What's your problem?:
On how participants understand and deal with experienced bodily problems in an online discussion forum about metabolism

A contribution to micro-analytic research that investigate online data

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Table of contents

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English summary

This thesis addresses the issue of how to understand and describe postings in an online discussion forum on health matters as social action. It does so by providing empirical analysis of naturally occurring online data from a Danish discussion forum on the health website netdoktor.dk.

Computer-mediated communication (CMC) receives increasing attention in research as its use and possibilities for use keep developing. Much research, however, either focuses on linguistic aspects of CMC, such as pointing to characteristic linguistic structures of CMC, or traditional sociological aspects, such as measuring effects and outcomes of internet technology, for example for healthcare.

This contrasts with the research interests in this thesis, as the question addressed here is how *participants* in the forum investigated achieve a common understanding, i.e. the thesis will be illuminating methods, including categories *participants* use to perform recognizable social action.

The methodology which this thesis builds on to address this question is ethnomethodological conversation analysis (EM/CA). One on the main objections of EM to traditional sociological research is that it takes social structures and categories for granted rather than take them to be topics for study. EM focuses on ways in which members of society accomplish social order, i.e. on the methods they systematically use to accomplish recognizable social actions. CA addresses this topic by focusing on sequential organization of naturally occurring talk-in-interaction as a resource for accomplishing social action and achieving a common understanding.

The material consists of four collections of data based on around 600 so called “threads”. These threads include written postings from the online health discussion forum on netdoktor.dk on the topic “metabolism”. The postings are written by participants who have obtained membership by joining the online forum by filling in a format, i.e. participation is a choice made by members, not established by professional obligations etc.

With an ideal to approach the material inductively, I have identified recurring patterns in terms of how participants categorize themselves and the problems they describe in the forum and in terms of the sequential structures they organize postings with.

In the first analytical section I describe three systematic and recurrent ways of organizing and categorizing social action in the forum. I describe 1) participants’ methods for initiating and responding to interaction which accomplished the sharing of personal experiences with problems understood to be relevantly placed under the pre-established topic metabolism; 2) participants’ methods for initiating and responding to interaction which accomplished to indicate and deal with metabolism as a possible cause for experienced problems as the topic; 3) participants’ methods for inviting to and providing “advice”.

In the second analytical section I focus on the organization of postings and the categories used in what I refer to as “responses to responses”, i.e. postings written by a thread initiator as a response to the response(s) that have been posted in a thread.

Analysis shows that postings have complex structures, and that actions are organized differently sequentially in online postings and in face to face interactions, as participants in online postings do not

respond to action on a turn-by-turn level. Postings and responses to postings, however, do have systematic structural organizations. Responses are oriented towards the details of the postings they respond to, i.e. to making social action recognizable. The chapters in the first analytical section shows three patterns in terms of how postings and responses are methodically organized sequentially as social actions by participants.

Analysis also shows that participants orient to particular categories as relevant, i.e. they make specific categories and actions recognizable through the organizations of actions through written language in postings. In the analysis this is demonstrated by pointing out 1) how participants categorize themselves and their problem, and 2) by how they categorize and orient to recipients and co-participants. Results of analysis indicate that participants use the forum to indicate and deal with experienced bodily, social, and medical problems, which they either construct as problems that are established or probable to be related to metabolism. They treat metabolism as a medical category. Participants orient to themselves as someone with experiences with bodily, social and/or medical problems related to metabolism, i.e. as lay persons. Further, they construct themselves as competent by orienting to themselves as someone who act on problems, in particular by acting in accordance with what they know from experience and medical knowledge.

By focusing on the resources, categories and understandings that participants use and orient to through the actions they accomplish when they interact in online forums, we get insight about how participants achieve a common understanding as they use resources available from certain technologies.

We also gain insight about how they understand aspects of society when they interact. In this case, rather than using methods such as interviews with questions formulated by researchers to guide the collection of answers from a collection of selected respondents, this thesis points to how people, who have chosen to participate in an online forum, accomplish activities in a specific naturally occurring setting as part of their everyday lives.

These results can qualify our understanding of how CMC is used, for example to interact about health issues, but also qualify how to use insights and methods inspired by EM/CA for the analysis of various types of CMC, including forum interactions.

Danish summary

Denne afhandling beskæftiger sig med hvordan man kan forstå og beskrive online debatfora om sundhedsfaglige emner som social handling. Det gør den igennem empiriske analyser af naturligt forekommende online data fra et dansk debatforum fra den sundhedsfagligt orienterede hjemmeside netdoktor.dk.

Computer-medieret kommunikation (CMC) undersøges i stigende grad videnskabeligt da CMC bruges i stigende grad, og da mulighederne for brug hele tiden udvikler sig. Meget forskning fokuserer enten på lingvistiske aspekter af CMC, såsom at udpege karakteristiske lingvistiske strukturer ved CMC, eller på traditionelle sociologiske aspekter af CMC, såsom at måle virkninger ved og resultater af internet teknologi, fx for sundhedssektoren.

Disse perspektiver på CMC kontrasterer med forskningsinteresserne i denne afhandling. I afhandlingen adresserer jeg spørgsmålet om hvordan deltagere i et online debatforum opnår en fælles forståelse, dvs. afhandlingen vil afdække metoder, inklusiv kategorier, deltagere bruger for at udføre sociale handlinger med de ressourcer de har til rådighed.

Metodologien, som afhandlingen bygger på for at undersøge dette spørgsmål, er etnometodologisk konversationsanalyse (EM/CA). En af EM's hovedindvendinger rettet mod traditionel sociologisk forskning er at denne tager kategorier for givet i stedet for at undersøge dem som et forskningsemne. EM fokuserer på måder hvorpå et samfunds eller en gruppes såkaldte "medlemmer" opnår social orden igennem handling, dvs. EM fokuserer på metoder medlemmer bruger til at udføre genkendelige sociale handlinger. CA adresserer dette emne ved at fokusere på sekventiel organisering af naturligt forekommende interaktioner som en ressource til at udføre sociale handlinger og opnå fælles forståelse.

Materialet, der bruges til analyse, består af fire kollektioner af data som er samlet på baggrund af at materiale på omkring 600 såkaldte "debattråde". Disse debattråde består af skriftlige "beskeder" fra netdoktor.dk's online diskussionsforum under emnet "stofskifte". Beskederne er skrevet af medlemmer eller "deltagere" som har opnået medlemskab af forummet ved at udfylde en blanket. Dermed er medlemskab et valg deltagerne har gjort og som udgangspunkt deltager professionelle ikke i beskedudvekslingerne.

De fire kollektioner, som jeg bruger som data til empiriske analyser, er samlet ud fra et ideal om at tilgå materialet induktivt, dvs. uden prædefinerede spørgsmål og antagelser. Kollektionerne afspejler mønstre jeg har identificeret, i forhold til hvordan deltagere kategoriserer dem selv og problemerne, de beskriver i forummet, og hvordan deltagere organiserer beskederne sekventielt.

I den første analytiske sektion beskriver jeg tre systematiske og genkommende måder at organisere og kategorisere social handling i forummet. Jeg beskriver 1) deltagernes metoder til at initiere og respondere på interaktion hvorigennem de opnår at dele personlige erfaringer med problemer forstået som værende relevante under emnet "stofskifte", som er det præ-definerede emne for alle trådene; 2) deltagernes metoder til at initiere og respondere på interaktion hvorigennem de opnår at behandle stofskifte som en mulig årsag til oplevede problemer som et emne; 3) deltagernes metoder til at invitere til og give råd.

I den anden analytiske sektion fokuserer jeg på organiseringen af beskeder og kategorier der bruges i såkaldte "responser på responser", dvs. beskeder der er skrevet af en deltager der har indledt en debattråd som en respons på de responser der er kommet i en tråd.

Analyserne viser at beskederne har komplekse strukturer, og at handlinger er organiseret anderledes sekventielt i online debatfora end i ansigt til ansigt-interaktioner, idet deltagere i online beskeder ikke responderer på handling på enkelttur-niveau, ligesom man ser i samtaler. Beskeder og organiseringen af beskeder og responser har dog systematiske og genkommende strukturelle organiseringer. Fx er responser orienterede imod detaljerne i de beskeder, de er skrevet som svar på, dvs. de orienterer sig imod at gøre social handling genkendelig. Kapitlerne i den første analytiske sektion viser tre mønstre for hvordan beskeder og responser er metodisk organiserede sekventielt som social handling af deltagerne.

Analyserne viser også at deltagerne orienterer sig imod specifikke kategorier som relevante for de sociale aktiviteter, som de udfører. Deltagerne gør specifikke kategorier og handlinger genkendelige gennem organiseringen af handlinger gennem skriftsproget i beskeder. I analyserne demonstreres det ved at vise 1) hvordan deltagerne kategoriserer dem selv og deres problem og 2) hvordan de kategoriserer og orienterer sig imod modtagere og meddeltagere i forummet. Resultater af analyserne peger på at deltagerne bruger forummet til at kategorisere og interagere om oplevede kropslige, sociale og medicinske problemer, som de enten konstruerer som problemer, der er etablerede som "stofskifteproblemer", eller som problemer hvor stofskifte som kategori muligvis er relevant. Deltagerne behandler stofskifte som en medicinsk kategori. De orienterer sig imod sig selv som nogen med erfaringer med kropslige, sociale og/eller medicinske problemer der er relateret til stofskiftet, dvs. som lægmænd. Ydermere konstruerer de sig selv som *kompetente* lægmænd med bestemte erfaringer der relaterer sig til stofskiftet, ved at orientere sig imod sig selv som nogen der handler på problemer, især ved at handle i overensstemmelse med hvad de ved om stofskifte fra egne og andres erfaringer, samt fra medicinsk viden om det.

Ved at fokusere på ressourcer, kategorier og forståelser som deltagere bruger og orienterer sig imod gennem de handlinger, de udfører, når de interagerer i et online forum, får vi viden om hvordan deltagere opnår fælles forståelse når de bruger ressourcer, der er til rådighed igennem bestemte teknologier. Vi får også viden om hvordan de forstår aspekter af samfundsstrukturer, når de interagerer. I stedet for at bruge metoder såsom interviews med spørgsmål der er formulerede af forskere, for at indsamle svar fra en udvalgt gruppe af respondenter, opnås igennem empiriske analyser i denne afhandling nogle beskrivelser af hvordan sociale aktiviteter udføres af deltagere, der selv har valgt at deltage i naturligt forekommende interaktion i et online forum.

Denne undersøgelse kan kvalificere videnskabelige forståelser af hvordan CMC bruges, for eksempel til at interagere om sundhedsfaglige emner, men undersøgelsen kan også kvalificere hvordan man kan bruge viden og metoder inspireret af EM/CA til at undersøge forskellige typer af CMC, såsom online debatfora.

1. Introduction

This thesis addresses the issue of how to understand and describe postings in an online discussion forum on health matters as social action.

Within the last couple of decades the advancements of the internet has afforded computer-mediated communication (henceforth CMC[1]) within various modes to be used to accomplish various tasks (see for example Herring 2013; Herring, Stein & Virtanen 2013a:3). Social and humanistic researchers have increasingly addressed issues related to the use of computers and other technological devices to communicate. Much sociological research has been concerned with developing measures and assessing effects of CMC (Cotton 2001). Research within pragmatics (Herring, Stein & Virtanen 2013b) has been concerned with characterizing the language use in computer-mediated settings (see chapter 2 for specification).

The purpose of this thesis is to illuminate aspects of *how* people accomplish to perform social action inter alia via written texts online, i.e. the purpose is to investigate participants' methods for accomplishing mutual understanding. Specifically I will focus on CMC occurring in an online discussion forum about health and illness on the topic metabolism (see chapter 5 on data for specification).

The research question that I attempt to address throughout is:

How do participants in online discussions achieve a mutual understanding?

Using discursive psychological and conversation analytic methods, this thesis will investigate how participants use, organize and arrange the resources available to them to achieve mutual understanding.

In this thesis the organization of the participants' interactions is in focus, and orderliness is identified on the basis of microanalysis of participants' actions and orientations. The ambition is to focus on the methods participants routinely use when they act in and through posting written postings online (see section 2.3 for an introduction to the concept of "affordances" and see section 5.2 for an introduction to the structures of the online discussion forum investigated). This ambition is approached by investigating this type of interaction in its own right with an ideal not to use analysts' categories, but participants' categories and with an ideal not to "psychologize", that is, attempt not to make interpretations of participants' actions based on analysts' guesses about participants' reasons, motives, and intentions. "Psychological" issues in discourse are dealt with in and through what participants make relevant about them. Hence, reasons, motives, and intentions are dealt with in analysis when they are constructed as topics or used as resources for participants in what they are doing *in* discourse (see section 3.4 on discursive psychology for specification). Ethnomethodology, conversation analysis, and discursive psychology offer perspectives and methodologies that are suitable for addressing such issues, i.e. issues of how actions are actually done and constructed by participants (see chapter 3 for an introduction to the approaches I apply).

[1] CMC is a term that is being used within a variety of fields. According to Wikipedia it refers to "any communicative transaction that occurs through the use of two or more electronic devices" ("Computer-mediated communication" 2013). Broadly, then, CMC refers to communication via computers or other electronic devices, but see chapter 2 for specifications.

As pointed out by Lamerichs and te Molder (2003), who suggest a discursive model of CMC by making use of discursive psychological methods, as of the early 2000s this has not been the dominant approach in studies of computer mediated discourse. They claim that contemporary perspectives on CMC build on the "cognitivist notion of identity" (2003:452). As an alternative, Lamerichs and te Molder propose a participant-centred and action-oriented account of how participants use CMC that can grasp the everyday dynamics of online dynamics (2003:542). In this thesis I build on these arguments as I hold the view that analysis that focus on everyday practices in CMC as accomplishments still lacks (for exceptions, see the work of Charles Antaki and colleagues (Antaki et al. 2005; Vayreda & Antaki 2009); Hedwig te Molder and colleagues (Sneijder & te Molder 2004; Sneijder & te Molder 2005; te Molder 2009) and Wyke Stommels and colleagues (Stommels & Lamerichs 2014; Stommels & Koole 2010; Stommels & van der Houwen 2013)) and would increase our scientific understanding of how CMC is in fact understood and accomplished by participants. However, the main focus of this thesis is not "psychology". Rather, it is on the use of resources to accomplish mutual understanding. Therefore I will be building heavily on ethnomethodological and conversation analytic views and methods. Concerning 'psychological' issues, I will build on *discursive* psychological investigations, which also employs ethnomethodological and conversation analytic methods[2].

In order to address the research question, the thesis is structured in the following way: In chapter 2 I provide an overview of how online interaction has overwhelmingly been approached within sociology and linguistics (i.e. approaches which address the use of online interaction), namely by focusing on either measures and effects or by studying language use as a topic. In chapter 3 alternative perspectives on how to study the use of online interaction are introduced, namely ethnomethodology, conversation analysis, membership categorization analysis and discursive psychology. These perspectives have a common interest in members' methods for accomplishing social action, and they have in common that they overwhelmingly study naturally occurring interaction. As will be pointed out, the approaches have primarily been applied to study face to face interaction and telephone calls.

In chapter 4 I provide an overview of empirical studies that focus on members' methods for accomplishing action, either in online interaction or in health care settings, i.e. approaches and settings that may have something in common with the setting studied in this thesis, which is online forum interaction in a health website on the topic metabolism.

In chapter 5 the data material is introduced. I describe how it was selected, I introduce to the terminology which is used when describing formal structures of CMC. I also indicate how I have dealt with some ethical and practical issues of how to anonymize participants' identifications, I note on translation of the data to English, and I introduce to the topic metabolism.

Chapter 6 consists of four empirical analyses of recurrent practices of how interaction is organized, which was found based on principles inspired by conversation analysis, membership categorization analysis, and discursive psychology (see chapter 3). In the analytical chapters the ambition has been to describe specific organizations as recognizable practices participants use to accomplish social action. Furthermore, the

[2] Although this investigation of the methods people have to accomplish "forum interaction" serves social analysis rather than for example linguistic analysis (Hougaard Rasmussen 2009), other sociological methods are not applied because they are typically "…dominated by the authorial voice of the sociologist" (Gilbert & Mulkay 1984:2), and/or "…make different assumptions about discourse –grounded theory, content analysis, social surveys, etc." (Potter 2003:787). Also, see chapter 2 for specifications about the methodologies used.

analyses attempt at pointing out how participants in and through the methods they use to organize interaction also display, indicate, imply and embed understandings of how they understand (categories in) the social setting they are engaged in.

In chapter 7 I summarize on the findings from the empirical analyses and in chapter 8 I discuss the findings, focusing on challenges and choices in terms of how to analyze the material from an ethnomethodological conversation analytic perspective.

2. "Traditional" perspectives on online interaction

In this thesis a computer-mediated discussion forum on health issues is the focus of investigation (see chapter 5 for specifications). Citizens' use of CMC is dealt with as a topic increasingly within several fields, such as (medical) sociology (Cotton 2001; Wells & Dolch 2001), sociological perspectives on health care technology (Webster 2006), sociology of information technology (Sassen 2002), digital or virtual anthropology (Hine 2000; Høybye et al. 2005), pragmatics of computer-medicated communication (Herring, Stein & Virtanen2013b), etc.

CMC has as just mentioned been and is currently being investigated from traditional viewpoints and approaches within these areas. In this chapter I present some of the approaches within the field of sociology and within pragmatics. I also introduce to what has developed into a core-concept in the most investigations and analyses of online interaction, including sociological and pragmatic ones too, namely "affordances". This term was coined by Gibson (1979).

2.1 Healthcare on the internet – a sociological perspective

Computer networks, most notable the internet, have received ever increasing public attention since the early 1990's (Cotton 2001:320). The internet developed into a decentralized computer network, originally for the American Defense in order to avoid risks related to storing large amounts of data in a hard disk. Today the internet[3] has had impacts on the way of life for most people, at a societal level because we now use the internet for knowledge sharing, communication, commerce, media and social networks, and at an individual level statistics point to the fact that people spend a lot of time online. Without touching on theories about the social or psychological impact this might have for people, we can simply establish that people choose to spend time in front of their computer on an everyday basis which was not an option a few decades ago.

In a report about Danish citizens' use of the internet in the year 2012, *Danske Medier 2012,* published by Danske Medier[4] (Danish Media), it is stated:

> The Danes love the internet and the online media increasingly gain ground in distribution and use of time at the expense of the traditional media. A marked increase in the use of the internet from mobile phones is found. (Danske Medier 2012:5, author's translation from Danish).

According to statistics (Danmarks Statistik 2012) in 2012 89 % of the Danish population had access to internet from their homes. In the age groups from 16-44 years the number is 99 %. According to Danish Media Danish citizens in average almost spend 100 minutes per day being on the internet (Danske Medier 2012:7).

The possibilities internet technology offer, for example in terms of information access and sharing, as well as the possibilities for participating in social interaction has already had an impact on how individuals

[3] Hine (2000:27) in a book about virtual ethnography provides a loose description of what internet could be understood to refer to; "the term 'Internet' is used to denote a set of application programs that enable particular kinds of communication and sharing of information. The applications that are available at any one time have a large part in shaping what the Internet is understood to be".
[4] This refers to an association of all significant organizations in Danish professional media ("Foreningen" n.d.).

gather health information. In 2001 when Cotton provided a status and implications of internet technology for medical sociology in the new millennium she pointed to the potential consequences of this technology for patient-provider interactions and to implications of internet communication for social support and health (Cotton 2001). As of the year 2013 Rozenblum & Bates acknowledge the impact social media and the internet has had and continues to have on societies, including on healthcare. In particular in regard to so-called patient-centered healthcare[5], which is winning ground, Rozenblum & Bates point at beneficial interplays:

> These three domains—patient-centered healthcare, social media and the internet—are beginning to come together, with powerful and unpredictable consequences. We believe that they have the potential to create a major shift in how patients and healthcare organisations connect, in effect, the 'perfect storm'… (Rozenbaum & Bates 2013).

According to Cotton (2001) some researchers suggest that the accessibility of healthcare information as well as practices that have been developed for sharing information and experiences have positive effects such as increased patient awareness of issues and options regarding each stage of the health care process; a potential for patient empowerment is pointed to, including involvement "in cooperative groups that share information, provide support and facilitate active coping and effective political advocacy" (Mechanic 1999:712). However, Cotton points to a lack of important research to qualify these suggestions. Especially research in "…how patients and providers interact" (2001:323) is needed in order to substantiate the mentioned possible effects and outcomes of internet technology for healthcare which if confirmed may change citizens understanding of healthcare and as a consequence hereof maybe even society's organization of the healthcare system.

In the Danish setting the Danish website "netdoktor.dk" is placed as number 111 on the list of the 200 most visited websites in the fourth quarter of 2011 (Danske Medier 2012). The focus of this thesis is the discussion forum of the website found under the title "Participate" (Danish "Deltag"). A thorough description of structures in this part of the website is found in the chapter about data (section 5.2). Netdoktor.dk is a website, which has as a goal to "…convey medical science in clear and understandable language in order to break down barriers between doctor and patient" (translated, for Danish original formulation, see "Om Netdoktor.dk" n.d.). This points to the fact that health care providers in Denmark are now exploring possibilities to provide health care services online. Statistics from the website, netdoktor.dk points to the fact that Danish citizens to a high extend embrace this possibility; in 2010 87 % of the adult Danish population used the internet to search for information about illness and health, and 67 % of all

[5] The International Alliance of Patients' Organizations has conducted a review of definitions and principles of so called patient-centered health care (The International Alliance of Patients' Organizations 2007). They conclude that there are numerous definitions of patient-centered health care, but no globally defined one. In the review it is noted that in a European context the World Health Organization European Observatory on Health Systems and Policies uses the US Agency for International Development (USAID) definition, which is provided as: "An approach to care that consciously adopts the patient's perspective. The perspective can be characterized around dimensions such as respect of patients' values, preferences, and expressed needs in regard to coordination and integration of care, information, communication and education, physical comfort, emotional support and alleviation of fear and anxiety, involvement of family and friends, transition and continuity."

adults in Denmark visit netdoktor.dk, they note. Furthermore they state that 400.000 Danish citizens visit the website every month and visit 4 pages each (see "Om Netdoktor.dk" n.d.).

