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How do the discussion forums of online alcohol support groups affect users' understanding of problem drinking?

By:

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Abstract

Background: Problem drinking remains a significant problem in British society and internationally (World Health Organisation, 2018a), with hospital admissions continuing to rise in the UK. Meanwhile, much has been written about the importance of ordinary (non-medical) people's beliefs about an illness or problem (their 'representation' of it). Research has shown how these beliefs can strongly affect what people decide to do about an issue, and therefore its health and social outcomes. It is, therefore, important to understand lay beliefs and where these come from, in order to work well with them.

Objectives: This research explores the representations of users of six alcohol online support groups (AOSGs), looking at whether, and how, the discussion forums of these groups have influenced them. It focuses only on non-12-step groups, i.e., those which do not follow the 12-step programme for recovery of Alcoholics Anonymous (AA). The thesis explores the information behaviours used in the forums which contribute to creating the impacts.

Methods: The research is a cross-sectional, multi-method qualitative study, consisting of thematic analysis of 1500 texts from three purposively chosen non-12-step AOSGs, followed by semi-structured interviews with 22 users of five such groups. The study uses Leventhal and colleagues Common Sense Theory of Illness Representations (1984) to analyse user beliefs.

Results: The findings showed that these discussion forums did impact upon user representations. They allowed users a space where they could be free to develop their own individual model of problem drinking, in contrast to AA. Secondly, they could impact on specific aspects of beliefs in a variety of ways. Thirdly, they had a powerful holistic effect on users' overall views of problem drinking and themselves-as-drinker, through helping them to find others like themselves, so reducing self-stigma. A new model of the role of information behaviours in the development of representations within these discussion forums is presented.

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Declaration

I, the author, Sally Sanger, confirm that the thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (www.sheffield.ac.uk/ssid/unfair-means). This work has not been previously presented for an award at this, or any other, university.

Refereed publications arising from this work

Sanger, S., Bath, P.A., & Bates, J. (2018). The Role of Stories in Three Non-12 Step Alcohol Online Support Groups. In: Chowdhury, G., McLeod, J., Gillet, V., & Willett, P. (eds). Transforming Digital Worlds. iConference 2018. *Lecture Notes in Computer Science*, 10766, 126-131. https://doi.org/10.1007/978-3-319-78105-1_16

Samuel G., Ahmed W., Kara H., Jessop C., Quinton S. & Sanger S. (2018). Is It Time to Re-Evaluate the Ethics Governance of Social Media Research? *Journal of Empirical Research on Human Research Ethics*, 13(4), 452–454. DOI: 10.1177/1556264618793773

Sanger, S., Bath, P.A., & Bates, J. (2019). 'Berrypicking' in the formation of ideas about problem drinking amongst users of alcohol online support groups. In: Taylor, N.G., Christian-Lamb, C., Martin, M.H., & Nardi, B. (eds). Information in Contemporary Society. IConference 2019. *Lecture Notes in Computer Science*, 11420, 806-816. https://doi.org/10.1007/978-3-030-15742-5_76

Sanger, S., Bath, P.A., & Bates, J. (2019). 'Someone like me': user experiences of the discussion forums of non-12-step alcohol online support groups. *Addictive Behaviors*, 98. 106028. https://doi.org/10.1016/j.addbeh.2019.106028

Sanger, S., Bath, P.A., Bates J. (2020). The sustainability of non-12-step alcohol online support groups: views from group users. *Proceedings of 18th International Symposium for Health Information Management Research (ISHIMR 2020)*, 131-140; ISBN: 978-91-89081-09-3. Chosen by the ISHIMR Committee for submission to a special edition of the *Health Informatics Journal.*

Chapter 1: Introduction

1.1 Introduction

Problem drinking remains a significant problem in British society and internationally (World Health Organisation [WHO], 2018a), with hospital admissions continuing to rise in the UK, and the cost to the economy estimated at £47 billion in 2016. Although some harmful aspects of it appear to be slowly reducing in the UK, notably amongst younger age groups, the situation is still of great concern. See Section 1.2.1 for further discussion of this).

Users' own 'representations', or beliefs about an illness or problem, have been shown to have significant impacts on its management and outcomes. This appears intuitive: for example, if something is not seen as an issue, it is unlikely to be addressed, and therefore its outcomes may be poor. This, in turn, raises questions about where these beliefs originate and develop. In terms of problem drinking, peer support has long been recognised as a powerful aid to recovery. It can be accessed via support groups both off- and on-line, and these groups are also recognised as important sources of information. The question then arises as to whether these groups affect their users' representations of problematic drinking, and, if so, how they do this. The research described in this thesis, firstly, explores how the discussion forums of a particular group of alcohol online support groups (AOSGs), called 'non-12-step groups', can impact upon their users' understanding of what it means to be a problem drinker. Non-12-step groups are those that do not follow the 12-step programme for recovery of Alcoholics Anonymous [AA]: they form a significant body of AOSGs that remain under-researched. Secondly, the thesis examines the information behaviours found in the forums which contribute to these impacts.

This chapter continues in Section 1.2 by further discussing the key concepts of 'problem drinking', 'representations' 'information behaviour' and 'online support groups' to set the scene. The research aims and objectives are then stated in Section 1.3, and the rationale for undertaking the study is given in Section 1.4. Section 1.5 describes some key assumptions underlying the thesis. Section 1.6 concludes the chapter with a brief summary and introduces the literature review (Chapter 2).

1.2 Key concepts

1.2.1 Problem drinking

There is no single unanimously accepted definition for 'problem drinking': it has, for example, in the past been seen as a moral issue or character flaw, a habit, a form of self-medication, an illness or as caused by social and environmental factors (Nicholls, 2009; Copoeru, 2014; Pickard, Ahmed & Foddy, 2016). Even within these general categories there are different specific explanations. These are further discussed in Section 2.4 but, for example, in terms of the category 'illness', problem drinking has been seen as an allergy, a disease of the brain, a neurological abnormality, a mental illness or the consequence of a particular endorphin system, amongst other things. There are also many names for the issue including 'problem drinking', 'alcoholism', 'alcohol addiction' and 'Alcohol Use Disorder' (AUD). The term chosen for use in this study is 'problem drinking', and it is used to indicate any form of problematic drinking of alcohol. This allows for the inclusion of problem drinking when it is seen as something other than a health issue (unlike Alcohol Use Disorder which is a clinical diagnostic term). 'Alcohol addiction' and especially 'alcoholism' are viewed as unhelpful and stigmatising terms by many, including the participants in this research and the researcher, and were therefore avoided (there is further discussion of this in Section 3.7.1). 'Problem drinking' is inclusive and avoids the requirement to engage in judgements about distinctions between different types of drinker, which are not appropriate here. In short, this research takes a person-centred approach, where 'problem drinking' signifies alcohol drinking that has become problematic for the individual to such an extent that they are seeking information and support to deal with it.

The revised national guidelines for alcohol consumption state that there is no completely safe level of drinking, partly due to relatively new-found links between drinking and many cancers (Department of Health, 2016). Alcohol is the largest risk factor for illness, disability and death amongst 15-49 year olds in the UK (Alcohol Change UK, 2021, citing an evidence review of 2016). It has been identified as a causal factor in more than 60 health conditions including heart disease, stroke, liver disease, high blood pressure, pancreatitis and mental health disorders such as depression (Health and Social Care Information Centre [HSCIC], 2014; Alcohol Change UK, 2021). The National Institute for Health and Care Excellence [NICE] guidelines NG16 (2015) on preventing dementia, disability and frailty state that high alcohol consumption can also increase the risk of these conditions. Alcohol is implicated in many injuries and accidents, including 8,700 drink/drive casualties in the UK in 2018 (Alcohol Change UK, 2021). It is a factor in much crime and is a cause of lost business productivity in terms of causing non-attendance and under-performance at work (see Table 1.1). In 2016, the total direct and indirect costs of problem drinking to the UK was estimated to

be £47 billion, with 13% of this being healthcare costs, including £3 billion to the NHS (Public Health England, 2016). The human costs of problem drinking to families and individuals are very significant, as it can lead to family disruption and breakdown, domestic violence, neglect of children, unemployment, financial, social and health problems. A recent report on alcohol harms by the Commission on Alcohol Harm recommended that "the UK Government must introduce a new alcohol strategy as part of the COVID-19 national recovery plans" (2020, p10). See Table 1.1 below for evidence of increases and decreases in harms over the last few years.

Table 1.1: Alcohol issues

Problem	Date of statistic	Figures	Source
Binge drinking in England (> 8 units in a day for men, >6 units for women)	2018	Men: reduced by 5% since 2006 Women: reduced by 4% since 2006	NHS Digital, 2020
Drinking at levels of increased and higher risk to health (>14 units per week) in England	2019	Varies with age group. Commonest amongst adults 55-64 (38% of male and 19% of female drinkers)	NHS Digital, 2020
Number of hospital admissions related to alcohol in England	2018-19	1.3m Increased by 8% from 2017/18	NHS Digital, 2020 Alcohol Health Alliance UK, 2020
Hospital admissions among over-65s for alcohol-related conditions in England	2016	14% increase since 2008	Public Health England, 2019, cited in Alcohol Change UK, 2021
Hospital admissions amongst under-18s for alcohol-related conditions in England	Between 2008-2016	54% decrease since 2008	Public Health England, 2019, cited in Alcohol Change UK, 2021
Alcohol-specific deaths (directly attributable) in England	2018	5,698 Reduced by 2% from 2017 but increased by 7% since 2008	NHS Digital, 2020
Prescriptions issued to treat problem drinking in England	2018	170,000 Reduced by 2% since 2017 but increased by 27% since 2008	NHS Digital, 2020
Estimated years of life lost to alcohol in England	2015	301,000	Commission on Alcohol Harm, 2020
Estimated cost to the economy in UK	2016	£47bn	Public Health England, 2016

Estimated cost of lost productivity from working hungover or under the influence of alcohol to UK economy	2018	1.2-1.4bn per year	Institute of Alcohol Studies, 2019

Whilst problem drinking in the UK is reducing amongst younger age groups, it appears to be growing amongst older drinkers. The largest age group for those drinking at increased and higher risk of harm in 2018 (more than 14 units per week) was aged 55-64. A systematic review of international qualitative evidence recently found that older people were less likely to recognise the risks of their drinking, despite age increasing the possibility of negative physical impacts and reducing levels of tolerance (Bareham, Kaner, Spencer & Hanratty, 2018). Bareham et al. state:

> "most older adults experiencing harm from their drinking would not view themselves as problematic drinkers, as despite drinking more frequently than younger age groups, older people tend to drink to less dramatic excess, where risks are less visible. Policy makers and health and social care workers fail to recognise alcohol-related harm amongst the older age group as a consequence." (Bareham et al., 2018, p2)

Despite remaining a major problem to society, treatment figures are not encouraging. Only approximately 10% of male and 7% of female problem drinkers discuss alcohol problems with their GP (HSCIC, 2015). Public Health England (2019) found that in 2018-19 the number of adults in specialist treatment was down 18% since 2013/14. Despite the increasing prevalence of problem drinking amongst older adults, only 11% of the 75,555 in treatment at that time were over 60, with the largest proportion in the 30-40 age group. Thirty-one percent of those in treatment in 2018-19 did not complete treatment. Improving understanding of, and access to, all forms of appropriate help with problem drinking thus remains vital.

The concept of 'recovery' from problem drinking is also complex and has differing interpretations. It has traditionally been measured in terms of reduction in amounts and frequency of consumption of alcohol (with much debate as to whether reduction as opposed to complete abstinence can count as recovery). However, one of the leading charitable/support organisations in the UK, Alcoholics Anonymous, the longest established, most well-known and heavily utilized of the alcohol face-to-face groups, sees spiritual improvement as indicating true recovery. More recently a 'recovery movement' has emphasised the importance of achieving wellbeing and good social and emotional, as well as health, outcomes (see the work of William White). Following a literature review in 2017, a

Recovery Science Research Collaborative meeting defined recovery as: “an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness.” (Ashford, Brown, Brown, Callis, Cleveland et al., 2019, p183). Witkiewitz, Montes, Schwebel and Tucker noted:

> “Future work is needed to ascertain whether reduced alcohol consumption and remission from AUD symptoms are essential elements in defining recovery or whether a strengths-based model that focuses on well-being and functioning is sufficient to characterize recovery from AUD, or if some combination of relative emphasis on these two broad domains is optimal.” (Witkiewitz et al., 2020, p9)

This study does not attempt to enter this debate as it is not a study of the outcomes of AOSG use and makes no judgements as to the recovery status of those posting in the forums or being interviewed.

1.2.2 User ‘representations’

The term ‘illness representation’ signifies: “the organized cognitive representations or beliefs that patients have about their illness” (Petrie, Jago & Devcich, 2007, p163) or “patients' beliefs and expectations about an illness or somatic symptom” (Diefenbach, n.d.). In this research, the term ‘representation’ (rather than ‘illness representation’) is used to accommodate beliefs about problem drinking as something other than an illness.

Lay representations have now been shown by a considerable body of research to have important impacts on outcomes, clinical and social, in relation to many physical and mental issues, (see, e.g., Petrie et al., 2007; Hagger, Koch, Chatzisarantis & Orbell, 2017; Rivera, Corte, DeVon, Collins & Steffen, 2020) and this research is discussed in depth in Section 2.3. For example, the explanation a person uses to account for their symptoms/signs will influence what they decide to do about a problem from the very outset, whether they seek treatment or other kinds of help or decide to do nothing. This, then, will impact on how the illness or problem is addressed, whether it is resolved or develops and what outcomes it has. If an individual does not believe that their drinking is a problem, they may not feel the need to change it and so may never ‘recover’ (however this is defined). In terms of problem drinking, the representations that individuals hold about it can vary, as was discussed above. These different beliefs influence the different treatments/methods suggested for handling problem drinking, and therefore its different health and social outcomes. In addition, lay

thinking about problem drinking, in the form of the commonplace, stigmatised image of the 'alcoholic', can be a significant barrier to treatment, affecting problem recognition and causing isolation, fear and self-hatred.

There are different tools for measuring representations of illnesses or health threats and many researchers have used Leventhal and colleagues' 'Common Sense Model of Illness Representation' (CSM), also known as the 'Self-Regulatory Model' (1984, 1992) in their work. This is used in the present research as a well-established model that held promise for a thesis on representations. It enables analysis of a representation into five aspects: beliefs about identity (the name of the illness and the 'symptoms' or signs that characterise it); timeline (how long it may last, i.e., whether it is acute, cyclical or chronic); its causes; its consequences; and its curability/controllability (including whether the patient or the health system can control it). A sixth aspect, coherence, was added to the model by Moss-Morris et al., (2002) in their revision of the Illness Perception Questionnaire (IPQ-R), which is the most widely-used scale for assessing illness representations using the CSM. Coherence was defined as: "the extent to which a patient's illness representation provided a coherent understanding of the illness" (2002, p2). This sixth dimension is not routinely used in studies employing the CSM and only the first five dimensions were used in the process of analysing user representations of problem drinking in this thesis, as these are very well established.

Appendix 1 gives the CSM model in full, and shows that illness representations are constructed and acted upon via two parallel processing tracks involving, respectively, a cognitive representation (comprised of the 5 dimensions), and an emotional representation or "feeling state" (Leventhal, Diefenbach & Leventhal, 1992, p146). These lead to the coping mechanisms chosen by the person to deal with the issue, followed by the appraisal or response of the person to the outcomes of these coping mechanisms. Each of these elements impacts on the other, e.g., the representation held influences the choice of method of coping, and the outcome of the coping method can impact back on, and change, the representation. The two tracks inter-relate as the emotions impact on the cognitive track (perhaps influencing choice of coping mechanism, e.g., fear leading to denial) and *vice versa*. Illness representations are organic, they develop as the individual acquires more information and experience: they are "in effect cumulative, with information being adopted, discarded or adapted as necessary" (Hale, Treharne & Kitas, 2007, p904). Leventhal and colleagues identified experience, information from others and lay beliefs in society in general as key formative influences on representations. Research using the CSM is discussed in Section 2.3.1. and it is compared with other models of health beliefs in Section 2.3.2.

1.2.3 Information behaviours

According to Wilson, 'information behaviour' signifies:

> "the totality of human behaviour in relation to sources and channels of information, including both active and passive information-seeking, and information use." (Wilson, 1999, p249)

Information behaviour includes identifying an information-related need, seeking information (or avoiding / hiding from it), sharing it, and/or evaluating, managing, and using it. Information behaviours include the ways in which people will obtain, or convey to others, their representations in the settings of their online groups; hence they form an important part of this study. The term 'information behaviour' is preferred to 'information practice' as arguably it is more inclusive: this study will need to explore both cognitive and social/cultural aspects of information use. Ford indicated that information behaviour can be analysed not just at the level of the individual, but also where people interact in groups, and that it may be a "distributed activity" (Ford, 2015, p9). As the present research is concerned with the forum participants as members of their groups, it includes consideration of the impact of group norms on their writing, and also their individual motivations, e.g., in seeking out the support groups in the first place.

1.2.4 Health support groups, including for alcohol

There are many support groups for health and lifestyle-related issues, and research on these in both their face-to-face and online forms is discussed in Section 2.6. The benefits of face-to-face groups have been shown to include: provision of empathy, support and encouragement; reduction of isolation; the opportunity to help others and to learn from them; that they are free and usually not time limited unlike many services, and that they are places to find helpful information, especially experiential information from individuals sharing the same condition as the user (Seebohm et al., 2013; Coulson, 2014; Worrall et al., 2018). Their effectiveness in the mental health field is attested to by Worrall et al.:

> "there is a strong, scientifically rigorous evidence base for the effectiveness of support groups in providing positive improvements to wellbeing and the recovery of participants. Outcomes include reduced symptoms, substance abuse, number of crises, hospitalisations and use of services; as well as improved social competence and social networks, increased healthy behaviours and perceptions of wellbeing." (Worrall et al., 2018, p90)

Many people may prefer to obtain this help online, either as their main form of support, or as a supplement to face-to-face meetings or treatment. Online support groups (OSGs) are websites where groups of people facing similar illnesses, life challenges or difficulties communicate with each other over the internet, providing each other with support, advice and information. For the purpose of this study, no distinction is made between these and groups calling themselves online 'self-help groups', 'peer-to-peer support groups', 'support communities' or 'mutual aid groups', provided they meet the above description. The benefits and disadvantages of these groups is discussed below and the scholarly literature on health OSGs in general is reviewed in Section 2.6.2. Research on AOSGs is explored in Section 2.8.

The benefits of face-to-face health groups are also found in online self-help groups (van Uden-Kraan, et al., 2008b; Coulson, 2014) although evidence around health outcomes is comparatively limited (Worrall et al., 2018). However, they have some additional advantages over face-to-face groups: they are more accessible, for example, for those with aural or mobility impairments, for people who are very ill or very shy for whom attending face-to-face meetings are difficult (or for those under social distancing requirements as in the Covid-19 crisis). They are unlimited by geographical barriers and are available any time of the day or night, unlike face-to-face groups or specialist services (Ziebland & Wyke, 2012; Turner, 2017). Online groups offer a greater possibility of anonymity than face-to-face groups, if personal details are managed carefully. Smith-Merry et al. (2019) found that this anonymity led individuals to feel they could be more 'authentic' and were better able to share personal information. As a participant in Bjerke's study of AA online found: "In a face-to-face meeting, you usually do not get too personal. You usually stay on a topic or the "crowd" is just not conducive to revealing too much stuff" (2009, p92). They are also easier to access for those who feel stigma or embarrassment about their condition or who want to ask about embarrassing aspects of an illness, or questions that healthcare providers might see as unimportant (Mo & Coulson, 2014; Allen, Vassilev, Kennedy & Rogers, 2016; Turner, 2017). Shoebotham and Coulson found that users of an online group for endometriosis felt empowered by their group and more in control as a result of knowing more about their illness:

> "I feel more confident about seeing medical professionals and getting a good standard of care as the support groups have provided me with sources of information that I have used to educate myself" (2016, p6)

Writing as the mode of communication offers advantages for some. It can be therapeutic, creating distance between the individual and the problem and helping them to make sense of it. Asynchronous discussion forums provide time to think over and craft responses (White & Dorman, 2001; Turner, 2017) and to go back to posts and re-read them. This means memory does not have to be relied on so much and complex discussions can be revisited until they are understood. Online groups can also offer access to a wider range of people and so to a greater variety of experience. Personal differences e.g., class or wealth, are not immediately visible which may reduce some social barriers. Users can also familiarise themselves with a group before deciding to contribute or make themselves known, which is not possible in a face-to-face group: even if they do not speak, they are still seen there (van Uden-Kraan et al., 2008a)

There are some disadvantages to online groups, however. There is the risk of incorrect information being given out, although this has been found in practice to be rare (van Uden-Kraan et al., 2008a; Esquivel, Meric-Bernstam & Bernstam, 2006; Cole, Watkins & Kleine, 2016). This is as likely to happen in a face-to-face format as online, if not more so, as there is no record of what is said in face-to-face meetings so less likelihood of inaccuracies being picked up on and corrected for all to hear after the meeting. There may be conflicting or confusing information, information overload (Ziebland & Wyke, 2012; Mo & Coulson, 2014) or the raising of false hopes, e.g., as treatments are discussed that are not available locally: again, the presence of a record online may help to mitigate this. Other problems include reduction of inhibition leading to more heated argument, trolling and 'flaming', and greater anonymity allowing for greater levels of deception (Mo & Coulson, 2014; Turner, 2017). The lack of visual or aural cues in communication make it harder to assess the credibility or sincerity of a writer as the reader has fewer cues as to what they are like. There is the possibility of getting no response to posting, and having to wait for a reply (Ziebland & Wyke, 2012; Turner, 2017). Conversely, a poster may get more responses than they would have done in a face-to-face group. Online groups, of course, are inaccessible if an individual is unable to read or write, does not have access to a computer and/or the internet, or the skills to search it.

Online support groups can include many different functions such as blogs, discussion forums, chat rooms and information pages. Discussion forums are the sections of an OSG's website where people can discuss topics and give each other support and information: "A venue or medium for discussion; (now) specifically (Computing)" (Oxford English Dictionary, 2013). They are distinct from chat rooms in that they are asynchronous whereas chat rooms are for discussions in real time. Chat rooms are not usually organised by topic or other divisions: they form a continuous stream of interchanges. For

the purpose of this study, the term ‘discussion forum’ is used interchangeably with ‘discussion / message boards’ and ‘online forums’. People using them are referred to interchangeably as ‘users’ or ‘members’.

In terms of alcohol, support groups are often seen as an important element of treatment. NICE recommended in its treatment guidelines (2011) that healthcare professionals inform anyone seeking help with alcohol problems about the availability and benefits of self-help groups. It also advised that they help their patients to participate through encouraging attendance and arranging support to enable this. It specifically mentions the groups AA and SMART Recovery (NICE, 2011, p19). A briefing by Public Health England (PHE, 2013) provides an evidence base for support groups’ roles in alcohol treatment, again mentioning AA and SMART Recovery. The Advisory Council on the Misuse of Drugs [ACMD]’s Recovery Committee stated in its second report that:

> “The roles of recovery community organisations and mutual aid, including Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery, are to be welcomed and supported as evidence indicates they play a valuable role in recovery” (ACMD, 2013)

in 2017, Kelly, Bergman, Hoeppner, Vilsaint and White found mutual support to be the most frequently utilised form of support for recovery from problem drinking (45.1% of their respondents, N = 25,080), followed by clinical treatment (27.6%) and other recovery support services (21.8%). Lastly, in 2020, the Cochrane Library updated a systematic review of the evidence for the effectiveness of AA and 12-step facilitation (TSF) programs compared with other treatments. (TSF indicates clinically delivered treatments using the 12-step philosophy of AA and can include counselling or brief interventions informed by AA beliefs, with the goal of encouraging participation in AA.) They found that use of AA produced higher rates of abstinence than the other treatments and concluded that:

> “clinically-delivered TSF interventions designed to increase AA participation usually lead to better outcomes over the subsequent months to years in terms of producing higher rates of continuous abstinence. This effect is achieved largely by fostering increased AA participation beyond the end of the TSF intervention. AA/TSF will probably produce substantial healthcare cost savings while simultaneously improving alcohol abstinence.” (Kelly, Humphreys & Ferri 2020, p3)

The authors concluded this review by noting that non-12-step groups may produce similar benefits and stated the need for further research in this area. All of the above indicate the importance of support groups as sources of help for problem drinkers and further justifies research to understand how they operate.

Section 2.7 will show that whilst there is a sizeable body of research on AA, there is comparatively little on other groups and still less on AOSGs and their discussion forums. This study will contribute to addressing these gaps.

1.3 Aims and objectives of the research

1.3.1 Aim

The overall aim of the research was to examine whether, and how, the discussion forums of non-12-step alcohol online support groups impact upon their users' understanding of their illness/problem (i.e., their 'representation' of it).

1.3.2 Objectives

The objectives of the research were:

- To carry out in depth, qualitative analysis of postings from selected non-12-step AOSG discussion forums, in order to establish whether the groups impact their users' representations and to understand the different ways in which they do this.
- To identify key information behaviours used to achieve these ends in the postings (e.g., story, advice, role modelling).
- To undertake in-depth semi-structured interviews with current and former users of non-12-step AOSGs about their views on the contribution their use of an AOSG, or AOSGs, made to their representation of problem drinking.
- To identify and discuss information behaviours used to achieve these ends with the interviewees
- To ascertain whether Leventhal and colleagues' Common Sense Model of Illness Representation (1984) is a helpful tool to use in qualitative analysis of the representations of problem drinking in these AOSGs.

1.3.3 Methods used

The study was a qualitative, multi-method analysis of the issues using analysis of posts from three purposively selected AOSGs, followed by in-depth semi-structured interviews with present and former users of five groups. Material was analysed using Braun and Clarke's (2006) method of thematic analysis and Brooks and King's template analysis (2014). The research provides help for those working with people with alcohol problems to direct them to the best sources of support, and makes an important contribution to new knowledge.

1.4 Rationale for undertaking the research

There were several key reasons for undertaking this research. Firstly, as explained above, alcohol misuse still poses major problems for individuals, families and for society. It is therefore important to ensure that problem drinkers, healthcare professionals, policy makers and others can be as fully informed as possible about potential treatment methods and how they operate. This is especially important, as AOSGs appear to be under-utilised by the NHS and, generally, only AA and Smart Recovery are well known to that sector, despite the fact that there is a far wider range of options actually available.

Secondly, whilst there has been research into the many effects of users' illness representations in relation to a wide range of diseases/conditions (see Section 2.3), there has been little on this in relation to alcohol. The role that an online support group can play in constructing users' representation of problem drinking is not known, despite the recognition of the importance of lay understandings of illnesses/problems. Thirdly, there are many different beliefs surrounding the nature of problem drinking, its causes and treatments. Thus, to have an understanding of it, or a representation, is not a matter of simply adopting an agreed and sanctioned interpretation. The individual has a choice of meanings, hence the need to explore and understand what may influence their uptake of one or another. This is especially the case as some research has shown that any group or service could work well provided it accords with the user's value system, and that there is no one-size-fits-all solution to recovery from problem drinking (Humphreys, et al., 2004; Atkins & Hawdon 2007; Worrall et al., 2018 and Best, Manning, Allsop & Lubman, 2020). If how people see their illness or problem has a clear impact on outcomes, then it is important to understand these perceptions and where they have come from.

This research contributes to new knowledge, as presented in Section 8.3 and also has implications for practice (Section 8.4). It will be of interest to anyone working with people with alcohol issues

including healthcare, social services, information services and the voluntary sector. It will help them to understand better how alcohol representations are formed and to use this knowledge when considering referrals to groups and in designing their own interventions. It will also be of interest and use to the groups and users themselves, who frequently discuss different aspects of problem drinking. It is hoped that it will contribute to raising awareness of the range of AOSGs available as potential sources of help to people with alcohol issues through dissemination of the results.

1.5 Key assumptions of the research

This section details some key assumptions that underlie the research. The first was mentioned above: there is no single definitive explanation of alcohol problems. The many different representations are all valid to different people and are worth studying. This thesis does not attempt to arbitrate among them or make any claims about which is the 'correct' one. Nor does it distinguish between types of problem drinking, being concerned with the individual for whom drinking is a problem to the extent that they are seeking information and help with it from an AOSG.

Secondly, it accepts that it is ultimately probably impossible to know precisely how a person acquired their representation of problem drinking without tracking them throughout their life which is clearly impossible. This is because of the large role that alcohol plays in UK (and other Western e.g., North American) societies in relation to socialising and marking significant life events. Individuals in these societies are exposed to many different sources of information, and judgments about, drinking throughout their life, some of which are not even consciously registered by them and so cannot necessarily be explained to a researcher. Messages about alcohol can be given by, for example, family and friends, healthcare professionals, teachers and other authority figures, colleagues and casual acquaintances, through mass media messages such as advertisements and in the presentation of alcohol in plays, films and books. Many of these views may be unconsciously registered, some forgotten and, as new information is received or new experiences occur, the person's views may change over time. However, a third key assumption is that it is possible to go some way to achieving a useful understanding of the significant influences on a person from what they tell us, and from seeing their interaction in the forum postings. This study sees both of these as valuable sources from which useful theory can be formulated. This is especially the case as use of an AOSG is a deliberately sought out experience, not a passing, unsought one that does not fully register.

Fourthly, although this thesis does not make claims to generalisation, it may be possible to discern patterns. For example, it was speculated before the data collection that individuals may tend to arrive at a group with their representation already in place, choosing a group that shares their beliefs; or that one particular method of creating, conveying or altering representations may be more heavily used in AOSGs than another. However, as a detailed, exploratory qualitative study, this was not the primary aim of the research, which was to theorise and to open the area for further study to confirm or refute its findings. In short, the thesis seeks to illustrate whether, and how, a non-12-step AOSG can contribute to the development of a user's representation, rather than to state definitively that they always do or do not, or that they always do this in one or more specific ways.

1.6 Conclusion

This chapter introduced the research, giving the background to it and the rationale for undertaking it. It set out the aims and objectives, gave some important assumptions underlying the work and described its key concepts of 'problem drinking' 'recovery', 'representations', 'online support groups' and 'discussion forums'.

The remainder of the thesis is structured as follows: Chapter 2 gives a detailed literature review of relevant existing research, focusing on three major areas. Chapter 3 sets out the methodology used in detail, including the paradigm and methods adopted. Chapter 4 provides background information about the groups and interviewees, and Chapters 5-6 present the findings regarding the impacts of the forums and the information behaviours identified. These are then discussed in Chapter 7. Chapter 8 concludes the work, exploring its contribution to knowledge and the implications for policy and practice.

Chapter 2: Literature review

2.1 Introduction

In Chapter 1, the research was introduced, together with its importance, and the rationale for undertaking it. The aims, objectives, key terms and assumptions were given. This chapter examines relevant research undertaken to date, in order to explore what has been done previously, identify where the gaps lie, and place the proposed study in context. After a description of the search strategies used in Section 2.2, the body of the chapter deals with research on the key topics central to this study: representations, especially in relation to problem drinking, information behaviours and alcohol support groups. The key concept of 'representations' is discussed in Section 2.3 (this was previously defined in Section 1.2.2). Section 2.4 gives an overview of the different representations of problem drinking and its treatment that have been seen over the years. The topic of information behaviours is dealt with in Section 2.5 with specific reference to the theories of importance in this study. Thirdly, existing research on groups is explored, starting with a brief overview of research on health-related support groups generally in Section 2.6. Section 2.7 focusses on face-to-face alcohol support groups and Section 2.8 explores research on online AOSGs. These particular topics are central to the study as it looks at the impact of AOSGs on users' beliefs about problem drinking. Section 2.9 then summarises the literature found, and Section 2.10 identifies gaps in research. The research questions are presented in Section 2.11 and Section 2.12 concludes the chapter and introduces the next.

2.2 Search strategies

This literature review had two key phases, the first in 2015-16 and the second in 2020. The first phase was to provide background and orientation to the subject in order to identify gaps in research and to ensure that the study had not been previously undertaken. The second phase was carried out to update the information, particularly important for material dealing with the rapidly changing field of information technology. In between the two phases, the researcher carried out searches as needed and kept abreast of developments in the area (see below for details). Material obtained from both phases is used throughout the following discussion, but is separated in the discussion of the gaps in research found in 2015-16 which informed this study's design.

In the first phase, four approaches were pursued: firstly, formal search strategies were created around the general topics of health support groups, alcohol online and face-to-face support groups and 'representations' including in relation to alcohol (see Appendix 2 for details of the search strings used and Appendix 3 for some examples of the results from these searches). These were executed in

2016, prior to data collection, in ProQuest, PubMed, Medline, Scopus and Google Scholar. ProQuest was included in order to obtain recent theses and dissertations, and proved a fruitful source for this topic. Medline was included as the most widely respected health-related database available, with sophisticated search functions. PubMed was searched as it can include more recent items not yet available in Medline, and Scopus was searched for its citation counts. Google Scholar was included given the topical nature of the subject-matter: whilst it did produce many false positives, it also contributed useful items from the initial pages returned.

The second method used was to focus on a search for the names of specific alcohol support groups (ASGs), both on their own and with the term 'online'. The group names chosen were those that had stood out from the first literature searches as often-cited by researchers. They were sought using 'all field' and 'title' searches, and the 'title' results examined. The first 50 items from the 'all field' searches were also investigated. It is recognised that this is not exhaustive, but it was necessary to limit searching in the interests of time management. Examples of the results from these searches are also in Appendix 3.

The third approach was forward and backward citation searching of key works identified in the earlier searches, e.g., those by Cain, whose research on the role of storytelling in AA is described in Section 2.7.1.1 and Coulson, who has written extensively on online support groups, including AOSGs. The fourth method was to pursue avenues serendipitously as they arose, where this appeared promising and sensible, e.g., at one point a special issue of a journal devoted to peer support groups was found in the course of a different search and so was examined. This continued to be examined at regular intervals throughout the development of the thesis.

After the initial phase, and throughout the subsequent research process, topic-specific searches were carried out on an *ad hoc*, as needed, basis. For example, once the six groups studied in this thesis had been selected, searches were carried out on their names to see if anything had been written about them. Searches on information behaviours such as 'berrypicking' and 'information encountering' form other examples (these concepts are discussed in Section 2.5). Forward and backward citation was carried out on useful materials, and serendipitous avenues pursued as before. Colleagues were consulted for recommendations (e.g., for the material on 'problem framing'), and suggestions received from Mendeley alerts were followed up when promising.

The second formal search phase involved re-running the initial searches, apart from that on health support groups generally and also searching for the names of the specific AOSGs used in the study. This was carried out for the years 2016-2020 in March 2020 at the time this chapter was written. The search strategy used in 2020 and the results are given in Appendix 4. The materials found during this search are included in the text as evidence alongside older items unless they marked a significant change to what has gone before, in which case they are discussed separately.

There were several difficulties with looking for research on the groups used in the present study (Groups A – F). Firstly, as is the case in the present research, sometimes groups were anonymised so it was impossible to say with certainty if they were the same. Secondly, one of the groups used in this research covered drugs other than alcohol so research on it that included alcohol had to be separated out (none was found but there were items about the group as a whole). Finally, in five cases the names of the groups effectively formed a phrase which is commonly used within alcohol discussions and therefore items containing the phrase but with no reference to the group needed to be removed.

2.3 'Representations'

This section discusses illness representation research, focusing on research using the model adopted to analyse representations in this study, the CSM.

2.3.1 The Common Sense Model of Illness Representations

The structure of this was described in Section 1.2.2 of the introduction. Illness representations have received substantial research attention and have been examined, using the CSM, in relation to many different diseases e.g., cancer, heart disease, diabetes, HIV and epilepsy (Hagger & Orbell, 2003). Studies have explored, for example, particular representations of individual diseases, their effects on different outcomes and their use in creating interventions.

There is now a strong body of evidence showing a link between illness representations, health behaviours, i.e., what people do about their health, and the results or 'outcomes' of these health behaviours (e.g., Hagger & Orbell, 2003; French, Cooper & Weinman, 2006; Petrie, Jago & Devcich, 2007; Broadbent et al., 2015; Hagger, Koch, Chatzisarantis & Orbell, 2017; Durazo & Cameron, 2019). The types of outcomes assessed have included, for example:

- Whether individuals seek diagnosis and treatment at all. This, of course, can then impact on medical outcomes including improvements/deterioration in health, or even survival;
- Adherence to treatment and consequent effects of this on health;
- How patients self-manage an illness;
- Adoption of healthy lifestyle behaviours;
- Emotional adjustment to illness;
- Satisfaction with consultations with health professionals (this may be diminished if the patient and professional's representations of an illness differ, as the patient may feel they have not been diagnosed correctly and therefore are not being taken seriously or treated correctly);
- Use of healthcare services (patients may attend surgeries repeatedly in the hopes of getting the 'right' diagnosis or treatment).

However, there has been some conflicting evidence: Petrie et al. (2007) reported some studies of cardiac patients where illness cognitions were not strongly related to outcomes, before overall concluding that beliefs and health outcomes are associated. Brandes and Mullan (2014) and Aujla et al., (2016) found that the five illness representation dimensions (cause, consequences, etc.) only weakly predicted adherence to self-management behaviours, concluding that it was not a good tool for predicting future behaviour.

Katavic, Tanackcovic and Badurina (2016) among others found that positive illness representations tended to be related to positive outcomes. Citing Iskandarsyah et al. (2013) and Husson et al. (2013), they indicated that provision of good quality health information to patients has been associated with more positive illness representations. Katavic et al.'s 2016 study quantitatively explored correlations between health information behaviours and illness representations in patients with rare chronic diseases to see which behaviours were conducive or inimical to creating positive illness perceptions. The study focused quite specifically only on the behaviours of information seeking frequency, information avoidance and sources used, in relation to sense of control (controllability), degree of understanding of the illness (coherence) and level of concern (emotional response). The results indicated that greater concern with an illness was associated with more health information seeking, and that a lower sense of the controllability and coherence of an illness was associated with information avoidance. They also noted that:

> "One of the least studied topics in this area is related to how people form illness perceptions and what sources they draw upon... Qualitative research is required to examine what people gain from particular information resources and why some affect illness perceptions more than others." (Katavic et al., 2016)

The present research contributes to addressing this gap for people with drink-related problems in terms of one particular resource. In 2017, Oh and Song also brought representations and information behaviours together. They explored the link between views of health seen in terms of the CSM and online health information seeking, finding that negative views (e.g., greater psychological distress and perceptions of own health as poor) were significantly associated with higher levels of information seeking.

More recently there has been a trend of analysing illness representation dimensions in clusters, and Rivera, Corte, DeVon, Collins and Steffen's systematic review of this research (2020) also indicated a common connection between positive clusters and positive outcomes in chronic diseases:

> "Clusters with fewer perceived consequences, fewer symptoms, and less negative emotion were consistently related to better health outcomes." (Rivera et al., 2020)

Lowe and Norman (2017) also concluded that illness representations could form "schema" in which beliefs, in terms of the label, other dimensions and coping mechanisms were interrelated, rather than independent of each other. Their study of the process of illness representation formation explored how the psychological processes occurred, and concluded that:

> "people automatically construe representations, in the moment, from knowledge stored in memory, with well-learned information being highly accessible. Illness representations comprise sets of related beliefs organized as schemas. Their schematic nature may mean situations are wrongly interpreted due to incorporation of inappropriate component beliefs." (Lowe & Norman, 2017, p21)

In terms of mental health, most research in this area has been on schizophrenia or depression. Lobban, Barrowclough and Jones (2003) argued that the CSM was particularly useful for mental health as, for example:

- It acknowledged the important role emotional reactions play, which is key in mental illness where emotions may be 'disordered';
- It had been well tested with good reliability and validity for a wide range of physical illnesses, proving its versatility;
- At that time, it had already been found useful in some mental health studies.

Petrie, Broadbent and Kydd (2008) and Baines and Wittkowski (2013) also found that the CSM worked well for different mental illnesses. Chan and Mak (2016), in a study including problem drinkers, explored how illness representations impacted upon acceptance of self-stigma and how this impacted upon recovery, finding that:

> "cognitive and emotional representations of mental illness determine the degree to which individuals internalize mental illness stigma, and influence their subsequent clinical and personal recovery." (Chan & Mak, 2016, p21)

According to them, the key dimensions for self-stigma were those of controllability and consequences plus the emotional representation of the mental illness.

Problem drinking has received very limited research attention in relation to the CSM. Bamford (2005) and Bamford, Barrowclough and Booth (2007) researched the effects of a difference in illness representation between problem drinkers and their significant others on relationship quality, aftercare attendance and distress of the significant others. Both articles reported on the same survey of 49 pairs recruited from an inpatient treatment programme following a Cognitive Behavioural Therapy (CBT) approach to recovery. The research found that congruence of the two perspectives was important with an association existing between dissimilarity and poorer relationships. The authors argued for the value of assessing the illness representations of those around a problem drinker. Ayu, Dijkstra, Golbach, De Johg and Schellekens (2016) evaluated a revised version of the IPQ for measuring addiction representations, using it to explore health professionals' representations of addiction. They concluded that it was a "valid and reliable instrument" for this purpose. Presky, Webzell, Murrells, Heaton and Lau-Walker (2018) included the Brief IPQ (a widely used, reduced version of the questionnaire) amongst measures employed in a study of illness representations and medication adherence amongst alcohol-related liver disease patients. They noted that these patients had little understanding of their illness or sense of control over it.

2.3.2 Other approaches to illness representation

Alternative ways of analysing illness or other representations include the Health Belief Model (HBM), the Theory of Reasoned Action (TRA) or the Theory of Planned Behaviour (TPB); all models for predicting health behaviour by looking at beliefs about illness/health threats. The HBM, developed in the 1950s and influenced by social learning theory, argues that the key dimensions of health beliefs about an illness are the degree to which an individual perceives themselves as susceptible to it combined with the perceived severity of its consequences. This will motivate them to preventive action or treatment, if the benefits are not outweighed by the barriers: for example, the treatment or behaviour may be seen, rightly or wrongly, as too harsh, difficult or costly to implement (Janz & Becker, 1984). A cue to action may be needed to initiate the health action (e.g., symptoms manifesting themselves), and modifying variables will have an impact, e.g., gender, race, personality traits. These variables will influence how the susceptibility, severity etc. are perceived. Motivation, and degree of self-efficacy were proposed as additions to the model, but not universally taken up (Carpenter, 2010). This model has been influential, and widely used: see, for example, Sharma (2011) for its use in relation to alcohol, and Willis (2018) where it was used to explore the impact of OSGs on medication adherence. However, it suffers from a lack of consistency in the way the elements of the model are defined in different studies (Janz & Becker, 1984). It also does not allow much role for the impact of emotions and is not as detailed as Leventhal and colleagues' CSM model.

The TRA's structure comprises behavioural and normative health beliefs. Behavioural beliefs are personal beliefs about an action and attitudes to it, e.g., how pleasant or useful it might be (or not). Normative beliefs are the views of significant others which have been internalised by the individual as acceptable ways to act. Both contribute to intention to act which leads to the action (Madden, Ellen & Ajzen, 1992). Whilst this model assumes action is under the control of the individual, (this is questionable in the case of problem drinking where this is often not felt to be the case), the TPB adds the dimension of perceived behavioural control, or beliefs about the opportunities and resources available to the person for performing an action. Again while the TPB has been widely used, and draws attention to the important aspect of normative beliefs, it lacks the detail of the CSM. For these reasons, it was decided to use Leventhal, Nerenz and Steele's model when analysing representations in the present study.

Finally, since the start of this study, Crum and colleagues have undertaken interesting work on 'mindsets' which they defined as being:

> "lenses or frames of mind that orient an individual to a particular set of associations and expectations. Mindsets, like beliefs, guide attention and motivation in ways that shape physiology and behaviour… mindsets are biased or simplified versions of what is right, natural, or possible (eg, "girls are not good in math")" (Crum & Zuckerman, 2017)

Similar to beliefs, mindsets impact on how individuals act which in turn can affect outcomes. Crum and Zuckerman (2017) noted that mindsets are affected by social networks, as well as religion and culture, and identified three factors that can change mindsets, for example, regarding what treatments will work: providing information, reframing information or establishing an emotional connection. The concept of mindsets will be returned to in the discussion chapter (Chapter 7) where this will be discussed.

The next section focuses specifically on representations of problem drinking to illustrate how this has varied over the decades and show that there is no one accepted definition but instead there are a number of interpretations.

2.4 Representations of 'problem drinking'

Problem drinking or 'alcoholism' is a concept that has fluctuated in meaning over time and has been attributed to many different causes, requiring different treatments and evoking differing attitudes. Nicholls (2009) showed clearly how society's attitude to drink both illuminates, and changes with, the cultural preoccupations of the time. Prior to the 18th century, drinking appears to have been viewed as a matter of social disorder, caused by sin and a problem to be dealt with by the clergy and the legal system (Edwards, 2010). The early 16th century saw six Acts of Parliament published targeting alehouses and drunkenness. The idea of it as a disease seems to appear first in the 17th century in the work of Everard Mainwaring "drunkenness… hath all the requisites to constitute a disease" (quoted by Nicholls, 2009, p67), but only gained ground in the 18th century, initially in the work of Hale (*ca*.1734) who viewed it as progressive, characterised by lack of control, and cured by abstinence. Nicholls described the disease concept as well established by the 1770s in Britain. The better-known work of Rush in the USA (*ca.* 1790), and Trotter in the UK (*ca.* 1804), also promulgated the idea of problem drinking as a disease. Trotter saw it as a habit that led to mental illness, to be dealt with by approaches similar to what we now would call CBT, a view that does not appear to

have lasted very long then (Edwards, 2010). For Rush, it was a disease with a moral dimension to be cured by religion. Both men also identified a public health angle.

Before the 18th century, excessive drinking was usually seen as something one did to oneself and over which one could have control (although the concept of inability to stop had appeared at least as early as 1673, in the work of Richard Baxter). This began to change gradually with the Enlightenment:

> "[Locke and Hume] opened the door to the possibility that habits may be less like things [deliberately] picked up by selves, and more like part of the fabric out of which selves are actually formed. If we become habituated to certain experiences, then those experiences play a role in shaping the mental processes out of which our identity emerges." (Nicholls, 2009, p67)

In the 19th century, 'inebriate' asylums developed in the US and problem drinking was seen as a brain disease, but also (by the same people) as a moral vice, cured by incarceration. The 19th century also saw Temperance movements in the UK and USA, which viewed drink itself (as opposed to drunkenness) as a problem whose use inevitably led to crime and poverty as alcohol acted on the moral centre of the brain (Sartor, 2005). Prohibition in the USA followed in 1920 – 1933.

Asylums had been abandoned by 1921 and, according to Edwards (2010), drinking declined in the UK between the world wars, only reviving in the 1960s (Nicholls 2009). The disease concept returned in the 1940s with the development of psychoanalysis and was well established as the dominant theory by the 1960s, where it has largely remained to this day. This was supported by the World Health Organisation which, in 1964, identified the concept of 'alcohol dependence' (covering both drinking as habituation and as an addiction, which had previously been separated). The public health aspect also came to the fore, together with measures to protect public health and concern with drinking at population level. Psychology-based treatments in specialist units began to be established and the continuum view of problem drinking as on a spectrum from non-pathological to pathological was introduced (Witkiewitz et al., 2020). In 1977, the WHO measured problem drinking by its negative social, psychological and physical consequences plus degree of dependence. This influenced the disease classification systems International Statistical Classification of Diseases and Related Health Problems 11th revision (WHO, 2018b) and Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). The former, as of 2019, uses the term 'alcohol dependence' for severe alcohol

problems and also has categories for 'harmful' use. The latest edition of the DSM (May 2013) has only Alcohol Use Disorder covering both misuse and dependence, putting them together on a continuum rather than as separate entities. The 21st century has seen more complex typologies of drinkers develop: "social drinkers, heavy drinkers, problem drinkers, dependent drinkers…binge drinkers" (Nicholls, 2009, p213). Purshouse, Brennan, Moyo, Nicholls and Norman (2017) also identified four types of heavy drinkers grouped by type of beverage, each with distinct socio-demographic characteristics.

Over time a plethora of more specific causes for excessive drinking have also been put forward. Grant (2014) has a summary of current interpretations including: genetic heritage and neurological abnormality predisposing an individual to problem drinking; negative societal and family factors; mental ill health, e.g., depression or anxiety; physical pain; or grief. Sartor listed personality traits that have been deemed to cause problem drinking and some of the medical theories, including "glandular dysfunction, abnormal metabolism, cerebral damage, and biochemical imbalances" (2005, p5). She drew attention to behavioural theory explanations such as conditioning where increased drinking results from positive reinforcement, and social learning theories, in which drinking behaviours are thought to be influenced by situational and social factors as well as personal ones. Levy presented addiction as a loss of control caused by competing beliefs arising from a "dysfunctional reward evaluation system" (Levy, 2014, p337). This list is not exhaustive: allergic reaction might also be added, as set out in AA's *Big Book* (2001, pxxvi and xxviii), where it is explained as a physical reaction to ethanol manifested as craving. Edwards (2010) included economic aspects in the sense of the availability of cheap alcohol in his list of causes and Copoeru (2014), looking at addiction as a cultural construct, argued that modern society defines problem drinking as a failure to behave rationally and loss of control caused by drink.

Differing explanations of the cause have led to different treatments being put forward. The 12-step programme of AA is predominantly concerned with spiritual recovery (steps 2 – 12, see Appendix 5). Cognitive-behavioural programmes address it as a habit, focusing on the role of thought. Medication-based treatments also follow a habit interpretation. Disulfiram (Antabuse) or naltrexone (used in The Sinclair Method) aim to provide physical solutions to break the habit (by causing aversion or by limiting the pleasure obtained from drinking). Other treatments that have been suggested include counselling, marital therapy, exercise, hypnosis and 'natural recovery' using resources developed in the community such as recovery schools, community centres and recovery homes (White, Kelly & Roth, 2012). Natural recovery steps away from the generally dominant model

of both specialist clinical care and mutual aid groups with their focus on the individual drinker, to look at the person's whole social environment including family and community (Drug & Alcohol Findings, 2020).

At the present time, whilst the UK Government has recognised problem drinking as a disease requiring treatment, its 2012 strategy presented it first and foremost as a social problem, concentrating on taking action at national and local level, e.g., a minimum unit pricing for alcohol, local powers to deal with antisocial behaviour and working with the drinks industry to encourage responsible drinking. The next strategy remains under development at January 2021.

The highest profile debates at the present time include whether or not problem drinking is a 'brain disease', evidenced by neurobiological changes to the brain. Lewis (2015, 2017, 2018) challenged this interpretation, arguing that brain changes in addiction are in line with those occurring with the development of any powerful habit and this has led to much debate: for discussion of this see, for example, Szalavitz, 2017; Hall, Carter and Barnett, 2017; Heather, 2017; Wakefield, 2017 and Vintiadis, 2017. Other current debates include the effects of the framing of problem drinking as a binary condition ('alcoholic'/ 'not alcoholic') rather than as on a spectrum ranging from mildly problematic to debilitating and destructive (see, for example, Morris, Albery, Heather & Moss, 2020).

Since the beginning of this research, the 'positive sobriety / sober curious' movement has increasingly come to public attention. This views recovery from problem drinking as an actively positive, beneficial choice to be celebrated, and not as a matter of deprivation. It encourages the avoidance of stereotyped labels such as 'alcoholic', in favour of terms such as 'alcohol-free' and the adoption of a more holistic lifestyle where giving up alcohol is seen as an act of self-care (Warrington, 2018; Nicholls, 2019). This movement offers a place for the person who may be questioning their drinking, but cannot identify as an 'alcoholic' in the stereotypical sense or as having a 'disease'. It will be shown in Chapter 5 that this is important in relation to the non-12-step AOSGs studied here. Nicholls pointed out that this movement is largely an online one, being "loosely comprised of a number of online groups and communities, organisations, blogs, magazines and social media accounts" (Nicholls, 2019). The movement has been criticised as 'commodifying' sobriety, promoting what some commentators have called "self-help merchandise and thousand-dollar yoga retreats" (Dufton, 2020), and treating recovery as a lifestyle choice, rather than

acknowledging it as a matter of life and death for some (Morris, 2020). Both Nicholls and Morris argued that positive sobriety is not for all and should be one approach amongst a range.

This overview has indicated several interpretations or representations of what it is to have a drinking problem: it has been seen, for example, as a social or economic problem, a sin or moral matter, a disease (which may be moral, mental and/or physical), a habit that can be controlled and/or a public health issue. It is important to note that sometimes these interpretations co-exist: as Edwards, speaking of the overall trend, cautioned:

> "it is too simplistic to see medicalization as having substituted for moralism. The two positions seem to have often coexisted or even to have operated in alliance" (Edwards, 2010, p803).

AA, for example, argued that problem drinking is a disease of mind, spirit and body, blending the moral and disease interpretations, calling it a "spiritual disease" (*Big Book* 2001, p64). Perhaps the situation is best summed up by Satel and Lilienfeld, who stated:

> "addiction [is] an enormously complex set of behaviors that operate on several dimensions, ranging from molecular function and structure and brain physiology to psychology, the psychosocial environment, and social and cultural relations." (Satel & Lilienfeld, 2017, p19)

To summarise, there are many interpretations of problem drinking, and beliefs about it are by no means universally agreed upon. As much research has shown that beliefs impact on outcomes, as was described above, it is important to understand what influences the uptake of a particular interpretation and the role AOSGs can play within this.

The next section explores research on information behaviours with specific reference to some of the concepts found to be important in this study.

2.5 Information behaviours

There has been a considerable amount of research on information behaviours in general (see, for example, Ford, 2015; Case, 2012 and Fisher, Erdelez & McKechnie, 2005 for overviews of theories and models).

Wilson's models of information behaviours are drawn upon in this study, particularly his Second General Model of Information-Seeking Behaviour (1996), which includes information processing and use (see Appendix 6). This model brings together the influence of context and person-related factors on information behaviour with an account of the process involved of moving from 'activating mechanisms' (whatever has prompted the search), through 'intervening variables' (possible influencing factors such as barriers and facilitators of information searching) to information seeking behaviours, information processing and use and back to influence upon the context/person and possible new information needs. The model can be combined with others and has been used by many researchers of information behaviour including Ellis, Dervin, Ford, Erdelez and Savolainen.

2.5.1 Information seeking

'Information seeking' was defined by Ford as:

> "[the] strategies a person devises in order to find information, which may include – but is not limited to – [information] searching. It may include the selection and use of a variety of search tools, and the use of other strategies such as browsing and monitoring." (Ford, 2005 p14)

It may take different forms as indicated here ranging from formal searching in information materials, such as databases, to meet a clearly defined information need to much less directed or linear activities, such as 'berrypicking' or information encountering, which are described below as important concepts in this research. Information seeking will involve a need of some kind – physiological, affective and/or cognitive - that impacts upon the individual's use of information:

> "Information-related needs…are defined as needs that have implications for the way in which we interact with information, whether seeking or avoiding it. They are more general than, but include, information needs." (Ford, 2015, p42-3)

In terms of problem drinking, the impulse to find information and support could arise from any or all of the three basic categories of need as drinking impacts on the body, emotions and cognitive aspects such as the ability to remember events.

2.5.1.1 Berrypicking

Marcia Bates's 1989 model of information searching as 'berrypicking' arose from work on human information seeking which showed that the formal, linear model did not reflect all of the information searching occurring in what Bates called 'real life'. Ford characterised linear models as working on

the assumption of systematic, sequential searching, where an information-related need is expressed and then matched with material that meets the need. Even where search queries are modified as a result of what has been found, "the process was still essentially one of progressively 'homing in' on the required information." (Ford, 2015, p62)

Bates's model was very different, described by Savolainen as a form of "exploratory search" (2018, p581) where the person has a tentative query about a vague or complex problem and explores the information domain relating to it. He characterised it as occurring when the context is "open-ended, persistent and multi-faceted…and [the search processes used] opportunistic, iterative, and multi-tactical" (2018, p580). Bates distinguished berrypicking from the linear 'one stop' search model in four key ways:

1. Queries change and evolve during the course of the search, and do not remain static from start to finish. It is not only the formulation of the search that can be modified but its very essence.
2. A range of search techniques are used: this may include exploratory browsing, area scanning and focused searching.
3. The domain searched may change, with individuals using multiple sources of different kinds.
4. The query is not satisfied by one ('best match') set of references, but "by a series of selections of individual references and bits of information at each stage of the ever-modifying search" (Bates, 1989, p410).

'Berrypicking' is so named for its eclectic nature, as the searcher selects and combines information from different sources in the manner of a person selecting the best berries from different bushes. Bates distinguished it from browsing as a more directed form of sampling and selecting (Bates 2002). Her work has been drawn upon by many researchers in the field of information seeking including Lueg and Bidwell (2005) in their writing on information behaviour and 'wayfinding', and Kumpulainen (2014) on information trail modelling.

2.5.1.2 Information encountering

Erdelez's original 'information encountering' is a theory which combines well with the berrypicking model (and was likened by Erdelez to 'gathering' as opposed to 'hunting', which puts it close to the language used by Bates for berrypicking). Erdelez described it as occurring:

> "when one is looking for information relating to one topic and finds information relating to another one…it also occurs upon bumping into information while carrying on a routine activity" (Erdelez, 1999, p25)

The first is also an instance of what Wilson called a 'passive search', (Wilson, 1997) which later became Erdelez's main definition of information encountering (Fisher et al., 2009, p180). The second ("bumping into information"), can be likened to Ford's 'passive attention' (2015, p53). Information encountering involves noticing a piece of information and then examining and assessing it. It may then be used in a variety of ways, e.g., saved for later, used, shared or ignored. Erdelez (1999) noted that the Internet was an environment particularly conducive to information encountering. She identified four key elements to this: the user of the information, the environment where the encounter occurred, characteristics of the information and characteristics of the original information need which the information addresses.

2.5.2 Information sharing

There are many different ways in which information can be shared between individuals in discussion forums. Talja defined this as:

> "an umbrella concept that covers a wide range of collaborative behaviors from sharing accidentally encountered information to collaborative query formulation and retrieval. Collaboration means that information sharing is not an individual behavior but a collective and collaborative effort occurring in social networks (i.e., communities of practice or communities of sharing)." (Talja, 2002, p147)

Talja (2002) described the three forms this can take as 'co-ordinated', (random and informal) 'co-operative' (routine and formal to achieve a shared goal) and 'co-constructive' (information use jointly reorganised to achieve a shared goal). Please see the Glossary for further definition of the differences. AOSG's discussion forums are essentially collaborative efforts in that users jointly create them, and all three levels are of interest, and relevance, to this study. However, this thesis is chiefly interested in the different forms of information sharing at the level of particular technique used, and this chapter introduces several of these below in its discussion of research on face-to-face AA (Sections 2.7.1.1-4)

Section 2.5 has noted key information behaviour models and theories drawn upon in this thesis. The next sections explore existing research on the last key element of the study: alcohol online support groups.

2.6 Health support groups

The following provides a brief overview of research on health support groups in face-to-face and online format, to set the context for a discussion of existing research on alcohol-specific groups in subsequent sections.

2.6.1 Face-to-face groups

There are very many health support groups for a wide range of diseases, conditions and health issues. It would be hard to estimate their total number as there are many small local ones that may not be in directories or databases, and as the field changes fairly frequently; however, the mental health charity, Mind, lists 300 peer support services for mental health alone in the UK (Mind, 2020). There is also a wide body of research on them, covering a range of topics notably:

a) the impact, benefits and outcomes of using a group (e.g., Seebohm et al., 2013; Longden, Read & Dillon, 2017; Worrall et al., 2018);
b) the relationship between self-help groups and healthcare professionals (e.g., Powell & Peron, 2010; Williams, Nielson & Coulson, 2018);
c) comparisons with other types of services (Backhaus, Ibarra, Parrott & Malec, 2016; Morriss et al., 2016; Watson & Dodd, 2017);
d) provision of support within them (Smedley, Coulson, Gavin, Rodham & Watts, 2015; Williams, 2018);
e) how they are facilitated and organised (Delisle et al., 2016; Brown, 2017); and
f) motivations for joining them (e.g., Sherman et al., 2008; Worthley, Hostetler & Frye, 2017; Hatano, Mitsuki, Hosokawa & Fukui, 2018).

There has been some limited research on problem representation in relation to face-to-face groups. Krause (2003) studied the changes in representation of chronic inflammatory bowel disease in a self-help group using participant action research. However, she used a number of interventions with the group so the outcomes cannot definitely be ascribed to participation in peer support. She reported that group members moved from a negative representation to a more positive one characterised by acceptance of the illness as something that patients could live with and as 'normal'. Her study

identified the provision of information, including between group members, as important in achieving this change. It will be shown that a similar normalization occurs in the AOSGs explored in this study in Chapter 5.

Many researchers have noted that information provision is an important aspect of support groups, particularly the exchange of experiential information (e.g., Hatano, Mitsuki, Hosokawa & Fukui, 2018; Jones, Sommereux & Smith, 2018; Gumuchian et al., 2019; Southall, Jennings, Gagné, & Young, 2019). In terms of studies focused on information behaviours within groups, Jessop, Cohen, Burke, Conti & Black (2004), for example, studied the information needs of members of a hepatitis support group and the success of the group in meeting these needs. The research showed that the support group was an important source that helped with acceptance of the illness (as in Krause's study), making decisions about care and dealing with side effects of treatment. Carey (2005) explored the information world of a self-help group for systemic lupus erythematosus in an ethnographic study, finding that users disseminated both expert knowledge from professionals and lay information drawn from experience and the group's culture.

2.6.2 Online health support groups

Use of the internet increases year on year, including for older age groups (ONS, 2019a) and in relation to healthcare purposes. In the UK, in 2019, the number of adults looking for health information online rose to 63% (ONS, 2019b, p7) from 54% in 2018. Usage for this purpose was higher amongst women at 68% compared with 59% of men (ONS, 2019b, p7) and was highest in the 25-34 age group (Statista, 2020).

Fox and Duggan (2013) established that 26% of internet users in the US had employed it to access another person's health or medical experiences in the preceding year. Sixteen percent had used it to access others with similar health concerns to themselves in the same period. Eight percent of these internet users posted a question or shared their health experience online: 40% of them posting comments or stories, 19% health questions, and 38% both. A US Pew survey (Fox, 2011) on 'peer-to-peer healthcare' showed seeking out similar others was particularly high among people with chronic diseases/conditions, with 23% of them doing so. This research highlighted that people primarily found peers/health OSGs useful for practical information about day-to-day matters and support. A more recent study (Madrigal & Escoffery, 2019) involving a smaller cohort compared internet usage amongst US individuals with chronic conditions and those without. Their findings are summarised in Table 2.1:

Table 2.1: Health internet usage in USA (n = 401)

Aspect of Internet usage	With chronic condition	Without chronic condition
Reading about someone else's health experience	40.3%	33.3%
Looking for others with similar health conditions	27.5%	24.2%
Using the information to make decisions about healthcare providers	40%	25.8%
Using the information to make decisions about treatment	49.2%	35%
Changing how user copes with the condition or chronic pain	40.8%	19.4%

It is noticeable that all five activities were higher amongst those with chronic conditions, showing the importance of internet health information for this group. It is surprising that the number of those looking for others with similar health conditions was low in this group, especially given the popularity of reading about others' health experiences.

There has been a large rise in the numbers of online health support groups (OHSGs) since the 1990s, covering many conditions including very rare diseases. Research into them has grown extensively. Some examples of what has been studied include:

a) the effects of the groups on health and other outcomes including their role in the self-management of chronic conditions (Eysenbach, Powell, Englesakis, Rizo & Stern, 2004; Ziebland & Wyke, 2012; Yang, 2020; Huber et al., 2017; Shoebotham and Coulson, 2016; Allen, Vassilev, Kennedy & Rogers, 2016);
b) different types of groups (Howard, 2014);
c) benefits and disadvantages of groups (Mo & Coulson, 2014; Smith-Merry et al., 2019; Turner, 2017); and
d) communication, social support provision and empathy within groups (Sharma & Khadka, 2019; Zhu & Stephens, 2019; Hargreaves, Bath, Duffin & Ellis, 2018; Zhang & Yang, 2015).

Smith-Merry et al. (2019) offered a helpful summary of research on mental health forums, finding that analysis tended to focus on the content of posts, the impacts of using forums and/or the reasons for their use. They noted, however, that: "we still lack insights into key questions on how they are experienced from the perspective of their users" (Smith-Merry et al., 2019).

There has been some research on problem representation in relation to OHSGs. Using the Health Belief Model, Willis (2018) examined the role of peer content in OSGs in forming attitudes to prescription medication compliance. Godbold (2012, p43) explored sense-making and the development of ideas in renal OSG discussion forums, finding that rather than having "stable 'knowledge structures'" beliefs were "transient and customised", based in information about experiences and rendered relevant to the individual:

> "Rather than coping with complex situations by developing simplifications, people added complexity. They contributed nuanced descriptions of their own situations, creating a loose-knit array of possibilities, from which new posts picked ideas and placed them in new arrangements as the need arose." (Godbold 2012, p67)

Chen (2015) used the CSM to explore the relationship of information use to illness representations in a two-part study of patients with fibromyalgia. In terms of representations, she focused only on the dimension of personal control, emotional response to the illness (the emotions 'track') and the sixth dimension of coherence, arguing that these are particularly important and interconnected for chronic diseases. She focussed only on how information was used (such as to understand an illness, talk to a healthcare professional, decide on a new treatment) rather than on how information was found or conveyed within a source. The first part of Chen's study looked at how information use affected illness representations at different time-points (onset of symptoms, diagnosis, the present day) finding significant associations between length of time since onset and greater coherence and between greater coherence and more positive emotional response to the illness. Interestingly, Chen (2015) found that using information to understand one's illness was negatively associated with control, whereas using information for coping was positively associated with control. She argued that this could indicate that there was a need to focus patients on information for coping as time progressed:

> "patient education and chronic illness self-management programs could suggest generic information on fibromyalgia and treatment information to those beginning to develop

> symptoms, but encourage those who have had the condition for a period of time to focus more on long-term condition management strategies" (Chen, 2015, p348).

The link between receiving information about the treatment and feeling less in control may be in part due to the absence of effective treatment for fibromyalgia. The second part of Chen's study explored how information use and illness representations differed in OSG forums and social media sites according to the role taken by the user, i.e., non-user, lurker, infrequent poster, frequent poster. She found that infrequent posters were the most likely to have least coherence or sense of personal control and the most negative emotional responses. Chen (2015) speculated that this could be because infrequent posters may be those moving from lurking to participation, particularly in need of information but not yet confident to post much, and argued that it could be useful to target them more specifically in interventions.

Hu, Bell, Kravitz and Orrange (2012) studied the use of information by members of the OSG 'Daily Strength' to prepare for medical appointments, looking at the different sources they used. The study focused on four predictors of information seeking prior to an appointment, one of which was the user's illness representation, measured using a short version of the IPQ and excluding questions on cause as participants had many different illnesses. It explored which dimensions of the CSM were most associated with information seeking in different formats including offline, on the Internet generally and on the OSG. The study found that information seeking before visits was frequent, and that group members were more likely than others to include a variety of sources both off- and on-line.

> "OSG members who turned to their online communities as they prepared for their visits were more likely to make use of other Internet health resources and offline information, including traditional media, family, and friends." (Hu et al., 2012, p974)

Those who mainly used the support group for information generally had illness representations with a high level of personal control of the illness, a perception of it as chronic and held negative emotions in relation to it.

Information behaviours have been explored in relation to OSGs. Topics researched include:

a) knowledge construction in OSGs (Kazmer & Lustria, 2014; Hara & Sanfilippo, 2016);

b) sharing information and knowledge (Kingod, Cleal, Wahlberg & Husted, 2017; Frost, Vermeulen & Beekers, 2014; Yan, Wang, Chen & Zhang, 2016; Shoebotham & Coulson, 2016; Savolainen, 2011, Zhang & Yang, 2015);
c) information seeking (Zhang, Sun & Kim, 2017; Plinsinga et al., 2019; Savolainen, 2011);
d) comparisons between online and offline information disclosure (Nguyen, Bin & Campbell, 2012); and
e) participatory patterns (Mo & Coulson, 2010; van Mierlo, 2014).

A frequently made point about information sharing in OSGs is the prevalence of experiential information, often concerning the everyday issues of living with an illness. However, Frost et al. (2014) found that respondents preferred to share clinical information rather than daily life information and that female participants shared information less willingly; this study however is something of an outlier (see e.g., Kingod et al., 2017; Shoebotham & Coulson, 2016). Nguyen et al. (2012) noted the existence of contradictory evidence regarding whether personal self-disclosure was greater in online formats compared with offline, or *vice versa* and, in a systematic review, found evidence for both arguments. They found that disclosure was influenced by contextual elements such as the relationship between 'speakers'. Savolainen (2011) analysed seeking and sharing information in different types of online interactive mechanisms (blogs and discussion forums) on sites dealing with depression. He found no significant differences between them with users in both drawing heavily on experience; and requests for factual information or "ways of possible action" (how to go about things) occurring less frequently than requests for opinion (2011a, p874). He noted that discussion forums could be seen as a type of Fisher's 'information grounds', places where individuals gather for a purpose unrelated to information seeking but where this nevertheless takes place. He also discussed them as sites where people could experience 'information encountering'. Reviewing previous literature, Savolainen noted that several studies had found that posts contained more information sharing than information seeking, more self-disclosure than questions, but that the latter did occur. In his 2011 study, Savolainen found that forum participants "do not spend much time and energy to seek information sources beyond their personal knowledge". He concluded that "there is a need to interview [bloggers] and discussion forum participants about their ways to use [sic] online forums in the context of everyday information practices" (2011, p883), which is something the present study seeks to address.

Section 2.6 has set the scene by exploring previous research on face-to-face and online health support groups, with particular reference to work on representations and information behaviours in

the groups. It has been indicated that both types of groups have had considerable research attention, and some of the topics examined have been given. The following sections focus on existing research on groups in the alcohol field, dividing these into face-to-face 12-step groups notably AA (Section 2.7.1), face-to-face non-12-step groups (Section 2.7.2) and online groups both 12-step and non-12-step (Section 2.8).

2.7 Alcohol support groups

2.7.1 Face-to-face 12-step alcohol support groups

12-step AOSGs include AA and other groups adopting the same 12-step programme for recovery. AA was formed in 1935 by two recovering problem drinkers and primarily sees recovery as a spiritual process in which stopping drinking is only the first step. (See Appendix 5 for the 12-step programme.) Since its inception, many AA groups have been set up worldwide: in 2015 there were an estimated 118,000 groups and two million members in approximately 180 countries (AA, 2021). The approach it takes is now often adopted by clinical treatment programmes which may mandate AA attendance. It is available face-to-face and online where both discussion groups and AA meetings can be found. Versions modified for many other addictions are also available e.g., Narcotics Anonymous, Gamblers Anonymous, Sex Addicts Anonymous. There are also other alcohol online groups, which are not formally linked with AA but do follow the same 12-step approach.

