an illness and an identity. *Sociology of Health and Illness, 28,* 284–305.

Shoham, S. (1970). *The mark of Cain: The stigma theory of crime and social deviation*. New York: Oceana Publications.

Spake, A. (2003, June 16). The science of slimming. *U.S. News and World Report, 134,* 21-27.

Smith, R. A. (2007). Language of the lost: An explication of stigma communication. *Communication Theory, 17,* 462-485.

Smith, R. A., & Hipper, T. J. (2010). Label management: Investigating how confidants encourage the use of communication strategies to avoid stigmatization. *Health Communication, 25,* 410-422.

Stern, S. R. (2000). *Making themselves known: Girls' www homepages as virtual vehicles for self-disclosure*. (Unpublished doctoral dissertation). School of Journalism and Mass Communication, University of North Carolina-Chapel Hill.

Stewart, M., Keel, P. K., & Schiavo, R. S. (2005). Stigmatization of anorexia nervosa. *International Journal of Eating Disorders, 39,* 320-325.

Sullivan, P. F. (1995). Mortality in anorexia nervosa. *American Journal of Psychiatry, 152*, 1073-1074.

TeenHelp. (2012). Anorexia Statistics. Retrieved from http://www.teenhelp.com/eating-disorders/anorexia-statistics.html

Tomaselli, K. P. (2008, May 5). Starving for perfection: The changing face of anorexia. *American Medical News*. Retrieved from amednews.com, December 4, 2010.

Tozzi, F., Sullivan, P. F., Fear, J. L., McKenzie, J. M., & Bulik, C. M. (2002). Causes and recovery in anorexia nervosa: The patient's perspective. *International Journal of Eating Disorders, 33*, 143–154.

United States National Library of Medicine. (2012). Anorexia nervosa. Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/000362.htm

van Dijk, T. A. (2003). Critical discourse analysis. In D. Schiffrin, D. Tannen, & H. E. Hamilton (Eds.). *The handbook of discourse analysis* (pp. 352–371). Oxford: Blackwell Publishing.

van Dijk, T. A. (1998). *Ideology: A multidisciplinary approach*. London: Sage.

van Dijk, T. A. (1995). The study of discourse. In T. A. Van Dijk (Ed.), *Discourse as structures and processes* (pp. 1–34). London: Sage.

Vandereycken, W., & Vreckem E. V. (2013). Siblings as co-patients and co-therapists in the treatment of eating disorders. In F. Boer & J. Dunn (Eds.), *Sibling relationships: Developmental and clinical issues* (pp. 109-123). New York: Taylor & Francis.

Watt, T. T., Sharp, S. F., & Atkins, L., (2002). Personal control and disordered eating patterns among college females. *Journal of Applied Social Psychology, 32*, 2502-2512.

Weiner, B. (1986). An attributional theory of motivation and emotion. New York: Springer-Verlag.

Winzelberg, A. (1997). The analysis of an electronic support group for individuals with eating disorders. *Computers in Human Behavior, 13*, 393-407.

Williams, S. E., Watts, T. K. O., & Wade, T. D. (2012). A review of the definitions of outcome used in the treatment of bulimia nervosa. *Clinical Psychology Review, 32*, 292-300.

World Health Organization (2007). *International statistical classification of diseases and related health problems 10th revision,* Anorexia Nervosa & Atypical Anorexia Nervosa F50.0 –50.1, Geneva, World Health Organization.

Wright, K. B. (1999). Computer-mediated support groups: An examination of relationships among social support, perceived stress, and coping strategies. *Communication Quarterly, 47*, 402– 414.

Wright, K. B. (2000). The communication of social support within an on-line community for older adults: A qualitative analysis of the SeniorNet community. *Qualitative Research Reports in Communication, 1*, 33– 43.

Wright, K. B., & Bell, S. B. (2003). Health related support groups on the Internet: Linking empirical findings to social support and computer-mediated communication theory. *Journal of Health Psychology, 8*, 39-54.

Yalom, I. D. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books.

Zipfel, S., Lowe, B., Reas, D. L., Deter, H., & Herzog, W. (2000). Long-term prognosis in anorexia nervosa: lessons from a 21-year follow-up study. *Lancet, 355*, 721-722.

Appendix A: Ana Creed

http://proanalifestyle.blogspot.com/2007/07/anas-creed.html

I believe in control, the only force mighty enough to bring order in the chaos that is my world.

I believe that I am the most vile, worthless an useless person ever have to existed on this planet, and that I am totally nonworthy [*sic*] of anyone's time and attention.

I believe in oughts, musts and shoulds, [*sic*] as unbreakable laws to determine my daily behavior.

I believe in perfection and strive to attain it.

I believe in salvation through starvation.

I believe in calorie counters as the inspired word of god, and memorize then accordingly.