These statistics support Cotton's point that there might be important effects and outcomes of internet technology for healthcare, and that research such as the present is needed to substantiate it.

Netdoktor.dk is a part of Netdoktor Media A/S. There is a variety of medical information written by medical professionals on the website, including general information about health and illnesses, which can be found in lists with titles such as "Illnesses" (Danish "Sygdomme") and "Health" (Danish "Sundhed"). The website also takes up themes and news, which they link to at the front page, and the website has advertisement. Both the articles and the advertisement may have illustrations such as photographs accompanying the texts.

The contribution of mainstream sociological research in terms of people's use of internet technology with regard to social aspects related to health and illness (i.e. the topics of medical sociology) is grossly speaking first and foremost developing measures and assessing effects, for example in terms of computer-mediated support:

> Current research is needed to develop new measures of computer-mediated support and assess the differential effects of computer-mediated and non-computer-mediated support on health status for both disease-specific and general populations. (Cotton 2001:329).

This calls for further research. As Cotton (2001) puts it:

> …medical sociologists should also examine why online support groups form, how social support is enacted in online groups, whether patterns of support seeking are similar for computer-based and non-computer-based supports groups, how social relationships may be affected by Internet use, and how these issues relate to health perceptions, health seeking behaviors, and health status (Cotton 2001:329).

Although Cotton does list as a sociological topic "how social support is enacted", this question is not addressed as the core issue of medical sociologists who do research on social support online. Furthermore, how this should in practice be investigated, i.e. described and analyzed, is not dealt with as a methodological concern by Cotton. Instead Cotton under the headline "Research methods for medical sociologists in the new millennium" (2001:329) addresses the use of online surveys and analysis of Internet interactions and texts in terms of "how to find text and interactions to examine" (2001:332).

As ethnomethodologists have pointed out, and as is implied in Cotton's description of the subject area of medical sociology addressing online support groups as a topic, sociology has a tradition of being concerned with describing connections and effects between social institutions, structures or categories. These categories are, as Cotton's description points to, taken-for-granted categories, and how they are understood or established in social interaction by members of society is not taken to be a concern or a topic of sociology in this understanding. This contrasts with my research interests, as I will focus on how *participants* in a forum achieve a common understanding, i.e. I will be illuminating methods, including categories *they* use to perform recognizable social action.

2.2 Language use in CMC

Whereas medical sociology has been particular concerned with developing measures and assessing effects of CMC, other fields such as pragmatics have been concerned with theorizing about and describing the language use in CMC.

In the Handbook Pragmatics of CMC (Herring, Stein & Virtanen 2013b), the perspectives represented have in common that they address specific types of linguistic phenomena ("…a particular set of topics that are defined as pragmatic, rather than syntactic or semantic" (Herring, Stein & Virtanen 2013a:6), or "…linguistic puzzles that cannot be solved in terms of grammar, or "the grammar" in a Chomskyan sense" (Herring, Stein & Virtanen 2013a:6)).

Topics that pragmatics of computer-medicated communication has addressed are, starting from the 1990'ies, classification ("Is CMC more like speech or writing?" (Herring, Stein & Virtanen 2013a:3), classification of modes or genres of CMC, and contextualized discourse studies of language use in online textual environments etc. (Herring, Stein & Virtanen 2013b). These topics are linked to theoretical discussions about the technological medium's role with regard to language use; how and to what extend is language and language use shaped by the constraints and affordances (see section 3.5) of the medium?

As the literature reveals, studies that address pragmatics of CMC research have on the one hand contributed with characterizations of different modes of CMC and on the other they have contributed with identifications and characterizations of pragmatic phenomena in CMC. These phenomena include the use of address terms, relevance, politeness, etc. (see for example Herring, Stein & Virtanen 2013b).

The pragmatics of computer-mediated-communication positions itself within a specific field of pragmatics, namely research on empirical naturally occurring interaction. This constitutes an alternative to another approach within pragmatics to how people construct meaning through language, e.g. speech act theory (Austin 1962; Searle 1979).

Thus, in the field of pragmatics Susan Herring, who has dealt extensively with CMC for more than a decade (for example Herring 1999; 2001; 2004a; 2004b; 2011; 2013) and who has co-edited the Handbook of Pragmatics of CMC (Herring, Stein & Virtanen 2013b), suggests a model for classifying and approaching CMC from a discursive analyst's perspective. Herring's suggestion on how to operationalize developments within the affordances (see subsequent section which introduces the term affordances as it was coined by Gibson (1979)) and use of technological advancements, which the term Web 2.0[6] is supposed to cover, is informative here, both because it provides a clear and systematic overview of the developments of "computer-mediated" phenomena investigated in the field of pragmatics from a temporal perspective, and also because it addresses how to understand the seemingly changing trends and new uses of web

[6] Web 2.0 is a term that has been used since 2004. Today it is according to Herring used to refer to "changing trends and uses of web technology and web design, especially involving participatory information sharing; user-generated content; an ethic of collaboration; and use of the web as a social platform. The term may also refer to the types of sites that manifest such uses, e.g., blogs, wikis, social network sites, and media-sharing sites" (2013: 2). Herring (2013:2) points out that the notion, Web 2.0, has been controversial from the outset, because opponents to the use of the term have argued that the term implies a revolution and change in the quality of the web that may not be real. Although this discussion is not one that is directly related to the motivations and concerns in this thesis it does testify to the fact that more research is needed in order to qualify discussions about how to understand developments in the use of the internet to perform social action.

technology and web design; “blogs wikis”, “social network sites”, and “media sharing sites” are mentioned (Herring 2013:2).

Herring suggests a model, which she refers to as “Computer-Mediated Discourse Analysis” (CMDA) (2013:4). The model consists of four levels; “structure”, “meaning”, “interaction management”, and “social phenomena”. In terms of methodology the idea is to adapt existing methods from linguistics (for example text analysis, semantics, pragmatics) and other fields that analyze discourse (for example conversation analysis, ethnomethodology). These methods and the phenomena that can be identified can then be mapped loosely onto the hierarchical model (2013:4 f.).

Besides these levels which include what Herring refers to as both “micro-linguistic phenomena”, “a more context-independent level of structure”, and “macro-level of contextualized social phenomena” (Herring 2013.4), Herring suggests to also include a level of multimodal communication, which would include methods from social semiotics, visual content analysis and film studies (2013:20). Herring in conclusion points out that the model, “CMDA”, is a lens with a certain focus: “language, communication, conversation, social interaction, and media co-activity” (2013:22). As the construction of the model points to, it has inbuilt classifications of what its phenomena may be, and how it should be operationalized.

Though branches within pragmatics are concerned with interactional phenomena and sequential organization, the purpose of such investigations is the study of linguistic phenomena. As mentioned above research that focuses on interactional and sequential issues has also been related to CMC, in particular in regard to chat. A short review of important studies follows in section 4.1.

As mentioned, this thesis focuses on participants’ methods for accomplishing *social action*, including aspects of the sequential organization of the CMC. In line with ethnomethodology (see 3.1), conversation analysis (see section 3.2), and membership categorization analysis (see section 3.3) the thesis sees studies of language as serving social analysis (Rasmussen Hougaard 2009). In line with discursive psychology (see section 3.4), which also studies language as serving social analysis, the thesis focuses on a social analysis of interacting about issues related to ”the field of psychology”, in particular how participants in the forum understand experienced problems.

2.3 “Affordances” of CMC

As described above, CMC has been approached by researchers within the field of pragmatics by applying a combination of existing methods to describe phenomena of language use.

The research questions I address in this thesis and the methods I apply to address the questions imply specific interests and perspectives as a starting point to investigate a specific kind of computer medicated communication (the communication of health issues in an online discussion forum that uses a bulletin board system) as social actions. The thesis does not address technological issues from a design perspective. Instead it sets out to investigate how participants in fact use some of the possibilities of communicating online in order to perform social actions and how they accomplish to communicate through social actions online. Nevertheless, findings in terms of how participants use the medium to communicate might be valuable input for designers of computer mediated technologies.

Since the point of departure here is to investigate how participants make use of resources to communicate, which is among other things afforded by technologies, and can be viewed as a specific niche[7] of communication, the term "affordances" will be described in terms of how it contributes to the framework I approach the data material with.

Within several fields within psychology, design, and interaction the term *affordances* is being employed, but the term is used in rather different ways for different purposes (see for example McGrenere & Wo (2000) on the introduction and development of the concept affordance within the Human-Computer Interaction community).

James J. Gibson coined the term affordances in the book "The Ecological Approach to Visual Perception" (1979) within the field of perceptual psychology. Gibson puts forward an approach to vision that can be understood and is presented as a counterpart to the approaches to vision within the fields of physics and visual physiology which were predominant at the time the book was published. Gibson suggests that perception should be approached, not in terms of physics, optics, anatomy, and visual physiology, but from the observer's perspective:

> The perceiving of an affordance is not a process of perceiving a value-free physical object to which meaning is somehow added in a way that no one has been able to agree upon; it is a process of perceiving a value-rich ecological object. Any substance, any surface, any layout has some affordance for benefit or injury for someone. Physics may be value-free, but ecology is not. (1979:140).

As Gibson stated in his book, the approach to perception which he put forward also challenged predominant views on perception within the field of psychology: "The old idea that sensory inputs are converted into perceptions by operations of the mind is rejected. A radically new way of thinking about perception is proposed". (1979:2).

For Gibson, the point of departure is an animal in an environment[8]. Gibson argues that animals, or observers, get information that is value-rich from the outset when they perceive objects in their environment. That is to say when observers perceive the composition and layout of surfaces they perceive what the objects afford. Gibson defines affordances in the following way:

> The affordances of the environment are what it offers the animal, what is provides or furnishes, either for good or evil. The verb to afford is found in the dictionary, but the noun affordance is not. I have made it up. I mean by it something that refers to both the environment and the animal in a way that no existing term does. It implies the complementarity of the animal and the environment. (1979:127).

Within pragmatics the concept of affordances has been applied and figures in pervasive themes in the literature. In the introduction to the Handbook of Pragmatics of CMC the term affordances is juxtaposed with the term "mode" and understood as communication pragmatic constraints: "the communication-

[7] Gibson (1979:128) suggests to use the term "niche" as a set of affordances.
[8] Gibson defines environment as "the surfaces that separate substances from the medium in which the animals live" (1979:127).

pragmatic constraints [are viewed] as captured in concepts such as ”mode” and ”affordances”” (Herring, Stein & Virtanen2013a:7). Research dealing with the pragmatics of CMC “…to various degrees, implicitly or explicitly [attempt] to explain language in CMC” (Herring, Stein & Virtanen 2013a:7), and Herring, Stein & Virtanen note that researchers have been concerned with questions of technological determinism and questions of whether CMC is deficient compared to spoken language.

This way of approaching affordances of the medium shows that researchers deal with affordances as predefined constraints, although researchers do discuss to which extend users' behavior is determined by the technological medium. Research often deals with so called “[m]edium effects” (2013:8), and describe affordances of different modes of CMC, i.e. researchers point out features that characterize different modes, such as chat or mailing lists and account for the usage in terms of these features.

Questions of how to understand the relationship between the affordances of technologies and users' use of the technology, not in particular in terms of language use, but rather in terms of social processes is discussed in the sociology of technology. Hutchby (2001a; 2001b) presents an outline of several social constructionist approaches within the field of sociology of technology. In particular he cites and refers to Grint and Woolgar (1997), who suggest that both the configuration and the interpretation of technologies are open negotiated processes (Hutchby 2001b:445). Hutchby acknowledges the point made by the constructivists that social processes are always involved in every aspect of technology, and he agrees that their rejection of technological determinism is useful, but he objects to the claim made by the radical constructivists that technological artefacts do not have any intrinsic properties (2001b:447). Contrary to what the radical constructivists argue, Hutchby claims that we must accept that technological artefacts do have affordances that constrain our interpretations and uses of the technologies. In fact, Hutchby (2001a:29) suggests, “it is these features [that are not constructed through accounts] that provide the very conditions of possibility for competing accounts to be sensibly made”.

Hutchby (2001b:444) proposes “…an approach to the study of technologies and social life which offers reconciliation between the opposing poles of constructivism and realism”. Furthermore, he suggests the term affordances,, to build bridges between the radical constructivist[9] position on the one hand and realism[10], which in some sense can be associated with technological determinism[11] on the other.

These questions and discussions point at central theoretical issues for researchers approaching CMC. My approach is inspired by Hutchby's (2001b) arguments. The kind of data material I am investigating is referred to as forum discussions occurring in bulletin board systems, which has been described in the literature to have specific affordances compared to other modes of CMC (see chapter 5 on data). Instead of dealing with that as a topic (for example explaining language use as being constraint by the affordances that researchers have defined) my basic concern is to describe what participants do when they interact in the forum as social action, and issues of how they use the affordances of the medium to perform social

[9] Constructionism is described as “the view that the very ‘reality’ of objects is itself an outcome of discursive practices in relation to the object” (Hutchby 2001b:443).
[10] Hutchby (2001b:443) defines realism as “the view that worldly objects have inherent properties that act as constraints on observational accounts”.
[11] Hutchby defines technological determinism as “...the view that forms of technology actively cause new forms of social relations to come about” (2001a:14 f.).

action will be addressed in analyses of what participants do with the resources available to them and when participants display an orientation that this is a relevant issue for them.

2.4 Summary

This chapter has presented views on how to study the use of CMC. I have briefly introduced to the kind of data I am working with, online discussions on a health website under the topic metabolism, and I have provided some outlines of how CMC has traditionally and overwhelmingly been approached within sociology and pragmatics. Much research within sociology has been concerned with pointing at the impact and effects CMC has on society. In medical sociology the impact social media and the internet has had and continues to have on societies, including on healthcare, is acknowledged. However medical sociologists also recognize that research still needs to be done in order to qualify *how* people actually use the internet to communicate about health issues. Within pragmatics aspects of language use is the topic of study. For example studies within pragmatics have focused on characterizing the language of CMC and classifying language use online in terms of modes and genres.

I also introduced the term affordances coined by Gibson (1979) and I suggested, inspired by Hutchby (2001(a);2001(b)) to acknowledge that CMC has intrinsic properties. From an ethnomethodological perspective, which I am inspired by, however, these properties become a topic of analysis when participants orient to them. In fact, in this chapter I have suggested that sociological and pragmatic approaches to the use of CMC, while addressing important issues and presenting valuable findings, overwhelmingly approach the topic with existing theories and methods within the fields. Thus, they do not focus on describing use of CMC from a participants' perspective, i.e. by focusing on the methods and categories used to accomplish social action. This is what I attempt to do in this thesis, and the approaches I am inspired by to do this are introduced in the following chapter.

3. Views on how to study society and language as social action

As mentioned, this thesis focuses on computer-mediated discussion forums on health issues specifically in terms of how users of CMC perform social actions when using computers or more specifically when interacting in online discussion forums. Moreover, it addresses how the participants in such discussions achieve an intersubjective understanding through these actions. In this section I introduce the approaches I am inspired by to study this. The approaches are ethnomethodology, conversation analysis, membership categorization analysis, and discursive psychology. These approaches are all grounded in ethnomethodology, i.e. an interest in the methods citizens use through which they achieve social structure and knowledge jointly. The approaches in part have different foci. Conversation analysis focuses on methods in naturally occurring interactions, membership categorization analysis focuses on citizens' methods for categorizing (themselves and each other) in interaction, and discursive psychology focuses on citizens' methods for categorizing and methods in general in relation to topics of interest for psychology. Hence, all of the mentioned approached are concerned with topics of relevance for this project.

3.1 Ethnomethodology

Ethnomethodology (EM) has since the 1960'ies developed itself and its literature to "explicating the ways in which collectivity members create and maintain a sense of order and intelligibility in social life" (ten Have 2005). Hence, EM views and investigates intersubjectivity as a practical accomplishment between members of society.

Harold Garfinkel is credited for developing EM as a distinctive perspective of social research (see for example Button 1991b; Heritage 1984; ten Have 2005), and, as his work testifies, he was concerned with respecifying sociology (Garfinkel 1991; see also Garfinkel 1967a;1967b). In ethnomethodological inquiry the *methods* for accomplishing members' activities are the *topics* of research (Psathas 1980:4), whereas in mainstream sociology members' methods to accomplish social action has traditionally not been addressed as a topic per se to address issues of society and humanity in research. Psathas formulates the basic ethnomethodological argument for being concerned with members' methods to investigate issues of sociality: "Society is not a "thing" or "object" of study apart from its members' activities" (Psathas 1980:7).

Also Button (1991b), Lynch (1993) and ten Have (2002) among others take up EM's relationship with mainstream sociology but also with the human sciences at large. Button points out that EM is fundamentally different from traditional human sciences including new (at the time in which the book was published) ideas such as post-modernist and feminist thought (1991b:4), which have "…[t]heorising, the epistemology of professional skepticism, [and] mathematicalising the social world" (1991b:4) in common. EM does not share this methodology. Instead of theorizing about the social world, i.e. providing explanations, ethnomethodologists try to answer questions by investigating the details of accountable actions, not by theorizing them as traditional approaches to sociology do (1991b:5). As Button puts it:

> Sociology does not require reference to the details of accountable actions in and as of the embodied practices of particular living breathing human beings - even though it is living human beings who, in the details of what they do, are being sociable – when it considers

> how to apprehend sociality, or considers of what sociality consists, or attempts to actually describe sociality. (Button 1991b:5).

As this quote points at, ethnomethodologists do away with the lack of concern in mainstream sociology with how people in fact accomplish social interaction, i.e. with the methods they use to interact with others socially. EM on the contrary studies practical activities as they are accomplished and seeks to investigate what sociality consists of by attending to details of actions.

Ethnomethodology is said to have a particular attitude in terms of how to view and study social action. In order to appreciate the ethnomethodological attitude (Psathas 1977) (which other approaches such as conversation analysis, membership categorization and discursive psychology which I will introduce in this chapter as well also build on) and its contributions to the field of sociology, some of its major influences and core concepts should be introduced.

Garfinkel started his career at Harvard University, in which at that time faculty members at the newly developed Department of Social Relations were devoted to emphasize a theory of action. This was chaired by Talcott Parsons (Heritage 1984:7). Parsons made an, at that time, novel and revolutionary claim that empirical research in the social sciences did not develop theory on the basis of collections of "raw facts". Rather empirical findings were the products of theoretical interpretations of empirical material. Parsons claimed that the social sciences all dealt with systems of social action. He formulated a theoretical concept of social action, which could be used to review previous accounts of action, and which could account for how individuals, subjects, act in institutionalized ways. Put simply, individuals were understood to have internalized common patterns of value systems, which make it possible for social interaction to be stabilized (Heritage 1984).

As Garfinkel notes, Parsons and his publication "The structure of Social Action" (Parsons 1937) is ethnomethodology's origin, but it is equally obvious that "…a certain agenda of themes, announced and elaborated in" The Structure of Social Action, "…has over the years offered a contrasting standing point of departure to ethnomethodology's interest in respecification" (Garfinkel 1991:11). Whereas the social science movement with Parsons as a spokesman suggested that there was no orderliness in concrete activities, and that orderliness could only be provided for by constructive analysis (1991:14), ethnomethodological studies are identified by the fact that they put "…[d]istinctive emphases on the production and accountability of order*[12] in and as ordinary activities" (1991:17).
Ethnomethodologists focus on methods to accomplish social interaction for a reason. Garfinkel rejected that a theoretical concept of social action as suggested by Parsons could account for social action, because the theory disregarded actors' common-sense world, in which actions are chosen and evaluated on the basis of reasonable, practical, considerations and not according to theoretically based choices. As will be pointed out in the following, in EM social action is understood as practical knowledge, which members make publically available by doing them and which is a way of achieving an intersubjective understanding in practice.

[12] "Order*" spelled with an asterisk, according to the notes, "serves as a convenient proxy", and the topic of order* should be understood as a practical achievement (Garfinkel 1991).

In works that position EM among the social and the human sciences (for example Button (1991b), Heritage (1984) and Hilbert (2009), Lynch (1993), and ten Have (2002)), phenomenology is emphasized as the theoretical foundation for ethnomethodology. As Psathas puts it, "ethnomethodology represents one extension and elaboration of a phenomenological foundation for studies of the world of everyday life" (2004:22). Phenomenology offers a philosophical perspective on subjectivity, which obviously inspired Garfinkel in his project to argue for an understanding of social action as a practical accomplishment rather than as a theoretical concept that can determine and explain actions in terms of predefined characteristics (Heritage 1984:36).

Husserl[13] is seen as the founder of phenomenology (Heritage 1984: 38). At the core, Husserl's project was to understand the nature of logic, and specifically it was "to understand, **not contest**, the objectivity of (especially) logic, but also mathematics, science and so forth" (Sharrock and Anderson 1991:53). Husserl objected to the philosophical starting point of objectivism; he objected to the tendency within science to take findings and suppositions of common sense at face value, because issues that ought to be up for philosophical inspection are taken for granted in doing that (1991:53). Instead, he argued that "…the calculative techniques of any science depend on an intuitive grasp of the distinctive subject matter of that science" (Lynch 1993:120). Husserl wanted to recover the pre-theoretical perceptions of phenomena (Sharrock and Button 1991:142), and he sought to explicate the phenomenological field of the life-world (Lynch 1993:120). For Husserl, then, the proper task for a thorough philosophy was to understand the sense of this supposition.

Husserl suggests that we can only know the world through our consciousness and that we only have access to our own consciousness. Essential forms of consciousness are the things that are in the world, and they are invariant because they are governed by universal laws. These essential forms of consciousness are the phenomenon that Husserl is interested in. Flaherty formulates it as a "rigorous science" of subjectivity (2009:219), and he refers to the phenomenon Husserl is interested in as the "universe of subjective processes" (2009:219).