Some research has argued that AA meetings are not homogenous in practice. Kitchin (2002) found differences between 'ideal AA' as embodied in the AA programme and the reality of meetings, whether face-to-face or online. Yarosh found that:

> "There was a great deal of geographic and demographic variety in approaches to recovery and interpretation of traditions within the same fellowship" (Yarosh, 2013, p3421)

Bjerke argued that AA grows organically and that "AA's 12 steps are not universal and strict beliefs, but instead simple suggestions to follow" (2009, p88). Certainly they are presented thus when first introduced in the *Big Book*: "Here are the steps we took, which are suggested as a program of recovery" (2001, p59) and AA's third tradition is that the only requirement for membership is "a desire to stop drinking" (AA, 1950) not that one must follow the steps. However, at the same time, AA unequivocally urges adoption of its beliefs on members "with all the earnestness at our command" predicting that failure to "completely give themselves to this simple program" will render recovery impossible (AA, 2001, p58). It states that: "Some of us have tried to hold on to our old ideas

and the result was nil until we let go absolutely" (AA, 2001, p58). The 12 steps and traditions are not presented as open to amendment.

There is a considerable amount of scholarly research already undertaken on AA. Table 2.2 presents the results of a search on the term "Alcoholics Anonymous" in April 2020.

Table 2.2: Search results: Alcoholics Anonymous, 2020

Database	**All field search**	**Title field search**	**Written since 1/1/16 (Title field search)**
ProQuest – books, conference papers, scholarly journals, thesis & dissertations, peer reviewed	6,264	520	36
Pubmed – books, documents, journal articles	1,512	341	93
Medline – books, articles, PsychArticles	1,513	162	36
Scopus	7,757	625	59
Google Scholar	58,800	2,160	148
Totals	**82,110**	**3,808**	**373**

Please note this table does not exclude duplicate or irrelevant items other than in the final column.

A wide variety of topics have been examined over the years including, for example:

a) AA's effect on outcomes: e.g., its effect on abstinence and relapse prevention; the effect of specific aspects of AA, such as that of 12-step work on abstinence, or sponsorship and service on outcomes (Jordan, 2019; Emrick & Beresford, 2016; Zemore, Kaskutas, Mericle & Hemberg, 2017; Karriker-Jaffe, Klinger, Witbrodt & Kaskutas, 2018; Kelly, Humphreys & Ferri, 2020. The last of these is a Cochrane systematic review of 12-step effectiveness, finding that it is more effective than other standard treatments);
b) How and why AA works (Galanter, 2014; Kelly, Hoeppner, Stout & Pagano, 2012; Kelly, 2017);

c) What makes a successful AA member, membership characteristics, personality differences between members and non-members, why some drop out (Krentzman et al., 2011);
d) AA and medical treatment (Marcovitz, McHugh, Roos, West & Kelly, 2020; Kastenholz & Agarwal, 2016);
e) AA in relation to particular populations: for example, adolescents (Hoeppner, Hoeppner & Kelly, 2014), women (Sanders, 2018; Kelly & Hoeppner, 2013), transgender people (Matsuzaka, 2018), Urban American Indians (Tonigan, Venner & Hirchak, 2020);
f) Spirituality and AA (Bluma, 2018; Kuerbis & Tonigan, 2018; Vermeulen, 2017); and
g) Historical studies: the history of AA (Galanter, 2014), AA in Poland (Jannasz, 2018).

Various aspects of information behaviour have been studied in relation to AA, notably as regards information sharing, and the next sections cover those of relevance to this thesis.

2.7.1.1 Storytelling

Representations of problem drinking and information behaviours come together in an extremely important way in face-to-face AA in its storytelling practices. This has received considerable research attention and focuses on the telling of the stories of members' lives or what AA calls "personal stories" (Cain 1991, p239). For those who view problem drinking as a disease, these 'personal stories' would fall into the category of 'illness narratives': "Illness narratives refer to the story-telling and accounting practices that occur in the face of illness." (Bury & Monaghan 2013 p91). They are more than an account of an illness in the manner of a case history, but rather an attempt to make sense of, and add meaning to, disease; to create a coherent structure where there has been disruption. The illness representation is embodied in this illness narrative.

Within AA, storytelling has a particularly central and significant role: indeed, as Swora suggested "sharing autobiographical narratives is AA's core practice" (1996, p9). The heart of the programme is the sharing of members' 'experience, strength and hope'. The narrative of the problem drinker is encouraged to be holistic "Our stories disclose in a general way what we used to be like, what happened, and what we are like now" (*Big Book* 2001, p58). AA meetings may have an opening speaker who talks about their life in relation to alcohol at some length, then each individual takes their turn to talk of their experiences. This might be the story of their drinking and recovery or an anecdote from this. They may relate it to what has already been said, identifying with other speakers, or use it to illustrate some topic under discussion, for example, one of the 12 steps. Some meetings will not have a speaker, but will otherwise be structured the same. Storytelling is

specifically invited by the *Big Book:* for example, Chapter 7 sets out in detail how to do the '12th step work' of carrying the message to others, advising that the encounter be entirely structured around telling one's own story. Stories are also an important part of the content itself: the 4th edition of the *Big Book* has a section entirely given to 42 personal stories, and there are many more within the information about AA and its programme in the first section. Both AA literature and AA meetings are narrative occasions.

Both Cain (1991) and Steffen (1997) identified a generic AA life-story structure (or 'community narrative' as Humphreys called it, 2000). This was simplified by Strobbe and Kurtz (2012) in their analysis of 24 life-stories from the *Big Book*, proposing a normative model for the AA story of early drinking, problematic drinking, hitting rock bottom, then progress in AA to reach steady sobriety. Steffen identified four types of sub-genres in AA: the life-story (autobiography), anecdote (excerpt from the life-story), clinical case history (comparatively rare, but there is Dr Silkwood's account in the *Big Book*) and myth, e.g., the life-story of the founders of AA, (Steffen 1997, p108). Flynn (1994) and Humphreys (2000) also described different categories of AA stories. In a study of recovery, Hanninen and Koski-Jannes (1999) explored storytelling amongst a wide range of different types of addicts, including problem drinkers. Noting the dominance of the AA narrative and the lack of research attention to accounts by non-AA members they found five types of addiction narrative: "the AA story, the [personal] growth story, the co-dependence story, the love story and the mastery story." (p1837) They argued that different genders and addictions adopted different story-types, e.g., AA narratives were usually told by male participants, whereas personal growth stories were more frequent amongst women. Dingle, Cruwys and Frings (2015) also identified two common addiction narratives: one of identity loss and one of identity gain where heavy drinking confers belonging in a group. Pienaar and Dilkes-Frayne (2017) also explored addiction narratives (predominantly of drug users), finding ones that included the benefits of consumption and described actively and successfully managing continuing addiction. This research showed that there are alternatives to the dominant fall and redemption AA narrative, although they do not look at this in relation to support groups. It is interesting that Kovacs, Mefozi, Gyarmathy and Racz (2020) in a narrative and thematic analysis of patient stories, found that those of patients recovering from addiction were more structured and homogeneous compared with those of patients with other chronic conditions, and this might reflect the dominance of the redemption narrative.

Cain's work (1991, 1998) showed how AA teaches newcomers its culture, beliefs and practices, largely through these stories. Newcomers learn to reinterpret their past and reconstruct their

identities and their representation of problem drinking, moving from being 'drinking non-alcoholics' to 'non-drinking alcoholics'. They do this through listening to the stories of others and identifying with them, interpreting their own story in the same way and telling it in their turn to help others, a process that can bring self-acceptance as they 'take ownership' of what has happened to them by speaking it aloud. They also learn from others' reactions to their stories, and by observing how other members apply stories to themselves: which parts of the narratives other members endorse (identify with), and which they correct. 'Correction' happens when a speaker tells similar stories from their own life with alternate, AA-compatible interpretations and explanations. The individual is not overtly corrected: this is done implicitly, with "advice disguised as self-disclosure", as Lewis put it (2014, p10). As Valverde and White-Mair (1999) have suggested, the telling of stories in AA is more about drawing individuals into a pre-existing set narrative than an exploration of individual feelings and thoughts. In short:

> "As the newcomer learns the structure of the AA story, and learns the model of alcoholism encoded in the story, he begins to place the events and experiences of his own life into this form. He learns to tell his own life as an AA personal story, and through this, to understand his life as an AA life and himself as an AA person. He comes to understand why and how, he is an alcoholic" (Cain, 1998, p96).

The stories of both newcomers and 'old-timers' (members who have been in AA a long time) bring benefits to members. The newcomer's story is valuable in reminding members what pre- or early sobriety is like and how much the more experienced member's life has changed since they were in that position (Swora, 2001). It helps to maintain the community as it provides confirmation of the old-timer's beliefs. The old-timers' stories show that it is possible to recover, and offer a way out from problem drinking, a role model to follow and a sense of being no longer alone, but understood. This latter aspect is an important factor in keeping the new problem drinker returning to the group, and thus continuing to learn and to endorse the model of problem drinking proffered.

Cain's work was convincingly used by Lave and Wenger in their early work on 'communities of practice' (1991) as an example of 'situated learning' or learning as a by-product of social activity, occurring as a result of actively participating in problem solving in a real world environment or simulation of it. They envisaged the old-timer as a practitioner or expert, and the newcomer as an apprentice who joins the group and, guided by the 12 steps, slowly moves from outsider to central or 'adept' status as s/he learns to become a 'non-drinking alcoholic' in the ways described above.

While AA would not like the idea of experts, as it is very egalitarian in structure, and rejects the notion of perfection ("we claim spiritual progress rather than spiritual perfection" AA, 2001, p60), the idea of learning through association with competent practitioners and as an outcome of group participation and practice in telling one's story, rather than from formalised teaching, is helpful.

Steigerwald and Stone (1999) identified problem drinking as a 'thought disorder' requiring cognitive restructuring. They argued that AA works in ways similar to therapy in changing beliefs and behaviours and pointed out that the need to "restructure" thinking is addressed in the *Big Book*. They analysed the 12-step programme's role in cognitive restructuring stating that:

> "Attendance at AA meetings, [sponsorship] and working the 12 steps provide a mechanism through which alcoholics learn new cognitions of recovery" (Steigerwald & Stone, 1999, p326)

Young (2011), however, challenged research emphasising cognitive change, arguing that dealing with problem drinking is rather about changing relationships. He used personal construct theory to explore how AA changes members' identities, arguing that social and spiritual changes are more important than changing "dysfunctional behaviors and thoughts" (p710). This is arguably more a matter of the process or mechanisms by which AA members change: ultimately the fact that their beliefs about drinking and about themselves are restructured as a result of participation in AA remains the same, whether this comes about as a result of cognitive, social or spiritual processes or all three. As Thomassen proposed:

> "In AA, the meaning of an alcoholic is negotiated and transformed, as individuals transform themselves into AA alcoholics" (2002, p193)

This study will explore at length whether similar changes take place in this sample of non-12-step forums.

2.7.1.2 Disagreements

Another form of information sharing is disagreement and debate, and research has noted that AA has a distinctive way of carrying this out in its face-to-face meetings. As discussed above, people partly learn in face-to-face AA through hearing the endorsement (or otherwise) of aspects of their interpretation of their story. 'Correction' is carried out through this and through hearing others tell

parallel stories with different interpretations. Alternatively, a person's statements may simply be ignored, thus not getting any reinforcement, whereas other peoples' views do. Social cognitive and social learning theory suggest that people learn through 'vicarious reinforcement', i.e., observing others' actions and the reactions, rewards and punishments the views get (Bandura, 1977). Within meetings, there is ample opportunity for members to see this happening.

Hoffman (2006) looked at deviance in AA including disagreement about AA norms and found direct criticism and open argument in meetings to be very rare, although they did occur outside meetings. Both AA principles and structure are formulated to discourage disagreement. For example, members are explicitly encouraged to look at their own shortcomings and faulty thinking (to take their own 'inventory' as per Step 4) not that of others, and to look for things in common ('identification') rather than differences. The first of the 12 traditions governing how AA is run is "Our common welfare should come first; personal recovery depends upon AA unity" (AA, 1952). All speakers, after the opening one in meetings, have equal opportunity to speak for an equivalent length of time, the right not to be interrupted and have access to a shared vocabulary, encouraging the idea of similarities:

> "members have access to and deploy an identical range of discursive practices. This, in effect, constitutes each member as having similar discursive roles and identities and is important in the avoidance of conflict" (O'Halloran, 2005, p536).

O'Halloran (2005) argued that the strong emphasis on speaking from one's own experience also mitigates against disagreement, as it is unchallengeable. The speaker is the only possible authority on the matter and is not overtly commenting on, or judging, anyone else, or talking of 'outside issues' that could lead to conflict. However, this is only partially true, as speakers will often draw a meaning from their experience and this could be open to debate. The means of debate used though, is a reinterpretation expressed through a responder's own personal story. Even if this story is intended as a challenge, the person aimed at is not directly confronted and is free to make their mind up as to whether they agree or not. Arminen (1996) pointed out that this absence of direct challenge contrasts with forms of therapy, in which challenge can be seen as a positive and helpful act, aiding the patient's recovery.

2.7.1.3 Slogans and mantras

The slogans of AA are connected to meetings not only via their use in members' stories but their frequent presence in large print on the walls of the meeting rooms. These forms of direct instruction

include, for example, ‘One day at a time’, ‘Easy does it’, ‘First things first’, ‘Keep it simple’. Members are encouraged to hold on to these sayings in their daily life and to practise them. Swora (1996) indicated how they are linked to AA traditions and the 12 steps and encapsulate beliefs about AA. To understand them properly, the reader needs to know about AA culture and how to interpret them, but once this is known they act as reminders and “as crystallisations of AA’s home-grown collective wisdom they are full of practical meaning and power.” (Valverde & White-Mair, 1999, p406). Slogans are not favoured in the context of non-AA groups or AOSGs other than 12-step ones; indeed, they may be criticised as ‘groupthink’ (Swora 1996), but, as this study will show, some non-12-step groups do have their own personalised versions of mantras and slogans.

2.7.1.4 Sharing facts, research and direct instructions

The AA meeting forum is not conducive to dissemination of medical or social facts/research (e.g., about the effects of drink on the body, costs and harms to society at a macro level); or referrals to books or websites. Thomassen argued that AA is actually unwelcoming to researchers as they:

> “represent an orientation to the problem that is directly antithetical to the group’s own understanding of the problem [that only one problem drinker can understand another]” (Thomassen ,2002, p181).

This needs to be qualified by acknowledging the number of research studies on AA, although it would be interesting to quantify how many of these actually worked directly with AA and how many were following up AA members via medical services, as Thomassen did.

There is, however, learning in AA meetings through direct, overt instruction. Swora (1996) noted that meetings begin with readings (e.g., the AA preamble or sections from the *Big Book*), which reinforce the key AA messages and explanation of problem drinking. It is common, for example, to read from the start of Chapter 5 called ‘How it works’ which includes the 12 steps. The meetings thus incorporate overt teaching of specific AA content, introducing and explaining AA to newcomers and acting as a reminder for old-timers. Readings are used not to provoke private research, but to set off thoughts about experience (Swora, 1996). Through repeated hearing at meeting after meeting the words can become extremely familiar. Members may also take turns in reading aloud so speaking the words themselves, which helps to further embed them. Words from these readings can enter AA ‘jargon’. Jones (2014) discussed AA speech as a specialised language and how it moves from the *Big Book* to individuals’ personal narratives. Ziebland & Wyke (2012) pointed out that the

way people describe their experiences is important and influences the vocabularies available to the listener, helping them in turn with their own story-telling. Steffen also noted how AA communication uses special terms, slogans and words, calling this "a kind of AA slang" (1997, p102) which is used at informal as well as formal occasions.

2.7.2 Face-to-face non-12-step groups

There are many face-to-face alcohol support groups that do not follow the 12-step programme of AA, but they have received much less research attention (Humphreys et al., 2004; Parkman, Lloyd & Splisbury, 2015; O'Sullivan, Blum, Watts & Bates, 2015 and Zemore, Lui, Mericle, Hemberg & Kaskutas, 2018). Where they have received research attention, it has tended to focus only on a handful of well-known groups, notably Smart Recovery (SR), Moderation Management (MM), LifeRing (LR), Women for Sobriety (WFS), Secular Organisation for Sobriety, also sometimes known as Save Our Selves (SOS) and Rational Recovery (RR). The same searches that were carried out for AA (see Table 2.2) were carried out in April 2020 for the first three of these groups to provide an indication of the difference in coverage. The findings are summarised in Tables 2.3-2.5. Please note these tables do not exclude duplicates or irrelevant items other than in their final colu**mn.**

Table 2.3: Search results for "Smart Recovery", 2020

Database	**All field search**	**Title field search**	**Written since 1/1/16 – title field search**
ProQuest – books, conference papers, scholarly journals, thesis & dissertations, peer reviewed	78	17	7
Pubmed – books, documents, journal articles	22	11	6
Medline – books, articles, PsychArticles	20	11	6
Scopus	207	23	17
Google Scholar	2240	99	33
Totals	**2,567**	**161**	**69**

Table 2.4: Search results for "Moderation Management", 2020

Database	All field search	Title field search	Written since 1/1/16 – all field search
ProQuest – books, conference papers, scholarly journals, thesis & dissertations, peer reviewed	47	10	0
Pubmed – books, documents, journal articles	6	4	0
Medline – books, articles, PsychArticles	6	4	0
Scopus	177	9	0
Google Scholar	942	32	1
Totals	**1,178**	**59**	**1**

Table 2.5: Search results for "LifeRing", 2020

Database	All field search	Title field search	Written since 1/1/16 – title field search
ProQuest – books, conference papers, scholarly journals, thesis & dissertations, peer reviewed	12	3	1
Pubmed – books, documents, journal articles	3	1	1
Medline – books, articles, PsychArticles	3	1	1
Scopus	23	2	1
Google Scholar	375	12	1
Totals	**416**	**19**	**5**

As can be seen from comparing Tables 2.2-2.5, it is clear that recent research on AA still far outpaces that for the three non-12-step groups. The following gives a short summary of key subjects researched, followed by a more in-depth look at some work of particular relevance to the present study.

Popular topics found in research on non-12-step groups include:

a) descriptive overviews of them, covering, for example, their history, organisation and publications (e.g., Horvath & Yeterian, 2012; Lembke & Humphreys, 2012; Kelly & White, 2012);
b) studies of the characteristics of group users (O'Sullivan, Blum, Watts, Bates, 2015; Waite, 2018; Zemore, Kaskutas, Mericle & Hemberg, 2017) including the link between personality type and group preference (McDowell, 2011);
c) studies of user experiences and life-stories (e.g., Falconer, 2013; Penn, Brooke, Brooks, Gallagher & Barnard, 2016); and
d) the efficacy of different groups, including in terms of: drinking outcomes (Campbell, Hester, Lenberg & Delaney, 2016; Parkman, Lloyd & Splisbury, 2015; Crawford, 2016; Beck et al., 2017); easing psychological distress (Raftery et al., 2020) and prevention of re-offending (Blatch, O'Sullivan, Delaney, Rathbone, 2016).

Outcome studies are the most popular topic overall.

A significant body of the titles found compared one or more of the non-AA groups with AA in some respect (e.g., Reardon, 2013; Kitzinger 2013; Flaherty, Kurtz, White & Larson, 2014; Tsutsumi, Timko & Zemore, 2020). Reardon (2013) identified the distinguishing features of non-12-step groups as being their secular approach, their rejection of the 12-step emphasis on powerlessness, their openness to change, recognition that membership might be temporary rather than lifelong and focus on the present and future rather than the past. Falconer (2013), in a phenomenological study involving ten semi-structured interviews that were thematically analysed, looked at participant experience in depth in LifeRing and why members preferred this group to AA. The research looked at the benefits of LifeRing identified by the participants and their criticisms of it. Using similar methodology, Kitzinger (2013) compared the experience of users of SR, SOS and WFS with 12-step recovery. Zemore et al. (2018) compared the effectiveness of 12-step groups with WFS, LifeRing and SR using data from a rare longitudinal study (the Peer ALternatives for Addiction (PAL) Study), with

findings “tentatively” suggesting that the non-12-step groups are of equivalent efficacy. Tsutsumi et al. (2020) used data from the same study to explore patterns of affiliation, and found that drop-out rates were low for both types of group (and associated with worse drinking outcomes), but that non-12-step group members were more likely to change groups at 6 months, usually to a 12-step group; this being accompanied by worse quality of life and an increase in negative emotions. Waite (2018) found no difference in the self-efficacy or motivation of AA and SR members, concluding that “broadening participation to include more than one type of fellowship may have greater benefit for some persons in recovery” (p3).

This focus on comparison is perhaps unsurprising given AA’s dominance in the field of recovery. Most of the non-12-step groups were established by people who had tried AA and disliked it, and have substantial percentages of members who have previously been to AA or who have attended, or still do attend, both groups. This influence can be seen in the AA terminology adopted by some of these groups: for example, SOS values include the following (my emphasis):
“As a group, SOS has **no opinion on outside matters and does not wish to become entangled in outside controversy**”. (SOS, n.d., p192). Compare this with AA’s 10th tradition:
“Alcoholics Anonymous has **no opinion on outside issues; hence the AA name ought never be drawn into public controversy.**” (AA, 1950)
Also: “To avoid unnecessary entanglements, **each SOS group is self-supporting through contributions from its members** and refuses outside support” (SOS, n.d., p192)
“There are no dues or fees for A.A. membership; **we are self supporting through our own contributions**” (from the Preamble of AA read at the start of UK meetings, AA 2013)

Several studies have looked at matching participants and treatment approaches. Atkins and Hawdon (2007) explored matching on the basis of approaches to religion and spirituality in 12-step, SOS, SR and WFS groups. They found that a better match led to increased participation in a group, which, in turn, led to better drinking outcomes, regardless of the philosophy of the group. This work is important for the present research in adding to the literature indicating that different types of groups can work well for different people and in demonstrating a link between beliefs, participation and improved outcomes. Furthermore, it showed strong correlations between membership of all the different groups and agreement with the group’s beliefs. However, it did not address the question as to whether a group can impact on, and change, participants’ beliefs, nor did it look at beliefs other than about religion/spirituality or specifically at the online format, as the present study did. Both Auxier (1994) and Wilmes (1999) looked at beliefs around locus of control as potential matching

criteria for clinicians to use to direct clients to appropriate groups. These two studies focussed on measuring beliefs rather than exploring their acquisition or the role of the group in creating the beliefs beyond simply attracting like-minded people. Chambers (2018) and Worrall et al. (2018) both found that alignment of personal beliefs with AA was important:

> "forceful referral of people to 12 step self-help groups without respecting their own explanatory models of understanding their addictions and illness was counterproductive." (Worrall et al.,2018)

The most famous matching study was Project Match (begun in 1989), an eight year, multi-site study, with 1,726 participants which, at the time, was the largest clinical trial of psychotherapies ever carried out. This compared 12-step facilitation therapy (note this is not the same as actual participation in a 12-step group) with CBT and Motivational Enhancement Therapy, looking at many patient characteristics such as gender, readiness for change, psychiatric severity and alcohol dependence. They did not explore beliefs about problem drinking as this thesis does, did not have a control group (presumably for ethical reasons) and, somewhat strangely, did not actually match patients to treatments in advance, but randomly assigned them. It should also be noted that recipients of all three treatments also attended AA meetings. Project Match results suggested that matching did not appear to make much difference to outcomes, with participants in all three therapies improving their drinking outcomes. However, it cannot be taken as having answered the question as to whether matching on the basis of beliefs or representation of problem drinking is beneficial.

The work of Kaskutas (1992) on beliefs in WSF and AA requires particular mention as relevant to this study. Kaskutas studied members' ideas about where power and control lie in terms of getting/staying sober (with God or with the individual) arguing that this is the most basic difference between AA and WSF (1992). However, similar to Godbold later (2012) in relation to online renal groups, she found that the women she studied held apparently dissonant ideas, merging beliefs from both groups. For example, those who had attended, or still did attend, AA also thought that their own state of mind was important and that they had control over their own sobriety, an apparently paradoxical stance given that recovery is believed to come from a 'Higher Power' in AA. Eighty percent of those who put AA ahead of WSF in importance to them nevertheless agreed that "My state of mind is the single most important thing for staying sober". Kaskutas concluded that women were adopting and incorporating aspects of different belief systems. This may, however, be

a matter of interpretation, based on an oversimplification of AA philosophy, as AA does highlight the importance of the right frame of mind: see throughout Chapter 5 in the *Big Book*, for example:

> "If we were to live, we had to be free of anger. The grouch and the brainstorm were not for us. They may be the dubious luxury of normal men, but for alcoholics these things are poison" (2001 p66).

A study by Humphreys and Kaskutas (1995) also analysed and contrasted the 'world views' of AA and WSF, exploring amongst other things Antze's belief that group world views act as "cognitive antidotes" to members' problems. They found some evidence for this proposal, but noted that:

> "not all mutual help group members experience or even want to experience world view change…it would be inappropriate to say that the effects of mutual help involvement are limited to what the organization offers as a cognitive antidote." (Humphreys & Kaskutas 1995 p241)

However, Klaw and Humphreys (2000) explored life-stories in MM, finding that attendance at this group often came about from the rejection of the 12-step philosophy, with members preferring the MM world view as a better match to their "experience, values and preferred self-narratives" (p779).

Kaskutas and Ritter's study (2015) of beliefs about recovery from a large online survey (n = 9,341) of people in recovery sought to examine whether treatment choice related to how the individual defined themselves and what they believed about recovery. Participants were asked to agree or disagree with statements describing recovery. The research used social representation theory to explore whether the ideas and language of recovery impacted on beliefs and thence behaviour. It evidenced a statistically significant difference in definitions of recovery between those who had no exposure to any treatment (self-changers) and those who did, specifically exposure to 12 step groups, clinical treatment or exposure to non-12 step groups. They concluded that:

> "Consistent with social representation theory's view that social collectives influence individuals' language, self-perception, beliefs, and behaviors….pathways to recovery are strongly related to self-definition, abstinence beliefs, and behaviour. These results...demonstrate the key role that recovery-based approaches play in how those

exposed to these collectives frame their recovery. *Ours in the first such large-scale study to empirically show this*" (Kaskutas & Ritter, 2015, p7, their emphasis).

This research supported the idea of the impact of groups on beliefs as going beyond passive attraction of like-minded people, to actively influencing these beliefs, like AA. The authors acknowledged limitations with their study, for example, questions were limited in scope to ensure a short survey. They also did not take enough into account the dominance of the AA discourse in US and other cultures, (although they did acknowledge this). It would be possible not to go to treatment of any kind yet still to absorb some of the beliefs, via mass media, for example. The survey was not a sufficiently flexible or responsive enough tool to explore this. Kaskutas and Ritter did not seek to explore the influence of the groups on beliefs about problem drinking other than in terms of recovery, which the present study did. They also did not specifically look for distinctive ideas from the non-AA groups - the process used to create the survey discovered a somewhat homogenous, AA-based definition in use in practice regardless of the treatment pathway.

It was noted in Section 2.7.1.1 that Steigerwald and Stone described problem drinking as a "thought disorder" and AA as providing "cognitive restructuring" (1999, p321). It is this process of 'restructuring' thought that appears to link many of the face-to-face groups together, although it is manifested differently in different types of groups. Whereas AA relies on the 'received wisdom' of the experience of AA members over the years and the teachings of the *Big Book*, some groups use specific, established forms of therapy. For example, CBT is used by SR to 'teach' people to unlearn drinking behaviour and create change. The process appears to be that members consider and identify the connections between thought, feeling and behaviour and isolate negative beliefs, challenging these. They introduce positive thoughts and behaviour and use homework activities to practise these between meetings (Kelly, Deane & Baker, 2015). RR employs Rational Emotive Behaviour Therapy (REBT), a form of cognitive psychotherapy developed by Albert Ellis (see for example, Ellis, 1962, 1993). This links emotional upset to thought and argues that emotions can be changed by changing thoughts through rational refutation. The founder of RR, Jack Trimpey, took these ideas and developed what he called Addictive Voice Recognition Training (see www.rational.org). This sees thoughts as voices in the head and argues that problem drinkers' thoughts are deeply irrational. He characterised the urge to drink as the addictive or 'beast' voice and the aim of treatment as to recognise it and refute its arguments. In this, the groups are very directly challenging and changing beliefs. WFS uses positive thinking to change thoughts, believing that thoughts shape behaviour and women begin drinking due to "faulty thinking". Positive thinking

can address and correct this, and WFS seeks to empower women to believe that they can change their thinking and their mental images. Group members use 13 positive affirmations including about belief in their own competency. At meetings, members talk about positive things that have happened from the week before. However, the group has been criticised for this emphasis on positivity as not allowing talk about true feelings.

There is limited research on information behaviours in non-12-step face-to-face groups, including around story-telling. Although Swora (1996) claimed that both SOS and RR have no tradition of formal storytelling, she acknowledged that SOS uses personal experience narratives to illustrate points and stated that "These narratives seemed to follow patterns of informal, conversational storytelling" (footnote p234). Kitzinger (2013) quoted one interviewee saying that they found listening to stories in SOS as inspiring as in AA, implying they do have an important role there. However, it may be, at least in some non-12-step groups, that story's role is intrinsically less important: LifeRing and WSF meetings, for instance, explicitly focus on the present and future and not on the past. Unlike AA, remembering is not essential to recovery, therefore stories may not be as important.

Swora's study also noted how SOS differed from AA in allowing direct advice-giving, 'cross-talk' and disagreement:

> "SOS participants address each other directly and comment upon or even challenge each other's statements. "Cross-talk," directly challenging or refuting another participant, is common in SOS meetings; disagreement can be overt." (Swora, 1996, p79)

She noted that slogans and mantras are generally avoided as 'groupthink' with the individual being required to find their own path and beliefs. The interviewee in Kitzinger's research on SOS, discussed above, mentioned identifying with others, and seeing those that do not stay in the group as reinforcing by negative example, which introduced the idea of role modelling as a way of conveying information. LifeRing members also learnt from observing role models, which one of Falconer's interviewees described as essential "The people who've been successful model behavior for the people who are just coming along" (quoted Falconer, 2013, p145). MM members also model behaviour change for each other (Kosok, 2005).

To summarise this section, there has been less research on face-to-face non-12-step groups than on AA, and many studies into the former incorporate comparisons to the latter. Popular themes include health and other outcomes, descriptions of the groups, the characteristics and experiences of users, and how to match individuals to groups including in terms of specific beliefs. The work of Kaskutas and colleagues was found to be particularly relevant to the present study, including research on the impact of groups on beliefs. The present study will build on the work done here and explore areas not covered by it.

2.8 Online support groups for problem drinking

Table 2.6 below indicates the results of searches carried out in April 2020 for online alcohol support groups, including those searched for in Tables 2.2-2.5 and the six used in the research (Groups A-F). All field searches were carried out, the first 100 items scanned and duplicate items excluded. For all ten groups several items found simply referenced the group rather than discussing it and in others the group was just included as a recruitment ground, to obtain participants. These items were excluded and only the unique, relevant items about the AOSGs were singled out and are presented in the data below.

Table 2.6: Search results for specific AOSGs, 2020

Database All field searches	**"Alcoholics Anonymous" AND online**	**"Smart Recovery" AND online**	**"Moderation Management" AND online**	**LifeRing AND online**	**Groups A - F**	**Total**
ProQuest – books, conference papers, scholarly journals, thesis & dissertations, peer reviewed	6	2	5	0	1	14
PubMed – books, documents, journal articles	0	0	0	0	1	1
Medline – books, articles, PsychArticles	0	0	0	0	0	0
Scopus	1	2	2	0	3	8
Google Scholar	6	0	7	2	2	17
Totals	**13**	**4**	**14**	**2**	**7**	**40**

It is interesting that there were roughly as many studies of Moderation Management online as AA online, suggesting that there has been more interest in the former in its online format compared to the face-to-face format.

2.8.1 General studies of AOSGs

Several studies have looked at AOSGs as part of discussions of internet interventions generally. Dugdale, Elison, Davies, Ward and Jones (2016) explored usage of digital technologies including self-help groups online in recovery in a mixed-methods study. They looked at what technology was used at what stage of the recovery journey, and how these resources related to offline resource usage. They found forums to be the most widely used resource except for individuals aiming to achieve abstinence who were more likely to use therapeutic resources looking at the causes of drinking and helping with coping. They also found an interaction between online and offline resources with use of one format providing help with, or useful references to, sources in the other. Holcnerova (2010) looked at the advantages and disadvantages of using internet-based interventions including self-help groups, concluding that the internet provides "an attractive addition rather than a real alternative" (p.110) to offline services. Bliuc, Doan and Best (2019) citing Chou, Robb, Clay and Chronister (2013), on the other hand, found online support groups offered similar benefits to face-to-face, although they acknowledged that compared to research on face-to-face groups there is still less empirical evidence. Grant and Dill-Shackleford (2017) who looked at preferences between the two formats found positive reactions to the online format, but that their survey participants (who had experience of both) preferred face-to-face. Interestingly, they noted that individuals felt better able to be honest in face-to-face meetings, but also said they were more likely to lie about their recovery or to be drunk in face-to-face meetings than they would online, which appears somewhat contradictory. Ashford, Bergman, Kelly and Curtis (2020) carried out a systematic review of research into the effectiveness of digital recovery support services including groups, and found that the evidence base currently lacked experimental evidence.

The UK Life in Recovery 2015 Survey (Graham, Irving, Cano & Edwards, 2018) explored the use of groups, websites and smartphone apps by people in recovery. Of their 766 respondents, they found 39.3% used one or more such interventions and only 31% did not use these online facilities at all (the remaining participants did not give complete information). Thirty-two percent of the users accessed support groups, 27% websites and 16% used apps. In terms of support groups, they most frequently participated in AA, NA, Smart Recovery, InTheRooms, Soberistas and Facebook support groups, and often used these sites for their information pages as well. 70% of group users found them helpful or

extremely helpful. The study found a statistically significant association between gender and use of support groups (*p=0.022)*, with females being more likely to use them.

2.8.2 12-step online groups

When dealing with the research literature on online 12-step groups, there are some issues that can cause difficulties: firstly, some of the AOSGs using AA in their name may not be constituted as AA groups and care needs to be taken when looking at them. AA's own online forum, developed by its General Service Office, is called e-AA and there are many local online groups affiliated with AA, particularly since the advent of Covid-19 and the inability to attend face-to-face meetings because of the lockdown, at least in the UK. These groups are most likely to represent AA practice, while others following the 12-step program may be less representative.

A second issue is that it is not always clear whether people were discussing 12-step **meetings** online or 12-step **discussion forums** online. There appears to be little research distinguishing between the two and this would be an interesting area for further study especially in regard to the structure of online meetings and whether, and how, these mirror or diverge from that of face-to-face meetings. Bjerke (2009) did touch on this, as one of the two 12-step groups he explored (neither being e-AA) had both email meetings and a discussion forum. An interviewee commented:

> "I must say at this point that e-mail "meetings" are often more discussion, reflection and commentary rather than straight sharing without commentary as it would be in face-to-face." (Bjerke 2009 p95)

This suggests online 12-step meetings may be more similar to online discussion forums, than face-to-face meetings, but more evidence would be needed to corroborate that. A final issue is that researchers, e.g., Kitchin (2002), who report atypical behaviour found in the forums do not always give the group's reactions to this. Behaviour that goes against a group's norms may be found anywhere: to get a true picture of what is, and is not, deemed acceptable it is necessary to explore other's reactions to it.

Several studies have compared the online and face-to-face formats of AA. Bell (2011), for example, compared the effectiveness of online and face-to-face social networking in preventing relapse, and reported no difference between the two formats. This quantitative research combined two pre-existing, validated scales with a descriptive element in a convenience survey of recovering problem

drinkers from AA. Bjerke (2009) explored user views of the two formats, and reported that a majority of members liked to combine them, and listed the benefits of each mode. Many of his participants found the ability to access a global range of views online particularly exciting, helping to "expand and enrich members' understanding of the AA program, and thus enhance their recovery process." (p98).

Looking at online groups only, Lyytikainen (2016) explored AA online in Russia as a case study, finding that, as with face-to-face AA, users came to an acceptance that they had a problem and a new view of their identity as someone with a disease rather than being weak-willed, and so to a new representation of problem drinking. The online format was particularly valued as there were few face-to-face options in Russia, and it was popular with women. Lyytikainen noted that advice-giving by old-timers was through storytelling, as well as reference to AA literature, with a process occurring that was similar to face-to-face meetings:

> "New forum members read others' recovery stories and learn how people have recovered from similar or even worse conditions. They also find a group of people they can relate to and start to think about their own life and dependence in the light of the older members' stories." (Lyytikainen 2016, p162)

Coulson (2011, 2014) performed a thematic analysis of 758 postings from 125 randomly selected threads in three UK publicly accessible alcohol discussion forums. He found accounts of experiences to be the most common information type used, although whether this was full life stories or anecdotes was not stated. Coulson indicated a typical pattern to storytelling in two of the three discussion boards analysed which clearly followed an AA/12 step philosophy. A newcomer typically posted details of their problems and/or desire to stop drinking. Sober members then:

> "note some level of similarity between 'their old self' and the new member. They described their own struggles with alcoholism, failed attempts to give up drinking, hopelessness and despair. They then described the tools and mechanisms they used to achieve sobriety…They were often very honest about the hardships they encountered…but they always concluded that it was worth it, as the new life they found was far superior to the old one…Finally, they suggested or encouraged the new member to consider undertaking similar steps i.e., detox first and then seek a local AA meeting, get a sponsor, get involved in the fellowship" (2011 p29-30).

This shows a process similar to, but not identical with, storytelling in face-to-face AA. The more experienced member's posting was related back to the preceding one, creating identification, but it was not clear whether this was done explicitly, or implicitly, as in face-to-face meetings of AA. Stories of personal experience then followed, similar to the typical AA story described by Cain (1991) and Steffen (1997), including failed attempts at sobriety and providing information on how they themselves became sober. However, the ending, which openly advises the newcomer, was different: in face-to-face AA, direct advice is not usually given. In the third discussion forum analysed in this research, there was no AA connection. Members there also gave advice on sobriety but suggested alternative methods of achieving this, e.g., medication, CBT, cutting down. Coulson (2011) did not state whether the pattern of communication was the same, and stories used. Coulson's work on AOSGs also described people acting as examples or role models for others.

VanLear, Sheehan, Withers and Walker (2005) examined support in different forms of AA online forums (i.e., asynchronous discussion groups, synchronous chat rooms and synchronous meetings). Using van Lear's Relational Linking System, revised for computer mediated communication, they explored people's individual 'self-presentation' and their 'other-orientation'. They found that asynchronous discussion groups, in comparison with the AA synchronous meetings and chats, amongst other differences, had statistically higher use of semi-private and private-personal self-presentations. In other words, there was more personal self-disclosure in the discussion forums than in the meetings, inviting the question as to how much use of personal story there is in online meetings and whether these contain abstract discussions and direct advice, rather than personal experiences, stories and anecdotes as in the face-to-face AA meetings.

How far AOSGs following the AA principles handle disagreement in the ways described in Section 2.7.1.2, and how far they engage in open debate (crosstalk) and tolerate dissent, is under-researched. VanLear et al., (2005) described a 'correction' process similar to that described above, as possible in online alcohol groups, but it is not clear if this was found in practice by them. Pleace, Burrows, Loader, Muncer and Nettleton (2000) carried out participant observation over five months in the chat room 'Friends of Bill W' (Bill W being one of the founders of AA). They indicated that disagreement about AA views could lead to tension and, in extreme cases, being banned from the chat room. They noted several types of exchanges including playful, friendly exchanges used to create trust and build relationships, and regulatory ones (forming 15% of the exchanges analysed): trying to keep the focus on alcohol, throwing out disruptive people, chastising by shouting with capitals. They also noted that, in a group that offers only one approach (i.e., the AA way), social

support may be conditional on accepting that approach. Although this deals with a chat room, Vayreda and Antaki (2009) and Lewis (2014) also found this last point in discussion forums outside problem drinking.

2.8.3 Non-12-step groups

For these groups there have also been comparisons of different formats: Kosok (2005), for example, compared MM's face-to-face and online forms, finding that the group was effective in both formats. Although face-to-face participants generally drank less and had had more successful attempts at the 30-day abstinence period advised by MM, all groups reduced by 50% both the amount they were drinking, their number of life problems and their degree of dependence on alcohol after use of MM. This survey approached all members of MM, with a response rate of 55%. The study indicated that, although the online format is not generally better than the face-to-face one, it is effective, leading to drinking reductions.

Other research has compared AOSGs with alcohol brief interventions, such as screening with feedback. For example, Cunningham (2012) compared the use of a drinking assessment tool on the site of an online group with complete access to all the resources on the site including support forums. Drinking outcomes were significantly better where access to the full resource was available, although the RCT only carried out six months of follow up of the 170 participants. Similarly, Hester, Delaney and Campbell (2011) compared 84 drinkers with access to a moderate drinking protocol plus MM with those with access to MM only in a Randomised Controlled Trial (RCT), with follow-up to 12 months. They found that those with the full package did better in terms of numbers of days that they were abstinent, although both groups improved significantly. Hester, Campbell, and Delaney (2013) compared an online course based on the beliefs of SR with use of SR only (online or face-to-face) in another RCT of 189 participants with six-month follow up. Both groups showed equal, and significant, improvement. There were also later studies on the effectiveness and outcomes of group use such as the systematic review of evidence about SR by Beck et al., (2017) and Kirkman, Leo and Moore's (2018) research on Hello Sunday Morning's impact on behaviour change. These studies add to the evidence-base on the effectiveness of non-12-step AOSGs.

Other areas of research include studies of single groups, e.g., Humphreys and Klaw's (2001) exploration of MM, Cunningham, van Mierlo and Fournier's work (2008) on AlcoholHelpCentre, and Chuang and Yang's work (2012, 2014) on information types in MedHelpAlcoholism. Research has been undertaken to analyse the content or themes of posts in discussion forums of online groups

(Cunningham, van Mierlo & Fournier, 2008, Coulson, 2011, 2014). Others have looked at users, e.g., Horvath and Yeterian (2012) who explored the demographics of online users of SR and Nagy et al., (2015) who studied user experiences of AOSGs. Support in AOSGs has received research attention: for example, by Chuang and Yang (2012) and Liu et al., (2020).

Several studies have looked at information and communication behaviours in AOSGs. Chuang and Yang (2014) explored the exchange of information (references, personal stories, facts, advice and opinions) in the forum, journal and note facilities of a MedHelp community for problem drinking using descriptive content analysis. They found slightly different information behaviours in the different formats with forums acting as venues for information exchange more than notes or journals. In the forums facts and advice were mainly requested and facts, advice and personal stories were most commonly provided. Their study was unusual in finding facts rather than experience as the most frequently exchanged form of information. Klaw, Dearmin, Huebsch and Humphreys (2000), for example, found personal disclosure more frequent than information / advice in posts. Urbanowski, van Mierlo and Cunningham (2017) also explored member communication patterns in the AOSG AlcoholHelpCenter using social network analysis. Their findings included that the majority of users made few posts, with the moderators and a few dedicated members providing most contributions. In an analysis of blog posts from Hello Sunday Morning, Carah, Meurk and Angus (2017) found that communication changed after a member's first month, with more evaluation of progress and distillation of their experience into advice to others at that stage. Hedges, in an auto-ethnographic study (2017), analysed storytelling in an online group, reaching conclusions similar to those of both Cain and Lave and Wenger's studies of face-to-face AA (1991). Hedges (2017, pii) found that users reach recovery through 're-storying' their identity, "crafting and enacting a recovery identity through recovery storytelling". Klaw and Humphreys (2000) explored themes in the life-stories of users of MM, drawing equally on those using the face-to-face format, those using MM online or both. They did not explore the structure of the stories but did show that the views of MM were attractive to the participants and a major reason for choosing it. This is put down partly to attraction to the group ("self-selection... [driven by] …person-environment fit" p798) and partly to direct influence of the group's ideas on them: "the world views of mutual-help organizations influence the personal life stories of committed members" (p798).

Finally, in work of much relevance to this study, published during the data analysis phase of the present research, Chambers, Canvin, Baldwin and Sinclair (2017) used Social Identity Theory to explore how users of the AOSG Soberistas saw recovery and identity. In 31 telephone interviews

with users, Chambers et al. identified a three-stage journey of recovery and use of the forum, moving from lurking to active participation and accountability in the site, and then, in the case of those with long term commitment and secure sobriety, to leadership in the group. Soberistas participants were often accustomed to using the internet for information and saw lurking as "a safe way" (p19) to get this. Chambers et al. argued that identity change was central to recovery including internalising a 'Soberistas identity' in line with the site's pro-sobriety, anti-shame stance. This is attributed to use of the forum and peer pressure from other members, plus the fact that the 'identity' resonated with individuals, seeming appropriate and true. There is no more granular discussion of how this is achieved or what information behaviours were used as this is not the focus of the work. This was followed by a second phase of the study (reported in Chambers' PhD thesis, 2018) which did not involve AOSG users but was based on a survey and interviews with hospital patients who had drinking problems. This led to development of a theoretical framework called "alcohol and recovery self-concept fluidity" and identification of the process of recovery as one of change. Chambers' work will be further discussed in Chapter 7 in the light of this research's findings.

2.9 Synthesis of the literature

Prior to the start of the empirical work in this study, the research literature described in this review indicated that there was a considerable body of evidence demonstrating the impact representations, or beliefs about a disease/problem, can have on health and other outcomes. This literature frequently used Leventhal and colleagues' Common Sense Model of Illness Representations, showing this to be helpful in analysing a wide range of illnesses, including mental health issues. The CSM offered a good level of detail compared with some other prominent models, and accounted for the impact of emotions on representation and action. The existing literature in 2016 (and since) supported the contention that representations are an important topic with real impact upon experience and outcomes, and suggested that the CSM might be a good tool to use in relation to analysis of problem drinking representations. Both before and after the start of the study a few items dealt with the links between information behaviours and representations (Chen, 2015, Katavic et al., 2016, Oh & Song, 2017), but not in relation to problem drinking. Chen's work was perhaps the most relevant as it looked at information behaviours and representation in relation to discussion forums and social media, but was somewhat limited in focussing only on three specific aspects of the CSM, and only on what purposes information was used for, unlike this study.

By 2016, there was also a substantial body of research on health support groups for many different illnesses and conditions, on many different aspects including the advantages and disadvantages of

attending these in both face-to-face and online format. This showed that, for some, there were many benefits to using groups online. Research also showed that information provision was an important function of health groups. In terms of alcohol, face-to-face AA had received considerable research attention in relation to various topics, including the outcomes of using it, how it works and its use in various populations. Research on the relationship between representations and information behaviours in face-to-face AA had been explored, with several different information behaviours discussed. For example, it was shown that storytelling (an information behaviour) connected with representation development as members learnt about AA and what it meant to be a problem drinker from listening to other members' stories and how these were responded to, endorsed or corrected. Members learnt to re-construct and 're-story' their own past, their beliefs and their interpretations of themselves and problem drinking through participation in storytelling in group meetings.

Face-to-face non-12-step groups had received much less research attention and, prior to the start of this study, most of this focussed on a handful of the better known groups. Topics researched in relation to them included their efficacy and outcomes, comparisons with AA, and matching of users and groups, with mixed evidence for the usefulness of this. Empirical evidence for the idea of group users mixing and merging ideas from different belief sets, was introduced by Kaskutas (1992), but Klaw and Humphreys (2000), and Atkins and Hawdon (2007), in contrast, implied a role for matching groups and users on the basis of shared ideas (see Section 2.7.2).

In terms of online alcohol groups, many studies looked at them as part of studies of digital interventions. Work on 12-step online groups had included comparisons of the digital and face-to-face formats, analysis of the themes of posts, of support in them and disagreements. Studies of online non-12-step groups had also compared different formats and explored group outcomes in comparison with other digital interventions. There were also studies of individual groups, the content of posts, of support and of the types of information exchanged.

Between the start of the study and the present time, several developments took place. Those of significance to this research included Crum and Zuckerman's work on mindsets which offered an alternative to using the CSM, that was considered but ultimately rejected (see Section 2.3.2 and Chapter 7), and Chambers work (2017, 2018) on recovery and identity (discussed at length in Chapter 7). The concept of problem drinking as a spectrum of issues rather than a binary choice, although introduced much earlier, came to the fore in this period and the debate around whether or

not problem drinking is a brain disease has occupied many researchers. More importantly for this study, the positive sobriety movement has challenged the stereotypical view of non-drinkers and of problem drinkers and can be seen as supported by the work set out in this thesis. At the same time, Pienaar and Dilkes-Frayne (2017) have drawn attention to more positive narratives of addiction.

2.10 Gaps in the literature

Key gaps in the literature identified included:

a) Whether and how particular information resources, specifically non-12-step AOSGS, impact on users' formation of representations of problem drinking; and
b) the information behaviours used to develop representations in these groups.

There was a need for research into how people form their representations of problem drinking, what sources and information behaviours they use to develop these. Kealey and Berkman (2010 p239) noted that "few studies have explored the relationship between sources of health information and mental models of disease". The work of Klaw and Humphreys (2000) discussed above, indicated that non-12-step groups influenced beliefs about drinking and recovery, but did not address the question of how this came about in any detail or whether it was created through similar information mechanisms to AA's, notably the use of story. Kaskutas and Ritter's study (2015) argued that the accounts of recovery provided by treatment programmes or groups influenced how members define this for themselves. However, they did not look at beliefs other than how recovery is defined, and did not look for differences between the definitions offered in the different groups, amalgamating these together to contrast them with those who had no exposure to a group or treatment programme. Their sample was not explicitly asked whether they had acquired their representation of recovery from the group or from elsewhere: it was assumed that this was so, given that those who were not exposed to groups or treatment defined recovery differently. There had also been some work suggesting that users may merge ideas from different belief systems (Kaskutas 1992, Godbold 2012), but with limited detail and not in relation to information behaviours online. This study contributes to filling these gaps by examining in detail the impact of non-12-step information resources (AOSGs' discussion forums) on users' representations of problem drinking and the information behaviours used to bring this about.

There were also gaps in the literature as regards:

a) work on the CSM in relation to problem drinking, apart from the work of Bamford and colleagues;
b) qualitative studies of how mental health groups were experienced from the perspective of their users;
c) work on non-12-step groups generally. Parkman, Lloyd and Splisbury (2015) called for more qualitative research on non-12-step groups and as late as 2017, i.e., after the start of this study, Zemore mentioned "the extreme scarcity of any data on mutual help groups that are not 12-step-based" (2017, p124); and
d) similarities and differences between AA meetings online and AA discussion forums online.

This study also contributes to addressing these gaps apart from d) which was not explored as the focus of the thesis is on non-12-step groups only.

2.11 Research questions

Understanding users' 'representations' is extremely important, given the many impacts these can have on an individual's handling of illness and recovery and their health and social outcomes. Understanding how AOSGs contribute to problem drinkers' representations is an area in which there is a need for, and gaps in, the research. In the light of the above, the research questions adopted were:

RQ1: How do the discussion forums of non 12-step alcohol online support groups (AOSGs) affect users' understandings of what it means to be a problem drinker (their 'representation' of problem drinking)?
RQ2: How do specific information behaviours (such as story-telling) contribute to the development of users' representations?
These questions align with the aim and objectives set out in Section 1.3.1 and 1.3.2.

2.12 Conclusion

This chapter has explored the research literature on representations, problem drinking, health support groups, and alcohol support groups both on- and off-line. Having also identified the gaps in research in this chapter, the following chapter will present and discuss the methodology chosen to provide answers to the research questions.

Chapter 3: Methodology

3.1 Introduction

In Chapter 2, existing research on illness representations and the Common Sense Model was examined, and changes in definitions of problem drinking over time were explored. Information behaviour research was introduced and several models used in this study were discussed. Literature on health support groups was summarised, and research on both face-to-face and online alcohol support groups was explored and gaps in the literature identified. The research questions to be examined were given at the end of Chapter 2. Following on from this, this chapter describes how these research questions were addressed. Section 3.2 sets out the chosen research paradigm and Section 3.3 the research methodology that was followed. Section 3.4 sets out the reasoning behind the specific methods used and Section 3.5 sets the context for the ethical challenges of the project, which are dealt with through the chapter. Sections 3.6 and 3.7 describe the implementation of the methods in detail and 3.8 the data analysis that was performed. Section 3.9 deals with the issue of research quality and Section 3.10 summarises this chapter.

3.2 Research paradigm

The research paradigm adopted *overall* was the pragmatic paradigm as described by Burke Johnson and Onwuegbuzie (2004), and Creswell (2003), as this is very capable of accommodating qualitative research questions such as those presently explored, but allowing space for some descriptive statistics. It also best accords with the researcher's beliefs that both constructivist and post-positivist approaches have value in terms of providing useful information, depending on the specific questions studied. Indeed, as Burke Johnson and Onwuegbuzie asserted, both approaches:

> "use empirical observations to address research questions…describe their data, construct explanatory arguments from their data, and speculate about why the outcomes they observed happened as they did…[both] incorporate safeguards into their inquiries in order to minimize confirmation bias and other sources of invalidity…[both] attempt to provide warranted assertions about human beings [and their environments]" (Burke Johnson and Onwuegbuzie, 2004, p15.)

The pragmatic paradigm gives primacy to the research questions, is more outcome-, and less philosophically-focussed and is not committed to any one set of ontological and epistemological beliefs (Creswell, 2003). It offers greater freedom to choose methods that suit the subject under examination (Denscombe, 2008).

Within this approach, the particular stance taken for different research may vary. For this particular study, the interpretivist / constructivist tradition offered the most appropriate route, and was most suitable for the research questions and topics studied. The research questions focus on how impacts are achieved on the participants and does not seek to quantify this, but to develop theory on the topic. The subject matters dealt with are social constructions: the groups and their discussion forums are social phenomena produced through social interaction with no 'actual' embodied presence or geographical location, although they do have a documentary 'reality' in terms of leaving a record online. Illness representations are also socially constructed entities: Conrad and Barker suggested that:

> "In contrast to the medical model, which assumes that diseases are universal and invariant to time or place, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems". (2010, p67)

Representations of problem drinking have manifestly been shaped by such systems as was discussed in Section 2.4. Social constructivism was chosen over social constructionism. These are complex concepts, (which Talja, Tuominen and Savolainen (2005) argue have been differently defined by different disciplines and philosophers), and are beyond the scope of this thesis to explore in depth. This research follows the explanation, found in Talja et al. (2005) and based on Gergen which states that constructionism focuses on how people develop meaning together through discourse, whereas constructivism concentrates on individual learning because of group interactions. Information users do not passively receive information but make sense of 'reality' influenced by their context, task and environment:

> "Social constructivism is a metatheoretical position which argues that, while the mind constructs reality in its relationship to the world, this mental process is significantly informed by influences received from societal conventions, history and interaction with significant others (Gergen, 1999, p. 60)" (Talja et al., 2005, p81)

Whilst the possibility of knowledge co-construction (creating meaning together) is explored, the emphasis in this thesis is on the development of the group members' personal views as a consequence of interaction within the groups.

In terms of ontological position, this study recognises firstly that there is no one 'truth' about problem drinking, but several sets of constructed beliefs, all of which have value for certain groups and can potentially lead to improved outcomes as some research has shown (Atkins & Hawdon 2007). This study is not concerned with which of these sets of beliefs is 'really' true, only with people's perceptions of this. However, it recognises that these beliefs are 'real' in the sense that ideas:

> a) Can have an embodied presence in documentary artefacts as was noted above (although this may be particularly ephemeral with virtual records of groups);
> b) Have practical effects on people and the way they lead their lives; and
> c) Can have a life lasting long beyond that of their creator, and as such impact on others. The 12-step programme of AA, for example, pre-exists any specific AA group, but has a very significant impact on all of them.

This study follows an interpretivist epistemological position which sees people and their meanings as primary data sources. The aim is to understand and generate theory, not to prove or test a hypothesis. An interpretivist will seek to explore research materials for what they can tell us about people's meanings, and explores context also:

> "An interpretive reading will involve…constructing or documenting a version of what you [the researcher] think the data mean or represent, or what you think you can infer from them. You may, for example, read a section of the interview transcript as telling you something about implicit norms or rules with which the interviewee is operating, or discourses by which they are influenced, or something about how discourses are constituted" (Mason, 2002, p149).

Here data were explored interpretively and literally, examining interview transcripts and forum postings for both literal and interpretive meanings, and including 'context' as data.

Interpretivism also requires the researcher to acknowledge that they can impact on the findings themselves and that a position of complete neutral objectivity with no preconceptions is not realistically possible. The researcher came to the project with good awareness of, and respect for, AA and its programme of recovery gleaned from past close associations with group members and attendance at AA meetings. However, equally she believed that AA does not necessarily suit

everyone and individuals need to know about alternatives that can help them. Additionally, having experienced the helpfulness of a bereavement online support group directly when widowed at a comparatively young age, she held a positive view of OSGs and a belief that they should be more widely known about, so that all who could benefit from them would have this option. Consequently, the researcher was very mindful of these facts when analysing the texts and interviewing users, and took a supportive stance to whatever the interviewees' views of AA were, whether positive or negative. She made reflexive notes after reading threads and after each interview to capture perceptions of the interactions, including noting any occasions when the interviewee may have become aware of her knowledge about problem drinking. Where this arose, the researcher was careful to turn the interview back to the interviewee's ideas, reflecting back what they were saying.

3.3 Research methodology

The research methodology used was cross-sectional, multi-method research (Venkatesh, Brown, & Bala, 2013; Bryman, 2016), i.e., research that uses two or more methods. It is a qualitative study, which works well with interpretivist/constructivist approaches, although the researcher agrees with the view that "there is no deterministic link that forces the use of a particular paradigm with a particular set of methods" (Morgan, 2014, p1). Although some descriptive statistics were obtained, to provide additional information on the interview questions and to describe the sample and participant characteristics, the topic, its complexity and under-explored nature was best suited to qualitative methods at this stage. These are excellent for in-depth studies examining complex phenomena, where people's personal experiences and ideas are being examined, which is what this study was about in terms of the research questions it addressed. A quantitative study looking at, for example, the relative frequencies of the different ways AOSGs can contribute to a user's representation might be a helpful second study beyond this one (see Section 8.5). The advantages of using more than one method are discussed in the next section.

Other methodologies, e.g., internet ethnography, phenomenography, were considered and rejected: please see Appendix 7, Table A7.1 which summarises the methodologies considered and why they were not selected.

3.4 Research methods

Two research methods were used: virtual document analysis and semi-structured interviews.

3.4.1 Forum post analysis

Firstly, thematic analysis was carried out on selected texts from three purposively chosen non-12-step AOSGs to identify and explore user representations and instances in which these were impacted by the forums. It was accepted that the texts did not provide an exact mirror to the participants' reality, being dependent on the writer's ability to process conceptions about problem drinking and express them in writing. There may also have been other reasons to present or endorse a representation online beyond an individual's belief alone, e.g., to access support/acceptance by the group. To address this, at least partially, it was important to look at the context of posts and their place and apparent purpose in the discussion, as well as at them as individual entities. It was important to recognise that the asynchronous format allows for much more careful crafting of communications than speech, although this does not necessarily imply more or less fidelity to actual opinion. Where individuals take time over a reply it may be that this is caused by the desire to consider and say exactly what they really mean. The texts did provide an indication (whether explicitly, or implicitly through general discussions) of the beliefs that participants wished to present themselves as holding, and showed examples of these being created, changed, confirmed, reinforced and/or challenged.

Thematic analysis using the Braun and Clarke (2006) method, (described in more detail in Section 3.8) was chosen as appropriate for (but not exclusively tied to) the epistemological stance adopted here (described in Section 3.2), and as it can provide rich, detailed and complex accounts of data. Using it, the researcher can also employ both data driven and theory driven codes (Fereday, 2006; Braun & Clarke: "bottom-up and top-down approaches are often combined in one analysis" 2013, p178). The literature review raised issues that were important to explore, but at the same time the researcher sought to find and analyse new themes. Thematic analysis of postings had also been used by, for example, Coulson in his analysis of the texts of AOSGs, where he described it as "ideal for exploring under-researched issues and identifying similarities and differences across a large dataset" (2011, p7).

3.4.2 Interviews

The second method used was in-depth, semi-structured interviews. Interviewing enabled the researcher to go into detail with group users, to get a rich sense of how they saw their representation and the impact of the group on it. It also allowed both researcher and participants to

ask follow-up questions for clarification and helped them to pick up on any misunderstandings, which was important when dealing with the complex concepts under consideration. Interviews were semi-structured to enable the researcher to have, on the one hand, a set of areas that she wished to cover, whilst on the other hand, the opportunity to follow promising leads and respond to each participant appropriately. The use of interviews was chosen in order to extend the data available from the post analyses, and also from a belief that the people who know best what effect the group has had on them are the users themselves. This respects the user's voice, the validity of their experience and the value of their viewpoint on the topic at hand. It does not imply that their view is the only possible good source of information, as people may not have considered particular aspects as having had any influence on them, when actually this has happened. Additionally, what they say may have, on occasion, been affected by the environment, their memory and ability to articulate what they want to say, and their desire to present the online community in a positive (or, indeed, negative) light (Lewis 2014). This was borne in mind when collecting and analysing the data and attempts made to minimise it by:

a) Conducting the interviews in the interviewee's medium of choice. Most were done by Skype or phone from their own homes contributing to their being relaxed;
b) Taking the interviews at the interviewee's pace, allowing as much time as they needed, with breaks and interruptions as required (e.g., to let a dog outside);
c) Following up on negative aspects of the forums mentioned, as well as the positive ones, in a sympathetic manner; and
d) Asking pertinent questions to explore meanings.

3.4.3 Benefits of using two methods

Together, the two methods yielded useful information and addressed each other's limitations. The interviews were informed by the outcomes of the text analyses, and the texts in turn were re-coded in the light of the interview findings. The methods provided opportunities for: triangulation, complementarity (elaboration and clarification of results), confirming or refuting theory, and/or suggesting alternative views / explanations, as will be shown in the findings (Chapters 5 and 6). The interviews elicited more spontaneous communication as speech rather than written events and allowed the opportunity to explore aspects not visible online (Lewis, 2014), and to ask follow up questions. They provided richer, more detailed data (Seale, Charteris-Black, MacFarlane & McPherson, 2010). The texts provided alternative perspectives to the interviews and were not subject to the researcher's influence. They also offered a non-intrusive way to observe how communication occurs within the groups and the opportunity to obtain and analyse a considerable

amount of data. As the participants determined what was discussed, this could introduce elements of importance to them, whereas the interviews allowed the researcher to guide the conversation according to the research interests. Finally, whilst the interviews provided the participants' retrospective interpretations of their group's role, the posts could offer a more current picture where instances of change could be seen as they happened. Both forms of evidence had their limitations: as stated, the interviews relied on the participants' memories, articulateness, willingness to share with the researcher, and the researcher's interpretations of what was said; the post analyses relied on the poster's ability to represent their thoughts well in writing and the researcher's interpretation (albeit supported by evidence from the text).

Two other methods (surveys and focus groups) were considered and rejected: please see Appendix 7, Table A7.2 for a discussion of these.

3.5 Ethics

A number of ethical challenges were identified from the outset, as the research involved potentially vulnerable people with the sensitive issue of problem drinking. Formal ethical approval was needed, in accordance with University of Sheffield research ethics policy (2021), and this was obtained in June 2016 (Please note in 2015-6 the version of the ethics policy was v6; the current version is v7.6). See Appendix 8 for the complete ethics application and Appendix 11 for the letter of approval. Throughout the project the researcher was guided by the principles set out in the University of Sheffield's ethics policy, and later by its guidance on social media research, produced after ethical approval was obtained (University of Sheffield, 2021). It also drew upon guidance from the British Psychological Society (2013) and the Association of Internet Researchers (Markham & Buchanan, 2012) on internet-mediated research. Issues involved in both parts of the study included:

a) Maintaining confidentiality, and the anonymity of groups, interviewees, forum writers and any relevant 3rd parties that they discussed; and
b) Obtaining informed consent.

Issues in relation to the interviews alone included:

a) The potential for discussions which could raise sensitive topics, with the possibility of the interviewees becoming distressed or disclosing reportable information;
b) Obtaining consent when the participant might be under the influence of alcohol; and
c) Researcher safety in face-to-face interviews.

The measures originally set out to deal with these are discussed in full in Appendix 8, and what was actually done is reflected upon in relevant sections throughout the remainder of this chapter.

3.6 Online discussion forum posts

Following ethical approval, and the literature review, the first part of the study involved the analysis of posts from the discussion forums of three purposively chosen groups.

3.6.1 Group selection

A master list of groups (available on request) was compiled using the search engines Bing, Google and Yahoo to meet the following criteria for selecting the AOSGs:

- Written in English;
- Publicly available to read: as well as confirming that there was no need to register or ask permission to access the forums, their privacy policy and other site information pages were examined for any active discouragement of researchers (as recommended in ethical guidance by Moreno, Goniu, Moreno & Diekema, 2013);
- Aimed at adults, i.e., not those under the age of 18, to avoid any issues concerning children's welfare and safety;
- Contained forums aimed at those with an alcohol problem themselves, i.e., not aimed at the families of people with alcohol problems or at people with other addictions;
- Dealt with any category of problem drinking, from mild to severe; and
- Active in September 2016 when coding began (i.e., 50 or more posts made to threads in the preceding three months).

At this stage, 12-step groups were also recorded. It should be noted that as only English speaking groups could be included, the culture of the groups was predominantly western, with the majority of groups from the UK or North America. One group that was particularly unusual was omitted as it would have been impossible to anonymise it to the researcher's satisfaction, as it was aimed at a very narrow, and particularly vulnerable, subset of problem drinkers.

Five non-12-step groups from the list were then approached to participate, being selected on the basis of contrast of approach, size and location. This was done to maximise the possibility for variation, with a view to identifying aspects shared by two or more of the groups. It was hoped that this would draw attention to aspects held in common to a greater extent than using a homogenous

sample would have done (Bryman, 2016). Although the discussion forums were in the public domain, the group owners were asked to provide consent in the interests of transparency. The University of Sheffield guidance recommends that:

> "attention [should be] paid to local cultural values and to the possibility of being perceived as intruding upon, or invading the privacy of, people who, despite being in an open public space, may feel they are unobserved" (University of Sheffield, 2021, v6, p30, and see also University of Sheffield, 2006; Eysenbach & Till, 2001; Markham & Buchanan, 2012).

It is worth noting that while AA guidance in this area is that "When we post, text, or blog, we should assume that we are publishing at the public level" (AA, 2014), this may not be the case with other groups (or even be fully understood by AA group members). Unfortunately, it would have been impossible to seek consent from every individual poster in the extracts analysed, and this is acknowledged as a concern. However, group owners were asked whether they had any further requirements for consent, and Group A notified their members about the study, offering them the option to exclude their posts (it did not appear that any did so). All three groups discussed participation with other moderators/Administrators to get their consent.

The first approach to each group was made by email or the site contact form to the central contact point, i.e., the owner, moderator or administrator of the group, as recommended by British Psychological Society guidance (Hewson, 2013). They were sent a covering message and information sheet about the research (see Appendices 8.1) which included information about the measures proposed for confidentiality, and encouraged them to request any further information they needed. To build trust and contribute to proving the research team's authenticity, links to University of Sheffield webpages about them and the PhD were included in the information sheet (Lewis 2014). Two groups refused to participate and three agreed (Groups A – C: see Chapter 4 for their details). The three groups differed in various ways: they had different approaches to treatment; two were lightly moderated and one tightly moderated; one was UK-based, one was USA-based and one was based in continental Europe; they ranged from small to medium to very large in terms of membership. As stated above, any advice from the central point of contact as to further action needed was followed.

3.6.2 Selection of forums and threads

Threads were requested that had been posted to during August - October 2015, and it was made clear that no posts after October 2015 would be analysed. This was for ethical reasons: to ensure that there was no possibility of individuals being deterred from posting by the presence of a researcher observing and analysing any current (2016) conversations.

Within the three groups, messages and threads posted to forums in the time period were purposively selected on the basis of relevance to the research topic. For example, for Group A, three of the four forums appeared initially to have threads of potential relevance to the research questions, with the majority of these occurring in two forums. These potentially relevant threads were read through from their start until October 2015. For Group A, threads were available from their inception in their entirety, and as many had several hundred messages, it became clear that it would not be practicable to analyse all this material. Therefore, a cut-off point of 50 consecutive messages per thread was decided on, with an overall total of 500 messages for the group. To achieve this, the threads most relevant to the research questions were selected and 50 posts taken from each, counting back in time from 31 October 2015. This led to variable starting points, as the time period covered by the 50 posts could vary from a few days to years. Some threads had fewer than 50 posts: hence it eventually proved possible to include 15 threads in total for Group A.

Threads were deemed relevant if they included one or more of the following:

- Discussion of what it is to be a problem drinker, what problem drinking means and/or representations of problem drinking;
- Discussion of what has been learnt from the group/forum;
- Discussion of how the forum/group has influenced the poster.

It was important to select consecutive posts given the nature of the research questions, so that discussions could be followed and changes in opinion observed if present. Taking more posts from fewer threads was considered, but rejected, as potentially offering a less balanced picture: it was important to ensure that the themes and ideas found were not just confined to one or two highly relevant, but exceptional, threads. Threads in Groups B and C were much shorter so the researcher was able to use all of the messages posted to relevant threads during the 3-month time period. In total, 500 posts were selected from each group, with a total of 1,500 posts in all.

At this stage, the site's information pages about problem drinking and pages about the site (such as its mission, posting guidelines and FAQs) were explored to establish the representation of problem drinking held by the site itself, its creator/s and administrator/s. These were looked at through the lens of Leventhal and colleagues' CSM (1984), specifically the five CSM dimensions of identity, timeline, causes, consequences, and controllability, together with the coping mechanisms proposed (see Section 1.2.2 in the Introduction for a description of the CSM and Section 2.3 in the Literature Review, for a discussion of why it was selected for use). This was to be able to see:

a) Whether the same ideas appeared in the information pages and the members' postings; and

b) Whether the CSM provided a helpful way of discussing alcohol representations, including non-illness representations, or whether too much was missed and the effect was to straightjacket the meaning and eliminate richness and depth.