I believe in bathroom scales as an indicator of my daily successes and failures.

I believe in hell, cause sometimes I think I live in it.

I believe in a wholly black and white world, the losing of weight, recrimination for sins, the alonegation [*sic*] of the body and a life ever fasting.

Appendix B: Tables

Table 1 – RQ1: Definitions of Recovery

IDEOLOGY	Theme	Categories	Examples
I. EMPOWERMENT IS IMPORTANT	Actions/Behaviors I Can Do For My Own Recovery	A. Start recovery B. Continue recovery	A. "*I am getting better by talking my meds and going to therapy*" A. "*you want to take responsibility for getting better*" B. "*I have a plan*" B. "*I am working towards recovery*"
II. RECOVERY TAKES TIME, BUT IT IS WORTH IT	Recovery Is A Process	A. Not an instant fix B. Have to start sometime C. Will work eventually	A. "*Feeling better takes time*" A. "*Things were better for years but recently I have been falling back into it*" B. "*You're taking the first step right now*" B. "*Get better*" C. "*The healing continues not without its potholes along the way*" C. "*It just keeps getting better*"
III. TAKE CARE OF YOURSELF, BUT ACCEPT HELP FROM OTHERS	Actions/Behaviors That Are Helpful	A. From myself B. From others	A. "*Eating crackers and fruit help get my energy up*" A. "*If I work hard now no one will be able to take it away from me*" B. "*Telling my family was really helpful*" B. "*Seeing a counselor*"
IV. YOU *CAN* FIND A GOOD DOCTOR	Characteristics of Doctors/Therapists	A. Good B. Bad	A. "*In the end I found a good doc, therapist and a group that could actually understand me and what i was going through*" A. "*It's a good thing I found a place to get help because life doesn't stop happening*" B. "*She's the chicken kind whose scared to stand up for my family/to my family*" B. "*My therapist is threatening a treatment program*"
V. YOU *CAN* FIND GOOD COUNSELING AND THERAPY	Characteristics of Counseling/Therapy	A. Good B Bad	A. "*Counseling helped enormously*" A. "*Sounds like you're shopping around for a dr and therapy*" B. "*I went to a psychologist a couple months back and was told that this is a teenager disease and I need to just grow out of it and eat*"
VI. IT IS HARD, BUT BE HOPEFUL	Characteristics of Recovery – Endurance	A. It is not easy B. It works	A. "*That was really hard*" A. "*I'm working on this through therapy and with the help of some very close people, but it's still a challenge*" B. "*This approach is working for me*" B. "*As for taking a step forward in diverting a flare up, you go girl*"

Table 2 – RQ2: Tangential Topics Discussed

IDEOLOGY	Theme	Categories	Examples
I. CONNECTIONS ARE IMPORTANT	Personal Connections	A. People B. Things	A. "*I am happy for others who have good relationships with their parents and I wish it could have been that way for me*" A. "*My husband is a great guy, staying with me through all the ups and downs*" B. "*That the only thing keeping me here was my fur-babies"* B. "*Sometimes home is the safest place you can be*"
II. IT IS IMPORTANT TO STAY HEALTHY	Healthy Habits	A. Food B. Medicine C. Exercise	A. "*eat something small, a few grapes, a stick of celery, a carrot*" B. "*I have taken Xanax in the past*" C. "*swimming is one of the best exercises you can do*"
III. IT IS OKAY TO EXPRESS YOUR WORRIES	Additional Worries	A. Physical worries B. Emotional/mental worries C. Medical worries D. External worries	A. "*My 26 year old cousin sexually assaulted me when I was 13. Then when I was 14, my mother married her 4th husband who sexually molested me for about a year right under her nose*" B. "*I have trust issues because some of the same people who claimed to be my friends used and abused me. They either robbed me blind of my money, or sexually and emotionally abused me"* C. *I was on huge amounts of pain killers (Morphine). My body was breaking down, the event that actually made me get serious about doing myself in, was a trip to the hospital E-room with major constipation*" D. "*media put the idea into your head that everyone who is normal should look and act just like the supermodels on tv, and that they are the image of perfection*"
IV. FAITH IS IMPORTANT	Faith	A. Authority figures B. Actions	A. "*our faith in God is another source of help*" A. "*Perhaps there is a Chaplain or Counselor on campus you can confide in*" B. "*Mantras keep you calm and relaxed so your meditations or prayers are deeper and more fulfilling*"
V. INFORMATION IS IMPORTANT	Resources	A. Experts B. Accessible	A. "*Sociologist Emile Durkheim believed that suicide wasn't a failure for the person who committed it, rather it was a failure of society*" B. "*I use self-help books as whatever I have access to*"
VI. FUN IS IMPORTANT	Fun	A. Entertainment B. Light hearted C. Activities D. Engaging with others	A. "*I like movies or music*" B. "*He laughed. I laughed. It was good*" C. "*Exercise helps*" C. "*It's amazing that I've ever been able to enjoy sex...*" D. "*My cats are my lifelines. As a matter of fact, as I type on my laptop, one in curled up right next to me, as if he is cuddling next to me*"