This means, the phenomenon of interest is seen as the human process of knowing the world, not a facet of the world itself. Husserl does not suggest any empirical methods for studying this phenomenon. In fact he rejects empirical analysis as a way of dealing with the phenomena. Empirical analysis is not possible because, he argues, in everyday life there is a "natural attitude" for suspending doubt concerning the contents of consciousness and taking the lifeworld for granted. This means, access to the essential forms of consciousness is blocked.

Since we cannot investigate this process, Husserl suggests an approach in which we can study this phenomenon; the process of perceiving the world as objectively existent. For doing this, phenomenological reduction is suggested. The idea behind phenomenological reduction is that even though human beings perceive objects in the world, which are partly obscured, they nevertheless identify the objects as certain recognizable objects. There is, then, a complex unconscious constructive process in human beings' minds that allows us to identify these objects. In phenomenological reduction the investigator suspends his

[13] Interestingly, like other prominent figures that have inspired and developed ethnomethodology such as Russell and Wittgenstein (Heritage 1984:39) and also Alfred Schutz and Harold Garfinkel, Husserl started his scientific career in another field. In Husserl's case he addressed some basic problems in mathematics by turning to philosophy. Also Russell and Wittgenstein came from mathematics, whereas Schutz had studied law and business and Garfinkel originally studied accounting.

believe in "…the objective existence of the objects of perception in order to examine how they are experienced as objectively existent" (Heritage 1984:41).

With his point that we only have access to our consciousness and not to knowledge of the world directly (Flaherty 2009:219) and by suggesting the device of phenomenological reductionism to study the subjective structures through which the world as objectively existent is experienced, Husserl has inspired phenomenological sociology, which is in particular associated with the work of Alfred Schutz.

Alfred Schutz should be pointed out as a source or basis for inspiration and stimuli for EM (Sharrock & Anderson 1991:54), although the ethnomethodological paradigm in some respects, and possibly increasingly after 1967 (Psathas 2004:21) contrasts with Schutz's approach (see below).

Although Schutz took from Husserl the emphasis on subjectivity, Schutz did not, as Husserl, believe that intersubjectivity (i.e. a common understanding between individuals) is given in the nature of human consciousness. For Husserl intersubjectivity could be approached as an abstraction, as the process in the mind that allows human beings in their everyday life to take their life world for granted. Schutz argues, instead, that "…intersubjectivity is accomplished through socialization and social interaction" (Flaherty 2009:222). This means, for Schutz the question of how intersubjectivity is possible is not a philosophical problem as it is for Husserl, but is treated as a practical problem that social actors solve in the social world (Heritage 1984:54). In ethnomethodological inquiry this approach to intersubjectivity is adopted, i.e. EM is concerned with members' methods to accomplish intersubjectivity in practice. There are, though, important ways in which Schutz and Garfinkel, and thus the ethnomethodological approach, differ in their approaches to the everyday world.
Schutz answered the question of how intersubjectivity is possible categorically by stating that human beings never can "…have identical experiences of anything, but that this is irrelevant because they continuously assume that their experiences of the world are similar and act as if their experiences were identical-for-all-practical-purposes" (1984:54). Garfinkel approaches the problem differently: "**Whatever** the intersubjective knowledge and understanding is that is achieved and **however** it is achieved become legitimate topics of investigation as to their 'what' and 'how'" (1984:71). At this point we see how EM developed an approach to intersubjectivity that, while clearly being inspired by phenomenology, focused specifically on members' methods for achieving intersubjectivity in everyday life.

Schutz and Garfinkel also have different takes on or concerns with subjects' knowledge of the everyday world. Schutz was concerned with the process of typification, "an abstractive act through which the specific here and now of an object or event is abstracted from its specificity and seen with regard to its character or quality" (Psathas 1980:9). Garfinkel "…radically transforms knowledge within the natural attitude to only that which is known by members on the occasion of their "doing". Members' "knowing" consists of whatever it is they "do,"[…] and an analysis of what the activity consists of is sufficient for all practical purposes to reveal whatever it is they "have in their minds."" (Psathas 1980:10). This means, in the ethnomethodological approach analysts focus on how people, members of society, accomplish, recognize and manage social order, whereas Schutz was concerned with describing an fundamental, abstract process, an ideational construct about how objects are made sense of.

As these different approaches within sociology and philosophy witness to, in the human and social sciences epistemological considerations about "subjectivity" and "objectivity" are fundamental (Sharrock and Anderson 1991; ten Have 2005). In EM, the perspective on epistemology stands out from most other humanistic and sociological approaches: Instead of being concerned with views of social reality as *"objective"* and as "*subjective"* as a philosophical problem, EM views this as a practical problem for members of society. For example, Sharrock and Anderson mention that doubt about whether something is "real" is not something people do motiveless as philosophical scepticism does (instead it is actively excluded, cf. the "natural attitude"), but doubts are specifically occasioned when there is reason for them (1991:56).

Ethnomethodologists take the position that an objective social reality cannot be realized, and that sociologists' theories about an objective social reality is the sociologist's conception of social reality (Sharrock & Button 1991:145). Such an objection could for example be made against Parsons' concept of social action. The sociologist can be seen to perform a modification of the "natural attitude" and take a "theoretical attitude" instead. This is because sociologists are also members of society, and in order to describe an objective social reality in sociological terms this involves theoretical reflections rather than the attitude of taking the everyday life for granted.
The main interest for EM is how members of society accomplish social order instead of theorizing about an objective social reality, which we, whether we acknowledge the existence of it or not, don't have access to.

The notion of membership is essential for ethnomethodological inquiry (Psathas 1980; ten Have 2005) and is related to epistemological considerations about subjectivity and objectivity. Ten Have defines the notion of "member" in ethnomethodological inquiry as referring to "capacities or competencies that people have as members of society; capacities to speak, to know, to understand, to act in ways which are sensible in that society and in the situations in which they find themselves" (2005:36).

For ethnomethodologists it is members' practices that accomplish social order (see above), but for members, it is assumed, "society" is an omnipresent and massive reality (Psathas 1980:6). Nevertheless, "…[o]bjective reality of social facts for members [is] an ongoing accomplishment, with the methods for that accomplishment being, for members, known, used and taken for granted" (1980:3). It is the members' methods for accomplishing social order, which is the focus of EM, and the aim is "…a description of the "methodology of everyday life," the ethno – (or member's) methodology" (1980:13).

This focus and "attitude" of EM is fundamentally different from most traditional social and humanistic research (which is noticed or implied in various accounts of EM (see above)). Social scientists, as ordinary people, are concerned with producing knowledge through actions, not with *how* they do it. Psathas specifies how this should be understood: "Members "know how" to produce an event or social situation through their actions, but they do not "know" how they do "recognizing." Their efforts to explain "how" they do it are simply inadequate to the task" (Psathas 1980:11). Another way of putting it is that members, be it (social) scientists or ordinary members, accomplish actions and draw upon methods for accomplishing actions as resources instead of as topics (Psathas 1980:5). In ethnomethodological inquiry members' ordinarily taken-for-granted resources are turned into the topic of study. There is a methodological problem inherent in this, though. As ten Have (2005:36) puts it: "For ethnomethodology, common sense

practices are the topic of study, but those practices are also, unavoidably, used as a resource for any study one may try to undertake". There are two problems involved. First, EM's topic is not a member's topic, as "…[t]he fully socialized member of society accomplishes everyday actions in a manner sufficient for all practical purposes. The manner in which he accomplishes such tasks remains for him an already "understood", taken-for-granted "fact" despite its actual mystery" (ten Have 2005:12). Hence, ordinary members accomplish practical activities, they don't ordinarily explicate how they do it (Psathas 1980:11 f.). Second, in order to study common sense practices as they are accomplished, we cannot ourselves avoid the use of common sense practices to do it. Thus, researchers rely on common sense practices to study them.

The problem that is sketched here clearly has connotations back to the Husserl's phenomenology. Husserl argued that consciousness as an abstract phenomenon is not accessible, because it is blocked by human beings' attitude in everyday life to take things for granted, the so called "natural attitude". The phenomenological reduction then involves investigating how a phenomenon is experienced as objectively existent rather than investigating or taking for granted "…the objective existence of the objects of perception" (Heritage 1984:41; see above).
The problem for ethnomethodologists is a sociological and methodological problem rather than a problem of how to get access to consciousness. This is because the achievement of a common understanding is understood to be a practical issue that members attend to in interaction.
As Ten Have indicates, some "methodological reductions" have also been suggested in order to deal with the methodological problems ethnomethodologists face in terms of how to study methods people ordinary use and take for granted in order to achieve intersubjectivity. Ten Have (2005:37 ff.) lists some compromises researcher have explored. He mentions 1) close study of sense-making activities in situations where they are especially prominent; 2) researchers studying their own sense making work by putting themselves in some kind of extra-ordinary situation; 3) closely observing situated activities in their natural settings and discussing them with the seasoned practitioners; 4) studying ordinary practices by first mechanically recording some of their "products", by the use of audio or video equipment. The fourth strategy is the standard practice of conversation analysis, which I will provide an overview of below.

The ethnomethodological approach to sociality, its objective that sociology should attend to "…the social organization of members' mundane practices" (Silverman 1998:58), has been highly inspiring for the process of doing this investigation from the outset of defining the research interests and questions to acquiring and developing a research method for analyzing the data for this thesis. As mentioned above, EM has also had a crucial impact on the development of the approach of conversation analysis (Silverman 1998:36), membership categorization analysis, and discursive psychology, whose findings I also rely heavily upon (see subsequent sections in which I introduce these approaches).

3.2 Conversation analysis

Conversation analysis (CA) picks up from EM's concern with explicating member's methods for accomplishing social action. CA approaches the study of members' methods for accomplishing social action in a particular way, namely by investigating the accomplishment of *interactional* social order in its own right

as a resource for achieving intersubjectivity. Studies of this are done by analyzing the details of naturally occurring data by following specific principles and by attending to the sequential organization of talk. The most fundamental procedures and organizations will be outlined below.

In the Introduction to the Handbook of Conversation analysis of 2012 (Sidnell and Stivers 2012:3) it is stated that "CA in the 21st century represents a rich and vibrant community of international scholars". This field, which has been developed and consists of research within Antropology, Linguistics, Psychology, Health and Communication, Mass Media and Communication among others (Sidnell and Stivers 2012:3) is rooted in sociological work by the scholars Harvey Sacks[14], Emanual Schegloff and Gail Jefferson, who pointed to the role of language as a means for doing social interaction. Inspired by Goffman's work that pointed to the interaction order as worth studying in its own right (Goffman 1983), and Garfinkel's work that pointed to members' methods to accomplish an intersubjective understanding in practice (see section 3.1 above), Sacks, Schegloff and Jefferson developed an approach to the study of spontaneous, naturally occurring social interaction.

Conversation analytic studies show that conversation is governed by conversational rules or rather "mechanisms" (Silverman 1998:52), and importantly in members' use of this machinery (1998:66). The rules, mechanisms or procedures of interaction that conversation analysis seeks to identify and describe are members' methods to achieve understanding in situated social interaction. In particular, conversation analysis focuses on and point to sequential organization as a resource. Silverman explains: "…Sacks argues that members, just as analysts, treat 'the positioning of an utterance' as 'a resource for finding what it's talking to'… and, thereby, use that positioning to display an understanding of something (as an invitation, a question, and so on)" (1998:66). Each turn, in fact, can be analyzed for how it displays an understanding about what the sequentially prior turn was about. This display of understanding is a crucial resource for participants in interaction in order for them to get insight into how something they said was understood by co-participants in the interaction. This is referred to as "next-turn proof procedure" in CA literature (Hutchby & Wooffit 1998:15). This display of understanding on a turn by turn level (see section 3.2.1 below) ensures the accomplishment of intersubjectivity in interaction, as participants can negotiate understandings and deal with interactional problems that may arise as such issues arise for the participants. The display of understanding of a prior turn-at-talk in each turn is not only a resource for participants in interaction. It is also a fundamental resource for analysts who can ground their analysis of interactional mechanisms in the actions and orientations of participants rather than on the analyst's theories, understandings and assumptions.

Although conversation analysis has been particularly concerned with and successful in pointing to sequential organization of talk as a resource for sense-making, the link between EM and CA is obvious, as Sacks here points to observability, i.e. the practical, social, publically available, demonstrable, resources for accomplishing intersubjectivity:

[14] Harvey Sacks was killed in a car crash in 1975, when he was employed as a professor at the University of California Irvine. Silverman (1998) provides a biography of Sacks career and work. Silverman points out that Sacks' work became known through transcriptions of his lectures, first delivered at UCLA and UC Irvine in the 1960s and 1970s. The lectures were taped and typed and was circulated among small groups, even before his death (1998:24). In 1992 the lectures were published with Gail Jefferson as the editor in two volumes (Sacks 1992e).

> …the initial things I am proposing are totally observable; you only have to look at any conversational materials you choose to see that they are so. Nothing, then, can be claimed about 'Wow, that's a fantastically neat thing to have seen. ' But one commonly tends to avoid making 'obvious' observations because it is not obvious what thereafter is to be done with them. But omnipresence and ready observability need not imply banality, and, therefore, silence. Nor should they only set off a search for exceptions or variation. Rather, we need to see that with some such mundane recurrences we are picking up things which are so overwhelmingly true that if we are to understand that sector of the world, they are something we will have to come to terms with. And, as it happens, they are a tremendous resource. (Sacks 1987:56).

The use of naturally occurring data for analysis has become an important principle in CA. In Harvey Sacks' dissertation he investigated tape recordings of calls to a Suicide Prevention Center (Sacks 1967), and the data for Schegloff's dissertation was also telephone calls. Mondada (2012:35) notes that telephone conversations were the kind of naturalistic data which was available at the time, and for this practical reason the first conversation analytic studies outlined some of the basic organizations of telephone calls (Sacks 1967; Schegloff 1967). Mondada (2012:35) also notes that early CA research (for example Sacks, Schegloff and Jefferson 1974) made use of a variety of tape recorded data, and that video recordings were used since the early 1970'ies.

In CA, researchers make use of transcriptions of data sequences. Gail Jefferson invented a system for transcribing data (see for example Jefferson 2004 and Hepburn & Bolden 2012), which has been highly influential for the CA tradition, because this system can capture elemental features of talk (Maynard 2012:12). Even though recordings remain CA's basic data, the researchers' work with transcriptions can help attending to the details of the interaction, and transcripts can be provided along with research reports, with the purpose of providing readers with the opportunity to compare the analysis with the transcription of the data (see Ashmore & Reed 2000 for an analysis and discussion of methodological practices in CA, in particular tape recording and transcription).

CA has traditionally been preoccupied with language. This is because the use of language is a means of accomplishing social interaction. Language is viewed as action instead of communication, i.e. language is investigated as a means for accomplishing action, not only as a means to exchange knowledge or information, which is the approach to language within formal Linguistics (see for example Coulter 1991:28; Levinson 2012). This preoccupation is shared with speech act theorists such as Austin and Searle (for example Austin 1962; Searle 1979) and later within linguistic pragmatics (see below and the previous chapter). But whereas the preoccupation for linguists, including speech act theorists, typically is the linguistic organization at the level of sentences, CA is concerned with the social organization of talk. This is outlined by Maynard among others, who points out that whereas formal Linguistics are preoccupied with describing language at an abstract and transcendent level, conversation analysis has another view of how to approach language: "Traditional units of grammar – syntax, morphology, semantics – are not fixtures to which talk is configured and instead are part of a repertoire of practices in use whereby participants assemble actions through turns and sequences providing for mutual understanding" (Maynard 2012:28). As

Maynard points out, in conversation analysis actions as they are organized in sequences are the basis for analyzing ordinary peoples' sense-making practices in naturally occurring interaction.

3.2.1 Basic organizations in conversation analytic studies

CA has contributed with core findings in terms of how naturally occurring verbal interaction is organized by participants. These include principles and mechanisms of turn-taking, sequence organization, and repair.

For the purpose of analyzing single instances of recordings of naturally occurring verbal interaction, ten Have (1999:128 ff.) proposes an explorative analytic strategy, where the analysts focus on these three types of interactional organization, as well as on the organization of turn design. Here I will use this division to describe some of the basic organizations that conversation analysis has identified.

3.2.1.1 Turn-taking

In CA, the study of social actions is approached by investigating what co-participants ascribe and assign as the main job that turns-at-talk are performing in interaction. Levinson notes that action ascription and action attribution is understood as "the assignment of an action to a turn as revealed by the response of a next speaker, which, if uncorrected in the following turn(s), becomes in some sense a joint 'good enough' understanding" (2012:104). This approach to the study of social action differs, as noted above, from other approaches such as the approach explored by speech act theorists, sociologists, and psychologists (2012:107).

In their famous 1974-paper Sacks, Schegloff and Jefferson noted that turn-taking is essential for the organization of conversation (1974:700). Drew describes what forms a turn:

> A turn is assembled out of components, notably turn-constructional units; speakers employ a variety of linguistic and other resources in designing these components and thereby building turns-at-talk, resources that include lexis (or words), phonetic and prosodic resources, syntactic, morphological and other grammatical forms, timing (e.g. very slightly delaying a response), laughter and aspiration, gesture and other bodily movements and positions (including eye gaze). (2012:132).

Participants accomplish taking turns by constructing units called "turn constructional units" (TCU's), and they use a variety of – most obviously - linguistic resources to do it. Importantly, as Ten Have points out:

> …what basically defines the 'units' of the turn-taking system, the TCUs [turn constructional unit], is not some objectively describable set of structural such as grammatical, prosodic or whatever, properties, but its action potential for participants.
>
> (ten Have 1999:129).

In short, the essential property of turn constructional units is their ability to perform some action.

The properties of this conversational turn-taking system include that it is “locally managed” as well as “interactioanally managed” or “party administered” (ten Have 1999:128). Furthermore, “facts” about the organization of conversation have been formulated which could be referred to as “one at a time, no gap, no-overlap properties” (ten Have 1999:129). These properties are formulated on the basis that interactants in conversation ordinarily take turns according to the norm that they should take turns so that one speaker speaks at a time, and so that gaps and overlaps are avoided. This implies that speakers coordinate their talk. Studies show that turn-taking occurs orderly and with a minimum of silence between turns and with little overlapping speech (Clayman 2012:150). Importantly, these properties rely on empirical findings and should be understood as norms for taking turns, i.e. should not be taken as “rules”. Furthermore, participants orient to these norms as “social”, meaning that they can be seen to orient differently to norms of how to take turns in different social settings.

The fact that turns are built of TCU’s, each of which can be understood as a coherent and self-contained utterance, allows for them to be “recognizable in context as ‘possibly complete’” (2012:151). A TCU’s completion establishes a “transition-relevance place” (TRP). A TRP is marked upon its occurrence, but notable it is also projected in advance, i.e. some of the practices in a turn-in-progress may be understood as foreshadowing a completion of a turn. The recognisability of *possible* turn completion for interactants affords turn-taking that is accomplished by orienting to norms of no gaps and overlaps. Clayman shows that this recognisability can also be used as a resource to circumvent turn transition, for example a speaker may speed up speech just prior to the end of a TCU and/or suppress terminal intonation at the grammatical completion point (2012:159 ff.).

The recognisability of TCU’s and TRP’s in context (see below or Antaki 2012) affords the accomplishment of conversation as an activity which is organized in turns, because participants can signal and project when a turn is possibly complete. In the turn-taking system participants also have methods for allocating turns.

Based on Sacks, Schegloff and Jefferson’s (1974) description of the turn taking system for conversation, Hayashi (2012:168) formulates a set of procedures that interactants normatively follow:

(a) When the current turn reaches its first point of possible completion, if its speaker has selected someone to talk next, then that current speaker should stop at that point and the one who has been selected should begin a next turn there.
(b) If, by contrast, at that first possible completion, the current speaker has not selected someone to talk next, then any other party may self-select and begin a next turn, with the first starter gaining rights to the next turn.
(c) If, at that first possible completion, the current speaker had not selected a next speaker and no one else has self-selected to take the turn, then the current speaker may (but need not) continue.

Participants have specific techniques for selecting a next speaker. This can be done through some form of addressing (Hayashi 2012:169), and it may also done by constructing the TCU as a specific type of action, which then restricts the set of relevant responses.

This means, each turn is viewed as action arranged in a specific sequential order, which is consequential for what the action is understood to accomplish.

Within Conversation Analysis it is assumed that the "basic" system of turn-taking is the system of conversational turn-taking (Sacks, Schegloff and Jefferson 1974). Sacks, Schegloff and Jefferson point out, though, that turn-taking systems can be investigated per se, and they note that different turn taking systems exist for different speech exchange systems (1974:701).

3.2.1.2 Sequence organization

As mentioned above in the CA-approach, a very central point is that conversation and more broadly talk-in-interaction (Schegloff 2007c) is sequentially organized. In fact, as also noted above, it is stressed that actions become recognizable as specific social actions, among other things via their locally accomplished sequentiality. Coulter points out that, in opposition to traditional linguistics and philosophy, CA considers the constraints of the sequential location of an utterance in order to analyze and understand its local rationale. He notes: "Sacks was among the first to notice that, among the array of possible relevant aspects of "context", sequential location was paramount, and furnished a crucial constraint upon the considerations of relevance to an utterance's possible intelligibility, illocutionary force and (thereby) susceptibility to assessment in terms of the true-false contrast class" (Coulter 1991:36).
In CA, then, the sequential organization of talk is what accounts for the relevance of specific actions, and it is in the sequential organizations that actions become recognizable and understood as accomplishing particular action.

Utterances, which are accomplished in turns-at-talk, are treated as doubly contextual, in that they are viewed as both context shaped and context renewing (Heritage 1984:242). They are context shaped, because the action being performed by the utterance in an ongoing sequence can only be understood adequately with reference to the context. They are at the same time context renewing because an utterance will make up the immediate context for some next action in a sequence (Drew & Heritage (1992a:18)).