The meanings of the dimensions were based on the definitions of them used in Leventhal et al. (1984, 1992) and Diefenbach and Leventhal (1996), but took account of different nuances found in the texts. This initial work indicated that the CSM could be usefully applied to representations of problem drinking, so justifying the case for continuing with it in the analyses of the posts.

3.6.3 Downloading, anonymising and secure retention of threads

Protecting the confidentiality and privacy of participants, including those who posted in the discussion forums, was extremely important due to the stigma surrounding problem drinking. Threads were downloaded into MS WORD, read and anonymised, with usernames and the name of the group being replaced by pseudonyms. The pseudonyms chosen do not reflect any specific differences amongst the posters, as a) this could break participant anonymity; and b) this cannot be accurately assessed from the limited information available on demographics. The titles of the forums and threads were anonymised and any real names of individuals were removed. Details about the posters, e.g., their geographical location, length of group membership were removed, together with any identifying details from the content. This was kept in a separate, password protected file only accessible to the researcher and was not used in the research except in aggregated format (see Section 4.3 for poster demographics). Any third parties mentioned in the texts were anonymised.

Quotations were anonymised later at the stage of writing up when the researcher changed their wording to ensure that they could not be tracked back to the group via public search engines

(University of Sheffield, 2021; Hargreaves, Bath, Duffin & Ellis, 2018). This was done very carefully so as not to alter the meaning of the quote. If re-wording and retention of meaning was not possible the quotation was not used. Descriptions of the groups were kept general in the write-up to prevent identification. Anonymising the names of the groups in practice proved to be the most difficult issue, as it limited the amount of information that could be given about the groups without their becoming identifiable and also made it impossible to quote other researchers who had named the group in their articles. With hindsight, the researcher would have asked permission from the groups involved to name them.

To support posters' privacy, secure data storage was needed to ensure the protection of the data from unauthorised access. All data were saved on the University Research Drive in encrypted, password-protected files with working copies held on encrypted memory sticks, which were kept at the researcher's home in secure storage or in the University laboratory in a locked drawer. Paper copies were avoided unless essential and were kept in the Information School or at the researcher's home, in locked storage and destroyed as confidential waste as soon as they were no longer needed. Code keys were kept apart from lists of names and pseudonyms in separate, password protected files on the University Research Drive. Permission for the research team to use the data in future research was obtained.

See Section 3.8 for discussion of the thematic analysis undertaken.

3.7 Interviews

3.7.1 Interviewee recruitment

It was debated whether the interviews should be confined to users of the three groups whose posts were analysed. This would have had the advantage of providing different viewpoints on the same phenomena, so supporting triangulation. However, whilst it was important to include them, using them alone would have excluded the opportunity to draw data from an even wider range and variety of groups, so achieving 'maximum variability' and obtaining differing perspectives. It would also have put considerable demands on the three original groups and did not seem likely to generate a sufficient number of interviews. As this is a hidden, hard to reach population, it was not expected that large numbers would volunteer and it was thought that several different approaches to recruitment might need to be made and the net to be cast quite widely. It was also considered whether the study should confine itself to people who post on forums (as opposed to those who just read without posting), but this was rejected, as it would have excluded a large proportion of users

who, research has shown, do benefit and learn from the groups (Preece, Nonnecke & Andrews, 2004).

Interview recruitment was carried out in two phases, starting in late August 2017. First, it was decided to write to the original three groups with a personalised approach to try to ensure some representation from them. The contact individuals for Groups A - C were approached with a personalised letter, a copy of an invitation to use to inform their members about the study and a detailed information sheet/consent form (see Appendix 10). They were also sent an update on progress of the research so far.

Group A refused permission in September 2017, after discussion amongst all the moderators, as they had received many requests for assistance with research at the time and did not want to overload their members. However, one of their moderators volunteered to be interviewed. Group B proved impossible to reach: they had, in the time since the researcher's initial contact, changed platforms and the site now had a different contact form and was still under development. Six attempts were made to reach them between late August and early October 2017, using both the new and old contact forms, and by private messaging the person who had liaised with the researcher before. Additionally, the site's chief administrator was contacted. It is not known why no responses were received as this group had been enthusiastic about the research initially, viewing it as relevant to their interests. Whilst the researcher had been aware that developments were planned for the site, no timescale had been given at the point where she had been analysing its posts. With hindsight, it would have been useful to have had a specific conversation with the contact person about how to communicate whilst the site was in flux. However, this might have made no difference as both researcher and moderator would have been likely to assume that the new contact form would work. By the time contact was resumed, sufficient interviews had been undertaken to generate the data required for the research and recruitment for interviews had ceased.

Contact with Group C was delayed considerably as the individual concerned was, at the time, in the path of Hurricane Irma and uncontactable due to preparing for, enduring and recovering from this for several weeks. Consent was eventually received in late October 2017, after which the Moderator sent the interview request to all members using private messaging. Nine members of Group C subsequently expressed an interest in participation which resulted in four interviews. Thus, this phase of recruitment only produced five interviews altogether. It later proved possible for the

researcher to establish that none of these five interviewees also featured in the posts analysed, so adding to maximum variability of the sample.

Given Group A's declining to participate, as well as the ongoing difficulties in reaching Groups B and C, it was clear that it was important to approach other groups as well. The initial master list of groups was reviewed and 13 were contacted in a second phase of recruitment in October 2017. The criteria used at this stage were that they:

a) Met the original criteria for the selection of groups, and so were recorded on the master list;
b) Were still active; and
c) Not AA/12 step-based in philosophy, as ascertained from the information pages.

Having had some contact with them in past research, two other groups (Groups D and E) from the 'Rejected' section of the master list were approached as well. It was felt that the numbers of posts publicly available (which had initially meant that they were not included) was a less important criterion for this part of the study. An additional group (F) was contacted after recruiting a former member during the consultation process on the interview plans, so making a total of 16 groups approached during this phase.

In all 16 cases, group moderators were contacted with a request to post information about the study or notify their members, a copy of the invitation to interviewees and the information sheet/consent form (see Appendix 10). Three of the 16 groups agreed to participate, and a fourth did likewise, following a Skype conversation between the researcher and the site founder. For this group, the researcher wrote an article on her personal experience of support groups, introducing the study and asking for volunteers. This was published on the site as a featured article and proved to be a very good recruiting tool, perhaps as it indicated that the researcher had lived experience as a user of online support groups. In total, 31 initial expressions of interest were received from members of three of the four consenting groups, with 11 dropping out after receiving the full information. This resulted in 20 interviews from this phase of recruitment. The final total obtained from both recruitment phases was 25 interviewees. This provided a large amount of rich data, with key ideas recurring, so recruitment was stopped.

Written informed consent was obtained from most interviewees with verbal consent recorded in one instance before the interview commenced. As it could have been off-putting to participants to

have to break their anonymity only first names were requested plus a contact phone number or email address. This is similar to Bond, Ahmed, Hind, Thomas & Hewitt-Taylor's study (2013) of contributors to online diabetes forums where only the participant's usernames and emails were recorded. Interviewees were encouraged to ask questions both before the interview took place and at its start.

During the interviews it emerged that three individuals had never used discussion forums and had interpreted the term as indicating any interactive functions in the group where they could communicate with other users (e.g., email listserv, blogs). Consequently, these three interviews were removed for separate analysis, leaving 22 usable interviews.

Whilst recruiting interviewees the researcher's understanding of AA and lack of understanding of other approaches, caused a potential problem. Group D's Administrator asked her to start a thread on the site to request interviewees. This was done but, unfortunately, using AA vocabulary and the term 'alcoholism' to frame the request. The linked webpage about the project also used similar language. This provoked an attack on the researcher from several members objecting strongly to the language used as outdated and offensive, and to the apparent endorsement of the 'disease' explanation for problem drinking. The researcher responded to all the comments online explaining her stance fully, including that there was no particular angle taken in the research as to the cause of problem drinking, and the conversation, after further reassurance, ended positively. It led the researcher to the following reflections which she acted upon, and which are given here as an example of her reflexive journaling (mentioned in Section 3.2):

"Found this upsetting at first, as it is quite a sustained attack. However, it is really useful:

1. Am I unconsciously using AA jargon? I need to watch this and be more careful.
2. It shows very strong feelings about labelling: I think I had better revise all communications and just use 'problem drinking' in the write up and interviews as this seems to have been acceptable.
3. It illustrates how easily there can be miscommunication online.
4. Two volunteered for interview via PM, one sent me a message apologising for the 'cold reception' and the main objector XXX has now volunteered to be interviewed. [They subsequently posted positively about the interview in Group D to encourage others to participate.] Their messages now and that of [name of another poster] are kind and

conciliatory, maybe this shows something about how disagreements are resolved in the group i.e., with discussion and respect in the end??

5. I worry my last post in relation to this point was too pro-AOSGs. I do think they are valuable and want to make them better known. I need to be upfront about this in the thesis, and also make sure that if people have had bad experiences, I am open to hearing that and working to understand why. I am fully aware of the potential problems with online support groups, but also fully aware that there can be risks with face-to-face groups too (for example, '13th stepping' in AA"). (See Glossary.)

Overall, this episode was beneficial to the study in ensuring that the researcher became aware of the strength of feeling regarding certain terminology and labelling and worked hard to avoid using it in a way that might cause offence in written materials and in the interviews. When asking about interviewees' representations of problem drinking, the first question asked, as a result of this episode, was what their preferred term for it was, to avoid inadvertently causing offence. Leventhal et al.'s concept of the 'Identity' dimension is that it is composed of 'Label' and 'Symptoms', so asking about their name for problem drinking was fully relevant to the topic as well as sensitive to each interviewee's feelings.

3.7.2 Development of the interview topic guide

The interview guide (see Appendix 12) was developed originally from the results of the post analyses and literature review. Comments were sought on it from three colleagues from the Information School and the researcher's supervisors. After revision, the guide was trialled in mock interviews with the three colleagues and also with three external lay people with only basic knowledge of the project and no health information expertise, to ensure question clarity. Test sessions were carried out between late August and the start of October 2017 and proved very helpful, with changes being made as a result to both the guide and general interview plans. It was very helpful to test the questions verbally as hearing the questions spoken aloud highlighted some issues (particularly overlong questions) that had not been picked up before. The comments of the lay volunteers were especially useful in testing question clarity and ease of understanding. Additionally, during this period, the Sheffield Addiction and Recovery Research Panel (ShARRP) was consulted on the guide and plans generally, and gave useful advice including, for example, the suggestion to offer Skype audio only as well as Skype audio and video. This is a panel whose work includes commenting on plans for research into alcohol issues, and which includes users of, and representatives from, local alcohol services plus representatives from the two universities in Sheffield. The researcher became

aware of the group at a conference and asked to present to them, which took place in early September 2017.

3.7.3 Pilot study

The initial guide was piloted in late October 2017 with the first four interviewees (whose data is included in the 22 interviews used) and then reviewed again for clarity and the effectiveness of the questions. Some minor changes to wording were made as a result. The main questions remained the same throughout the interviews, but use of the sub-questions was flexible depending on interviewees' answers to the questions and the need to pursue particular issues in more depth, either because the interviewee had much to say that was of interest, or because they introduced new, relevant topics that required further exploration.

3.7.4 Adaptations during the main interviews

Following a request from one participant to see the questions in advance, these were sent to all five remaining interviewees, as it was thought it might be helpful for them to think about the issues in advance. In practice, this did not seem to make any difference to either their understanding of the questions or the amount they had to say when compared with those who did not receive the questions in advance.

One issue that emerged was that Group C had such a clear explanation for problem drinking and its treatment that Question 4 was redundant: 'When you think about your main group's discussion forums, how do you think they would describe problem drinking? Is there a general view, a group view?' However, this simply gave more time to focus more on the sub-questions around how the group handled posters who diverged from the group view. Questions 5 and 6, which were more structured, were initially derived from what had been observed in the forums with additions from interviews as these progressed, in an iterative process of development. This was deemed acceptable as the aim was to explore ideas not to test or prove hypotheses:

> "in exploratory studies the questioning may continually improve as the researcher learns more about a topic, ideally resulting in a sophisticated form of interviewing receptive to the nuances and complexities of the topic explored." (Brinkmann & Kvale, 2015, p139)

Interviewees were also asked for basic demographic data (age, ethnicity, gender and level of education) to characterise the study's sample and to see if this study's respondents were similar to those in other researcg: the sample characteristics are presented and discussed in Section 4.4.

Requesting age also helped to ensure no one under 18 years old participated. The information was collected in standardised format and used to provide descriptive statistics. This was carried out at the end of the interview as it seemed less intrusive and blunt if it was administered after discussions, when the interviewees had had a chance to assess the researcher and decide whether they felt comfortable in giving personal information. In hindsight, although being over 18 was included in the information sheet, it might have been better to have asked about age explicitly in the consent part of the form, as had any interviewees been under 18 (which none were) their interviews could not have been included. All interviewees answered all of the demographic questions.

3.7.5 Interviewing procedures

Interviewees were able to request interviews by phone, Skype (either visual and audio, or audio only) or in person. One individual requested email as they felt they communicated better in writing and this was accommodated. Table 3.3 presents the numbers of interviewees per format.

Table 3.3: Modes of interview

Mode of interview	Numbers of interviews using this mode
Phone	9
Skype - audio and visual	7
Skype – audio only	4
In person	1
Email	1
Total:	22

It was very beneficial for the researcher to gain experience of using a mixture of interview channels. It had been expected that using audio only would prove difficult, but this was not particularly the case, with the most noticeable difficulty being establishing what silence meant, i.e., whether a prompt was needed or not. In most cases the interviewees' vocal patterns became clearer as the interview progressed and the researcher was able to gauge better when they were thinking and when they had not understood. Where there were visual cues, i.e., in the face-to-face or audio/visual Skype interviews, this was found to be slightly distracting, as the researcher had to concentrate on their own visual reactions as well as listening to the interviewee and thinking whether prompts were needed. Email proved the least rewarding medium as there was no additional visual or aural information and follow up questions could not be probed in depth with the

same immediacy as when using Skype or the phone. However, the email answers were very focussed on the topic at hand, with fewer digressions and filler chat.

All phone interviews were conducted at the university in a quiet private room. Skype interviews largely took place at the researcher's home, which was quiet and completely private. The conduct of the email interview was discussed between researcher and interviewee and it proceeded, at the latter's request, with questions being sent one at a time, together with any follow up questions to the last set of replies, if needed. The in-person interview took place at the interviewee's home, for health reasons. The interview plans had originally ruled out visiting interviewees' homes for safety reasons, but, in this case, the researcher and interviewee had already met professionally and the researcher felt that this was a safe option and clearly best for the interviewee's health. All interviews were recorded on two digital recorders, and downloaded to the University Research drive, with copies kept on password protected memory sticks which were stored securely.

In all cases, the researcher wrote field notes straight after the interview, reflecting on it and noting any problems, or interruptions. Interviews lasted between 47mins and 114mins with 13 of the 22 being longer than 60mins. The email interview took place over approximately four months, between late October 2017 and the start of March 2018. The other 21 interviews took place between late October 2017 and February 2018. On two occasions the researcher did not have enough time in the interview to ask all the questions, and those remaining were sent to the interviewee to respond to by email.

3.7.6 Ethical issues

Ethical issues as regards the interviews included that they involved discussions which could (and did) bring up potentially highly sensitive issues when participants introduced information about the impact of their problem drinking on their life as part of the discussion of their representation. This included topics such as sexual violence, the effect on relationships and on physical and mental health. These topics were not introduced by the researcher, or actively followed up, but were dealt with sympathetically including checking whether the interviewee was upset and able to continue the interview (all were happy to continue). If the individual had become upset, they would have been offered the option of having some time out, to move on from the distressing topic or to terminate the interview, and they would have been offered details of local support services if this had been appropriate. These aspects of interviewee's lives are not included in the thesis in any way that could identify them. The information sheet used for obtaining consent from participants made clear to

them their right to withdraw at any time from the study, and any restrictions on this, e.g., that this was only possible until the data had been anonymised and so was no longer traceable to the participant. They were also informed via the consent form of how to raise any concerns or complaints, in accordance with University of Sheffield guidance.

Risks to the researcher at interview, including from those under the influence of alcohol did not prove to be an issue in practice as only one person was interviewed face-to-face and they were already known to the participant in a work context. As individuals were consented by email, the issue regarding consenting someone who had been drinking was only relevant for one person, and this did not appear to be the case either before the interview or from what was said in it. It was not specifically enquired about, as this would likely have been unnecessarily intrusive and offensive to the individual.

3.7.7 Transcription, anonymization and file security

All interviews were listened to and initial notes were made. Following this, five of the interviews were transcribed by the researcher in order to gain experience of doing this, working to the notation system set out in Appendix 13. Statements relating to the interview itself, for example, 'Is it OK if I record this?' were not transcribed, nor were pauses shorter than one second. As transcribing was not found particularly to aid the researcher's familiarity with the data, and due to the number and length of the interviews, it was decided to get the remaining 19 audio files (including the three interviews with non-forum users) transcribed by a transcription agency (Business Friend). Using external help is supported by Brinkmann and Kvale (2015) in their guidance on interviewing. Business Friend operated to the standards required by the University of Sheffield and as set out in the ethics application for this project. The audio files were password protected and uploaded to the agency's secure file transfer facility which used "military grade 128-bit Transport Layer Security (TLS) encryption". Transcription took place between February and April 2018. All transcripts were then carefully checked word by word by the researcher against the recordings (and anonymised where necessary, removing names). This was very useful in ensuring transcript accuracy and also in developing immersion in the data. Particular care was taken as the original recordings are due to be deleted at the end of the project, so any future research will rely on the written transcripts only.

In all research materials, apart from the audio recordings and consent form, both groups and participants were referred to by a pseudonym. The pseudonyms chosen here reflected the white, Anglo-Saxon, middle class nature of the posters as a group, and their specific gender, but not further

differences amongst them, in the interests of protecting participant anonymity. Transcripts were password protected and securely stored on the University Research Drive and on encrypted, password protected memory sticks kept by the researcher. Paper copies of transcripts were only made if they were deemed essential and were kept locked away when not in use, and confidentially destroyed as soon as they were no longer needed. No personal identifiable information was worked on while using public transport or in public venues, but only at the researcher's home and on the Information School's premises. Consent forms were kept in a locked cupboard in the Information School only accessible to the researcher and supervisors. After the end of the project they will be destroyed as confidential waste. Permission for the research team to use the transcripts in future research was obtained from all interviewees.

3.8 Data analysis

Thematic analysis of the material was in 3 stages: firstly, each group's forum postings were analysed in turn using Braun and Claarke's six-step method of analysis. Secondly, this material was set aside and the interviews carried out and analysed. Thirdly, the posts were returned to and re-coded using template analysis. The following presents more information about each part of the process.

3.8.1 Post data analysis, Part 1

Table 3.4 sets out the analytic activities undertaken at this stage and indicates how these aligned with Braun and Clarke's method of thematic analysis. Their method is then explained and the steps taken in this research further discussed.

Table 3.4: Summary of post data analysis

Data analysed	Braun & Clarke phase of thematic analysis	Steps taken for each group A – C	Relevant appendices
Post data analysis – Part 1	Phase 1	1. Familiarisation and note taking	
	Phase 2	2. First coding pass, adapting and adding to a priori codes as appropriate	Appendix 14: Initial codes used for forum post analyses
	Phase 3	3. Tentative identification of themes with draft notes on meaning	
	Phase 4a	4. Extracts re-read to check correctly coded	
	Phase 4b	5. Second coding pass using complete set of	

		codes from first pass, adapting and adding others as appropriate	
	Phase 5	6. Definition and naming of themes	
	Phase 6	7. Draft write-up	

Braun and Clarke's (2006) method was chosen as it:

> "encourage[s] a rigorous and systematic approach to coding and theme development, but…[is] also fluid and recursive, rather than rigid and structured…[it offers] the qualitative researcher flexibility in terms of the theory informing their use of TA, and how precisely they enact TA (a constructionist or essentialist framing, an inductive and/or deductive orientation, and latent and/or semantic coding), but in doing so, it require[s] the researcher to articulate the assumptions that informed their approach and how exactly they enacted TA" (Braun & Clarke 2019, p591-2).

The 6 stages of their process, briefly are:

1. Familiarisation with the data set
2. Initial coding
3. Tentative identification of themes

4a. Re-reading the data extracts to ensure they are coded correctly and fit the provisional themes.

4b. Re-reading the data as a whole, coding any elements missed.

5. Definition and naming of the themes
6. Writing up the report

In 2019, Braun and Clarke identified three categories of TA: 'coding reliability TA', 'codebook TA' and 'reflexive TA', but this occurred too late to influence the data analysis in this thesis. Of the three, the method detailed here most resembles 'codebook TA' which is positioned somewhere between the other two:

> "'Codebook' TA captures a cluster of methods that broadly sit within a qualitative paradigm (albeit with some pragmatic compromises). They use some kind of structured coding framework for developing and documenting the analysis, but consensus between coders and inter-rater reliability are not usually measures of quality. Themes are typically initially

> developed early on, as they are with coding reliability, but in some methods can be refined or new themes can be developed through inductive data engagement and the analytic process" (Braun & Clarke 2020, p6)

The analysis began with close preliminary familiarisation with the data, reading it several times and making notes to generate initial ideas of possible codes and patterns of meaning. Next, all the posts were systematically coded, beginning in January 2017, with those from Group A. Initial "concept-driven" codes (Brinkmann & Kvale, 2015, p227) arose from the research questions, literature review and the preliminary reading of Group A. They are provided in Appendix 14 and included the CSM concepts, codes indicating the ways in which representations can be affected (e.g., being changed, confirmed, challenged) and ones for different information behaviours including those noted as important in the literature review (e.g., story), plus terms developed from the initial reading of Group A. New concepts ("data-driven" codes) were added as they were generated from the data, thus, the coding was a mixture of deductive and inductive approaches. Coding was carried out on NVivo 11 and data extracts supporting the codes were logged on this also, with enough of the post to enable the context to be assessed (Bryman, 2016). The unit of analysis was each post and these were allocated to as many different codes as was appropriate. Inconsequential items were not coded, e.g., greetings, reporting of unrelated activity, or off-topic sidebar conversations. Coding was carried out using the approach Braun and Clarke call "contextualist" which:

> "[sits] between the two poles of essentialism and constructionism…[and which] acknowledge[s] the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of "reality"." (Braun & Clarke, 2006, p9)

Codes were then tentatively grouped into initial themes and sub-themes with draft notes produced on the meanings of each. Themes are here defined as:

> "captur[ing] something important about the data in relation to the research question, and represent[ing] some level of *patterned* response or meaning within the data set" (Braun & Clarke 2006, p10, their emphasis)

This thesis does not, however, follow Braun and Clarke's later (2019) distinction between 'domain summary' themes and 'true' themes:

> "Domain summary themes are organised around a shared topic but not shared meaning – they aim to capture the diversity of meaning in relation to a topic or area of focus." (Braun & Clarke 2019, p593)

Dismissing domain summaries seemed at the time of write up to the researcher to be unnecessarily restrictive and dismissive of important aspects of data. Domain summary themes are very valid aspects of inquiry and ones that have been frequently found using TA in research. Here, they usefully reflected the materials studied, enabling productive discussion of the topic. In 2020, Braun and Clarke stated that in 'codebook TA' "themes may consist of summaries of data domains" (Braun & Clarke, 2020, p14) which would indicate that this researcher's approach was valid in their view.

Data extracts were then re-read to ensure that they were correctly coded and supported their host theme. The whole data set from Group A was then re-coded to check the suitability of the themes and to identify any material that had been missed on the initial pass. The codes/themes were then written up in draft form, and Groups B and C were coded following the same process. The same initial skeleton code (Appendix 14) was used for each group with codes specific to individual groups being added during the process. Where a concept introduced in one group was found in another, the same terminology was used. Starting with the same initial code set for each group meant that differences between groups as well as similarities or developments could be retained at the end of the process. When all of the posts had been coded and drafts for each group had been written, the post analyses were set aside until after all of the interviews had been carried out and analysed, when Phase 2 of the post analysis took place (see Section 3.8.3).

3.8.2 Interview data analysis

Table 3.5 sets out the analytic activities undertaken with the interview data and indicates how these aligned with Braun and Clarke's method of thematic analysis, discussed above.

Table 3.5 Thematic analysis

Data analysed	Braun & Clarke phase of thematic analysis	Steps taken for each group A - C	Relevant appendices
Interview data analysis	Phase 1	1. Familiarisation and note taking	
	Phase 2	2. First coding pass, including limited data cleaning	Appendix 15: Initial high level codes for interview analyses
	Phase 3	3. Themes reviewed	
	Phase 4a	4. Extracts re-read to check correctly coded	
	Phase 4b	5. Second coding pass	
	Phase 4b	6. Interviews back-coded	

Interview data were coded using the same process as described for the forum posts. Following familiarisation, interview transcripts were coded one by one and in group order, so all interviews from Group C were coded sequentially, then Group D etc. The initial set of codes for the interviews was formed from the original code skeleton, the interview questions plus items found in all three of the forums (see Appendix 15 for the high level codes), and was added to incrementally and inductively with each transcript. It was felt that this would help to highlight differences between individuals and groups. Limited data cleaning of the transcripts (removing hesitations and repetitions) took place during first coding, in accordance with Braun and Clarke's advice:

> "It's acceptable to delete hesitation and repetition without acknowledgement (removal of such features can be characterised as 'cleaning up' the data)" (Braun & Clarke, 2013, p25.)

At the end of this first coding pass, the code set was considerably larger than at the beginning. Provisional themes and sub-themes were reviewed and all data extracts per code were read to ensure that they fitted within the codes and themes they were lodged under. Codes were re-named or amalgamated and posts recoded where necessary. The next step was to recode the transcripts for any items that might have been missed and, finally, all transcripts apart from the final one were back-coded (using only codes identified during the re-coding) in order to ensure consistency and so that all interviews had been coded by the same set of codes. No new codes were added at this stage.

3.8.3 Post data analysis, Part 2

Table 3.6 sets out the steps taken to recode the forum posts in the light of the interview findings and codes. The use of template analysis is then discussed.

Table 3.6: Post data analysis, Part 2

Data analysed	Steps taken for each group A – C	Relevant appendices
Post data analysis – Phase 2	1. Third coding pass of forums using template analysis and key codes/themes from the final interview codes	
	2. Interview and forum data loaded into one file and codes cleaned	
	3. Thematic map development	Appendix 16: Final themes and sub-themes
	4. Combined model developed	Appendix 17: Combined Model

When the coding of the interviews was complete, the forum posts were re-coded using the final codes from the interviews (available on request). Recoding was undertaken to check whether important items that had been found in the interviews were also present in the posts, but had not been noticed previously. It ensured that:

a) The final codes had been derived from all the data and were reflective of it; and
b) Consistency was achieved by having all data ultimately recoded from this set of codes in regard of the key aspects. Themes and codes that were of less relevance to the research questions were kept in a 'Miscellaneous' category and were not used at this stage, nor were any new codes introduced.

At this stage, the process used was template analysis, rather than Braun and Clarke's 2006 procedures. This is a form of thematic analysis (labelled as one type of 'codebook TA' by Braun & Clarke, 2019, 2020). It allows the coder to focus on key themes and go to a greater depth of coding with them (Brooks, McCluskey, Turley & King, 2015), rather than spending considerable amounts of time recoding aspects that have not proved significant.

> "Template analysis…enable[es] a more detailed development of the template where necessary to reflect depth and complexity in the data and consequently the analysis... [it allows the researcher] to tailor the analysis, and focus on particularly important and interesting thematic areas." (Turley, 2018, p151-8)

It is a flexible method that has often been used with interview data, and one which is particularly helpful where the researcher has a large amount of material (King, 2012), as was the case here. It has been used in health research and with the CSM previously (King, 2012; Brooks, McCluskey, Turley & King, 2015).

3.8.4 Thematic map development

After coding was finished, it was possible to combine the data from all sources in NVivo. The codes were then cleaned again with duplicates combined. Themes were developed, named and defined in an iterative process and several iterations of a thematic map were produced and discussed with supervisors. The final thematic map (see Appendix 16) was used to generate a model of the role of information behaviours in representation development (Figure 7.1, Appendix 17): this is discussed at length in Chapter 7.

3.9 Ensuring research quality

There are many frameworks and criteria for assessing quality in qualitative research including, for example, those applying values transposed from core quantitative research criteria (notably validity and reliability, but also objectivity and generalizability), to frameworks specific to qualitative research, such as that of Lincoln and Guba (1985), Tracy's eight 'Big Tent' criteria (2010) or Spencer, Ritchie, Lewis and Dillon's 18-point checklist (2003). Many of the methodologists cited in this chapter have produced advice, e.g., Mason (2002, Ch 9), Braun and Clarke (2013, Ch 12) and Brinkmann and Kvale (2015, Ch 9 & 15), and this thesis has been influenced by them as regards the specifics of using different methods. However, overall, it used Lincoln and Guba's framework for trustworthiness as being well-established and appropriate to the study, and its methodology and research paradigm. Their framework consists of four main criteria: credibility, transferability, dependability and confirmability. Various methods were used to ensure these criteria were met, some of which have been described elsewhere in this chapter, but which are here drawn together for clarity.

3.9.1 Credibility

This quality criterion asks whether the findings presented are believable, grounded in the data and the arguments hold up to scrutiny. To achieve this here, all arguments were supported by evidence obtained from the data sources and the study focused on ideas that were found in more than one group. The overall research design with the use of two different data sources provided triangulation (corroboration or otherwise of results), development (e.g., questions for the interviews arose from the text analyses), expansion (development and explanation via the interviews of themes observed in the forum posts) and complementarity as defined in Section 3.4 (see Venkatesh et al., 2013 and Johnson & Onwuegbuzie 2004). Extensive use was made of quotations to support the claims that were made. The methods that were used were well-established, and previously validated (i.e., Braun & Clarke's 2006 method of thematic analysis and Brooks & King's template analysis), as were the models that were drawn upon (e.g., Leventhal el al.'s CSM, Wilson's General Model of Information Seeking). There was consistency in applying the methods, for example, all transcriptions were carefully checked for accuracy and completeness, procedures have been documented in detail here, so that they are transparent and reproducible. Lincoln and Guba (1985, 1986) stated that prolonged engagement contributes to credibility and ample time was allowed for familiarisation and immersion in the material. Coding schemes were discussed with peers and supervisors and negative cases have been acknowledged and are discussed in the thesis in Chapters 5 and 6 on the findings. Respondent validation, recommended by Lincoln and Guba, was considered but not attempted other than within the interviews themselves, and in the summaries of research to date plus details of publications that were sent to the groups. This was because, in practice, although it can provide some interesting feedback, it can also raise many issues, for instance, the possibility of censorship by the respondent, or over-willingness to agree and endorse the researcher' viewpoint. Participants and their groups will be sent a final summary of the findings after thesis completion.

3.9.2 Transferability

This deals with whether the findings are applicable elsewhere to similar groups. The study sought to maximise the possibility of this by having a range of interviewees and groups with different representations, and by focusing on aspects held in common. The overall approaches and general characteristics of the groups have been provided in Section 4.2 and points throughout are illustrated with thick description, offering sufficient context and detail for others to judge transferability. The research's transferability is discussed further in the Conclusion (Chapter 8)

3.9.3 Dependability

Dependability enquires whether the same results would be found if the procedures were repeated, which is a difficult concept for qualitative research, as it is unlikely that the same procedures would produce identical results in any study. As Brinkmann and Kvale stated:

> "Different interviewers, using the same interview guide, may produce different statements on the same themes, due to varying levels of sensitivity toward, and knowledge about, the topic of the interview…With another interviewer, a different interaction may be created and a different knowledge produced" (2015, p34-5)

The researcher's knowledge and immersion in the subject inevitably influences the coding. However, Lincoln and Guba stated that assessors should "examine the process of the inquiry, and in determining its acceptability the auditor attests to the dependability of the inquiry" (1985, p318). The entire project received supervisory oversight with two supervisors discussing and commenting on all of the material that was produced, the plans that were made and executed and on the findings.

Two sets of discussions about codes were also held with colleagues from the same University of Sheffield research group with experience of working on online social media and health. At the end of the first post coding pass, two threads from the group were chosen at random and coded by a colleague who indicated any possible new codes. Differences were discussed and the codes revised where necessary. Secondly, following the initial coding of the interviews, the codes were used by, and discussed with, two other colleagues. They coded two anonymised extracts from the interviews and these were then compared with the researcher's coding. These were not formal inter-rater reliability tests as this is not appropriate for qualitative work as discussed above. The value of the exercise lay in the discussions about the codes and the identification of new codes or areas where existing ones were not clear. For example, codes suggested at this stage that were subsequently added included: 'Controllability – belief in cure'. Codes renamed included 'Methods of conveying information' changed to 'Ways of conveying information'.

See also Section 3.7.2 for a discussion of the consultation on the interview guide.

3.9.4 Confirmability

This asks whether the researcher has avoided biasing findings. The researcher's reflexive approach (discussed in Sections 3.2 and 3.7.1) has sought to minimise this, together with the discussion of contradictory findings. The research has also been related to, and contrasted with, previous theory in the area. Discussions with supervisors and peer coders have also contributed to address this by identifying points that were not clear or did not seem justified to them.

Care was also taken to meet good ethical standards as discussed in Section 3.5. The relevance of the study to practice (its 'ecological validity' or relevance in the everyday world) is discussed in Section 8.4.

3.10 Conclusion

This chapter has set out how the research questions were addressed, including the ethical issues involved, the research paradigm chosen, the reasoning behind the specific methods selected, how these were implemented and how the data was analysed. Section 3.9 dealt with the issue of quality in research.

These first three chapters have set out the background to, and rationale for, the study, reviewed the existing literature on the topic and related areas and given the methodology that was followed. The next chapter sets the scene for the findings by briefly describing the groups, those posting in them during the relevant period and the interviewees. Chapters 5 and 6 then present the thematic findings.

Chapter 4. Setting the scene: the groups, their users and the interviewees

4.1 Introduction

This chapter sets the scene for the ones that follow by describing the groups studied and their users. This includes discussion of interviewee demographics, and of forum member demographics where they are available.

4.2 Descriptions of the six groups

Six alcohol online support groups (AOSGs) were drawn upon in total: three for the forum post analyses (Groups A – C) and five for recruiting the interviewees (Groups A and C plus Groups D – F). One thousand, five hundred discussion forum posts from conversations held prior to October 2015 were analysed for the first phase of the study (500 from each group). Twenty-two in-depth, semi-structured interviews were obtained in the second phase.

4.2.1 Group A (used for post analyses and interviews)

Group A was a medium size AOSG, based in the UK which in 2016-17 when the post analyses were carried out had four well-used forums. It was unobtrusively moderated by non-professional volunteers who were users and who drew on their own experience of recovery from problem drinking. It was aimed at all those who have a problem with drinking, including people who wished to abstain, those who wanted to moderate or cut down and those just concerned about their drinking. The site had a clear representation of problem drinking as a learned habit, used by people to help them deal with difficult situations/emotions, and as best treated with psychotherapy.

4.2.2 Group B (used for post analyses)

Group B was a very large AOSG, based in continental Europe which in 2016-17 had two main sections, each covering many different drugs and both including a forum specifically on alcohol. The site as a whole was very well used with approximately four million views per month when study of the group commenced. It was unobtrusively moderated by staff members and volunteers. It was primarily interested in information provision, being aimed at those who wanted to ask questions and have open and frank discussions about drugs, including alcohol. It also provided some support for problem drinkers. The site stated that it took a very open and impartial attitude to drugs and how to recover from addiction to them, seeing them as neutral substances with the potential to be used or abused. It did not promote any particular treatment, but gave information on many.

4.2.3 Group C (used for post analyses and interviews)

Group C was a small AOSG, based in North America which in 2016-17 had six sections with varying numbers of forums in each. It was intensively and visibly moderated by volunteers with experience of using the particular medication-based method espoused by the group to recover from problem drinking. The site was aimed at all those wishing to use this method to achieve moderate drinking or abstinence. It had a clear representation of problem drinking as a learned behaviour in combination with a susceptible genetic predisposition. It aimed to provide accurate, reliable information and advice about using the medication-based method, plus support to help and encourage those using it.

4.2.4 Group D (used for interviews)

Group D was a small AOSG based in North America which, in 2017-18 when the interviews were held, included two forums. It was not moderated other than by its users and followed a harm reduction approach, explicitly rejecting 12-step principles and the disease model of addiction, and instead endorsing a choice and empowerment model in which users set their own goals (reduction, moderation or abstinence) and found ways to achieve these that worked for them. Whilst a programme for recovery was offered, there was no obligation to follow this.

4.2.5 Group E (used for interviews)

Group E was a medium-sized AOSG based in North America which in 2017-18 had a mixture of open and closed forums. It contained two open forums holding threads of 'sticky' content, i.e., content that had been recognised by the group as particularly helpful or well written and which was therefore to be retained and highly visible on the site. There were also several other forums for which registration was needed in order to view. The forums were moderated by volunteers from amongst the users. Similar to Group D, it followed a harm reduction approach and offered guidelines for achieving moderate drinking, which were not compulsory. Users could decide between moderation and abstinence, and choose amongst the tools on offer.

4.2.6 Group F (used for interviews)

Group F was a large AOSG based in the UK with approximately twenty-five forums in 2017-18. It was moderated by staff and followed a pro-abstinence approach, but did not identify with the 12-step programme. It encouraged a positive approach to abstinence as greatly preferable to drinking, but would also provide support to those with other goals. There was no formal programme for treatment suggested but information to help with recovery was available.

Table 4.1 summarises the main characteristics of the six groups included in the study.

Table 4.1: Summary of group descriptions

Name	Brief description	Approach to recovery endorsed in information pages	Moderated?
Group A	Medium* size AOSG, based in the UK	Cognitive Behavioural Therapy (CBT)	Y
Group B	Very large* AOSG, based in Continental Europe	None in particular, neutral approach to drugs and alcohol	Y
Group C	Small* AOSG, based in North America	Medication based treatment	Y
Group D	Small* AOSG, based in North America	Own harm reduction programme	N
Group E	Medium* size AOSG, based in North America	Own harm reduction programme	Y
Group F	Large* AOSG, based in the UK	No specific programme, promotes abstinence	Y

*** Small = <5,000 members; medium = 5,000 - 10,000 members; large = 10,000 - 75,000 members, very large = 75,000+ members**

4.3 Forum member demographics / usage statistics

Tables 4.2 - 4.6 give descriptive statistics about users' demographics and forum usage amongst those who posted in the material selected for analysis from Groups A – C. (Interviewee demographics and forum usage are dealt with in Section 4.4.) The details that could be found varied greatly between groups with most coming from Group B, very little from Group A and still less from Group C. In Group C, no demographic details were available other than those occasionally offered in postings if a writer found it appropriate to mention them, or by the side of avatars at the writer's discretion: for example, posters occasionally put their country of origin there.

Table 4.2: Nationalities of posters within the sample of forum posts

Country	Group A		Group B		Group C	
	Number	% of total	Number	% of total	No data available	
North America	11	8%	112	60%		
UK	44	31%	21	11%		
Not given	84	59%	31	16.5%		
Continental Europe	1	1%	12	6%		
South Asia	1	1%	0	0		
Australia	0	0	7	4%		
Ireland	0	0	3	2%		
Middle East	0	0	1	0.5%		
Total	141	100	187	100		

Table 4.2 shows the majority of Group A posters did not give their location; of those that did, the largest group were from the UK, where the group is based. The majority of Group B posters were from North America, although the group is based in continental Europe.

Table 4.3: Frequency of posters by gender

Gender	Group A		Group B		Group C	
	No data available		Total	% of total	No data available	
Male			133	71%		
Female			54	29%		
Total			187	100		

Data on gender was only available for Group B and indicated that, within this sample of posts, users were predominantly male.

Table 4.4: Frequency of posters by age group

Age band	Group A		Group B		Group C	
	No data available		Total	% of total	No data available	
Not given			84	45%		
18-21			2	1%		
22-30			39	21%		
31-40			37	20%		
41-50			17	9%		
51-60			6	3%		
61-70			1	0.5%		
70+			1	0.5%		
Total			187	100%		

Again, data was only available for Group B participants, and indicated that the predominant age groups were between 22 and 40.

Table 4.5: Number of messages posted by each person

Amount	Group A		Group B		Group C	
	Total	% of total	Total	% of total	Total	% of total
< 10	11	8%	43	23%	30	34.1%
11-500	59	42%	88	47%	31	35.2%
501-1000	19	13%	22	12%	2 (these are the two moderators)	2.3%
1001 – 5000	38	27%	30	16%	0	0
5001+	11	8%	4	2%	0	0
Not available	3	2%	0	0	25	28.4%
Total	141	100%	187	100%	88	100%

In each group, the largest number of posters had posted 11-500 posts each. There was a higher proportion of individuals posting more than 1000 posts in Group A compared with Groups B and C.

Table 4.6: Year poster joined group

Year	Group A		Group B		Group C	
	Total	% of total	Total	% of total	No data available	
2005	0	0%	9	5%		
2006	0	0%	9	5%		
2007	0	0%	20	11%		
2008	5	4%	8	4%		
2009	9	6%	1	0.5%		
2010	10	7%	14	7.5%		
2011	28	20%	8	4%		
2012	16	11%	13	7%		
2013	14	10%	23	12%		
2014	22	16%	43	23%		
2015*	35	25%	39	21%		
Not known	2	1%				
Total	141	100%	187	100%		

***The period from which data was selected ended at October 2015 as detailed in the methodology (see Chapter 3)**

Over half of the members of Groups A and B had joined in 2015 or the preceding two years, although there were members from ten years prior to 2015 in B.

Group B provided the clearest picture of the users posting in the extracts analysed. It can be seen that the majority of these were male and from North America, with the largest known age group being the 22 to 40 age range. This is somewhat younger than typical AOSG users, for whom the 30-50 age group is usually in the majority (Atkins & Hawdon, 2007; Coulson, 2011; Cunningham et al., 2008; Graham, Irving, Cano & Edwards, 2018; Kirkman, Leo & Moore, 2018; Kosok, 2006; Liu, 2017; Sinclair, Chambers & Manson, 2017; Sotskova, Woodin & Cyr, 2016). Seventy percent had posted 500 posts or fewer and most had joined in the preceding 3 years.

4.4 Interviewee demographics

The demographics obtained from the 22 interviewees are summarised in Table 4.7, together with their length of time using the site and frequency of use. As they were not asked for their usernames, in order to respect their privacy, it is not possible to estimate the number of posts accrued by each.

Table 4.7: Demographic and usage details of interviewees

Pseudonym	Group	Nationality	Gender	Age group (years)	Education*	Time using site	Reported frequency of use
Anna	Group A	UK	F	50 -60	Level 3*	5 years +	Daily
Ben	Group C	North America	M	30 – 40	Level 2	< 1 year	Daily
Cathy	Group C	North America	F	40 – 50	Level 3	< 1 year	1-5 times a week
Julie	Group C & previously E	Rest of the world	F	50 – 60	Level 3	< 1 year	Highly variable
Marianne	Group C	North America	F	60 – 70	Level 2	< 1 year	Daily
Alan	Group D	North America	M	40 – 50	Level 3	1-2 years	1 – 5 times a week
Bethany	Group D	UK	F	40 – 50	Level 2	< 1 year	Daily
Christine	Group E	North America	F	50 – 60	Level 3	5 years +	Daily
Dawn	Group E	North America	F	70 – 80	Level 2	3-4 years	Daily
Jackie	Group E	North America	F	50 – 60	Level 4	2-3 years	1 – 5 times a week
Joe	Group E	North America	M	30 – 40	Level 3	1-2 years	1 – 5 times a week
Ariana	Group F	North America	F	50 – 60	Level 2	< 1 year	Daily
Cara	Group F	UK	F	40 – 50	Level 2	4-5 years	Variable
Erin	Group F	UK	F	50 – 60	Level 1	1-2 years	Variable
Grace	Group F	North America	F	50 – 60	Level 1	2-3 years	Daily
Isabelle	Group F	UK	F	50 – 60	Level 1	1-2 years	Daily

Joanne	Group F	UK	F	60 – 70	Level 3	< 1 year	Daily
Megan	Group F	UK	F	40 – 50	Level 1	< 1 year	Daily
Robert	Group F	UK	M	50 – 60	Level 2	2-3 years	D/K
Theresa	Group F	North America	F	60 – 70	Level 3	2-3 years	Daily
Tina	Group F	North America	F	50 – 60	Level 3	< 1 year	Daily
Yvonne	Group F	UK	F	50 – 60	Level 1	4-5 years	1 – 5 times a week

*** Education: highest level of educational attainment**

Level 1: School; Level 2: Undergraduate degree obtained; Level 3: Masters degree obtained; Level 4: Doctorate obtained

Table 4.7 showed that the largest group of interviewees was based in North America (54.5%), followed by the UK (41%), with only one person outside of these categories. These interviewees tended to join a group based in their own country: Groups C and E are based in North America and have mostly North American members whilst Group F is UK-based with the majority of its members from the UK. There was no notable association of particular age or levels of education with particular groups. All interviewees described themselves as white, and the majority were female (82%), and highly educated to graduate level and above (77%). In terms of age, half the participants were in the age group 50-59 years. This was not typical of participants in research studies on AOSGs (see above). However, the interviewees were typical in their other characteristics: firstly, they were white:

> "Rates of participation of persons of color within most secular recovery mutual aid societies remain quite low" (Evans, Achara-Abrahams, Lamb & White, 2012, p183. See also Atkins & Hawdon, 2007; Kosok, 2006; Liu, 2017; Nagy et al., 2015 and Sinclair et al., 2017)

The users in this study were highly educated, which was also reported in studies by Kosok (2006); Khadjesari, Stevenson, Godfrey and Murray (2015); Nagy et al. (2015); Sinclair et al. (2017) and Sotskova et al. (2016). Studies are mixed as to whether respondents are usually predominantly female or male. Klaw, Huebsch and Humphreys (2000) found in their work that:

> "Interestingly, despite men's greater likelihood to experience alcohol problems…women authored 72% of the posts identifiable by gender." (p544. See also Coulson, 2011; Cunningham, 2008; Davison & Pennebaker, 1997; Kirkman et al., 2018; Kosok, 2006 and Nagy et al., 2015.)

However, other studies found a majority of respondents were male (e.g., Atkins and Hawdon, 2007; Graham et al., 2018; Liu, 2017). Interviewees had used their group for varying lengths of time: nine had been members for less than a year, nine for between one and four years, and four over four years. Most were heavy users, with over half using their site daily.

4.5 Conclusion

This chapter has introduced the groups analysed, their users and the interviewees. It has shown that the groups were divergent in size, location and treatment approach. The interviewees were, in some ways, typical of non-12-step users as described in other research, notably in being white, highly educated, and also possibly in being female. They were, however, older than that reported in many studies. The next chapter and the following one will turn to the two main themes identified in terms of the research questions, together with their sub themes. The first theme is the impact of the forums on users' representations of problem drinking (Chapter 5) and the second, information behaviours reported by the interviewees and observed in the forum post analyses that contributed to the development of user representations. (Chapter 6).

Chapter 5: Findings: Impacts on the users' representations

5.1 Introduction

The previous chapter introduced the six groups involved in the research, setting out some of their key features in order to give context to the findings described in this and the following chapter. Chapter 5 discusses findings relating to the first research question, about the impact of the discussion forums on users' representations of problem drinking. It looks, firstly, at the overall beliefs of forum members and shows that there is no requirement to adhere to the same views that are held by the site administrators / moderators or other members. Users are free to develop their own detailed representations of problem drinking and to change these over time. This being said, the general approach of the group is shown as often important in attracting and keeping users engaged. The chapter then explores specific instances where users' beliefs are found, changed, challenged or confirmed on the forums. It ends with an exploration of the impact on user beliefs and emotions of seeing 'someone like me', in terms of drinking, in the forums, perhaps for the first time. This has a powerful effect on how they understand and feel about problem drinking and themselves-as-drinkers.

As was discussed in Chapter 3, the interviews supplied richer data pertinent to the research questions, and therefore the findings from them are reported before those from the forum post analyses. In practice analysis was very interactive, moving frequently between both sources.

5.2 'No requirements of belief'

5.2.1 Introduction

This section discusses aspects of the overall beliefs of users of the forums as presented in the interviews and post analyses. It will be shown that a distinguishing feature of all six of the groups dealt with was the freedom afforded individuals to develop their own beliefs: users are not required to follow an existing, comprehensive belief system, which they saw happening in AA. The section will focus on demonstrating this in relation to the groups and the contrast with AA will be explored in the discussion chapter (Chapter 7). However, the section will affirm that whilst there are 'no requirements of belief', the general approach of the group was important in attracting and maintaining usage. **Please note that, as it is somewhat different in this regard, Group C is dealt with separately in Section 5.2.4.** The issue of stasis in beliefs is also explored and it will be shown that beliefs are often seen as fluid, developing over time.

There are at least two different sets of beliefs at play in these groups as a whole: firstly, there are those presented by members in the interviews and by individuals within the forum posts that were analysed. Secondly, there are those expressed by the creators and/or Administrators of the groups in their information pages. These are the 'official' views of the site and may be detailed or general, offering a coherent philosophy about problem drinking and how to treat it, or some less well formed ideas. (See Table 5.1 for a brief description of each group's approach.)

Table 5.1: 'Official' group beliefs

Group	General approach endorsed	Provides a detailed programme for recovery?
A	Cognitive Behavioural Therapy (CBT)	No, but offers access to counselling plus advice on the therapy in the information pages
B	None in particular, neutral approach to drugs and alcohol, supports harm reduction	No, provides information about many different treatments
C	Medication based treatment which is designed to enable safe, moderate drinking	Yes
D	Own harm reduction programme	Yes
E	Own harm reduction programme	Yes
F	No specific programme, promotes abstinence	No

5.2.2 Members' beliefs about problem drinking

The interviewees

Interviewees were asked about their ideas around problem drinking (their 'representations' of it) and these were analysed using the dimensions of Leventhal et al.'s Common Sense Model of Illness Representations (CSM) as a sensitising concept (Leventhal, Nerenz & Steele, 1984; Leventhal, Diefenbach & Leventhal, 1992). The structure of the model was given in Section 1.2.2, and Table 5.2 sets out the meanings of the dimensions.

Table 5.2: CSM dimensions (aspects of representations)

CSM dimension name	**Meaning**
Cause	What causes problem drinking, why do individuals become problem drinkers?
Consequences	What are the consequences of problem drinking?
Controllability	Can problem drinking be controlled? Can it be managed by the individual or do they need outside help e.g., from healthcare systems?
Timeline	Is it chronic, acute or cyclical? Is it something individuals will always need to be mindful about or can it be resolved and left behind?
Identity - Label - Symptoms	 What does the person call 'problem drinking'? What do they see as its 'symptoms' or characteristics?

Interviewees had many opinions on these dimensions, which, when put together, resulted in each one of the 22 holding a slightly different overall representation. The diversity of views can be illustrated, for example, when looking at responses to the question about 'label', where the following (amongst others) were mentioned by people as their preferred term for describing problematic drinking: 'problem drinking' (e.g., Anna, Group A, Bethany Group D), 'alcoholism' (Alan, Group D, Grace, Group F), 'over-drinking' (Christine, Group E), 'Alcohol Use Disorder' (Marianne, Group C), 'excessive drinking' (Erin, Group F) and 'immoderate drinking' (Dawn, Group E). Jackie (Group F) stated that she used the phrase 'My relationship with alcohol is complicated' rather than a label. Megan did not use one consistent label preferring to tell people 'I don't drink' or saying to old friends: "I'm not on it at the moment" (Group F).

Similarly, wide ranges of opinion were presented by interviewees when discussing the cause of problem drinking or its typical consequences. Not all users had clear cut representations of this, even after some years in the forums. To take one example, when discussing causes, users were asked what they thought about AA's explanation of problem drinking as a disease. Views on this varied but were generally ambivalent, illustrating that some might hold different views at different times:

> "I don't know, I'm a bit ambivalent about the disease thing. I can see the analogy, but I don't necessarily believe, [pause] that it acts in the sa--, I don't--, it's not a disease is it? You can't

> catch it, you can't--, you can't be treated for it, like in the sense of you can't be admitted to hospital and just treated for it, you have to like, cure yourself of it, it's a mental thing really." (Isabelle, Group F)

Isabelle identified what the characteristics of a 'disease' were for her (you catch it and get treatment for it from the healthcare system), showing that problem drinking did not fit with these and therefore not with her representation of illness (although, of course, it should be pointed out that problem drinking may result in hospital treatment). Ariana (Group F) described AA as contradictory about the disease explanation saying that she herself thought it was not a disease but created a diseased state, finally concluding "I don't know, I'm not quite sure". Ben stated he "lean[ed] more" towards considering it a disease (Group C) and Dawn thought:

> "because it runs in, it seems to run in families and you know I think there is a, there is a disease, or something. I don't know if I could call it a disease, but there's something." (Dawn, Group E)

Many members' ideas changed during their time in the forums and this is discussed at length in Sections 5.3 and 5.4. Some stated or implied that their definition of problem drinking and beliefs around alcohol, even after a period of using the sites, were still not fixed and were likely to change in the future. So, for example, Christine (E), Cara (F), and Megan, who summarised her perspective on her ideas as follows:

> "Are they brand new ideas? No I don't think they are. I think they've taken a long time to get to where they are. And I'm sure they're not going to stagnate at what they are now, they'll continue to evolve. [Pause] Is it all down to [Group F]? No, but there will definitely have been influences there. Definitely." (Megan, Group F)

This presents her ideas as fluid and evolving, rather than 'stagnant', a negative interpretation of stasis. In this she sees fluidity and change in beliefs as positive aspects. It is worth noting that this fits with the nature of recovery itself, which is regularly presented in the forums as a process or journey. with its opposite being immobility or being stuck in a vicious circle. It also fits with the nature of forums as fluid entities which are characterised by movement over time and by two-way communication. As the poster Ozzie suggested:

> “forums change, they ebb and flow, trends come and go. They are in flux, not static” (Ozzie, Group A)

The forum post analyses (A & C)

Limited information only was available for the beliefs presented by individuals in the forum post analyses, and it was not possible to determine whether they all had different ideas. However, it can be seen that they presented a variety of views in the forums without backlash. In terms of labels for problem drinking a wide range of terms were used in Group A without comment including ‘problem drinking’ (e.g., Andrew, Alice, Abigail), ‘binge drinking’ (Alice, Ann, Elizabeth, Abigail), and ‘being an ‘alcoholic’ (Eleanor, Alexander). Anita alone used at least six different ways to describe problem drinking. Eliza was similar to interviewee Megan, described above, in saying: “I say "I’m not drinking today" or "don't fancy it right now, thanks"”. Members of this group also talked often of drinking as a ‘vicious circle’ (e.g., Brenda, Bertha, Kate), and of the Wicked Alcohol Elf tempting them to drink.

People in Group B used ‘alcoholism’ most frequently, but also talked of ‘binge drinking’ (Leslie, Henry), ‘addiction’ (Leslie, Fred, John, Mark, Claire), having a ‘drinking habit’ (Caleb), ‘alcohol abuse’ (John, Caleb, Henry), ‘problem drinking’ (Morris, Nicholas), being a ‘heavy drinker’ (Eddie) and ‘alcohol dependency’ (Ulrich). Some distinguished between psychological addiction and physical dependence (e.g., Primrose, Ophelia) and Fabricio distinguished between ‘alcoholics’ and problem drinkers.

In Group A, there were differing causes of problem drinking espoused (e.g., social and cultural pressures, family example, habit, boredom, the desire to self-medicate for stress, anxiety or depression), together with an acceptance that people drink for different reasons. Generally, AA’s disease explanation was not mentioned (the only examples found were its rejection by Boris, and Anita who described her drinking as ‘unhealthy’ but she herself as not “ill”.) Some individuals were not certain about which explanation to go for, for example:

> “So why do I drink…perhaps it’s to avoid things and detach: it does alter the brain. But it is also a learnt habit, and that’s important” (Ozzie, Group A)

Some also talked about not understanding why they drank and how they found it painful that they could not work this out. Abigail, James, Eliza, Primrose and Brian amongst others all expressed being

conflicted between the desire to drink and the desire to remain / become sober. There were also some instances of this in Group B, for example:

> "I drank 750ml every day between ages 22 and 25. It made me insane. I don't know why I went on with it so long. You'd think a week would do enough harm; I thought that the first week I started, but then I couldn't stop." (Fred, Group B)

Again different causes were mentioned in Group B, including the addictive nature of alcohol (Ophelia), social/cultural pressures (Mark, Patroclus, Fred), genetics (John), drinking to escape problems (Patroclus, Ursula, Simon) and using it to self-medicate social anxiety (Fred, Ophelia) or depression (Simon, Ophelia). Positive motivations were also given such as drinking for fun and enjoyment (Oriel). Overall, there were many ideas that were put forward without argument or disapproval.

There was discussion of ideas having changed because of time in the forums and life-experience in Group A, and some mention of ideas as still developing and not static. For example, in Group A, Holly implied that she was expecting her ideas to change in the future: "I know I can never be a "normal" drinker. I think, truly, the best and final answer will be to just go for abstinence." This suggested that she expected to change her view of the best coping mechanism. Carol also described herself as on the cusp of changing her ideas: "Now on day 22 and feeling a bit tempted by all I've read about quitting for 3 months!" (as opposed to stopping after 30 days abstinent). Posts from Group B did not mention expecting future development of ideas.

5.2.3 The group's 'official' beliefs and the individual

The interviewees

Interviewees agreed that there was no requirement to adopt the official beliefs of the site (Group C is a partial exception to this which will be discussed in Section 5.2.4). This freedom of belief was seen by several interviewees as a key benefit of the groups and as something that kept them with their site, for example:

> "I think that is one of the real strengths of [Group A] that you can have a whole range of opinions, and a whole range of approaches…even people with very different views about how best to tackle problem drinking are able to tolerate the fact that there are other views there." (Anna, Group A)

Many members made the point that there were a lot of diverse views in practice and it was fine for users to hold different beliefs about problem drinking e.g., Anna (Group A), Bethany (Group D), Dawn (Group E), Grace, Megan and Theresa (Group F).

> "[there are] a lot of different views, people come from all sorts of places and not everybody thinks the same, there's definitely not a group think" (Alan, Group D)

Users could adopt ideas proposed in the information pages or choose their own way. Twelve-step groups, especially AA, were seen, in contrast, as being intolerant and requiring unquestioning compliance with the beliefs about problem drinking and coping mechanisms set out in the *Big Book* (2011). Some users explicitly contrasted their group with AA. The following, for example, was typical:

> "I used to go to AA and I liked in AA the support, particularly women's meetings, but what I didn't like was the insistence that certain beliefs must be had and that that was the only way to succeed. So what I truly like about [Group F] is that it offers that same support but without any particular requirements of belief" (Ariana, Group F)

This indicated the importance to her of freedom to develop her own ideas rather than taking on a standard philosophy. The interviewees that disliked AA presented similar negative beliefs about it: as dogmatic and 'cult-like', relying on faith and obedience, with an emphasis on not thinking and anti-intellectualism.

> "[I didn't like] the approach of you know, my way or the highway…it's around clichés and slogans and things like that, there's not any sort of thinking as such… and I found that anti-intellectualism very, very frustrating." (Robert, Group F)

Even those who went to AA and found it helpful (e.g., Alan, Group D) did not necessarily accept all of its beliefs, and could understand why the dogmatism of some members damaged its reputation with some people.

Whilst there were no 'requirements of belief' in these non-12-step groups it is important to stress that the general approach of the group was important. This was at a high level and not at the level of detailed sets of belief. It mattered to many of the interviewees whether a group was 12-step or not,

whether it saw moderate drinking as a viable goal, or whether it was open to people developing their own ideas and choosing their own goals and methods of recovery. Many interviewees stated that they were drawn to their group as it was not AA, and allowed for freedom of ideas about the nature of problem drinking and its treatment. In short, whilst the groups all expressed ideas about the nature of, and treatment for, problem drinking on their information pages, they did not insist on members following these interpretations.

In practice, some interviewees felt that site views and members' views were generally aligned, e.g., Yvonne, (Group F) and Joe (Group E). Some of those who said that different views were accepted, also felt that, at the same time, there was some level of agreement amongst members, at a general level. For example:

> "whether they advocate total abstinence or controlled drinking I think the vast majority of people [on Group A] would agree… that you can't just leave a void where drinking used to be" (Anna, Group A)

> "There are quite a lot of different views on there…[but] the prevailing wisdom on there I think is that you've crossed a fine line and you can't get back [to drinking moderately]… I also think that the prevailing wisdom is--, is quite anti AA in some respects, it's not a disease…it's a positive thing to do" (Cara, Group F)

Dawn was somewhat different in stating that there were core techniques in Group E (as well as a "core belief" that moderate drinking was possible):

> "you do practice abstention work on there, and you work on habits, you work on looking at the situations in which you drink and think about other ways to handle them, and that kind of thing. I think there's a kind of core set of not just beliefs, but also kind of techniques that are shared by most people, and certainly by the people who stay over time." (Dawn, Group E)

Yvonne was particularly interesting as she put forward the idea that different leaders within the field were linked by the attitude of recovery as a positive thing to do, rather than it being about deprivation, with this tracking back ultimately to the work of Jason Vale (2011) and Allan Carr (2005).

The forum post analyses (A & B)

The Group A information pages recommended CBT as a way forward for those seeking recovery. This is an approach that has been found to be effective in the treatment of problem drinking and other addictions (NICE Guideline 115, 2011, p262) and which has a number of subtypes. In the site's information pages, CBT was presented as involving the examination of thoughts and emotions and whether or not they were contributing to problem drinking. Unhelpful ideas could then be challenged and new ways of coping learnt. It was seen as important to learn from mistakes without self-criticism and to predict triggers and prepare plans for dealing with them. People chose their own goals to achieve. There was no pressure in the forum posts analysed for individuals to use this specific therapy and no discussions of it as a theory. There are a few mentions of individuals undertaking it and a few references to specific techniques included in it: Lucy discussed 'Negative Automatic Thoughts' and examining these using 'thought diaries' and Ozzie talked about 'cognitive restructuring'. However, whilst rarely referring specifically to CBT, in practice, Group A members' posts frequently focussed on its core elements of exploring triggers to drinking and making plans to prevent problems in the future and deal with difficult situations. Members also drew on psychological techniques from other therapies to help them deal with cravings, for example 'arguing against expectations' (thinking through the potential negative consequences of drinking) and 'decatastrophising' (minimising the seriousness of relapses rather than seeing them as a terrible failure). These were presented by Louise as coming from literature on counselling. It appeared that, whilst there was no requirement to engage in CBT, as such in A, there was an orientation towards working with thoughts and beliefs within this Group.

Group B offered no particular programme and provided information about several different treatments and models of addiction in its information pages. Its overall stance, in 2016, was that it was neutral as regards drugs generally (including alcohol) and sought to provide a platform for individuals to discuss them in a "mature, intelligent manner". Its primary purpose was described in the information pages as to act as an information hub, providing information as an alternative to the "propaganda, horror stories and ignorant journalism often found in the media" (Factsheet 1, Group B, n.d.).

In 2016, the site did not explicitly mention having a harm reduction approach and stated that it supported "people who are using and people anywhere in in recovery" (Factsheet 2, Group B, n.d.). However, by 2020 the mission statement makes specific reference to harm reduction, describing it as a "core value" (Factsheet 3, Group B, n.d.). It is particularly interesting that in the posts analysed

from 2015, the members perceived the site as being about harm reduction (this is further discussed in the next section), even though this was not in the mission statement or information about the forum. It could be speculated that the later inclusion of harm reduction as a core value came from the members' views, rather than the site administrators / moderators. This suggests that the direction of influence may at times run from members to site, as well as from sites to members.

5.2.4 Group C

The interviewees

At first glance, Group C appeared more like AA as it offered a clear programme of treatment that users were expected to follow and not to modify. It provided a representation of problem drinking that explained why the treatment worked and, similar to AA, had a key text setting out the method that its users likened to a Bible. The moderators within this site were more directive than in the other groups as they wished to support and encourage members to implement the treatment correctly, rather than in an ad hoc fashion, and 'compliance' with their main rule was frequently mentioned. All four interviewees agreed that the group was directive as regards the protocol and members not giving medical advice. However, there was no requirement to adopt the interpretation of problem drinking behind it, or to take on a particular world view and lifestyle. Group C did not place problem drinking at the core of the person, marking them out as fundamentally different from other people, as does AA.

In practice, divergent beliefs were also found amongst interviewees from this group. In terms of labels the moderators used the term 'Alcohol Use Disorder' and disliked 'alcoholism'. Ben noted that he had changed the term he used when posting because of this:

> "So now that I've been on the site for a while and I know that it's offensive to some, I try not to use that term when I post." (Ben, Group C)

However, within his own social group, Ben used 'alcoholism'. Julie avoided labels as problem drinking presents in many different ways:

> "you get your constant drinkers, you get binge drinkers, you get your drinkers that don't drink much, but when they do they get violent or something…it's not like one label fits everybody…we have a lot of things in common, but there's differences too." (Julie, Group C)

Cathy used the term 'binge drinking', and Marianne 'Alcohol Use Disorder'. She felt strongly about not using 'alcoholism' as she saw it as "emotionally fraught":

> "it's become equated with really negative things, like alcoholic equals helpless, alcoholic equals loser. Alcoholic equals no character or a character flaw." (Marianne, Group C)

Similar to Julie, Marianne also noted the variety of different drinkers and felt that AUD as a term better encompassed that. Interestingly, the information pages attached to the site include many by the founder of the treatment who appears to have used the term 'alcoholism', and the group's rules on posting make no mention of terminology required.

As regards causes, Group C as a site saw problem drinking as a learned habit, brought about by a powerful association between drinking and pleasure reinforced each time a person drinks. This reinforcement might be enhanced by the individual's particular genetic make-up in terms of their endorphin system. One would expect to find this underlying explanation reflected in all the interviewees' accounts of cause. However, they were not: for example, Ben and Marianne both mentioned a genetic pre-disposition to problem drinking, but Ben did not include the learned behaviour explanation as well. Julie explained problem drinking as caused by a mixture of habit, psychology, physiology, genetics and social pressures.

The forum post analyses

Within the forum post analyses from Group C, again there was some information available about the beliefs presented by some individuals. In practice, the commonest term used to label problem drinking was 'alcoholism' (e.g., Lily, Ralph, Roger, Richard, Mike), followed by Alcohol Use Disorder (e.g., Margaret, Lily, Rose), and 'binge drinking' (e.g., Hugh, Maurice, Rose). Other terms used included: 'daily drinking' (Doris), 'alcohol abuse' (Dorothy), 'alcohol issues' (Gary, Poppy), 'addiction' (Dorothy, Gretchen), 'habit' (Bert). 'Alcoholism' was used without negative comment, and some individuals (e.g., Rose) used more than one term.

As with the interviewees, in practice, there were varied comments on the causes of problem drinking. Some, including of course the moderators, agreed with the received explanation regarding the endorphin system: "Some of us are programmed to learn to drink". However, Richard, who attended AA meetings as well as using Group C, described problem drinking as a "disease". This did not lead to any criticism or argument. Both moderators were present in the discussion, so would

have read what had been said. Richard later also accounted for his problem drinking as a habit which, in the free time of retirement, became a serious problem, so invoking circumstances as a contributory cause. Dorothy talked about using alcohol to "soothe" psychological issues, Kyle drank to medicate anxiety, Angus to alleviate boredom and Rebecca to deal with loneliness and to fit in socially. Stress was mentioned as a common cause.

The evidence from both the interviewees and the forum postings in Group C, then, would suggest that, as with the other groups, there are no firm requirements of belief about representations of problem drinking. There are firm requirements as regards the treatment protocol, but users are given freedom in their explanations of problem drinking.

5.2.5 Conclusion

This section showed how individuals were not required to follow the official beliefs of their site, even in the case of Group C, and that, in practice, each interviewee developed their own unique representation of problem drinking. This could change over time: having fully formed and fixed ideas did not appear to be essential, with members comfortable with fluidity and a degree of uncertainty, accepting that they had changed in the past and might change again. At the same time, the approaches of the groups did seem to influence members, e.g., members of Group A working with therapy techniques. In the case of Group B, it is possible that the members' approach caused the site to adopt a harm reduction approach formally. Whilst many interviewees said there was no 'group think' they did acknowledge some general ideas that they felt members held in common.

5.3 Confirming, changing, challenging representations

5.3.1 Introduction

It was noted in the previous section that users mentioned their views having been changed in the forums. This section focuses on examples of small specific instances where ideas can be seen to be impacted in some way.

5.3.2 Acquiring or changing ideas

Individuals might acquire some of their ideas from the forums or change the opinions they already held as a result of reading or writing in them.

The interviewees

The interviewees mentioned a number of ideas that they credited the forums with giving them. For example, Anna (Group A), Bethany (Group D), Jackie (Group E) and Isabelle, Tina and Yvonne (Group F) mentioned tips and ideas for dealing with difficult situations. Ben (Group C) mentioned the concept of 'mindful drinking' and what to do to get a prescription for the treatment medication and Alan (Group D) learnt how to safely taper off alcohol drinking. The theory behind the preferred method of Group C was gained at least partly from the forums by Cathy and Julie (Group C). Alan (Group D) first learnt about Group C's method in Group D's forums. Interviewees were also asked which were the most important of these changes to their ideas, a summary of which is given in Table 5.3. (Please note that the most significant change to ideas is not necessarily the same as the most significant aspect of the forums to them or the most significant change in themselves).