Table 3 – Qualities of Effective Support Communities

from Barak et al. (2008)	from Current Study
Ability to express thoughts through writing	Ability to express thoughts through writing
Express emotions	Express emotions
Gather information	Gather information
Improve knowledge	Improve knowledge
Develop interpersonal relationships	----------
Cultivate better decision-making skills	----------
	Emotional support
	Esteem support
	Direct mentions of support

Table 4 – RQ3: Evidence of Effective Support Provided

IDEOLOGY	Theme	Categories	Examples
I. HAVING A SAFE PLACE TO SHARE AND PEOPLE TO LISTEN IS IMPORTANT	Express Thoughts Through Writing	A. A place to talk B. Someone to talk with C. A safe place	A. "*It's good to have a place to go to and talk and blow off some steam*" B. "*I'm here if you want to talk*" C. "*some people - myself included - are more apt to send a message offering a place to vent without judgment*"
II. SHARING EMPATHY AND APPRECIATION IS IMPORTANT	Express Emotions	A. Sharing B. Compassion C. Thank you	A. "*Well I just wanted to share this*" B. "*I'm having so much trouble coping with - everything right now and having someone who understands would be great*" C. "*I appreciate your compliment*"
III. GOOD ADVICE AND INFORMATION SHOULD BE VALUED	Gather Information	A. Advice B. Information	A. "*Good advice, ethos. That's something I should take to heart...*" B. "*You can always fill up on healthy foods and add more fruits and veggies to your diet and they're better for you too*"
IV. YOU NEED TO IMPROVE KNOWLEDGE THROUGH OTHER PEOPLE AND RESOURCES	Improve Knowledge	A. Learn from others B. Specifics	A. "*the more often you learn to do it, the more light there will be*" B. "*When you exercise, the body needs as much protein and fuel as it can get because your muscles need it*"
V. GETTING AND GIVING SUPPORT IS IMPORTANT	Emotional Support	A. Concern B. Empathy C. Affection	A. "*We are always here and available to help you*" B. "*I know how you feel and I understand*" C. "*Thanks for your message ☺*"
VI. GETTING AND GIVING COMPLIMENTS IS IMPORTANT	Esteem Support	A. Success is achievable B. Appreciation C. Compliments	A. "*you can do it. dont think, just eat. if you start feeling guilty or sick, just do something to take your mind off it. (easier said than done, i know) im rooting for you :) [sic]*" B. "*Thanks soo much!!!!!!!!! U made me feel good about myself today*" C. "*Have a great day, beautiful*"
VII. MENTIONING SUPPORT DIRECTLY IS APPROPRIATE	Direct Mentions of Support	A. Getting B. Giving	A. "*Most people get the support they need here*" B. "*Here is me, offering support*"

Table 5 – RQ4: Stigma Management Strategies Used

IDEOLOGY	Theme	Categories	Examples
I. BECAUSE OF STIGMA, SOMETIMES YOU HAVE TO AVOID SITUATIONS	Avoiding Stigmatizing Situations	A. Avoiding people B. Changing habits in public	A. "*I cannot sit and trust. I'm not comfortable in public*" A. "*I've been avoiding most of the mean people and ignoring the rest*" B. "*The constant need to hide my eating habits made it hard for me to connect and reach other[s]*" B. "*i have two other girls living in the room with me, so it will still be difficult to get away with*"
II. SHARING WITH PEOPLE WHO UNDERSTAND IS HELPFUL	Affiliating With Others Afflicted	A. Participating on the site	A. "*Hard for me to connect and reach others while I've been away at school*" A. "*looking forward to others replies, as i'm sure i can learn from them, just as i learn from you.....*"
III. RECOVERING ANOREXICS ARE BETTER THAN THE OTHERS	Downward Comparison	A. Comparison to other girls	A. "*You are worth far more than those other girls*" A. "*So I don't look at others and want to be like them. That is an unrealistic goal. I look in the mirror and see where I can improve*"
IV. IT IS NOT ALL YOUR FAULT	External Attributions	A. Blaming current problems on other factors B. Blaming outcomes on other factors	A. "*Now as a result of the trauma of living with him and my own separate issues, I've been diagnosed with PTSD*" B. "*The doctors and paramedics were all laughing about it. That's when I decided to end it*"
V. YOUR ANOREXIC SELF IS NOT YOUR REAL SELF	Detaching	A. Be the real you	A. "*Don't try and be like other girls, try to be like yourself, the real you*"