Thus, by formatting a turn in a particular way, speakers display their understanding of the prior turn, and they indicate particular expectancies on what the turn that follows should do. Turns that follow a particular course of action can be understood as a sequence, and a sequence can consist of many and elaborate turns (Levinson 2012:107). Nevertheless in conversation analysis many sequences are understood to be built up of elementary adjacency pairs. The concept of "adjacency pair" (Schegloff 2007c:13), which consists of "two pair parts", such as for example a question and an answer is seen as the basic sequence. Sacks (1987) describes it in the following way:

> The basic sequence is a two-unit sequence; the two turns in which the parts of the sequence occur are placed adjacently to each other; and for all of them you can discriminate what we will call 'first pair parts' from what we will call 'second pair parts', so that the parts are relatively ordered (see Schegloff and Sacks 1973 for a fuller description of 'adjacency pairs'). And a further feature obtains between first and second pair parts, which is that they are 'type-connected', by which I mean only something as weak as this (though it is enough for a

> great many things): if a party does, for example, a first pair part of some type, such as greeting, question, offer, request, compliment, complaint, things like that, then the party who is going to do a second pair part to that first pair part picks it from the sorts of alternatives that fit the type. Then for greetings this involves greetings, for questions, various sorts of answers, for offers, acceptances and rejections, for announcements, congratulations or condolences; and so on. (Sacks1987:55 f.).

When constructing a turn, which is recognizable as a first pair part this puts constraints on the actions that can relevantly be done as a second pair part. When constructing a turn as a question, for example, it makes a turn that is constructed as an answer relevant. As Levinson notes, though, alternative action types are usually available as a relevant response. First pair parts may be formatted in ways that indicate expectancies or preferences (see below) for a particular type of response. Levinson mentions as an example that compliance may be indicated as the expected and preferred response to a request, although refusal may also be a relevant action that may work as a, typically dis-preferred, response to a request.

The adjacency pair is the core instrument for the analysis of sequential organization, but a full sequence typically includes more than just two pair parts. For example Schegloff (2007c:26) distinguishes three kinds of expansions to adjacency pairs, a pre-expansion that is placed before the first pair-part, an insert expansion that is placed between the first and the second pair-part and a post-expansion that is placed after the second pair-part.

The fact that adjacency pairs are constructed as recognizable elements in sequences that make out courses of action is important for how adjacency pairs are understood, i.e. for what action they can be understood to accomplish in the specific sequential context in which it is placed. Levinson specifies: "…[S]equences contribute to action formation and recognition in two ways. First […]the location of a turn maps sequential expectations of action content onto it. Second, though, the fact that an action is part of a larger sequence changes the very character of it". (Levinson 2012:110).

3.2.1.3 Doing repair

So far basic mechanisms in the sequential organization of talk have been outlined in conversation analytic terms. As has been pointed out, these mechanisms are understood as resources to accomplish an intersubjective understanding, for example by taking turns and by orienting to actions as organized in pairs occurring in sequences. Empirical studies of talk-in-interaction also show that interactional trouble arises in speaking, hearing and understanding talk (Schegloff, Jefferson & Sacks 1977). Conversation analytic studies have also investigated how interactants deal with this to ensure that intersubjectivity is maintained or restored. Interactants' methods for dealing with interactional trouble has been described and studied as the phenomenon of "repair" (see Schegloff's extensive work (for example 1979; 1987; 1992; 1997a; 1997b; 2000). For an overview, see Kitzinger (2012).

Conversational repair is defined as a mechanism used to deal with trouble in speaking, hearing or understanding (Schegloff, Jefferson & Sacks 1977). When repair occurs, an utterance is oriented to as a

trouble source. This can be done by the speaker of the utterance (in that case it is called "self-initiated repair") or by another participant in the conversation (in that case the type of repair is called "other-initiated repair"). Also, repair can occur "in third position" which is the turn after the first response after the utterance containing the trouble source (ten Have 1999:133 f.). Furthermore, a distinction is made between the "initiation of repair" and the "actual repair" itself, so that one participant can mark something as a trouble source and the same participant or another participant can do the actual repair. (Hutchby & Wooffitt (1998:61).

Hutchby & Wooffitt highlights the functions of repair:

> …one important function of the repair system as we have outlined it here is the maintenance of mutual orientation to common topics and fields of reference in talk-in-interaction…the organization of repair is closely bound up with the question of interpersonal alignment, or intersubjectivity, in social life (Hutchby & Wooffitt 1998:66).

Here, we thus see clearly the link between EM and CA; "conversation analysis may be conceived of as a specific analytic trajectory which may be used to reach a specific kind of systematic insight in the ways in which members of society 'do interaction'" (ten Have 1990). As Hutchby and Wooffitt point out, analyses of talk-in-interaction from the conversation analytic approach has, among other things described the phenomenon of repair as one of the techniques people have in ordinary conversation to negotiate and achieve a common understanding, just as mechanisms identified and described in conversation analytic terms such as turn taking and sequence organization are seen as mechanisms interactants use to achieve intersubjectivity.

3.2.1.4 The organization of turn-design

The basic idea that underlies the focus in conversation analysis on the organization of turn-design is that "…a turn is designed as a meaningful choice" (ten Have 1999:137). Participants in interaction will design and understand utterances so that they fit the situation and context and will be informed by a speaker's knowledge of the situation in general and of the participants in particular.

According to ten Have (1999: 136 f.), investigating the organization of turn-design in terms of "recipient design" and "preference organization" is fruitful. The idea of recipient design is that participants construct utterances in ways that orient to making them understandable for specific recipients. Utterances therefore entail information about the knowledge that the speakers presuppose recipients to have. When participants can "choose" between performing different actions, one action is often expected and chosen. Which actions are "preferred" and "dispreferred" by participants in situated social interactions are demonstrated in the turn shape of the actions. According to Pomerantz (1984:64 f.) a "preferred-action turn shape" in conversation will be performed with a minimization of gap after the prior turn's completion, and will maximize the occurrence of action that is expected. A "dispreferred-action turn shape" in conversation will on the other hand be characterized by being "…delayed, downplayed or withheld" (Pomerantz 1984:95).

3.3 Membership categorization analysis

Besides sequential organization of actions, another resource members of society have for achieving an intersubjective understanding in interaction is through their use of categories. Sacks introduced the notion of "membership categorization" around 1963-1964 (Schegloff 2007a). His work with membership category analysis has been printed in the publication of his lectures most of which were delivered at the University of California from around 1965-1972 (Sacks 1992e).

Membership categorization analysis (MCA) can be viewed as a strand within EM (Hester & Eglin 1997:2). While both CA and MCA have their roots in Sacks' work, Hester and Eglin note that the two forms of inquiry have developed to a large degree independently of each other (1997:2). They also note that CA is now the most widely practiced branch (also see Housley & Fitzgerald 2002:59). Hester and Eglin argue that CA's focus on the sequential organization for understanding how participants accomplish a common understanding in conversation, and MCA's focus on categorizational aspects of conversation can inform each other and that they are "…so closely intertwined as to be separable only for purposes of analysis" (1997:3).

Hester and Eglin define MCA in the following way:

> The focus of MCA (Membership Categorization Analysis) is on the use of membership categories, membership categorization devices and category predicates by members, conceptualized as lay and professional social analysts, in accomplishing (the sociology of) 'naturally occurring ordinary activities.' MCA directs attention to the locally used, invoked and organized 'presumed common-sense knowledge of social structures' which members are oriented to in the conduct of their everyday affairs, including professional sociological inquiry itself. The presumed common sense knowledge of culture is made available through a method by which the ordinary sense of talk and action is made problematic (for the purpose of analysis) and is conceptualized as the accomplishment of local instances of categorical ordering work. The aim of such analysis is to produce formal descriptions of the procedures which people employ in particular, singular occurrences of talk and action (cf. Sacks 1984:21) (Hester and Eglin 1997:3)

In this description of MCA, MCA's ethnomethdological roots are obvious as Hester and Eglin point out that what MCA attempts to is to describe the methods people have in ordinary interaction to accomplish categorization work. The notions "membership categories", "membership categorization devices" (MCD's) and "category predicates" require some elaboration; Schegloff provides this in "A tutorial on membership categorization" (2007a:467): "A Membership Categorization Device is composed of two parts – first, one or more collection(s) of categories, and, second, some rules of application". People can be taken as members of all sorts of categories (categories related to gender, religion, nationality, age, professions etc. are mentioned) (2007a:467). These attributions are inference-rich, in the sense that what is "known" about the category to which a member is taken to belong, is presumed to be so about them. Categories are organized into collections. Collections may be organized for example in terms of gender, religion, nationality, age and professions. However, it remains an empirical question how the collections are in fact organized by members. A "…MCD gets activated, gets made relevant, and thereby its categories and the common-sense knowledge that can come with them" (Schegloff 2007a:471).

Sacks also suggested some rules of application. The two rules are referred to as "the economy rule" and "the consistency rule" (Sacks 1992e; Schegloff 2007a:471; Hester 1998:134). In Sacks' commonly known lecture, "The baby cried. The mommy picked it up" (1992c:246), "the economy rule" is formulated as: "A single category from any membership categorization device can be referentially adequate". This rule is based on observations that it is usually understood to be doing adequate reference to a person by using a single category to refer to that person. "The consistency rule" is formulated as follows: "If some population of persons is being categorized and if a category from some device's collection has been used to categorize a first Member of the population, then that category or other categories of the same collection may be used to categorize further members of the population" (1992c:246). Sacks applies these rules to two sentences in a childrens' book, as indicated in the title of the lecture, "The baby cried. The mommy picked it up"; "the baby" is recognized as an adequate reference to a person (i.e. the economy rule), and the consistency rule makes us recognize the "The mommy" as belonging to the same collection, i.e. relevant given the use of "baby". Since the two rules in itself are rather weak as they are formulated as possibilities rather than necessities, Sacks adds a "hearer's maxim": "If two or more categories are used to categorize two or more Members to some population, and those categories can be heard as categories from the same collection, hear them that way" (1992c:247).

Specific activities and actions are, by the common-sense culture, taken to be especially characteristic of a category's members. "Crying" as tied to the category "baby" is one example. This tie that is taken to be between members of a category and specific activities and actions is termed "category-bound activities" by Sacks (1992c:248). Schegloff notes that this connection does not only apply to someone's descriptions of action performed by people categorized in a certain way; by describing action in certain ways people can activate the relevant invocation of a category, also (2007a:470).

Schegloff (2007a) critizes some of the work on membership categorization since Sacks introduced the framework for having changed it considerably, while committing itself to being closely linked to CA and EM. For Schegloff, the main problem with this work is that membership categorization has not been approached consistently through actual data analysis that shows how parties to a conversation orient to categories. Instead researchers have provided their interpretations and their theoretical solutions to how categories are understood and used to accomplish intersubjectivity (Schegloff 2007a:477). Schegloff urges research on membership categorization devices and membership categorization analysis to ground claims in the conduct of the parties, not in the beliefs of the writer (2007a:476).

3.4 The discursive psychological approach

The approach of discursive psychology (DP) is heavily connected to both EM, CA and MCA. Key figures in the development of discursive psychology are Derek Edwards and Jonathan Potter (Potter & te Molder 2005:2 f.). In DP "psychology" is approached as it is oriented to, used and understood by participants in interaction as a resource for accomplishing an intersubjective understanding when doing social action.

Edwards and Potter (2005:242) give an a outline of the discursive psychological approach in which they clarify the use of the term "psychological" within DP; "psychology" is to be understood in a common-sensical way, but "commitment to an inner life of the mind" (2005:242), individualism, and academic psychology are rejected.

Discursive psychologists approach "psychology" differently than mainstream psychology does. The main objection to mainstream psychology is its treatment of discourse, because discourse has been viewed as a means to study cognitive structures such as thoughts and intentions. Instead DP is concerned with how psychological issues are handled, managed and oriented to in discourse and thus how psychological issues become topicalized and used in achievements of actions in discourse.

Thus, the contribution of DP to the social and human sciences is an approach to study psychology in practice without starting with or bringing in a predefined model of the human actor. This is one of the ways in which DP's link to EM becomes apparent. Like EM, DP investigates how people accomplish social action, DP in particular with the concern to illuminate how people manage psychological issues in social interaction. DP studies are thus not concerned with explaining conduct or generating theoretical concepts of the social actor in the same sense as EM rejects to build theory.

As concerns conversation analysis (see above or for example Hutchby & Wooffitt 1998), discursive psychologists are concerned with what people do with language. This view also influences the view on psychological issues; discourse is studied as action instead of a result of cognitive processes. As an opposition to traditional psychological approaches to the connection between psychology and language, DP considers psychology as an object *in* and *for* interaction (Potter & te Molder 2005:2).

Hence, DP is an approach with very specific theoretical assumptions and methodological principles that are intertwined and coherent with the overall aim to illuminate how participants accomplish social actions in the forum. The DP approach has a specific focus on psychology. As the material I am investigating concerns people who experience health problems, discursive analytic views on how to study "psychological issues" in interaction has also informed this study.

DP has been criticized, for example by social scientists for treating itself as a distinct paradigm for studying the social world rather than as a method (Hammersley 2003). Potter (2003) explicitly positions DP between method and paradigm, and he specifies the discursive psychological project. Potter makes it clear that the research topic of DP is discourse, i.e. the active use of language, and he points to the fact that mixing discursive psychology "with methods that have a different view of discourse is a recipe for incoherence" (2003:785). This means that DP is not simply a method; it has a specific theoretical conceptualization of language, which is bound up with how DP is applied as a method, and furthermore with the types of research questions that are typically posed in DP. The questions often emphasize action and construction (2003:786).

In this thesis an approach to and understanding of DP which is coherent with EM and CA is chosen, i.e. the interest in "psychology" is in terms of how "psychology", "identity" or "personhood" etc. are dealt with in interaction in the accomplishment of situated, sense-making actions.

3.5 Summary and implications: Members' methods for accomplishing social interaction

In this section, I have introduced perspectives that contribute with theoretical insight and/or methodological principles for how to study intersubjectivity as a practical accomplishment in social interaction. The approaches address issues of how it is that we are able to make sense in practice of somebody else's and our own situated actions, even though we don't share every experience and all

knowledge with others. The approaches which have been presented, EM, CA, MCA, and DP, all agree (since they are all rooted in ethnomethodology) that we should address these issues by focusing on members' methods for accomplishing action, i.e. the methods members use to publically, observably, display an orientation to what it is they are doing.

From the outset, EM's project was to respecify sociology, and Garfinkel, who is seen to be the founder was inspired by phenomenology and phenomenological sociology. He took from these philosophical fields the point that we cannot study objective social reality. Instead EM suggests to investigate the methods members of society have for accomplishing a sense of social order in practice. CA, MCA, and DP can be seen as approaches that pick up from this ethnomethodological view on how social activities should be investigated and each suggest a specific focus and specific methods for doing empirical analysis that focus on specific methods members have for accomplishing intersubjectivity. Studies within CA, MCA, and DP overwhelmingly focus on empirical analysis of naturally occurring interaction.

In CA, which was founded by Sacks, Schegloff and Jefferson, members' methods for achieving intersubjectivity in the sequential organization of talk is the main focus. Empirical studies have shown that participants in talk-in-interaction accomplish talk in turns that often are organized in pairs, which are then organized in sequences. The systematicities that can be identified in terms of how participants accomplish talk point to the fact that participants use the mechanisms in the sequential organization of talk to accomplish social interaction and to make sense of it.

In MCA the categories people use to accomplish an intersubjective understanding are in focus. Instead of taking the use and understanding of categories for granted, MCA studies how categories are "…locally used, invoked and organized 'presumed common-sense knowledge of social structures' which members are oriented to in the conduct of their everyday affairs, including professional sociological inquiry itself" (Hester and Eglin 1997:3), i.e. how the use of categories is both a resource for members of society for accomplishing social action and is a phenomenon that can be studied by researchers who are interested in social interaction and sense-making.

DP specifically focuses on psychology as a member's issue in social interaction, i.e. how issues related to "psychology" is used to accomplish social action.

As noted, most noticeably CA, but also MCA and DP have been developed and applied on ordinary face-to-face interaction or telephone calls. Some researchers might object to whether it makes sense at all to apply these approaches to online data, since the resources for interacting with "talk" and with written postings are not the same. The motivation for applying these specific approaches is that they offer a participants' perspective that focuses on how members accomplish to perform social interaction; this perspective is generally lacking in the literature on CMC, even though the perspective with its inductive starting point may illuminate perspectives on CMC which perspectives with pre-established theories and perspectives on which categories and understandings might overlook.

The approaches I have chosen have particular concerns with social interaction as they focus on describing the methods people have for making sense with each other. Since the resources available for accomplishing that in face-to-face interaction and in written postings in online forums are not the same, choosing approaches that overwhelmingly have described methods people use in face-to-face interaction may be

problematic. In particular, the conversation analytic focus on the achievement of intersubjectivity by taking turns at talk by using specific techniques (see above) may to some be sufficient argument for excluding exploring the techniques people in online interaction make use of to interact in sequential organized interaction online.

However, although there is a tradition within CA to study the sequential organization of talk per se, investigating the organization of social interaction as a resource to accomplish an intersubjective understanding in online interaction should not be excluded categorically.

Drew initiates a chapter in the Handbook of conversation analysis with the title "Turn Design" in the following way:

> When interacting with one another, whether face-to-face, via the telephone or other media, we take turns to talk. Each turn we take is designed to 'do' something. Inter-action consists of the interplay between what one speaker is doing between what one speaker id doing in a turn-at-talk and what the other did in their prior turn, and furthermore between what a speaker is doing in a current turn and what the other will do in response in his/her next turn. Hence a turn-at-talk is contingent in some fashion on the other's prior turn, and sets up contingencies of its own for what comes next, for how the recipient will respond. (2012:131)

Drew here points to the fact that the perspective advocated by CA is that social interaction involves turn-taking in which speakers deal with the turns *as* action. He further points to the fact that speakers deal with each turn in terms of what came before and what will come after. It is such an understanding of how to approach social interaction that I bring into my analyses when studying online interaction.

In the following chapter I will review some important studies that have focused on sequential organization and discursive management in CMC and in health care settings in order to further introduce to approaches that are concerned with how people accomplish an intersubjective understanding and in order to point at findings from previous studies that have informed this investigation.

4. Approaches and findings in studies of online interaction and in studies of health care practices

This investigation branches out into several research areas, because it sets out to investigate the accomplishment of intersubjectivity in an online discussion forum by making use of an ethnomethodological conversation analytic approach. Ethnomethdodological conversation analytic approaches to online communication do not make out an established research field; the literature is sparse, but in recent years growing, and attempts have been made to establish an international community of researchers under the title "MOOD: Microanalysis of Online Data". This was initiated with a workshop in Radbound University, Holland, in January 2013.

In this section, I provide reviews of more or less well-established approaches, which have inspired and informed my approach to how to analyze the data I am investigating, an online discussion forum on health issues. Firstly, I point to studies within pragmatics and sociolinguistics that are inspired by CA and its focus on sequential organization to study CMC. Secondly, I introduce a discursive psychological inspired approach to investigate online data, which was suggested by Lamerichs & te Molder (2003), and thirdly, I summarize the extensive conversation analytical literature on communication in healthcare settings.

4.1 Structure in action (CA inspired research of CMC)

As previously mentioned, research within pragmatics and sociolinguistics has been concerned with classifying, identifying and describing features of different modes of CMC. Some of these studies have been inspired by the conversation analytic focus on the sequential organization of social interaction.

Within pragmatics of computer-mediated-communication research has been conducted with the purpose of characterizing communication in bulletin board systems or newsgroups (see chapter 5.2 on data for a specification of the terms), including communication about health or illness (Morrow 2006), sociolinguistic phenomena in chat (Golato & Taleghani-Nikazm 2006), interactional phenomena in chat such as floor holding (Herring;1999; Hougaard 2002; Ong 2011; Simpson2005a;2013), and sequential organization (Markman 2013; Simpson 2005) of actions in chat (Baym 1996; Taleghani-Nikazm 2006).

In terms of interaction management (Herring 2001:618) real-time chat[15] has received most attention (for example Herring 1999; Hougaard 2002; Nilsen & Mäkitalo 2010; Rintel & Pittam 2001; Schonfeldt & Golato 2003; Simpson 2005a; Simpson 2013). Chat has been called "conversational" as it is characterized as being synchronous[16] as the texts appear for users in "real-time" and as they are usually short[17] (Paolillo &

[15] Paolillo & Zelenkauskaite (2013:109) initiate their description of chat in the following way: "Chat is a CMC mode in which users who are simultaneously sharing a computer system exchange text messages. Messages tend to be short, and they appear for users as soon as they are available".

[16] Or as Markman notes, "quasi-synchronous", since most "…chat systems are designed so that participants are not able to monitor the ongoing construction of their interlocutors' turns" (2013:541).

[17] Markman notes that there seems to be a pattern between the size of a chat group and turn lengths, since "…[m]ore participants generally equals more turns, and therefore potentially increases not only the instances of disrupted turn adjacency but also the distance between adjacent turns" (2013:559), and this, it is suggested, explains why turns tend to be shorter in large public chat rooms.

Zelenkauskeite 2013). Therefore perhaps, researchers have been concerned with sequential coherence and turn-taking in computer-mediated text-based chat.

Nilsen & Mäkitalo (2010) provide a useful overview of the findings of micro-analytical studies of CMC with a focus on the research conducted on chat. For example Nilsen & Mäkitalo note, that it has been found that conversational rules or mechanisms work differently for chat than for ordinary spoken conversation; the norm in ordinary conversation that one speaker should speak at a time (Sacks et al. 1974) does not apply to text-based chat, since "…chat systems are designed so that several persons can post messages simultaneously, which means there is no competition for the floor since all messages sent off will be posted" (Nilsen & Mäkitalo 2010:92). Since everyone can contribute to the ongoing interaction at any point in time[18], a practical problem of coherence arises. Several studies have dealt with this and have suggested terms such as "threading" (Markman 2006; Markman 2013) and "conversational floor" (Simpson 2005a; Simpson 2013). Markman defines a "thread" in chat as "…the observable contextual relations […] between messages, most notably the discourse topic" (2013:545). A thread in chat is not a visual tie, i.e. formal threading as for example in the data used for this thesis, but is, according to Markman, accomplished by participants. Markman (2013) shows that for the small-group team-meetings she investigated, discourse topics such as lexical cohesion, adjacency sequences, addressivity, and speakership roles were important resources for establishing coherence. Nilsen and Mäkitalo (2010) in a study of chat from in-service training courses also pointed out addressivity, recycling and reformulations of content as strategies for co-ordinating chat-postings.