Table 5.3: Most significant change to ideas

Most significant change to ideas about drinking	**CSM dimension topic located in**	**Name (Group)**
It is not shameful or unusual to have a drink problem, but a widespread issue. There are others like them	Identity	Anna (A), Christine (E), Erin, Joanne, Isabelle, Megan, Theresa, Tina, Yvonne (all F)
Recovery is possible	Controllability	Julie (C) Jackie (E), Cara, Joanne, Megan, Tina (all F)
Overall, how to achieve one's sober goal	Coping mechanism	Ben, Cathy & Julie (all C), Bethany (D), Jackie & Joe (both E)
Self-knowledge including - identifying own triggers and patterns - accepting that had a drinking problem - learning self-compassion	 Cause Identity Emotions	 Bethany (D), Isabelle (F) Erin (F) Christine (E), Grace & Joanne (both F)
Tips and tools - Help with dealing with difficult situations around drinking - Insights and strategies to use in daily life as opposed to theory - Specific techniques	Coping mechanism	Anna (A), Julie & Marianne (both C), Grace & Yvonne (both F)
Information about a specific treatment including: - What to expect when using it in reality (as opposed to theory) - How to obtain a prescription for the medication - General information about the treatment	Coping mechanism	Ben, Cathy, Julie & Marianne (all C); Alan (D)
Redefinition of 'alcoholism' and 'normal' drinking	Identity	Ben, (C); Joe, (E); Cara & Theresa & Yvonne, (all F)

Not drinking is a positive thing to do	Identity	Ariana, Isabelle (both F)
How to apply ideas already held in relation to another addiction to alcohol	Coping mechanism	Dawn (E)
Cause of own addiction	Cause	Joe (E)

Eighteen of the interviewees mentioned more than one idea, and only one stated they had not acquired or changed any ideas. The CSM dimensions of timeline and consequences do not appear in the above table, and ideas about 'cause' were only appeared in three interviews. However, identity was important, particularly for Group F members, in the sense of realising that it was not abnormal to have a drink problem and redefining their previous concept of an 'alcoholic', as will be discussed in Section 5.4. Controllability was important to the interviewees, but the main topic of interest for them appears to have been coping mechanisms or, as Cara (Group F) suggested, "how to stop and stay stopped".

The cumulative and longitudinal aspects of the forums were both important in changing ideas, as they presented users with the opportunity to observe many people over a period of time. For example, in terms of coping method, Bethany and Alan (Group D) and Jackie (Group E) saw multiple examples of others trying and failing to drink moderately and, because of this, changed their own views on its feasibility. The forums provided more instances than might be obtained from a face-to-face group.

> ""I see it again and again and again on the site, I see so many people saying that they thought they had it under control, and they went away, and then they're back and, they know, they realise they're not in control" (Jackie, Group E)

Here, the forums impacted on beliefs about problem drinking's controllability and the appropriate coping mechanisms to deal with it, and this involved both a cumulative effect and the movement of time (longitudinal aspect) in seeing or hearing about others' progress in the forums. The longitudinal and cumulative aspects of the forums were elsewhere important in relation to creating positive emotions, such as hope and a sense of self-efficacy. For example, Ben (Group C) described reading about people who were not getting on well with recovery and then reading further and finding that "they came out of it and they're doing fine" which was a source of encouragement to him. Isabelle (Group F) described the cumulative effect, enabled by the forum format, of seeing others like her as enabling her to change her image of problem drinking into something much more positive:

> "you just start to like really recognise yourself in them and just think, "Hang on, I'm not, [pause], first of all I'm not a weirdo, [laughs]" (Isabelle, Group F)

The cumulative and longitudinal aspects of the forums could also contribute to more specific ideas about problem drinking: for example, observation of multiple people's stories on the forums led Grace (Group F) to believe that stress and the menopause were key causes of problematic drinking.

The forum post analyses

In Group A, requests for information about the following, for example, were found:

- The alcohol support group Smart Recovery and its ideas;
- What is 'normal' on stopping drinking e.g., getting a long-lasting headache;
- How to deal with difficult situations or drinking triggers;
- Help to understand why they continued to drink despite not wanting to;
- Others' drinking experiences e.g., amounts drunk in the past; and
- Others' sobriety experiences, what it feels like to be in recovery.

The following appeared to indicate moments of insight and the adoption of ideas as posters identified with ideas put forward by others:

> "I think you were absolutely spot on when you said I need to be with people who have the same goal." (Katie, Group A)

> "You were so right about it being Friday...the idea of another weekend at home alone is depressing" (Chris, Group A)

Support and information provided by the forums could lead to changes in motivation and behaviour, which in themselves led to changed ideas. For example, Carol's gradual extension of her abstinence as a direct result of reading the forums suggested an accompanying change in goals and beliefs about coping mechanisms:

> "Had a rough time the first few days when I was on the weekly challenge, and I read about days 6 and 7 being wonderful and so didn't want to waste it and wanted to see what it was

like…so I carried on not drinking. Then I found 7 days without alcohol felt good, and I read such a lot about it that I thought I'd see how 30 days was. I'm now 3 weeks in, and somewhat inclined by all I've read to go abstinent for 3 months! I don't know if this means I'm on the way to abstinence, but it's an incredible journey" (Carol, Group A)

Reading the posts affected her ideas about her coping mechanism. Initially she thought that being alcohol free was painful. However, her reading decided her to continue with sobriety: others' positive assessments combined with her evaluation of her own experience encouraged her to believe that it would be a good way to go.

In Group B, requests for information about the following, for example, were found:

- Others' drinking experiences, e.g., is it possible to drink moderately without craving;
- Facts about alcohol, e.g., where is Gordon's gin made;
- Interactions between drugs, caffeine and/or alcohol;
- Manipulating drug tests;
- Managing anxiety by using alcohol;
- Achieving or maintaining abstinence;
- How to achieve an alcohol high without becoming ill;
- Getting a prescription for a medication to deal with problem drinking; and
- The definition of a relapse.

Examples of individuals taking up new ideas were found, for example, Griff took up Caleb's idea of using caffeine pills to stay awake and drink for longer. There are also examples of changes: Kristen shared her experience of injecting alcohol and was severely criticised for not having done enough research on this, for using poor sources of evidence (the TV programme 'Jackass') and for saying she might consider injecting again in future. She appeared to change and take the advice given:

"Have given it some thought and I reckon I won't do it when I'm 21. You were right it's a daft thing to do. I'll drink alcohol and use my veins for better drugs"

Where the medical profession apparently failed in giving harm reduction advice, (the doctor in the hospital had already advised her about the dangers involved), it looked as if the forum had succeeded. However, as ever, we do not know the true motivations behind this post, she might just

have wanted to put a stop to the argument: and, in fact, hers was the last post in the thread for two years.

In another thread in Group B, Ursula stated that others' stories gave her hope and, by the end of the thread, she had achieved some episodes of abstinence from alcohol:

> "It's happening gradually but now I definitely don't see myself at the point where I was and that's not saying much, but...it's the first step, your actions follow your ideas right?" (Ursula, Group B)

She changed from a position of certainty that she needed to be in residential rehab to making a start on recovery outside the medical system. This suggested a change in coping mechanism (she was not already in rehab as far as we know), in self-image (she became able to envisage herself sober) and in controllability (she came to think that achieving sobriety was possible for her). It is interesting that the last post before her first update reporting some recovery was from John, offering her advice and encouragement including via personal messaging (PM) if required. This highlighted a difficulty with studying online support groups: it was possible that these two posters held a PM conversation that changed her perceptions, rather than that John's public post did so: if it was the forum at all. Either way, Ursula's statement "your actions follow your ideas, right?" was interesting in suggesting the importance of getting one's thoughts in the correct mode as the first step to changing. This was agreed with by John: "everything first begins with your mind, ideas and your outlook."

In Group C, requests for information about the following were found:

- Getting a prescription or obtaining the treatment medication without prescription;
- Implementing the preferred method including dosage, brand of medication;
- Side effects of the medication; and
- Questions to clarify queries and goals.

In Group C, acquiring information about how to implement the recommended treatment was a major aim of the site. There were many examples of answers to specific questions, and occasions when advice or information was clearly acquired from the forums, e.g.:

> "From looking at others' stories, I reckon my cure will come when I've followed the treatment for about 9 – 18 months." (Doris, C2,6 Again this indicated the cumulative effect of reading in the forums)

> "The doctor didn't appear bothered [which specific medication he prescribed] for me, so I went for [name of medication] because a) it costs less and b) has fewer side-effects from what I've seen on these threads." (Matt, C3,17)

However, because of the way the site was constructed, sometimes it was unclear whether newly acquired knowledge had come from the forums or from a related area online:

> "I started to keep a diary of amounts drunk [recommended in the thread] …I read the book and watched [the video about the preferred method] and I'm so happy I made this link. Its helped me to realise that [problem drinking] is not about willpower or self-control." (Jake, C3,13)

This was very typical in terms of showing that the individual consulted multiple resources, both online and offline (see Section 6.3.3). The interpretation of the cause of problem drinking, as not being about moral issues or willpower, might have come from any or all of the sources Jake mentioned.

5.3.3 Confirming or reinforcing ideas

The forums also worked to confirm or reinforce ideas that people held already. Confirming ideas here indicated where someone had thought something already and had this confirmed by others on the site. Reinforcing was similar, but with an element of supporting and strengthening what another had said.

The interviewees

Cathy (Group C) described how the forum confirmed for her that there were better solutions and explanations for problem drinking than the ones put forward by AA, saying "that conviction is stronger now, now that I know that it's shared". In other words, it is both confirmed and reinforced by being held by other people as well as herself. Isabelle (Group F) described how seeing others like herself in the forums who drank confirmed to her that she was a problem drinker:

> "slowly, but surely it drip feeds into your consciousness and you think, "Yeah I'm recognising myself in so many of these blogs, I am--, I am a problem drinker, you know I'm an addicted drinker" so I think it helped a lot really with kind of coming to terms with that." (Isabelle, Group F)

This description very much presented the changes in her ideas as a process happening gradually ("slowly but surely it drip feeds") rather than a one-off revelation. Jackie (Group E) said that the forum confirmed her hope that the way forward for her would be moderate drinking: "I think that most, overall I think it actually confirmed what I thought going in". Joe felt that Group E reinforced his belief about the difference between types of problematic drinking: "it further cemented the existence of problem drinking as a separate situation from alcoholism."

The forum post analyses

There were many points where people responded to others saying that they agreed with them and had had the same thoughts themselves: in other words, a member had confirmed what they already thought, for example:

> "Many great posts on this thread, including [Gerald's]. I especially liked what [Fern] said - and it's so true…. I've thought that myself for ages, but I do like how well it's been put." (Carly, Group A)

People more frequently explicitly reinforced each other's ideas, as for example:

> "I agree [using the group is like] group therapy, I couldn't have done all my alcohol-free days if I hadn't had the group" (Carol, Group A)

The following example from Group B indicated how powerful and helpful having ideas reinforced in the forums could be:

> "I appreciate your response so much. It matters lots to have someone telling me I'm not getting it wrong with what I reckon I should do." (Ursula, Group B)

Bob (Group B) found the thread on what people love about sobriety "inspiring" and stated it had "showed me lots of good reasons to carry on with my recovery". It could be that some of these

reasons were new to him and he had acquired them in the forums, but the basic determination to deal with his drinking was already there, and was reinforced by what he read. Wayne found the thread on cold turkey versus tapering very interesting and noted its reinforcing effect:

> "Have cut down slowly and others' advice / experiences that I've read about here have fixed that idea in my brain." (Wayne, Group B)

Examples of confirming or reinforcing ideas in Group C were also found, for instance:

> "Doris: [Rebecca]--If making yourself have abstinent days makes you crave, I would give it a miss. When you read here it's obvious everyone takes it in their own time and has different reactions. Perhaps you could make the time you start drinking later, little by little?
> Margaret: Hello [Rebecca]: I agree with [Doris]." (Group C)

> "Hi [Kyle], that's a sensible way of doing it – let your body have time to acclimatise to the medication again." (Margaret, Group C)

5.3.4 Challenging ideas

Individuals in the forums also challenged others' ideas. These challenges could come without any debate or argument ensuing, yet still alter users' ideas.

The interviewees

Bethany (Group D) described how some would ask others:

> "what is actually your plan when you break it down?" It's all very well saying you're going to have an [abstinence] day on Monday, what are you going to do instead?" (Bethany, Group D)

They then might follow up on the plan asking how it went, something that she separated from "calling people out" or judging them but which could still be seen as challenging. Dawn (Group E) also described members challenging each other to make plans. Cara found the forums like therapy in their potential to challenge ideas:

> "actually it helps to have the input and someone else to…pick you up on a thought process or stop it" (Cara, Group F)

Isabelle described the thinking behind challenging others and its value:

> "there's no point just going, "Oh never mind it's all fine, just ignore it" because then you're just going to do [the same] next time… it's not all right to just kind of go, "There, there, there", put a plaster on it" (Isabelle, Group F)

She described this as 'tough love'. Joanne did not see Group F as having disagreements/debates "it's not a challenging site in that way" and Marianne felt the same about Group C: "if people have a difference of opinion they'll state it, but it's never in a very challenging way." Theresa, on the other hand, experienced tough challenging when posting about her worries regarding her first summer holiday sober:

> "I was terrified that I couldn't do it cos I was used to just drinking all day… [and other members] wouldn't let me go with that, they were like "What do you mean, you can do this, blah, blah, blah" they were tough, tough, tough on me, it was hard…so that was, I don't know what you'd call that but it was very direct." (Theresa, Group F)

Many of these examples were, then, concerned with reinforcing motivation by challenging unhelpful thoughts or complacency with a greater or lesser degree of sternness.

The forum post analyses

In Group A, people challenged ideas and tried to persuade posters to different viewpoints. This was regarded by members as a benefit (although sometimes it caused distress) as, for example:

> "it isn't OK just to say 'there, there' when people aren't doing well. Nice words are not always useful if they're just accepting of what's happened." (Kim, Group A)

Group A also gave examples of individuals challenging others to plan properly: for example, Holly challenged Ozzie to quantify his goal for cutting back, and Courtney later challenged him to a period of abstinence, something reinforced by Chloe (although the wink emoji softens the challenge):

> "[Ozzie] ...you getting down to it? great time to try for it when there are others doing the same thing."

In Group B, ideas were frequently challenged in the forums, especially around coping mechanisms. An extreme example of this would be the injecting alcohol thread, where the idea of doing this was, at times, very harshly questioned and criticised.

In Group C, moderators challenge the ideas of some of the members and *vice versa*. Challenges were polite and evidence-based: for example, Poppy, a moderator, responded to a statement by Kendall that she disagreed with:

> "[Kendall said]**:** [the medication] is totally safe up to [amount of medication]. (If you and your liver can take it.) Its Half-life l is [length of time], at least at [amount] doses. ~~Taken together, these facts suggest that you can take [amount and regularity of medication], at least in the short term. Perhaps you should do that for a bit.~~
>
> **(ABOVE SENTENCES EDITED BY THE MODERATOR - PLEASE DO NOT INCREASE YOUR DOSAGE OF [the medication] WITHOUT TALKING TO YOUR DOCTOR FIRST. AND SEE BELOW, MY POST GIVING MORE INFORMATION ON DOSAGE AND HALF-LIFE.)"** (Poppy, Group C)

This comes across as a strong challenge: words were crossed out and the comment inserted into another's post was in bold, capital letters. However, it should be noted that Poppy did not delete the disputed advice from view. Her subsequent post also did not simply assert Kendall's incorrectness, but drew on expert opinion, linked to an information sheet produced by her and the medical adviser to the group, and included a specific quote from the sheet. The challenge was also softened by Poppy at the start of her subsequent post:

> "I just feel I should just ask for some caution around [Kendall]'s post however. Yes, they are right that, in experiments, large amounts of the [medication] was tested and shown to be safe. HOWEVER I talked to Dr [X] about this topic recently …" (Poppy, Group C)

She credited Kendall with being technically accurate and minimised the scale of the challenge ("some caution"). This is very typical of Group C.

5.3.5 Conclusion

This section has explored some of the effects of the forums on users' beliefs, specifically the acquiring, changing, confirming, reinforcing and challenging of ideas held. The next section will look at the impact on users of finding someone like themselves.

5.4 'Someone like me'

5.4.1 Introduction

This section discusses what is perhaps the most profound and holistic change that these forums exerted on their users' representations of drinking and drinkers. It first explores how they felt about themselves-as-drinker, showing that drinking could give or destroy a sense of identity. The section moves on to examine three key stereotypes of drinkers found in the forums: the 'normal drinker', the 'non-drinker' and the 'alcoholic'. It shows that users were not able to identify with these, which could lead them to feel isolation, self-stigma and a sense of being abnormal. The section then explores links and contradictions between the stereotype of the 'alcoholic' and other significant aspects of identity, specifically gender, age and parenthood. It goes on to show how the forums offered an alternative representation of problem drinking with which users were able to identify, and which de-stigmatised excessive drinking for them, altering their definitions of problem drinking and ideas around coping mechanisms. For them, this was an image of 'someone like me'. Instances where individuals find people 'not like me' in the forums are also examined, and the section concludes by briefly discussing another aspect of the sub-theme: the degree to which the persona that individuals present in the forums reflects their 'authentic self'.

5.4.2 User views of themselves-as-drinkers before the forums

The interviewees

Drinking may have originally contributed positively to an interviewee's sense of self, giving them an identity, for example, as a party person, sociable, and/or part of a particular group. So, for example, for Anna (Group A) and Cara and Isabelle (Group F) drinking was a part of belonging to a social group:

> "I was quite a shy, lonely sort of teenager…and all of a sudden this like magic thing comes along where you fit right in and it turns out you're great at being a party girl, and off you go" (Isabelle, Group F)

For others, drinking was a necessary part of fitting in at work. Christine (Group E), for example, was expected to drink in the Asian business culture she had been employed in; Ben (Group C) described how drinking was expected when conducting business deals and, for Megan, it was expected and a way to belong and fit in at work:

> "I was working up in London, and it was the culture. It was the absolute normal thing to do. You'd go out with clients, you were encouraged to do it…I think especially I started out in the '80s, and there weren't many women, in that field. And you drank to keep up with the lads… it was seen as the more you could drink the better person you were. And the more fun you were." (Megan, Group F)

This echoes Dingle et al.'s work (2015) on social identities as pathways in and out of addiction. She discussed an 'identity loss and redemption' narrative as typical of many problem drinkers (and frequently referenced in AA studies), but she also identified a 'drinking as identity gain' narrative. However, by the time of arriving in the groups, drinking had usually had a negative effect on interviewees' sense of self, causing loss of, or hatred of, their own identity. Ariana described this very powerfully as akin to the loss of self in the '*Lord of the Rings'* caused by the ring of power. Asked about the consequences of problem drinking, she stated:

> "I think more than anything else [it causes] a sense of being disassociated from one's own life…. when I was a kid I had a certain self and that self was very clear to me in my mind about what I needed and wanted and how I wanted to proceed with my life. And alcohol tends to [pause] obliterate that self… <u>it</u> becomes the imperative, more than one's own real self." (Ariana, Group F, her emphasis)

This loss of self was echoed by Isabelle, Theresa and Erin (Group F). However, it is important to point out that it was not found amongst interviewees outside Group F, although it was noted in Groups A and B forum posts.

The interviewees described many different negative consequences to problem drinking (e.g., health issues, isolation, the hiding of drinking leading to a double life, guilt, shame, impacted relationships), all of which contributed to a negative image of themselves and a sense of self-stigma. Many of them used harsh terms for how they felt about themselves before coming to the forums including: "freak", "bad" (Christine, Group E), "weak", "crazy", "stupid" (Marianne, Group E), an "anomaly" (Ariana,

Group F), and “abnormal” (Cara, Group F). Yvonne (Group F) talked about the “self-loathing” caused by drinking. They also felt that they were very different from other people (including both the ‘normal drinker’ and the ‘alcoholic’, as will be shown): they were effectively socially dissonant, belonging nowhere.

Forum post analyses

Drinking as giving a positive identity was occasionally touched on in the forum postings, for example, it made Kylie feel glamorous, like Carrie Bradshaw and friends in the TV series ‘Sex and the City’:

> “people who know me are aware that I was the one who loved cocktails, believing I was in Sex and the City and all that rubbish.” (Kylie, Group A)

For Hugh, drinking was an important part of his working and social life, as well as enjoyable, hence the desire to drink moderately rather than be abstinent:

> “I know I won’t be abstinent for the rest of my life, because of my job (I’m a salesman) and my social life” (Hugh, Group C)

Richard described missing the social aspects of drinking and enjoying good wines with friends (Group C). However, many users of the forums described self-hatred arising from problem drinking, for example:

> “when I drank so heavily all the time I felt self-hatred and hopelessness that I wasn’t able to control the amount I drank – I just couldn't stop. I wasn’t proud of the amount and I was envious of those who didn't drink like me. I felt really ashamed of my alcoholism.” (Eleanor, Group A)

Gretchen described her drinking as making her feel like “a freak and a failure” (Group C) and Susan in Group B spoke about a sense of shame in terms implying a recovery of her true self:

> “Now I don’t have that sense of shame that I did have every day. I don’t have to hide my awful secret from other people. I’m just me, it really is a fantastic feeling.” (Susan, Group B)

This occurred in a thread dedicated to people's accounts of what they liked best about recovery, and was echoed by several other members. To summarise, by the time of their arrival in the forums, many (although not all) forum users and interviewees expressed a dislike of themselves-as-drinker and linked this with painful feelings including self-stigma and alienation from themselves.

5.4.3 Representations of drinkers in the forums

This section will discuss three particular stereotypes of drinkers found in the forums: the 'alcoholic', the 'normal drinker', and the 'non-drinker', before turning in later sections to talk about the changes to these brought about by using the forums, and the importance of this.

A. The 'alcoholic'

The interviewees

All interviewees arrived at the forums with pre-existing beliefs about problem drinking. As was noted in the literature review in Chapter 2, alcohol holds a significant place in Western society, associated with many events of importance, for example, weddings, celebrations, funerals. The vast majority of adults, including AOSG users, will be exposed to many sources of information and opinion about drinking as they grow up, including cultural stereotypes. It was noted in Section 5.2.2 that all the interviewees held a slightly different representation of problem drinking, and this should be borne in mind throughout the rest of this section. Nevertheless, many interviewees presented themselves as arriving at the group with a stereotypical, stigmatised representation of the 'alcoholic' as someone who drank compulsively and obsessively to the detriment of their life, who had reached 'rock bottom' having lost everything, who was dependent upon alcohol, needed it to function and whose life was in chaos. In this representation 'alcoholics' were often presented as drinking not just daily but throughout the day, (so failing to conform to socially acceptable times and places for drinking), and as physically, not just psychologically, dependent. The interviewees could not identify with this, overtly separating themselves from it. The following was typical:

> "I suppose I would have seen [an alcoholic] as somebody whose life was really getting out of control. In whatever way, whether that be that they weren't performing well at work or, you know, they were having difficulties in relationships or, those kind of things. And none of them applied to me." (Anna, Group A)

This quotation highlighted the importance of the dimension of controllability as well as consequences: the 'alcoholic' is not able to, at least, appear in control of their drinking. As is

described in AA's *Big Book* they are "powerless over alcohol" (AA, 2001, p59). As they could not identify with this stereotype, these users might question or downplay their problem, failing to recognise it:

> "you do think about, when you've got an alcohol problem "Am I an alcoholic?" And just because I'm not having vodka on my breakfast and that type of thing, you know you don't think you've really got a problem, when you know that you have." (Yvonne, Group F)

This suggests that Yvonne is in a state of cognitive dissonance, thinking at the same time that she does and does not have a problem. Rodner found similar events amongst drug users:

> "Due to the simplicity of the drug discourse, the informants can easily find elements in their own drug use which undermine general understandings which label them as drug abusers" (Rodner 2005. p343)

Bareham et al. (2018) noted this 'othering' as very typical of older drinkers, where it acted as a barrier to getting help. Other interviewees also acknowledged the 'alcoholic' stereotype, and distinguished themselves from it, e.g., Cathy, Julie and Marianne (Group C). Joe (Group E) expressed dislike of the stereotype and its presentation of the 'alcoholic' as powerless, as did Bethany (Group D) and Ariana (Group F). The latter two, however, did put themselves in the class of 'drinking like alcoholics' rather than being functional drinkers.

> "I don't like to say, but I'm the only one I would actually describe as an alcoholic." (Bethany, Group D)

The stereotype might also be accompanied by a perception of AA and/or alcohol services as solely for this type of drinker, meaning that the individuals did not feel they would belong there. For example, Erin (Group F) saw rehab and alcohol services as more for prison/hostel/street drinkers and not for her, and Cara stated that:

> "When I first started on [Group F] I thought a real alcoholic was someone that had lost everything, you know? ... I would not have gone to AA in the first year that I was sober…I just didn't see myself as an alcoholic basically." (Cara, Group F)

Unlike the 'alcoholic', the interviewees had been still functioning (this word recurs in several accounts), managing to carry out their obligations in important roles e.g., as parents and as employees. This created a separation in their minds from 'alcoholics' and meant that they could not identify with the stereotype and therefore with the dominant ways of addressing it: medical services, or AA. This is extremely important: as Rogers, Pinedo, Villatoro and Zemore (2019), citing other researchers noted, inability to recognise a problem is a major barrier to treatment and therefore to positive treatment outcomes.

Leventhal, Phillips and Burns (2016a) noted that the CSM distinguishes between 'prototypes' and 'representations' with the latter being individual interpretations of an illness at a particular instance in time, where the former is a more consistent template, held in the memory. Representations may match aspects of more than one prototype – or, as here, may not fully match with a dominant prototype causing this sense of lonely uniqueness. This study will use the term 'stereotype' to signify Leventhal et al.'s prototypes as it specifically refers to shared social beliefs.

It will be argued in Section 5.4.5 that using the forums afforded the interviewees a different representation of excessive drinking to which they could relate more comfortably. What they saw in the forums redefined problematic drinking for them, so that it became wider than the 'alcoholic' stereotype. 'Alcoholic' might even, through this redefinition, become a label they could apply to themselves as describing their drinking, although generally only in certain circumstances. For example, Cara and Isabelle (Group F) described how they would be happy to use the term in recovery circles such as Group F because it is 'properly' understood there, as opposed to the stigmatised image held by general society. Others might still maintain their representation of an 'alcoholic' as a separate category to themselves as, for example:

> "I don't think I'm [physically] dependant [on alcohol], so I don't think I'm an alcoholic but I do think that I have a problem with alcohol." (Joanne, Group F)

Ben (Group C) and Alan (Group D) were the only two to apply the label 'alcoholic' to themselves comfortably: "I'm okay internally with calling it alcoholism" (Alan). This might suggest a gender difference in play, with 'alcoholism' seen as a problem usually occurring in men, meaning that they are more comfortable with the term than women. In Ben's case he avoided using the term on Group C as the moderators found it offensive, and it is notable that both moderators were female.

Joe said that he had thought in purely binary terms of people being alcoholic/not alcoholic before Group E, but that using the group had changed this. Several other interviewees questioned this dichotomy, pointing out that the situation was, in reality, not that simple, with the distinction between 'normal' and 'problem drinking' hard to discern at times:

> "I can go out with some mates and a completely normal individual whose life is all together maybe gets way too drunk, is he a problem drinker? Not really, not necessarily, you know. It's in our culture to do that, and we've trained our bodies to be able to handle this alcohol. So it's really a difficult situation – what is a problem drinker" (Christine, Group E)

The line between 'problematic' and 'normal' drinking varied with different environments and cultures with several interviewees comparing differing attitudes to drinking in the places they had lived, including Japan, Australia, France, Austria and Sweden. Cara described how her partner drank a glass of wine every evening and asked whether that meant he was a problem drinker: on the one hand, it was daily drinking, often seen in the UK as problematic; on the other hand, they were living in a European country with different drinking patterns that saw this as 'normal'.

The forum post analyses

In Groups A and C, the stigma of 'alcoholism' was discussed and it was again seen as an issue of control, for example:

> "I have felt like I was useless and a weirdo - why couldn't I drink sensibly and only have one or two like everybody else…In my AF [alcohol free] time on Antabuse [my husband would say] 'why don't you have one - one is fine'. He didn't realise that that was impossible for me…I couldn't do it." (Gretchen, Group C)

In Group B, the 'alcoholic' was also seen in stereotypical terms characterised by lack of control, drinking large amounts, experiencing physical withdrawals and negative consequences. Other aspects mentioned included solitary or hidden drinking (Nicholas), drinking straight from the bottle (Henry and Geraldine) and regular drinking (Victoria). However, users of all three forums appeared more comfortable with the label of 'alcoholic' than the interviewees, probably as they were amongst understanding others in the same situation. It was adopted frequently by people to describe themselves, and some reported accounts of their lives that matched the stereotype e.g., Robin (Group A), John (Group B) and Bridget (Group C).

> "I started to lose control of my drinking at about age 28...soon I had I lost my partner, house business and yet I still absolutely believed that I wasn't an alcoholic…to all intents and purposes I was unemployable and my day was focussed around drinking. All in all, I'm a serious alcoholic. It has destroyed my life" (Bridget, Group C)

Bridget here implied different levels of severe problem drinking and in all the groups users occasionally separated themselves from 'hard-core' problem drinkers. The following exchange showed this and also how the lack of a particular symptom could be used by a person to reassure themselves that they were not 'alcoholic' (as with interviewee Yvonne above):

> "I'm not a serious alcoholic but it has been really bad to the extent that I need to cut it out." (Doris, Group A) Robin replied: "I thought the same – that I wasn't a 'serious alcoholic'…Strangely, I thought it wasn't serious as I wasn't going into withdrawals at that point. Yet i did have a lot of other problems"

Several members distinguished between "functional alcoholics" and other types:

> "functional alcoholics exist; people who drink a lot after work is over but maintain a good career during the day" (Bill, Group B)

Some users described themselves in ways that implied there were different types of 'alcoholics', rather than rejecting the label completely: Orville, for example, called drinking daily "light alcoholism" as opposed to drinking constantly, implied as 'serious' alcoholism.

B. The 'normal' drinker

The interviewees

Whilst some interviewees could not identify as 'alcoholics', they also did not feel that they fit with the other choice available, the 'normal' drinker:

> "normal people don't stand in the shower each morning and tell themselves that tonight I'm not going to drink as much as I did the night before, and then they do that every single day. And I was that person" (Alan, Group B)

> "I knew that it wasn't actually normal to drink a bottle and a half of wine every night, seven days a week, that was not normal behaviour" (Anna, Group A)

'Normality' was defined by them as being able to control the amount they drank rather than never drinking excessively or more than planned. Interviewees in this isolated position were unlikely to know anyone like themselves or to think that anyone like them existed. The forums for some were the place where they first found 'someone like me', outside both socially available representations of 'normal' drinker and 'alcoholic'.

However, some interviewees did feel they could return to 'normal' social drinking in terms of achieving moderate drinking, for example, Dawn and Jackie (Group E). Although they saw themselves as needing to be careful in regard of drinking (e.g., "I can never relax about it" Jackie), both described others in the forum for whom drinking was no longer an issue, not something they needed to worry about. Ben in Group C also believed that it was possible to return to being a normal drinker:

> "you can reverse your brain back to the way it was before you ever had your first drink and you can drink like a normal person" (Ben, Group C)

Views were not necessarily related to the philosophy of the group: both Groups E and C allow for moderate drinking as a valuable goal; however, so did Group D where both interviewees felt that abstinence was the solution for them and that moderate drinking was not possible.

The forum post analyses

Again, the 'normal' person was presented as someone who drinks but is able to control it and stop at will in all three groups, e.g.:

> "I don't have cravings for alcohol now, and even at holidays like Christmas and New Year when I was around lots of drinkers, I just had a couple and that was it… I'm pretty much normal…but I don't know why or how I did it." (Abel, Group B)

> "I really want to reach being normal again one day. I want it not to control me, but for me to be able to have a drink or more and it's not a big deal." (Kyle, Group C)

Group C appeared to hold out the promise of becoming a normal, social drinker again to its members through the treatment recommended, and some found that it did this: Richard, for example, described how:

> "drinking when I choose to, without having any of the previous cravings is fantastic! Being able to share a good bottle of wine with a nice dinner, and not worry about going off the rails again is a really great, 'powerful' feeling. And not craving drink for the next few days is an even more powerful feeling. Drinking like a normal person again is incredible." (Richard, Group C)

Note the emphasis on power (over alcohol) being regained, and this power marking the person out as 'normal'. The greyness of the line between problem and 'normal' drinking is also implied at times, in terms recalling interviewee Christine's words on the same topic (above):

> "What is drinking in a normal, healthy way? Take my friend who doesn't drink at home, can take it or leave it when we're socialising but occasionally has a bit of a session, gets tipsy and may feel a bit rough the next day." (Anita, Group A)

This also links normal drinking with healthiness.

C. The 'non-drinker'

The interviewees

The degree to which drinking felt socially required and abstinence was viewed as strange was a recurrent theme particularly (but not solely) among the Group F interviewees. Ironically then, 'alcoholics' who achieved abstinence were still not 'normal', still not conforming to society's norms:

> "so the idea is normal adults drink. Normal adults drink, they don't have a problem with it, they can set the glass down when they want to" (Tina, Group F)

> "going down the pub or whatever is seen as a very normal thing to do, and there's more people that drink than don't drink." (Julie, Group C)

The unconventional nature of not drinking is reflected in some of the reactions to interviewees' abstinence reported, for example, Theresa talked about "your friend that keeps saying "Just have

one, why don't you want some, it's good, have some, what's wrong with you?" (Group F). Many interviewees came to object to the ubiquitous role of drinking in society. The following was typical:

> "it's embedded in our culture, it's shoved down our throats" (Christine, Group E)

> "drinking's so normalised. It's so, so accepted as the norm in society that that can wear you down a bit when you stop." (Isabelle, Group F, her emphasis)

'Not drinking' alcohol was also noted by Chambers et al. as being "socially deviant" (2019, p208), and Banister, Piacentini and Grimes (2019) stated:

> "most research points to the challenges faced by those experiencing the collective label of the non-drinker in the social sphere; themes of not belonging, social exclusion and social stigma are key" (Banister et al., 2019, p3)

However, this view of abstinence may be changing: it is important to note the existence of the 'sober curious' or 'positive sobriety' movement (Nicholls 2019; Morris 2020), a predominantly online trend that promotes not drinking or mindful, moderate drinking as positive; as bringing benefits not deprivation, as fashionable, and as something to be sought out and to be proud of. This has emerged relatively recently, and would not have been in as prominent at the time of the interviews, however, several interviewees from Group F did mention how this group presented not drinking as a positive thing to do. An important role of the forums was to link ex-drinkers and consequently to normalise not drinking, remove the self-stigma and reinforce it as an attractive choice: see Cara, Megan and Isabelle (Group F):

> "And having a group of people whose opinions you've come to sort of trust, having a group of them saying "No, actually not drinking is a perfectly reasonable choice, you know it's actually the best choice. …" You know that kind of just reinforces what you're trying to achieve…it helps you to just feel sort of normal and like, quite proud of what you're doing. Instead of like, the skulking weirdo with the drink problem" (Isabelle, Group F, her emphasis)

Bethany (Group D) and Erin (Group F) both talked about wanting to reach a place where drinking was no longer an important issue that they had to think about. Both compared themselves with enthusiastic AA members which can be argued to be a sub-type of the non-drinker that is here called the 'reformed alcoholic' (to adopt Banister et al.s' term, 2019, p13). These are individuals for whom

the identity of recovering, sober 'alcoholic', as defined in AA, is a very important part of who they are, which they are open and evangelical about. For example, Bethany criticised AA:

> "one of the things that really put me off [AA] was that I'm going [to have to] sit here [at meetings of AA] and I'm going to spend the rest of my life making alcohol important… and I don't want it to be important that's the whole point." (Bethany, Group D)

Erin (Group F) also wanted to move beyond her recovery being a central part of her identity, and compared herself with a local group of 'reformed alcoholics'. She stated she did not wish to become a person "stuck" in recovery, by which she meant a person constantly talking about drinking and recovery and retelling their story in meetings or forums.

The forum post analyses

In the forum posts of Group A, there were many examples where people could be seen planning and preparing to avoid being labelled as a non-drinker because they wished to avoid intrusive questioning about it and the suspicion of being an ex-problem drinker. They decided, for example, how they would resist pressure to drink, in a way that presented them as 'normal'. Not drinking was seen as socially acceptable in certain circumstances, notably if one was driving, on contraindicated medications or for health reasons, and these excuses were called upon:

> "Mostly I say that I was concerned about my health so I gave up drinking and started exercising and I feel much better for doing that" (Daisy, Group A)

> "i'm going to say I'm detoxing.... like I'm dieting...and just say i'm not drinking because of health reasons....and to reduce calories" (Kylie, Group A)

> "I'll tell them that I'm driving later (actually I've lost my license!)" (Martha, Group A)

The last two excuses are what Banister et al. (2019) described as "temporal techniques" of 'identity refusal' – evading the socially disparaged label of non-drinker by indicating it is only temporary. (Interviewee Megan also took this approach in Group F: "I take the train up to London sometimes and tell people I have to drive home from the station when I don't."). Martha's quote showed that she felt she needed to be dishonest to protect herself, just as others had described being in relation to hiding their problem drinking. Concealing non-drinking, like concealing excessive drinking, took

work. Others described taking the car or avoiding social situations altogether so the issue did not arise: “It’s all just much simpler and easier if I don't go out or socialise” (Marion, Group A). Banister et al. also talked of the non-drinkers’ “determination not to be ‘found out’; their identity talk takes the form of silence, coupled with various concealing practices.” (2019, p8)

As drinking and not drinking had such significance for group members, they assumed it would be significant to the outside world and so developed strategies to handle it, sometimes finding, in practice, that outsiders were not actually interested:

> “I’m seeing some friends soon, and the more I think about it, the more I think it's me not them who reckons it’s so important to have a drink. Everyone else doesn’t really mind a jot whether I do or don’t drink! ” (Marina, Group A)

Not drinking was not discussed in the Group B extracts, and was less relevant to Group C, where individuals were obliged to continue drinking in order to achieve success with the prescribed method. They may have eventually become abstinent, but always had the option of drinking with this method. However, Suzanne expressed similar thoughts to Marina above regarding:

> “it was such an eye-opener for me during my initial month on [the preferred method] to see how many people don’t drink! Makes me hope that I can be "normal" and really participate in the most important life moments!”
> (Suzanne, Group C)

5.4.4 Drinking and other aspects of the self

Amongst both interviewees and forum users, problem drinking is shown as sometimes in conflict with, affecting, or being affected by, their performance of other roles, for example, as a parent, employee, female or male, young or old, healthy or ill. They may modify their drinking because of the social requirements of these other roles or their drinking may affect their assessment of their performance of them in a negative way. It can affect their representation of themselves-as-drinker and compound the sense of self-stigma and shame, as they no longer drink in ways deemed acceptable in these roles by society. This section will briefly explore the interplay between three aspects of their identities (age, gender, parenthood) and drinking, and contributes to addressing the lack of research identified by Dingle et al. into “how these broader social identities might play a role in addict[ion] and recovery” (Dingle et al., 2015, p3)

A. Drinking and age

The interviewees

Many of the interviewees had started drinking whilst under 16 and the negative consequences of drinking on the young, still developing, brain or personality were discussed by Alan (Group D), Robert (Group F) and Joe (Group E). Heavy drinking was presented by several as more accepted by society when one is a young adult, for example:

> "I think when you're younger there's a whole thing of, you know partying and getting drunk, and what have you, and it's all kind of acceptable because you're young. It's the done thing to do." (Julie, Group C)

Cathy (Group C) described the idea that drinking wine was a way of appearing "grown up and sophisticated" as being a social norm, as did Yvonne (Group F) "people say it's sophisticated to drink wine and all this". Christine noted how young people in [an Asian country] routinely expected to drink and often to excess:

> "you will see kids, young people, in their 20's, 30's, you will see these kids out puking on the streets, helping each other throw up…it's not a shameful thing or anything, they support each other through this and it's a part of the culture, so it's not seen as a problem" (Christine, Group E)

Three of the interviewees described aspects of their youth as part cause of their drinking, for example, Anna (Group A) stated she drank to feel less self-conscious when young and Isabelle (Group F) to cope with being a shy, lonely teenager. In this, alcohol was helping them create a different social persona, one which fitted in better. However, Tina (Group F) and Anna (Group A) both noted that growing up and getting away from home could mean increases in drinking as then they had more autonomy and freedom.

Isabelle and Megan described heavy drinking as less acceptable in middle age:

> "I'm 51, and I think for quite a long time I'd been thinking, "God, I'm still partying like I'm in my 20s, I need to cut down." You know it's an idea that floats round in the back of your mind" (Isabelle, Group F)

> “why would anyone of my age [47] want to be seen drunk like that?... it's just an awful sight to see.” (Megan, Group F)

Christine (Group E) noted that the effects of heavy drinking on health were worse in middle age and Erin (Group F) described it as a poor example to younger people. Megan felt, from using Group F, that her age group and older were now the main problem drinkers, noting that “there is talk in the newspapers that this is the age group and there is a big problem”. (See https://www.alcoholpolicy.net/2019/06/alcohol-and-older-adults-time-for-change.html for some corroboration of this in the UK.) On the one hand, Christine (Group E) and Theresa (Group F) both noted that problem drinking could start in middle age and Grace (Group F) suspected that there was a connection between menopause and addiction. Additionally, in later years, according to Isabelle (Group F), children may be older and less needy, freeing up time for drinking or the person may have more money to spend on drink (Grace & Isabelle, Group F). On the other hand, middle age could be the time that people first realised they had a problem and found the motivation to address it, for example:

> “I'm wondering if it's a time of life thing and for women in particular that you like, [pause], got to a point with work and brought your family up, and you sort of think “Well actually I've still got a few years left, what are those few years going to mean for me?”…And you just, [pause], reach a point of like wanting it to not be the same as it is now, you want it to change, you know." (Isabelle, Group F)

Jackie (Group E) mentioned individuals realising they had missed out on their children’s childhood because of drinking and wanting to rectify this with grandchildren.

There was little specifically on older age (post 65) and drinking, but Dawn illustrated that drinking can begin post retirement, and at that point age can worsen health impacts and lessen the amount a person can drink without problems. She described how drinking in the evening moved from the hobby of being a connoisseur of wine to an unhelpful habit:

> “we had sort of slipped into opening a bottle of wine every evening, and I started to feel like I wasn’t feeling well, I wasn’t sleeping well, and that a significant contribution to that was

that I was drinking too much. So I would wake up every morning and think, well you know I have to stop this" (Dawn, Group E)

The forum post analyses

In all three forums individuals mentioned how the effects of drinking worsened with age, for example, Anita and Eleanor (Group A), Jenny, Simon and Barbara (Group B) and Ralph (Group C). In Groups A and B there were references to how getting drunk is seen as more acceptable by society in youth and less so as one gets older:

"Drunkenness is frowned over as we get older. We're not teens anymore." (Fred, Group B)

"Mum is over 80 and I hate seeing her upset because of me, her middle-aged child that's still getting drunk, even after the terrible things I've done over the years." (Martha, Group A)

The last quote implied that drunkenness should not be happening in middle age, which Sarah identified with "I'm still bingeing even though I'm middle aged and more" (Group A).

In Group B, the youth culture of drinking to excess was seen negatively by some and provoked criticism:

"people usually follow social norms. Some end up drinking these insane amounts. I don't know how the youth culture of "Heroic Boozing" came about, but I discourage it, always" (Mark, Group B)

In a thread started by Griff, a 20-year-old college student, about how to stay awake longer in order to drink more, several other posters expressed contempt for him in terms of his youth, e.g., Quentin who repeatedly told him to grow up. Vince implied that the types of negative consequences brought about by excessive drinking change with age: he stated that Griff was more likely because of his age (and student status) to die in a "hazing incident" (i.e., ritual student drinking session) than because his blood pressure was affected by drinking.

Both amongst interviewees and forum posters, an association of youth and excessive drinking was commonplace, whilst getting older meant drunkenness was deemed less socially acceptable, whether this was measured by what one's peers are doing, as was stated by Mark (Group B), or by

age. This could compound the stigma felt by middle aged members and act as an additional barrier to problem recognition.

B. Drinking and gender

The interviewees

Gender and drinking was a topic of particular interest in Group F, which is a predominantly female group according to previous research. Ariana, Isabelle and Joanne all identified the site as mainly female, with two of them linking this with its culture of supportiveness. Isabelle and Yvonne (Group F) both described similar patterns for women's drinking over their lifespan, which they presented as typical of female problem drinkers (and which united the three aspects of age, gender and parenthood). In both cases they suggested that women's heavy drinking started in their 20s. Children then might impact on lifestyle with the person needing to stay home more, and at this stage, drinking alone at home began (Yvonne). The stress of bringing up children and/or of work contributed to a habit of using alcohol to de-stress, which escalated over time. (It must be noted that this pattern should not be taken as 'typical' of all women's experiences). Megan and Yvonne both talked about the so-called 'ladette' culture of the 80s and 90s, when women drank heavily at levels more usually associated with young men on nights out. The term 'ladette' implied that a woman drinking heavily was behaving in a male fashion, suggesting a cultural norm where drinking was more associated with men. Christine (Group E) also talked of this in Asia with women being increasingly expected to drink but still not to get drunk "it's unseemly for a woman to become drunk at the business parties". (Wilsnack, Vogeltanz, Wilsnack & Harris illustrate how men are associated with heavier drinking across many different cultures, 2000.)

Several interviewees saw a causative link between female hormones and drinking e.g., Cara, Theresa and Yvonne (Group F), as did Bethany (Group D). They talked of a link between the female menstrual cycle and cravings to drink, and also between drinking and the menopause (Grace and Yvonne, Group F). The consequences of drinking also had a gendered aspect for some interviewees: for example, Julie (Group C), Christine (Group E) and Cara (Group F) all mentioned thinking that vulnerability to sexual violence was a potential outcome for women who got drunk. It was interesting that there were no comments on how drinking can disinhibit men, so that they commit violence, sexual or otherwise. Overall there is much less about men and drinking (Christine talks of how male pride can get in the way of asking for help with a drinking problem). The men interviewed did not raise the issue of gender and drinking.

The forums

The gendered aspect of consequences was found in Group A, in which Oliver stated that the consequences of drinking on health for women is worse than for men. There were few other references to women and drinking in Groups A and C, but there was discussion of heavy drinking as particularly associated with men in Group B, a group which appeared to have more male members than the other two. Mark described boasting about heavy drinking as "macho boozy braggadocio", John felt that his excessive drinking made him "the fucking man" and Kiernan stated:

> "I don't drink often, but when I do I'll drink a LOT, almost enough for alcohol poisoning (haha I'm the greatest man in the world thing)". (Kiernan, Group B)

Fred, Mark and Tom all saw excessive drinking as motivated by a desire for sex and this is sometimes described in ways implying sexual violence: "Alcohol's a drug for people…who want to try and get close to girls who've passed out" (Fred, Group B). Whilst the tone used is contemptuous of the men who do this, there is no explicit criticism of them or reflection on the issue. In Group B, toxic masculinity and a hostility to women amongst some members could be noted, for example, in the way in which Tom described sex as "fuck some bitches in the pussy", Vladimir's implication that a man with a drink problem does not have a good wife "he wouldn't HAVE to drink or take drugs every day if he had a caring wife" and Dominic's contempt for female drug users. This was not found in the other two groups, and contrasts with Courtney's criticism of her husband in Group A which was affectionate and teasing:

> "The husband tried dryathalon in January [i.e., not drinking in January] (although of course HE doesn't have a problem) and although he moaned that he didn't feel better and he missed it, he did admit after a month that he felt much better." Courtney (Group A).

The only discussion of gender found in the posts analysed from Group C mentioned the side-effects of the preferred treatment being particularly hard for post-menopausal women and came from one individual.

In both the interviews and the forum postings, heavy drinking was seen as more 'acceptable' in society's eyes for men than women, and as harder on women's bodies than on men's. Both causes and consequences of drinking are presented as related to gender in the effect of hormones on drinking described and the association in both forums and interviews between drinking and sexual

violence against women.

C. Drinking and parenting

The interviewees

This has been touched on in the previous two sections in terms of children shifting some mothers' drinking to the home setting, the stress of child-rearing as encouraging drinking and the advent of grandchildren as a motivator for recovery. Some noted that, with children growing up, and becoming more independent, they were needed less and at this point their drinking may have escalated or they may have noticed it as problematic for the first time. Anna (Group A) described how she realised she was a problem drinker when parenting started to impact on her drinking time:

> "what brought that into sharp focus was that my daughter was getting older so she wasn't going to bed [early], you know, because all the time she was very young and she was going to bed it kind of didn't matter so much cos she wasn't seeing, but I became aware as she got older that, actually, this isn't what sane parents do and I've got to stop it" (Anna, Group A)

Cara (Group F) described a similar story and Jackie (Group E) identified her child as a strong motivator for quitting drinking. (Please note that Paul, one of the interviewees who had not used the forums, also cited wanting to be there for his daughter as his "number one motivation", so this is not necessarily linked to gender). Erin, Grace and Theresa (Group F) described how their drinking impacted on their parenting, preventing them from being the parent they wanted to be, and some mentioned enjoying other members' talking about their delight at being able to parent better when not drinking. Several referenced society's expectations that pregnant women should not drink at all, and mothers of younger children not too much, for example, Anna (Group A), Julie (Group C), and Cara (Group F), who described initially editing her drinking story on the forums because of this. Cara also mentioned her fear of losing her children because of her drinking and her initial fear that just using the forum could lead to this:

> "I just thought I was going to lose my children, you know, if anything was found out and I was like--…I was scared about creating a separate email account" (Cara, Group F)

On the other hand, Cara and many others also referred to the stereotype of stressed out mothers enjoying a drink or two and that being seen by society as normal and acceptable. For example, when she visited her GP for help with her drinking, Cara noted:

> "I'd been to the doctors who was just like "Oh, you know, you're a single mum, yeah, of course you drink a bit too much, don't worry about it"." (Cara, Group F)

Here the stereotype of the stressed single mum's expected drinking actually prevented Cara getting help with her problem. Christine emphasised the seriousness of her drinking by contrasting it with the stereotype:

> "because I was really kind of a tough case you know, it wasn't like "Oh Mummy's drinking too much wine on Fridays" [laughs] I was kind of screwed" (Christine, Group E)

Tina (Group F) also described how when she decided to drink, she chose spirits rather than more stereotypically acceptable 'female' drinks like fruity cocktails as she thought: "[if] I'm going to be a drinker, I'll be a real drinker not, you know, not somebody who buys the mummy juice". On the one hand, the mother was expected to like a drink, even to need it to unwind after childcare, but on the other hand must not drink too much: it was a gendered version of the delicate balancing act of the 'normal' drinker.

The forum post analyses

Some of the same themes were touched upon in the forum posts: children were shown impacting on drinking and vice versa, children could be powerful motivators for change, but also stressful, triggering cravings for drink in either gender. Members of Groups A (e.g., Ann and Elizabeth) and B spoke about the impact of drinking on children, for example:

> "My family, including my three children, have watched me dissolving in front of them for years and suffered, again and again, because of this." (Vivienne, Group B)

Sara described how she could not begin her drinking until after she had 'taxied' her children around. Children could be a powerful motivator for recovery:

> "I'm determined to deal with my problem drinking BEFORE it is irreparable, especially as regards my children, who are still in school and living at home" (Jennifer, Group C)

They could also be a source of stress and potential trigger for drinking:

> "My own kids actually triggered cravings today" (Ian, Group A)

Overall, however, impact on parenthood appeared less in the posts than it did in the interviews: there was more discussion of the impact of drinking on 'family' and relationships generally than on children specifically.

5.4.5 Changing the 'alcoholic' into the 'functioning problem drinker'

The interviewees

A key impact of the groups noted by many users was that the forums showed them a different type of drinker to the 'alcoholic', 'non-drinker' and 'normal' drinker stereotypes. This new type was one with which users could identify. The following account was typical of many interviewees and so is given in full:

> "there was an article in the *Sunday Times*…and I just thought "That is my story". And it didn't feel--, she wasn't ashamed, you know, she was just like--, she was just a normal woman, I mean that was it, you feel so abnormal. She just looked like a normal person with a job and children and, you know, and I just thought "That's for me" … [On looking at the site] Just every story I identified with. They were all just, you know, for me people with drink problems had lost everything and here were just women who were managing to be a mother and managing to go to work every day and yet were just drinking too much every night. And I mean I didn't identify with all of the stories, I still managed to separate going, "Okay, so you were a real alcoholic" [laughs] um, but, you know, there were a few who, who seemed to be a lot worse but most of the people were just like me really." (Cara, Group F)

The extract indicated how Cara's drinking had made her feel different, ("abnormal") but she did not identify with being an 'alcoholic' (they were people who "had lost everything" unlike her). The site gave her an alternative, a picture of problem drinkers that were coping with life and appearing to function successfully. It effectively provided space to incorporate the idea of problematic drinking into the life of a functioning person without any need for shame, showing Cara a category with which she could identify. Shortly afterward she described the relief of finding people like herself as a weight lifted from her shoulders. This is also conveyed in the repetition of the word 'just' in the extract quoted above, suggesting a sense of the problem reducing and normalising. Several other users, particularly in Groups E (Christine, Dawn, Joe, Marianne) and F, (Ariana, Erin, Grace, Isabelle, Megan, Robert, Theresa, Tina and Yvonne) identified finding others like them as a key impact the forum had on their representation, moving them from believing they were negatively unique, to seeing it as not abnormal to have a drinking problem. It is worth noting that whilst the forum initially

provided Cara with an alternative image to the 'alcoholic', later she came to redefine and accept the latter term as including functioning problem drinkers. Asked to clarify how she differed from a "real alcoholic", Cara responded:

> "[Laughs]. My views on that have changed. Okay, a real alcoholic looks like me [laughs]…now I don't mind the word alcoholic because actually it makes things quite clear for me. That said, I don't go around with it written on my head, I don't drop it into conversation but, you know, if it's [pause]--, within sobriety or recovery circles I'm quite happy to say I'm an alcoholic" (Cara, Group F)

She went on to discuss 'grey areas' where it was difficult to work out what or who was a problem drinker, concluding "I don't know. But I know my opinions on this change all the time." This suggested that her representation of the concept was fluid and open to change. Later, she stated that she preferred to avoid thinking about the issue too intently as it could make her question whether she really had a problem which could lead back to experimenting with alcohol. In this sense, exact definitions were not important, and what counted was whether the individual believed that they had an issue. Representations, then, could impact negatively when over-rigidly defined both before and after achieving recovery. Whilst the offering of an alternative representation to the stereotype of 'alcoholism' could be very helpful in enabling problem recognition, acceptance, and action, over-defining it could make users question their membership of the category. Moving away from the binary choice of 'alcoholic'/'normal', away from specific definitions and stereotypes allowed the space for them to create their own understandings of drinking as a problem and themselves-as-drinkers. In short, the forums provided many users with images of people like themselves who did not drink 'normally' but also did not fit into the stigmatised category of 'alcoholic' and this could:

> a) confirm to them that they did have a problem;
> b) show them that functioning people like themselves could have difficulties with alcohol, that this was normal and not shameful or unique; and
> c) that something could be done about it.

This changed their representation of problem drinking, for example, in relation to its consequences (one did not have to lose everything) and symptoms (one did not have to drink all day or experience

physical withdrawals). Smith-Merry et al., 2019, also found that normalisation was a key function of the online support groups they studied.

Other users spoke of finding 'someone like me' as being important in different ways to the above. Bethany mentioned several times that finding others like her helped her to understand herself by showing her patterns of behaviour that she then identified in herself. Cathy talked about the reinforcing effect of talking to others with the same views on treatment, and Ben mentioned liking the fact of being with others undertaking the same treatment:

> "you're reading about people that have been there and done that or are currently doing it, or currently starting it. It's just nice to be able to relate to some of those people who want to do the same things you are." (Ben, Group C)

Overall, only four interviewees, Anna (Group A), Julie (Group C), Alan (Group D) and Jackie (Group E), did not talk about finding people like themselves being important to them.

The forum post analyses

In Group C there were examples of people feeling better about themselves, but generally when they had found the treatment rather than 'someone like me'. There was a similar pattern of moving from self-hatred because of excessive drinking (described in terms typical of the 'alcoholic' stereotype) to self-acceptance and understanding. For example, Jake presented himself in terms of the stereotype and described gaining hope from the forum's explanations of the cause of problem drinking:

> "I think I could lose everything because I am just crap when I drink. I'm sick of waking up feeling crap in the morning, having blackouts, and finding I've posted rubbish on Facebook. Detesting myself. So I couldn't believe it when I read about [the treatment] and how drinking is about changes in the brain. It's not just about lack of willpower or being undisciplined with no self-control. It gave me hope." (Jake, Group C)

He was reassured by others who identified with him, for example:

> "I really get that awful early morning self-hatred, and the manic Facebook checking! I wanted to say…am seeing slow but steady improvements and one of the biggest is in terms of the self-hatred... I feel lots better about myself…Stick with it - you're not on your own. (Jill, Group C)

Gretchen described how finding the treatment moved her from self-hatred and feeling abnormal because of her 'alcoholic drinking' and inability to drink 'normally', to self-understanding via identification with another's story: "that could have been me!". Several others expressed this desire to be 'normal':

> "I just want to feel normal, i.e., not obsessing over drinking all day, every day…" (Jennifer, Group C)

Rather than moving from the category of 'alcoholic' to functioning problem drinker, they were aiming to return to the category of 'normal drinker'. In common with the interviewees, they experienced the same internalised sense of stigma and shame which was changed for them by understanding the treatment, the primary function of Group C forums.

These forums also played an important role in reassuring users that treatment was going as it should, through showing them others like themselves:

> "I must admit I'm a bit concerned that it won't work in my case, but from my reading, it looks like I might not be the only one with slow progress." (Lois, Group C)

The moderators are frequently involved in reassuring people that there are many others like them:

> "If you read some of the stories on here, you'll find lots of people have come across bumps in the road - and sometimes, mountainous one. What I mean is, you're not unique in having setbacks and it so is not the end of the line." (Margaret, Group C)

In Group A, Eleanor's pain at being 'alcoholic' echoed that of Group C members. However, she did not redefine herself as 'non-alcoholic', but rather re-worked the concept to include herself while sober:

> "so I confess I still have a problem with drink and am still an alcoholic, the difference is that now I don't want that problem and so choose not to drink alcohol…I have to work at it though and one way I work at it is through this group, for which I'm grateful." (Eleanor, Group A)

This was close to the AA line of once an alcoholic, always one, and it was interesting that she used the word "confess" implying there was some residual shame there. However, she did not go into detail of how the forums helped her with her view of herself-as-drinker. Other individuals talked of finding comfort in seeing others like themselves, for example, Tamara and Sarah. Several posters described how this reduced their sense of isolation and gave them strength to deal with their drinking:

> "the more we hear the stories of other people, the less alone we feel and the more we can draw strength from others. That's the beauty of [Group A]." (Bertha)

> ""We all need each other. We're stronger together than we ever could be on our own. I take strength from all of you, and I hope my support helps others in turn" (Kate, Group A)

Others included Kate, Shaun and Carol (Group A), who also referred to the role of stories in this process: "seeing so many likenesses in people's stories, you come to feel you're not on your own" (Carol, Group A). This echoed the interviewees' accounts of how seeing others like them normalised problem drinking, getting rid of the sense of lonely, negative uniqueness.

5.4.6 People who are 'not like me'

The interviewees

It is important to note that not everyone felt they belonged to the community, or were known and understood, in the sites. Robert had some particularly negative experiences with other members which were put down by him to his questioning of 12-step philosophy. Of his first group he stated that:

> "there <u>were</u> some sort of open minded people on there but generally it was people who were die-hard or down the line 12 steppers, would accept no alternatives…if it was outside the Big Book, you were jumped on, and this got quite oppressive to the point whereby actually I was stalked online… he'd threatened a visit to my home and stuff like that, so I thought, "No this isn't for me really"." (Robert, Group F, his emphasis)

His next group, LifeRing also developed a strong AA stance and "that got quite unpleasant again". However, interestingly when asked why he had stayed with the two groups for over a year each, he noted that it was because he had found others like himself:

> "There were always people who you were like-minded with and I could always take the attitude of, you know I'll hang onto that and forget about the rest." (Robert, Group F)

Again, it was finding 'someone like me' that appeared to have been a key factor in keeping him with the sites. Dawn recounted how she had not made friends in Group E, putting this down to being more introverted and not as self-revealing as others, and to feeling that members were not interested in her. She contrasted Group E with another (non-alcohol related) online group where she had felt 'known' after meeting people in person. This was a smaller group with a less transient population. It was interesting that Dawn described herself as not presenting her true self online which, it could be speculated, may also have contributed:

> "I have a presence in the group, but it's, it's not, [pause], erm, I don't, it's not really me. It's kind of, it's a little bit, you know a person who I, I mean I try to be sort of open" (Dawn, Group E)

Here she sounded uncertain and hesitant, suggesting this was not an easy thing to discuss. Later she stated that she "censored" what she said to others online to some extent. Tina distinguished finding people like herself in terms of drinking (which did happen) and finding others with similar outlooks (which did not):

> "I don't feel as alone because I see that, "Oh my gosh, there's all these people that are experiencing problem drinking like me", but, at the same time, I feel very different and sometimes very isolated with how I [pause] view things" (Tina, Group F)

She put this down to her communication style being different to others. She stated that she adjusted this style to fit better with the group (for example, in terms of emphasising the positive). Erin described being slightly intimidated by other women on the site and so choosing to remain as a lurker:

> "I just felt that they were more confident than I was, more articulate than I was, you know, and, and so I couldn't quite make that, take the next step and [post]" (Erin, Group F)

She preferred Group F to another one she accessed as she did not feel there were people like her in the latter in any numbers: "they're very sort of young London gang, you know, sort of, I just don't

think, you know, I'd fit in". Hence she did not continue with that group. Bethany (D) and Megan (F) discussed people they did not feel fitted in well, with Bethany describing how those who "broadcast only", i.e., they only posted about themselves, received fewer responses over time.

The forum post analyses

In Group A, Ozzie complained of being ignored when people did not reply to his posts, and also about favouritism, factions and intolerance arising because of dogmatic beliefs (on the part of those committed to abstinence). Denise described moving from thread to thread to get away from "the abstinence only gang". This was partly about people driving out those who were not like them in terms of their goals, but was even more about lack of respect for difference. It is not the fact of having divergent ideas or goals in itself which is seen as problematic: Denise went on to say that she had had much good advice from people with aims different to hers. Later she talked about there being cliques in the forums: "Personally I find some threads are like cliques with it taking time to fit in, and now and then you just don't fit in ever" (Denise, A). This is interesting in that it highlights that a person may find people like themselves in certain threads but not others, and may be behind the exhortations in the newcomers' thread for new people to read around and find where they felt comfortable. Overall, there was an expectation in Group A that people would respect difference and could benefit from hearing others' ideas.

There were disagreements, trolling and flaming in Group B, but no discussion of feeling different to others in the group. Those who were seen as not conforming to the group ethos of harm reduction received harsh treatment (see Section 6.5.3) which contrasted strongly with the polite arguments in Group A. In Group C this topic was not touched on in the posts analysed.

5.4.7 Persona on the forums

The interviewees

Tina and Dawn's comments in Section 5.4.6 raised the question of how far the online persona was a true reflection of the offline 'real' person: i.e., was actually 'someone like me'. Whilst this is ultimately unknowable, it raises an interesting contradiction in AOSGs: on the one hand, users' on-site presences were constructed entities, composed by themselves, sometimes with great care and much thought, as Christine (Group E) described: "when I want to write something that's in my mind, I'll spend a good couple of hours crafting a long piece for people". Similarly, Marianne (Group C) stated of posting: "I work on it a lot, I don't just like write something down and hit send right away, I really do work on it". Theresa (Group F) attributed the need for care at least partly to the digital

medium with its inability to convey facial expressions and Christine also described how people on the forums chose their words with great care because of their potential effect on others. On the other hand, there was also a view in the sites that the forums were places where people could reveal their true selves, showing what was hidden from the outside world. Megan Group (F) stated: "I think the, the benefit of the forum is that everyone's very genuine because they start out anonymous". However, this is perhaps a false dichotomy as crafting posts could be seen as trying to reflect truly what one thinks: as, in fact, a more reliable way to get thoughts across accurately than writing or speaking without thought. This was certainly implied by Isabelle (Group F):

> "it might be an idea that's been bubbling away and then you kind of can't quite, you start writing it out and then you think, "No, no I've not nailed that" …. And then when you, when you think you've got it you put it on the site, you know…." (Isabelle, Group F)

Crafting posts, creating them with care and thought over time, is perhaps more appropriately contrasted with venting or 'getting things off one's chest' in moments of emotion than with honesty.

However, the idea of the forums as not reflecting true personas was mentioned by other interviewees also. Theresa discussed a change in ideas regarding explanations of problem drinking put forward by the founder of Group F, implying that the latter's role determined what she said, rather than her own personal beliefs:

> "I think she does it because she has to manage a huge corporation practically now so has had to appeal to a larger audience... you know what, who knows what she thinks when she's all alone, maybe her views change day by day too." (Theresa, Group F)

Cara (Group F) talked about "airbrushing" her story in the forums to make the narrative more acceptable and Erin stated:

> "I think people mould themselves to the, to sort of like what they think the collective is, so if you're not prepared to do that then you're going to be left out." (Erin, Group F)

This implied that what is said online can be said for ends other than expressing the self, for example, getting support. Joanne and the researcher discussed the question of the individual as both an artificial construct and the 'real me'. Joanne felt that:

> "people are always creating personas. And at the end of the day, when you are putting yourself in the public forum and you are writing…then you are constantly filtering it and thinking, "How do I want people to read this?"… there is that layer inevitably because you're writing.
>
> Researcher: Right, I see. But that presumably doesn't mean people aren't being honest does it?
>
> Joanne: Well I don't know, well, um [pause]… oh it's quite a complex thing, that really... I can be honest and, and tell you what I think today and I can be honest tomorrow and tell you something but it won't necessarily be the same thing, because you know, because it's like that, that's the way people are, and, and therefore creating a persona doesn't mean I'm being dishonest, it just means that that's one aspect of me that I want you to see but I don't want you to see the whole thing, you know?" (Joanne, Group F)

This presented beliefs as fluid entities, and creating a persona as a benign activity, part of human nature (something echoed by Megan). Bethany (D) described more negative examples of people pretending to be other than what they were in the forums to get what they wanted or to cause trouble: e.g., "we once had a group of about six researchers in Sweden pretending to be one person"

The forum post analyses

There is no discussion of this in the forum post analyses, other than a mention of the kind of persona Ozzie (A) presented online, as seen by another member of the group.

5.5 Conclusion

Chapter 5 has explored how the groups did not require users to follow the site's official beliefs, leaving individuals free to create their own representations of problem drinking in terms of the specifics of cause, consequence etc. However, a group's overall approach had an important role to play in attracting users to groups. The chapter also looked at detailed examples of the forums having impact on beliefs in terms of acquiring, changing, reinforcing and challenging ideas held. Section 5.4 explored the impact on users of finding someone like themselves in the forums. For many, this changed their emotional and cognitive representation of themselves-as-drinker and of the nature of problem drinking, particularly in terms of consequences, controllability, label and symptoms. Three stereotypes – the 'alcoholic', the 'normal drinker' and the 'non-drinker' were described and it was shown how an alternative to these was provided to users by the forums. It was also shown how

other roles or identities could impact upon, or be impacted by, drinking, notably gender, life-stage and parenthood. After discussion of seeing people 'not like me' in the forums, the section concluded by looking at how far the personas presented in the sites reflect their creators' 'real' thoughts and ideas.

The evidence from the findings in this chapter indicate that the discussion forums of AOSGs do have significant impacts on user representations. The next chapter focuses on the information behaviours used in bringing this about.

Chapter 6: Findings: Information behaviours and activities

6.1 Introduction

This chapter focuses on information behaviours described by the interviewees and/or observed in the discussion forums of the three groups whose postings were analysed. It begins in Section 6.2 with a broad overview of users' information journeys in the forums, then focuses on information seeking in Section 6.3, and information avoidance in Section 6.4. Section 6.5 explores how users shared information, focusing on methods of particular interest. Section 6.6 looks at other information-related activities occurring in the forums and Section 6.7 briefly describes key norms regarding writing in these forums. Please refer to the Glossary for definitions of 'information behaviour', 'information searching' 'information seeking' and 'information sharing'.

6.2 The information journey with the forums

In this section, the information journey taken within the forums (from finding the groups to leaving them) is outlined to provide a setting for subsequent discussions of specific types of information behaviour. The section highlights where this relates to the impacts of the forums upon user representations.

6.2.1 Finding the groups

The interviewees

Initially, interviewees began their information journeys with the groups in one of three ways. Some of them started by searching for information around the general theme of help for problem drinking. Anna (Group A), for example, used the search engine Google to look for 'alcohol help', Marianne (Group C) used it to look for 'alternative treatments', and Robert (Group F) for 'alcohol recovery forums'. Bethany (Group D) searched Google for ways to taper off alcohol gradually and Joe (Group E) for online programs that did not follow the 12-step programme of AA. This seeking was different to browsing as it was actively directed to a goal, which might be quite specific, as in Bethany's case, or very general, as in Anna's. It was not, however, about looking for a particular named group, and frequently not for a group at all. Google searching was the commonest method found amongst interviewees and Yvonne implied it was behaviour typical of problem drinkers:

> "I don't know what, what your history is, but anyway, the main thing is, like, you Google, 'How do I know if I'm an alcoholic', and 'Where do I get help', and all that kind of [pause], thing" (Yvonne, Group F)

Secondly, and much less commonly within the sample, two interviewees had been referred directly to the group: Joanne (Group F) by a hospital nurse and Grace by a friend who had heard about Group F in the news. The last could be seen as an example of 'information by proxy' whereby information is found by someone else who shares it "on their own initiative" (Savolainen 2011, p866), as the friend appeared to have acted without any prompting from Grace. Thirdly, some interviewees heard of their group by chance, when looking for some other topic or using some other media, e.g., reading a newspaper. For example, Jackie read about Group E in a magazine, Alan (Group D) heard his group discussed on the radio, and Dawn (Group E) and Julie (Group C) found their groups whilst searching for something unrelated online:

> "I think I found it completely by accident. [Pause], I think something else that I was looking for mentioned it." (Dawn, Group E)

These are examples of Erdelez' original 'information encountering', a theory described in Section 2.5.1.2, which combines well with the 'berrypicking' model of information seeking described in Section 2.5.1.1 and discussed below (Section 6.3 & Chapter 7). To recap: Erdelez (1999) described information encountering as taking place in two situations: finding information during an unrelated search, or finding it whilst engaged in some other routine action. Dawn and Julie were examples of the former and Jackie and Alan of the latter.

The elements of information encountering described in Section 2.5.1.2 can be seen in the description given by, for example, Jackie: her information encounter came after a general search for a group (not Group E specifically) that proved fruitless:

> "but then I read an article just a few months later in a magazine, and I think it was *Oprah…* it was like something I picked up at the gym and I saw the name…and then I googled it and found it." (Jackie, Group E)

Here Jackie was the information user, she described the information need (looking for a group), the offline environment where the encounter occurred (the gym), the information source (the magazine) and how she acted upon the information.