Simpson (2005a; 2013) suggests that the notion of "conversational floor" is better suited for chat than models of conversation based on turn-taking (see 3.2). Based on Cherny's noticing that "…[g]iven that there is no competition for the channel per se, but rather competition for attention or control of the discourse, notions of shared or collaborative floor seem to be more helpful than the standard turn-taking literature" (Cherny 1999:174), Simpson revisits Edelsky's (1981) definition of "the floor". He suggests that there are three definable elements to the floor: "(1) The topic, the aboutness of the discourse; (2) the communicative action: how things are being said in the discourse; and (3) the participants' sense of what is happening in the conversation" (Simpson 2005a:345). Similar to the point Ashmore & Reed make (2000), Simpson notes that the analyst has access to a closer participant's sense of what was going on in the chat rather than what is available from most transcriptions[19] of spoken discourse, because participants in chat "…themselves are denied the range of visual and aural feedback cues; any ratification must ipso facto appear in the text itself" (Simpson 2005a:345). Simpson shows how participants can accomplish different types of floors in a community of English language learners and teachers who communicate via synchronous text-based CMC. The three most habitually occurring floor types are "the speaker-and-supporter floor"; "the collaborative floor"; and "the multiple conversational floor" (2005a:348). Simpson suggests three contextual aspects that may influence floor development; "participants and their roles within the group; verbal activity (topic and communicative action); and a selection of medium-related features" (2005a:350).

[18]This may relate to the findings in Markman (2013:549) that the most prominent role in the data investigated is that of the self-selected new speaker.

[19] Importantly, this point concerns the analyst's practical problem of pointing at participants' sense-making practices in ordinary conversation by making use of transcripts.

Although Markman (2006;2013), who suggests threading as a useful notion when describing the accomplishment of coherence in chat and Simpson (2005a), who suggests the notions of conversational floors, have different data sets and address the issue of coherence in different ways, Markman in terms of participants' use of resources to establish a sense of cohesion and Simpson in terms of floor-holding, both studies point at discourse topic, communicative action, and participants' roles as relevant aspects for establishing coherence in chat.

Participants' accomplishment of coherence has not only been found to be a recurrent feature of chat; Reed in a study inspired by ethmethodology and conversation analyses investigated newsgroup[20] interaction. He suggests that "…[n]ewsgroup activity is characterized by sequential integrity. Messages are constructed in such a way as to exhibit both relational (between messages) and internal (in the text messages) features that mimic and respect sequential ordering" (2001:1). Reed builds on approaches to naturally occurring textual interaction based on ethnomethodology and conversation analysis such as Mulkay (1986) that recognize how participants negotiate access over time to the interaction, i.e. achieve to take turns in text based interaction. Reed takes this even further: "Not only is the accomplishment of 'turn-taking' a recognized concern for the participants (in that they do turn-taking) it is also seen as the product of knowledgeable and competent social actors who are themselves aware of the importance of such structures in interaction. The assertion is then that participants actively construct turn-taking units through particular practices and that these practices act to construe textual interaction as conversation-like" (Reed 2001:2). Hence, Reed points to the fact that participants manage interaction locally, and that the construction of turn-taking units in text based interaction is indicative of the primary nature of local sequence management (2001:9).

Antaki et al. (2005) also argue for an ethnomethodological conversation analytic perspective on CMC, for example with a purpose of uncovering "…users' displays of accountability that are not available from interview accounts, by user survey, or by participant observation: What users display to each other, in the detail of the organization of their turns, may be the prime site where online meaning is made visible" (2005:129). Antaki et al. (2005) in their study of an online forum setting focused on "accountable"[21] action, i.e. "how people make their messages achieve recognizable social and personal objectives while attending to the discursive perils attendant on any contribution to the social scene" (2005:115). Antaki et al. reported a case study of a thread-initiating message and its first response, and they showed how the initial message accomplished a "declaration of love" and how this social achievement was ratified by a subsequent user. In particular Antaki et al. pointed to "…the message's placement as an initiating first turn; its prefatory work as an announcement; its selection of next speaker; and its internal design as a turn-at-interaction" (2005:114) as resources the participant made use of to exploit the structural features of the medium in order to attend to accountability of the message.

[20] The data for Reed's study is from Uk.media.tv.friends, and characterized as "…a lively discussion of issues relating to an American situation comedy" (Reed 2001:3). Wikipedia's description of Usenet newsgroups is initiated as follows: "A **Usenet newsgroup** is a repository usually within the Usenet system, for messages posted from many users in different locations. The term may be confusing to some, because it is in fact a discussion group. Newsgroups are technically distinct from, but functionally similar to, discussion forums on the World Wide Web. Newsreader software is used to read newsgroups" (see "Usenet newsgroup" 2013). According to this description, then, newsgroups and discussion groups, which the data for this thesis may be characterized as, may be functionally comparable.

[21] The notion of accountability is taken from Garfinkel (1967a), and in the words of Antaki et al. it "…usefully crystalises the notion of normative responsibility" (2005: 115).

Another way the conversation analytic perspective has recently been applied to computer-mediated interaction has been in analyses of the sequential organization of particular actions, or speech acts (Iimuro 2006:75), such as request sequence organization in chat (Golato & Taleghani-Nikazm 2006) and accounts for requests in e-mails (Iimuro 2006). Iimuro concludes that participants in her study, which includes e-mail messages by Japanese second language speakers of English, "…orient towards preference organization[22] using accounts and delaying the dispreferred requested action" (2006:104). Among other things she found that accounts for requests were recurrently placed in particular positions, which were in the same turn as the request, and she found that participants utilize the affordances of the medium of e-mails (also, see section 2.3 about affordances) to display orientation to the dispreferred action. Iimuro mentions emoticons and smiley faces as affiliative strategies used to display orientation towards other-self relationships and social solidarity. Furthermore "written pauses", for example "…" were pointed out, as a way to slightly delay the production of dispreferred actions of requesting. Both strategies were also pointed out by Golato and Taleghani-Nikazm (2006), who had as their data a chat log from the web chat program of a popular German radio station. Ong (2011) has conducted a study of ellipsis mark turns (or suspension dots (Simpson 2005b) such as "…") and blank turns in quasi-synchronous chats with a purpose of analyzing preference organization of these turns with a conversation analysis-informed approach. Ong concludes that "…ellipsis dots do not function merely as punctuation marks as reported in prior literature but index a number of pragmatic meanings and floor functions in different contexts and sequences" (2011:227). In Ong's data, ellipsis marks-only turns were used for turn elicitation, disagreement, confusion and disapproval, and blank turns were used for floor holding, turn elicitation, and disagreement. Ong shows how "…elliptical turns and blank turns are identified as marked responses or dispreferreds of assessment pairs indicating disagreement which are accounted for in preference organization" (2011:218).

Conversation analytic inspired studies of CMC have, then, focused on different aspects of the organization of computer-mediated interaction; on the one hand some studies have focused on illuminating participants practices for establishing coherence (see for example Herring 1999; Markman 2009; Markman 2013; Nilsen & Mäkitalo 2010; Simpson 2005a; Simpson 2013), and on the other hand some studies have focused on the sequential organization of actions or speech acts. These studies have for example pointed to preference organization as a relevant aspect (Golato & Taleghani-Nikazm 2006; Iimuro 2000; Ong 2011). Other studies again have argued for an ethnomethological approach to online communication, i.e. an approach that focuses on participants' accomplishment of recognizable social action and human achievements by utilizing mechanisms they have available (Antaki et al. 2005; Reed 2001).

The approach I am taking is, similarly to Antaki et al. (2005) and Reed (2001), ethnomethodological conversation analytical. This means, the starting point is to illuminate members' methods for achieving intersubjectivity in the forum. In my analyses I focus on how participants accomplish to perform recognizable actions in sequences.

[22] Iimuro refers to conversation analytic literature on preference organization such as Heritage (1984) and Pomerantz (1984).

4.2 Discursive management: discursive psychological approaches to online talk

Another approach to how to study online interaction in terms of methods people use to achieve intersubjectivity is the approach of discursive psychology. In 2003 Lamerichs and te Molder suggested the perspective of discursive psychology to be applied on CMC, because they found that the existing models, such as "the SIDE model" (Postmes et al. 1998; 2001); Spears and Lea (1992), referred to in Lamerichs and te Molder (2003) ignored participants' everyday understandings of media use and media characteristics. They find in their detailed analysis of participants' talk in practice that identities and social norms are much more dynamic than what is proposed by what they call cognitive models of which the SIDE model is an example.

Since about 2003 especially Dutch researchers have conducted discursive psychological oriented studies on CMC, in particular on health issues such as depression (Lamerichs 2003; Lamerichs & te Molder 2003) and eating (Sneijder & te Molder 2004). These studies will be drawn upon in the analytical chapters, in particular see chapter 6.2 on explaining illness.

In Lamerichs' PhD she "…aimed to examine how participants who take part in [a] support group [on the topic depression] describe experiences and events in relation to their disease, and what kind of interactional work these descriptions are oriented to. This involved exploring:

- how participants categorize themselves in relation to other participants and the outside world;
- how they interactionally manage to give and receive 'support';
- how they interactionally manage to elicit and deliver 'advice'."

(Lamerichs 2003:186)

The research interests and the perspective that Lamerichs describes have a particular focus; language is regarded as pervasively oriented towards social action (Lamerichs 2003:47), and is viewed as a resource which enables participants to "…accomplish all sorts of interactional work, such as minimising or maximising responsibility, accounting for absence or presence or establishing a trustworthy account" (2003:184). Lamerichs' study is particularly concerned with investigating members' methods for "…establishing the kind of person they are" (2003:187), which Lamerichs argues is a pervasive concern for the participants.

Lamerichs takes her point of departure for analyzing the salient topics she has defined in "the discursive Action Model" developed by Edwards and Potter (Edwards & Potter 1993) (2003:59). She identifies three elements that she uses to approach the data with; 1) variability; 2) the rhetorical dimension of talk; 3) accountability feature.

As Antaki et al. (2005:115) notice, applying the approach of discursive psychology to address such issues (i.e. using discursive methods to analyze issues of identity and discursive management in forums) does "…not capture the ways in which users perform recognizable social actions by exploiting those aspects of the medium that corresponds to, or are variants of, the turn-taking and turn-design rules that obtain in face-to-face interaction".

This can be demonstrated if we consider Lamerichs' use of data excerpts, for example in the first analytical chapter in her thesis, chapter 4, which focuses on participants' self-introductions in the online support group on the topic of depression. Lamerichs shows that participants account for being depressed instead of for example simply describing how it feels to be depressed. She argues that participants accomplish to present their depression as a result of external causes instead of as a result of personal fault or flaw. She thus points out that a concern for the participants in the forum is to present themselves as depressed, but competent. Hence, the focus is put on aspects of identity in terms of discursive management rather than on sequential organization as a resource to manage issues related to identity.

Lamerichs' study, her research interests, methods, data, analytical topics, and conclusions in many ways coincide with the perspective, analyses and findings in this thesis on an overall level. Despite from the fact that the two studies on a broad scale have much in common, Lamerichs' focus on discursive management and methods individuals use to deal with and manage norms[23] and accountability[24] does not take either the turn-taking, turn-design, and sequential placement of contributions into consideration or how participants use the resources afforded by the medium to make their actions recognizable to (specific) recipients into consideration.

In this thesis it has been the ambition both to take the sequential placement of postings and the specific resources afforded by the medium into consideration, when illuminating how participants perform recognizable social actions via texts online.

4.3 Conversation analysis on healthcare practices

Apart from the fact that the data material investigated in this thesis can be categorized as a type of CMC, it can also be categorized as a type of health communication, as a starting point because the interactions occur on a public health website under the topic metabolism in which people who experience health problems may interact with each other. Detailed analysis in the analytical chapters will point at how participants specifically orient to and accomplish what it is they are doing.

Conversation analysis has been widely applied in order to study social interaction within institutional settings (Antaki 2011; Drew 2003; Drew & Heritage 1992b; Freed & Ehrlich 2010), among other things within healthcare settings (Beach 2013; Heritage & Maynard 2006a; Pilnick et al. 2010).

Research on doctor-patient interaction from a conversation analytic perspective has illuminated some of the fundamental organizational features and interactional processes within medical encounters (Pilnick et al. 2010). An overall sequential structure of medical encounters has been identified on the basis of participants' orientations in medical encounters as opposed to ordinary conversation (ten Have 2001). CA studies, for instance of acute doctor-patient interactions, have pointed out that these interactions typically

[23] Lamerichs (2003:134) notes that "norms" are not a body of stringent rules that guide participants' behavior, but rather a set of interpretative resources that participants orient to, to make sense of their ongoing interaction with others.
[24] Lamerichs (2003:37) notes in a theoretical chapter on norms and rules that "…in everyday conversations, people account for their actions and hold each other accountable against the backdrop of a normative orientation, rather than simply follow norms or rules".

have the same overall structural organization, which include specific located activities such as an opening, a presentation of a complaint, an examination, an evaluation, treatment recommendations and a closing (Heritage and Maynard 2006b:14). This structure differs from participants' orientations in ordinary conversation. Hence, one of the ways of increasing our understandings of medical encounters is by investigating the ways in which participants structure and accomplish their business in the interaction. As Heritage and Maynard point out, this knowledge is "…valuable in providing access to understandings about the nature of the medical visit which are drawn upon by physicians and patients in their joint management of its progress" (2006b:15).

One of the recognizable phases, the phase in which the patient presents his or her problem, has been studied by Heritage and Robinson (2006) among others. Heritage and Robinson (2006) considered the phase of patient problem presentation in videotaped acute medical visits, and they described practices patients use "...to manage the social accountability of their decision to visit physicians and, in particular, to justify the decision to seek medical care" (2006:48) in that phase. Heritage and Robinson point to an underlying tension between lay and professional judgment as a way of understanding the relevance of the practice of "…accounting for the visit" (2006:84). Other aspects of patients' practices for describing health problems they experience have for example been described by Halkowski (2006), who focuses on patients' narratives of symptom discovery, and Gill & Maynard (2006), who focus on sequences in medical encounters in which patients propose explanations for their illness and doctors respond to that.

CA studies have been successful in pointing at and showing how activities, even in doctor-patient interaction, which is often managed or controlled by the medical professionals (see for example Beach 2001), are in fact accomplished jointly between the doctor and the patient. Furthermore, some CA studies have attempted at illuminating aspects of patient participation in medical care in terms of "lay diagnosis" (Beach 2001; ten Have 2001). Studies that have dealt with lay diagnosis have, for example, focused on patient involvement in medical encounters and to "…how lay persons, not formally trained to diagnose and treat 'biomedical' problems, nevertheless describe, explain and otherwise make available their understandings and concerns to medical professionals, family members and others" (Beach 2001:13). As the quote above indicates, but does not single out, however, lay-diagnosis is not about how non-professionals diagnose themselves or others, but about how they understand and make sense of diagnosis (2001:15). Ten Have points to the fact that many things that happen within the clinical encounter serve as a resource for later re-telling, elaboration, and decision making (2001:258). He problematizes how to conceive of pre- and post-clinical lay diagnoses and problematizes how to investigate it.

The analyses in this thesis clearly illuminate aspects of lay diagnosis understood as aspects of how non-professionals understand and make sense of diagnosis; by investigating online interaction in which people who experience illness interact with others we can gain insight about how they understand and describe their experiences (chapter 6.1), how they understand and describe causes for their experienced illness (chapter 6.2), and what they indicate to be relevant in order to act on the experiences they have (chapter 6.3).

4.4 Summary

This chapter was initiated with a review of studies that has been conducted with a specific focus on structural features in CMC. I outlined findings in regard to different communication modes such as chat and bulletin boards, among other things studies have shown that participants are concerned with creating coherence and are able to construe textual interaction as conversation-like (Reed 2001:2).
I then provided a review of studies that have mainly been concerned with discursive management which have applied a discursive psychological approach. In particular I focused on a PhD thesis, which had been conducted to study everyday practices in an online forum on depression (Lamerichs 2003). I pointed out how the study's focus on the discursive management of social norms did not take structural features such as sequential organization into account when analyzing actions.
Finally, I pointed at conversation analytic studies that have described practices in face-to-face settings in health care. I pointed to the fact that acute doctor-patient interaction are recurrently accomplished with a similar overall structural organization, and I mentioned findings from studies of patients' presentations of their problems in health care settings. I also noted that some CA studies have dealt with patients' perspectives on illness, which is referred to as lay diagnosis.
The reviews of studies that have focused on the structure of CMC, the studies on discursive management in online interaction and the conversation analytic studies of interaction in health care settings represent various perspectives on members' methods for accomplishing action. The perspectives have been mentioned here because they either directly or implicitly have informed this study. In particular I have been inspired by studies of CMC that have had an explicit ethnomethodological orientation, i.e. studies that have attempted to describe the resources participants make use of to display accountability "…in the details of the organization of their turns" (Antaki et al. 2005:19). My analyses have also been informed by studies that describe phenomena, which can be seen to be recognizably similar to phenomena I have identified in my data. This in particular applies to practices in doctor-patient interaction and to the studies of discursive management in online settings about health and eating.

5. Data

The material for this thesis consists of around 600 threads from the online discussion forum from the website http://www.netdoktor.dk (See section 2.1 for an introduction to netdoktor.dk) ("Debat" n.d.) on the topic metabolism ("Stofskifte" (n.d.).

In this chapter I will elaborate on how the material has been selected, collected, and I will address the issue of how the formal structures are referred to. I will also provide an introduction to the topic, metabolism. Participants in the forum refer to medical information about the topic, and readers who are not familiar with medical aspects of metabolism can consult this section for clarification of participants' use of this information in the data I present in the analytical chapters.

5.1 Selection

From the outset the project was defined to address the issue of intersubjectivity in "online discussions about health matters" (see research question in the introduction). Quite early in the process of selecting data the discussion forum on the website netdoktor.dk was chosen, because the discussion forum at the time I initiated the project was well-established and entailed discussions on a wide variety of topics related to illness and health. I read through the data set that was available under the available topics on the discussion forum on netdoktor.dk in the initial phase of the project. It occurred to me that different topics were dealt with in different ways, and that I would need to reduce the data set in order to collect data that would be appropriate for micro-analysis with a basis in EM/CA principles (see chapter 3).

A simple count of the amount of threads within all topics in the discussion forum and the process of reading through the material showed that the topic that had generated most threads among the topics available and a topic that had generated complex discussions on how to understand, explain and deal with illness was the topic "metabolism". Therefore I chose to focus on interactions occurring under the topic metabolism for this project.

Even though I had delimited the data set I still had available around 600 threads, each with all from one - 416 postings (on December 2nd 2010 at which time I made the count).

At this point of the process in which I was trying to identify patterns and working with the assumption that there is "order at all points" (Sacks 1984:22), I explored the possibility of coding and categorizing each contribution in each thread. I used the program NVIVO (see for example www.qsrinternational.com/products_nvivo.aspx, visited 22nd August 2013) for that. It soon turned out, though, that, as I was also working inductively with a principle referred to as unmotivated looking[25], it was necessary for me to keep on adding coding categories in order to categorize the actions in the contributions that participants accomplished. This "exercise" showed me that I needed to select a delimited set of phenomena on the basis of what, to me as a member[26], was recognizable as recurrently accomplished

[25] The term "…is intended to imply that the investigator is "open" to discovering phenomena rather than searching for instances of already identified and described phenomena or for some theoretically preformulated conceptualization of what the phenomena should look like" (Psathas 1990:24).

[26] Members of society in the ethnomethodological understanding have "…capacities to speak, to know, to understand, to act in ways which are sensible in that society and in the situations in which they find themselves" (ten Have 2005). This member's

activities within this setting. The data used for the thesis are collections of such phenomena based on the data available at "Stofstifte" (n.d.) at the date of which the data was archived, 18th February 2012, by using an online archiving program (http://www.httrack.com/).

One of the first things that occurred to me in the initial part of the data collection process was how methodic participants seemed to deal with postings despite their complexity. It seemed that participants were really attentive to details of how postings were posted when responding. Furthermore, it seemed that there were certain topics and ways to describe and deal with "problems" that recurred. Some of these methodic ways of initiating exchange of postings and responding to them, and of dealing with topics are described in the first analytical part (chapter 6.1 - 6.3) as ways participants perform recognizable social action and achieve a sense of intersubjectivity. In the second analytical part, consisting of chapter 6.4, I focus on aspects of how thread initiators respond to the responses they have received. The methods used to display understanding of the interaction so far and possibly initiate further interaction shows that participant have particular understandings of how their problem should be dealt with in the forum (see analyses).

5.2 Terms for describing formal structures of CMC

Previous sections in this thesis that deal with theory and method imply that there already are established traditions and conventions in terms of defining and categorizing CMC (see for example section 2.2).

Some of the implications that can be drawn from micro-analytic studies like this one might be that (some of) the terms that are being used within these established traditions (especially within pragmatics of CMC (see below)) do not correspond to the actual practices in CMC, and thus some terms may in some sense be misleading. Nevertheless, in order to refer to various phenomena in recognizable ways, I will use some of these terms. Because the use of these terms might imply specific understandings about the phenomena, which I do not intend to imply by using them, I will provide a bit of specification on the use of the terms I use most recurrently.