Finding the site for many was experienced as an unplanned, accidental event, for example:

> "I wasn't even really seeking out any type of forum or any type of support, it just kind of happened across my computer" (Ben, Group C)

> *"*I stumbled across [it]… I stumbled on it online. Yah, I'd never heard of it before." (Christine, Group E)

The path from getting the reference to using the group might be straight-forward or circuitous: Julie (Group C), for instance, googled 'tapping' and accidentally found a DVD about a particular treatment for problem drinking. She then found a website about the treatment and from this linked to Group C whose forums she used. Some users immediately accessed their group on hearing of it, others put the information aside and came back to it later (e.g., Megan & Cara, Group F). Although some participants had had previous good experience of online support groups which would incline them to look at AOSGs (e.g., Jackie, Group E), most did not.

The forum post analyses

It was difficult to tell from the forum postings how users found the site as they did not tend to discuss this. Some users in Groups A and C, where there were threads specifically for newcomers to introduce themselves, said what they had liked about the site at the time of joining (see Section 6.2.2). In Group B, there was no newcomer venue, meaning that newcomer introductions were interspersed within the text and not always signposted as being first posts. Comments from users on why they liked the forum at the time of posting (implying why they stayed with it) were more frequent, and could be found in any type of post, not just newcomer ones.

Elizabeth was a rare example of someone who had clearly specifically looked for Group A as she said that she had heard many good things about the group. She did not say where the initial prompt came from. In the sample of posts analysed from Group A, there were only two other comments on finding the site, both instances of finding it via Google: Anita (similar to interviewee Anna, also from Group A) put 'alcoholic help' in Google, and Kate (similar to interviewee Yvonne from F), generalised googling as typical of users:

> "It's my guess that at some point we all typed "help for drinking" or something like that into a search engine and ended up here." (Kate, Group A)

Nothing was found in the texts from Group B about how anyone had found the group. In Group C, particularly in the part of the forum for newcomers, members chiefly discussed how they had found out about the treatment rather than the forum, and Jake started a thread specifically enquiring about this. Again, using Google appeared to have been the commonest method, for example, Lois googled "new science on alcoholism". Richard (like Kate and Yvonne above) generalised this across members: "I would think the Internet is a common option for people looking for alternatives to AA". The information site linked to C was also a source for learning about the treatment (Bridget) and about Group C (Olive), as in one case was AA (Richard). Serendipity was also indicated in Group C, e.g.: "I only found the…method by chance, I'm lucky." (Alfred) Thus the information from the forum postings is in line with the explanations given in the interviews: most started their journey by using the Internet, but serendipity also played an important role.

6.2.2 Selecting and staying with the groups

The interviewees

Once arrived at the groups, users were attracted to them for a variety of reasons, remaining with them sometimes for the same factors and sometimes because of different ones. Information regarding this is listed below in Table 6.1.

Table 6.1: Interviewees' reasons for joining and staying

Factor	Important at joining group	Important in remaining with group
Overarching approach to problem drinking / treatment recommended e.g., not 12-step, secular not spiritual in approach, allowing individuals to choose their own goals. Liking the treatment recommended	Group A (Anna) Group C (Ben, Cathy, Julie, Marianne) Group D (Bethany) Group E (Christine, Dawn, Jackie, Joe) Group F (Ariana, Isabelle, Joanne, Robert, Theresa)	 Group C (Cathy, Julie) Group D (Alan, Bethany) Group F (Isabelle, Yvonne)
Social dynamics e.g., wanting to find others like them (identification), hear others' experiences	Group A (Anna) Group C (Julie)	Group A (Anna) Group C (Ben, Cathy, Julie, Marianne) Group D (Alan)

	Group F (Cara, Erin, Grace, Isabelle, Megan, Robert, Tina, Yvonne)	Group E (Christine, Dawn, Jackie, Joe) Group F (Cara, Grace, Isabelle, Joanne, Megan, Tina, Yvonne)
Group values / norms, specifically supportiveness, confidentiality, being non-judgmental and not didactic	Group A (Anna) Group C (Julie) Group E (Christine, Joe) Group F (Grace, Megan, Robert, Yvonne	 Group C (Cathy, Marianne) Group D (Bethany) Group E (Christine, Dawn, Joe) Group F (Joanne, Theresa, Tina, Yvonne)
Size and functionality e.g., interactive options, availability	 Group E (Jackie, Joe) Group F (Grace, Joanne, Megan)	Group C (Marianne) Group D (Alan, Bethany) Group F (Cara, Erin, Grace, Isabelle, Megan, Tina, Theresa, Yvonne (F)
Information range and quality	Group A (Anna), Group C (Ben, Cathy) Group F (Erin, Megan, Robert, Tina, Yvonne)	Group A (Anna) Group C (Ben, Cathy) Group F (Erin, Megan, Robert, Tina, Yvonne)
Motivating, encouraging		Group A (Anna) Group C (Ben, Cathy, Julie) Group E (Christine, Dawn, Joe) Group F (Ariana, Cara)
The only group available or the first one found	Group D (Bethany) Group E (Dawn, Jackie) Group F (Megan, Theresa, Yvonne)	

The overall approach of the group was the main reason given for choosing it and the social aspects the main reason why people stayed with it. However, as can be seen in Table 6.1, individuals were drawn to, and remained with, groups for a wide variety of reasons including information range and quality. Those who felt this to be important at the start, also felt it was important later in their usage and gave it as a reason they stayed with the group. They specifically mentioned liking the ability to share information (Cathy, Group C), the amount and range of information (Erin, Group F) and the

fact that the information on the site was felt to be good quality (Robert, Group F). Erin also noted posts as intelligent and articulate, but found this less positive as it inhibited her from posting:

> "they're quite intelligent the way that they speak and what they write about, there's very few that come on with, you know, daft comments, it's all quite well constructed, and I think that's quite daunting in many ways"

Later she stated that she liked Group F as the information was up-to-date and relevant. Information was particularly important to Group C as the group formed a rare source of facts and advice about the treatment it supported. For some, the group was seen as a part of the treatment itself:

> "I believe that the forum-- is actually a very important part of the treatment. Because…your GP is uneducated and cannot give you the correct information necessarily…then the forum [is] that place where you actually get information on how to implement [the method] correctly and most effectively." (Julie, Group C)

This suggests difficulties with finding information from healthcare professionals, something that was explicitly reiterated throughout Group C forum postings and by its interviewees.

The forum post analyses

Table 6.2 below gives information about the reasons for joining and staying with the groups seen in the forum post analyses.

Table 6.2: Reasons for joining and staying given in forum post analyses

Factor	Important at joining group	Important in remaining with group
Wanting information, guidance and advice, including in their specific circumstances	Group A: Skye, Katie, Joan, Elizabeth, Abigail, Veronica, Archie, Doris Group B: Eddie Group C: Hugh, Valerie, Mike, Bridget, Victor, Rebecca, Suzanne, Richard, Agatha, Millicent, Charlotte, Albert, Carrie, Terri, Alfred, Maureen	Group A: Bertha, Kate, Denise, Elizabeth Group B: Wayne Group C: Rose, Bridget, Alfred
Overarching approach to problem drinking / treatment recommended	Group A: Denise Group C: Agatha	
Social dynamics e.g., wanting to find others like them (identification), hear others' experiences	Group A: Skye, Katie, Milly, Elizabeth, Simone, Sarah Group B: Lisa, Amelia Group C: Jill, Jennifer, Bridget, Lois, Agatha, Alfred	Group A: Abigail, Bertha, Ozzie, Oliver, Sarah, Denise, Lucy, Elizabeth Group B: Ursula, Wes, Belinda, Vince Group C: Lily, Rose, Bridget, Richard
Group values / norms	Group A: Joan, Elizabeth, Veronica Group B: Amelia Group C: Jill, Valerie, Agatha	Group A: Abigail, Holly, Bertha, Ozzie Group B: Fabian, Wes Group C: Lily, Rose
Size and functionality		Group A: Ozzie
Information range and quality	Group C: Olive, Lois	
Motivating, encouraging	Group A: Elizabeth, Adrienne, May Group C: Jake, Dorothy, Olive	Group A: Bertha, Ozzie, Denise, Greg, Elizabeth Group B: Ursula, Xeno Group C: Angus, Lily, Marge, Gary
General desire for help with drinking	Group A: Kate, Edna, Archie, June, Emma	

In Group A, the newcomer forum was populated by twice as many 'returners' or people who had used the forum before, then left and were returning, as by completely new members. In both cases, these members were more likely to imply why they chose the group by saying what they needed from it, than by stating directly why they had chosen it. To take one example:

> "I'm looking for better ways to deal with issues and make my life better. Not drinking isn't really the main thing, dealing with stress [is]. I'd like to find tips and suggestions from people who've been sober longer than me, and in turn also maybe I can support people by sharing my experience." (Skye, Group A)

In Group A, wanting advice and information and wanting to find others like themselves were the key reasons for joining that were mentioned. In Group B, there were only three (different) examples as to why the forum was chosen: Lisa stated that she was looking for others' experiences, Eddie asked for advice and felt that he fitted in and Amelia was clearly looking for emotional support. There was much more discussion of what people were looking for in the newcomer forum of Group C. In most cases, individuals began their posts by asking one or more questions, thus implicitly indicating that they needed information and/or advice. For example:

> "Hello – What's the best way forward for a person with a pattern of binge drinking? ..If I only use [the medication] on a couple of days a week will this make adjusting to it harder?" (Victor, Group C)

This was in line with the importance of information provision to the site mentioned before and indicated that they chose it as they believed it would be a place where they could get their questions answered. Social dynamics were also important to users of C at the start. In A and B (as with the interviewees), social dynamics came to the fore as the most important reason for staying with the groups but, interestingly, this decreased slightly in importance in Group C.

To summarise, amongst the interviewees, the group's overall approach appeared to be the commonest factor attracting them to it, whereas it appeared in the forum postings that people were seeking information and advice as their primary motive. It could be argued that this is inextricably linked with the overall approach, as the group's general approach would directly influence how questions were answered and what advice was given. If users assessed a group as a place that could answer their questions they had probably some idea of the group's approach. This is extremely likely in the case of Group C, where the rarity of sources about the overall approach led to many information requests about managing the approved treatment. However, it is not as clear in the other two cases and depends to an extent on the questions asked: it may be possible to find useful tips for handling difficult specific situations and resisting cravings in a site with a very different

approach to that of the user. Overall, most interviewees and forum posters were likely to stay with their groups because of social dynamics.

6.2.3 Usage of the forums

The interviewees

Table 6.3 below indicates overarching usage patterns amongst the interviewees. It shows that members had used their groups for varying lengths of time, with the majority having used them for more than one year. None of the interviewees had less than four month's experience and only two had more than five years. There was no particular pattern as regards length of time using the site with a range of members from each group in each time category. Most interviewees were heavy users of the forums, with 13 out of 22 using it daily and a further four using it between two and five times a week. Jackie (Group E) was the only interviewee to use the forum just once a week. Changes in usage patterns (the last column in Table 6.3) are discussed in Section 6.2.4 below.

Table 6.3: Overarching usage patterns of interviewees

Pseudonym	Group	Time using site in years	Frequency of use now	Has use of the forums and/or site as a whole changed over time?
Anna	Group A	5 years +	Daily	Y
Ben	Group C	Less than 1 year	Daily	Y
Cathy	Group C	Less than 1 year	2-5 times a week	D/K
Julie	Group C & previously E	Less than 1 year	Very variable	Y
Marianne	Group C	1-2 years	Daily	D/K but likely to have changed as she had become a moderator recently
Alan	Group D	1-2 years	2-5 times a week	Y
Bethany	Group D	Less than 1 year	Daily	D/K
Christine	Group E	5 years +	Daily	Y
Dawn	Group E	3-4 years	Daily	Y
Jackie	Group E	2-3 years	1 a week	Y
Joe	Group E	1-2 years	2-5 times a week	Y
Ariana	Group F	Less than 1 year	Daily	Y
Cara	Group F	4-5 years	Variable	Y
Erin	Group F	1-2 years	Variable	Y
Grace	Group F	2-3 years	Daily	Y

Isabelle	Group F	1-2 years	Daily	Y
Joanne	Group F	Less than 1 year	Daily	D/K
Megan	Group F	Less than 1 year	Daily	D/K
Robert	Group F	2-3 years	D/K	N
Theresa	Group F	2-3 years	Daily	Y
Tina	Group F	Less than 1 year	Daily	Y
Yvonne	Group F	4-5 Years	2-5 times a week	Y

The forum post analyses

Table 6.4 shows a variety of lengths of time of usage by forum posters across Groups A and B. Group C did not contain this information.

Table 6.4: Time using site

	Group A		**Group B**	
Number of years of use	**Number of users**	**% of total**	**Number of users**	**% of total**
10	0	0	9	5%
9	0	0	9	5%
8	0	0	20	11%
7	5	3.5%	8	4%
6	9	6%	1	0.5%
5	8	6%	14	7%
4	28	20%	8	4%
3	16	11%	13	7%
2	14	10%	23	12%
1	22	16%	43	23%
Less than 1	34	24%	39	21%
D/K	5	3.5%	0	0
Total	141	100%	187	100%

Table 6.4 shows that the majority had used their group for more than one year. However, for both groups, the largest sub-group was those who had joined within the last year. No data were available on frequency of use for the forums

6.2.4 Changes in usage over time

The interviewees

Most described their usage patterns changing over time, in a variety of different ways. Some reported that they had made more use of other parts of the site in the past: for example, Jackie (Group E) and Cara (Group F) used to participate in web chats in the past; Dawn and Christine (both Group E) moved from using the forums to the listserv available on the site. A change in role such as becoming a moderator appeared to alter the parts of the forums looked at (e.g., Anna (Group A) began monitoring the emergency threads for people in distress). Some initially confined themselves to a specific thread and then expanded to other threads, e.g., Ben (Group C) and Theresa (Group F). Others moved in the opposite direction, e.g., Alan (Group D) moved from commenting on all posts to looking only at shorter threads and focusing on helping newcomers. Nine of the interviewees began as lurkers on the site, subsequently progressing to posting in all bar one case.

Early general queries evolved as members' gained more experience and their use of the forums advanced. It was common to find searches becoming increasingly specific as the user moved on to questions around dealing with every-day, challenging situations that arose over time, such as how to act at an event where they would be encouraged and expected to drink (Anna, Group A; Isabelle & Theresa, Group F; Christine Group E).

Over the longer term, there was typically a move from seeking information and help to giving it, as information needs were satisfied, and helping and supporting others became more important. There also appeared to be a pattern of using the information pages on the site more at the beginning of users' time there, as this was when they had the most unanswered questions e.g., Anna (Group A), Ben and Julie (Group C), Christine, Jackie and Dawn (Group E) and Grace, Megan and Isabelle (Group F). As these questions were satisfied, information pages became less important: Christine (Group E) described how initially she read the information pages because "when you're new you squirrel away everything", but later focused on providing support and acting as a role model. In short, information gathering became somewhat less important with time, as well as the information queries changing from more to less general and the emphasis moved from seeking to giving help. (For a discussion of the topics asked about by the interviewees and in the forum postings, please see Section 6.3.2.)

The forum post analyses

Information on changes of usage behaviour over time in the case of Group A was fragmentary and came from occasional comments, such as "I've become a lurker, but I'm like to post about what the

last person said" (Marika, Group A). Newcomers were often encouraged to read around to find where they felt 'comfortable' (i.e., not to remain in one place but test things out) and Denise gave a detailed description of how she moved from thread to thread in search of a place where she felt accepted. The data analysed from Group B did not show individuals talking about their modes of use, in this way. In Group C one of the moderators described general overarching patterns of usage:

> "Once [members] don't any longer feel that they need support, and they've got a grip on their lives and their drinking, they generally make contact less and eventually move away to get on with their lives...I don't usually have much communication with them as they drift off…the people still on the forums are mostly those who still need help...they ask questions and want support." (Poppy, Group C)

As with Group A, individuals sometimes also returned for another attempt at the treatment.

Table 6.5 presents the number of messages posted by each person. (This data was located immediately below the poster's avatar). Small percentages of the people in Groups A and B accounted for a very high number of posts (5001+) with the largest sub-group in A and B providing between 11 – 500 posts each. Only 8% of users in Group A and 23% of users in Group B accounted for a very low number of posts (10 or less). The pattern was slightly different in Group C where the numbers of those contributing a large number of posts was again very small, but the number of individuals contributing 10 or fewer posts was similar to the number posting 11-500 times.

Table 6.5: Number of messages posted by each person

Number of messages posted per person	**Group A**		**Group B**		**Group C**	
	Total	**% of total**	**Total**	**% of total**	**Total**	**% of total**
< 10	11	8%	43	23%	30	34%
11-500	59	42%	88	47%	31	35%
501-1000	19	13%	22	12%	2	2%
1001 – 5000	38	27%	30	16%	0	0
5001+	11	8%	4	2%	0	0
Not available	3	2%	0	0	25	28%
Total	141	100%	187	100%	88	100%

Previous research has shown that, in online support groups, there is often what is known as a 'critical mass' or 'core group', consisting of those who post most frequently:

> "The core group is defined by the power law in message distribution, indicating that a very small group contributes significantly more content than do average members… Members of the core group often perform a large proportion of community building and maintenance work such as…writing and reading messages" (Ren, Kraut & Kiesler, 2007, p398)

This has also been called the 1% or the 90-9-1 rule, for websites where users create content as well as reading material. This, van Mierlo (2014) argued, signifies that it will often be only 1% of group members who produce the majority of the content, with 9% contributing sporadically and 90% remaining as lurkers. The groups reflected this in that the numbers accounting for large numbers of posts was very small. However, the number of posts in the 11-500 category for A and B seems more than would be indicated by the term 'sporadic' and forms a much higher percentage than 9%.

6.2.5 Leaving the forums / groups

The interviewees

There was only one interviewee who was an ex-member of their group (Erin, Group F). She left as she became involved with a face-to-face service that took much of her time and which she preferred. Alan (Group D) had withdrawn somewhat from his group: he was still involved but less heavily, as he found dealing with moderate drinkers difficult and a potential threat to his recovery. However, several others had left groups other than their current one in the past. The commonest former group was AA or a 12-step based group and the reasons for leaving these were:

- Dislike of the group's beliefs: Bethany (Group D), Cathy (Group C), Christine (Group E) Ariana, Grace and Robert (Group F);
- Practical reasons, e.g., distance away from meetings: Grace and Joanne (Group F);
- Concerns re anonymity: Grace (Group F);
- Bullying from other members, related to questioning AA beliefs: Robert (Group F);
- Programme did not work for them: Julie (Group C); and

In terms of non-12-step groups, Robert (Group F) left one for practical reasons concerned with the group's administration. Theresa (Group F) unfollowed Facebook groups as they were mainly populated by newcomers who she felt could not help her and who she could not help as they were at a different stage to her. Tina (Group F) left a group as it was not "robust" and Yvonne (Group F) left one because it was "negative" however, neither of them could define these terms exactly. Cathy (Group C) had left a group as it was hard to use and "didn't really click for me". Julie (Group C)

appeared to have disliked Group E which she had used in the past, criticising some (not all) of the people involved as “weirdos” and “uneducated”, and the group as being more dictatorial than Group C and with more disagreements (an interesting view that contrasted markedly with that of Christine and Joe, Group E). Marianne (Group C) followed individuals to her site from another one. This showed that a variety of reasons caused people to leave groups, with the commonest one in relation to leaving AA being dislike of its beliefs. This was also an important reason why some other people had never joined AA in the first place (e.g., Anna (Group A), Theresa (Group F)). The influence of individual people or groups of people, and the practicalities of using a group were also factors mentioned by more than one person.

The forum post analyses

There was some discussion in Group A of leaving the forum in the context of two arguments (these are analysed in Section 6.5.3 below). Marika felt that there was “a new trend for defending the continuation of drinking” and “a lot of good people are leaving the forum”. Later she offered to leave herself:

> “if you and others think I’ve done something mistaken, then that's fine, and if you feel you have a better grasp of things, then of course I'll be quiet and go somewhere else” (Marika, Group A)

The person she was arguing with asked her not to do this, which was reinforced by another user (Kate); however, Marika did not post again in the extract analysed. In a second argument which referenced the first, Denise described moving from thread to thread at length, looking for a place where her approach to drinking would be acceptable. This was interesting in depicting usage in more detail than is customary:

> “I began on [Thread 7] and was really happy that there was somewhere I could go when all I wanted to do was cut down. Then some people came on saying that moderation can’t work and the only way is abstinence. I got discouraged and moved [elsewhere]…Then there was a "Thread [6]" thread which seemed an even better fit but again the abstinence-only gang arrived to complain that it promoted moderation as they think abstinence is the only way. So I left there, and thank goodness this thread was introduced and it seemed like it was a perfect match for me.” (Denise, Group A)

She described the thread she was in at the time as her “last hope thread on [Group A]”, implying that she might leave the group altogether if it became anti-moderate drinking. This argument was resolved with no-one leaving. In both cases, disagreements about beliefs around coping mechanisms appeared to be the key factor prompting some to consider going, showing the impact of user representations on usage.

In Group B, there were no discussions of leaving the group in the extracts analysed. In Group C, one of the moderators described the customary exit pattern that members followed, quoted above in the discussion on forum members’ patterns of use changing (Section 6.2.4). In this group, a cure was considered to be a possibility, so there was no requirement to stay with it for life, as in AA. Finally, in both Group A and Group C, leaving was not necessarily the end of the journey, as people might come and go, as was noted above.

6.3 Searching for information about problem drinking

6.3.1 Introduction

This section explores ‘Information seeking’ in the forums: for a definition and discussion of this concept please see Section 2.5.1 and the Glossary. It looks at which topics relating to the nature of problem drinking were discussed, the use of sources and search techniques and how information was selected or discarded.

6.3.2 Topics sought

The interviewees

The interviewees were not asked about which topics they had sought generally but rather about ideas around problem drinking that they had obtained or developed in the forums, and which were the most important, as these were likely to be more memorable for them. These were discussed in Section 5.3 with tips and tools for recovery and ways of using particular methods being frequently mentioned. The most important change in ideas brought about by the forums, mentioned by 9 out of 22 interviewees, was realising that drinking problems were not unusual or shameful and that there were many other drinkers like themselves. Others mentioned seeing that recovery was possible, gaining self-knowledge and learning how to achieve one’s sober goal. For several interviewees, the forums reinforcing their existing ideas was the most important element. Section 6.2.4 showed how topics that were sought changed over time.

Forum post analyses

The forum posts provide different evidence to the interviews, as it is possible to see the actual questions asked in them. However, when looking at these it is important to bear in mind that, a) many of the posters here might have looked up topics in the forums rather than asking questions, with their ideas changing as a result of this, and b) people who post could have benefitted from a topic but decided not to comment or ask further questions about that particular thing, so not providing evidence about what was important to them. Therefore, it is not possible to say which topics were the most important ones to the posters in these groups. There are occasional comments where a poster specifically stated that they found something particularly helpful, for example:

> "There are lots of good suggestions on here to help [with getting sober], from people who have been here before me. So I have clung here as if to a life-raft over the last few days." (Iris, Group A)

> "Thanks for your wise words. I will try [what you suggest] next time I drink." (Griff, Group B)

The topics discussed in the groups were examined in Section 5.3. For Groups A and C, many questions appeared to revolve around the issue of coping mechanisms and how to get and stay sober. Group B discussed a wide range of types of topic including coping mechanisms, consequences and controllability of problem drinking, with an emphasis on questions related to controlling alcohol for one purpose or another. There were more questions in Group B than Group A, with several threads opened by a question and followed by multiple answers from different members in a pooling of knowledge (see also Section 6.5.7). Factual questions that could have been answered using Google tended to receive rebukes either from other members or in the Post Quality Reviews, as did unclear questions (presumably because these were wasting time). Post Quality Reviews were comments on posts which appeared beneath the text and indirectly provided information about what was important to users and what was criticised, illuminating their values and interests. Again, the changes in topic over time are shown in Section 6.2.4.

6.3.3 Multiple sources

Users employed a range of different sources. Both the interviewees and forum posters indicated that they did not confine themselves to using the forums only, but made use of different parts of the site. They also went outside it, to other materials, formal and informal, including other AOSGs.

The interviewees

Once in contact with their group, users drew on it from multiple areas for ideas about problem drinking. This included the forums and the information pages (provided by all except one group which linked to a related site effectively providing the same function). Several groups offered other functions for interacting with users and getting information, for example, chatrooms, a listserv or blogging facilities. Users might move between functions over time, or use several simultaneously. Table 6.6 below indicates the numbers of interviewees who had made use of facilities other than the forums in their respective groups at some point:

Table 6.6: Areas of sites used

Areas of own site used	**Group A (No of users / total no of users)**	**Group C (No of users / total no of users)**	**Group D (No of users / total no of users)**	**Group E (No of users / total no of users)**	**Group F (No of users / total no of users)**
Blogs	Facility not available	Facility not available	Facility not available	Available but not used	11 out of 12
Listserv	Facility not available	Facility not available	Available but not used	4 out of 4	Facility not available
Information pages: At the start only:	1 out of 1 (mainly at start)	3 out of 4 1 out of 4	1 out of 2 1 out of 2	1 out of 4 3 out of 4	9 out of 12 2 out of 12
Chat room	Facility not available	Facility not available	Available but not used	2 out of 4	2 out of 12
Webcasts	Facility not available	Facility not available	Facility not available	Facility not available	3 out of 12

All interviewees used, or had used, at least one function other than the forums, with information pages being used by all except for one interviewee.

Interviewees were a mixture of those who had only ever used the one group under discussion: Anna (Group A), Ben (Group C), Joe, Jackie and Dawn (Group E), Megan, Grace, Tina and Joanne (Group F); those who had used other groups in the past: Cathy, Marianne and Julie (Group C), Christine (Group E), Theresa, Robert and Isabelle (Group F), and those who were using more than one at the time of interview (Alan, Bethany (Group D) Yvonne, Ariana, Cara and Erin (Group F)). It would appear that most interviewees (59%) did explore and try out a few groups, with 22% using more than one at the same time. The ones who had used other groups in the past included those who had just looked at them and rejected them and those who had used them for a number of years. A variety of different

groups were named including spin-off groups from the main sites on Facebook. At least 11 users from four groups had used AA in some form. Blogs, apps and a WhatsApp group were also mentioned by four people.

Users were exposed to many sources of information and opinion about problem drinking before, during and after arriving at the forums. It was noted above that they were likely to arrive at their group with some existing ideas about drinking received from multiple sources over their lifetime. These sources included individuals such as family and peer group members, the cultural attitudes of the society they grew up in and/or had lived in, previous reading including novels and autobiographies, treatment services or groups attended and media such as cinema, TV and film. The quote below indicated some examples of typical sources:

> "it really is a mix of multiple sources and information for me to change the way that I think about alcohol. As I stated my [relative] is an alcoholic and has been sober for [more than thirty] years…it was a mix of educational sources from the people that I met and, and my intensive outpatient programme from rehab. The people in detox in the programme that they provide. From AA sources, from reading books, from *Rational Recovery*, I read that book, reading the AA literature and books, and, you know getting educated on the forums" (Alan, Group D)

Alan had initially experienced the lived example of his relative's drinking and sobriety, and he also said elsewhere that he came from a family of problem drinkers. Before arriving at the forums, he had been exposed to treatment in the form of rehab services, to other drinkers and those working with them and to multiple books and other literature, as well as to AA. His experience is typical in several ways, in that many of the interviewees came from families of problem drinkers and many had had experience in AA before finding their group.

Within the threads of all the groups (apart from Group D according to Bethany, but not Alan) users exchanged references which they went on to follow up. Almost all moved outward from the site to get ideas from books, articles, podcasts or other media introduced to them as helpful by other users or the site's information pages. Both popular and scientific materials were recommended: particularly commonplace was what some members of Group F called 'Quit Lit' (a pun on Chick Lit or books for women). It should be noted that this is now a 'genre' on the Goodreads review site, so clearly has currency as a concept outside Group F: see https://www.goodreads.com/genres/quit-lit.

'Quit lit' was not rigidly defined by Group F but, for them, seemed to comprise, firstly, a number of autobiographies and blogs detailing individuals' experiences of recovering from problem drinking (for example, *Sober is the New Black* by Rachel Black; the 'Mummywasasecretdrinker' blog and its companion book, *The Sober Diaries** by Claire Pooley; books by Lucy Rocca; celebrity autobiographies); self-help books (notably Jason Vale's *Kick the Drink Easily*,* Allen Carr's *The Easy Way to Control Alcohol** and Annie Grace's *This Naked Mind*),* and more theoretical, popular science books (such as *Drink** by Ann Dowsett Johnston, which explores the relationship between women and alcohol, or *Alcohol Explained** by William Porter). References to these materials were chiefly noted by members of Groups E and F, but all interviewees except for one agreed that one function of the site was to exchange references and that they found this helpful.

In summary, the information sources used by interviewees were very wide ranging. This is similar to Sillence's findings on health decisions in online support groups (OSGs):

> "Participants recognised the importance of OSGs in their health decision-making but also stressed that it usually formed just one part of their overall strategy. Discussions with friends, family and healthcare professionals (HCPs), as well as more general web-based information, were also important" (Sillence 2017, p995)

The interviewees were likely to acquire information from many sources before their arrival at the forums, during their time on them, and when they left them to explore elsewhere. This multiplicity of sources is typical of the type of information seeking called 'berrypicking' developed by Marcia Bates (1989), where users select information from many different sources in the manner of an individual selecting berries from different bushes. This was described in Section 2.5.1.1, is further discussed in Section 6.3.5 and in relation to the findings in Chapter 7.

The forum postings

A similar pattern was observed in the forum posts analysed. In Group A, users frequently commented on, discussed or referred each other to different threads. They discussed other parts of the site much less often, but this did occur, as for example:

> "You'll find articles via the links about problem drinking, and I think there's also a couple about how to quit" (Frances, Group A)

**Also in Goodreads Quit Lit category at February 2020*

They frequently referred each other to materials outside the site. The following indicated that they also typically used several sources of help at once, e.g.

> "Those weeks [of recovery] wouldn't have been managed without logging onto [Group A] every day for hours, listening to Kevin O Hara alcohol podcasts while exercising, reading Jason Vales' book, and the mummywasasecretdrinker blog." (Carol, Group A)

Books were often recommended as a source of information about problem drinking, and readers were referred to podcasts, poetry and general recovery material also. The most frequently recommended website for information was Smart Recovery, but others included 'Addictions and Recovery' and 'Adult Children of Alcoholics'. There was some evidence that some members also participated in other AOSGs (e.g., Smart Recovery and AA) whilst using Group A.

In Group B, medical articles published in academic journals and the DSM-5 manual were referenced, as were other threads. Links to the information pages on the site were frequent but these were added by the software rather than at the poster's discretion. Users also referenced some external websites (links to other discussion boards were banned but could nevertheless be found). Popular culture was referenced too: for example, Jackass (a TV programme), Trainspotting (a film about a group of heroin users) and the pop group 'Motley Crue''s autobiography. Compared to Group A, there was less mention of reading for any reason, and fewer accounts of reliance on multiple sources of information. However, people were exhorted to 'do their research' about alcohol or the drugs they used:

> "Make sure you're do your research, look after yourself and the people around you" (Dean, Group B)

This fitted with the emphasis on good information presented in Group B's information pages (see Section 6.7). In terms of other groups attended, Cameron appeared to attend a 12-step group simultaneously with Group B, and Ursula and Amelia indicated that they had done this in the past:

> "I had a lot of support from NA when it was needed and I went to SMART meetings as well… I found so much helpful information and lots of tips and tools there. I went to rehab as an outpatient as well, and it was really useful." (Amelia, Group B)

AA, NA and Smart Recovery were the groups most often suggested to others for support in getting sober, although in the case of AA this usually came with a caveat that the person suggesting it did not like it or had not found it helpful.

There were many references to other materials and resources in Group C, focusing on a body of work about, and experts in, the particular treatment endorsed. This included:

- Writings and scientific trials by the founder of the treatment and the expert on it who advised the site;
- Reports on other scientific studies of the treatment, including RCTs and meta-analyses;
- Articles from academic journals;
- Books e.g., the founder of Group C's memoirs;
- A documentary about the treatment;
- Other websites exploring the treatment.

Group C sat as part of this body of work and threads within it were also referenced as useful to read, as was a related information site which effectively provided its information pages. Some members had experience of other groups also.

To summarise, it appeared quite clear that posters in the forums, like the interviewees, did not confine themselves to this one source of information but ranged widely on and off the site.

6.3.4 Search techniques

The interviewees

The most popular way of using the forums was by having a regular, favourite thread. Eighteen users had one or more particular threads that they went to routinely (though not necessarily exclusively). The thread might be important because of its topic, or it might be more of a 'home' thread, where the key factor was the individuals who used it, both of which are shown in the following:

> "the thread where there's a sentence that says 'I will not drink today, because…' I always visit that every day…there are other threads that I feel particularly close to…I would post on them just because I kind of know the people quite well now" (Anna, Group A)

Cathy (Group C) always went to the progress thread, Isabelle (Group F) to the '100-day' thread and Ben (Group C) initially used the newcomer and progress threads then expanded outward to all areas over time. Sometimes these home threads were described as communities within a community, and as forming sub-groups to the main group: "I feel very much a part of the 100-day thread community." (Joanne, Group F). Theresa described how she:

> "found a forum of about maybe 12 ladies that were in and out, maybe a core group of 3 or 4 that were always there, and I didn't even know about the larger site and the blogs and things, I just stayed with that forum…that was my support group and um as a matter of fact I've stayed friends with those women" (Theresa, Group F)

Sometimes, heavy use of one particular area was a site feature and generated further use because of this popularity: "So I will normally post on the daily goals…Just because we all do" (Bethany, Group B) "First I check the new forum posts, then I back-read the monthly thread that a lot of us post on daily." (Joe, Group D). This is interesting as it showed regular patterns of usage, employing only a specific part of the forums rather than searching for particular topics. It could be argued that this was a negative aspect as people might have missed out on wider ranges of opinion or new topics by keeping to the same areas of the site. It was possible to remain in a 'thought bubble' as regards coping mechanisms, e.g., using only a thread for abstainers and therefore not being exposed to ideas around moderation. On the other hand, it could be seen as positive, in that lengthy attendance on a thread could help develop the important element of community and a sense of belonging, which helps to keep people with OSGs (Ren et al., 2007). It could also be seen as efficient usage, allowing users to concentrate on the parts of the site of greatest relevance to them. Chambers saw it as a way of establishing accountability "Establishing smaller, more personal communities within the larger Soberistas network was a common way of creating accountability" (Chambers, 2018, p66).

Many sought out specific people, whom they liked to read, perhaps either because they wrote well, because they had followed them for a long time, because they saw them as role models or because they could identify with them:

> "So there'll be other people that, you know, stopped about the same time, so we're going through the same sort of things….and then there's people that you just like their writing style, they're particularly insightful. There's some [pause], again, some names that I know

from the first time round that I'm genuinely interested to hear how they're doing" (Megan, Group E)

Some looked for newcomers to offer help to, others for experienced "thought leaders in the group" (Julie, Group C). This suggested that people could hold a variety of roles in relation to each other, i.e., they might be friends who one catches up with, people whose ideas were respected and who were looked up to, or people who were peers, at the same stage or going through the same things. This way of searching takes advantage of the longitudinal aspect of the format: people could be followed over time to see how they get on, what worked and what did not work for them (assuming they stayed on the forum).

Where people did search for specific topics, this might be proactively by asking questions or inviting opinions and suggestions on a topic. Alternatively, they might use the forums like a reference book, looking up what others had already said about particular issues. This showed that it was not always necessary to ask questions, or even write in the forums in order to have one's questions answered. However, several users made the point that the forums were not a manual that told users exactly what to do. Other ways of searching included browsing, looking for replies to their own posts (Julie, C) or looking for specific types of information e.g., stories. Table 6.7 illustrates some of the different ways of searching used by interviewees: it should be noted that all except for one of them used more than one technique.

Table 6.7: Search techniques used by interviewees

Search technique	**Name (Group)**
Has a 'home' thread	Anna (A), Ben, Cathy (both C), Alan, Bethany, (both D), Christine, Jackie, Joe (all E), Ariana, Cara, Grace, Isabelle, Joanne, Megan, Robert, Theresa, Tina (all F)
Searches by types of people or for specific individuals	Anna (A), Julie (C), Alan, Bethany (both D), Christine, Dawn (both E), Erin, Isabelle, Joanne, Robert, Tina, Yvonne (all F)
Browses	Cathy, Julie (both C), Alan (D), Christine (E), Ariana, Robert, Theresa, Tina (all F)
Looks for stories	Julie (C), Cara, Grace, Tina, Yvonne (all F)
Searches by topic	Christine, Dawn, Jackie (all E), Cara (F)
Looks for new posts/threads, what is current	Joe (E), Erin, Tina (both F)
Checks all areas	Ben, Marianne (both C)

Looks for replies to own posts	Julie (C)
Looks for short threads	Alan (D)

The forum post analyses

It was usually difficult to establish the search techniques used by people posting on the site. However, some information could be seen or inferred: in Group A many individuals did appear to have a 'home thread', a place that they went to routinely. For example, when writing in Thread 4, members described themselves as 'groupies' (a play on the name of the thread), or they called themselves '[Thread 4]-ers':

> "many [Thread 4]-ers are in positions very like mine as regards their addiction" (Marika, Group A)

She went on to say "I miss my old thread [4] mates" meaning people who were regulars but had left. Kim similarly described members of the thread as "we groupies, old and new". Thread 5 formed another example of a thread with regular users, as members frequently did "roll calls" or shout outs to other members, seeking to ask after everyone who used the thread routinely. Again, some referred to those on this thread as '[Thread 5ers]'. The presence of regular members could be seen by other posters as either good or bad: for example, Denise described some threads as like cliques, and noted that "now and then you just don't fit in ever" On the other hand, for example, Ann likened Thread 5 to a family:

> "Like you I love the people on this thread, it's a fantastic group of people!... For me [Oliver] is like the group's wise Dad who wants what's best for us all." (Ann, Group A)

The following post from someone on an emergency thread for those seriously struggling also implied regular attendance at a home or 'normal' thread:

> "I reckon everything's been getting me down. I'm going to go back to my normal threads as I don't feel at risk now" (June, Group A)

These findings may be supported by the affordances provided by the group's structure: Group A (unlike Groups B and C) had many threads dedicated to specific goals, thus implicitly inviting those with the same aims to group together on the relevant thread. Similar goals implied holding certain

aspects of a representation, e.g., if an individual believed problem drinking could be cured/resolved and that it was possible to return to normal drinking this implies that it was not seen as a permanent condition (relates to the dimension of timeline), did not require abstinence to deal with it (coping mechanism), and was something that was controllable (controllability). However, it is also important to note that, in practice, individuals might have chosen the threads because of the people rather than shared ideas.

Many threads were practically-oriented, providing advice on what to do to get sober. However, there were also threads that offered debate, e.g., 'What's a drink problem?' and 'What's a relapse?' The presence of these threads indicated an interest in defining problem drinking, but none were highly viewed or posted to, as indicated in the site statistics given for each thread. This may suggest that members preferred to concentrate on practical matters, such as triggers for drinking and tips and tools for staying sober.

Other modes of searching were also suggested. For example, Mary described how she, at times, chose a thread that she had not read before. As stated in Section 6.2.4, newcomers were encouraged to browse for themselves to find their comfortable place. However, more directed searching could also be advised in the newcomer forum, with more established members directing new users to places they felt would be of interest to them as, for example:

> "take a look at the thread on relationships, there you will see others in situations like yours and can get information and advice from them" (Emma, Group A)

Clearly then, some members were (at least encouraged to) use browsing techniques and also to follow up references. Frances suggested that new members "Take a look around and get to know others on the site" (which, it could be speculated, could have led to individuals 'following' the people they like as was discussed in relation to interviewees). There is then evidence to suggest more than one method of searching is used, but that finding and regularly going to a particular thread or threads is a favoured method, as for interviewees.

In Group B, unlike Group A, threads were organised by substance used with, in the case of alcohol, a forum for addiction as well as one for general questions. Individual threads were random in topic, meaning users were not encouraged towards home groups or shared goals, but rather towards whatever interested them at that moment in time. Threads were usually focused on a specific

question, mostly of a practical nature such as 'Is a 6 pack on a weekend night OK?', 'Gordon's gin – where's it made?' or 'How do I get rid of anxiety caused by hangover?' In the forum dealing with addiction, threads usually started with one person asking for advice and help with their particular situation. It was noticeable that there were no forums or threads for newcomers to introduce themselves. This is unusual for an online support group, and may have contributed to a problem reported on the site about newcomers posting in inappropriate threads and having to be redirected by more experienced members. A newcomer to the addiction forum would see that it was most commonplace to start a new thread for themselves, and that there were very few general forums. Most threads asking a straightforward question were quite short (around 10 posts), whilst the fewer general threads were longer e.g., 'What is it you like about sobriety?' (55 posts) and 'Thread about injecting alcohol' (69 posts) both of which invited people to pool their experiences and opinions on the topic. Whilst the variety of topics was eclectic, the users did keep to the broad remit of the overarching forum, mostly asking for help in the addiction forum, and asking other types of questions in the alcohol forum. There was no sense of being a 'family' or community, as in Group A, or of relationships forming. For example, in the texts analysed only one individual encouraged another to message him privately and chat outside the forums. Overall, it was not really possible to see from the material analysed how members in this group go about searching for what they need other than by topic. It should be noted that, at least in the forum extracts analysed, B was less self-reflexive than Group A, where the site itself was frequently discussed.

Group C's primary aim was to support individuals in their implementation of the treatment it promoted and help them to manage the medication and practices involved. Unsurprisingly, therefore, threads were chiefly about different experiences of the treatment or related issues, such as how to obtain a prescription, where to find treatment-friendly doctors, whether to reduce or increase dosage and how to deal with side effects. In light of this, it seems likely that individuals also searched by topic. In the material sampled, out of 55 threads only one dealt with something more theoretical, i.e., how alcohol affects the brain, and this only consisted of a link and one very short comment. Comments on how individuals were using the forums were infrequent: Olive stated "I want to read and catch up on what's most up to date on this forum" which might suggest searching for active recent posts.

6.3.5 Selecting information

The interviewees

Most of the interviewees described acquiring their ideas in a way which fitted well with Bates' model of berrypicking, which is discussed in full in Chapter 7. It was notable that individuals appeared

comfortable with selecting pieces of information from conflicting sources. For example, Alan belonged to both AA and Group D, which had very different ideas about problem drinking. The philosophy of AA is very well established. It is set out in the *Big Book*, and focuses around the 12-step programme, service to the group and attendance at AA meetings. The treatment approach advocated, i.e., complete abstinence, clearly conflicts with Group D's approach, which recommends the person decide for themselves between the different options available. Group D focuses mainly on providing advice and information about moderate drinking. Use of conflicting sources appeared to occur often amongst interviewees: Erin, for example, attended groups with differing ideas (AA and Group F) and Robert spent over a year in a 12-step group where he disagreed with the approach. Conflicts of approach alone did not seem to cause insurmountable difficulties, users simply chose ('berrypicked') the elements that they liked. This was stated many times, for example:

> "I took in all the information, cos I like, I've read probably 100 books on alcohol use…and I've read all kinds of different pages online and everything I could get my hands on. I immersed myself in it, but then what I'd do is I sieved it…and I hold on to what connects to my reality, and so what I came up with is just my reality…I get all the information but then I make up my own mind." (Theresa, Group F)

Alan stated that the Group D programme was a good "soft start" for those beginning to look at their drinking and that:

> "by soft start I mean that it's not abrupt, people can take what they want and kind of leave the rest" (Alan, Group D)

Julie stated of Group C that "you just choose what you listen to", Bethany described herself as taking "a bit of everything…. I will take anything that helps. I'm not proud" (Group D) and Isabelle "you just kind of read everything and then pick out what speaks to you really" (Group F). To extend the berrypicking metaphor, this presents a picture of individuals drawing not just on separate berry bushes of one type, but on a variety of different types of berries and merging them into their own unique interpretation, which was self-developed rather than following a set recipe.

It is important to note the emphasis on selecting what resonates, suggesting a confidence in their ability to choose correctly for themselves and a level of trust in their own judgement. They appeared to be testing information against their own experience and ideas, rather than against other criteria,

e.g., scientific evidence. It is possible that the demographics of participants in the study, who for the most part were highly educated, contributed to this confidence. This cohort may have had more confidence in selecting and assessing information and therefore felt more at ease with rejecting group beliefs that did not feel true to them.

The typicality or otherwise of this group is addressed in Section 7.9 on study limitations.

The forum post analyses

In the forum postings from Groups A and B it was difficult to see berrypicking in action as members rarely discussed the sources of their ideas in detail. What was clear in Group A was that behaviour that would be supportive to berrypicking was encouraged, notably tolerance, acceptance of others' ideas and an interest in listening to a variety of experiences:

> "Saying something different to what others have said doesn't mean anybody should leave. Quite the opposite. When we say what we really think we can learn from each other and understand each other better." (Kate, Group A)

Members encouraged newcomers to find what they could relate to: for example, Shaun recommended that Abigail "browse about and see what works for you". James added:

> "Make yourself familiar with the different threads, you'll find one for more or less anything, and spend some time reading here, post anywhere you like and most important of all, feel at home!" (James, Group A)

Emma advised Skye to "look round the many different threads and join in wherever you feel comfy". The emphasis was on reading a variety of material, finding the place where the person felt comfortable and picking out what spoke to them. There were also examples of picking and choosing amongst helpful tips for resisting cravings. For example, Myles pointed out a tip from Louise as "I found this bit especially helpful" and Iris selected networking as a useful tool: "that's definitely in my box". Some members used tools from Smart Recovery as well as from Group A, and others (e.g., Gerald) drew on AA ideas. However, whilst they showed tolerance, they also at times a) argued about their views, for example, on whether it was appropriate to express tough love; and b) sometimes found conflicting ideas difficult, as, for example, in the quotation below:

> "I'm having a hard time with the idea of drinking occasionally …Everyone defines it differently. For me it is, or ought to be, just when I'm out" (Courtney, Group A)

In Group A, members several times expressed, and once explicitly discussed, the phenomenon of cognitive dissonance, first proposed by Festinger in 1957. This is where two opposing beliefs or emotions are held at the same time, or where there is a conflict between beliefs and behaviour, causing distress to the individual. So, for example:

> "I wanted alcohol away from my life because it was ruining it, yet at the same time I needed it to cope. I really believed both at the same time and it was doing my head in." (James, Group A)

Examples of cognitive dissonance were rare in Group B and were not found in C, nor was it specifically mentioned by the interviewees.

Group B was very much geared to information seeking rather than support, with users drawing on a wide range of sources and being encouraged to 'do their research' and share knowledge. As was noted in Section 6.3.4 above, many of the threads were dedicated to a specific question requesting opinion, accounts of experiences or facts. Typically, other users would then give their ideas and share links to other resources, references or extracts from outside sources, so building up a collection of materials about the topic or co-developing a knowledge base (see Section 6.5.7). In a typical example, Lisa started a thread asking for people's experiences of going 'cold turkey' to help her decide what to do. She stated that she was: "Just assembling information, I have a doctor's appointment today, so will ask him too". She was given a lot of advice, accounts of experiences, and facts. However, (again typically) we do not know what she decided to do as she did not post again in the thread. Consequently, it was impossible to see what exactly (if anything) was selected and whether she berrypicked from different posts and outside sources and merged information together or selected one source to follow. Elsewhere, there was some evidence of berrypicking, for example, Theo in Group B described how he had learnt useful things from many different recovery programmes before settling on moderate drinking:

> "I did try out a variety of recovery methods and had some success but I'm just not happy leaving all alcohol and drugs behind. However, I did learn pick up some important tips on how to get a better grip on life." (Theo, Group B)

Group C was different again as its purpose was to provide support and information about a particular method, relying on the available body of scientific evidence about this, two experts and what had worked in practice for members over time. The moderators were a very visible presence, monitoring the information provided and intervening if suggestions or experiences stepped outside the current protocols. For example, in one thread extensive discussion took place on the importance of accurate information, when Rose asked for advice as to whether she should modify her dosage of the medication. Todd, another member, offered advice supporting this, suggesting a very low dose and the moderator, Poppy, then stepped in to disagree with him. She remained polite and supportive, but sought to explain why she was not happy with a change to the protocol, whilst still making it clear that she respected what the poster had to say in terms of his own experience:

> "It's the first time I've heard of someone maintaining using [drug]. It works for you, so that's great... And indeed, maybe in the future [amount of drug] may be found to be too much. But for the time being, when I help people with the method, I keep to it in line with [name of founder's] advice… The idea of someone changing how the treatment is done, away from the clinically proven method, makes me cringe. What I suggest to people is founded on what I know has been proved to succeed." (Poppy, Group C)

However, this did not seem to stop the process of deciding for oneself: Rose responded by saying that she would go ahead with her original idea of halving her dose and would report back. Todd and Poppy went on to debate sources of information about a low dose version of the treatment. The episode was notable for the respectfulness with which the argument was handled by the moderator, the amount of explanation of her advice that was given and also the extent of her checking of the resources mentioned by Todd. When asked by Todd to examine information sent by him, Poppy went to great lengths to do so, including following up the trials on which the article rested, as well as reading the article itself. It was both controlling in the insistence on drawing from the received source, which is not conducive to berrypicking, but also gentle in the handling of both Todd and Rose, leaving Rose ultimately free to choose what to do without any comeback.

The findings in Section 6.3 suggested that people interviewed for this research followed an information seeking process more like the berrypicking model than the traditional linear model of information searching, and this will be discussed at length in Chapter 7. To summarise, users' queries altered as their forum experience went on, they used a variety of information techniques to search

and a range of sources. They were not put off by conflicting ideas and might stay with a forum even if the majority view differed from their own ideas. Instead they took what felt true to them and left the rest: they berrypicked. However, the group's overall approach was important to most of them. What mattered the most was that the group either had a different approach to AA, or that it was supportive of the general direction they wanted to go, e.g., reduced drinking rather than abstinence. There were also observable instances of berrypicking in the post analyses of Groups A and B, but in Group C this was largely controlled by the moderators who encouraged reliance on the accepted sources / experts.

6.4 Information avoidance

It is important to note that, as well as seeking information in the forums, users sometimes also specifically avoided it. This section will focus on occasions where people chose not to receive information, or to question their representation, as these activities could be harmful to their recovery. Avoiding information in terms of not sharing it with those in authority is also seen in the forums, and this is a key problem in treatment as Young noted:

> "Drinkers, however, retain a high degree of agency in disclosing ''symptoms'' and the stigma associated with positive diagnosis provides incentive for them to minimize those symptoms or refrain from disclosing them altogether. Denial is therefore a logical, self-interested response to an identity threat." (Young, 2011, p386)

The interviewees

Discussion of users' drinking pasts (their 'war stories') or current heavy drinking was one form of information that might be discouraged by interviewees. Bethany described it and explained why it was unhelpful:

> "one thing I do, I personally actively discourage, and so do a few others, is when someone will come on and say, "Oh my god, I drank…a whole bottle of wine yesterday." And then there'll be a couple of people who'll say, "Oh that's nothing. I drink a bottle of vodka every day" …what you're doing is making those people that do drink a bottle of wine every day feel that they don't need to be there. And if they feel they need to be there, that's their business." (Bethany, Group D)

Some interviewees mentioned that they disliked drinking stories (e.g., Dawn and Christine, Group E; Theresa, Group F) but others that they had found them helpful either now (Joe, Group E, Cathy, Group C) or at the beginning of their time on the forums (Erin, Group F; Joanne, Group F).

Some interviewees avoided information if it formed a potential threat to their recovery, for example, Theresa:

> "I have to be careful, I have to protect my sobriety and if I read too much about failure it can be a struggle, it's not healthy for me…I don't want to forget about what it was like to be at the beginning, but I can't be constantly reading about the failures." (Theresa, Group F)

This implied a delicate balancing act between remembering the past in a beneficial way so that it acted as a deterrent to present drinking and enabled her to help newcomers (see Section 6.6.4), and not dwelling on it too much, but focusing on recovery and the present. Similarly, Alan partially withdrew from Group D because:

> "I've found that…moderation is not a solution for me, and that reading stories and helping people maintain moderation made me think that I could or should do moderation as well and I simply don't have that willpower and can't." (Alan, Group D)

This suggested a need to be predominantly in an environment that supported his goal of abstinence, to avoid being influenced by what others were doing. Moderate drinkers threatened his representation of problem drinking, specifically his chosen coping mechanism. As previously noted, Cara did not want to dwell on the definition of a problem drinker, as this would have encouraged her to question whether she was one. The repetition of 'and' in the sentence below gives the effect of Cara piling up evidence to persuade herself:

> "if I start getting into the what is a problem drinker then [pause], I start to question myself almost, if that makes sense... But I suspect [pause]--, I suspect I would end up back where I was at some point and I'm not prepared to take that risk, and it <u>had</u> got worse and, you know, all the stories that I see on sobriety forums where people test the water it ends badly, so I don't, I don't feel like I need to--, I know I'm a problem drinker." (Cara, Group F)

Smith-Merry et al. also noted a similar potential triggering effect in their study of a mental health OSG:

> "participants might need to establish and negotiate boundaries around how they used the forums, including allowing others to respond to certain posts rather than responding themselves or even staying off the forums, especially if they were feeling unwell" (Smith-Merry et al., 2019)

Other examples of avoiding information included Jackie (Group E) who felt that the causes of problem drinking did not matter and that people could focus too much on this: what mattered was dealing with the problem, and knowing why a person drank was just a distraction. Therefore, she encouraged newcomers not to dwell on it. Tina struggled with the genetics explanation for problem drinking, as to endorse it might make her feel predestined to drink and unable to overcome this:

> "the behavioural and societal is a much larger part of problem drinking. And, I, I feel like I have to feel that way because otherwise I would have no hope that I would then--, that I would, you know, not be able to conquer my own family history with alcoholism." (Tina, Group F)

This implied that exploring information about alcohol and genetics could have been a potential threat to her sense of self-efficacy, affecting her beliefs about the controllability of problem drinking. Her explanation of cause is deliberately adopted as a safety mechanism supporting her recovery.

The forum post analyses

In Group A, there was much discussion of avoiding certain thoughts (e.g., the idea that moderate drinking is possible or that one drink would be nice) or learning to manage them (e.g., distracting one's thoughts away from drinking, questioning the likelihood of happy outcomes to having 'just one drink', not dwelling on relapses). There was little about avoiding information. Andrew suggested taking a break from the site as "reading about someone else relapsing kind of justifies me drinking, a little bit" which echoed the concerns of interviewees Theresa and Alan, above. Similarly, Primrose had to avoid listening to a particular download that spoke about moderate drinking, as it led her to plan to try this herself.

Rosemary, in contrast, described avoiding recovery information at a time when she really wanted to drink, indicating that avoiding information can be a warning sign:

> "Have read a lot of recovery material recently, and on the whole have found it helpful, perceptive and honest (sometimes brutally honest). But now, when that would actually be most helpful to me, I'm resisting reading it." (Rosemary, Group A)

Group B also had discussions of managing thoughts, and also of being in denial and refusing to listen to good advice or accept feedback about the self (Ophelia generalised denial as "the number one characteristic of almost all alcoholics"). Avoiding information in case it threatened the achievement of recovery goals was not discussed in Groups B or C.

6.5 Information sharing

6.5.1 Introduction

Information sharing is defined as incorporating:

> two major aspects: providing information to others to be shared, and receiving information that has been given for this purpose" (Savolainen 2011, p865)

Receiving information has been dealt with in the previous section, so this section will focus on providing information to others.

6.5.2 General findings: the interviewees and the forum post analyses

Information shared by users, both the interviewees and those within the forums analysed, included: advice and opinions; user accounts of their experiences; facts of different types; quotations from outside materials, and links/ references. Research has shown that experience is a highly valued form of information in discussion forums (Savolainen, 2011; Chuang & Yang, 2010) and this was also the case here. Isabelle described what was shared as "anecdotal evidence rather than preaching and dogma quoting" (Group F), and Cara saw this as a norm of the same group: "we're more supposed to share our experiences rather than specifically 'telling each other what to do'." For Christine the main benefit of her group was shared experience:

> "You say something and you get a response, you get human there, the shared experience, it's real. Not slogans or books or pictures or, you know. There's all that, we share that but that's not the core" (Christine, Group E)

As was shown above in Section 6.3.2, much practical information around coping mechanisms, i.e., tips and tools for recovery, was shared in the forums. It would not be correct, however, to assume that information of other types was not valued. For example, many references and quotations were included from scientific articles and books of many types, and these were appreciated: for example, interviewee Erin obtained the reference to the book that changed things for her from her group.

> "the book I read which really, really changed me was Jason Vale, and they'd recommended it on their website and I read that book and I--, it really resonated with me…like no other book ever has" (Erin, Group F)

Thanks for references and praise for non-experiential material was found in post analyses from all three forums, for example: Alice and Robin thanked Rosemary for an "excellent" article (Group A) and Group B Post Quality Reviews often praised quotations and facts. Experiential information is ultimately not fully separable from theoretical information as experience influences ideas: the image of problem drinking depicted through the accounts of member experiences could lead individuals to reinterpret their ideas about the nature of 'problem' and 'normal' drinking.

Information was passed among users in different ways including as direct answers to questions, in disagreements and debate, through role modelling, in the form of mantras and sayings and as anecdotes and stories. These information behaviours were found in all three sets of forum postings analysed and were mentioned by many interviewees. The latter all stated that they used, or saw used, the following in their forums:

- Questions and answers
- Stories and anecdotes
- References and links (with the exception of Bethany)

Table 6.8 indicates the number of interviewees using different ways of conveying information and the groups in which they were found.

Table 6.8: Ways interviewees exchange information

Ways of exchanging information	Total number of interviewees	Groups found in
Asking and answering questions	22	A, C, D, E, F
Telling stories	22	A, C, D, E, F
Providing references & links	21	A, C, D, E, F
Telling anecdotes	19	A, C, D, E, F
Role modelling	18	A, C, D, E, F
Providing slogans & mantras	16	A, C, D, E, F
Disagreements	13	A, C, D, E, F
Advice giving & instruction	9 (but qualified by many e.g., 'if asked', 'on request', 'suggest')	C, D, E, F

The remainder of this section will explore some of these ways of communicating, firstly in the interviews and secondly in the forum postings. **Please note: advice giving and instruction are dealt with in the sections on stories and disagreements.**

6.5.3 Disagreements

The interviewees

Disagreements can be useful to examine as they illustrate clashes of ideas and may lead to participants changing their beliefs. Whilst thirteen interviewees agreed that disagreements took place in their forums, several of them qualified this, saying, for example, that it was done "in a friendly way…non-confrontational" (Cathy, Group C), that the forums were "generally pretty friendly" (Jackie, Group E), and that disagreements were less frequent than in AA (Robert, Group F). One interviewee felt that disagreements were not to be avoided: "it's OK to have a healthy argument or healthy, you know, challenge people" (Erin, Group F). Individuals from three of the groups with moderators (Groups A, E and F) commented that the moderators usually stepped in to sort out problems with arguments. In Group D there was no moderator and the two interviewees viewed this as problematic to varying degrees. Alan stated that it brought "challenges" and implied that it led to more name-calling because of the medium involved:

> “I can't look in your eyes and have you tell me that I'm a piece of crap or whatever but it's really easy to type that on a keyboard and shoot it off to nowhere or into space” (Alan, Group D)

For Bethany, the absence of moderation had led to a situation where she felt pushed into the role herself by other members. She experienced this as being oppressive and as limiting her freedom to say what she thought:

> “I've been told that I am one of the peer leaders and role models. And I don’t like that. At all… [it] means I don’t get to be a user” (Bethany, Group D)

According to her, the members had to deal with arguments, flame wars and trolls themselves. Interestingly, members of Group C were particularly reluctant to admit there could be disagreements in their discussion forums and all saw it as a very respectful and supportive environment, where people disagreed only a little in a friendly way. There could be varying explanations for this: it may be that this reflected the strong moderation and there were actually few arguments allowed. It could reflect the way that the moderators modelled disagreement when contradicting users (as described above, Section 6.3.5). Alternatively, it could be that, because of its promotion of one treatment to a set protocol, it did not allow room for alternatives so that, as Cathy put it: “I don’t know that anybody would waste their time in there” arguing against the treatment. The small size of the group may have supported familiarity and mutual friendliness, or it may be that the group attracted those with a high level of netiquette. Julie contrasted Group C with Group E as it had been when she used it:

> “There is a little bit of disagreement occasionally, but it's often couched in a way that's kind of pleasant…Whereas, as I said, [Group E] is a completely different forum, there you were disagreeing and some people weren’t so nice” (Julie, Group C)

However, Ben admitted that the moderators did become uncomfortable about posts with medical advice in them and that they did, as he described it, “squish” these, and Marianne acknowledged that:

> “No one is ever going to say, “Well it's just my opinion, but you know I really think you should always take your [medication] before you drink.” I mean there are some things that yeah, there is like ‘don’t’.” (Marianne, Group C)

She then qualified this saying the moderators were not autocratic and always used a respectful tone.

The forum post analyses

There were two lengthy arguments in the forum postings from Group A, which were on similar issues. The first in Thread 1 was concerned with tough love and its desirability, provoked by an individual (Fraser) apparently leaving the group after being challenged. Marika brought in a second emergency thread (Thread 2) saying the fact that Fraser posted there meant that challenging him was the right thing to do. This was contested by Ozzie who distinguished between the nature of the threads:

> “i haven't referred to anything written in [Thread 2]! (where did you get that from) and you will hear hard truths on there obviously. Am replying from the point of view of this thread and how [Fraser] wasn't ready to be challenged” (Ozzie, Group A)

This is interesting as it implied different modes of posting were considered appropriate for different threads: Thread 1 was a place for Fraser “to write about his follies” (Denise), whereas Thread 2 was for serious emergencies and frank talking. This illustrated what Kate described: “every thread generally has its own "vibe"”. As well as the acceptability of tough love, the argument touched on the issue of abstinence versus moderate drinking as coping mechanism, with Marika claiming that abstainers were being “chastised”. The second argument, which started two days later on Thread 3, was in some ways a continuation of the first, being prefaced by explicit references to the first argument:

> “I lurked and read some messages on other threads where people were asking if [Group A] had altered, and was "enabling" its users to drink.” (Chloe, Group A)

This shows the fluid movement of individuals and ideas between threads. The second argument illustrated some distinctive points about the group and is therefore described here in full. The first post by Ozzie enthusiastically endorsed the group as a family helping one another:

> "that's why [Group A] is here…We're all in this together!..everyone here… we're joined together, we are all family, we help each other" (Ozzie, Group A)

However, a subsequent poster, Holly, took exception to the inclusion in this group of a certain category: "the [people] that don't want to stop [drinking]". Later her words were interpreted by another poster, Denise, as showing a desire to exclude those who wished to drink moderately rather than abstain. Despite the fact that the site officially endorsed moderation as a viable goal, Denise argued that, in practice, pro-abstainers took over threads and criticised those who wished to drink moderately, effectively driving them out. This suggested a serious tension in practice around coping mechanisms, between those who viewed abstinence as the only way and those seeking moderation in drinking, with both sides feeling attacked. In Thread 1, abstainers felt chastised, and in Thread 3 the moderate drinkers felt the same. Denise was supported by Ann, who said that she felt bullied by the abstainers. This was a long way from the group's usual atmosphere of support and encouragement. Holly apologised, but Ozzie re-entered and gave a very different view of the forums to the one expressed previously by him, describing a divided group:

> "there is an element like a pack that goes from one thread to others having their safety in numbers! A Freudian interpretation would be that there's deep routed insecurity there around staying abstinent. This shows up in actions like blatantly ignoring posts, being really harsh to some people and not others, creating factions because of rigid, one-way-only belief systems. Massive intolerance of opinions that do not fit in with theirs." (Ozzie, Group A)

It is interesting that two such opposite portraits of the group were put across in the same thread by the same person only 18 hours apart, according to the time of the posts. It could be speculated that this was for immediate effect and sympathy, with Ozzie constructing an account of the group in terms of what he thought people wanted to hear at that particular point in time. Which of these views (if either) Ozzie actually believed was impossible to tell and it highlights the importance of not assuming that what is posted reflects what is actually believed, or that what is said at one point may necessarily be endorsed at another. It would also be interesting (subject to ethical considerations) in future research to link what is said by the same person in interviews and in postings to explore how far the two sources contradict or support each other. This might clarify occasions where it appeared that the poster had altered his/her thoughts to suit the site.

This was the apex of the argument. Subsequently it was resolved with apologies, putting it down to a misunderstanding, further explanation and a hug emoji. Denise reported having been stressed for a day for posting such a critical "rant", suggesting again that supportiveness was the norm and she had acted outside of this. She went on to strongly encourage all to post on the thread, whatever their goal and later on described her own behaviour toward Holly as "horrendous". However, it is worth noting that she did not change her position as to what was happening in the group, endorsing Ozzie's Freudian interpretation, and describing some threads (not the one where this argument takes place) as feeling 'cliquey'. Holly and Ann both expressed great relief that they had not fallen out and the customary supportive atmosphere was resumed.

These two disagreements were interesting for, firstly, questioning the prevailing view of the forum as supportive. Secondly they showed the fluid nature of usage of the threads in practice, with people and debates shifting between them. They both described and demonstrated fluidity of movement between threads, as what happened on one was taken up in another. However, this could be seen by members as potentially problematic:

> "I saw (and I've seen it in the past too), replies to posts in a particular thread being posted on a different one and the posts being contradictory to the aim and nature of the second thread. Then other people join in and it leads to a row or debate about their being opposed to the thread's nature in general." (Denise, Group A)

This implied that a norm of the group was that individuals should respect the purpose of the threads and chose carefully amongst them according to their needs, and that importing information (as, for example, that about Fraser above) from one thread to another might not always work successfully. Thirdly, the disagreements emphasised emotions and how the participants felt about the situation. They were also noteworthy for the amount of apologies and apparent dislike of arguing. Lastly, in terms of the disagreements changing ideas, Ozzie stated that he came to understand Marika's position better, but the focus was more on resolving the argument through apology than on changing minds.

There were at least seven arguments in the sample threads selected for Group B, of which two were of particular interest in illustrating the site's values and norms around seeking information. Both appeared to provoke considerable anger in the participants, usually directed at irresponsible and dangerous attitudes towards alcohol. In the first argument, this was described as a theme of "macho

boozy braggadocio". The argument started when Griff asked what he could use to stay awake longer when drinking. He rejected "pussy shit" suggestions such as drinking more slowly and suggested smoking or using drugs as a possibility. John suggested some drugs but condemned mixing drugs and alcohol as "irresponsible". His post received the comment "against harm reduction" (whether this was meant as criticism for the combinations suggested or as supportive, backing up John's comment on irresponsibility, was not clear). Nevertheless, the message was given that responsibility and safe practice were valued in this thread. Other posters went on to deal with Griff in a variety of ways, including some who condemned him harshly and angrily. The only indication that the forum has changed his ideas is that he said that he would take up the idea of using caffeine pills (which was gently suggested by Caleb).

Within the thread there was also a subsidiary argument between John and Mark about the unhelpfulness of exaggerating amounts drunk. In contrast to the first argument, these two posters talked their issue through, with Mark explaining why he got angry and eventually apologising. He acknowledged John's good intentions and asked if John understood his point of view. The difference in the two arguments within this thread seemed to be predominantly caused by the different attitudes of the offending posters: Griff taking a frivolous attitude to excessive drinking, whereas John's was serious, using his drinking as an example of what not to do and explaining himself at length. The difference may be explained ultimately as having arisen from the members' shared representation of harm reduction as the best coping mechanism to avoid problems with drinking.

The other notable argument was actually a set of mini-arguments, again about irresponsible use of alcohol *viz* injecting it. Here it was interesting to contrast responses to the original poster William (e.g., "Are you joking?", "you do have to question the intelligence", "that's just really stupid") who was contemplating experimenting on himself by injecting whiskey, with the responses to Zachary who asked about it from a more theoretical angle:

> "I've seen people saying "don't inject alcohol" often, but what's the reasoning behind it?... [I] can see it wouldn't be wise to inject [types of alcohol] or anything not pure, but what about stuff that is just pure alcohol?"

The Post Quality Reviews described this as "a good question" perhaps because it appeared to show a quest for knowledge. This was in line with what the site presented itself as there for: sensible but open discussion of drugs and alcohol, where there was no recovery agenda other than harm

reduction and managing the use of drugs to achieve pleasant effects. In this we do see a poster changing their coping mechanism, in that Kristen decided not to inject alcohol.

Group B was considerably more negative and harsh than either A or C in its disagreements. Savolainen suggested in an article on the criteria members use to judge the quality and credibility of discussion forums that more negative posts than positive are posted in them because of cultural norms:

> "Internet discussion forums tend to emphasize the role of disputational discourse questioning rather than accepting the views presented by others…The cultural norms of online discussion lead the participant to think that messages indicating "me toos" are unnecessary because they just waste bandwith and attention" (Savolainen 2011b p1243, p1250)

Health online support groups are usually very different with the provision of support, comfort and reassurance being at least as important as the provision of information. It is possible that Group B's emphasis on information rather than support opened a space for aggression when the site's norms were seen as being violated. The dominance of men within the group might also be seen by some as affecting this, leading to a less sensitive, more forthright way of speaking.

Whilst there were points of difference amongst members/moderators of Group C, and accounts of differing experiences, there was only one lengthy argument in the sampled threads. This was between Todd and Poppy, and was discussed above in Section 6.3.5. The style of this was polite, non-aggressive and respectful. (It should be noted that this was another example of drawing on a discussion from a separate thread, as Poppy illustrated how she usually corrected possibly inaccurate information by referring to an example from elsewhere.) This would support Group C interviewees' assessments of their site as having little disagreement: it was there, but was handled in a very different way to the forthright, sometimes aggressive, nature of Group B, or indeed the distress at disagreeing and emphasis on emotions in Group A. Both participants in C were open to having their positions challenged and sought to understand one another's views: Poppy conceded that Todd may be proved right in the long term, and Todd followed up links sent, encouraging Poppy to send more and expressing respect for her personally.

6.5.4 Role modelling

The interviewees

Role modelling signified individuals acting as role models and conveying their ideas and advice to others by modelling them. Both Wang (2010) and Smith-Merry et al. (2019) have noted role modelling as a function of peer support provision in groups and Bandura noted that "observing the performance of others" could lead to improvements in self-efficacy (1982, p126). This was touched on in Section 6.3.4 on user search techniques in the sense of looking for role models as one of the ways by which people might structure their searches. Eighteen out of 22 interviewees from all five groups felt that they had found role models in the forums. Jackie described how this came about for her:

> "I looked [from the start] and saw that there were people who'd been on the list for more than, you know, 1000 days, and that was like "OK, you know I want to be like you, I wanna…know how you do it, and I wanna be like you…I know that when I would post a question or a comment and they would respond I would really pay attention to what they said" (Jackie, Group E)

Whilst becoming a role model would generally happen passively, i.e., people were not apparently setting out to be one, it was occasionally seen as deliberate:

> "you can see some people you know, almost creating a persona, yeah, where they become a role model. And there are a couple of people who do that and it's really--, it's lovely." (Joanne, Group F)

Joanne liked this, as it both helped her and worked to support the person themselves, reinforcing their recovery by introducing an element of accountability in the need to live up to the persona created. However, there could be negative sides to role models: they could cause envy or irritation:

> "there was a woman called [Gladys], right, and she was one of those, she was on all the time and [Gladys] this and [Gladys that and everybody talking about [Gladys], and [Gladys] wrote a book, and you know it's almost like you think 'fucking [Gladys]!" (Erin, Group F)

Erin (and others) also pointed out that if a role model had a relapse that could be taken as giving implicit permission to drink. Generally, however, interviewees stated that they felt role models to be

helpful and inspiring, impacting on their representations by showing that recovery was possible. The following was typical:

> “having role models and people that you really admired was quite a big thing really, because you’d think, "Blimey, you know if that person has come from there and is now here it makes it possible for anybody"” (Anna, Group A)

Interviewees also implied that they saw negative role models when they spoke about watching others they identified with over time and saw what did not work for them, so they knew what to avoid as well as what to emulate. In three cases, interviewees felt that they were looked up to as role models, (Bethany & Alan, Group D; Marianne, Group C). Roles could vary on different sites: Julie rejected the concept of role models but stated that she had taken the role of ‘thought leader’ in the past in Group E but did not do so with Group C. Generally, those with more experience of recovery or length of time on the site were those who were seen as role models.

The forum post analyses

Both positive and negative role models were identified in the Group A forum postings. The positive ones were sources of inspiration and chiefly admired for their recovery achievements. In two cases, their supportiveness and the fact that they did not pressurise others to follow their ideas was also mentioned. Role models were usually other members of the forums rather than external people and posters were quite open about identifying someone as such:

> “[James] and [Oliver] write some of my favorite posts, and they are good at trying to persuade us that a life without alcohol is actually much better. They don’t pressure us just act as good role models.” (Denise, Group A)

This indicated that a role model could work to influence a person’s representation, here specifically the coping mechanism to be chosen (i.e., abstinence). Marina indicated how she would use Martha as an example to inspire her in a difficult situation:

> “I shall think about you tonight when I'm at dinner with my mates and I’ll try to be strong like you!” (Marina, Group A)

Ozzie pointed out the value of negative role models:

> "Hearing about your daily life problems [Fraser] acts as an example of alcoholism that other members can reflect on. Your trials help others here." (Ozzie, Group A)

He held those like himself who were still drinking as examples to help those who were sober, reinforcing their ideas by reminding them why they abstained. Oliver also presented himself explicitly as a negative role model and, through this, he found purpose in his suffering:

> "I want to alert others here about all the varied health issues …. I 'd like others to use me as an example of the permanent suffering problem drinking can bring." (Oliver, Group A)

By setting himself out as an example, he was drawing attention to what for many might be new information about the health consequences of problem drinking. Posters could then include this in their representation (and hopefully allow it to influence their coping mechanisms). However, as was noted by Erin and others, negative examples did have risks: Andrew pointed out that reading of others having slips "justifies me drinking, a little bit".

In Group B, similar effects were found. Both negative and positive role models were used, sometimes explicitly: John, for instance, set his drinking past out as a "point to encourage Griff away from alcoholism". He explicitly held himself up as a model not to follow. Occasionally a poster was described as an inspiration to another member, and as altering their thinking:

> "Your story is inspiring – I've thought about trying [name of medication]. Thank you for the post." (Anonymous, Group B)

The Group C posts were somewhat different: role models were not explicitly talked about, and the 'heroes' of the site were those who were expert in the method such as its inventor, the site's founder and its medical advisor who was also author of the definitive guide to the method (known as "the book" by members and described as "essentially, the Bible for [the method]" by one of the moderators). The moderators were often talked of admiringly and deferred to: "Your advice is CRUCIAL as always, Miss [Poppy]" (Rose). They could also be described as role models, however, there was perhaps less a sense of 'I want to be like them' than 'I want to hear their advice".

6.5.5 Mantras

The interviewees

Many interviewees reported that mantras, in the sense of repeated slogans or statements were found on the sites, encapsulating key elements of their ideas and used by many of their members

(for example, Groups E and F had KOKO – Keep On Keeping On which encouraged perseverance and not giving up, and Group D had a unique motto signifying that any improvement was welcome and encapsulating its attitude of tolerance). Opinions varied as to whether conveying information via mantras/slogans was helpful or not: it was sometimes viewed as being too similar to AA and as avoiding real thought and expression:

> "[AA is] too [pause] insistent on slogans and on, [pause], non-thinking, on, on believing but not analysing" (Ariana, Group F)

Joanne (Group F) felt slogans could be "cult-like", Erin (Group F) saw them as "trite little comments" and Robert as "clichés". Cara (Group F) and Bethany (Group D) amongst others, on the other hand, saw the mantras as helpful, encapsulating useful wisdom and easy to remember in a crisis: "these are soooo helpful for snappy reminders when you're struggling" (Cara, Group F). They appeared to be more important for reinforcing messages or reminding people than changing representations. Sometimes they were a form of short-hand rather than being inspirational, for example, Group E members often mentioned being "by the chapter" which meant they were following the site programme for recovery. Some interviewees also mentioned as mantras the sayings or affirmations placed after member signatures to convey an inspirational or thought-provoking message. Ariana (Group F) characterised these as: "something people enjoy saying for themselves and then other people can take it on if they like".

The forum post analyses

Signature mantras were frequently seen in the forum posts analysed for Group A, with many members adopting their own to entertain, remind, affirm or inspire, for example:

> "I want to be the best person I can be" (Robyn, Group A)
> "The answer isn't at the bottom of a glass" (Ian, Group A)
> "On and up again" (Taylor, Group A)

It was not possible to determine if there were mottoes that crossed the group as a whole, but certain phrases did repeat within the extracts analysed, for example discussion of "tool boxes" full of tips for coping with cravings and difficult situations, the 'Wicked Alcohol Elf' which appeared to be unique to this site, and 'You're worth it' adopted from L'Oréal hair care advertising (Bertha, Caroline).

Group B members in the extracts analysed did not appear to have signature mantras, or slogans. These were only used by two posters in the extracts analysed from Group C, which had its own vocabulary in terms of shorthand for aspects of the method and the preferred medication.

6.5.6 Stories and anecdotes

6.5.6.1 Definitions of stories and anecdotes

Wang (2010), citing Preece, indicated that personal stories were one of the major message genres found in online health support groups generally. Storytelling has been defined as occurring when a story-teller:

> "takes a listener into a past time or 'world' and recapitulates what happened then to make a point, often a moral one" (Riessman,1993, p3)

> "[Story-tellers] recount the events of their lives and narrate them into temporal order and meaning" (Sandelowski, 1991, p. 161)

Both definitions indicate three elements to storytelling: events or actions, a temporal element or sequence to these, and meaning, or how the person makes sense of what happened, what the point of the action is and therefore why the story has been told. An anecdote is similar but focused around one event or incident. It is a brief account of an episode or event that is told to illustrate a point, or as Steffen described it in relation to AA: a "small pedagogical tale with an implicit moral". (Steffen 1997, p107). Stories and anecdotes are discussed together as the dividing line between them is not always clear.

Stories were shown in the literature review (Section 2.7.1.1) to be particularly important in conveying AA's messages and teaching new members how to become 'non-drinking alcoholics'. This section will explore whether stories and anecdotes also had an important role in the non-12-step discussion forums and how they were used. It will show that story was an important mechanism for transferring information gained from personal experience, and that it played a range of roles within the groups.

6.5.6.2 The interviewees on stories

All of the interviewees had seen or used stories in the forums and most found them very helpful and important. For nine interviewees, stories were the most helpful method to them of conveying

information and advice, with Jackie (Group E) describing stories as "probably most of what goes on there [in the forums]" People learnt about aspects of problem drinking through these, for example, Alan (Group D) learnt about its consequences, Ben (Group C) about coping mechanisms, Cara (Group F) about causes in her own case, and coping mechanisms in general. Lessons were learnt through the accumulation of multiple stories illustrating the same message through the events recounted: for example, in this way Grace (Group F) became convinced that stress and menopause were causes of problem drinking, as previously mentioned. On the other hand, Christine (Group E) found that the variety of stories on the forum showed her that there were many different ways problem drinking could happen, leading her to a belief that anyone could become psychologically addicted to drinking.

Stories could support a number of functions: they could show readers that there were others like them and that they were not alone or 'crazy', thus supporting the theme of 'Someone like me' (discussed in Section 5.4), and working to counteract self-stigma and isolation. The relatability could draw people into the groups in the first place: for example, Cara (Group F) on reading the founder's story decided to explore Group F as: "I just thought "That is my story"." Recovery stories could also provide encouragement and inspiration, even stories that were not like one's own:

> "I think you can take a lot from, from all sorts of stories. To the people that have ended up hospitalised or homeless, or that you can't relate to [pause] but…you also think, if they've managed to get into recovery, everyone can…all stories have got something to give." (Megan, Group F)

Stories could change their views on coping mechanisms, e.g., Isabelle (Group F) "they make [abstinence] seem plausible, you know and believable, and actually quite wonderful rather than a punishment." For Alan (Group D), Ariana and Cara (both Group F) stories were good reminders as to why they were using the forum and trying to recover (contributing to the forum as a memory aid, see Section 6.6.4). They could form a helpful record from which a person could see progress, remember how bad things were at the end of their drinking, and also come to identify their patterns of behaviour and causes of drinking: for example, through telling her story, Cara realised that she relapsed as a result of hormone changes during her menstrual cycle. Grace found telling her story online therapeutic:

> "when I wrote it I could put it on paper, I could look at it and go, "That's it. That's my story, I don't have to live with that floating around in my head anymore". You hit submit, it's out there, it's not driving me crazy" (Grace, Group F)

She linked it with accountability, describing it as very different to writing a journal, as its online form meant others were seeing it, and so she had to take ownership of the story. (This contributes to the forums as places for accountability, see Section 6.6.2.) Stories were also seen as simply entertaining / interesting e.g., by Ariana and Erin (Group F) and Julie, (Group C).

Some discriminated between types of story, usually in terms of liking accounts of recovery and improvements in problem drinking, but not stories describing drinking per se, e.g., Bethany (Group D), Christine and Dawn (Group E), Erin and Theresa (Group F). For some, e.g., Erin and Joanne (Group F), stories were more important at the start of their time on the forums. Jackie stated that, typically, people shared their story when they arrived and after that only on request, if things were going well, implying a norm of modesty:

> "once you feel like you've got it under control and you've kind of shared that a couple of times, you don't keep doing it, because you don't want to sound like a bragger". (Jackie, Group E)

Anecdotes were discussed in the context of accounts of what did and did not work for people in terms of recovery as members used them to illustrate points they wanted to convey to the researcher e.g., Anna (Group A), Marianne (Group C), Bethany (Group D), Christine (Group E) and Theresa (Group F). Isabelle saw them as a key way in which advice was conveyed online: if someone on Group F stated that they thought abstinence was not for them:

> "people will sort of talk them through their own experiences really of like, "Yeah I thought that and then made the mistake of having a few drinks". You know there's a lot of sort of more anecdotal evidence" (Isabelle, Group F)

Robert (Group F) felt that, similar to stories, anecdotes could help people to realise that others have felt the same as them, and Tina (Group F) that they could help with handling difficult life situations as well as drinking-related issues.

6.5.6.3 The forum post analyses: posters on stories

Individual posters wrote about the effect and value of stories to them and many of these findings mirrored those found in the interviews. Firstly, the most important use of story in AA was noted in the literature review (Section 2.7.1.1) as the giving of "advice disguised as self-disclosure" (Lewis, 2014, p.10). This was also found in the non-12-step group posts:

> "I wanted to reach [Griff] with my story…and divert him away from alcoholism, I wasn't boasting about my boozing" (John, Group B)

John gave his drinking-story to draw Griff in, to capture his attention, and to show him what might happen if he continued with his problem drinking. Its success depends upon the reader identifying with John and because of this taking the advice. The notable difference from the AA structure is that here the writer is quite explicit in applying the story to Griff. Anecdotal evidence might be used instead of "preaching and dogma" (Isabelle, Group F) but, nevertheless, in practice, in all three groups, meanings were made explicit. These groups (unlike AA) allowed members to openly disagree, to advise and correct each other and to give feedback: they did not need to imply these through story. Stories could reinforce messages rather than having to convey them on their own.

Secondly, users often found stories to be inspirational, providing them with encouragement and motivation. All three groups demonstrated this, for example:

> "I like to hear success stories about people …I 've followed some posts and stories that …are really inspiring." (Carol, Group A)

Stories gave hope that a member could achieve the success that others had. This was especially the case for Group C, where users of the preferred method often experienced frustration at their lack of progress: "it's always encouraging to read about someone else's success, especially when you've been trying a long while." (Sophie, Group C)

Thirdly, hearing other peoples' stories could lessen members' sense of isolation, and of being unique in their drinking. This along with the encouragement mentioned above, helped to develop feelings of self-efficacy and strength in them:

> "the more we hear the stories of other people, the less alone we feel and the more we can draw strength from others. That's the beauty of [Group A]." (Bertha)

This reinforces the theme of finding 'Someone like me' analysed in Section 5.4. Fourthly, some might tell stories as a memory aid:

> "I'm so happy I don't do that anymore, but I have to remember it often, how awful it was" (Eleanor after telling her drinking story, Group A)

Fifthly, anecdotes and stories in Group A could act as a mechanism to provide a sense of group coherence, a sense of community. This happened when users shared stories that only members would appreciate and understand: this might be in terms of the story's humour, or its significance. For example, Brandon (Group A) told an anecdote about a colleague who advised him to deal with his drinking problem by purchasing fine, expensive wine and drinking less of it. He commented: "If only I'd come up with something so clever, huh? This is the kind of thing you have to deal with sometimes." Other members understood the annoying nature of this and responses included: "some of the things other people say are a bloody nightmare" (Anita, Group A). One gave their own anecdote of annoying outsiders This is also an example of venting annoyance – getting it out of the system in a safe environment. Group B did not have the same sense of community but, in Group C, the 'outsiders' were often the medical profession as so many of them did not understand the preferred method. Healthcare practitioners had to be 'managed' so that they would give users their prescriptions. Accounts of problems with the medical profession were often found amongst treatment stories in this group (see below on treatment stories).

6.5.6.4 The forum post analyses: types of stories identified

Stories and anecdotes were frequent in the sampled material with at least 98 identified. Story lengths varied, ranging from one sentence to many and at times were spread out over more than one thread. Sometimes a poster would post an account of what had happened very close to the time it occurred. For example, in Group A, a poster wrote for advice about an ongoing difficult situation due to her drinking on holiday with the family, whilst she was still on that holiday.

Four recurring types of stories were identified and their structure analysed. These were:

- Drinking and recovery stories;
- Moderate drinkers' stories;

- Experimenters' stories;
- Treatment stories.

Drinking and Recovery Stories

There were at least 11 drinking and recovery stories in Group A. Whilst no two were identical, there were common elements that appeared in many:

Table 6.9: Drinking and recovery stories: Group A structure

Element	Number of stories found in (out of 11)
Identification with a previous poster	5
Description of speaker's drinking at its worst, negative consequences, struggles with alcohol	10
Failed attempts at recovery	6
A turning point	5
How they achieved recovery	6
Current situation and how they felt	11
Not 'there' yet, i.e., where they wanted to be	5

This is a structure very similar to that identified by Coulson (2011) in relation to a 12-step OSG, where a story was typically given when a newcomer posted about their problems, and was accompanied by advice to the newcomer. It is interesting that this was identified as acceptable in 12-step online (as opposed to face-to-face) groups, suggesting that freedom to give advice may be more about group format than philosophy. This will be further discussed in Chapter 7. The difference was chiefly in the typical ending of the story where Group A members stated that they had not yet 'cracked it' in the sense of being where they wanted to be. Their drinking stories occurred for one of a few reasons: they might be sparked off by the teller identifying with a previous poster, the teller might be responding in some other way to a previous story or topic, they might be introducing themselves as newcomers (e.g., Elizabeth, Abigail), or they might be answering a specific question to them or a request for their story (e.g., Holly, Melanie).

In Group B, there were 15 drinking and recovery stories and the structure was typically somewhat different:

Table 6.10: Drinking and recovery stories: Groups B and C structure

Element	Number of stories found in Group B (out of 15)	Number of stories found in Group C (out of 9)
The start of drinking or problem drinking	11	6
Descriptions of drinking often focused on specifics such as substances and amounts	14	6
Descriptions of excessive drinking	15	6
Negative consequences of this	14	9
The remedy found or proposed	9	
How the person came across the recommended treatment		5
Experience of other treatments		6
Their hopes for or experience of the treatment		9

This story structure differed markedly from Group A and AA, apart from the focus on the negative consequences of drinking. Stories in B occurred to set the scene for requests for advice or to explain advice subsequently given (e.g., Angus, Amelia, Henry), to provide a warning to others (e.g., Griff, John) or as a response to a direct request (e.g., Deborah, Nicholas, Rachel). In Group C, the nine drinking and recovery stories followed the same pattern as in Group B, but usually continued into an explanation of how the person came across the recommended method and their hopes for it if they were about to start it, or experience with it if they had begun. They might also include failed attempts at other treatments.

Moderate Drinkers' Stories

These were found in all the sources and followed a formulaic structure that could be described as a community narrative. The following, from Group A, was a typical example:

> "Despite all I said and my boasting about beating drink I fell down once again. You all know the story. The start was innocent enough. Two beers at supper then the permission to drink thoughts started…Well, I slipped again and I wonder sometimes what on earth I'm doing. I like being sober when I am sober." (Greg, Group A)

"You all know the story" implied that the drinking pattern to be described was typical, following a pattern familiar to the community. The individual decided to try moderate drinking but this was inevitably followed by reduced control and escalation of drinking, which they found hard to understand as they did value recovery. This pattern was repeated several times in Group A threads, for example:

> "I thought I would let myself have a beer sitting outside and a glass of wine at dinnertime. When I came home I began having a bottle occasionally and that just took off (anyone recognise the pattern?)" (Martha, Group A)

Drinking often happened as a treat or on a holiday. It recurred frequently in the thread on planning for the future, with individuals (e.g., Eliza, Tim) expressing an expectation that one drink would in the end lead back to many:

> "For myself, I know - and always have - that if I let myself drink ANYTHING, whatever was happening, then I'd be back up to my old behaviour pretty quick." (Daisy, Group A)

However, this was not universally the case: Group A forums also showed four examples of individuals successfully moderating or being 'mostly sober' with the very occasional drink.

Group B had two very brief examples of the moderate drinker's story and, like Group A, it also showed examples of individuals who had learnt to successfully moderate their drinking. Group C contained one example of this story, and several examples of moderate drinking using the protocol. The structure was the same in all three groups. It was also touched on by half of the interviewees including Alan (Group D), Dawn and Jackie (Group E), Cara, Joanne, Tina and Yvonne (Group F). Again, in the interviews this is often recounted as a story seen repeatedly and as typical:

"I see it again and again and again on the site, I see so many people saying that they thought they had it under control, and they went away, and then they're back and they realise they're not in control" (Jackie, Group E)

The ubiquity of the Moderate Drinker's Story as a frequent community narrative in AOSGs is an original finding from this research, which has not been noted elsewhere.

The Experimenter's Story

These were found in Group B, particularly in the thread on injecting alcohol. They typically contained the following elements:

Table 6.11: The Experimenter's Story

Element	Number of stories found in (out of 13)
What the person did	12
Why they did it	8
Outcomes/consequences	12
Advice or a moral arising from the story	8

For example:

"SWIM [someone who isn't me] has injected different types of alcohol including some he can't even remember the name of. It was inspired by hearing about somebody doing this is in the Motley Crue autobiography…SWIM did this several times, including a couple of times when he'd shoot up several times in succession. SWIM noticed NO effects (and yes, he does know how to inject correctly.) SWIM's belief is – doing it is harmless. His experience is that it's completely useless and pointless, plus it could be dangerous if someone doesn't know how to inject correctly" (Chris, Group B)

The story began with what they did and why (they followed a celebrity example). They then described the outcomes (zero effects) and drew an explicit conclusion that injecting was both pointless and potentially dangerous. These kind of stories could provoke very strong reactions as they were often about something that was risky and went against the members' ethos of harm reduction.

There were no experimenter stories in Group A's posts, but there were seven accounts of experimenting in Group C, including one 'live' experiment with a particular form of the medication, in which the individual reported her experience to the forum as it was happening. These did not follow any particular structure, but always contained an account of what the person did or planned to do.

Treatment stories

Treatment stories were found in Groups B and C and were accounts of treatments experienced, together with their outcomes. These might be self-devised, informal treatments or formal ones from medical services. They included the following elements:

Table 6.12: Treatment stories in B and C

Element	**Group B: number of stories found in (out of 11)**	**Group C: number of stories found in (out of 19)**
Reason for describing the treatment	8	
Why it was needed	11	
What it consisted of, details of the treatment	11	19
What the outcome was	10	19
How they felt about it		16
Advice to others or request for advice		16

In Group C most related to the recommended treatment and how individuals were progressing with it, and several tended to merge with drinking and recovery stories.

Much research has been carried out on drinking and recovery stories, mostly in AA, but the present study suggests that there can be other story types with their own structures. It would be particularly interesting, in future research, to explore the moderate drinker's story as a community narrative in its own right as this was so commonplace in the present data.

6.5.7 Co-creating a knowledge base

This can be defined in different ways (see, e.g., Amann & Rubinelli, 2017 and Hara & Sanfilippo, 2016), but here it signifies when information sharing has the effect of co-creating a body of knowledge about a topic. (This is similar to Hara & Sanfilippo's category of "knowledge re-use" p1588). The shared information can then subsequently be used by existing and future users to find answers to questions. It may or may not have been an intended consequence of user participation in the forum, and occurs when a variety of them share information about the same topic, drawing on a range of sources including experiential information and/or theoretical and scientific material, including books, articles, other websites.

The interviewees

Using the forums as a repository of knowledge was mentioned by two interviewees. Christine (Group E) described how the forums differed from the listserv in being 'stickys', i.e., remaining permanently on the site:

> "everything that's been written there is there, posted there. You can resource that, yeah, there's tons of resources there …information from trial and error and what's worked for many individuals" (Christine, Group E)

Yvonne (Group F) described how she would draw on the knowledge store of the forums rather than ask questions online.

The forum post analyses

The process of co-developing a repository was most clearly seen in the forum postings of all three groups. To take two examples, a thread in Group B covered use of the drug Baclofen to treat problem drinking. The thread started with Abel's experience of using it, given for the express purpose of spreading knowledge:

> "Well I started this thread because I think that few people know about baclofen and its use in treating addicted drinking" (Abel, Group B)

He provided the background to his drinking, his reason for taking baclofen, why it was prescribed for him, his dosage, how the drug affected him and why he thought it worked. This post was highly rated by others with four comments praising it as, e.g., "useful", "an inspiration" and a "great

report". The thread proceeded with others adding what they had heard or read about Baclofen, and/or their experiences with it, both negative and positive. One poster provided a link to another discussion of the medication in a different thread on the site, another a link to an academic article and a separate website with accounts of using Baclofen. Nicola described another approach as an alternative to the medication, making the point that "I don't want to derail [Abel], but just to point out that there are other options as well." Overall, the thread brought together different sources of information and different experiences to provide a body of knowledge of different kinds about Baclofen, with a strong emphasis on its safety or lack thereof. There was no consensus or conclusion as to whether Baclofen was ultimately a good idea, with one poster strongly recommending it and another equally strongly advising against it. The reader could draw their own conclusions.

Another example from Group C showed users creating a body of knowledge about the comparative benefits and side effects of two versions of the recommended medication. Members responded to an initial question by pooling a wide range of experiences and information. This included drawing on sources outside the forum as the moderator decided to contact people in the pharmaceutical industry. One moderator decided to self-experiment by testing one of the drugs on herself and reporting on the experience. Links were posted for particular individuals to read, there was an explanation of NICE guidelines and the medication patient information leaflet, and many questions and answers provided information.

Summary of Section 6.5

This section has explored what types of information were shared by interviewees and forum users and what techniques were used to do this. Some of these were examined in more depth, specifically disagreements, role modelling, slogans and mantras, telling stories and anecdotes and co-creating a knowledge base. Stories were particularly popular and prevalent, and the presence of a pervasive community narrative, the moderate drinker's story, was noted for the first time.

6.6 Information-related activities

6.6.1 Introduction

The previous sections showed that the discussion forums of the six sites analysed provided a platform for seeking information and for sharing it with others, something that research has indicated occurs in many OSGs. Discussion forums can also act as a venue for many other information-related activities that affect aspects of users' representations, and these are dealt with in this section.

Analysis of the forum postings in the first part of the study indicated some information-related activities e.g., using the forum as a place to plan, to get therapy and/or to remember things. These were then explored with the interviewees, and they were also asked if there were other functions the forums performed for them, which led to several additions. The forum postings were then re-examined for instances of the new activities mentioned by the interviewees. The findings are set out in Tables 6.13 and 6.14 below and are discussed in the subsequent sections.

Table 6.13: Interviewees' ways of using the forums

The forum as:	Group A members agreeing	Group C members agreeing	Group D members agreeing	Group E members agreeing	Group F members agreeing	Total no. agreeing*
Venue for planning	Anna	Cathy	Alan, Bethany	Christine, Dawn, Jackie, Joe	Ariana, Cara, Grace, Isabelle, Joanne, Megan, Theresa, Yvonne	16/22
Accountability tool	Anna	Ben, Cathy, Julie, Marianne	Alan, Bethany	Christine, Jackie, Joe	Ariana, Cara, Erin, Grace, Isabelle, Joanne, Megan, Theresa, Tina	19/22
Venue for therapy	Anna	Ben, Cathy, Julie, Marianne	Alan, Bethany	Christine, Jackie, Joe	Ariana, Cara, Grace, Isabelle, Joanne, Megan, Robert, Theresa, Tina	19/22
Memory aid		Cathy, Julie, Marianne	Alan, Bethany	Dawn, Jackie, Joe	Ariana, Cara, Erin, Grace, Isabelle, Joanne, Megan, Theresa	16/22
Lifeline	Anna	Ben, Cathy, Julie, Marianne	Alan, Bethany	Christine, Dawn, Jackie, Joe	Ariana, Cara, Erin, Grace, Isabelle, Joanne, Megan, Theresa, Tina	20/22
Celebration venue	Anna	Ben, Cathy, Julie, Marianne		Christine, Dawn, Jackie, Joe	Ariana, Cara, Grace, Isabelle, Joanne, Megan, Robert,	19/22

					Theresa, Tina, Yvonne	
Venue for becoming politically aware around drink-related issues	N/A**	Cathy	N/A**	Christine, Joe	Ariana, Cara, Grace, Isabelle, Joanne, Megan, Robert, Theresa, Tina, Yvonne	13/22

*Indicates the number of interviewees who had either carried out the activity in the forums or who had seen others do so

** Not asked

Table 6.14: Ways of using the forums observed in the posts analysed

The forum as:	Observed in Group A	Observed in Group B	Observed in Group C
Venue for planning	Y	Y	Y
Accountability tool	Y	N	Y
Venue for therapy	Y	N	N
Memory aid	Y	N	Y
Lifeline	Y	Y	N
Celebration venue	Y	Y	Y
Venue for becoming politically aware around drink-related issues	N	N	Y

6.6.2 Planning and accountability

The interviewees

Using the forum as a venue for planning signified that members used the forum to describe an issue or situation and either ask for ideas on how to deal with it, or propose what they planned to do about it, sometimes with a request for feedback. They would then usually receive feedback on their plans and suggestions of what to do. Anna summarised the process:

> "I would go on there and say "Right I've got this, whatever it be event coming up, I don't know how I'm going to handle it" and they would…other people would sort of plan a survival strategy" (Anna, Group A)

Christine (Group E) described using the forums for both planning around drinking-related issues, and around larger plans for her life overall. Several users including Bethany (Group D) and Dawn (Group E) described how people would encourage each other to make plans, rather than relying on hope to get through something:

> "when people say, "Oh this is happening and I hope I don't drink too much… people say, "No, no, no, hoping is not going to do it for you, you need a plan." (Dawn, Group E)

Using the forum as a place to set out, obtain ideas for, and obtain feedback on, their plans affected users' views on the coping mechanisms available to them and could change or confirm these. It also affected their perceptions of problem drinking's controllability, as potential solutions were found, or reinforcement was obtained, for the solutions they suggested.

Planning was also linked with accountability:

> "it's something that [Group E] encourages strongly is that you make plans and not only do you make plans but that you share them with people, so that you have some accountability." (Jackie, Group E)

Interviewees were asked whether writing in the forums made their goals feel more real and themselves more accountable to the group for them, and many identified this as a key function. What they wrote there (in contrast with a diary, for example) was witnessed and could be followed up by others. Bethany described how accountability worked:

> "It's where you're not calling people out, but saying, "Oh, what happened with that plan?" (Bethany, Group D)

Members asked about plans and then, if unsuccessful, encouraged the person to explore why they had not worked, helping them to identify patterns and relapse triggers, so aiding future planning. In this, it not only helped with developing coping mechanisms and regaining a sense of controllability, but also with identifying personal causes of drinking.

Whilst Joe saw this accountability as a motivator, Erin identified a negative aspect to being accountable to the forums, saying it might lead to individuals leaving them:

> "by saying it out loud it's like, you know, "I'm gonna, I'm not gonna do this", and it makes people carry on sort of like, or so either they have to leave the forum because they're too embarrassed to go back on…but I suppose that's the same for all groups but I certainly think the accountability's a massive thing if you are posting" (Erin, Group F).

The forum post analyses

Posters in all three groups used the forums as a planning tool, particularly as regards coping mechanisms for difficult situations of various types. A great deal of the planning in Group A was about handling situations in which people would normally have drunk, as, for example:

> "am having lunch today reuniting with some friends from school...one I haven't seen one for decades and the obvious thing would be to have a glass of bubbly together to celebrate. But I won't: I'm going to say I'm driving (in reality I've lost my driving license)." (Martha, Group A)

As was noted above in Section 6.3.4, Group A encouraged an orientation towards setting goals and planning through its structure in that several of the threads available invited the user to think and write about what they wanted to achieve. Planning may be an example of the site's philosophy in actions: its information pages offered a clear representation of problem drinking as a learned habit, used by people to help them deal with difficult situations or emotions, and best treated with CBT. As presented on the site, this therapy was seen as involving self-exploration, focusing on reasons for drinking, on goal selection and planning, e.g., "you must foresee probable triggers for drinking, so you can make plans for dealing with them" (Information Sheet 1, Group A). Members rarely mentioned CBT in their posts, but they often talked about planning and its importance:

> " Putting plans like this in place massively changed things for me, at the start of my sobriety'' (Kate, Group A).

> "All the planning you're doing is very good – you're putting lots into it. It will help you so much to cope with things without alcohol" (Alistair, Group A).

Members encouraged one another to set goals and make plans, made suggestions for what to include in these, supported, praised or critiqued each other's plans, set out their own plans and reported back on how these went. On occasion, the act of arriving at a plan was shown 'live' in the forums. For example, Eliza discussed what she should do about attending a wedding and participating in the toasts at it. First, she considered and dismissed trying to moderate, then introduced another strategy only to argue against it herself, writing in a style that implied thinking aloud:

> "Oh, I just had an idea – I could tell the people getting married that I'm teetotal now, but want to join in toasting with something fancier than juice – yes! But that could imply I'm alcoholic. Do I care? What I'm really thinking is if I have one, and say 'no more, thanks', I'll appear to be a normal drinker. Ha! I know I'm not so why am I fooling myself?" (Eliza, Group A)

Here the forum was being used as a practice site to test out different courses of action and their implications, moving back and forth between the pros and cons. Eliza then received feedback about her ideas from two other posters including praise for a possible solution suggested, and identification with the dilemma. She thanked them acknowledging that: "I sort of knew anyway what I should do but I needed to think out loud". Another example of this occurred when Courtney debated whether to aim for abstinence or moderate drinking. Again, this recorded the movement of thoughts behind the planning, apparently as these are encountered by the thinker, ending with a resolution to 'just get on with it'.

In the Group B extracts, planning was observed around coping mechanisms for managing cravings, anxiety or withdrawals: e.g., Ken requested views about his plans to manage anxiety using alcohol, and John assisted Ursula at length with her plans for recovery. Sometimes entire plans were offered unsolicited to others, usually presented as suggestions. A common feature of this site, not found in the other two, was the use of the term SWIM ('someone who isn't me') to distance a poster from the content of a post. This might be because it discussed something illegal or foolish, and enabled them to avoid accountability.

In Group C, there were several instances of people setting out their own plans (e.g., Rose, Frank, Gene) or suggesting plans to others. This frequently focused on doctors and how to approach them for a prescription, for example:

> "When you've pinpointed a doctor, it could be an idea to think carefully about how you approach them... You could be better off pretending to be abstinent, and say you react badly to injections [to avoid Vivitrol which is given by injection]." (Gene, Group C)

Moderators also gave personalised, detailed advice, e.g.,

> "Have had a look at your record of drinking. It looks like you drink the majority of your units on Fridays and Saturdays. What's going on, on those days?... there's also a few days when you hardly drink – often Mondays …These places are the most obvious ones to start to look at making some little changes. (Poppy, Group C)

The following described offline planning, but showed the lengths moderators would go for members:

> "As well as talking online, Roger and I had many long telephone calls to talk about all the benefits and down-sides of [the method for] someone who has already quit drinking through AA… We explored every single thing that could possibly happen that we could think of, and came up with a 'plan' for them all." (Poppy, Group C)

Other offline activity by the moderators that contributed to planning included relaying queries that they could not answer to knowledgeable clinicians or external organisations and returning their answers to the posters. This raises the question as to why the moderators of this group went to such lengths to assist users. Firstly, it may be because this was practically possible in Group C, because it is a small AOSG with fewer members to support. Secondly, it may also be because of its position as a rare source of information and advice for those wishing to use the approved method.

In all three groups then, the forums were used as places to set out forthcoming difficult scenarios or problems, and plans to address them. In terms of accountability, in Group A writing was felt by some of the members to make their goals more 'real', and to make themselves more accountable for them, thereby aiding the process of moving ideas into action: "I have an evening ahead tonight where I think I might come under pressure to drink, so am just posting here as a kind of resolution" (Mabel, A). Some found 'checking in' helped them stay sober, indicating that writing was more effective for them than reading only:

> "Yesterday I knew from the minute I woke up that I was going to let myself drink, I knew because of the way my mind was working and I knew phoning a friend or coming on the forums would help me and I did think about it but not very sincerely.... now I understand that I HAVE to check in here on a daily basis" (Adrienne, Group A)

The negative side to this was at least one user feeling they had let the group down if they relapsed. Group A had a thread specifically for individuals to post their "confessions" in, which appeared to start as a place to post goals, but moved very quickly into posts about failing to meet goals. This echoed the interviewee Joe's view that individuals felt that they must "fess up" (confess to failing), on their site. Group B was not as cohesive a community as Group A, and there did not appear to be the same sense of accountability to the group: although people did update on their progress or decisions there, they did not appear to feel they had let the group down by relapsing. In Group C the site was seen more as a place to report progress either in real-time or after an event, using the forums in a manner reminiscent of a diary:

> "I took [amount of medication] an hour and a half ago and started drinking a beer 40 minutes ago…. this is an account in real-time. An hour after I took the tablets I felt a bit dizzy… I'm haven't got the nice fuzzy feeling I usually get from my first bottle." (Mike, Group C)

Many of the site users talked of 'checking in' to the forum with updates on their progress or to see how others were doing:

> "It's Day 3 and I am really hopeful – more than I've been in years. I'll carry on checking in on this thread to report my progress." (Gary, Group C)

There were no comments about letting people down in the Group C extracts that were analysed.

6.6.3 The forums as 'therapy'

The interviewees

Many interviewees said that they saw the forum as a form of therapy, but what they actually meant by this varied. The commonest interpretation was that, similar to therapy, the group was somewhere that a person could express themselves fully and freely, and they could also receive useful feedback and help with working through their issues (e.g., Anna, Group A; Alan, Group D;

Christine, Group E; Cara, Group F). In this it links again to coping mechanisms, but also potentially to re-evaluation of any aspect of views about the self and drinking.

> "It's even better therapy, I've been in therapy multiple times… [in therapy] you're expressing yourself and someone else is maybe giving you another view and maybe suggesting another way to look at it, you know, to help you see things in a different way. So, that's exactly what you do when you have a support group." (Christine, Group E)

Others described it as similar to therapy in:

- Providing support (Julie, Group C; Jackie, Group E; Grace, Group F);
- Being non-judgmental (Bethany, Group D);
- Leading to the discovery of insights about the self (Isabelle & Joanne, Group F);
- Being a place where very serious issues could be discussed, e.g., abuse (Jackie, Group E);
- A place to receive validation and unconditional positive regard (Cathy, Group C);
- A place to get encouragement (Ben & Julie, Group C);
- A place to help others (Marianne, Group C); or
- A place where one could hear what others were going through (Ariana, Group F).

It should be noted that a major difference from both individual and group therapy is the absence of a therapist: members and moderators did not perform this role in any official way. This was not mentioned by the interviewees.

Forum post analyses

In the Group A forum posts, the idea of writing as a form of therapy was explicitly put forward several times: perhaps not surprising in a site that saw therapy as the primary coping mechanism for problem drinking, as is noted above. There was a similar definition of therapy as a safe place, where members could express their thoughts honestly and get feedback:

> "in many ways, talking on here is like group therapy, it gives us lots of different views on ourselves and others…." (Ozzie, Group A; the next two posters endorse this)

Writing was also seen as therapeutic in leading to greater self-understanding, as indicated in the quote above, and in the sense of being cathartic, allowing members to offload the thoughts and feelings that they otherwise might have drunk on: "I offloaded on here lots so it has been like a type of group therapy, you could say" (Anita). Andrew did raise the issue of the absence of a therapist:

"we all think we're talking to professional alcohol counsellors, but actually we're just problem drinkers".

In Group B there were a few references to therapy (e.g., Ursula reported having therapy but this not helping with her drinking), but not to the forums as therapy. Group C generally supported counselling, and provided access to it themselves: discussions revolved around obtaining it partly because, at that time, NICE guidelines required those in receipt of the required medication to also have parallel psychosocial counselling. Again, there were no mentions of writing as therapy.

6.6.4 The forums as a memory aid

The interviewees

In AA it is seen as very important to remember the past including the negative effects of, and losses caused by, problem drinking so that this can act as a deterrent to relapse. Amongst the interviewees also, the forums were often seen as places to write about the past in order to remember it. Cara stated that "it's good to have a record to see how you feel as well, that you can look back on it and see how much progress you've made or you can recognise patterns" (Group F). Marianne (Group C) and Tina (Group F) also mentioned how looking back at the past could enable individuals to recognise their patterns of behaviour, and/or achieve insights into the self and the causes of their drinking. Reading others' stories could act as a memory aid: Alan (Group D) described them as "a good reminder to stay on the straight and narrow" and Christine (Group E) spoke of how "you tend to forget how absolutely devastating it [problem drinking] can be".

The forum post analyses

In Group A, writing in the forums was sometimes presented as a way for individuals to remind themselves of ideas/beliefs they needed to hold close:

> "Sorry, I know all these things [about coping mechanisms to prevent drinking] are really self-evident. I just want to remind myself of what's useful and that's why I'm putting them down here more than anything else!" (Emma, Group A).

Anita described writing her story repeatedly in order to fix it in her mind. Denise encouraged Chloe to keep the memories of a recent hangover close to act as a deterrent to further drinking. Eleanor and others found that hearing others' stories acted as useful reminders:

> "you were helpful to me, as what you wrote made me recall how difficult it used to be to resist buying alcohol in the past when it was still enjoyable" (Eleanor, Group A)

In these examples, memory is seen in a way similar to how it is seen in AA, i.e., as a deterrent to drinking and as a useful recovery aid, a coping mechanism, in keeping the suffering caused by drinking in the mind, and maintaining the representation of it as negative by highlighting its consequences. Memory was also an important coping aid in dealing with relapse. The approach in Group A appeared to be something of a balancing act: users should not dwell on relapse or berate themselves about it on the one hand but, equally, they should remember and look back with a view to analysing it, establishing what went wrong and what the triggers were. This could then lead to plans to avoid it happening again:

> "I reckon the best thing now is to pick yourself up and think it through. Why did I have a slip? What caused it and, next time, how can I do things in a different way?" (Martina, Group A)

Remembering in A could also form a more pleasant activity: for example, Emma advised another to remember how good being sober felt: "Remember when you were amassing those days sober, how fantastic you felt".

There was an example of memory acting as a coping aid in Group B, although this was not related to use of the group:

> "I reckon with a bit of willpower some people could deal with their usage so that they balance out the immediate urge to consume with an awareness of what that will cost them in the future. Things like how bad the withdrawals could be after indulging. Recalling [an unpleasant symptom] really puts me off!" (Ophelia, Group B)

There was the same emphasis as in Group A on not berating oneself for relapses, but there was less emphasis on analysing the past to avoid repeating it. The following was typical:

> "Relax! You're doing really well, don't beat yourself up as that will probably push you to drink more than anything, I think… Even if it was a slip it's fine, just pick yourself up and keep on. We've all been there. You'll get over it soon I'm sure." (Penny, Group B)

In Group C, there was little emphasis on, or importance attached to, remembering the past. Any discussion of memory was instead about being able to remember things now that they were drinking less or were abstinent, e.g., "[I] watched films til midnight and could remember them...normally my memory of the night before gets lost" (Sara, Group C). Moderators also talked of the importance of remembering coping mechanisms, such as the Golden Rule, and Margaret (like Emma in Group A), mentioned the benefit of being reminded of useful coping mechanisms: "It helps us all to be reminded that we need to persevere and keep at it" (Margaret, Group C). However, memory played a very important role in the preferred treatment, which relied on breaking the mental association between drinking and pleasure. After using the method, drinking was no longer seen as a positive experience or something to be craved: so the representation of drinking was radically changed by the treatment. Memory, ultimately, was the underlying rationale for the preferred method, but otherwise remembering the past did not appear important in this group.

6.6.5 The forums as a lifeline: providing help in a crisis

The interviewees

A large majority of the interviewees agreed that the forum was used as a lifeline to assist members in times of crisis with their drinking, so impacting on ideas about coping mechanisms and self-efficacy (controllability). They might have used the forums in this way themselves or, much more commonly, have seen them used as lifelines by others. For example, Cara described how individuals would contact the group for help from challenging events whilst these were actually going on:

> "it was funny how many times on [Group F] people would, like, blog from the toilets of a party [laughs]…And just go "Help [laughs], everyone's drinking and I want to drink"" (Cara, Group F)

Grace described a similar situation and noted the possibility of a quick response as one of the reasons that forums were such good resources:

> "Because when you want a drink you want to drink now…. your brain doesn't understand that it needs to wait for two hours for someone to call you back" (Grace, Group F)

Because of their constant availability, the forums could be used to get help at the time of crisis, not only in advance or after the fact. However, other interviewees noted limitations to this, for example, the fact that responses depended on who happened to be online at the time: this could be someone

experienced and knowledgeable or the opposite as Jackie pointed out. Equally, of course, no-one might be available to respond, particularly for smaller groups:

> "it depends if people are on or not. [Group C] there's not always people on. [Group E] was definitely like that, there were always people on there and it was a much bigger forum." (Julie, Group C)

The forum post analyses

Group A explicitly invited people to use the forum as a lifeline, as it had emergency threads, including one where individuals could post if they were on the brink of drinking. In this group, there was discussion of the emergency threads as cries for help, and there were examples of people using the forums for support when in crisis. For example, June wrote: "Everyone, I need help - please read this and help". Less than 15 minutes later they received a reply with practical advice and encouragement from Melissa. Further advice followed later from Courtney and Carolyn, the latter reassuring June that: "we're with you! And we'll help however we can!" However, the disadvantages of the asynchronous format could be seen when the following request did not receive a response for nearly seven hours:

> "I'm really struggling ... drink is calling me and saying, "Why don't you…"…Urgh! This is horrible. The cravings are so powerful. Please help!" (Tim, Group A)

Tim did eventually receive two very supportive posts full of practical advice on what to do, and encouragement to resist, but he did not post again in this extract. Given the immediacy of the crisis, it may be speculated that the help came too late. Interestingly, cries for help were sometimes posted on more than one thread: two of the cries for help sent out by June referenced their posting in other threads also. Robin used information given by Chris about him/herself in one thread to provide personalised advice in a crisis on another thread.

In Group B, cries for help usually attracted prompt attention, advice and support: an entire thread, for example, was devoted to advising Ursula, together with her updates on progress. Advice in this group appeared to be less sympathetic than in A and with more emphasis on the mechanics of drinking: how much, when and why. Instruction was frequent, and at times robust, using scare tactics, e.g.:

> “You just mustn’t take [name of medication
>] with alcohol. That combination could lead to you dying in your sleep or in a blackout. It’s not if, it’s when, this is going to happen. You should stop drinking now. Alcohol isn’t doing anything good for you.” (Fred, Group B)

Group C also provided practical advice, support and encouragement to posters in crisis, with replies often coming from moderators after only a short time lapse.

6.6.6 The forum as a place to celebrate

The interviewees

Discussion forums were seen as important venues to share successes around drinking and receive praise for them as a) individuals may not want, or feel safe, to disclose information about their drinking outside the forums whilst still wanting to celebrate their achievements, and b) other members were more likely than outsiders to understand the significance of a success:

> “Where else could you do that, you know…these people get it, you know, and they know what an effort it sometimes takes and what a big deal it is” (Jackie, Group E)

Members could also remind others on the forums of past shared successes to strengthen and encourage them:

> “those people on [Group A] would say, "Look at what happened last year when you went through all that stress, you never drank once" you know, and you think "Actually yeah I am, I am strong enough and I don’t have to [drink] and I can do it".” (Anna, Group A)

Sharing successes could also provide ideas to help others by suggesting coping mechanisms:

> “when I have a breakthrough, I discover something, I share it with the group in the hopes that it’ll help somebody there” (Christine, Group E)

Grace reported finding this particularly useful. However, achieving success could inhibit a person from posting. Both Jackie and Dawn (Group E) described posting less about their successes after their initial period on the forums to avoid daunting others:

> "one of the reasons that I don't write as often now is that I feel like I'm doing well… And I sometimes like feel it's not particularly helpful for me to say, "Oh I'm doing so well, I'm so happy", you know." (Dawn, Group E)

This was somewhat of a balancing act, because sometimes people liked to hear that success was possible as this was encouraging, but not too much:

> "I mean I say, this worked well for me just because people sometimes like to hear that it does work, but I don't do it a lot." (Dawn, Group E)

For Marianne, sharing successes and celebrating achievements was one of the most important functions of Group C:

> "in terms of being valuable to me, I find it very valuable to share my stories and to share what works and what didn't work, and I do like to hear other people's stories, especially when they are so thrilled that they're seeing a change. That's always really awesome" (Marianne, Group C)

Interestingly, Tina described the group style of F as tending to positivity and emphasis on progress. She stated that she altered her style of writing to be more positive in order to fit in: one example of group culture constraining an individual's freedom of expression (see also Section 6.7).

The forum post analyses

There were many examples in Group A of individuals sharing their own successes e.g., Anita, Katie, Chloe, Olivia:

> "Hey...you'll never guess! I put down the blasted bottle . I had a stern word with myself, had a nap, then took out the orange juice. Anticipating a Sunday morning where I won't have to wake up thinking ...ooo damn." (Chloe Group A)

They frequently complimented each other on achievements ranging from lengthy periods of time staying sober, to attempting a first day or simply recognising that a situation might prove difficult. For example, Emily, Tiffany, Carol, Emma and Kate all complimented Anita on two months of recovery and Eliza congratulated Alistair on going for "the dreaded first day. Good for you, that's an

achievement". Members may remind each other of past successes to reinforce their determination to recover, for example:

> "you were so happy and positive when we did the week-long challenge. I loved it when you said you thought getting sober was like giving yourself a present. It's still that...I know it won't feel like that right now, but this lovely gift you gave yourself…do you really want to throw it away? No you don't" (Sam, Group A)

Carol, like interviewee Marianne, derived pleasure from success stories and also found them inspiring. There was an emphasis on positivity similar to that noted by interviewee Tina, for example, Kate's response to Zara's relapse at ten days sober:

> "It can be hard to get momentum in sobriety [Zara] . Don't get discouraged, 8 days is a great beginning!" (Kate, Group A)

Ozzie described an evening resisting temptation by 'urge surfing' (sitting through a craving) then reported he had not resisted the previous evening. Responding, Daphne first praised the urge surfing before briefly addressing the slip.

In Group B individuals also shared their own successes and congratulated others on their achievements, for example:

> "You cut down by half? Wow, that's impressive, good for you [Ursula]. You're really making progress now. And 2 days without alcohol is awesome. Hopefully, you're getting to feel better and better now." (Wendy, Group B)

Group C contained the most examples of shared successes and celebrations of achievement, for example:

> "[the method] is working!! My drinking is in a steady decline" (Jill, Group C)

> "Good for you. I'm right behind you at 60 days, and its declining for me too." (Agatha, Group C)

Again, hearing success stories inspired others:

> "It's great to hear that news. My partner has been using the method for 3 months and is experiencing setbacks which have discouraged me a lot, so this makes me feel better" (Verity, Group C)

For all groups and most interviewees, the forums clearly acted as a valued site to share success with others who truly understood the significance of their achievements in tackling problem drinking. In this it helped to reinforce a representation of recovery as highly positive and encouraged others' sense of self-efficacy, changing their perception of the problem's controllability.

6.6.7 The forum as a venue for awareness raising and empowerment

The interviewees

Empowerment of individuals in the sense of reinforcing their self-efficacy was mentioned above. Additionally, some of the interviewees, notably those from Group F but also Group C, arrived at greater awareness of certain political aspects to drinking and treatment as a result of their involvement in the forums. This changed their representation of 'problem' and 'normal' drinking (as was discussed in Section 5.4) and sometimes led them to take practical action in the offline world to protest. Several members of Group F became aware through the forums of the ubiquity of alcohol drinking and its marketing, or saw that others who were new to thinking about drinking had become aware of the issues. For example, when asked if the forum was a place where she could get motivated about or active around alcohol issues in society, Ariana had the following conversation with the researcher:

> "Ariana: Yes, so in society you mean become an activist type of thing?
> Interviewer: More that kind of thing but it might be that one does it just quite low key like...?
> Ariana: Okay, yeah definitely then." (Ariana, Group F)

Cara described these activities as being more along the lines of 'coming out' as a problem drinker and telling one's story, rather than instructing others not to drink:

> "I think gradually I am starting to say--, but just in a 'this is my story' way, not 'you've all got to stop drinking' or 'do you know what it's doing to you?'" (Cara, Group F)

Grace and Theresa (Group F) described the sharing of news or information about campaigns in the forums. These could be used to enlighten others, and Joanne noted that the issues would provoke discussions. Theresa described the forums' impact in the most detail:

> "we start to get a feeling that we're not alone, but that in the bigger sense is the fact that we can become a voice for the fact that our culture has become too alcohol centred…. I really took a stand, I would not have done that without [Group F] behind me, cos I learned so much from them and [a few other] groups that have formed… and some other women who've been writing to other companies …and so it gives us a collective voice and we're not afraid to speak up in a bigger way about, we're going to change the world, we're not going to make alcohol normal anymore. And that, you wouldn't get that without a group." (Theresa, Group F)

This highlighted three aspects: information provision, ("I would not have done that without [Group F] behind me, cos I learned so much from them"); seeing examples of others taking action which could be followed ("women who've been writing to other companies"), and, importantly, the strength and empowerment the forums created in members, arising from being part of a like-minded group: "it gives us a collective voice and we're not afraid to speak up in a bigger way" Finding others like them empowered these members to find their voices in the offline world. (Smith-Merry et al. (2019) also noted this of mental health forums).

Group C members also discussed becoming motivated to speak up about alcohol issues, but here the focus was on publicising the preferred method espoused by the site:

> "And we talk quite frequently about how, how can we get the message out and we try everything I mean, I talk about it frequently. I talk with my doctor and encouraged him to try to talk to some of his associates" (Ben, Group C)

The forum post analyses

The forum postings analysed from Group C also showed examples of individuals taking action to raise awareness of the method. Rose described producing information packs for doctors in her area, plus:

> "I got some tops printed advertising [name of documentary]. I've put [Group C] leaflets in the local library and shop." (Rose, Group C)

There was also discussion amongst both Group C interviewees and posters of the role of the pharmaceutical and treatment industries in failing to promote the method. They felt that this was caused by finance, as the main drug was out of patent, and also by the treatment industry's preference for traditional rehabilitation which earned it more money as users tended to relapse and need further treatment:

> "my opinion on that is that there's no money in it for anybody. [Name of drug] is a cheap generic drug. Rehab facilities, which are real expensive, kind of make their money on people relapsing... nobody makes any money off of [the method] so nobody--, who's going to promote it? … I hate to say it, nobody really cares. There's no money in it." (Marianne, Group C interviewee)

Rose also put this down to the ingrained traditional methods of treating problem drinking with abstinence: "the you-have-to-be-abstinent mentality is very ingrained [in my area]". The forum showed many examples of individuals struggling to get prescriptions for the medication and having to take alternative routes, e.g., obtaining it from online pharmacies, changing doctor or going to other medical services. The forum offered support in the form of a list of doctors who would prescribe the medication. There were also many accounts of misprescribing (in terms of the preferred method):

> "I've had two sessions with a psychiatrist and I've now got a script for [the medication]. But I'm supposed to take it once a day, every day. I did try to persuade the psychiatrist about [the method], but she insists I take it daily." (Mike, Group C)

Poppy confirmed that this would not work as the medication would block all sources of pleasure, not just from drinking.

There were no discussions of becoming politically aware and active within the extracts analysed from Groups A and B.

6.6.8 Discussion

This section explored ways that the forums were used by interviewees and posters for information-related activities other than searching for and sharing information. It looked at the forums as venues

for planning, accountability, remembering, getting 'therapy' (defined differently by different users), as a lifeline that could provide help in a crisis, a venue for celebrating successes and a place where one could become more politically aware and motivated to change public representations of drinking. These aspects are less frequently discussed in the literature and show that providing information and emotional support are not the only functions carried out in forums. The activities are all ones which may impact on user representations in different ways, as was detailed in the sections above.

6.7 Site norms for information sharing

Site norms for sharing information online are briefly discussed here as they constrained what could and could not be shared in the forums and therefore impacted on the forums' effects on users' representations. All of the groups included in the study included guidance on what the site was for, and what it covered in a general sense e.g., cutting down, quitting alcohol, getting reliable advice, sharing experiences, providing support and information. This established the kind of content that would be welcome. Information pages about the sites set out their values, with all of them endorsing being non-judgmental; however, this notably did not impact on practice in Group B, as has been shown.

In terms of information standards, Groups B and C particularly stressed provision of good quality information when sharing on the site. In the information pages, Group B described itself as "a high-quality information centre" and at the end of each post, individuals had the opportunity to comment in 'Post Quality Reviews'. The content of posts was the aspect most frequently commented on, with praise for information contributing to harm reduction, for correcting information or providing information that was useful or interesting. Sometimes posters singled out, and agreed with or praised, the key message of a post. Second to this were reviews praising the writer for supportiveness or a related quality such as being reassuring, kind or encouraging: these were mainly in the Addiction forum. There were 11 such messages where there were 35 comments on content. Specific instructions about how to post or write, or praise for the way something was written, were next in prevalence (8) and there was also praise for questions posed (3). The type of material that attracted praise in B appeared to be that which:

- Met customary practical rules for posting e.g., not quoting entire posts when replying to them, not using SWIM, using correct grammar;
- Promoted harm reduction;

- Asked thoughtful rather than provocative questions;
- Contained factual information that directly answered a question;
- Drew on information from reliable sources;
- Was relevant;
- Was honest and open if giving someone's experiences; and/or
- Provided useful, unusual information, e.g., a post with detailed experiential information on a relatively unknown medication for problem drinking attracted four expressions of praise. The only other post with four positive comments was also for experiential information.

The majority of comments were positive, but there were three critical ones: criticism of the quality of the evidence supplied, of a post as unhelpful (it was negative about the possibility of getting sober), and of an unnecessary correction to information. Whilst Post Quality Reviews, and the information pages about the site, showed a support for high information standards, in practice these standards were frequently broken by posters without comment from others or the moderators: for example, use of SWIM was frequent and supportiveness often lacking.

In Group C, the moderators held a high value for accuracy, evidence and scientific studies. They warned members away from unmoderated sites on the grounds that information provided there might be well intentioned, but inaccurate:

> "Please note and take care - people on any discussion forum will give their opinion and ideas with kind intentions, but they still might not be accurate…" (Poppy, Group C)

The concern for information standards on the part of the moderators was shown in the following: they emphasised that neither they nor the members were clinical experts and that the doctors who acted as clinical advisors to the group should be consulted if anything was in doubt. No medical advice was to be given on the site, instead individuals were encouraged to take physician guidance. (This created an interesting tension in the forums between respect for doctors and frustration with them as ignorant of the method recommended and unfriendly towards it. There were also occasions when a moderator or member advised lying to doctors in order to qualify for a prescription, or reported actually doing so.) One moderator stated that they did not just report what experts had said to them, but quoted them. Poppy saw support as very good as long as it was based on facts/evidence. She saw her role as to "politely" correct misinformation. Overall, there was a level of

care and respect for information standards here that was not noted in Group A or even Group B, despite the latter's official emphasis on information provision.

6.8 Conclusion

This chapter has explored the theme of information behaviours in the forums, beginning by describing the typical information journeys of users and then analysing information seeking and sharing. Indications were given that users berrypick information from the forums and other sources, using multiple search techniques. This will be discussed further in Chapter 7. Different ways of conveying information, including disagreements, role modelling and story-telling, were described and their impacts on user representations indicated. The chapter then discussed information-related activities, and concluded by discussing the sites' views on information standards, which set the context for what could and could not be shared on the site. The next chapter will discuss the research's findings drawing information behaviours and representation development together.

Chapter 7: Discussion

7.1 Introduction

In the previous two chapters, the findings of the research were set out. Chapter 5 looked at the impacts of the forums on user representations and Chapter 6 explored the information behaviours found in the groups. This chapter begins by discussing the gaps addressed by the research (Section 7.2) and briefly summarising the main findings as presented in Chapters 5 and 6 (Section 7.3). It then introduces and explains a new model of how information behaviours in the forums contribute to the development of representations about problem drinking (Figure 7.1, also presented in Appendix 17 for ease of reference). This has been developed from the findings in conjunction with established theory in this area. The model is applied to two examples of the interviewees' transcripts to show how it operates in practice. The links between information behaviours and the formation of user representations is discussed (Section 7.4), and the chapter goes on briefly to consider the contrast between the conclusions drawn here and previous findings in the research literature regarding the development of representations in AA (Section 7.5). Section 7.6 briefly discusses the 'restructuring' of beliefs and the question of matching users to groups is then revisited, in terms of matching on the basis of representations (Section 7.7). The chapter concludes by discussing the research's limitations (Section 7.8).

7.2 Gaps addressed by the research

Existing research (discussed in Chapter 2) has shown the importance of ordinary people's 'representations' or beliefs about issues, and that these can have significant impacts on problem recognition and management, and therefore on outcomes. Section 2.3 also demonstrated that there have been many studies exploring representations in relation to different diseases, conditions and health topics. Many of these have used Leventhal and colleagues' Common Sense Model of Illness Representation to analyse and measure the belief sets. Leventhal and his colleagues identified experience, information from others and lay beliefs in society in general as key formative influences on representations (Leventhal, Nerenz & Steele 1984). By implication, discussion forums, as sources of information from others, could have a strong potential to affect representations. However, it had been noted by several researchers (e.g., Benyamini 2011; Brooks, McCluskey, Turley & King 2015) that there is little research on the role different types of sources play in forming representations:

> "One of the least studied topics in this area is related to how people form illness perceptions and what sources they draw upon... Qualitative research is required to examine what people

gain from particular information resources and why some affect illness perceptions more than others." (Katavic, Tanackcovic & Badurina 2016)

Kealey and Berkman (2010 p239) noted of mental health studies generally that "few studies have explored the relationship between sources of health information and mental models of disease" and the IPQ-R site states that "An important question that we have little information on at present is where do illness beliefs come from?" (http://ipq.h.uib.no//, accessed 30/4/20). Katavic, as recently as 2019, re-stated that there was a need for research on what sources are used to develop illness representations. This study contributes to addressing this gap by focussing in depth on one such source – alcohol online support group discussion forums.

Sections 2.6 and 2.7 showed that there has been much research on self-help groups for different conditions, that information provision is an important function in them and that, in terms of problem drinking, AA has been well explored in its face-to-face format. However, a key gap was identified in the paucity of theoretical attention paid to non-12-step groups. Zemore et al., for example, stated that there was an "extreme scarcity of any data on mutual help groups that are not 12-step-based" (2017 p124). What research there is has tended to focus on the same handful of groups when, in practice, many more are available. A third key gap in the literature, noted by Smith-Merry et al. (2019) and Savolainen (2011a) is the need for qualitative accounts of forum use in the context of participants' daily lives.

The study reported in this thesis sought to address the gaps identified above by analysing postings from three very different, under-researched non-12-step AOSGs, and data from in-depth, qualitative semi-structured interviews about discussion forum usage and beliefs about problem drinking. The study focused on exploring the role these sources of information and support played in the development of user representations.

7.3 Brief summary of key findings

The results of this study are consistent with Kaskutas and Ritter's work (2015) in finding that the influence of alcohol groups goes beyond the attraction of like-minded people, to actually altering beliefs. This research found that the forums of non-12-step AOSGs contributed to users' development of their representations of problem drinking at two levels that are outlined below.

Firstly, ideas found in the forums could change specific aspects (small or great) of the cognitive representation held. The forums provided information of different types, e.g., facts, references, advice and opinion, and experiential information including stories and anecdotes, that affected users' representations on a detailed level. Examples were given in Section 5.3 of instances where the forums had contributed to creating, changing, reinforcing, challenging and/or confirming aspects of representations. It frequently altered members' views of the coping mechanisms to be used through the provision of tips and suggestions (e.g., for dealing with cravings or difficult situations such as weddings). However, due to the prevalence of alcohol drinking in Western and other societies, the forums are but one source, however influential, amongst many that a person will be exposed to over their lifetime.

Secondly, they can also change representations in a more holistic fashion as was shown in Section 5.4. Finding 'someone like me', often mediated by hearing other members' stories and anecdotes, could have a profound impact on how a user felt and thought about problem drinking as an issue and themselves-as-drinker. It could change their conception of 'the drinker', normalising problem drinking, enabling problem recognition and acceptance, and stopping denial or avoidance caused by barriers of shame and fear. In making acceptance easier, it could enable more appropriate choice of coping mechanisms, and subsequent information behaviours, such as information seeking and sharing. Moving individuals from the framing of problem drinking as a binary choice between the stigmatised image of the 'alcoholic' and the 'normal drinker', to a situation where it is seen as a spectrum with no exact divisions between drinkers is important. It can be seen in this study, that forums are venues that can actively contribute to this move to a nuanced, spectrum interpretation of problem drinking. This is very significant: pointing out the many ways in which drinking norms differ in practice for different individuals, groups and societies at different times, Young summarised that:

> "helping a problem drinker to develop a perception of ''normal drinking'' as variable rather than universal reframes problem drinking as a breach of the norms of society rather than a more egregious breach of the norms of humanity" (Young, 2011, p390)

Chambers contrasted using terms such as 'alcoholic' as "essentialising nouns" and as "descriptive adjectives". The former would reflect a situation in which being a problem drinker is the essence of a person; the latter where it is a description of behaviour and not something that represents their core being. Many participants in the present study, as in Chambers' work:

> "appeared to conceptualise their drinking in terms of a destructive behaviour that has the potential to impinge on valued identities, rather than problematic alcohol use representing their fundamental essence as a person [as in AA]." (Chambers 2018, p63)

Moore, Pienaar, Dilkes-Frayn and Fraser (2017) also refuted the binary concept of addiction, but from a different angle, pointing out that this ignores the benefits people may find in maintaining excessive drinking:

> "the disease model of addiction and its emphasis on individual compulsion, loss of control and an irresistible yearning for drugs…neglects the meanings people invest in [drinking] and the benefits they derive from it" (p525).

Providing other narratives, they argued, could lead to less "pathologising" formulations of drinking problems (2016, p534) and so result in less stigma and alienation. This would certainly ring true for many users in Group B, for whom drinking was a balancing act between avoiding harms and gaining benefits. Morris' work (2020) has also highlighted the issue of framing and problem recognition, pointing out that harmful drinkers (as opposed to 'alcoholics') are under-served, and that this can lead to 'othering' ('I'm not like them') and steps such as ignoring information. In short, the framing of problematic drinking is very important, and the forums can play a significant role in relation to this in terms of expanding and developing people's ideas about what it is to be a problem drinker.

At the same time as this holistic effect, seeing 'someone like me' could also impact on any, or all, of the specific dimensions of the CSM. Their explanations of causes may change, e.g., seeing people like themselves led many to stop believing that they were problem drinkers because something was 'wrong' with them. It could widen users' understanding of consequences through seeing a wide variety of experience in the forums, and change their view of how controllable problem drinking was, and its timescales. It could also change their ideas in terms of general approach to treatment, for example, users might see instances of successful moderate drinkers and conclude that moderate drinking is possible.

The difference between the two forms of influence can be clarified by considering Case's 'spectrum of motivations'. Case (2012) described the spectrum as bounded by an Objective pole at one end and a Subjective pole at the other. Objective information needs are:

> "driven primarily by a rational judgment that some uncertainty exists that would be resolved by specific information…the prototypical search from the Objective point of view is one in which there is a well-defined need to retrieve a specific fact to make a decision or solve a problem." (Case 2012, p86)

So, for example, users of Group C had many factual queries about their treatment's medication and adjusting dosage, Group B included threads on where a particular drink was made or what was special about another, Alan in Group D learnt how to safely taper away from drinking alcohol, and many members throughout the groups asked for tips around managing specific difficulties. On the other hand, Case described subjective information as about making sense of the world, with searches for information:

> "prompted by a vague feeling of unease, a sense of having a gap in knowledge, or simply by *anxiety* about a current situation… [this view] emphasizes that humans are often driven to "make sense" of an entire situation, not merely its component "data"" (Case 2012, p86, his emphasis)

This brings to mind the interviewees' distress, confusion and anxiety about their drinking as they wondered if they were 'alcoholics' or not. Finding their groups and seeing others like themselves brought relief and helped them start to understand and make sense of their situation.

The Social Identity Model of Recovery (SIMOR), developed by Best and colleagues, also focused on the central importance for recovery of similar others in social networks. They argued that group benefits "appear to be dependent on the degree to which those providing support are perceived to be relevant, similar and connected to the self." (Best et al., 2016, p112). Drawing on the example of AA, they also found that:

> "Th[e] emerging [recovering] social identity is gradually internalised, so that the individual comes to embody the norms, values, beliefs and language of recovery-oriented groups." (Best et al., 2016, p114)

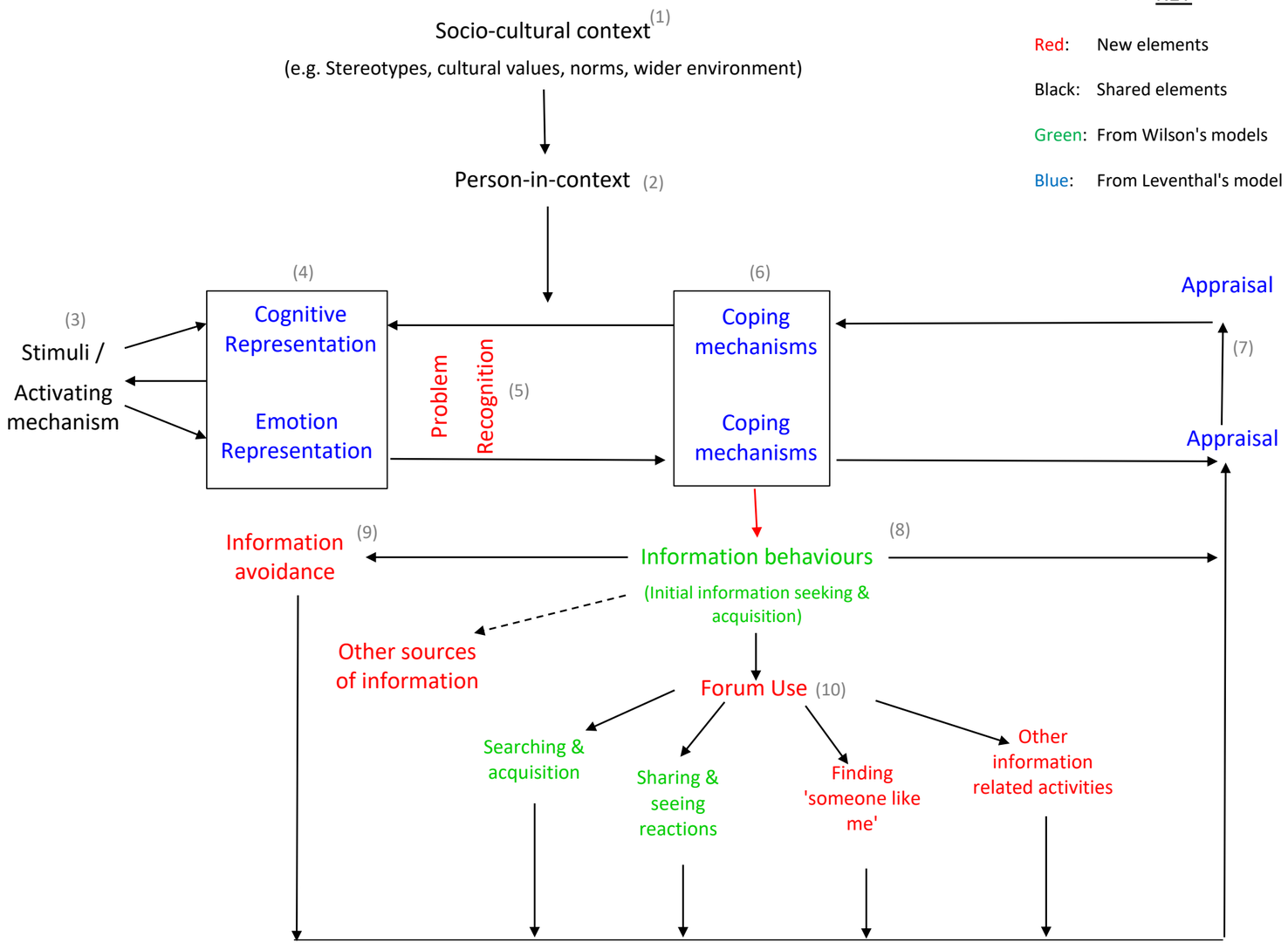
Whilst this may be true of 12-step groups, (see also Bathish et al., 2017) this research has shown it was not the case for the non-12-step groups. None of them obliged their users to adopt a particular

worldview. Whilst users might adopt the norms, practices and language of their group, to fit in with it (e.g., supportiveness, focusing on triggers and planning, and talking about the Wicked Alcohol Elf in Group A), they did not have to 'embody' its beliefs about problem drinking. Having 'no requirements of belief' meant that their members could, and did, develop their own sets of ideas, berrypicking the information that 'resonated' with them. It is this berrypicking that is a key feature of the information behaviours used in these forums, in terms of the queries they searched for, and the sources and search techniques they used. It is speculated that this may well be found in other online support groups, especially where there are contested explanations for a condition. However, it is also important to note the parameters, in terms of the general high level group ethos that existed amongst members, notably being non-judgmental. When users went against this, arguments or criticism could result. In addition, the study found that the group's representation of problem drinking (at a high level only, not at the level of detailed world view or programme for recovery) was of importance in user selection of groups. The general approach of a group was the most frequent reason given by interviewees as to why they chose and/or stayed with it. Many were drawn to their group by its openness to goals other than abstinence.