Firstly, as indicated in the introduction, I will refer to communication that is mediated by a computer (or other devices such as tablets or smartphones) as "CMC". Although there may be important differences in how participants communicate depending on whether they sit in front of a stationary computer in their homes or whether they use a mobile phone to communicate with wherever they are, this is not the focus of this thesis, as I am investigating the contributions as they have been posted, and as I don't have access to the typing process itself.

Secondly, CMC has been divided into "modes" (see for example Herring, Stein & Virtanen 2013b). The mode I am investigating can be referred to as a "discussion forum", as a type of "bulletin board". It is in some ways similar to "usenet newsgroups" (see for example Reed 2001) and "mailing list communication" (see for example Gruber 2013). Although there are technical ways of describing the mode of online discussions, I will focus on the possibilities they afford for users, i.e. I will focus on how they are used to communicate, for example in comparison with other so called modes.

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knowledge is inevitably drawn upon and reflected on in order to address the issue of how a common understanding is achieved. Also, see section 3.1 on ethnomethodology.

As a wikipedia search on “bulletin board” reveals, bulletin board refers to several “surfaces”; it refers to a physical board, traditionally made of cork, that can be placed in public spaces which affords the “…posting of public messages, for example, to advertise items wanted or for sale, announce events, or provide information” (“Bulletin board” 2014), and it refers to “online boards”:

> Internet forums are becoming a global replacement for traditional bulletin boards. Online bulletin boards are sometimes referred to as message boards. The terms bulletin board, message board and even Internet forum are interchangeable, although often one bulletin board or message board can contain a number of Internet forums or discussion groups. An online board can serve the same purpose as a physical bulletin board. (“Bulletin board” 2014).

The wikipedia definition of a bulletin board suggests that online discussion boards are replacements of physical bulletin boards in public spaces. Perhaps following this analogy we can notice that some of the terms that have been used to describe physical bulletin boards in public spaces are also used to describe internet forums; we see terms like “message”; “message board”; “posting” being used (see above). Analysis (the analyses in this thesis among others) of cause reveals that not all “postings” are constructed as “messages”, i.e. as a discrete unit of information; postings may do the work of announcing, inquiring, complaining, inviting to responses, responding to responses etc., but nevertheless I use the term “message”, or more recurrently “contribution” and “posting” to refer to the text that is posted, displayed, and viewed as a unit along with a title provided by the poster of the text. Furthermore, information about the username of the author of the posting is provided, so is the date and time the author joined the forum, the data and time the posting was send.

The following is an example of a posting, which I analyze in the first analytical chapter:

Example A1: 1st posting, “stofskifte-forstyrrelse/svimmelhed”:

WR1 Tilmeldt: 30-06-2008 10:03	Den 30-06-2008 21:30 **stofskifte-forstyrrelse/svimmelhed**	

1 Hej
2 Jeg lider af lavt stofskifte og er igang med fin-justering med eltroxin. Mit TSH ligger på
3 2,6 og jeg er blevet øget til 100 mikrog. eltroxin for 1 uge siden. Er der nogen der,
4 ligesom jeg, lider af en voldsom svimmelhed? Jeg tror selv det skyldes at jeg netop er
5 øget i dosis, men er selvfølgelig nervøs for at TSH er på vej op.....
6 Lider derudover også af en voldsom "summen" eller "snurren" i benene, særligt om
7 aftenen - er der nogle der har erfaringer med dette?
8 hilsen Xxxxx

English translation:

WR1 Joined: 30-06-2008 10:03	On 30-06-2008 21:30 **metabolic-disturbance / dizziness**	

Hello,
I suffer from hypothyroidism and am working on fine-tuning with eltroxin. My TSH is at 2.6 and I have been increased to 100 mcg. eltroxin 1 week ago. Is there anyone who, like me, suffers from a severe dizziness? I myself think it is because I have just increased the dose, but am obviously nervous that TSH is coming up .....
In addition I also suffer from an intense "sum" or "tingling" in the legs, especially at night – are there some who have experiences with this?
regards xxxxx

This posting shown above consists of various information such as information about the author and about the time for posting the posting. The text is complex and consists of various actions. For example, it initiates with a greeting (line 1), which is followed by a description which includes various personal and medical information (line 3-8). The text also includes questions (line 4-5 and 8) and a closing (line9). Referring to this as a "message" in the meaning "a discrete unit of information" is thus not consistent with the complex set of actions provided in the posting and not intended in this thesis.

In CMC, which occurs via bulletin board systems "…all members or participants can read everything entered in that specific group. These types are both asynchronous, meaning that messages can be written, sent, and read at different points of time, leaving time for reflection before they are sent or replied to" (Fornäs et al. 2002:17).

The online discussion forum on www.netdoktor.dk is public. This means *anyone* who has navigated to the discussion forum ("Debat" n.d.) can read the interactions that occur in the discussion forum. In order to *participate* in the online discussion forum on www.netdoktor.dk one must however be an official member of the forum, which is done by following some steps, which includes choosing a username, which will occur on the top of postings which the specific participant posts.

The interactions in the online discussion forum on www.netdoktor.dk are organized in "threads".
On www.businessdictionary.com "discussion thread" is defined as a…

> Chain of written ideas or opinions (exchanged among two or more participants in an online discussion) linked in the sequence in which they were espoused by the participants. Through the use of hypertext, discussion threads allow new or old participant to start at any point and follow the entire discussion from its very beginning to its latest idea or opinion. Introduced by collaborative software such as Lotus notes, they are now an integral part of the discussion group sites. ("Discussion thread" n.d.).

As this definition highlights, every posting that has been sent as a contribution to a specific topic (which refers to the title of the thread given by the participant who initiated the thread) will occur in the sequence in which it is posted in time, and the posting will remain as a contribution in that sequence, so that

participants at any time can read the interactions that has been posted in a thread until the present. This also implies that it is not possible to indicate by the use of "physical" placement of a posting to which posting or element in a thread, if there are several posts in it, any posting responds to if not the one it immediately follows. As has been pointed to, in conversation, the sequential placement of contributions to talk is by contrast essential in order to make sense of what a contribution accomplishes (see section 3.2 on conversation analysis). Furthermore, it is normally not possible to rewind and (re-)listen to a part of an ordinary conversation in which you are a participant, as participants in the forum can (re-)read postings. This may have implications for the ways participants deal with prior interaction and with how they construct postings. Although this question cannot be determined definitively, my analyses point at how participants accomplish complex actions in postings, and how they in responses orient to the complexity and sequential organization of actions in prior postings, which might not be possible without the possibility of revisiting postings which are responded to.

5.3 Participants and practices for anonymization and translation

I have obtained permission from Netdoktor.dk to use data from the discussion forum on metabolism on the website www.netdoktor.dk for this thesis on the condition that I anonymize the participants' usernames. It would not be possible to obtain permission from participants individually, since the majority of the participants can only be identified on the basis of their usernames, which makes it impossible to get in connection with every participant. The data material I investigate is publically available, i.e. participants have interacted in an open forum, which implies, as mentioned, that anyone can read the interactions. Since I am concerned with investigating social norms in terms of methods for acting in the forum (see chapter 1 and 3) I don't have an interest in individual or personalized practices as such. Psathas (1990:4) notes that the main interest of ethnomethodological-conversation-analytic studies is the organizational or structural features of the interactional phenomena themselves, not their connection to the particularities of persons. The condition that I should anonymize participants' usernames, and the restriction that I cannot get in contact with participants individually, are not obstacles that prevent me from investigating members'[27] practices (see section 3.1 on ethnomethodology). Anonymizing participants' usernames hopefully works as a way to protect and respect participants' identities.

In the analysis I have anonymized the participants in the following way:
A participant who initiates a thread is referred to as "WR1", and a participant who provides the first response to the first posting is referred to as "WR2" consistently. When I provide more than one response in a thread I refer to the participant who posted the posting I show as "WRX" ("X" refers to the number of the posting in the thread). WR1, WR2 etc. thus refer to the participants "roles" as "thread initiators" (WR1) or "thread respondents" (WR2, WR3 etc.) and not to specific individual people. This might be compared to practices within conversation analysis, in which participants are often referred to in terms of their institutional roles (for example doctor and patient) or their discursive roles (for example "story

[27] The term "member" is used within ethnomethodology to refer to members of society in terms of their "…capacities to speak, to know, to understand, to act in ways which are sensible in that society and in the situations in which they find themselves" (ten Have 2005:36). In this thesis the term is also used to refer to participants who have obtained membership of the forum. "Members' practices" is used to refer to the ethnomethodological topic of investigating how it is people accomplish social order.

teller/recipient, inviter/invitee, or questioner/answerer" (Zimmerman 1998:92)). The identifying terms I have chosen, of course, identifies participants in terms of their action of having written and posted a contribution in a thread and in terms of the placement of the contribution within the thread. Participants are not identified by referring to them as WR1, WR2 etc. in terms of what they accomplish with their actions. This will be dealt with empirically in the analytical chapters.
In the final analytical chapter, chapter 6.4, in which I focus on thread initiators' responses to the responses their initiatives have received in a thread, I refer to a thread initiator, who responds, as "WR1*". This practice is also used in other analytical chapters in which I analyze responses in threads written by the participant who has initiated the particular thread.
In texts when participants refer to names, the names have either been replaced with X's or with the identities I use to refer to the participants (for example WR1, WR2 etc.).

The data is in Danish. Data used for analysis has been translated into English for the purpose of making analysis available and understandable for readers who do not read Danish. Both the Danish original text and the English translation are presented in the analytical chapters.
There have been some challenges related to translating the data. For example the Danish material includes some discourse particles such as "vist", "jo" and "da", which recurrently indicate epistemic modality (Davidsen-Nielsen 1996). In English epistemic modality is not expressed in such a way Hence, I have translated the particle into expressions and constructions that indicate epistemic modality in English, but as epistemic modality is expressed differently in English, some of the meaning expressed with the Danish particles may be altered. For example "vist" might be translated to "I think", "jo" might be translated to "surely", and "da" might be translated to "naturally". My sense is that the English expressions I have used for translation may draw more attention to the indication of epistemic modality than the Danish particles, since the English expressions may be clauses rather than particles. Also changes in word meaning, word order etc., when translating from Danish to English may have consequences for our sense of the meaning being conveyed, how the text is structured and which parts are marked.
Because of possible changes in meaning and structure when translating data material, the original Danish material is presented with and approximate English translation.
Participants do not always according to current spelling standards, and in the data there are examples of what could be interpreted as socalled "typos". In the English translation I have not attempted to imitate these "deviations" from current spelling norms

In the appendix you will find collections of data material that resemple structures I describe in the analytical chapters (Examples resembling the structure described in chapter 6.1 are marked with "AA", examples resembling the structure described in chapter 6.2 are marked with "BB", examples resembling the structure described in chapter 6.3 are marked with "CC" and examples resembling the structure described in chapter 6.4 are marked with "DD"). Further, when I present analysis of responses to postings (and when the postings that are responded to are not presented and analysed) the postings that are responded to are presented in the appendix as well (examples marked with "ReD").

5.4 Metabolism as a topic

Depending on the perspective one takes, “metabolism” can be defined and referred to in different ways. In the section of netdoktor.dk in which health professionals provide an overview about what metabolism is, they stress the fact that metabolism refers to all chemical reactions in the body, and not only to the speed with which the body burns calories, which is the way metabolism is often referred to colloquially.

In the description of what metabolism is in the text written by medical professionals, the main focus is put on what it means to have a problem with the metabolism from a medical point of view. From this point of view, having a problem with the metabolism is typically understood as a problem with the regulation of the hormones in the thyroid gland. The thyroid is located at the front of the neck and has the function to ensure that the body's cells function properly. The hormones are regulated by the Thyroid-stimulating hormone “TSH”, we are told in the overview, which is produced in the pituitary gland; “When you talk about that there is something wrong with your metabolism, it is about imbalances and metabolic disease, that is typically on the regulation of thyroid hormones ...” (“Sådan fungerer stofskiftet” n.d., author’s translation).

We are also told that the symptoms of the body have a big impact on how our body functions, and that a metabolic condition can reveal itself in many ways. Furthermore we are told about how health professionals can establish whether a patient suffers from a metabolic condition; this can be established through measuring the amount of TSH hormone in the blood, i.e. by taking a blood test.

Metabolism may be normal, “too low” or “too high”. In case of too low or too high metabolism it can cause a number of widely varying symptoms (stomach upset, headache, sore muscles, heart palpitations, changes in appetite and weight etc.).

The website for Danish metabolic patients, “Thyreoidea” (http://www.thyreoidea.dk, visited 20th August 2012), also entails medical information about metabolism. Among other things there is information about the production of thyroid hormones:

> The thyroid produces the thyroid hormones Triiodothyronine (T3) and thyroxine (T4). The release of the metabolic hormones from the thyroid is regulated by the thyroid-stimulating hormone, TSH, which comes from the pituitary. The metabolic hormones ensure the energy conversion in the body and are vital for humans. (Thyreoidea Landsforeningen n.d., author’s translation).

Furthermore, information found on the website specifies how the hormones relate to each other and mention a theory that some metabolic conditions and depression tendency may be related:

> In people with a normal thyroid, this will produce two hormones, namely T4, which constitutes the largest part, and T3, which represents a much smaller part. T4 is a pre-

> hormone to T3, which is the active hormone. When the thyroid gland produces T4, this will be converted to the active hormone T3, by using an enzyme, locally in various tissues. This enzyme is found in varying concentrations in various tissues in the body. Studies on rats have shown that the brain has low levels of this enzyme, and the theory is that some patients will have reduced quality of life and depression tendency, if not having replenished T3 directly from the thyroid gland. (Thyreoidea Bladet: 2007, author's translation).

Normal metabolic hormone values are[28]:

> TSH: 0,3 - 4,0
>
> T3: 1,1 – 2,6
>
> T4: 60 – 140 (”Gode råd om stofskiftet” n.d.).

If the metabolism is too high, the TSH value is low relative to the normal values, and T3 and T4 levels are high.

If the metabolism is too low (also called hypothyroidism) the TSH value is high and the T3 and T4 values are low.

Medication can be prescribed by medical professionals in order to regulate metabolism if a metabolic disorder has been established. In the forum, participants often indicate the medication they take if they take medication in order to regulate their metabolism. Most typically, the medication mentioned is “Eltroxin” and “Liothyronin”. Liothyronin refers to “synthetic iodothyronine” (T3) (“Liothyronine” n.d.). Eltroxin refers a drug with “synthetic thyroxine” (T4) (“Eltroxin” n.d.). “Euthyrox”, another type of medication, also entails synthetic thyroxine hormone (T4) (“Euthyrox” n.d.). Participants occasionally refer to “New Eltroxin” and “Old Eltroxin”. Apparently a medical company started producing a metabolic drug and then changed the binders/additives and the possibilities to divide the tablets. Patients experienced changes in their condition as a cause of the changes in the drug. The drug referred to as Old Eltroxin is then used to refer to the drug before the changes were made, and New Eltroxin refers to the drug after the changes were made.

Other perspectives on metabolism provide other views on how to understand metabolism, for example “Institute of the Psychology of Eating”. They argue that it is not possible to separate mind, body and cosmos, and thus argue that we are able to affect our metabolism with our mind and mood (see for example http://psychologyofeating.com/, visited 7th July 2014).

These different perspectives on metabolism point to the fact that we cannot take for granted what metabolism refers to and how it is understood. Furthermore, we may get a sense that people's understandings of what metabolism means is crucial for how they deal with it.

[28]Different doctors use different reference values, though, see, “Normalværdier for TSH”: 2009 for a medical explanation of what a “normal TSH value” refers to, also see Knudsen 2006.

6. Analysis

The aim of the thesis, to investigate members' methods for achieving a common understanding in an online discussion forum about metabolism, is explored in the process and results of doing empirical micro-analysis.

As mentioned in chapter 5 on data, the postings that comprise the treads in the forum are strikingly complex, for example compared to turns at talk or even chat postings. Rather than leaving this noticing aside, this became the fundamental observation that has guided my questions and analyses.

Being highly inspired by the ethnomethodological conversation analytic approach (see chapter 3), I wanted to investigate how participants accomplish social action and make their actions recognizable as social action. Writing complex postings is definitely a fundamental resource participants in the forum make use of. Observations and initial analyses indicated that postings have a recognizable structure. Furthermore, observations and analyses pointed to the fact that participants build their postings in systematic ways that indicate particular understandings and make particular responses relevant. Analyses of responses showed that these understandings were oriented to by the co-participants. Along with structure, the use of categories proved to be a resource for participants for achieving a common understanding. By using particular categories in postings that indicate actions, participants make certain understandings of the activity, the topic, themselves and other forum participants relevant.

How 1st postings are built as complex units that are recognizable as particular social actions that make particular understandings and responses relevant and how these understandings are dealt with in responses, are the questions that have guided the first analytical part. The first analytical part (chapter 6.1 - 6.3) constitutes specifically descriptions and analyses of three phenomena recurrently found in thread initiations and first responses.

Firstly, in chapter 6.1, I focus on ways in which participants accomplish to "share experiences" in the forum. As will be shown, this is done by telling stories about experienced bodily (and/or psychological) problems and inviting to indicate recognition of the problem. Respondents to 1st postings recurrently orient to the resources made relevant in 1st postings; they also tell stories. Such stories are constructed as "second stories" (see chapter 6.1), which orient to and relate to the details of 1st postings. Thus, responses often accomplish to indicate and demonstrate recognition of a story by telling a story of experiences. Analyses of several threads in which participants are concerned with "sharing experiences" show that participants in and through the ways in which they construct their postings, including their tellings, deal with how they understand particular tellings of experiences in relation to the pre-established topic of the forum, metabolism. It turns out, not every problem is recognized and acknowledged as a "metabolic problem" by forum participants.

Secondly, in chapter 6.2, I focus on 1st postings, in which participants inquire about causes for problems, and their responses. Also when dealing with causes for illness participants have recognizable ways of doing so. However, such postings and the patterns that are identified are also complex. Participants initiating

threads inquiring about causes for illness recurrently indicate an understanding that they don't expect a final diagnosis from other forum participants, i.e. they don't orient to themselves and each other as "doctors", and they don't orient to the possibilities the forum affords as similar to the health care services. Rather, they are asking about "possible" causes for illness and indicate "metabolism" as a "candidate answer" (see Pomerantz 1988 for a study of "candidate answers" offered as information seeking strategies) themselves. Both participants who initiate threads inquiring about possible causes for problems and respondents orient to details of how problems are presented, in particular in regard to the medical information indicated. Respondents recurrently initiate their responses with acknowledgements (possibly after greeting). However whether they acknowledge metabolism as a possible cause or whether they acknowledge the problem described as a candidate medical problem differ, particular in regard to the medical information provided in the 1st posting. Chapter 6.2 thus describes another aspect of how structure and (membership) categories are used to indicate and orient to particular understandings of the activity and the problems that participants are faced with and interact about.

Thirdly, in chapter 6.3, I focus on instances in which advice giving is made relevant by the actions and categories used in 1st postings. Also, the phenomena of advice giving in the forum is complex, as participants use various resources to do this and as respondents use various resources to in fact provide actions recognizable as "advice" that orient to the details of 1st postings. Detailed analyses of various postings in which advice is oriented to as relevant from the outset shows that participants specifically indicate categories such as "advice" and "help" and in this way among others make these categories relevant. I also show that by making these categories relevant and by proving actions that are recognizable as advice, participants treat the activity they are involved in as "advice giving" rather than for example as a "troubles telling" (Jefferson & Lee 1992). These means, they treat the problem they have as something that should be acted on and they treat themselves and other forum participants as someone who act competently when experiencing problems. In this case, as I show, this involves gathering medical information and acting in accordance with that.

The second analytical part consists of chapter 6.4, specifically focused on "responses to responses", i.e. responses provided by the same respondent who provided a 1st posting in a thread after (s)he had received one or more responses. The analysis points at how participants treat this "slot" as a "juncture" in which it is relevant to deal with the interaction so far and also indicate understandings of what should happen next. The actions accomplished, then, highly orients to the sequential placement of the posting. But not only that. Responses to responses in dealing with the interaction so far and in making particular actions relevant also indicate *understandings of the interaction so far.* In particular, understandings and (membership) categories such as whether indicated experiences by respondents are understood as being "shared", whether participants share understandings of problems and possible causes, and whether participants, in and through their actions, treat problems as a matter of how to act competently on them, is shown to be oriented to in the methods used to close and open interaction in responses to responses.

In conclusion (chapter 7), I will sum op on the findings of the analytical chapters and then discuss the findings (chapter 8), particularly in regard to the challenges and choices made in terms of the "unit of analysis" for the analysis of online forum data inspired by ethnomethodological conversation analysis.

6.1 “Sharing experiences”: Characterizing a problem

6.1.1 Introduction

This chapter will be concerned with the aspects of the phenomen of ”sharing experiences” in the forum.

However, the chapter starts out by pointing to the fact that postings are complex and entail various actions packed into a unit. This is a different way of organizing actions than what we can observe people to do in other types of interactions such as face to face conversation (Sacks, Schegloff & Jefferson 1974) or online chat (Paolillo & Zelenkauskeite 2013; Rintel & Pittam 2001). The actions that participants recurrently perform in postings in this data include greetings, problem presentations, invitations to respond by posing questions, and closings. As will be argued, these actions seem to work in service of presenting problems in particular ways and inviting to respond and in doing so deal with the problem presented in a particular way.

As will be demonstrated, participants present descriptions of problems in terms of how they experience pain and disturbances in their body currently and recurrently. In many cases, the problems that are being presented are presented as presently unexplained problems, i.e. problems to which no cause has been definitively established. However, participants indicate their understandings of possible causes for the problems. They do so by indicating suggestions about possible causes and/or they indicate specific information as relevant for understanding the problem they present. As will be pointed to, this includes in particular medical information.

Participants who present yet unexplained problems make it relevant that respondents provide particular types of responses. In this chapter one common way of doing so is outlined, namely by inviting respondents to indicate recognition of the problem they have described. By inviting to action that should indicate recognition on the part of respondents, participants indicate their understandings of the purpose of the forum and on what to expect from recipients. They take it that participants in the forum might have similar experiences to share, and they take it that it might be relevant to do so in order to understand and deal with their own problem.