The information sharing behaviours of role modelling (Section 6.5.4) and of listening to others' stories and anecdotes (6.5.6) were found to be of particular importance in showing people others like themselves, and were key ways in which individuals conveyed an understanding of themselves. This study also demonstrated that the forums could act as platforms for information-related activities other than information searching and sharing, which does not appear to have been explored in depth before. Finally, as part of the exploration of storytelling, a new 'community narrative' was also identified.

The next section attempts to theorise the findings by presenting a model of the formation/development of user representations of problem drinking in the non-12-step online discussion forums studied. This places information behaviours into the structure of the formation of representations as viewed through the framework of the CSM, and is explained and exemplified below.

Figure 7.1: Combined Model (for representation formation through information behaviours in AOSG discussion forums)



7.3.1 Combining two models

This new model in Figure 7.1 combines and adapts Leventhal et al.'s Common Sense Model of Illness Representations (shown in Appendix 1) with elements from Wilson's second General Model of Information-Seeking Behaviour (Appendix 6). Concepts are adapted in light of the findings to make it appropriate for the development of representations about problem drinking. The structure and choice of the CSM were discussed in Section 1.2.2 and the findings showed that it worked well in practice for analysing the detail of representations and also the broad structure of the process. It proved to be a helpful model for the following reasons, first, because it was relevant: the five dimensions and coping mechanisms were of interest to the groups and were discussed in them. Second, it has a helpful level of detail, so using it brought out the fact that all interviewees differed in their belief sets. Examining the forum posts using the five dimensions as a lens also helped highlight what aspects the groups' members were more or less interested in, as well as showing what they had to say about these topics and where commonalities and dissimilarities lay. Third, it allows a significant place for emotions, which are extremely important in problem drinking because of the fear, shame and guilt that the stigma associated with it can generate. The CSM encourages exploration of the effects of the emotions on illness representations and coping mechanisms.

Fourth, the CSM is iterative and dynamic: forming a representation was shown in the findings typically to be a process (as indeed recovery can be), not a one-off event. The CSM, unlike, for example, the Health Belief Model, does not just present static, core components of representations. It was particularly suitable because of this for Research Question 1 looking at the role of the forums in influencing the development of a representation. Fifth, its distinction between prototypes and representations (Leventhal, Phillips & Burns 2016) is helpful, for example, by drawing attention to the negative impact of underlying stereotypes like the 'alcoholic', that could discourage users from confronting their drinking problems. Sixth, it acknowledges the importance of context and personal characteristics in influencing representation formation, and, seventh, a basic principle underlying the CSM is that people are active, motivated problem solvers. This renders the CSM appropriate to use with self-help groups whose members are motivated by a desire for help and advice with a problem. Eighth, it has been successfully used for mental health issues previously (Lobban, Barrowclough & Jones 2003; Baines & Wittkowski 2013; McAndrew et al., 2018), and is a well-established and validated model. Finally, the literature review showed that, although helpful, it has rarely been used

for representing people with alcohol-related problems, so the present study expands the literature on this.

The disadvantages of using the CSM include the following:

- The concept of having symptoms does not fit very well with instances where members do not see themselves as having an illness. The term 'signs' might be better in this instance. The concepts of label, cause, consequences, timeline and control are already compatible with discussing a problem and do not pose a difficulty.
- At first sight, self-efficacy appears to be a missing aspect that is of importance in terms of problem drinking. However, this can be seen to be accommodated within beliefs about personal control (controllability) over the problem.

As was discussed in Section 2.5, Wilson (1981, 1995, 1997) produced several overlapping models of information behaviour, which build upon one another and which he saw as working together. This study primarily used Wilson's Second General Model (1995), but referred to the other models where these are seen as elucidating the former. This model was chosen for the following reasons: first, some of its concepts overlap with those of the CSM. The Leventhal and Wilson models share some concepts which are similar but not identical, for example, the socio-cultural context which both agree influences the person within it, but which Leventhal described in terms of institutions, groups and roles, and Wilson in terms of environment and social role. Second, Wilson's model was explicitly designed to be open to combination with other theories including from disciplines such as psychology, which is where the CSM originated. As he stated, the model:

> "has no pretentions to *explaining* everything to do with human information behaviour, but it is *hospitable* to explanations set out by others and it prompts the researcher to ask the question, "Given my findings, what are the implications for these related areas?"" (Wilson in Fisher, Erdelez & McKechnie 2005, p35, his emphasis)

Wilson himself located some non-information theories, e.g., stress/coping theory within his Second General Model. Third, Wilson's model (like the CSM) treats information seeking as a process and as iterative, unlike models such as Ellis' Model of Information-Seeking Behaviour (which details six components of information seeking by social scientists but does not show their relationships). Fourth, Wilson's model covers more information behaviours than many other models with the

inclusion of information processing and use. It is not solely about information seeking. Fifth, like the CSM, Wilson's model allows a role for the impact of emotions. Wilson's early Information Need and Seeking Model (1981 Appendix 18) effectively elaborated on the category of person-in-context in the later model, and indicated that he viewed affective needs (as well as cognitive and physiological) as playing a role in affecting information seeking behaviour. Sixth, Wilson's model is a well-established and validated model that here enables breakdown of the information behaviour aspects of CSM coping mechanisms.

The two models were able to be combined because of the similarities between them and the presence of overlapping concepts, noted above. They complement each other, with Wilson's model effectively elucidating one of Leventhal et al.'s possible 'coping mechanisms' and providing detail for this. Leventhal et al.'s model was described by its authors in 1984 as an "information-processing system that integrates current stimulus information with both innate and acquired codes or memories" (p219). It is, then, a model with information at its heart which adds to its suitability for combination with Wilson's model.

7.3.2 Explanation of the model

First, the Combined Model (Figure 7.1) shows how the socio-cultural context (1 on Figure 7.1), especially aspects such as cultural norms, stereotypes, and values around drinking in this instance, influences the person-in-context (2). Everything that takes place within the process of developing a representation is influenced by the person's biopsychosocial makeup and their experiences, which have, in turn, been influenced by the societies and cultures to which they have been exposed. Aspects of the person-in-context that were felt to be influential by users in the findings included genetics, biochemical makeup, family history, peer group influence, demographics such as age and gender, cognitive and affective traits, work/role experiences, economic situation and environment. All these may also have contributed over a lifetime to creating the cognitive and emotional aspects of the representations held by the person (4) before finding the forums. When the protagonist experiences an issue with drinking, i.e., Wilson's activating mechanism or Leventhal et al.'s stimuli (3), (or indeed Dervin's "gap") this might be dramatic or gradual and cumulative (Chambers describes the latter as "droplets of awareness", 2018, p59). When this happens the person's existing cognitive and emotional representation of problem drinking (4) will be activated (this could be seen as one of Wilson's 'intervening variables' from his model, mediating between an activating mechanism and information seeking behaviours). For most, this will include stereotypes of the

'alcoholic', the 'normal drinker' and the 'non-drinker'. It will also include their representation of themselves-as-drinker, including in relation to other roles such as employee or parent.

This existing representation will then influence their ability to recognise or accept that they have a problem (their 'problem recognition' (5)) and their subsequent choice of coping mechanism (6). In terms of information, this coping mechanism may involve, for example, avoiding it (9), deciding on action with an information need as a constituent element or it may be experienced as a need for information alone. This leads into the initial act of information seeking to find help (8), represented in parenthesis because once the group is found and adopted that search is not repeated until the seeker decides to go elsewhere. The findings showed that any of Wilson's information seeking behaviours may be used at this stage: passive attention or encountering the forums by chance (Erdelez' information encountering theory can be encompassed here); passive search (finding them during a search for something different), or an active search, frequently in the forum of Marchionini's semi-directed browsing, as described by Ford:

> "Semi-directed browsing is halfway between directed and undirected, and refers to a situation in which the person is actively searching, but not in an intensive systematic and focused way. An example is entering a general word into a search engine and browsing through what is retrieved to see if there is anything interesting" (Ford 2015, p54)

A user googling 'alcohol help' (e.g., interviewee Anna, Group A) is an example of this. Alternatively, searching at this point may be part of Wilson's 'ongoing search' behaviour: "where occasional continuing search is carried out to update or expand one's framework" (Wilson, 1997, p562). Christine (Group E) and Alan (Group D) are examples of this as they had both used other information resources about problem drinking prior to arriving in their forums.

Material from the initial information seeking is then appraised (7) and the person may decide to pursue using the forum they have found as their coping mechanism (10). Alternatively, they may decide to ignore what they have found (9) or to go to other sources (or, of course, choose something else entirely as their coping mechanism). Assuming that they wish to proceed with the forum they can then use it to search for and/or share information, to find others like themselves, and/or to carry out information-related activities such as celebrating successes, using it as a lifeline or as a memory aid. Information searching often takes the form of berrypicking (Bates, 1989), as noted above, with shifting queries, use of multiple sources and search techniques and selection and combination of

information from different sources. This leads to a situation in which each user forms a slightly different view of problem drinking. The outcomes of these activities are then appraised (7) in the CSM loop, typically against what seemed right to the person – what 'resonated' or made sense to them. They often led to changes to the representation held in one or more of its five dimensions (4), and could change problem recognition (5) and the coping mechanisms (6) selected. The whole is conceived as an iterative loop capable of continuous development over time, and also as a process capable of taking place very quickly: there may be little gap in terms of time between finding the group, finding others like themselves and/or sharing online.

7.3.3 Examples of the model in action

Viewing user accounts of developing their representations in the light of the model is a consistent way to illuminate key elements and the differences between their stories.

Anna's representation of problem drinking

Whilst Anna (Group A) did not talk about socio-cultural impacts on her ideas (1), she did mention their impact on other people's views, for example, saying that norms about young people's drinking in the UK had changed over time with the advent, and acceptability, of 'pre-loading' and drinking purposely to get drunk. In terms of herself as the person-in-context (2), the aspects of her life that she highlighted as influencing her thinking about drinking included her work role and environment which, when combined with the stereotypical representation of drinking held, impacted on the coping mechanism (6) she chose because of the need to prevent others from knowing about her drinking: it meant, she did not wish to attend AA, her GP or alcohol services. As her job was stressful (2), she also identified it as a cause of her drinking: alcohol became a form of medication for stress and other negative emotions, as well as a way to achieve self-confidence when a young woman. She noted that, from an early age, her social life had revolved around alcohol and pubs and that leaving home led to increased drinking with the increased freedom it brought (2). She also noted that everyone had their own representation of problem drinking (4) and this "depends on your personality, depends on your background and lots of other things".

The stimuli (3) that prompted her to action was her child getting older and staying up later so delaying Anna's starting time for drinking, and causing her discomfort. A number of representations were activated by this (4): firstly, the image of the 'normal' drinker, secondly, the stereotype of the 'alcoholic' as someone whose life and drinking were out of control, and who was losing everything and thirdly, her representation of herself-as-drinker which did not match either stereotype. She also

held a negative representation of AA as somewhere shameful to go to and cult-like whose approach she would not agree with: “I just would not have felt comfortable with it at all, not at all” (her emphasis). This is derived from her experience of talking to AA members, not from using the group. Deciding to look online (8), her initial search on Google was, as noted above ‘semi-directed browsing’. Once she had found the forums, she evaluated them (7) and moved quickly to post (10):

> “I posted the first day that I found it…everybody that goes to the site is encouraged to introduce themselves…and I think because I got several responses almost instantly, that kind of makes you think, "Ooh, you know, this is somewhere that I feel quite comfortable", really from the beginning.” (Anna, Group A)

This implies at least two quick iterations of the ‘coping mechanism – appraisal – coping mechanism’ loop: initially, she assessed the forums as somewhere she would try posting and secondly, through the responses to her post, as somewhere she felt comfortable and therefore would continue posting (the forum impacted emotionally as well as cognitively). She subsequently used the forums to search for and share information, and for the information-related activities of celebrating successes, getting ‘therapy’, being accountable and planning (10). She searched by home thread, and later, when she became a group moderator, by threads for newcomers and by threads for emergencies. Thus her search mechanisms altered over time, as did the parts of the site she used (initially she used the information pages much more than she did later). She noted the iterative, loop effect of using the forums: reading and sharing led to support from others which enabled her to feel safe and to be still more honest with herself and the group, leading to more support, feeling even safer, and more sharing, so aiding problem recognition (5). In terms of the impact of the forums on her representations, she noted that it had helped her realise the importance of mental attitude and motivation, the need to put something in the place that alcohol had previously occupied and that it had given her useful information on coping mechanisms, such as dealing with difficult situations. It also changed her view of how widespread problem drinking is (‘normalising’ it), and of its controllability. It is also important to point out that these changes in her representation of problem drinking, and herself-as-drinker, were also influenced by the outcomes of the actions she took at the same time in altering her drinking.

Megan’s representation of problem drinking

Megan (Group F) talked about a number of socio-cultural impacts (1) on her representation of drinking including the so-called ‘ladette’ culture of the 1990s in the UK, the embedded nature of

drinking in Western society and differences in cultural attitudes to drinking in different societies including the UK, USA and Sweden. She also talked about drinking's place within London business culture. In terms of herself as the person-in-context (2), the aspects of her life that she highlighted as influencing her thinking about drinking included her work environment (she previously worked in a heavy drinking environment where it was seen as the norm), peer pressure from her social group and how being the mother of a young child influenced the coping mechanisms open to her. She presented herself as someone very influenced by her circumstances and habit, who did not see the influence of genetics as important.

The stimuli (3) that prompted her to use the forums was accidental in that she encountered information about Group F whilst flicking through a magazine. She took the information away and came back to it later after "a slow dawning realisation that [she] probably need[ed] to do something about it [her drinking]". Representations activated by this realisation (4) were those of the 'normal' drinker and that AA was something that she would not like and that was not practically possible because of her child. Throughout her journey she remained someone who tried hard to maintain the appearance of a 'normal' drinker, giving socially acceptable excuses for not drinking, such as being a designated driver or not drinking 'at the moment'.

After checking out the forum (8) she evaluated it (7) as something she "could relate to" (she said the same of the Quit Lit that she also read: see Glossary). She assessed the forum as 'interesting' with 'diverse' members and continued to use it (10), predominantly to read posts, but also to comment on others' posts and give support. She was a berrypicker, using multiple sources, different ways of searching (for tips, for different types of people) and explicitly taking bits from different places:

> "so you're going to find your person that you can relate to…you're not going to go on to [Group F] and think, "Oh there's no one like me on there". Even if you pick little bits from different people" (Megan, Group F)

Her usage changed with time, moving from having more questions at the start to posting to provide support. In terms of information-related activities, she saw others using the forums in those ways rather than undertaking them herself, although she did use the forum as a lifeline and a place to celebrate (10). In terms of the impact on her representations (4), it appears to have changed how she saw the symptoms of problem drinking. It also made her realise how widespread problem

drinking was and that something could be done about it (5, 6). Overall, she regarded the forum as having reinforced her ideas and as having contributed to them along with many other sources.

7.3.4 Strengths and weaknesses of the combined model

The combined model is useful as it allows space for the influence of the many contextual factors impacting on beliefs about problem drinking which reflects what interviewees said and what was seen in the texts that were analysed. It is also flexible, describing an ongoing process capable of many iterations: several of the interviewees noted that developing a representation is not a static process. The model is useful in drawing attention to different core elements of, and influences on, representations of problem drinking. Ford (2015) noted that it is helpful and important to build on existing theory which the combined model does in joining and developing two well-respected models. Like the original Wilson model, it can incorporate other theories, as was shown in the discussion of modes of searching above. However, it should not be taken as a rigid process, neither should it be expected that all elements come into play in every instance, as was shown in the two examples above where information avoidance did not appear. It is limited in that it does not include any coping mechanisms other than information-related ones.

7.4 The links between information behaviours and user representations

This study is unique in exploring in detail how information behaviours within these online groups contributed to the development of representations of problem drinking in non-12-step AOSGs. It was shown that using the forums could impact on the ideas/representations held, but also that ideas from the forums could influence the way they were used and the information behaviours adopted. Interviewee Alan is a good example of how using the forums led to changes in his belief about coping mechanisms: he came to see moderate drinking as rarely successful, a view brought about by seeing many stories and anecdotes of failure in the forums. This change in belief led in turn to changes in his use of the forum (he withdrew from it, posting less frequently). This example also illustrates the importance of the cumulative and longitudinal aspects of the forums, as it was seeing many examples of moderate drinking failing over time (as well as his own experience) that caused this belief / behaviour change.

Finding ‘someone like me’ can both cause and be caused by specific information behaviours. The desire to find someone like themselves can lead users to choose and stay with a particular group, as was discussed in Section 6.2. In other words, it may prompt initial information seeking, and affect group selection and continuing membership. It may impact on the searching techniques then used

as people search for others like themselves, and on the selection of information as they focus on those with whom they identify (see Sections 6.3.4 and 6.3.5). Conversely, they may join the groups and use them regularly for other reasons but with this leading them to recognise others like themselves. Again, there is an important cumulative and longitudinal effect as people use the site over time, enabling them to assess who is like them and who is not and to see how things develop for people like themselves.

Behaviour and beliefs were also intertwined in the way that users searched: as there were 'no requirements of belief', berrypicking was acceptable behaviour, and was appropriate, even encouraged, as, for example, with newcomers in Group A. Berrypicking effectively freed users to make their own decisions, using material from any sources that 'resonated' with them. As a consequence, each person's representation was unique to them. This freedom was also supported by the fact that there are many different sources of different types for users to choose from, and many different explanations of problem drinking.

The presence of berrypicking as a form of information-searching in online support groups has not been noted before, although some descriptions of users mixing and matching ideas come close. For example, Kaskutas argued that women were "adopting aspects of several belief systems" in her study of WFS and AA (1992, p645). Godbold, in an analysis of renal OSG discussion forums, found that beliefs were "transient and customised" (2012 p43) By 'customised' she was signifying that beliefs were individualised and made personal rather than being adopted wholesale. Her description of sense-making in the groups appears to be similar to berrypicking in terms of the selection of material:

> "They contributed nuanced descriptions of their own situations, creating a loose-knit array of possibilities, from which [those writing] new posts picked ideas and placed them in new arrangements as the need arose." (Godbold 2012, p67)

The mention of beliefs as being transient also points to fluid beliefs that change over time. Other scholars have noted that illness representations develop as the person acquires more information and experience: they are "in effect cumulative, with information being adopted, discarded or adapted as necessary" (Hale, Treharne & Kitas, 2007, p904). Whereas AA relies on the 'received wisdom' of the experience of AA members over the years and the teachings of the *Big Book*, it was shown that many of the other groups required the person to discover their own interpretation of

problem drinking, selecting tools and explanations as they chose, rather than having a one-size-fits-all approach. Berrypicking may prove a useful theory for understanding information behaviours in other online support groups particularly where there are multiple and/or contested explanations of the problem. It should be noted that a factor that may have contributed to berrypicking may be the levels of education of the participants. It is possible that, being highly educated, this cohort had more confidence in selecting and assessing information, and therefore felt more at ease with rejecting group beliefs that did not appear true to them.

Godbold was writing from a social constructionist perspective, in which knowledge is seen as developed jointly with others and people collaborate to achieve understanding. At first sight, this appears a highly appropriate theory to explain what was observed in the present study. The groups themselves and beliefs about problem drinking are social constructs, as was discussed in Section 3.2. It could also be said that members' self-presentations on the sites are, ultimately, constructs influenced by the norms, language and habits of the forums (see Section 6.7). It cannot be assumed that what a person says online is an accurate reflection of their 'real' beliefs or that these beliefs are settled. The findings indicated that the non-12-step group users do partly work out their ideas through seeing and talking to others in the forums, using material shared by others to create their representations. They test ideas in the forums and sometimes indicate that they find it important to challenge each other. However, they do not necessarily arrive at joint meanings with their group and the emphasis is very much on finding what works and rings true for them personally. They also use private study to develop their ideas and draw on multiple sources, with some participating in more than one group at once.

Godbold argued that descriptions of experience in the renal OSGs were central to creating beliefs: "generic information such as facts was usually contextualised by descriptions of lived experiences" (201 p43). Many previous scholars (e.g., Hartzler & Pratt, 2011; Coulson, 2014; Chuang & Yang, 2010; Allen, Vassilev, Kennedy & Rogers, 2016; Kingod, Cleal, Wahlberg & Husted, 2017) have noted the importance of experiential information in support groups, and the present study supports this. Experiential information is at the heart of the way users are expected to communicate. Some discussions on moderate drinking by the interviewees also showed that they operated by allowing people to enact their own ideas and reach their own conclusions, again showing a respect for experience. However, it was also noted that other types of information are valued, including scientific articles, recommendations, direct advice and references. This is something that is seen by

group users as very different to AA, which is described by several as anti-intellectual and emphasising believing, not thinking or questioning.

When it came to the evaluation of information found, the key element appeared to be that their representation should make sense to them. They used their experience and current ideas to evaluate the information they found, working out what 'resonated' with them, a word repeated by several interviewees, signifying what felt right and made sense in terms of their life and experience. This term was also noted by Chambers (2017) with regard to Soberistas. Users did not generally adopt beliefs because they were the most authoritative by scientific criteria and their ideas were not always clear cut or consistent (again, as also noted by Chambers, 2018). It was shown that some groups valued information standards, notably Group B in theory and Group C in both theory and practice, but, overall, members displayed a confidence in, and reliance on, their own judgements.

A number of other information behaviours were identified as being used in the forums: people share information in a variety of ways and also use their site for information-related activities. As noted above, the sites effectively act as equivalents of Fisher's 'information grounds' (Fisher in Fisher, Erdelez & McKechnie, 2005), but for information-related activities other than information seeking: for example, although people use threads to diarize or celebrate they are unlikely to have sought out the forums for these specific purposes. Information avoidance was also found, and was not always about denial or negativity. It can operate as a protective mechanism and a positive action, as in the case of interviewee Cara (Group F), who avoided debating the question of 'what is a problem drinker' in order to protect her sobriety "if I start getting into the what is a problem drinker then [pause], I start to question myself almost, if that makes sense?"

7.5 The contrast with AA/12-step groups

Whilst this study focused only on non-12-step groups, it is interesting here to highlight briefly the contrast with 12-step groups, specifically AA, as regards use of information. AA in its face-to-face format is the dominating presence in the field of alcohol support groups, has received considerable research attention and has influenced many alcohol specialist services: it is thus a presence that needs to be acknowledged. In its face-to-face format it was attended by several of the interviewees and was still used by at least two of them. Prior to this study, the researcher thought that non-12-step groups might operate in a similar way to AA, but this was shown not to be the case in practice.

The present findings, when contrasted with the research literature on AA, show that there are some notable differences between the discussion forums of non-12-step AOSGs and face-to-face (F2F) meetings of AA groups in terms of information sharing. Most obviously, there are different approaches to disagreeing, commenting or feeding back directly on another member's share, and to providing advice. These activities are acceptable and commonplace in non-12-step groups, but not in F2F AA meetings. AA's distinctive method of conveying disagreement and/or advice using story and "advice disguised as self-disclosure" (Lewis 2014, p10) was discussed in Section 2.7.1 of the literature review. 'Cross-talk' or "directly challenging or refuting another participant" (Swora 1996, p79) is strongly discouraged in AA meetings, but was acceptable in the non-12-step online forums. According to users, as mentioned above, there is also a different approach to scientific research, intellectual discussion and providing references to non-AA literature. AA was seen by them (fairly or not) as opposed to these and promoting acceptance and belief, rather than independent analysis, thought and judgement.

The present findings have highlighted berrypicking as a key feature of the non-12-step discussion forums and argued that it is possible because there are 'no requirements of belief'. AA, at least in its face-to-face format, is not a hospitable environment for berrypicking. It expects users to adopt its beliefs and definition of problem drinking and to re-work their identity in line with the AA community narrative. Lave and Wenger (1991), amongst others, have argued convincingly that it falls closer to a 'community of practice' model whereby newcomers are taught AA's world vision and gradually move from the periphery of the group to the centre, becoming experts in the philosophy through the telling and retelling of stories. This was discussed in full in Section 2.7.1.1 of the literature review. Further research is needed to confirm whether this distinction is the key difference between AA and non-12-step discussion forums when it comes to information behaviours.

Other differences in terms of information are that role modelling, found in the non-12-step groups, is officially discouraged in AA as all members are equal. AA does encourage sponsors, but there is a difference: a role model is someone that one would want to emulate, whereas an AA sponsor is someone that guides a person through working the programme, whose advice should be followed. Both AA meetings and non-12-step discussion groups use mantras but, as was shown, these are often personalised in non-12-step AOSGs to the poster, whereas in AA they are the 'crystallised wisdom' of the group, common to all members.

The present study was focused upon online non-12-step groups and did not analyse postings from AA online meetings or discussion forums, or interview its users. What it does show clearly is that the representation of AA held by interviewees and in the forums contrasts clearly with the non-12-step groups. Members' experience of AA in practice has come from the face-to-face meetings not AA online: and it appears that they see significant differences between AA face-to-face meetings and non-12-step discussion forums.

7.6 'Restructuring' beliefs

In the literature review (Section 2.7.1.1) it was noted that Steigerwald and Stone (1999) argued that problem drinking was a thought disorder dealt with by 'cognitive restructuring' and that this could be achieved through participating in different aspects of AA or by therapy. Young (2011), in contrast, argued that it is by restructuring relationships and identities that AA achieves its effects. The present study supports both to an extent in showing how peoples' representations of themselves-as -drinker changed as a result of the forums, in terms of both their cognitive representation, and their identities.

The question remains whether it is the 'representation' of problem drinking that is changed, or their 'mindset' as regards drinking. Mindsets are defined as "lenses or frames of mind that orient an individual to a particular set of associations and expectations" (Crum & Zuckerman 2017). This study has found the concept of representations very useful for analysing users' sets of beliefs in a nuanced and consistent fashion and for highlighting alterations of specific dimensions as a result of using the forums. Where the concept of 'mindset' becomes helpful is perhaps in terms of thinking about groups' overall approaches, which were shown to be important to users, and appear to be a factor in their choice of group. Users may match themselves to groups with similar mindsets, but, within this, have the freedom to berrypick and make their own specific, personal representation.

7.7 Matching users to groups

Healthcare professionals, particularly alcohol specialists, undoubtedly have a role in providing information about sources of support (including AOSGs) to those with alcohol difficulties. The findings of this study have implications for the question of 'matching' participants to groups in terms of beliefs, i.e., taking account of the beliefs of the group and the individual and seeking a good match between them. The overall research evidence on matching is mixed, as was discussed in the literature review (Section 2.7.2), and this was supported in the present study. In terms of matching on the grounds of beliefs about problem drinking, it seemed to be important for potential users to

consider the overall approach of the group, but not the detailed programme of how to get sober, and the specific explanations of problem drinking. In these forums the detailed representations set out by the founders or administrators in the information pages did not necessarily filter through into member posts. It did not appear to matter to many of the interviewees whether or not their own ideas were in line with the group as a whole. One person accepted being out of line with the majority of the other members. This finding challenges Antze's (1976) statement that:

> "Each [self-help group] claims a certain wisdom concerning the problem it treats. Each has a specialized system of *teachings* that members venerate as the secret of recovery." (p324, his emphasis)

Chambers (2017, 2018) took a similar view that members are required to adopt their AOSG's beliefs. However, a large part of the point of several of these groups was, in fact, that they did not require members to 'venerate' their teachings and allowed them the freedom to judge for themselves.

It was also noted in the findings that threads within forums differ. If matching were to be considered, it may be that, as well as looking at the overall approach of a group, the differences amongst particular threads need to be considered. Referring potential users, not just to a group, but to particular sections within this could prove positive in helping users reach congenial areas quickly, but has a number of downsides. Firstly, it might discourage free exploration or lead the user to discount a group based on one thread. Secondly, the thread may change over time, so any referrals on this basis would need to check it regularly which is likely to be unfeasible. Thirdly, it may limit the benefits obtainable from a group by avoiding any constructive challenging or widening of ideas, and keeping the user in a 'thought bubble' of likeminded people. Overall, it is suggested that those involved in matching activities, such as those working in alcohol services or primary care, should a) take the overall approach of group and user into account as important and b) alert users to the possibility of variation between threads and recommend that they sample several before joining or dismissing a group. Further implications for practice are considered in the next chapter.

There are, of course, variations between the groups as well as similarities and this too needs to be taken into account if matching. For instance, the extent to which both users and the sites themselves saw the forums as an information source, and the predominating type of information sought and offered in them, varied among the groups. It was shown that, in Group B, many threads were in a question and answer format and the site was primarily presented as an information source. In Group

A, it was primarily seen as a source of support and empathy where people were encouraged to find places that appealed to them emotionally. Group C, like Group B, used a question and answer format and was seen as an information source, but in a way that was more similar to consulting an expert or handbook, as the moderators presented their knowledge as definitive answers based on scientific research into the method. Another aspect of variation involves the groups' cultures, and what might be right for the individual character: Group A primarily seemed a nurturing, encouraging and affectionate place, where Group B was more factual and harsh, and C was more logical and scientific, albeit supportive. It could be speculated that these differences in culture and in ways of communicating reflect the dominant nationality and accompanying communication patterns of the members, or of those who run the groups. For example, Group B is US dominated and the politer, less argumentative Group A is UK dominated, as far as we can tell. However, Group C is also US dominated and is extremely courteous, so this should not be exaggerated, and each group taken on its own merits. The specific culture of the group is probably more important that its nationality, and does need to be borne in mind if matching users to groups. Overall, this suggests that matching is a complex matter that needs to take at least these aspects into account.

7.8 Study limitations

There were some limitations inherent in the methodology, notably that the forum posts and the interviews may have been influenced by factors such as participants' accuracy of recall, desire to please (the group or the researcher) or to present themselves or their group in a particular light (see Sections 3.4.1 and 3.4.2 for a discussion of this and how it was mitigated). However, the use of the two methods worked well in counterbalancing some of each other's downsides (for example, the posts were not influenced by the researcher, where the interviews may have been).

The decision not to name the groups was possibly erroneous as it rendered it very difficult to provide information about them or to cite other researchers who had named them in their texts. On the other hand, it added an extra layer of protection to participant anonymity, which was very important.

In terms of implementation, as this is a stigmatized population that protects its anonymity, it was expected that recruiting interviewees would be difficult and this initially proved to be the case. Consequently, interviewees were recruited from groups on the basis of convenience with different numbers being obtained from each group. It could be argued that, as a result, Group F is over-represented in the sample. However, the study focused specifically on findings that were found in

more than one group and the researcher was particularly mindful at all stages not to over-emphasise findings from Group F. The recruitment strategy achieved its objectives in obtaining a range of differing groups, with variations in size, nationality and, above all, approach. Another limitation on recruitment is that the materials directed at recruiting interviewees may not have been sufficiently clear that participants needed to have past or present experience of using discussion forums, although this is set out in the information sheet as a prerequisite for participation. This may be a problem of terminology: it might be that, for those who were interviewed but could not be included, 'discussion forums' signified any interactive facility on the site. In future, the researcher would specify the scope of the phrase more precisely indicating that listservs and blogs were not included.

As was shown in Chapter 4, the interviewees were self-selected, white, predominantly highly educated, middle-aged and female. Apart from age, these demographics match those of many other studies of AOSGs, as Table 7.1 below illustrates (please note that not all data was available for all categories). It may be that this type of participant is more likely to choose to participate in research or that the researcher, being of the same demographic, attracted this group, but it is equally possible that this is a true reflection of users of this media. For example, in a 2017 article on online support groups generally, Turner noted that "The overwhelming majority of online support group participants are white" (2017 p13) and that they are typically highly educated. Citing Perrin and Duggan (2015), she argued that "Age and educational levels are factors in the general usage of the Internet, so it seems natural they would play a part in online support group usage" (2017 p13). She identified 52 or younger as the predominant age groups. Rowley, Johnson & Sbaffi (2016) also noted being female and more highly educated was associated with more health information seeking on the Internet.

Table 7.1: Demographics of participants in previous research on AOSGs

Author	Female	White	Majority age-group: 40-60	High level of education
Ashford et al., 2020		Y	Y	
Kirkman et al., 2018	Y		N	
Sinclair et al., 2017		Y	N	Y
Grant et al., 2017	Y	Y	Y	
Urbanoski et al., 2017	Y		N	Y
Sotskova et al., 2016			N	Y
Best et al., UK Life in Recovery Survey, 2015	N	Y	Y	Y
Khadjesari et al., 2015	Y	Y	Y	Y
Nagy et al., 2015	Y	Y		Y
Coulson, 2011	Y		N	
Hester et al., 2011	Y	Y	Y	Y
Cunningham et al., 2008	Y			
Kosok, 2006	Y	Y	N	Y
Klaw et al., 2000	Y			Y
TOTAL:	**10/11**	**8/8**	**5/11**	**9/9**

Being highly educated may have influenced participant confidence levels in terms of assessing and selecting information, making them more capable of berrypicking.

Another limitation is that of the possible impact of the researcher on the research in terms of her level of awareness of problem drinking and recovery (this was discussed in Chapter 3, Section 3.2 and 3.7.1). It is quite possible that many of the interviewees will have realised that the researcher had a degree of 'insider' knowledge and this may have influenced what they said and potentially have made them more comfortable to discuss matters openly. It was discussed on two occasions and both interviewees stated that they felt it to be an advantage, for example:

> "I think it's interesting. I think it makes you more insightful with the questions that you ask, so I think it's, it's a better thing." (Megan, Group F)

The interviewees were certainly not afraid to disagree with the researcher and to express their views. The researcher was very aware that she had good understanding of Alcoholics Anonymous and made every effort not to speak in the jargon of the group or to demonstrate any opinion on it following the discussions with Group D. This was not an issue with the non-12-step groups as she had little prior knowledge of them before commencing the study.

The thesis presented here is not intended to be generalisable to specific groups, but every effort has been made to contextualise points and provide rich description so that others may determine the transferability of findings. There will be limitations to this, for example, the nationalities here reflected the drinking cultures of Westernised societies and not the experiences of those from non-drinking countries. The findings are most likely to be transferable to other groups for stigmatised conditions, and those where there is no universally accepted explanation for the condition covered.

7.9 Conclusion

This chapter has discussed the findings obtained and explored their theoretical implications. It began with a brief recap of the findings and then presented a model for the role of information behaviours in developing representations in these non-12-step forums. The model was described and how it operates in practice was illustrated in relation to two of the interviewees. The chapter then went on to analyse how information behaviours contribute to user representation formation. It contrasted the present findings with research on AA and re-visited the debate about the matching of users to groups. Finally, the chapter looked at the study limitations.

The following chapter concludes the thesis, explores its contribution to knowledge, its implications for practice and suggestions for future research.

Chapter 8: Conclusion

8.1 Introduction

As explained in Chapter 1, the aim of this thesis was to examine how the discussion forums of non-12-step alcohol online support groups impact upon their users' understanding or 'representation' of problem drinking. In order to meet this aim, 1,500 posts from three such groups differing in location, size and approach to problem drinking and its treatment were analysed using thematic analysis. Twenty-two users from five non-12-step groups were also interviewed in depth about their representations and use of their group. Chapter 1 introduced the study giving background to key concepts. Chapter 2 reviewed the literature regarding representations and health support groups including those both offline and online for people with drinking problems, and presented the theoretical framework. Chapter 3 set out the methodology used and Chapters 4 – 6 presented the findings of the study. Chapter 7 discussed the implications of the findings, and presented a model of the role of information behaviours in representation formation in these groups. This chapter concludes the thesis by summarising the answers to the research questions (Section 8.2) and then setting out the study's contribution to new knowledge (8.3), its implications for policy and practice (8.4), and providing suggestions for future research (8.5).

8.2 Research questions

The research questions were first presented in Section 2.11.

Research question 1

Research question 1 was: 'How do the discussion forums of non 12-step alcohol online support groups (AOSGs) affect users' understandings of what it means to be a problem drinker (their 'representation' of problem drinking)?'

The study found that the discussion forums of non-12-step AOSGs influenced users' representations in two main ways, and these were discussed in Section 7.3. To summarise, firstly, they can alter (e.g., change / confirm / develop) specific aspects of the representation (for example, altering an individual's view of the way to deal with a difficult drinking situation). Secondly, as places where users could meet others like themselves (perhaps for the first time), the forums could have a more holistic effect and change how the person felt and thought about problem drinking and 'themselves-as-drinker'. This could have a profound impact in terms of alleviating self-stigma, enabling problem

recognition and acceptance and leading to changes in the representation and coping mechanism chosen.

Research question 2

Research question 2 was: 'How do specific information behaviours contribute to the development of users' representations?'

This study explored information behaviours found in the forums (such as seeking, sharing and using information) which contributed to the construction of representations of problem drinking. Berrypicking was identified as a key information seeking behaviour and it was argued that the absence of 'requirements of belief' supported the use of this. Each user was free to create their own explanation for problem drinking, rather than absorbing the interpretation offered by their group. Story-telling was shown to be an important way of sharing information, but in a slightly different fashion to how it is used in AA meetings (see Section 7.5). Whilst both types of groups use stories and anecdotes to convey members' thoughts and experiences, in AA this is presented without overt application to the individual addressed: it is 'advice disguised as self-disclosure' (Lewis 2014). In the non-12-step groups direct discussion, cross-talk and advice-giving was permitted. Disagreements were handled differently in the non-12-step forums compared to within AA, with debates and arguments being permissible in the former. Role modelling, slogans and mantras were also used and again, in a different fashion to AA as discussed in Section 7.5.

8.3 Contribution to new knowledge

8.3.1 Empirical

The study's empirical findings provide a number of contributions to knowledge, the first three of which were discussed in Section 7.2. To recap, firstly, the research expands the scant literature available on non-12-step AOSGs, by including the analysis of lesser-known groups. Secondly, the findings contribute to addressing the gap in knowledge about the relationship of information sources to representations noted by Katavic et al., (2016) and others. Thirdly, the research addresses the gap in qualitative studies of user experience of discussion forums of non-12-step AOSGs, providing a rich picture of their information journeys on the sites. This adds to the limited literature giving the voices of this hard-to-reach group, as noted by Smith-Merry et al.:

> "there is a clear lack of in-depth, qualitative accounts of experiences of forum use in the context of an individual participant's life." (Smith-Merry et al, 2019)

In addition, fourthly, the research brings together information-related activities and functions carried out in the non-12-step AOSGs which, to the researcher's knowledge, are not discussed together elsewhere in the literature. This includes using the site:

- As a memory aid;
- To celebrate;
- As a lifeline;
- For planning and accountability;
- As a form of therapy; and
- As a place for empowerment and awareness raising.

The research presented in this thesis suggests that the groups could be seen as forming an equivalent to Fisher's 'information grounds' but for information-related activities other than giving or receiving information. Fifthly, the study contributes to the literature and recurrent debate about matching participants to groups, here in terms of matching based on the concordance of group and user representations of problem drinking. It suggests that matching, in terms of the overall approach held to problem drinking, is important, but that matching on specific dimensions of representations or the detail of coping mechanisms is not. The practical implications of this will be considered in Section 8.4. Sixthly, the research highlights differences in the ways that F2F AA and non-12-step groups share and convey information, specifically around disagreements, direct advice-giving, role models, mantras and stories. Finally, the study, in exploring information behaviours used in these forums, identified 'The Moderate Drinker's Tale' as a community narrative, important in its own right in several AOSGs, not just as a part of the AA 'resurrection' narrative. It also identified other possible community narratives.

To the best of the researcher's knowledge, there appear to be no other in-depth studies of the role non-12-step AOSGs and their discussion forums play in creating or influencing representations, despite the interest in, and debate about, beliefs about problem drinking. Chambers' work (2017, 2018), written well after the start of the present research, comes closest to addressing this. In the first part of her study of problem drinking and recovery identity, she interviewed users of the non-12-step AOSG Soberistas and found that identity change was central to recovery including internalising a Soberistas "group identity" (2017 p76) and a Soberistas 'worldview' in line with the site's pro-sobriety, anti-shame stance. This is attributed to use of the forum and peer pressure from

other members, plus the fact that the 'identity' resonated with the person, seeming appropriate and true (Chambers et al., 2017). This sounds similar to how AA operates (discussed below). However, as described in more detail in her thesis, users do not absorb a detailed and comprehensive worldview, as in AA, but rather a general approach and ethos, limited to the elements of being pro-abstinence, in favour of healthy living, and non-judgemental. Chambers' work with this AOSG differs from the present study in not exploring the different aspects of beliefs about drinking or where these have come from. The findings of the present study support her conclusions as to the importance of identity change away from the stigmatised label of 'alcoholic', but do not support the implication that this is done by substituting a different kind of group identity / philosophy. On the contrary, they indicate that freedom to develop one's own label and definition of problem drinking and the self-as-drinker was seen as key.

The second part of Chambers' work, looking at hospital patients, included in-depth interviews with 26 diverse individuals six months after hospital attendance. This study did emphasise the individuality of recovery and recovery stories and explored what affected users' development of an identity as a problem drinker, specifically the effect of degree of dependence upon alcohol and beliefs held about the cause of problem drinking. In terms of cause, Chambers noted great heterogeneity and inconsistency of ideas among people and even within them at different times. Chambers went on to argue that one explanation for this may be the presence of many different discourses about problem drinking that are available:

> "further analysis suggested that even treatment-naïve participants had been exposed to numerous 'addiction' discourses via the media, their social networks, or during their hospital attendance/admission…These discourses might include an amalgamation of views from healthcare professionals, other people with lived experience, researchers and/or policy-makers" (Chambers, 2018)

Chambers agreed with Pickersgill et al. (2011) that her interviewees were "bricoleurs' assembling explanations by combining elements from different belief sets. This comes close to suggesting the berrypicking approach to developing beliefs that the present study's findings support, but does not explore beyond the dimension of cause, nor discuss the role of information behaviours in the formation and conveyance of representations. The present study analyses how information behaviours support the 'bricolage' and explores users' beliefs in greater detail than Chambers' work. The level of detail brought to the study by using the CSM, highlighted that users were not absorbing

a world view: each of the interviewees had a slightly different representation, and they set great value on freedom of thought. This research thus raises questions about Chambers' claims that non-12-step AOSG users have to conform to group beliefs, finding that the 'bricolage' Chambers observed in hospital patients is closer to what is occurring in these AOSGs.

8.3.2 Theoretical

The study offers a new model of the role of information behaviours in the formation of representations, bringing together and adapting two existing and well-established models. It is also the first study to explicitly identify Bates' berrypicking (1989) as a key information-seeking activity in non-12-step discussion forums and the first to show how the four main features of the theory appear in the forums. This contrasts with Lave and Wenger's findings (1991) that AA follows a 'community of practice' model in conveying its messages to users through the telling of stories. It is possible that berrypicking may also be found in other online support groups, particularly where the condition covered is contested and/or has no single definitive explanation. This study also explored the use of Leventhal and colleagues' Common Sense Model to analyse user representations, finding this to be very helpful. The study thus extends the literature on the CSM and provides additional support for its use.

8.4 Implications for policy and practice

Peer support is recognised (including by NICE, 2011) as important in recovery from problem drinking. However, many of the interviewees and several of the forum posters made it clear in this study that they actively disliked AA, or did not wish to attend it, preferring groups with other approaches and greater flexibility as regards members' beliefs. AA does not appear to work for everyone: as the recent Cochrane Collaboration's review of the evidence on the effectiveness of support groups noted:

> "forceful referral of people to 12 step self-help groups without respecting their own explanatory models of understanding their addictions and illness was counterproductive." (Kelly, Humphreys & Ferri, 2020)

There is, then, a need for alternatives providing peer support, information and different models of addiction to users. Non-12-step groups are candidates to meet this need, and this study indicated that they were seen as beneficial by many of the interviewees. At the same time, less is known about these groups compared to 12-step groups and they are less well-researched. The information

journeys described by the interviewees here indicated that serendipity and passive information searching frequently played a role in finding these groups and only one individual was referred by a healthcare professional. It seems likely that many of the healthcare professionals who come into contact with people with alcohol problems are unaware of the groups and would benefit from information about them, as indeed could policy makers such as NICE or Public Health England. This would extend the range of options they can suggest to their patients/clients who request information about, or would benefit from, peer support. They should also not restrict themselves only to the better known non-12-step groups, e.g., Smart Recovery, Moderation Management, Women for Sobriety, but make people recovering from alcohol problems aware of the wide range of support available to them online. At the same time, it is acknowledged that there can be downsides to using online groups (as is also the case for face-to-face groups) and people may need advice on how to select a group and how to stay safe in one. It is important to raise awareness further amongst policy makers and practitioners of the groups, their benefits and drawbacks and how best to use them.

One of the reasons some of the interviewees used the online groups was that they potentially offer more privacy compared to attending a face-to-face AA meeting or entering an alcohol service. Because of this, they are very helpful for people who wish to remain hidden (such as, for instance, interviewees Anna and Grace). The option to lurk may be particularly attractive to the demographic group seen in this study (as well as others), i.e., of educated, older women whose lives are still apparently functioning well. This strength of the groups should be part of the awareness raising with healthcare professionals and policy makers.

This study has shown how stereotypes such as that of the 'alcoholic' can act as a barrier to problem recognition and acceptance. It supports the work of other scholars (e.g., James Morris) and organisations (e.g., Alcohol Change UK, Scottish Drugs Forum) on the framing of alcohol problems. There are important implications in this for practitioners and policy makers and how they diagnose and describe problem drinking and how they present interventions. Use of terms such as 'alcoholic' can prevent people from recognising they have a problem and renders the issue a binary matter (alcoholic / not alcoholic) rather than a spectrum of difficulties. Avoiding terms such as 'alcoholic' could lead to greater problem recognition and acceptance, and improve uptake of treatments and help, particularly among the under-served demographic of drinkers who are not yet at the extreme end of the scale of problem drinking.

Finally, as regards the issue of matching users to groups, the findings suggest that this may be helpful when done in terms of overall approach to problem drinking, but that it is not necessary at the level of site-specific programmes for recovery. The research suggests that individuals will form their own representations about problem drinking, taking what they find helpful and leaving the rest. Some suggestions have been made in Section 7.8 about matching: if this is to be carried out, it should not be done just on the basis on beliefs but take other factors into account such as group culture and purpose.

8.5 Suggestions for future research

This study focused on six non-12-step AOSGs but there are many more which are similarly under-researched, or not researched at all. There is, then, considerable room for further studies in this area to explore different aspects of the lesser-known groups and how they work. This would include investigating them in the light of the present study's findings and comparing them with 12-step groups, notably AA. With the move to digital services, especially during the Covid-19 pandemic, such studies would be very timely, and would also benefit future participants who will have grown up, or become accustomed to, using online services and so might be inclined to look at digital options first.

This research included analysis of forum threads over differing periods of time, but it did not follow any one individual's representation development over time. It would be very interesting to carry out a prospective longitudinal study tracking this development in one or more people. This could include usage of different parts of a site (e.g., the chat or listserv functions as well as the discussion forums), and also explore movement between different AOSGs. This would require careful consent and ethical procedures to protect the individual(s) and groups from identification as much as possible and to ensure they were aware of the risks.

The berrypicking approach was found to be very helpful for explaining the process of representation development in these non-12-step groups. It would be useful to explore its presence in other AOSGs, and also in other types of online support groups, particularly where the explanation of a condition is contested.

The interviewee Yvonne speculated that the view of giving up alcohol as a positive beneficial thing to do could be tracked back to the writings of Jason Vale and Allen Carr (see Section 5.2.3). Future research could explore the intertextuality of Vale and Carr's writings with later 'Quit Lit' to see if this

surmise is validated. It would also be interesting to examine the moderate drinkers story as a community narrative, and its use and ubiquity in alcohol writings.

Finally, this study found a clear difference between the groups studied and face-to-face AA. However, there are still unanswered questions as to whether or not there are differences between AA meetings online and offline, and also between AA meetings held online and AA discussion forums online. It would be very interesting to explore this with reference to representation development and to see if there is greater latitude for berrypicking in online groups compared to offline ones, and in one or other form of meeting.

8.6 Conclusion

In conclusion, this study has explored the contribution of the discussion forums of non-12-step AOSGs to the development of users' representations about problem drinking. It has found that the groups have an impact on members' belief-sets beyond simply attracting like-minded people. The groups may alter one or more specific aspects of the representation, and/or impact holistically on views, changing how a person thinks and feels about problem drinking and themselves-as-drinker. Perhaps their greatest impact is in showing people who feel stigmatised and ashamed that there are others like themselves and they are no longer alone. This is very important, because stigma is a powerful barrier to acceptance of the problem and to treatment of any kind. In this field, as in so many others, people's beliefs matter greatly as they affect problem recognition, the coping mechanisms used and, therefore, the outcomes achieved.

The study is particularly timely as the advent of the Covid-19 pandemic has brought restrictions on people's movement and socialising in groups, affecting face-to-face meetings for recovery. As the Alcohol Health Alliance has stated, there is a need for:

> "services that [ensure] people affected by alcohol harm have the resources they need to continue their work during, and after, lockdown. With treatment services facing increased cuts over the last 10 years, peer support groups have been absolutely crucial in reducing alcohol harm so it is essential that they can continue to function effectively in this age of social distancing." (Alcohol Health Alliance UK, 2020)

For many, the online groups are highly valuable alternatives to, or supplements for, in-person meetings and services, and this is likely to increase as more and more services move online in the UK whether from necessity or choice.

List of Abbreviations

AA	Alcoholics Anonymous
AOSG	Alcohol online support group
CBT	Cognitive Behavioural Therapy
F2F	Face-to-face
HBM	Health Belief Model
HSG	Health support group
LR	LifeRing
MM	Moderation Management
OHSG	Online health support group
OSG	Online support group
PM	Personal message(ing)
RCT	Randomised Control Trial
RR	Rational Recovery
SOS	Secular Organisation for Recovery / Save Our Selves
SR	Smart Recovery
SWIM	Someone who isn't me
TA	Thematic analysis
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
WFS	Women for Sobriety

Glossary

Collaboration (in information behaviours)

Co-constructive collaboration: "At a co-constructive collaborative level, information flows and use are collectively reconceptualized and reorganized (rather than just being executed) in order to achieve a common goal." (Ford, 2015, p83)

Co-operative collaboration: "At a co-operative collaborative level, where participants share a common goal, information tends to be shared routinely and formally. An example would be of participants sharing information in order to explore an issue and come to a decision." (Ford, 2015, p83)

Co-ordinated collaboration: "At a co-ordinated collaborative level, although they share information, participants do not do so on the basis of having a shared goal. At this level, sharing is often random and informal. For example, a university researcher might come across and share information that they think might be useful to a colleague working on another project." (Ford, 2015, p83)

Discussion forum

Discussion forums are the sections of an online support group's website where people can discuss topics and give each other support and information: "A venue or medium for discussion; (now) specifically (Computing)" (Oxford English Dictionary, 2013). They are distinct from chat rooms in that they are asynchronous whereas chat rooms are for discussions in real time. Chat rooms are also not usually organised by topic or other divisions: they form a continuous stream of interchanges. For the purpose of this study, the term 'discussion forum' is used interchangeably with 'discussion / message boards' and 'online forums'. People using them are referred to interchangeably as 'users' or 'members'.

Information behaviour

This study follows Wilson's definition, where 'information behaviour' signifies:

> "the totality of human behaviour in relation to sources and channels of information, including both active and passive information-seeking, and information use." (Wilson 1999, p249)

Information behaviour includes identifying an information-related need, seeking information (or avoiding / hiding from it), sharing it, and evaluating, managing, and using it

Information searching

Looking for information using a particular search tool, for example, a database or search engine (Ford, 2015)

Information seeking

The general activity of looking for information, which may employ the technique of information searching, but also activities such as browsing. (Ford, 2015)

Information sharing

Sharing information with another person or persons, either publicly or privately

Non-12-step group

An alcohol support group that does not follow the 12-step programme for recovery of AA

Online support group

Websites where groups of people facing similar illnesses, life challenges or difficulties communicate with each other over the internet, providing each other with support, advice and information. Also known as online 'self-help groups', 'peer-to-peer support groups', 'support communities' or 'mutual aid groups'.

Problem drinking

There are many definitions for this, but here it is taken as signifying alcohol drinking that has become problematic for the individual to such an extent that they are seeking information and support to deal with it.

Quit Lit

A sub-genre of literature, comprising popular materials about recovery from problem drinking. This can include, for example, biographies, autobiographies, novels, self-help materials, popular science books, blogs and webpages

Representation

Representations are "the organized cognitive representations or beliefs that patients have about their illness" (Petrie, Jago & Devcich, 2007, p163) or "patients' beliefs and expectations about an illness or somatic symptom" (Diefenbach, n.d.). In this research, the term 'representation' (rather

than ‘illness representation’) is used to accommodate beliefs about problem drinking as something other than an illness.

Thirteenth stepping

Pursuit of new members of AA groups by more experienced members for sexual/romantic purposes

Twelve-step group

An alcohol support group that follows the 12-step programme for recovery of AA. This may or may not have links to AA itself.

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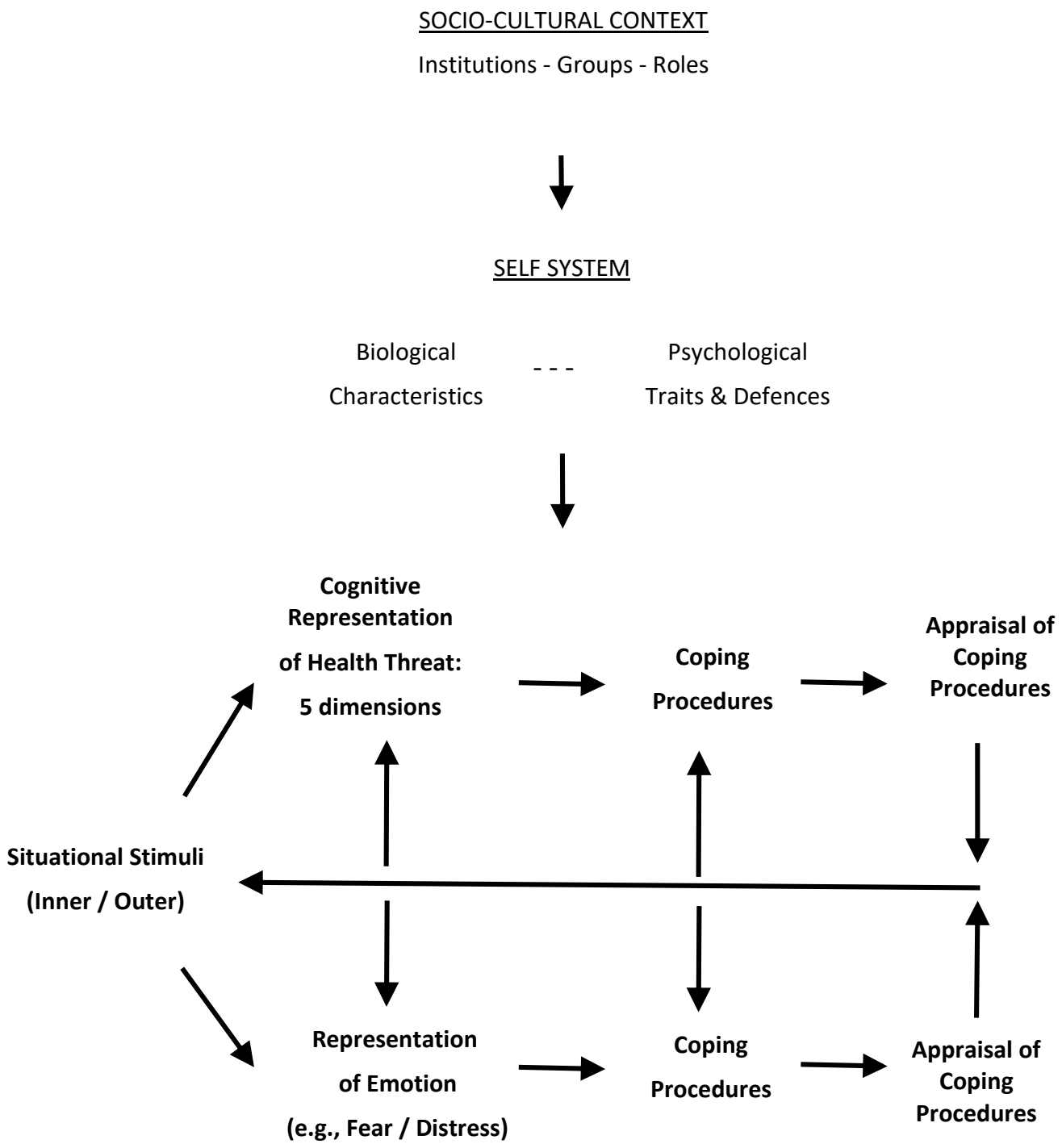
Appendix 1: Leventhal et al.'s Common Sense Model of Illness Representation



Adapted from Leventhal, Diefenbach & Leventhal (1992)

Appendix 2: Search Strategy, 2016

1. General topics covered

Any previous research into:

- Illness representations including in relation to alcohol
- Support groups
- Alcohol online and face to face support groups (AOSGs)

2. Generic limiters used

- English
- Preferably scholarly journals

3. Sources used

- ProQuest: proved to be a very fruitful source of research, particularly for PhD level theses as the subject matter is topical
- Pubmed: chosen for currency as including items not already on Medline
- Medline: chosen for coverage and search facilities
- Scopus: helpful for pursuing citation searching
- Google Scholar: used given the up-to-date nature of the topic

4. Search topics

- Search 1: anything written on **illness/condition representations,** including in relation to other central topics
- Search 2: anything written on **health support groups** and **online health support groups**
- Search 3: anything written on **alcohol support groups** and **alcohol online support groups**
- Search 4: what roles can **online support groups** generally play in constructing users' **illness/condition representations?**
- Search 5: what roles can **alcohol online support groups** generally play in constructing users' **illness/condition representations?**

Additional searches were conducted on the names of the most publicised alcohol support groups: Alcoholics Anonymous, LifeRing, Moderation Management, Rational Recovery, Smart Recovery and Women for Sobriety, Secular Organisations for Sobriety

5. **Key terms and generic search strings used**

Alcohol, Alcoholism, Alcoholic, Drink(ing), Problem drinker(s), Problem drinking, Problem alcohol user(s), Alcohol use disorder (AUD), Alcohol misuse, Alcohol abuse, Alcohol related problem(s), Alcohol dependence, Alcohol dependence syndrome (ADS)

Generic search string 1

alcohol* OR drink* OR "problem drink*" OR "problem alcohol user*" OR "alcohol use disorder" OR "AUD" OR "alcohol misuse" OR "alcohol abuse" OR "alcohol related problem*" OR "alcohol dependence" OR "alcohol dependence syndrome" OR ADS

Illness, disease, condition, habit

Generic search string 2

Illness OR disease OR condition OR habit

Representation, belief, interpretation

Generic search string 3

Representation* OR belief* OR interpretation*

"Illness representation*"

Support group(s), self-help group(s), 12 step group(s), mutual help group(s), mutual self-help group(s)

Generic search string 4

"support group*" OR "self?help group*" OR "12 step group*" OR "twelve step group*" OR "mutual help group*" OR "mutual self?help group*" OR "mutual aid group*" OR "self?help communit*"

Online support group(s), Online self-help group(s), Online community(ies), Online 12 step group(s), Internet group(s), Online mutual help group(s), Online mutual self-help group(s), Virtual community

Generic search string 5

"online support group*" OR "online self?help group*" OR "online communit*" OR "online 12 step group*" OR "online twelve step group*" OR "internet group*" OR "online mutual help group*" OR "online mutual self?help group*" OR "virtual communit*" OR "online mutual aid group*" OR "online self?help communit*"

6. Specific search string combinations used

Generic Search Strings (as described above)

1 = alcohol, 2 =illness, 3 = representation, 4 = support group(s), 5 = online support group(s)

Search 1: anything written on **illness/condition representations,** including in relation to other central topics

Strings 2 AND 3

Strings (2 AND 3) AND 1

Strings (2 AND 3) AND (4 OR 5)

Strings (2 AND 3) AND (4 OR 5) AND 1

Search 2: anything written on **health support groups** and **online health support groups**

String 4 AND health

String 5 AND health

Strings (4 OR 5) AND health

Search 3: anything written on **alcohol online support groups** and **alcohol support groups**

Strings 1 AND 4

Strings 1 AND 5

Strings (4 OR 5) AND 1

Search 4: what roles can **online support groups** generally play in constructing users' **illness / condition representations?**

Strings 5 AND (3 AND 4)

Search 5: what roles can **alcohol online support groups** generally play in constructing users' **illness / condition representations?**

Strings (1 AND 5) AND (3 AND 4)

Appendix 3: Tables giving examples of the search results for groups, 2016

Table A3.1: Alcohol online support group generic search 1, 2016

This search identified one relevant item which was an analysis of an individual AOSG.

Database / Search Engine	Date	All field search	Title field search	(Of these) Journal articles
ProQuest	26/5/16	0	0	0
Pubmed	26/5/16	263	0	0
Medline	17/5/16	22,391	0	0
Scopus	7/1/16	0	0	0
Google Scholar	13/2/16	0	0	0
Relevant & duplicates removed		1 (from first 50 items per source) Specific item re AlcoholHelpCenter	0	0
Total number unique items to date (all field and title field totals): 1				

Table A3.2: Alcohol online support group generic search 2, 2016

This identified no journal articles with the terms in the title, but did identify some relevant items in the All field searches.

Database / Search Engine	Date	All field search	Title field search	(Of these) Journal articles
ProQuest	26/5/16	12,174	0	0
Pubmed	26/5/16	4	0	0
Medline	26/5/16	9,292	0	0
Scopus	26/5/16	715	0	0
Google Scholar	26/5/16	17,300	0	0
Relevant & duplicates removed		12 (7 of which are about individual groups)	0	0
Total number unique items to date (all field and title field totals): 12				

Table A3.3: Alcoholics Anonymous search, 2016

A search on "Alcoholics Anonymous" produced the following:

Database	Date	All field search	Title field search	(Of these) Journal Articles
ProQuest	17/12/15	16,297	1,160	806
Pubmed	17/12/15	1,406	307	295
Medline	16/5/16	1,404	304	304
Scopus	17/12/15	2,373	528	387
Google Scholar	13/2/16	39,000	824	824

This illustrates the large volume of work on AA: please compare with the figures retrieved in the next two tables.

Table A3.4 Searches for specific non-12-step face-to-face groups, 2016

Name of group	Database / Search engine	Date	All field search	Title field search	(Of these) Journal articles
"Smart Recovery"	ProQuest	17/5/16	540	28	15
	Pubmed	17/5/16	9	5	5
	Medline	16/5/16	9	5	5
	Scopus	17/5/16	83	12	11
	Google Scholar	17/5/16	1,140	51	51
Relevant & duplicates removed			8 (from first 50 of each individual search)	19	11
Total number unique items to date (all field and title field totals): 27					
"Rational Recovery"	ProQuest	20/5/16	346	13	4
	Pubmed	20/5/16	5	3	3
	Medline	20/5/16	5	3	3
	Scopus	20/5/16	96	9	7
	Google Scholar	20/5/16	1,100	39	10
Relevant & duplicates removed			8 (from first 50 of each individual search)	12	7

Total number unique items to date (all field and title field totals): 20					
"Moderation Management"	ProQuest	20/5/16	127	14	13
	Pubmed	22/5/16	6	4	4
	Medline	22/5/16	6	4	4
	Scopus	22/5/16	148	9	6
	Google Scholar	22/5/16	688	32	32
Relevant & duplicates removed			9 (from first 50 of each individual search)	13	7
Total number unique items to date (all field and title field totals): 22					
"Women for Sobriety"	ProQuest	22/5/16	258	12	9
	Pubmed	22/5/16	0	0	0
	Medline	22/5/16	6	2	2
	Scopus	22/5/16	117	6	6
	Google Scholar	22/5/16	930	18	18
Relevant & duplicates removed			10 (from first 50 of each individual search)	13	10
Total number unique items to date (all field and title field totals): 23					
LifeRing	ProQuest	19/5/16	33	3	1
	Pubmed	19/5/16	0	0	0
	Medline	16/5/16	0	0	0
	Scopus	19/5/16	9	1	1
	Google Scholar	19/5/16	239	9	1
Relevant & duplicates removed			4 (from first 50 of each individual seach)	5	1
Total number unique items to date (all field and title field totals): 9					
Secular Organisations for Sobriety (see columns for variants used)	ProQuest	19/5/16	63 "Secular organi?ations for sobriety" 92 "Save Our Selves"	2 0	1 0
	Pubmed	19/5/16	3 "Secular organi?ation* for sobriety" 2 "Save Our Selves"	1 0	1 0

	Medline	19/5/16	159 "Secular organi?ation* for sobriety" 0 "Save Our Selves"	1 0	1 0
	Scopus	19/5/16	31 "Secular organi?ation* for sobriety" 1 "Save Our Selves"	1 0	1 0
	Google Scholar	19/5/16	272 "Secular organizations for sobriety" (0 results from spelling as per Scopus) 613 "Save Our Selves"	1 0	1 0
Relevant & duplicates removed			4 (from first 50 of each individual search)	2	1
Total number unique items to date (all field and title field totals): 6					
Total number unique items for all groups: 108					

Table A3.5: Searches for specific AOSGs, 2016

Name of group	**Database / Search engine**	**Date**	**All field search**	**Title field search**	**(Of these) Journal articles**
"Alcoholics Anonymous" AND online	ProQuest	23/5/16	3,443	0	0
	Pubmed Medline	7/1/16 17/5/16	3 6,060	0 0	0 0
	Scopus	7/1/16	428	0	0
	Google Scholar	13/2/16	17,800	1	1
Relevant & duplicates removed			0 (from first 50 of each individual search)	1	1
Total number unique items to date (all field and title field totals): 1					
"Smart Recovery" AND online	ProQuest	23/5/16	82	2	2
	Pubmed Medline	23/5/16 23/5/16	1 3,256	1 1	1 1

	Scopus	23/5/16	19	1	1
	Google Scholar	23/5/16	575	1	1
Relevant & duplicates removed			1 (from first 50 of each individual search)	2	2
Total number unique items to date (all field and title field totals): 3					
"Rational Recovery" AND Online	ProQuest	23/5/16	83	0	0
	Pubmed Medline	23/5/16 23/5/16	0 5,440	0 0	0 0
	Scopus	23/5/16	5	0	0
	Google Scholar	23/5/16	345	0	0
Relevant & duplicates removed			0 (from first 50 of each individual search)	0	0
Total number unique items to date (all field and title field totals): 0					
"Moderation Management" AND Online	ProQuest	23/5/16	54	1	1
	Pubmed Medline	23/5/16 23/5/16	3 5,431	1 1	1 1
	Scopus	23/5/16	58	0	0
	Google Scholar	23/5/16	367	0	0
Relevant & duplicates removed			5 (from first 50 of each individual search)	1	1
Total number unique items to date (all field and title field totals): 6					
"Women for Sobriety" AND Online	ProQuest	23/5/16	72	0	0
	Pubmed Medline	23/5/16 23/5/16	0 2,907	0 2	0 2
	Scopus	23/5/16	10	0	0
	Google Scholar	23/5/16	373	1	1
Relevant & duplicates removed			4 (from first 50 of each individual search)	3	3
Total number unique items to date (all field and title field totals): 7					
LifeRing AND online	ProQuest	24/5/16	13	0	0
	Pubmed Medline	24/5/16 24/5/16	0 4,672	0 0	0 0
	Scopus	24/5/16	1	0	0
	Google Scholar	24/5/16	389	0	0

Relevant & duplicates removed: 0			0 (from first 50 of each individual search)	0	0
Total number unique items to date (all field and title field totals): 0					
"Secular Organisations for Sobriety" AND Online (see columns for variants used)	ProQuest	24/5/16	23 "Secular organi?ations for sobriety" AND online 20 "Save Our Selves" AND online	0 0	0 0
	Pubmed	7/1/16	0 "Secular organi?ations for sobriety" AND online 0 "Save Our Selves" AND online	0 0	0 0
	Medline	24/5/16	284 "Secular organi?ations for sobriety" AND online 7,579 "Save Our Selves" AND online	0 0	0 0
	Scopus	7/1/16	0 "Secular organi?ations for sobriety" AND online 0 "Save Our Selves" AND online	0 0	0 0
	Google Scholar	13/2/16	142 "Secular organizations for sobriety" AND online (0 results from spelling as per Scopus) AND online 96 "Save Our Selves" AND online	0 0	0 0
Relevant & duplicates removed			0 (from first 50 of each individual search)	0	0
Total number unique items to date (all field and title field totals): 0					
Total number unique items for all groups: 17					

Appendix 4: Tables giving examples of the search results, 2020

Search strings

1 = alcohol* OR drink* OR “problem drink*” OR “problem alcohol user*” OR “alcohol use disorder” OR “AUD” OR “alcohol misuse” OR “alcohol abuse” OR “alcohol related problem*” OR “alcohol dependence” OR “alcohol dependence syndrome” OR ADS

2 = Illness OR disease OR condition OR habit

3 = Representation* OR belief* OR interpretation*

4 = “support group*” OR “self?help group*” OR “12 step group*” OR “twelve step group*” OR “mutual help group*” OR “mutual self?help group*” OR “mutual aid group*” OR “self?help communit*”

5 = “online support group*” OR “online self?help group*” OR “online communit*” OR “online 12 step group*” OR “online twelve step group*” OR “internet group*” OR “online mutual help group*” OR “online mutual self?help group*” OR “virtual communit*” OR “online mutual aid group*” OR “online self?help communit*”

Search 1: anything written on illness/condition representations AND alcohol

Strings (2 AND 3) AND 1

Search 2: anything written on alcohol online support groups and alcohol support groups

Strings 1 AND 4

Strings 1 AND 5

Search 3: what roles can online support groups generally play in constructing users’ illness / condition representations?

Strings 5 AND (2 AND 3)

Search 4: what roles can alcohol online support groups generally play in constructing users’ illness / condition representations?

Strings (1 AND 5) AND (2 AND 3)

Searches were filtered by dates 2016-2020 and the first 100 items per search reviewed

Table A4.1: Searches for illness/condition representations and alcohol, 2020

Database	Anywhere	Title field search	New and potentially relevant
ProQuest	143,657	106	5
Pubmed	789	789	1
Medline	139	139	2
Scopus	1,195	6	4
Google Scholar	20,400	0	8
Totals	166,180	1,040	20

Table A4.2: Generic search on the term AOSG, 2020

Database	Anywhere	Title field search	New and potentially relevant
ProQuest	59,999	6,907	11
Pubmed	451	451	17
Medline	110	16	7
Scopus	158	43	3
Google Scholar	855,000	0	4
Totals	915,718	7,417	42

Table A4.3: Roles of OSGs in constructing users' illness / condition representations, 2020

Database	Anywhere	Title field search	New and potentially relevant
ProQuest	1612	0	3
Pubmed	128	128	4
Medline	8	0	0
Scopus	19	19	2
Google Scholar	16,600	0	5
Totals	18,367	147	14

Table A4.4: Roles of AOSGs in constructing users' illness / condition representations, 2020

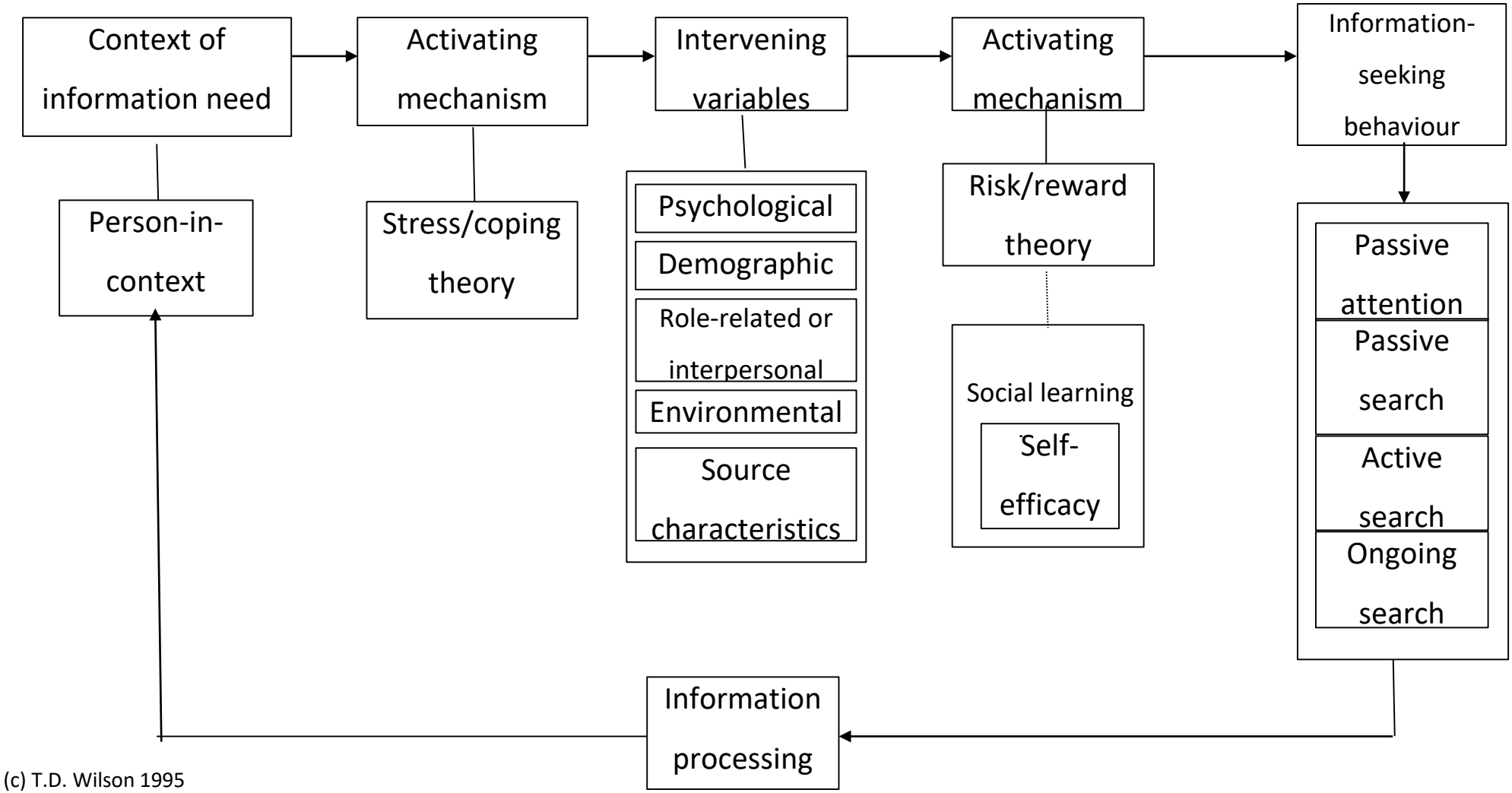
Database	Anywhere	Title field search	New and potentially relevant
ProQuest	303	0	1
Pubmed	5	5	1
Medline	109	24	1
Scopus	0	0	0
Google Scholar	16,200	0	0
Totals	16,617	29	3

Appendix 5: The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood him,* praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Their emphasis. Taken from Alcoholics Anonymous, 2001, p59-60)

Appendix 6: **Wilson's Second General Model of Information-Seeking Behaviour**



(c) T.D. Wilson 1995

Appendix 7: Rejected methodologies and methods

Table A7.1 Rejected methodologies

Methodology	Reason not selected
Phenomenography	This was considered but rejected, as the focus with this is on the **experience** of something rather than its **development** over time. "Phenomenography focuses on investigating the central characteristics of variation in how participants experience a particular phenomenon, instead of the cognitive processes associated with constructing these characteristics, differences and change" (Yates, 2012, p99). The present study analysed participants' beliefs but mainly sought to focus on how AOSGs contribute to these. This was expected to include, for example, exploring how groups use specific cognitive processes to change people's ideas. For instance, Group A advocated use of CBT, and it was possible that examples of this in action would be seen in Group A's forums. Phenomenography also requires no preconceptions in the researcher at data analysis, but, in this study, ideas were explored that had been derived from the literature review. The review was important to confirm that the research questions had not been answered already.
Internet ethnography	This was considered but rejected, due to a desire not to affect the community by participating in it. The researcher did not find it ethically appropriate to join the group covertly, and wanted to avoid impacting the way participants posted and the Hawthorne effect by overtly observing ongoing discussions. As participant welfare is paramount, the researcher did not wish to risk discouraging individuals from posting in what might be their lifeline whilst dealing with very difficult issues.
Longitudinal study	Tracking an individual through the forums over a long period of time was considered, but would, in practice, have been very difficult given the amount of threads and posts involved and the lack of direct links from a person's posts in one thread to their posts in another. This could have involved

	processing massive amounts of data for relatively little return. Ethically, even with participant consent which would be essential, this would have provided much greater risk of participant identification as all their posts would be put together and analysed, and therefore it was rejected. In terms of the interviews this would have involved identifying someone considering using a group and interviewing them before usage and again after a certain time period to see how the group had impacted their beliefs. To identify someone before they had decided to use the group or immediately as they started and to get their informed consent would have been a) practically extremely difficult, b) inappropriate for distressed newcomers and c) would create an artificial situation as they would know the aims of the study and that they were going to be interviewed in future, thus creating risk of the Hawthorne effect. The last would have also been the case if the individual had been identified mid-use of a group and re-interviewed after a period of time. The study dealt with an ephemeral population that is not easy to retain contact with; a longitudinal study would have been asking a great deal of participants and would have risked generating more data than could be used within the timeframe of a PhD.
Multiple case study or comparative study	This was closely considered as a viable possibility, and two short case studies were used to illustrate the Combined Model developed as an outcome of the research. However, it was decided against as the predominant methodology as the researcher did not feel the subject of the study constituted a 'case'. The research questions do not look holistically at the groups in detail or at the process of developing a representation in one particular person in detail. "With a case study, the case is an object of interest in its own right, and the researcher aims to provide an in-depth elucidation of it" (Bryman, 2012, p69). Yin (2014) also stated that case studies need to study the phenomenon in its 'real-world' context i.e., people's everyday situations. This study did not seek to do that, as the semi-structured interviews were retrospective, handled in an informal but nevertheless artificial situation. A case study approach would also have limited the researcher to interviewing people only from the 3 groups studied initially, which would have limited the interviewee pool too greatly.

Table A7.2 Rejected methods

Method	Reason not selected
Surveys	These were considered as they would have enabled a larger number of individuals to be approached. However, they were rejected as insufficiently responsive and sensitive instruments, that could lead to misunderstandings or superficial data. They do not enable a researcher to follow up answers, to ask for more detail or clarification, or to explain complex concepts.
Focus groups	Interviews were preferred to focus groups as the study seeks individual ideas, not a consensus. In a group some views may remain unexpressed, the researcher would not be able to ask detailed follow-up questions of individuals to clarify and explore topics, nor could they ensure participant understanding as effectively as in interviews. In addition, and perhaps most importantly, the groups would break participant anonymity, revealing problem drinkers to one another.

Appendix 8: Full ethics application

University of Sheffield Online Ethics Application Form

Section A: Applicant details

First name: Sally Last name: Sanger Email: ssanger1@sheffield.ac.uk

Department: Information School Date application started: 08/01/16 Applying as: Student

Does your application need to be reviewed by a department that is not your home department?

No

Please enter the title of your research project: Alcohol online support groups: the role of discussion forums in constructing users' understanding of their disease / condition

Is this a generic research application: No

Generic research applications cover several sufficiently similar UG/PGT research projects - see https://www.shef.ac.uk/ris/other/gov-ethics/ethicspolicy/approval-procedure/review-procedure/generic-research-projects

Section B: Basic information

B1: Co-applicant(s)

Please add each of your co-applicants below:

Name: Professor Peter Bath Email: p.a.bath@sheffield.ac.uk

Name: Dr Jo Bates Email: jo.bates@sheffield.ac.uk

B2: Proposed project duration

Start date (of data collection): 1 June 2016

Anticipated end date (of project): 30 September 2019

B3: URMS number (where applicable): N/A

B4: Suitability

Please indicate if your research:

- Is taking place outside the UK

  Some posts and Skype or phone interviews may originate in other countries, mainly the USA or Canada. However, processing of all data will take place in the UK.
- Involves the NHS No
- Is healthcare research No
- Is ESRC funded No
- Is being led by another UK institution No
- Involves human tissue No
- Is a clinical trial No
- Is social care research No
- Involves adults (over 16s) who lack the capacity to consent No

B5: Indicators of risk

Involves potentially vulnerable participants: Yes: people recovering from alcohol issues

Involves potentially highly sensitive topics Yes: it is possible that sensitive topics e.g., physical or mental health conditions, or difficult personal situations, may be brought up by the interviewee in the course of the interview in order to explain their beliefs about alcohol. However, the difficult topics are not the focus of this research.

Section C: Summary of research

C1. Aims & Objectives

C1.1 Background

Lay people's illness representations are extremely important. They are: "the organized cognitive representations or beliefs that patients have about their illness." (Petrie et al., 2007, p163). Research has shown illness representations can impact on behaviour and outcomes including diagnosis seeking (e.g., if a problem is not seen as an illness then diagnosis will not be sought), acceptance of diagnosis, compliance with treatment and therefore clinical outcomes…In the case of alcohol, it may impact on their entire world vision and how the individual lives their life, including emotional and spiritual aspects of it.

Excessive drinking is a major problem for society, its impact on health, crime, domestic violence, for example, being well known. It is therefore important to help people to find ways to deal with it. Many do not enter the formal treatment system and so will not get help, information or an illness representation there. Another alternative for them is to go to a self-help group such as AA, and this has been recognised in the UK and elsewhere as important for recovery (see NICE Clinical Guideline 115, Public Health England, 2013). It is also recommended for those leaving formal treatment. For those who do not want, or are not able, to attend face to face groups, an alcohol online support group (AOSG) is an option. These can have several advantages e.g., greater anonymity, no geographical restrictions, helpful for those with access issues such as mobility or hearing problems.

Online support groups (OSGs) are powerful sources of information and support, and there has been much research on their information role. However, we know comparatively little about *alcohol* online support groups (AOSGs). We do not know what role they play in constructing users' understanding of the illness/condition/problem of alcoholism or problem drinking*, or whether people get their representation of it from there. We do not know how the groups deal with disagreement about/challenges to the representation endorsed by the majority of their members, and the relationship of support to this. As outcomes are best if the person is in a group that is in accordance with their own beliefs, it is important that we know more about alcohol representations and how they are constructed. This research will help those working with, using or developing AOSGs.

*NB: Alcoholism, problem drinking: this study looks at drinking that has become a problem for the individual to the extent that they are seeking information or support about it, it does not follow a fixed medical definition. As there are many interpretations of what causes problem drinking/alcoholism and what it is (e.g., a disease, moral failing, bad habit) the study needed a capacious definition to accommodate this and to extend the pool of groups eligible for study. As problem drinking is not always viewed as an illness, the term used for the individual's beliefs and ideas about alcohol from now on will be 'representation'.

C1.2 Aim

To examine the contribution AOSGs, particularly their discussion forums, can make to the process of users' construction of their beliefs (representations) about alcoholism / problem drinking.

C1.3 Objectives

- To carry out in depth, qualitative analysis of postings from selected AOSG discussion forums, in order to understand better the different ways that the forums can support the acquisition or development of representations of alcoholism / problem drinking.

- To undertake in-depth semi-structured interviews with current and former users of AOSGs about their views on the contribution their use of an AOSG, or AOSGs, made to their representation of problem drinking.

- To explore how disagreement is managed when representations are questioned, and how this relates to the provision of support using the above methods

C2. Methodology

C2.1 Overarching approach

This will be a two-arm study comprising analysis of posts from selected AOSGs' discussion forums and interviews with current or former users. It is envisaged that it will predominantly use thematic analysis and some descriptive statistics.

C2.2 Selection of support groups and discussion forums

A list of as many AOSGs as possible will be compiled in this academic year. Inclusion criteria will be:

- Written in English
- Publicly available to read, in accordance with the University of Sheffield *Ethics policy governing research Involving human participants, personal data and human tissue* (N/D). As well as confirming that there is no need to register or ask permission to access the forums, their privacy policy and other metadata will also be examined for any active discouragement of researchers (as recommended by Moreno et al., 2013)
- Have discussion forums
- Be aimed at adults, not those under the age of 18
- Have forums aimed at those with an alcohol problem, i.e., are not groups / forums aimed at the families of people with alcohol problems or exclusively at people with other addictions. However, some groups used may cover more than one addiction or include a separate forum for families
- Deal with any alcohol issues, from problem drinking to alcoholism
- Be active groups (i.e., 50 or more posts in the last 3 months made overall in its forums)

It is anticipated that three to five of these groups will be purposively selected on the basis of achieving a range of different beliefs about alcoholism / problem drinking. The first approach will be made to the central contact point i.e., moderator or administrator of the group, as recommended by the British Psychological Society's guidance (Hewson, 2013) to request permission to analyse the forums (see Appendix 9). The moderator's advice will be followed as to any other people that need to be informed / or to give consent. Whilst the forums to be used are publicly accessible it is important "that attention is paid to local cultural values and to the possibility of being perceived as intruding upon, or invading the privacy of, people who, despite being in an open public space, may feel they are unobserved" (University of Sheffield N/D, p30, and see also University of Sheffield 2006, Eysenbach 2001, Markham & Buchanan, 2012). It is worth noting that while AA guidance in this area is that "When we post, text, or blog, we should assume that we are publishing at the public level" (Alcoholics Anonymous, 2014), this may not be the case with other groups, or even fully understood by AA group members. If these groups do not give approval others will be approached.

Forums will be purposively selected for analysis and will have the following inclusion criteria:

- Written in English
- Publicly available
- Aimed at adults with a drinking problem of any kind
- Forums where it would be reasonable to suppose the nature of alcoholism / problem drinking will be discussed. This may include newcomer forums (for those new to the group) and 'study' ones such as those where the 12 steps or the 12 traditions of AA are discussed. (The 12 steps are the AA program for recovery, and the 12 traditions are the principles by which the groups operate.)

Within forums, threads posted to in an agreed specific time period will also be purposively selected on the basis of relevance to the aim and objectives.

Existing forum posts (including formal archives) rather than currently active ones, will be analysed. With this there is no possibility of the Hawthorne effect where the study itself influences what people post.

C2.3 Data analysis of posts from discussion forums

It is anticipated that thematic analysis will be carried out on selected texts from 3 purposively chosen AOSGs to identify and explore instances where a participant appears to be acquiring,

developing or confirming their representation of problem drinking using a discussion forum, or helping someone else to do so. The following questions will be explored:

- What is the dominant representation of the site as a whole? Of the forum under analysis?
- How does it appear that newcomers pick up this representation? Is this happening in newcomer forums?
- What methods are used to convey the representation? Different ways that could exist include overt instruction, sharing stories of experience, examples in action ie demonstrating knowledge by putting it visibly into practice in the forums.
- Is there a difference in forums aimed at the more experienced e.g., for AA those concerned with study of the 12 steps or 12 traditions?
- What role does the personal story play in forums outside AA?
- What do posters say about the process of developing beliefs around alcohol in the threads?
- What happens if someone challenges the majority viewpoint? How does the community react and what techniques do they use to reaffirm the majority view?
- What is the role of support in relation to disagreement?

The code development process will be as follows:

- Themes for coding will be drawn out until theoretical saturation is reached as defined by Guest et al. “the point in data collection and analysis when new information produces little or no change to the codebook” (2006, p65)
- Random samples from the forums chosen will then be coded by a colleague from Sheffield University, who will be bound by a confidentiality agreement.
- Themes will be discussed, revised and agreed
- All material will be re-coded by me

C2.4 Interviews

The initial step will be via the central contact point as before, but all groups on the AOSG list will be approached. Permission will be requested to approach members for interviews. As these will be in depth interviews, it is expected that around 25 people will be sought. It is expected that 25 interviews will provide enough coverage for data saturation in the sense of no further significant changes to the code emerging (see e.g., Guest et al., 2006). Interviewees will be asked about:

- Basic, relevant demographic data (age, ethnicity, gender and level of education to see if they are in line with other studies’ findings about the typical users of OSGs: usually middle aged,

white, female and highly educated. This information will be used to provide descriptive statistics for the sample. Requesting age can also help to exclude any under 18s.)

- Their group usage: do they use more than one group, or groups with differing views? How do they manage this?
- Their 'representation' or beliefs about alcohol as described above, now and in the past
- Whether this is the same as the majority view in their group
- How they found the online group
- Whether their representation changed as a result of using the forums
- What was their group's role in constructing it?
- What importance do they credit to the group in this regard?
- What happens if people disagree with the majority view and how is this managed in their forums?
- Is there any link between this and support?

It is important to note that this may include individuals based outside the UK, as a) most groups are US based and b) usage of groups is international in any case. This will mean that some interviews will have to be conducted by Skype or, if the individual prefers, by phone. These methods are preferred to online email asynchronous interviews as there is greater personal contact with more information cues available. Individuals may also feel better able to say certain things verbally than to write them down. Interviews will be recorded by audio recorder, with participants' permission, and notes will also be taken.

C2.5 Analysis of interviews

These will be analysed using a mixture of quantitative and qualitative methods including descriptive statistics and thematic analysis. It is anticipated that the code developed during post analyses may be used, but with careful attention to new themes arising. The same process as above Section 2.3 will be followed for new thematic development.

C3. Personal Safety

Does your research raise any issues of personal safety for you or other researchers involved in the project? Yes

C3.1 Explain the issues of personal safety raised and how these issues will be managed

There is always some risk with one on one, face to face interviews with strangers, therefore it is important to identify a suitable space to hold them. Additionally, if an interviewee is under the influence of alcohol they may act inappropriately, including potentially violently (although this is unlikely). Because of this, interviewees will be met in a public place initially and then move to more private space for interview. The preferred option would be to meet the interviewee at a coffee shop near the university and then move to the Information School meeting rooms for the interview. There is a possibility of this risking their anonymity if someone from the department sees them with the researcher and recognises them. Therefore, the person will be asked when their interview is being arranged if they know anyone at the university / Information School and if that is problem for them. The point will be made that a considerable amount of research is done at the School, and unless the observer also knows the researcher (i.e., are in the Information School) they will not know that the visitor is possibly involved in this research and therefore may have alcohol problems. If the participant does not want to come to the university, Voluntary Action Sheffield will be approached for a meeting room in The Circle as a neutral venue with adequate privacy, wheelchair access including to lifts and toilets and disabled parking plus portable induction loop systems. Disabled access is always important, but may be particularly needed as online groups are especially useful for those with mobility or hearing issues who may find it hard to access face to face meetings. Interviews will not be carried out in public places due to the risk of compromising participants' anonymity (as well as the difficulties of recording there).

For individuals unable to travel to Sheffield it will be necessary to interview by phone or Skype. If participants behave inappropriately during any interview they will be asked to desist, and if they do not do so the researcher will explain that she has to terminate the interview. Skype contact will be via a dedicated Skype account established for the purpose and phone interviews from a landline at the University.

Section D: About the participants

D1. Potential Participants

D1.1 How will you identify the potential participants?

Posts:

A list of as many AOSGs as possible will be compiled in this academic year. Inclusion criteria will be:

- Written in English

- Publicly available to read, in accordance with the University of Sheffield *Ethics policy governing research Involving human participants, personal data and human tissue* (N/D). As well as confirming that there is no need to register or ask permission to access the forums, their privacy policy and other metadata will also be examined for any active discouragement of researchers (as recommended by Moreno et al., 2013)
- Have discussion forums
- Be aimed at adults, not those under the age of 18
- Have forums aimed at those with an alcohol problem, i.e., are not groups / forums aimed at the families of people with alcohol problems or exclusively at people with other addictions. However, some groups used may cover more than one addiction or include a separate forum for families
- Deal with any alcohol issues, from problem drinking to alcoholism
- Be active groups (i.e., 50 or more posts in the last 3 months made overall in its forums)

It is anticipated that three to five of these groups will be purposively selected on the basis of achieving a range of different beliefs about alcoholism / problem drinking. If these groups do not give approval others will be approached.

Forums will be purposively selected for analysis and will have the following inclusion criteria:

- Written in English
- Publicly available
- Aimed at adults with a drinking problem of any kind
- Forums where it would be reasonable to suppose the nature of alcoholism / problem drinking will be discussed. This may include newcomer forums (for those new to the group) and 'study' ones such as those where the 12 steps or the 12 traditions of AA are discussed. (The 12 steps are the AA program for recovery, and the 12 traditions are the principles by which the groups operate.)

Within forums, threads posted to in an agreed specific time period will also be purposively selected on the basis of relevance to the aim and objectives. Existing forum posts (including formal archives) rather than currently active ones, will be analysed. With this there is no possibility of the Hawthorne effect where the study itself influences what people post.

Interviews:

Potential participants will be current or former users of alcohol online support groups over the age of 18, with an alcohol issue themselves (i.e., not friends or relatives of problem drinkers) who speak

English. They will be self-selected volunteers, identified predominantly via AOSGs that allow public access who have agreed to inform their users of the study. They can be lurkers (those who read but do not post) or posters but will have used their group for a minimum of 2 months so as to give it a chance to have made an impact on them. Twenty-five will be sought, the first 10 being taken on a first come, first served basis, The range of representations of the first 10 will be reviewed and if they are very biased towards one approach, more recruitment will be undertaken using the same methods but targeting groups with approaches that have not been covered. See Appendix 10 for materials aimed at potential interviewees.

D2. Recruiting Participants

D2.1. How will the potential participants be approached and recruited?

Request to analyse posts:

The first approach will be made to the central contact point i.e., moderator or administrator of the group, as recommended by the British Psychological Society's guidance (2013) to request permission to analyse the forums (see Appendix 9). The moderator's advice will be followed as to any other people that need to be informed / or to give consent. Whilst the forums to be used are publicly accessible it is important "that attention is paid to local cultural values and to the possibility of being perceived as intruding upon, or invading the privacy of, people who, despite being in an open public space, may feel they are unobserved" (University of Sheffield N/D, p30, and see also University of Sheffield 2006, Eysenbach & Till 2001, Markham & Buchanan 2012). It is worth noting that while AA guidance in this area is that "When we post, text, or blog, we should assume that we are publishing at the public level" (Alcoholics Anonymous, 2014), this may not be the case with other groups, or even fully understood by AA group members. If these groups do not give approval others will be approached.

Request to interview members:

All the moderators / administrators of the groups on the list will be approached via the AOSG, preferably by personal messaging rather than by posting. This will be done after it has been determined which forums' posts will be analysed as this was felt to be less demanding on sites than asking them all at the same time to participate in both arms of the study. Most will only be asked to contribute interviewees so this reflects the 'ask' more accurately. It is likely that the moderator will want the request posted on the site itself, or they will want to contact their members themselves. Some sites have forums specifically as places for researchers to post requests and these will be accessed directly, if it is quite clear that advance permission is not needed. Requests will be also be

tweeted, making it clear that participants need to be a discussion forum member or former member. Alcohol voluntary organisations such as Alcohol Research UK, Alcohol Concern will be contacted to ask them to put out the request. It is envisaged that it will be necessary to cast the net widely.

D3. Consent

Will informed consent be obtained from the participants? Yes

D3.1 If yes: How do you plan to obtain informed consent? (i.e. the proposed process)

Please see attached information sheets (Appendices 8.2 & 8.3). All have been checked for ease of reading by non-academic colleagues with no knowledge of alcohol issues.

For both posts and interviews the moderators / administrators will be contacted via the AOSG. They will be sent the covering invitations and the information sheets, and will be encouraged to contact the researcher if they need further information, a meeting, a Skype or phone conversation. Permission for the research team only to re-use the data in subsequent research will be sought.

Interview participants: all potential interviewees will have access to the information sheet which must be loaded on the site together with the invitation to take part, or sent via the moderator with the invitation. They will also be invited to ask further questions, via their preferred medium of email, phone or Skype. At least 3 days will be allowed for 'cooling off' between agreement to participate and attending for interview. Written consent will be requested before the interview (either emailed, or to be taken in person before interview). It could be off-putting to participants to have to break their anonymity therefore only their first names will be asked for plus a contact phone number or email address, and these will not be used in reports of the research and will be held securely (see below). This is similar to Bond et al.'s study (2013) of contributors to online diabetes forums where only the participant's usernames and emails were recorded.

Capacity to give consent:

It is possible that participants may be under the influence of alcohol when they agree to take part (hence the cooling off period) or when they are interviewed. If this is clearly the case at consent/interview, the event will be postponed. However, it should be noted that it may not be possible to tell that they are affected. Asking everyone interviewed if they have had a drink that day would be intrusive and personal, and therefore inappropriate. Therefore, there is a risk that participants may be under the influence of alcohol but this will have to be taken. In all cases, the

participant would be able to contact the researcher to withdraw information after the interview should they wish.

D4. Payment

Will financial/in kind payments be offered to participants? Yes

If yes: Please provide details and justification for this payment:
Participants will be offered travel expenses, to ensure access to the study for the economically disadvantaged. This will be reimbursed via cheque or postal order. Under no circumstances will this be commuted to cash, so as to support the participant in their sobriety.

D5. Potential Harm to Participants

D5.1 What is the potential for physical and/or psychological harm/distress to the participants?

There is no risk of physical harm, however there is a risk of damage to reputation and of experiencing distress.

Analyses of posts

Anonymity is the main issue here, for example, if a post can be tracked to a particular user and from that to an individual there could be risk to reputation or social standing, as there is still stigma around alcoholism. To address this, any descriptions of groups and participants in the research reporting will need to be very general – if this is not possible e.g., in the case of a group with a unique approach to alcohol, then permission will be sought to include the detail needed and any implications discussed with the moderator/administrator (or poster if appropriate). This will be a factor in the selection of groups for study. Moderators of groups will be fully informed of how the post data will be stored, protected, used and disclosed via the information sheets (see Appendices 8.2 & 8.3). Withdrawal of permission to use it must be by the time data analysis starts.

Quotes from posts will be paraphrased ensuring the meaning is carefully preserved, so that they cannot be traced via public search engines (as per advice from e.g. Bond et al., 2013, and in line with the Space for Sharing project (University of Sheffield http://www.sheffield.ac.uk/is/research/projects/sharedspace) which this study complements). This will be checked i.e., a search will be undertaken on the re-wording to ensure it does not lead back to the original quote. If re-wording and retention of meaning is not possible the quotation will not be used.

Group anonymity

There is also the (comparative) anonymity of the group itself. The British Psychological Society's third principle, social responsibility: "maintaining respect for and avoidance of disrupting social structures, and carefully considering consequences and outcomes of a piece of research" (Hewson 2013, p16) includes the suggestion that users may not want to have their group brought to public attention. Whilst this is unlikely because a) these groups are publicly accessible and b) more public attention may enable the group to help more people, this possible outcome will be discussed with moderators expressing interest in the research. They will be informed about the anonymization procedures to be used, as discussed above.

Interviews:

The participants are vulnerable people with the sensitive issue of alcoholism or problem drinking. . During the interview, the focus will be on their beliefs and ideas about the illness/problem, how these have changed over time and the role of the forums in acquiring these beliefs. They will not be specifically asked for details of the negative consequences of their drinking history and these would only come up if the participant decides to bring them up. The range of additional issues that could come up whilst talking about a drinking past is very wide and could include sensitive issues such as crime, sexuality, health problems, etc. It will be made clear to participants on the information sheet, and at consent/interview that they will not be asked about their drinking histories. If they choose to bring this up, the information will be kept confidential and will not be used in the research unless it is essential to explain the beliefs they hold in which case explicit permission will be sought and the implications discussed with the participant. If used the data would be anonymised and all identifying details removed. If the individual becomes upset they will be offered the option of a time-out, to move on from the distressing topic or to terminate the interview, and they will be offered details of local support services if this appears appropriate. Permission may be requested to use the data given so far. The information sheet will make clear to them the right to withdraw at any time from the study, and any limits on this. They will also be informed via the consent form of how to raise any concerns or complaints, in accordance with University of Sheffield, N/D.

If problems around issues other than alcohol (e.g., eating disorders, drug taking) emerge during interview, and support for this is likely to exist, the researcher will offer to send the person information including sources of support. "If during research a researcher obtains evidence of physical or psychological problems of which a participant is, apparently, unaware, the researcher has a responsibility to inform the participant if s/he believes that by not doing so the participant's future

well-being may be compromised or diminished. If the issue is serious and the researcher is not qualified to offer assistance, then an appropriate source of professional advice should be recommended to the participant" (University of Sheffield N/D, p33)

If they had a bad experience with the group they used, this may be distressing to recall. Discussing disagreements in the forum may also be upsetting to some (see UREC 2006). Those who expect that this will be the case, may be less likely to volunteer to participate, but others may be affected unexpectedly. Questions will need to be worded sensitively and with the emphasis away from the personal. The approach taken will be to ask them to comment on disagreements they have witnessed / read, and the choice of whether to discuss specific ones they participated in will be theirs.

Third parties

There is also a risk of harm to third parties in both post analyses and interviews e.g., if people discuss other group members who have not agreed to participate and are not present. As far as possible, using third party data will be avoided, however, if it must be used it will be anonymised. This will be particularly difficult if the person has a role that needs to be referenced e.g., moderator, administrator, even with the group unnamed. However, it could be argued that by taking on this role the person has accepted the risk a higher profile than average brings. Each case will need to be taken on its own merits, but as a general principle, if there is a risk of identification, permission will be sought from the third party, as per University of Sheffield N/D.

D5.2 How will this be managed to ensure appropriate protection and well-being of the participants?

Please see previous section D5.1

Section E: About the data

E1. Data Confidentiality

E1.1 What measures will be put in place to ensure confidentiality of personal data, where appropriate?

Analyses of posts:

To address this, any descriptions of groups and participants in the research reporting will need to be very general – if this is not possible e.g., in the case of a group with a unique approach to alcohol,

then permission will be sought to include the detail needed and any implications discussed with the moderator/administrator (or poster if appropriate). This will be a factor in the selection of groups for study. Moderators of groups will be fully informed of how the post data will be stored, protected, used and disclosed via the information sheets. Withdrawal of permission to use it must be by the time data analysis starts.

Quotes from posts will be paraphrased ensuring the meaning is carefully preserved, so that they cannot be traced via public search engines (as per advice from e.g. Bond et al., 2013, and in line with the Space for Sharing project (University of Sheffield http://www.sheffield.ac.uk/is/research/projects/sharedspace) which this study complements). This will be checked i.e. a search will be undertaken on the re-wording to ensure it does not lead back to the original quote. If re-wording and retention of meaning is not possible the quotation will not be used.

Only the texts selected to be analysed will be downloaded and retained, and at this point the names of groups and posters' usernames will be removed and replaced with a pseudonym or code. Any detail about the posters' (usually found near the avatar) will also be removed e.g., their location, length of membership, and kept in a key to the codes, together with any identifying details from the content. This will be kept in a separate, password protected file only accessible to the researcher. The texts and code will be mastercopies, kept securely on the University Research drive, in password protected files. Copies of the anonymised mastercopies to work on will be kept in and used on the researcher's personal and secure University drive and no paper copies will be made.

Participants will be informed that the research will be presented at conferences and in journal articles.

Interviews:

All participants will be informed of how their data will be stored, protected, used and disclosed via the information sheet (see attached), and will be offered another copy to take away at interview. They will be made aware of the process for withdrawing from the study and at what point this will be no longer possible (once data analysis has started).

As discussed in D3.1 above, for the purpose of getting consent, they will only be asked for a first name and a contact number or email address. These details will be shared with supervisors if

necessary and kept as described in the next section. In all research materials, apart from the audio recordings, both groups and participants will be referred to by a code or pseudonym. As far as possible, any identifying details from interviews will not be used eg unusual facts, or sets of details which if put together could lead to identification. *The only exception to this would be where a participant feels very strongly that they do not wish to be anonymised and that they wish to be linked with their interview. If this occurs the implications will be thoroughly discussed with them including any risk to third parties. If there is any such risk, the participant will still be anonymised, but otherwise their wishes will be respected.* [The words italicised were added after a suggestion by the ethics reviewer]

A confidentiality agreement will be put in place with any agency carrying out the interview transcribing. The agency will type these using interviewees' codes. Transcripts must be password protected and only emailed as Word documents encrypted using 7 Zip as set out in the Information School transcription agreement. Participants will be made aware that a transcription agency will be used and that they will be subject to these security measures. No personal identifiable information will be worked on while using public transport or in public venues. It will only be worked on in the Information School laboratories or the researchers' homes.

Any circumstances in which confidentiality would legally have to be broken e.g. suspicion of child abuse, will be explained to participants at consent and again, with reminders if the conversation appears to be heading in that direction.

Participants will be informed that the research will be presented at conferences and in journal articles.

E2. Data Storage

E2.1 How and where will the data be stored, used and (if appropriate) destroyed?

Posts:

The anonymised texts will be kept securely on the University Research drive, backed up in the researcher's personal and secure University drive, in password protected files. Copies of the anonymised master-copies to work on will be kept in and used on the researchers' personal University drive. Paper copies will be avoided unless essential and will be kept in the Information School or at the researcher's home in locked storage and destroyed as confidential waste as soon as

no longer needed. The code key will be kept as a separate, password protected file on the research drive in a different location to the downloaded texts.

Permission to retain the texts for future research by the project research team will be sought. To allow this, the data will be passed to the supervisors for ongoing safe storage after successful completion of the PhD and any publication activities

Interviews:

Consent forms: These will be kept in a locked cupboard in the Information School only accessible to the researcher and supervisors, and retained until successful completion of the PhD. After this they will be destroyed as confidential waste.

Audio recordings: These will be downloaded onto computer and kept on the University research drive. They will be transferred securely to the transcribing agency if one is employed, using the Information School's recommended protocol. They will only be shared with supervisors and after successful download will be deleted from the recording equipment. At the end of the period after the PhD when the results have been written up for journals and conferences the downloaded interviews will be deleted. This will be no later than two years after the completion of the PhD. The advice of the Information School IT department will be taken as to the best way to ensure these deletions are made non-retrievable

Transcripts: These will be kept on the University research drive, backed up in the researcher's personal University drive, in password protected files. Paper copies will only be made if necessary and will be kept locked away when not in use and confidentially destroyed as soon as they are no longer needed. Permission to retain them for future research by the project research team will be sought. To allow this, the data will be passed to the supervisors for ongoing safe storage after successful completion of the PhD.

Section F: Supporting documentation

Information & Consent

Are the following supporting documents relevant to your project?

Participant information sheet(s)	Yes
Consent form(s)	Yes

Section G: Declaration

I confirm my responsibility to deliver the research project in accordance with the University of Sheffield's policies and procedures, which include the University's 'Financial Regulations', 'Good Research Practice & Innovation Practices Policy' and the 'Ethics Policy Governing Research Involving Human Participants, Personal Data and Human Tissue' (Ethics Policy) and, where externally funded, with the terms and conditions of the research funder.

In signing this research ethics application form I am also confirming that:

- The form is accurate to the best of my knowledge and belief.
- The project will abide by the University's Research Ethics Policy: https://www.shef.ac.uk/ris/other/gov-ethics/ethicspolicy
- The project will abide by the University's Good Research & Innovation Practices Policy: https://www.shef.ac.uk/ris/other/gov-ethics/grippolicy
- There is no potential material interest that may, or may appear to, impair the independence and objectivity of researchers conducting this project.
- Subject to the project being approved, I undertake to adhere to any ethics conditions that may be set.
- I undertake to inform the ethics reviewers of significant changes to the protocol (by contacting my academic department's Ethics Administrator in the first instance).
- I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data, including the need to register when necessary with the appropriate Data Protection Officer (within the University the Data Protection Officer is based in CiCS).
- I understand that the project, including research records and data, may be subject to inspection for audit purposes, if required in future.
- I understand that personal data about me as a researcher in this form will be held by those involved in the ethics review procedure (e.g. the Ethics Administrator and/or ethics reviewers) and that this will be managed according to Data Protection Act principles.
- If this is an application for a 'generic' project, all the individual projects that fit under the generic project are compatible with this application.
- I understand that this project cannot be submitted for ethics approval in more than one department, and that if I wish to appeal against the decision made, this must be done through the original department.

Signature: Sally Sanger

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Appendix 9: Request to moderator to analyse posts, and information sheet

Dear

Alcohol online support groups: what roles can their discussion forums play in helping a user develop their beliefs about alcoholism/problem drinking?

Please can you help? I am currently carrying out a PhD research study exploring the role that the discussion forums of alcohol online support groups can play in helping users to develop their beliefs about alcoholism / problem drinking.

As you know, peer to peer support is recognised as very important for recovery by many, but so far there has been little research attention paid to the online form of this. What there is, has focussed on better known groups such as AA, yet a far wider range of groups are out there. Alcohol online support groups can hold major benefits for some over face to face groups, and it is important that more is understood about them and that more potential users know about them as an option. Having a match between the beliefs of a support group and those of its user has been shown to lead to much better outcomes for the individual and a better experience. It is hoped that this work will raise awareness of alcohol online support groups as potential, powerful sources of help amongst those working in the field and future users, as well as lead to a greater understanding of how they work.

I am writing to ask permission to explore and analyse some of the threads on your forums? This would involve looking at threads that are publicly available already, where registration is not needed, and would be those posted to in a 3 month period during 2015. I would not be looking at current discussions. I attach a sheet giving further information about this.

The research is being carried out at the University of Sheffield and has been ethically approved by its Information School in the Faculty of Social Sciences. We are extremely mindful of the need to maintain confidentiality and anonymity of posters, and the attached sheet describes how we would propose to do this.

I would be really grateful for an answer either way: it would be great if you could you email me at ssanger1@sheffield.ac.uk . If you need more information or would like to talk to me or my

supervisors before making any decisions we can arrange that and this can be in person (if you are in the UK), by Skype, email or phone. Please do let me know anything you need to help your decision.

Thank you very much for your time and attention. I look forward to hearing from you.

Kind regards,
Sally Sanger

Post analysis information sheet

The University of Sheffield Information School	Alcohol online support groups: what roles can their discussion forums play in helping a user develop their beliefs about alcoholism/problem drinking?

Researchers

Sally Sanger, Lead Researcher: ssanger1@sheffield.ac.uk ; Peter Bath, Supervisor p.a.bath@sheffield.ac.uk; Jo Bates, Supervisor: jo.bates@sheffield.ac.uk

Further information on the research team can be found at: http://www.sheffield.ac.uk/is/pgr/students/sangers; http://www.sheffield.ac.uk/is/staff/bath; https://www.sheffield.ac.uk/is/staff/bates

This project has been ethically approved via the University of Sheffield Information School ethics review procedure and is funded through a University of Sheffield Faulty of Social Sciences scholarship.

Purpose of the research

This study explores online support groups for people with alcohol issues and the role that their discussion forums can play in helping people to develop their beliefs about alcoholism / problem drinking. Beliefs about a problem or illness are very important. Research has shown these can impact on whether help is sought in the first place, what solutions are pursued to deal with the issue, how well people manage it and what use of any services they make. We hope that this research will help improve understanding of, and awareness about, the groups particularly amongst those working with people with alcohol issues. This might then lead to more people who need the groups being given information about them.

Who will be participating?

We will be approaching a wide range of alcohol online support groups.

What will you be asked to do?

We are asking you to allow Sally, the lead researcher to analyse past postings from publicly accessible forums on your website.

What are the potential risks of participating?

The risks of participating are the same as those experienced in everyday use of the forum. Posters anonymity and privacy will be rigorously and carefully protected.

What will we do with the data?

The data is for inclusion in a PhD thesis. Only the texts selected to work on will be downloaded and retained, and at this point the name of the group and posters' usernames will be removed and replaced with a pseudonym or code. Any detail about the posters e.g., their geographical location, length of membership will also be removed together with any identifying details from the content. This will be kept in a separate, password protected file only accessible to the researcher and will not be used in the research.

Any descriptions of groups and participants in the research reporting will be very general. If this is not possible e.g. in the case of a group with a unique approach to alcohol, then permission will be sought to include the detail needed and any implications discussed with the moderator / administrator (or poster if appropriate). This will be a factor in selection of groups for study. Quotes from posts will be paraphrased ensuring the meaning is carefully preserved, so that they cannot be traced via public search engines. This will be checked i.e., a search done on the re-wording to ensure it does not lead back to the original quote. If re-wording and retention of meaning is not possible the quotation will not be used.

All data will be held securely in firewall and password protected university drives.

Will my participation be confidential?

We are very mindful of the importance of protecting your anonymity and privacy: please see the section above for how we will do this.

What will happen to the results of the research project?

The analysed anonymous information will be used in the PhD thesis and disseminated at conferences and via articles. If you give us permission, the anonymised texts will be kept by the University of Sheffield for use in future research by the research team only.

If you would like a summary of the results, please let the researcher know, who will arrange this. Please note this is unlikely to be before Autumn 2018 as the research and write up continues until then.

Interested?

If you are happy to allow the researcher to proceed, please email Sally Sanger at ssanger1@sheffield.ac.uk . Please feel free to ask any questions you want before deciding.

Thank you very much for your time. It is much appreciated!

Note: If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, please contact Dr Jo Bates, Research Ethics Coordinator, Information School, The University of Sheffield (ischool_ethics@sheffield.ac.uk), or the University Registrar and Secretary.

Appendix 10: Material for interviewees

Invitation to interviewees

How has your alcohol online discussion forum helped shape the way you think about alcoholism / problem drinking?

Can you help? We are looking for present or past users of alcohol online support groups to talk to for a PhD research study. The research will explore the role these groups can play in helping people develop their beliefs about alcoholism / problem drinking (for example, beliefs around its causes, consequences, whether it can be 'cured' or not). We would like to informally interview users (those who post and those who read) who are over 18 about their beliefs, how their views have changed over the years and the role the discussion forum they use has played. All interviews will be completely confidential and can be done over Skype, the phone or in person: whichever suits you.

Self-help support is very important for recovery, but so far there has been little research attention paid to the online form of this. What there has been has focussed on the better known groups such as AA, yet there is a far wider range than this out there. Alcohol online support groups can hold major benefits for some people over face to face groups, in terms e.g., of their accessibility and anonymity. More needs to be understood about them especially as a match between the group's beliefs and the user's beliefs has been shown to lead to better outcomes for the person and a better experience. We hope that this research will raise awareness of alcohol online support groups as potential, powerful sources of help amongst those working in the field and future users, as well as lead to a greater understanding of how they work. But we can't do this without you…. if you might be interested, please do read the attached for more details or contact Sally Sanger on ssanger1@sheffield.ac.uk.The research is being carried out at the University of Sheffield and has been ethically approved by the Information School in the Faculty of Social Sciences.

Many thanks,
Sally Sanger, Peter Bath and Jo Bates
University of Sheffield, Information School

Interview information sheet

The University of Sheffield Information School	Alcohol online support groups: what roles can their discussion forums play in helping a user develop their beliefs about alcoholism/problem drinking?

Researchers

Sally Sanger, Lead Researcher: ssanger1@sheffield.ac.uk ; Peter Bath, Supervisor p.a.bath@sheffield.ac.uk; Jo Bates, Supervisor: jo.bates@sheffield.ac.uk

Further information on the research team can be found at: http://www.sheffield.ac.uk/is/pgr/students/sangers; http://www.sheffield.ac.uk/is/staff/bath; https://www.sheffield.ac.uk/is/staff/bates

Purpose of the research

This PhD study explores online support groups for people with alcohol issues and the role that their discussion forums can play in helping people to develop their beliefs about alcoholism / problem drinking. Beliefs about a problem or illness are very important. Research has shown these can impact on whether help is sought in the first place, what solutions are pursued to deal with the issue, how well people manage it and what use of any services they make. We hope that this research will help improve understanding of, and awareness about, the groups particularly amongst those working with people with alcohol issues. This might then lead to more people who need the groups being given information about them.

Who will be participating?

We are inviting adults over the age of 18 who have used (or are still using) at least one discussion forum of an online alcohol support group and have done so for a minimum of two months. This could be using it in the sense of posting to it or just reading it. We are approaching a wide range of groups and would like to talk to about 25 people.

What will you be asked to do?

If you agree to take part, we would like to talk with you about your beliefs about alcoholism / problem drinking, how they have changed over time and the role your online discussion forum has played in adding to or changing your beliefs. We expect that most interviews will last between 60 – 90 minutes but this is flexible. You can be interviewed in person, via Skype, or by phone: whichever is best for you. For those who would like to be interviewed in person this will take place in Sheffield and we will reimburse reasonable travel expenses (i.e. from within the UK) by cheque. We are happy to interview participants from abroad by Skype or phone.

If you are interested in participating, but need further information, could you email Sally, the researcher who will carry out the interviews, at the address above with your questions? Do feel free to ask for any information you need. Then, once you have had your questions answered, if you are happy to take part, let Sally know. She will get back to you within a few days to arrange the interview in the format best for you and at a time that suits you. Before the interview she will go through this form again to make sure you are clear about the study and what will happen with the information you give us. She will ask you to sign a copy to say you are happy to participate and have had your questions answered. She will then give you a copy of this. Sally will ask for your permission to audio-record the interview so as to capture accurately what is said and to help us avoid missing anything. These recordings will only be used to type up the interview.

What are the potential risks of participating?

The risks of participating are the same as those experienced in everyday use of the forum. You will not be specifically asked about the negative consequences of your drinking history, but it is possible you may wish to introduce this and find this upsetting. If this is the case we can take time out, end the discussion or move on to the next topic.

We will anonymise all information you give us so it will be impossible to identify you.

What data will we collect?

Sally will ask you about the topics described above. If you give permission the interviews will be audio recorded and Sally will also take notes on paper. These will be kept confidentially in secure storage.

What will we do with the data?

The data is for inclusion in a PhD thesis. The original audio recordings made will only be heard by the research team (Sally, Peter and Jo). They will be downloaded to the University's secure computer research drive and will then be confidentially and permanently deleted from the recording equipment. The recordings on computer will be transcribed (typed up) by Sally or by a transcription agency which will be bound by a confidentiality agreement operating to the high standards set by the Information School, including safe transfer of files. The recordings will be securely deleted from the computer at the end of the PhD project.

The interview transcriptions will be carefully anonymized immediately after transcription and all identifying details removed. The transcripts and typed field notes will be stored on the Information School's research data drive which can be accessed by only by the research team. A copy will be stored on the researcher's secure personal University drive. These drives are firewall and password protected. Paper copies will only be made if necessary and will be kept locked away when not in use and confidentially destroyed as soon as they are no longer needed. If you give us permission, we would like to retain the transcriptions after the end of the project for use in future research by the research team.

Your completed consent form will be held in securely locked storage in the Information School and will be confidentially destroyed at the end of the project.

Will my participation be confidential?

We are very mindful of the importance of protecting your anonymity and privacy. For the purpose of getting consent, we will only ask for your first name and a contact number or email address and you

will not need to tell us your online username. All information you give us will be carefully anonymised when the interviews are transcribed, and names, usernames and any details that could identify you or other people will be removed. The interview will not explore the negative consequences of your drinking history, and if sensitive information about this comes up (which will be your choice) it will not be used in the research unless it is essential to explaining your beliefs, in which case we will seek explicit permission from you during the discussion and discuss any implications with you. Your decision will be final. You will be able to withdraw your information at any point during or after the interview until the data has been anonymised and is no longer traceable back to you: when this is expected to be will be discussed with you in advance of the interview.

What will happen to the results of the research project?

The results of this study will be included in the PhD thesis which will be publicly available (please contact the Information School). If you would like a summary of the results, please let Sally know at interview, and she will arrange this. Please note this is unlikely to be before Autumn 2018 as the research and write up continues until then. The results of the research will also be reported in journal papers and at conferences

- I confirm that I have read and understand the description of the research project, and that I have had an opportunity to ask questions about the project.

- I understand that my participation is voluntary and that I am free to withdraw at any time without any negative consequences.

- I understand that if I withdraw I can request for the data I have already provided to be deleted, however this might not be possible if the data has already been anonymised or findings published.

- I understand that I may decline to answer any particular question or questions.

- I understand that my responses will be kept strictly confidential, that my name or identity will not be linked to any research materials, and that I will not be identified or identifiable in any report or reports that result from the research, unless I have agreed otherwise.

- I give permission for all the research team members to have access to my responses.

- I give permission for the research team to re-use my data for future research as specified above.

- I agree to take part in the research project as described above.

Participant Name (First name only)	Date
Researcher Name (Please print)	Researcher Signature
Date	

Note: If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, please contact Dr Jo Bates, Research Ethics Coordinator, Information School, The University of Sheffield (ischool_ethics@sheffield.ac.uk**), or the University Registrar and Secretary.**

Appendix 11: Ethical approval letter

Downloaded: 23/07/2020

Approved: 24/06/2016

Sally Sanger

Registration number: 150112514

Information School

Programme: PhD

Dear Sally

PROJECT TITLE: Alcohol online support groups: what roles can their discussion forums play in helping a user develop their beliefs about alcoholism/problem drinking?

APPLICATION: Reference Number 008813

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 24/06/2016 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 008813 (form submission date: 07/05/2016); (expected project end date: 30/09/2019).
- Participant information sheet 1017999 version 1 (07/05/2016).
- Participant information sheet 1017998 version 1 (07/05/2016).
- Participant consent form 1018000 version 1 (07/05/2016).

The following optional amendments were suggested:

Please see the comments above. HOWEVER, these are suggested amendments only, and you are not required to submit any changes for approval. The research may commence as described in the application.

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Matt Jones

Ethics
Admini
strator
Music

Please note the following responsibilities of the researcher in delivering the research project:

The project must abide by the University's Research Ethics Policy:

- https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy /approval-procedure The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix 12: Interview guide

1a. Can I start by asking you a bit about your use of [name of group]? (10 mins)

Optional prompts:

a. How did you find it originally? What were you looking for?
b. Why this particular group? What drew you to it?
c. Why do you stay with it/like it? OR Would you mind if I ask you why it was you left the group?
d. Do you write or read there?
e. Did you lurk or post straightaway?
f. How long have you used it?
g. How often do you use it in an average week?
h. How do you use it? Are there particular forums or threads that you use and like more than others?
i. Apart from the forums, do you use the site as a whole? Do you read other parts of it, for example, the information pages, blogs?
j. Do you use other online alcohol support groups as well? If so, which ones?
k. Do you use any of them as much or more than -----?
l. If yes, which is your favourite group out of all of them? Why?

If don't know which group they are from:

1b. Can I start by asking about your use of the discussion forums of alcohol online support groups?

Optional prompts:

a. What groups have you used?
b. How did you find them originally? What were you looking for?
c. Is there a particular group that you'd regard as your 'home' group now i.e., the one you use most?
d. Why this particular group? What drew you to it initially?
e. What keeps you with it now? Why do you stay with it?
f. Do you write or read there?
g. Did you lurk for a while when you found it, or did you post straightaway?
h. How long have you been using it?
i. How often do you use it in an average week?
j. How do you use it? Are there particular forums or threads that you use and like more than others?

k. Apart from the forums, do you use the site as a whole? Do you read other parts of it, for example, information pages, blogs?

l. Are you currently using any other groups as well? Which ones?

2. Now I'd like to ask about your ideas on problem drinking, if that's OK. First, what's your preferred term for it? Why that? (15 mins)

Optional prompts:

a. What would make you think someone was a problem drinker? What, if anything, singles them out from ordinary drinkers?
b. What do you think causes problem drinking?
c. What are the consequences, the outcomes, of problem drinking typically?
d. Do you think it's a problem that can be resolved and left behind? Is that down to the individual or is help needed e.g., from alcohol services? Is it controllable?
e. How should it be dealt with?
f. When you think of someone having a 'relapse', what would that look like?

3. Where would you say your ideas came from? What sources? Which were the most important to you?

a. Did the forum have an influence?
b. What ideas did it influence?
c. How did it influence them? Eg change, challenge, reinforce?
d. What's been the most significant change in your ideas as a result of using the forum?

4. When you think about your main group's discussion forums, how do you think they would describe problem drinking? Is there a general view, a 'group view'? (15 mins)

Optional prompts: if there is a group view

a. If so, what is it?
b. If no one view, are there lots of different ones? Tell me about some of them
c. Is this view different to your own?
d. Is it a pretty consistent group view or does it tend to change over time?
e. Is something the group disagrees with more likely to be ignored or challenged?
f. If a person agrees with the group ideas does this affect the amount of support they get or does it make no difference?

g. Do the other groups you use have different ideas about problem drinking?
h. If they do, does this matter? Do you find it difficult in any way?
i. How do you deal with it? Can you give an example?

5. There are various different ways that forums can help people. Can I read these to you and see if any strike a chord with you. Have you used any of them? Or found it helpful when others used them? How? (15 mins)

a) The forum is a place where I can get help and advice
b) The forum is a place where I can help others
c) The forum is a place where I get encouragement and tough love
d) The forum is a place where I no longer feel alone or different, and can find people like me
e) The forum is a place where I have found role models
f) The forum is a place where I can plan ahead, write my plans down and think things through in advance
g) The forum is a place where I can write about the past in order to remember it when I need to
h) The forum is a place where I can write about the present in order to remember it in future when I need to
i) The forum is a kind of therapy. [Can you tell me more about that?]
j) Writing in the forum makes my goals seem more real, and I feel more accountable to the group for them
k) The forum is a place where I can practice how I'd like to be in the real world (e.g., things like being more assertive or arguing without falling out)
l) The forum is a place I can get help and advice in a crisis at the time it's happening
m) The forum is a place where I can share successes with drinking
n) The forum is a place where I can get motivated about, or active around, alcohol issues in society. For example, the prevalence of alcohol in Western society
o) The forum is a place to vent ideas and get them out of my head
p) The forum is a place where I can learn about coping with life
q) The forum is a place where I learn about me

6. There are various different ways in which people express their ideas in a forum. Can I read these to you and see if any strike a chord with you? Have you used any of them? Or found it helpful when others used them? How? (15 mins)

a. People tell each other stories about their drinking and/or recovery
b. People tell each other examples or anecdotes about what does and doesn't work for them
c. People ask questions and give answers
d. People tell each other what to do, give instructions
e. People give each other references and links to useful materials like books, articles, other sites, podcasts, DVD
f. Some people act as role models, positive or negative, for others
g. People sometimes don't agree, and challenge each other or have disagreements
h. People have slogans and sayings such as 'One day at a time'
i. People share pictures and photos

What ways did you find most helpful? Why?

How else do people share ideas on the forum?

What do you think about drinking life-stories told online? Are these important to you?

7. Is it OK to ask for some basic demographic data?
   [Age, ethnicity, gender and level of education were asked about]

8. Is there anything else you'd like to add or to go back to? (5 mins)

9. Are you happy for the anonymised transcript of this recording to be used in future research by myself and my supervisors or would you prefer that it's only used for this project?

Appendix 13: Notation system used in transcribing the interviews

Decided not to transcribe:

1. Statements relating to the interview, e.g., is it OK if I record this? Can you hear me? Shall I start?
2. Practical interruptions e.g. putting the dog outside, were indicated briefly, not transcribed exactly, e.g., [puts dog out]
3. Pauses unless longer than one second

To transcribe:

1. All words, including fillers like 'sort of'
2. [] indicates interviewee sighs, laughs or other action
3. {} indicates prompt from interviewer that doesn't interrupt the flow
4. All sounds made by interviewee, e.g., umm, hmm, er
5. Pauses longer than one second

- Identity of speaker: the names of the interviewer and interviewee were removed and replaced with [interviewer] or [pseudonym of interviewee]. Other names were removed and replaced with their role in the forum [e.g., Administrator, user] or other title as appropriate
- Indicating turn taking: new line unless is just a filler sound/word either encouraging the speaker or interrupting / speaking over them, in which case it is indicated in the text by {}
- Laughing, coughing etc: [laughs] indicates the person speaking laughs, [both laugh] indicates both interviewee and interviewer laugh, [coughs] indicates the person speaking coughs. Other actions indicated with the same notation
- Pauses: [Pause] = 1 sec, [Long pause] = longer than 1 second.
- Abbreviations: only those stated by the speakers are used. If they say the abbreviation in full then it is written in full
- Overlapping speech: only indicated by {}
- Inaudible speech: indicated by [unclear]
- Non-verbal sounds: spelt phonetically, e.g., uhuh, mm hmm, mm, ooh, eurgh
- Use of punctuation: tries to reflect the speech, rather than grammatical correctness
- Cut off speech: indicated by --
- Emphasis on words: indicated by <u>underlining</u>
- Reported speech/thought: in inverted commas, e.g., so I thought "OK I'm gonna go for it".

- Vernacular usage & mispronunciation: represented phonetically. Accents are not reflected.
- Names of media, e.g., books, blogs: in single inverted commas ‘Sober Mummy’
- Names of groups: anonymised, and relabelled as Groups A - F.

Appendix 14: Initial codes for forum post analyses

Codes related to the CSM (Leventhal codes)

- Causes
- Consequences
- Controllability
- Coping mechanisms (the subcategories below were taken from reading about Group A)
  - CBT
  - AA
  - TSM
  - SR
  - Moderating drinking
  - Harm reduction
  - Willpower / white knuckling
- Identity
- Timeline

Changes in beliefs / Effects of the forum on representations

- Acquiring
- Developing
- Changing
- Already developed

Methods of communicating

- Methods – Cognitive restructuring
- Methods – Physical reprogramming of brain
- Methods - Instruction/fact-giving
- Methods - Research/intellectual inquiry
- Methods - Reading/writing posts
- Methods - Feedback
- Methods - Crosstalk
- Methods - Disagreement/debate
- Methods - Sharing/requesting full or outline stories of experience:
  - Experience when drinking

Experience of getting sober

Methods - Short anecdotes / single occasions

Experience when drinking

Experience of getting sober

Methods - Story

Drinking story

Group narrative

Methods - Tips and advice

Methods - Role models

Methods - Action/practice

Methods - Slogans/sayings

Methods – Support, e.g., praise for achievements, encouragement, welcomes, reassurance,

Community language – alcohol

Community language – other

AA language

Additional from reading Group A

Emotions

Normality

The site – for comments on the site

Miscellaneous

Appendix 15: Initial high level codes for interview coding

Gender

Information pages' usage

Information standards

Leventhal categories

- Cause
- Consequences
- Controllability
- Coping mechanism
- Evaluation of coping
- Identity
- Timeline

Methods of conveying information

- Advice
- Disagreement
- Instruction
- Most important method
- Pictures and photos
- Questions and answers
- References
- Role models
- Slogans and sayings

Normality

Not alone

- Identification
- Identity

Representations

- Effects on interviewee representation
- Site representation

Self-efficacy

Story

- Anecdotes
- Role
- Types

The site

How found it

- Most important function
- What use site for
- Why chose it, liked it
- Why like it now
- Why used online

Thought processes

- Brain chemistry
- Forward planning
- Insanity
- Memory
- Self-deception

Appendix 16: Final themes and sub-themes

Forum impacts on representations

- Cumulative element
- Effects of forum on interviewee representation
- Longitudinal element
- 'No requirements of belief'
- 'Someone like me'
- What use site for

Information behaviours

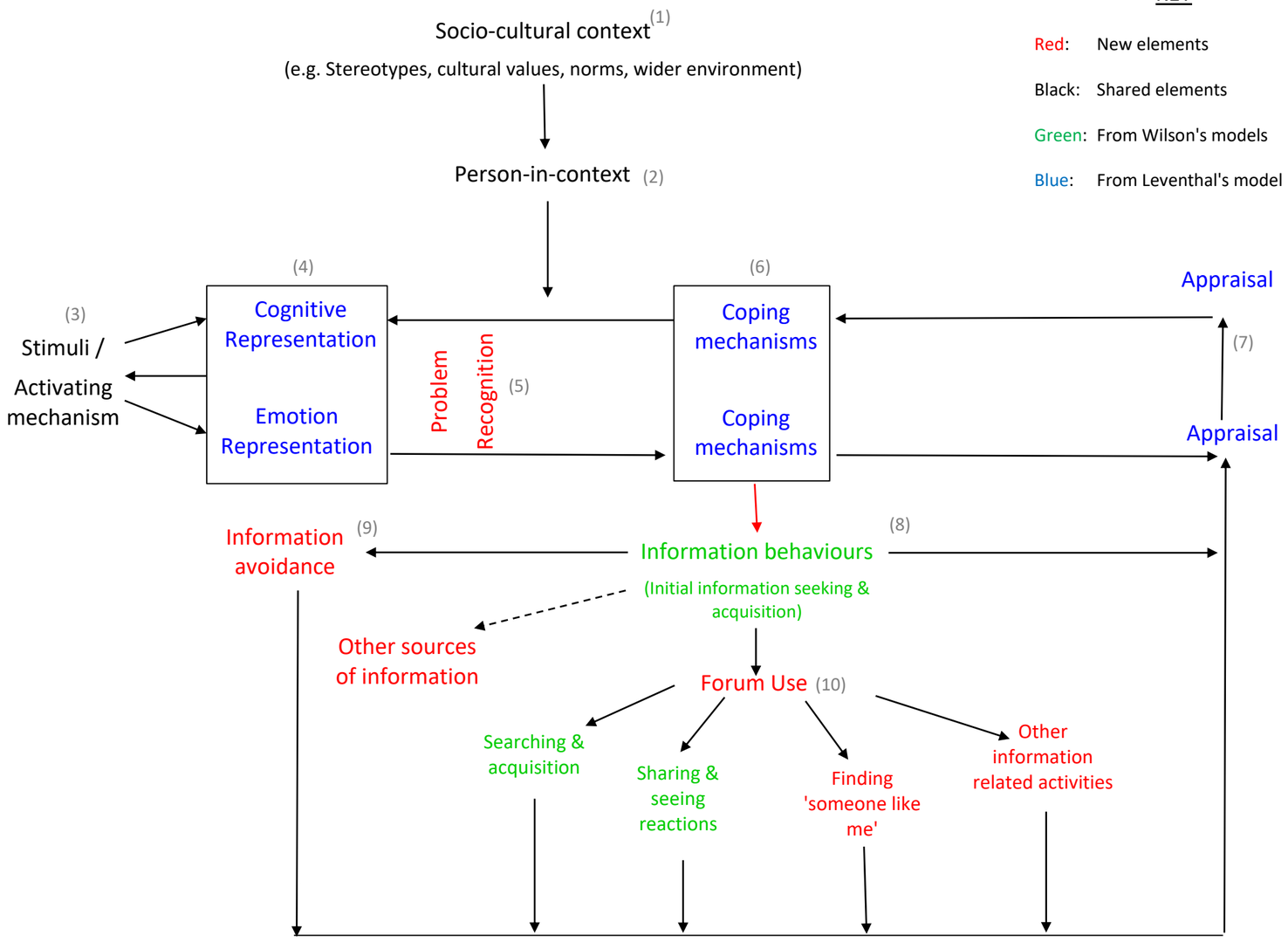
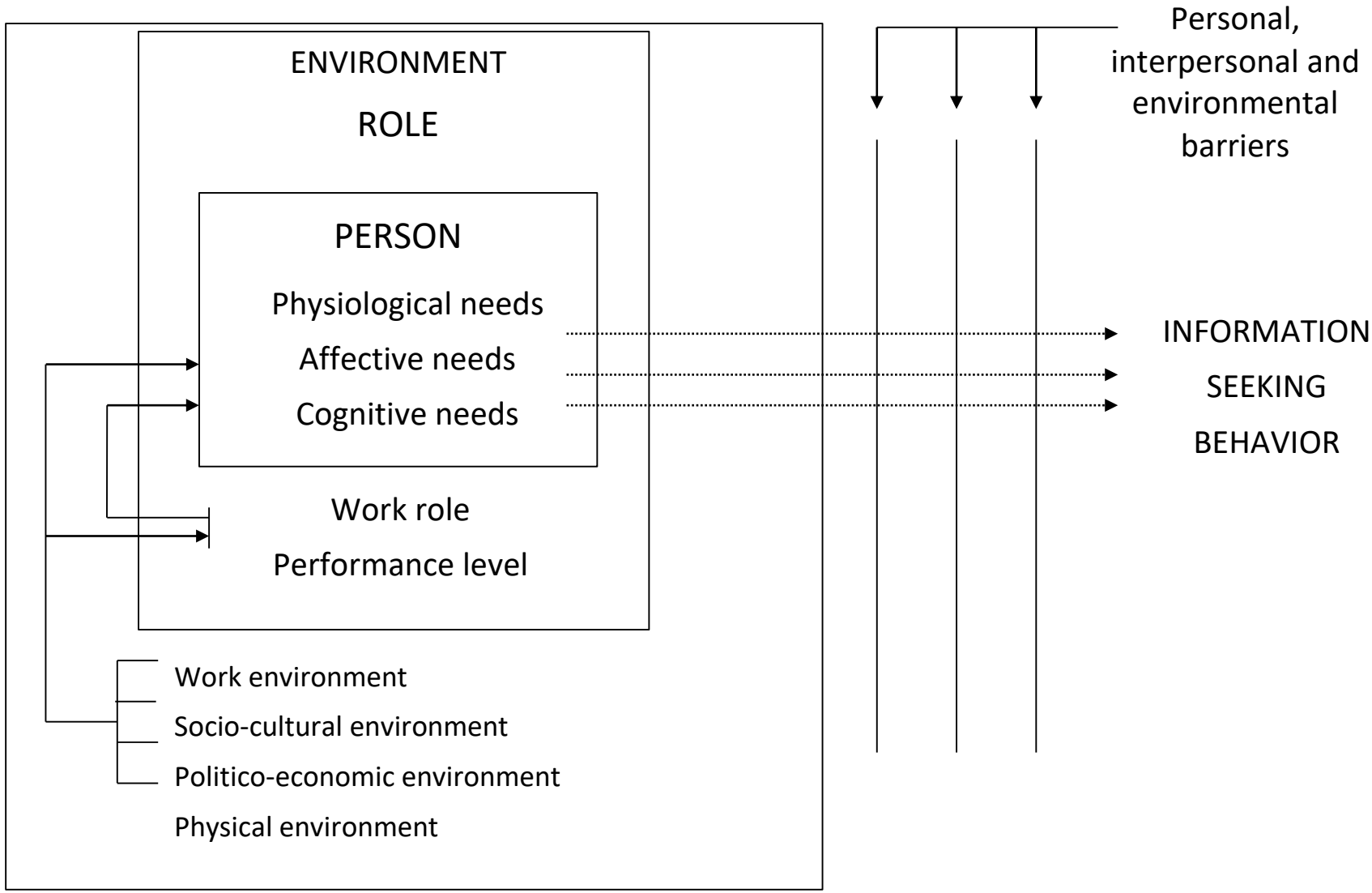
- Berrypicking
- Experiential information
- Forum - affordances, characteristics
- Information pages' usage
- Information standards
- Research
- Search patterns
- Site usage
- Sources outside the site
- Ways of conveying information

Z - Miscellaneous

NB: Material from two previously identified themes 'difference and similarity' and 'fluidity and change' was re-located during the thematic map development, mainly into the two sub-themes 'no requirements of belief' and 'someone like me' as these phrases seemed to capture the essence of the meaning better.

Appendix 17: Combined Model (Figure 7.1)

Figure 7.1: Combined Model (for representation formation through information behaviours in AOSG discussion forums)



Appendix 18: Wilson's Model of Information Need and Seeking, 1981