When participants indicate recognition of problems in responses they clearly orient to the details of problem presentations and question formatting in the first posting in which this was initiated. Respondents make their responses recognizable as responses. Furthermore, they not only acknowledge recognition of problems by stating that they recognize experiences. They also recurrently demonstrate experience. In this way participants accomplish to establish a shared understanding about how problems are experienced and about specific characteristics of these problems, which are oriented to as possibly relevant. Participants rarely, however, stop here, although in many cases all that has been made relevant by posing questions, i.e. inviting to action, was to indicate recognition. Participants also very often indicate their understandings of candidate explanations for the unexplained problems and they indicate their understandings of relevant ways of acting on problems based on these understandings. Thus, we see that the establishment of having shared experiences with others in the forum provide for other actions to be carried out, such as using shared experiences to exchange understandings of possible causes and relevant ways of acting. Furthermore, participants clearly orient to the status of their current problems as yet unexplained, by inviting to action about similar experiences. In this way they don’t exclude any particular causes, but rather

show that a way to understand their own experiences would be to share experiences and not for example "self-diagnose" themselves.

As this chapter is concerned with how participants present and share experiences, the chapter begins with an outline of primarily conversation analytic studies dealing with storytelling and "second stories", specifically with the accomplishment of sharing experiences by telling second stories. As Sacks points to (see below), in ordinary conversation second stories, i.e. stories told by a recipient of a "first story" following a first story, are very often chosen according to the role of the teller; recurrently the story teller has a similar role in the second story as the story teller of the first story. This method accomplishes to indicate that the teller of the first story and the teller of the second story have experiences of a "similar sort".
After having summarized on these studies, which I use as a basis to inform my analyses, I will provide analyses of data from four different threads in order to show how sharing experiences is used in the forum. I initiate with an analysis of a message exchange consisting of three messages in a thread in which sharing experiences is done in a straightforward and prototypical way. As will be demonstrated, the pattern is that WR1 describes a problem and invites respondents to indicate recognition of the problem. In the first response this is responded to with an acknowledgement of recognition and a demonstration of how the problem is recognized.

After providing an analysis of a prototypical case I provide three posts from another thread in which the first respondent acknowledges to recognize the experiences described by WR1, whereas the second respondent not only acknowledges recognition, but also demonstrates how she recognizes the problem described by WR.

The two cases show that the accomplishment of sharing similar experiences by telling stories that focus on the description and demonstration of personal experiences with a health problem is not only used by participants to display their understanding of the point of the first story by providing a second story that is readable as "similar" (see Sacks 1992b:768). Sharing of experiences by telling similar stories also contributes to the characterization of the problem by contributing with a personal, subjective, experience, and to validate the first story as relevantly placed within the category "metabolic problems", and sometimes within a specific kind of metabolic problem, such as hypothyroidism.
Sharing experiences is not always used in this way, though. To make this point, I analyse the 1st message and the first response from two threads in which sharing is oriented to as relevant, but not as a method to validate a particular experience as a specific metabolic problem. Instead it is used as a method for providing grounds for, or entitlement to, suggesting alternative causes. The differences in the uses of sharing experiences will be outlined in the conclusion of this chapter.

6.1.2 Storytelling, second stories, and sharing experiences

6.1.2.1 Storytelling

In Labov and Waletzky's, fundamentally linguistic, study of storytelling, in part based on story telling in interviews, the concern was to find "…the invariant structural units which are represented by a variety of

superficial forms" (Labov and Waletsky 1967:13). Their approach was "functional" (1967:13), and they wanted to investigate "…complex narratives until the simplest and most fundamental narrative structures are analyzed in direct connection with their originating functions" (1967:12). Neal Norrick, coming from a branch of linguistic pragmatics, also deals with conversational narrative, and he has suggested a particular definition of narrative[29] as well as a set of analytic procedures in order to describe conversational storytelling. With his approach Norrick (2000) views the so-called "internal elements of narrative organization" as separable from the so called "external factors such as contextual preliminaries to storytelling and interpersonal relations between tellers and listeners" (2000:45), and he does that for the purpose of "extracting an underlying narrative from a particular story telling performance" (2000:28).

Within the tradition of conversation analysis, storytelling is approached as action, and thus conversation analytic work on story telling has "…a focus on the production of storytelling sequences" (Hutchby and Wooffitt 1998: 131; Jefferson 1978; Sacks 1992e), i.e. as an activity in conversation that is brought about and responded to in its interactional contexts. Hutchby and Wooffitt (1998) take up story telling sequences as a phenomenon that can be analyzed from a conversation analytic perspective, and they in particular show how storytellers in conversation construct their telling for a specific recipient (c.f. the concept of recipient design, see section 3.2 on conversation analysis). Moreover, they note that in conversation, although stories involve extended multi-unit turns at talk, stories are in a sense co-constructed, as story recipients also take turns during the story telling sequences.

Labov and Waletzky's and Norricks' linguistic approaches and findings in terms of defining a narrative structure on the basis of conversational narratives strengthen the ethnomethodological point that people construct their actions in recognizable ways for their recipients (see section 3.1 on ethnomethodology)[30]. In this study the main ambition is exactly to describe some of these practices people engaging in online discussions use to achieve an intersubjective understanding. Hence, ethnomethodological conversation analytic studies of storytelling in conversation, which are concerned with describing participants' sense making practices in social interaction, provide insights that may inform this study.
This study does not attempt to contribute to, develop, or criticize the idea of or concrete underlying models of narrative structure. Instead it tries to illuminate some of the resources participants use to make their actions recognizable and understandable as contributions in social interaction, i.e. for example as actions recognizably constructed as stories.

[29] "Narrative element" is defined as "a past tense clause describing an action or change of state" (Norrick 2000:28), and "narrative" is defined as "a coherent set of two or more narrative elements" (2000:28).
[30] Of course, linguistic approaches which have as their goal to present an underlying model of a narrative structure that is presented as a pattern eventually outside of its' social context is fundamentally different in its assumptions and, thus, methods from ethnomethodological conversation analytic approaches. Silverman, in his presentation of Harvey Sacks's work, mention the linguist Noam Chomsky as a source of inspiration, as they were both interested in how language works and both in a broad sense interested in generative rules. Silverman, though, stresses that the kinds of rules that Chomsky and Sacks each were concerned with were different in nature; "Sacks seeks to understand the rules that participants demonstrably attend to understand the rules that participants demonstrably attend to in actual sequences of conversation" (Silverman 1998:30), whereas Chomsky wanted to "decipher the structural rules of language beneath imagined cases" (Silverman 1998:30). I think we can argue that something similar is the case if we compare Labov and Waletzky's (1967) study and Norrick's (2000) approaches with ethnomethodological conversation analytic studies of storytelling, although both Labov and Waletzky's and Norrick's studies in other important aspects are not comparable with Chomsky's generative grammar approach.

6.1.2.1 Second stories

In one of his lectures Sacks dealt specifically with second stories (Sacks:1992b). On the basis of a specific conversation, a telephone conversation between two elderly women, he made some observations as to what generally seems to characterize second stories. He suggested that "…[s]torytelling is an interactional business" (1992b:771) by for example pointing to the fact that second stories are specifically fitted to a first story (1992b:765). Furthermore, he noted that, at least in the interaction on which he focused, participants oriented to the telling of the first story as more than a telling; the telling was introduced by requesting "for help" (amounting to participation in the storytelling, which might be initiated with an invitation to sharing experiences (1992b:765)). Sacks used this observation to point to the fact that some stories[31] can be designed for specific recipients who may be expected to "…produce[…] a next action specifically directed to that story when it is finished" (1992b:765).

Conversely, he also notes on the task of the story recipients:

> …listening […] involves as its appropriate task that one listen in such a way as to be reminded of one's own experiences. Why that should be, might be developed along the following lines. One routine task of participation to a conversation is to be able to show that they understood something another said. In doing that, what they do in part is to analyze what the other said so as to then find something to say which can exhibit, to one who will analyze what this one says, that he has understood what the other said. And one large source of things to be used to show that one understands are 'things you already know about,' i.e. things that you are reminded of. (Sacks 1992b:768).

Sacks suggests that people have a method for choosing relevant second stories, that is, not every story counts as a relevant second. In the lecture he for example said:

> …the role of the teller is something that is specifically criterial for the search [for relevant second stories]. Or in any event, that is one procedure of search that generates results, that provides for a story that shows that you understand the point of the prior story. And the point of the prior story is what it is that the co-participant was telling. (Sacks 1992b:769 f.).

For the purpose of the current study, Sacks made at least two important points here; firstly that people engaged in ordinary conversation searching for a second story have at least one method for choosing a relevant second story; "Search for such a story as involved you in playing an equivalent role to the storyteller in his story" (1992b:769). Secondly, Sacks points out that participants use second stories to display their understanding of what has been said, accomplished and made relevant with the first story.
As I will point out in subsequent analyses in this chapter, problem presentations are often constructed as stories about personal experience, and these problem presentations are recurrently responded to by indicating recognition. This is done by telling a story that is recognizably similar, exactly because the storyteller constructs experienced problems as similar to the problem described initially by the thread-initiator. Both storytellers, thus, have the role of an "experiencer" of metabolic problems or of a problem, which they construct as possibly related to the metabolism (also see chapter 6.2 on explaining illness).

[31] Sacks (1992b:765) mentions story telling in newspapers and story telling to audiences as exceptions.

6.1.2.3 Sharing experiences as reinterpretation

Arminen (2004) has investigated the use of "second stories" in meetings of Alcoholics Anonymous (AA) from a conversation analytic perspective. Second stories are defined as "stories told in a series in which later stories are designed to achieve a recognizable similarity with the first (or previous) story" (2004:319). Arminen shows that second stories are achieved by means of their sequential placement and design. He notes that the relationship between first and second stories is reciprocal in the sense that second stories are conditionally relevant responses to first stories, and second stories are relevant for the interpretation of the first stories (2004:340). Arminen claims that many of the functions of this kind of storytelling "…depend on stories being organized as series in which subsequent speakers display their understanding and the appreciation of the previous turns" (2004:338). He specifies that the participants in AA meetings orient to mutual help as a different way of getting help than for example professional counseling. He mentions the fact that members avoid explicit advice-giving and focus on their own experiences that only indirectly offer a new understanding of others' experiences (2004:340 f.).

Although problems with alcohol addiction and problems with the metabolism are of course of two completely different sorts, the setting of an AA meeting has some similarities with an online discussion group about a health issue, such as this one, because 1) both are voluntary, and 2) both involve non-professionals. In addition, both in AA-meetings (see above) and in this data (see Example A3, line 2, and example A6, line 4-5) some participants indicate it as a goal of the interactions to provide each other with mutual help. Equally in both settings participants use storytelling in a series to accomplish this goal.

6.1.2.4 Sharing experiences and similarity

Wootton (1977) who acted as a researcher/therapist at a psychiatric hospital for a period of eight months (1977:348) conducted an ethnographic study which focused on outlining how a conventional notion within psychiatric treatment, sharing experiences, was introduced to patients as a form of patient participation in group therapy, and how sharing experiences in practice could be seen as a complex accomplishment (1977:346).

The study focuses mostly on one aspect of sharing experiences, namely instances in which "…the patient provided information about herself which was in some sense analogous to that provided by another patient" (1977:334). In Wootton's own words, he was investigating how patients and staff use "…the rule 'Share your experiences with other patients'" (1977:335). He shows how mundane reasoning complicates the rule, and he outlines recurrent interpretational practices in terms of topic organization, knowledge, rules and reasoning procedures that are relevant to the accomplishment of sharing experiences in group therapy.

Of particular relevance for the present study, Wootton notes on "similarity" as a relevant category and on the (membership[32]) category of "(candidate) sharer" as categories patients deal with in interactions. Sequences in which participants deal with these categories are typically initiated with a statement uttered by a member of the hospital staff in group therapy, namely a version of "There must be other patients who can share…" (1977:338). These kinds of statements occurred recurrently after a patient had mentioned

[32] Wootton's study is not a study that is placed within the field of MCA (see section 3.3 on membership categorization analysis). It is an ethnographic study, which, then, cannot capture the details of how categories are used in interaction. Nevertheless Wootton is, like MCA, concerned with how participants use categories in interaction.

some personal experiences, Wooton notes. In his study Wootton outlines ways in which patients and staff deal with "…the question of whether two instances are similar and the question of the amount of information it is necessary to have before a judgment of similarity can take place" (1977:342 f.).
Important aspects of doing sharing experiences in the sense of telling a story about oneself that in some sense can be understood as analogous to that provided by another participant in the setting of face to face group therapy within psychotherapy according to Wootton, then, involves interpretational – and interactional - work that deal with similarity. Similarity is thus dealt with locally and interactionally as relevant for sharing and not taken for granted in and through sharing a physical presence, sharing a membership as patients, sharing a history or the like. In this investigation we will see that something similar is the case; participants do not simply take it that they have similar experiences with and understandings of metabolism, the pre-established topic of the forum; participants describe particular experiences. Neither do they simply claim to recognize experiences, they provide descriptions of experiences that are recognizably similar to the first story. Thus similarity is demonstrated and accounted for in interaction.

6.1.3 Analysis

6.1.3.1 Sharing experiences by telling stories

In this chapter one aspect of sharing experiences is investigated, namely sharing experiences accomplished by sharing similar stories. As indicated in chapter 5 about data, participants in the forum investigated here do not "share" any of the experiences they describe per se, i.e. they presumably have never met in face-to-face encounters.
However, participants recurrently construct tellings as involving, or as being about, experiences with health problems, which are understood as being related to the metabolism. In this chapter I focus on how these stories are constructed, how participants invite to the sharing of experiences, and I focus on how second stories are constructed to acknowledge recognition of, deal with or relate to the story indicated in the text that initiates the thread concerned.

A pattern has been identified in terms of how this kind of sharing typically occurs. Prototypically an activity involving the sharing of experiences is invited to in 1st messages (or in responses that describe a problem which has not been touch upon in the thread) by providing a narrative, which describes a problem, and by formally requesting for other participants to indicate recognition. These requests are typically constructed as a version of "Is there anyone who can recognize this?", that is, as a "yes/no interrogative" (Raymond 2003) requesting for display of recognition of aspects of experiences by using verbs such as "recognize", "have experience with", "be familiar with", "know of" etc.

Example A1 illustrates this. For other examples, see Appendix, Example AA1-AA9.

Example A1: 1st posting, "stofskifte-forstyrrelse/svimmelhed":

WR1 Tilmeldt: 30-06-2008 10:03	Den 30-06-2008 21:30 **stofskifte-forstyrrelse / svimmelhed**	

1 Hej
2 Jeg lider af lavt stofskifte og er igang med fin-justering med eltroxin. Mit TSH ligger på
3 2,6 og jeg er blevet øget til 100 mikrog. eltroxin for 1 uge siden. Er der nogen der,
4 ligesom jeg, lider af en voldsom svimmelhed? Jeg tror selv det skyldes at jeg netop er
5 øget i dosis, men er selvfølgelig nervøs for at TSH er på vej op.....
6 Lider derudover også af en voldsom "summen" eller "snurren" i benene, særligt om
7 aftenen - er der nogle der har erfaringer med dette?
8 hilsen Xxxxx

English translation:

WR1 Joined: 30-06-2008 10:03	On 30-06-2008 21:30 **metabolic-disturbance / dizziness**	

Hello,
I suffer from hypothyroidism and am working on fine-tuning with eltroxin. My TSH is at 2.6 and I have been increased to 100 mcg. eltroxin 1 week ago. Is there anyone who, like me, suffers from a severe dizziness? I myself think it is because I have just increased the dose, but am obviously nervous that TSH is coming up .....
In addition I also suffer from an intense "sum" or "tingling" in the legs, especially at night – are there some who have experiences with this?
regards xxxxx

The text in Example A1 is from a 1st posting with the title "stofskifte-forstyrrelse/svimmelhed" (metabolic-disturbance/dizziness). Medical categories are indicated; a medical condition, "stofskifte-forstyrrelse" (metabolic-disturbance), and after a slash a category recognizable as referring to an experienced problem, "svimmelhed" (dizziness). The text roughly consists of a greeting (line 1), a problem description[33] (line 3-7), which in this case also include invitations to responses, and a closing (line 8). As already mentioned above, this way of constructing social action is complex and different from what we can observe to happen in face to face encounters (Sacks, Schegloff & Jefferson 1974) and also different from how participants ordinary organize online chat postings (see section 4.1).

Actions that in face-to-face interactions normatively are accomplished in pairs of two actions sequentially adjacent to each other (cf. adjacency pairs, see section 3.2.1.2) are accomplished in different sequential

[33] As mentioned in section 4.3, Heritage & Robinson conducted a CA study of the phase of patient problem presentation in videotaped acute medical visits. They define patient problem presentation as "...a phase of interaction in which circumstances recognizable as "problems" are presented with whatever elements of cogency or disorganization, affective expression, and recognizable structure and content". (Heritage & Robinson 2006:49). I take the term "problem presentation" and the definition of the term from their study, but I more often use the term "problem description" to denote something similar. This is because participants in the forum may use problem descriptions to accomplish different action and contribute to the accomplishment of different courses of actions than what would correspond to "a phase of patient problem presentation" (see above) as such. The intention with the analyses is to point out the methods participants make use of to make what it is they are doing recognizable as certain actions, such as describing a problem.

ordering in bulletin boards. For example participants do not wait for someone to greet them after they have greeted other forum participants. Rather, several actions are indicated by a participant in a posting. This internal sequential structure provides participants with resources for indicating actions and for indicating how actions should be understood. As will be shown, respondents orient to the actions, understandings and internal structure of postings when responding.

However, as will also be touch upon in chapter 6.4 in which I take up practices for initiating and closing activities, participants do seem to orient differently to norms of responding to actions such as greetings in the forum as opposed to the norms of responding to greetings in face-to-face encounters. The logic of this may be related to perceptions of obligations to respond when being addressed in the physical or hearable presence of a speaker, as opposed to perceptions of obligations to respond in a forum. In face-to-face encounters we greet someone in particular, whereas in bulletin boards presence and/or availability is not monitored. The fact that respondents do not orient strictly to responding to actions such as greetings may also be related to the sequential organization of actions and the complexity of postings. In chapter 6.2 for example, I show examples of responses that initiate with acknowledgements such as “Ja” (Yes) rather that with greetings. Thereby participants may orient to other actions as relevant to initiate postings with rather than with a greeting.
In this chapter the concern with the sequential complexity of postings will be to investigate how the posting is constructed in order to present a problem in a particular way and how participants are invited to treat that problem in a response.

The text is constructed as a telling of experiences. This is done by providing descriptions of actions (“Jeg lider af” (I suffer from); “er igang med” (am working with); “jeg er blevet øget til” (I have been increased to…”) and information in several “units”. Some of the experiences are categorized in terms of medical diagnosis and medical categories (for example “lavt stofskifte” (hypothyroidism)), other experiences are also described in terms of when, how, and/or possibly why these problems are experienced. This is the case with WR1’s experiences with "sum" or "tingling" in the legs: “en voldsom "summen" eller "snurren" i benene, særligt om aftenen” (an intense "sum" or "tingling" in the legs, especially at night).

Interestingly, WR1 starts her telling of by indicating medical categories; WR1 indicates that she has a medical diagnosis, hypothyroidism (i.e. low metabolism), and that she is concerned with regulating the medication she takes in order to treat the medical condition. Hence, she orients to identifying as a member of the group of people with problems with the metabolism by indicating that she has a medical diagnosis.
Embedded in this is of course information that WR1 is being treated medically with a certain drug, eltroxin (line 3-4). As already mentioned, we can notice that WR1 chooses the verb “lide af” (suffer from) to indicate that the facts that she indicates has to do with experience and pain. She does not only orient to her membership category as being based on a medical diagnosis, but also on experience with specific bodily pain. Furthermore, the verb (as most other verbs in the posting) is in present tense, in this case indicating that the action described is ongoing and relevant in the present (see Edwards 1994 on script formulations).
We can now start to notice that the activity in the posting has to do with describing and categorizing experiences understood to be related to medical problems being established by referring to a medical diagnosis (also see chapter 6.2 in which I show how respondents also orient to indications of medical

diagnoses). We see that medical categories and information is being indicated in the presentation - and telling – of problematic experiences.

As mentioned, story telling in CA has been investigated for how it is organized cooperatively by participants in multi-unit turns in face to face encounters (Hutchby & Wooffit 1998; Sacks 1992e; Silverman 1998:115). In the postings the participants accomplish actions and units by using the resources of written language. Sequences, or units, are built by participants by indicating various recognizable actions with language, and by using typography.
As opposed to "prototypical" narratives in which clauses for example should be in past tense (Norrick 2000; see above), tellings in this forum include present experiences indicated as current and recurrent. This, of course, shows participants' understandings of their problem and of the activity in which they are engaged. Participants are not concerned with telling stories as such. They are concerned with indicating problems they experience in the present in the hope of getting response that might help them understand and deal with these specific experienced problems as competently as possible.

We see that participants are concerned with getting relevant responses and increasing their understandings of their problems when looking at the actions participants make relevant on the part of respondents. After having established some medical facts (line 2-3), WR1 formulates an invitation to indicate recognition of a problem experienced by WR1: "Er der nogen der, ligesom jeg, lider af en voldsom svimmelhed?" (Is there anyone who, like me, suffers from a severe dizziness?) (line 4-5). This invitation is formally a yes/no interrogative, i.e. a question to which a yes/no response would be type conforming (Raymond 2003).
We see here that WR1 embeds a categorization of an - apparently yet unexplained – problem, "Svimmelhed" (Dizziness), in her question formulation. What this category refers to is not elaborated on, but taken to be understandable and recognizable simply by referring to the category. However, WR1 does elaborate on her understanding about possible causes for why she experiences dizziness: She suggests that it has to do with a recent increase in the dosage of medication she takes (line 4-5). To this she adds a concern that the hormone, THS, will increase ("men er selvfølgelig nervøs for at TSH er på vej op....." (but am obviously nervous that TSH is coming up .....), line 5). This can be understood as an argument for increasing the eltroxin dosage, although one might experience possible side effects. Notice that this account for why it makes sense to increase the dosage of eltroxin is constructed as a concern WR1 has in terms of what the consequences would be for the TSH hormone level if she did not increase the dosage. She thereby shows that she is concerned with and has knowledge about how to use blood test results to monitor the state of her illness.
Another problem is added in the text, namely experiences with an intense "sum" or "tingling" in the legs occurring mostly at night. Here, again, the problem she has is constructed as experienced by her currently and recurrently and is indicated as a problem out of the ordinary and related to pain ("Lider derudover også af" (I also suffer from), line 6). As noted, WR1 constructs the description, not as information, but as a telling about experiences by describing a series of actions she experiences.
To this description a request for participants to indicate recognition is added: "- er der nogle der har erfaringer med dette?" (– are there some who have experiences with this? (line 7)), which is also constructed as a yes/no interrogative formally requesting for a yes/no typed response. The relevant membership categories respondents are guided to orient to with this formulation are people with

experiences with specific described problems, and specifically problems that are recognizable as (possibly) related to a metabolic condition. In the request WR1 uses an indexical expression, “dette” (this). As I already implied, the use of the dash, “-“, after having described an additional problem (line 6) and before inviting others to indicate recognition (line 7), works to mark the two actions as connected, and “dette” is understandable as referring to the problem just indicated. Hence, WR1 uses linguistic resources and typography to indicate how elements in the posting should be understood as connected.

In the 1st posting in Example A1 we saw that, although the text entailed a lot of medical information, the text was constructed as a telling about experiences, in particular a telling about how WR1 dealt with having a metabolic condition and how she experienced yet unexplained problems possibly related to (the treatment of) her medical condition. This understanding was indicated by indicated medical information and by indicating possible medical causes for experienced problems (see chapter 6.2). WR1 used particular categories to refer to the experience of yet unexplained problems (for example dizziness, and summing in the legs). Instead of simply indicating the categories, WR1 described when, how, and/or possibly why these problems were experienced. It was also noticed that WR1 invited other participants to indicate recognition of the experiences, and that these requests were formatted in yes/no interrogatives and followed descriptions of experiences with problems constructed as connected to a metabolic condition. In the telling of her experiences with particular problems, WR1 displayed her understanding of how it is relevant to describe presently experienced but yet unexplained problems in the forum, i.e. by not simply indicating particular categories understandable as referring to symptoms (i.e. claiming to have experiences with particular problems), but also demonstrating how the problems are experienced and possibly why. This way of describing a problem provides recipients with a resource as to how they are expected to indicate recognition of the problem WR1 has described, and not simply referred to (see Schegloff 2007b). This means, when requesting for indication of recognition of a problem in a yes/no interrogative format after telling about experiences with the problem, it implies that WR1 indicates that simply claiming recognition, for example by responding with “yes” or “no” (which are type conforming responses to the requests (Raymond 2003) is not being a sufficient response, i.e. it would not “match” the methods WR1 used to indicate a problem.

The first response, provided in Example A2, shows the first respondent’s understanding of relevant things to do and deal with as stipulated above:

Example A2: First response, "stofskifte-forstyrrelse/svimmelhed":

WR2 Tilmeldt: 16-06-2008 14:46	Den 30-06-2008 23:05 **Re: stofskifte-forstyrrelse / svimmelhed**

1 Jep, jeg kan godt nikke genkendende til dine symptomer. Jeg er nu også oppe på
2 100 mg/dag, har uro i benene om aftenen, og er svimmel, når jeg rejser mig hurtigt,
3 f.eks. når jeg luger i haven.
4
5 Jeg synes, at symptomerne ændrer sig meget, hver gang jeg er blevet sat op i dosis.
6 Lige nu døjer jeg også meget med spændingshovedpine, hvilket også var det første
7 symptom.
8
9 Jeg håber nu, at jeg kan blive sat op i dosis igen mandag, og så måske endelig kan
10 få den rette dosis.
11
12 Mvh Xxxxxxxxxx

English translation:

WR2 Joined: 16-06-2008 14:46	On 30-06-2008 23:05 **Re: metabolic-disturbance / dizziness**

Yep, I can recognize your symptoms. I'm now up at 100 mg/day, have restless legs at night, and feeling dizzy when I stand up quickly, for example when I'm weeding in the garden.

I think that the symptoms change a lot, every time I have been set up in dose. Right now I suffer a lot from tension headache too, which was also the first symptom.

I hope now that I can be increased in the dose again on Monday, and then maybe finally get 8 the right dose.

Sincerely Xxxxxxxxxx

The first response to the 1st posting with the title "stofskifte-forstyrrelse/svimmelhed" (metabolic-disturbance/dizziness) shown in Example A2 initiates with an explicit identification marker ("Jep" (Yep)) which can be understood as a type conforming response (Raymond 2003) to one, or both, of the yes/no interrogatives requesting respondents to indicate recognition in case they recognize the personally experienced problems described. WR2 does not provide a greeting as WR1 did[34] (see Example A1, line 1). "Jep" is followed by a description that displays what "Jep" should be understood to do, namely acknowledge recognizing the "symptoms" described by WR1 ("jeg kan godt nikke genkendende til dine symptomer." (I can recognize your symptoms.)). Here we may also notice that WR2 categorizes the problems WR1 described as symptoms, which implies that the problems are understood to be medical, to

[34] This study does not include a systematic investigation of greetings and closings (but see the final analytical chapter for a few examples and analyses of greetings and closing, and for example Waldvogel 2007 on the use of greetings and closings in work place emails). From this and other examples (see for example chapter 6.2 on explaining illness) a tentative pattern can be pointed out; response texts are often initiated with greetings or with acknowledgement (or agreement) tokens such as "Jep" in this case. Both greetings and acknowlegdement (or agreement) tokens are organized as the first thing in response texts, and the use of one of the actions, seems to exclude the other. Work that specifically investigates the use of greetings and closings may further illuminate how interactional norms are established and oriented to in the forum.

fit into a particular pattern, to have a cause, and to have a fitting diagnosis. WR2 thus orients to the membership category, being someone with specific bodily experiences that can be recognized as having a medical cause related to the metabolism, made relevant by WR1 with this acknowledgment.

Indicating *recognition* of WR1's problems is thus oriented to as the first relevant thing to do in the first response. After this follows a list of descriptions about daily intake of medication ("Jeg er nu også oppe på 2 100 mg/dag " (I'm now up at 100 mg/day)), and problematic experiences formulated as discomfort localized to a specific part of the body (legs) occurring recurrently (i.e. the events are formulated as scripted, see Edwards 1994; 1995), at specific times a day (at night) or in connection with specific activities ("er svimmel, når jeg rejser mig hurtigt" (feeling dizzy when I stand up quickly)), and as specific, categorizable, patterned phenomena; "har uro i benene om aftenen, og er svimmel, når jeg rejser mig hurtigt, f.eks. når jeg luger i haven." (have restless legs at night, and feeling dizzy when I stand up quickly, for example when I'm weeding in the garden.), line 2-3. Hence, WR2 orients to a specific kind of information as relevant in order to demonstrate *how* she recognizes the problem described by WR1, which orients to the descriptions made relevant in the 1st posting. WR1 has specifically made dosage of a drug, experiences with dizziness and tingling in the legs relevant (see Example A1). WR2 accomplishes with her descriptions to demonstrate in what way she recognizes the problems described by WR1. Details of how problems are experienced are thus oriented to as relevant. Furthermore, as WR2 indicates recognition by demonstrating how she has experienced the problem and as she orients to the categories and information introduced by WR1 in her telling in her 1st posting as relevant to describe her problem, WR2 shows that she acknowledges and *agrees* with WR1's way of understanding her problem.

As can be seen, WR2 moves on from recognizing WR1's problems as described by telling about her own experiences, as WR2 introduces a candidate explanation for the (re-)appearance of symptoms (line 5) ; "Jeg synes, at symptomerne ændrer sig meget, hver gang jeg er blevet sat op i dosis" (I think that the symptoms change a lot, every time I have been set up in dose). WR2, then, in this way notes a subjective, but possibly logical ("Jeg synes" (I think)) observation based on experience, namely that she has experienced a severe change in her symptoms in connection with increasing her medicine dosage. She indicates her suggestion is based on empirical observation, it is not constructed as a general hypothesis about connections between increase in medical dosages and symptoms explicitly. This, again, shows how participants construct aspects of their problems as *experienced* by them instead of as known facts or claimed guesses (also, see chapter 6.2 about practices for dealing with explaining illness). Notice that the suggested possible explanation indicated by WR2 aligns with the explanation WR1 suggested as being a cause for her dizziness (Example A1, line 4-5). We may also notice that both WR1 and WR2 use phrases indicating subjectivity, "Jeg tror" (I think) (A1, line 4); "Jeg synes" (I think) (A2, line 5) when indicating a possible explanation for experienced problems, however WR1 indicated a possible explanation for a single case (having just increased her dosage of medicine), whereas WR2 indicates a recurrent pattern based on her experiences: That symptoms change a lot every time her dosage of medication is increased. In fact, as this can be identified as a systematic course of events, and not only a single case observation, it not only aligns with WR1's suggested explanation, but also provides some validation.

WR2 indicates another problem, namely tension headache: "Lige nu døjer jeg også meget med spændingshovedpine, hvilket også var det første symptom." (Right now I suffer a lot from tension headache too, which was also the first symptom.). Tension headache is constructed as a symptom by referring to it as

a symptom and as connected to the symptoms already acknowledged as relevant, with "også" (too). The relevance of mentioning tension headache, that is making it relevant to mention here and now, is done by indicating that WR2 is currently suffering from this ("Lige nu" (Right now)), and that she experienced tension headache as the first symptom. Here is an orientation towards telling about current and recurrent experienced problems and characterizing them as a (possible) medical condition rather that telling stories as such. WR2 in line 7-8 provides her understanding of what would contribute to a bettering of WR2's own condition, namely that the doctor would recommend an increase in her dosage of medication, which may lead to an optimal dosage of medication for her ("Jeg håber nu, at jeg kan blive sat op i dosis igen mandag, og så måske endelig kan få den rette dosis." (I hope now that I can be increased in the dose again on Monday, and then maybe finally get the right dose.")). WR2 signs of in line 12.

WR1 replies to the first response by WR2 about 12 hours after WR2 has posted her response, see Example A3. In the forum investigated here, the writer of the 1st posting does not always post a "thanks message" (see Morrow 2006) or another kind of response, but by looking at a case in which the first writer does actually respond, we get informed about WR1's understanding of the relevance and use of WR2's first response. Such responses to responses will otherwise be the focus of the final analytical chapter (Chapter 6.4).

Example A3: Second response, "stofskifte-forstyrrelse/svimmelhed":

WR1* Tilmeldt: 30-06-2008 10:03	Den 01-07-2008 12:43 **stofskifte-forstyrrelse / svimmelhed**	

1 Hej
2 Må sige det er dejligt at udveksle erfaringer - bliver beroliget. Jeg lider også meget
3 af spændingshovedpine og har migræne flere gange om måneden. Egentlig tror jeg
4 er det tydeligste symptom på for lavt stofskife - jeg er i besidelse af - er væske i
5 hænder og fødder. Det er jeg ikke kommet helt af med, men satser da på at det
6 forsvinder når den rette dosis er nået.
7 Hvad er dit TSH fortiden og hvor meget Eltroxin tager du?
8 Hilsen Xxxxx

English translation:

WR1* Joined: 30-06-2008 10:03	On 01-07-2008 12:43 **Re: metabolic-disturbance / dizziness**	

Hello
Must say it's great to share experiences – I get reassured. I also suffer a lot from tension headaches and migraines several times a month. Actually, I think the clearest symptom of low metabolism – which I am endowed with - is fluid in the hands and feet. I have not quite gotten rid of it, but am counting on it to disappear when the correct dose has been reached.
What is your TSH currently and how much Eltroxin do you take?
Regards Xxxxx

In Example A3, the second response in the thread "stofskifte-forstyrrelse/svimmelhed" is shown. This posting has been initiated by WR1*, hence the same author as in Example A1 (WR1). The text in Example

A3 initiates with a greeting (similar to the greeting in Example A1). The greeting is done as the first thing in a posting that follows a posting by WR2 who has responded to WR1's first posting. The placement of the greeting makes it recognizable as a greeting addressed at WR2. After greeting, WR1* assesses the action of sharing experiences; "det er dejligt at udveksle erfaringer" (it's great to share experiences) (line 2). WR1* in this way makes a categorization of what she and WR2 are doing, and possible also a categorization of what others in the forum are doing. At the same time she acknowledges her appreciation for the activity WR2 has contributed with accomplishing, namely to "share experiences". WR1* adds a positive effect she gets from sharing experiences: reassurance (line 2). This is another way of orienting to the activity of sharing experiences as not simply a matter of telling stories. The activity of sharing experiences is oriented to by the participants as a way of dealing with experienced problems.

WR1* then indicates a problem she has. She suffers from tension headaches recurrently (several times a month), (see line 2-3), a symptom introduced by WR2 as relevant for the topic brought up by WR1. She uses the same category as WR2 to refer to the problem, tension headache (see Example A2, line 6). She constructs the problem as an experience that is bothersome ("Jeg lider også meget af" (I also suffer a lot from), Example A3, line 2-3). WR1* deals with WR2 having introduced a problem, tension headaches, in her response by indicating that she, WR1*, has experiences with the problem and by specifying how often she experiences this problem. WR1* does this even though WR2 did not explicitly request for indication of recognition, i.e. from WR2's indication of a problem, and indicates thus that she understands it to be relevant to indicate recognition of the problem.
Then, in line 4-5, she introduces yet another symptom, categorized as "det tydeligste symptom på for lavt stofskife - jeg er i besidelse af - er væske i hænder og fødder" (the clearest symptom of low metabolism – which I am endowed with - is fluid in the hands and feet.). Noticeably, this problem is indicated as the most obvious symptom of low metabolism and only in an inserted comment the problem is indicated as also personally experienced ("- jeg er i besidelse af – "(– which I am endowed with –), line 4). WR1* in line 4-5 indicates that the symptom is still present and that she expects it to disappear when she has reached the right dosage of medication. Hence, she shows how she has dealt with the problem as a symptom of low metabolism (see chapter 6.3 on advice giving), and she provides a candidate explanation for why the symptom is still present even though she receives medical treatment for the condition (see chapter 6.2 on explaining illness). This description, thus, is not constructed as a yet unexplained problem. In fact, this problem is indicated not as a candidate metabolic symptom, but rather one of the symptoms that characterizes low metabolism. By using this formulation WR1* implies that indications of recognition of this by telling about personal experiences is needless.
In line 7 WR1* addresses WR2 with a request for information: "Hvad er dit TSH fortiden og hvor meget Eltroxin tager du?" (What is your TSH currently and how much Eltroxin do you take?). Here she shows that she finds it relevant to share information about hormone levels and medicine dosages with WR2. WR1* orients to the sharing of experiences as possibly complete here. She moves on from indicating recognition of personal experiences (line 2-3) to indicating information about the most obvious symptom of low metabolism (line 3-4), to indicating her understanding of connections between symptoms and causes (line 4-6) to requesting WR2 to share information about blood test results and drug dosages (line 7). Another indication WR1* makes to indicate that she understands the sharing of experiences as possibly complete is in the initial part of the posting, in which she displays appreciation of the activity of sharing experiences.

Sharing experiences is oriented to by WR1 and WR2 as a reciprocal activity; that is, both participants deal with the experiences described by the other participant and indicate recognition of them by also indicating to what degree and/or how they can recognize the particular symptom. Both participants furthermore deal with aspects of causation, and in this way, among others, make their understandings of the described problems as symptoms of low metabolism clear. This is an understanding that they also share. After WR1 and WR2 has shared personal experiences with symptoms and have displayed similar views on potential causes, the next step made relevant by WR1 is the sharing of specific medical information.

We may take from the analysis of the first three postings in the thread "stofskifte-forstyrrelse/svimmelhed" (metabolic-disturbance/dizziness) that the postings are complex and entail various action oriented to indicating a problem and inviting to particular action, in this case by inviting to indication of recognition by posing questions inquiring about recognition of experiences.
When participants indicate problems they don't simply list medical categories or tell stories. Rather they describe current and recurrent problems as they are experienced. In doing that they also indicate medical information, which indicates an understanding on the part of the participants that the problems they experience are medical and possibly related to metabolism.
Participants make it relevant for respondents to respond to these descriptions in a particular way. Participants are invited to indicate recognition. This informs us that participants don't take it for granted that they in fact have relevant experiences to share. Participants orient to demonstrating experience with a problem, as they do not simply indicate medical categories in a list, such as it might be presented in a medical encyclopedia. This means, *demonstrating* experience with a problem counts as a way to establish whether they have relevant things in common. In particular, the participants in this data orient to it as relevant to describe, at least in some detail (recurrence and degree to which a problem is having an effect in the quality of life are particularly oriented to as relevant when describing problems), *personally experienced* problems. In the ways the participants share their experiences with problems we see that both participants, WR1 and WR2, are contributing with new candidates, which they offer other participants to "say something about", i.e. indicate recognition of.

6.1.3.2 Categorization work

As the problem description activity unfolded here, the participants initiated with problems oriented to as being less common and expanded with symptoms as being more common; we saw that as the most obvious symptom of low metabolism according to WR1* was mentioned last (see Example A3, line 3-4).
We can see how this practice of sharing experiences with problems accomplish to establish a set of descriptions of experiences that may be understood as a *characterization of a medical condition* in terms of how it is, or may be, experienced, and in terms of which kinds of categories, here in particular medical categories, may be relevant. By indicating and sharing several experiences with particular problems, the participants accomplish to establish a shared understanding that the problems they experience belong in the same category. This category, here low metabolism, is then established as the (candidate) underlying cause for the participants' experienced problems, including the problems that have been unexplained so far.
This categorization work in regard to how to understand experienced problems that participants accomplish collaboratively also categorizes the participants in terms of how they understand themselves as

members of the group of people who interact in the forum under the topic "metabolism". Participants categorize themselves as someone who *experiences medical problems* related to metabolism.

Everyone can obtain formal membership of the online forum and post postings. However, we see that participants who use the forum do not take their membership for granted; they account for why they have problems that are relevantly described within the category chosen. Participants in the forum themselves seem to establish and orient to understandings and norms for relevant ways of not only how to interact socially with others in the forum, but also of how to interact socially with others in the forum about this topic, metabolism. What this should imply is that participants clearly establish and orient to social norms for how to understand and talk about the experience of problems, which are suspected or known to be related to metabolism. This can be understood as ways in which participants orient to this as a public forum and to themselves as non-professionals, who, however, attempt at competently to deal with their bodily experiences which they treat as possibly caused by metabolic conditions. In chapter 6.2 it will be further demonstrated how participants orient to medical categories as relevant when they interact about possible causes for illness. Further indications of participants' orientations to membership categories, i.e. their understandings of themselves and the social activities they engage in in the forum, will be pointed out in chapter 6.3. In chapter 6.3 it will be shown how participants orient to the interaction as a service encounter rather than as a troubles telling (cf. Jefferson & Lee 1992) when interacting about treatment, i.e. they categorize themselves as advice seekers and advice givers rather than troubles tellers and troubles recipients. They do so, however, without challenging the knowledge of health professionals, which will also be pointed to.

6.1.3.3 Acknowledging and demonstrating recognition

The following example illustrates another case in which an initiator of a thread, again referred to as WR1, indicates personal experiences that are constructed as problematic and (possibly) connected to the metabolism. As in the first case shown (Example A1), WR1 invites other forum participants to indicate recognition:

Example A4: 1st posting, "For lavt stofskifte- Svimmel og træt":

WR1 Tilmeldt: 06-03-2009 13:45	Den 06-03-2009 14:52 **For lavt stofskifte- Svimmel og træt**	

1 Hejsa...
2 Jeg lider meget af svimmelhed og blir ekstrem svimmel når jeg f.eks har ligget ned
3 og så rejser mig op...
4 Er også enormt træt, føler at jeg bare kan smide mig på gulvet af træthed...
5
6 Er der nogen der kender til de symptomer?
7
8 Hilsen Xxxxx

English translation:

WR1	On 06-03-2009 14:52	
Joined: 06-03-2009 13:45	**Too low metabolsim– Dizzy and tired**	

Hi there …
I am suffering a lot from dizziness and become extremely dizzy when I for example have been lying down and then get up again …
Am also extremely tired, feel that I can just throw myself on the floor because of fatigue …

Is there anyone who is familiar[35] with those symptoms?

Regards Xxxxx

In the 1st posting in Example A4 the title "For lavt stofskifte- Svimmel og træt" (Too low metabolism– Dizzy and tired) is chosen. The title entails categories referring to a medical condition, too low metabolism, and categories readable as referring to experienced problems, and/or symptoms, dizzy and tired.
The text initiates with a greeting (line 1) and a description of a problem, line 2-3, categorized as "svimmelhed" (dizziness). The description is constructed as a telling about recurrent experiences, which is similar to the practices used in example A1, A2, and A3 to present problems. WR1 indicates the problem with dizziness as severe ("meget" (a lot)) and recurrent ("Jeg lider"(I am suffering)). This way of presenting her problem works to demonstrate that WR1 has actual experiences with dizziness and to point to the seriousness of the problem, i.e. she categorizes herself as a member of people with painful bodily experiences. An extreme case (see Edwards 2000) is then formulated in terms of some of WR1's experiences with dizziness: "og blir ekstrem svimmel når jeg f.eks har ligget ned og så rejser mig op..." (and become extremely dizzy when I for example have been lying down and then get up again ...), (line 2-3). She thus indicates that she 1) suffers from dizziness as a current and recurrent problem, and 2) experiences it as a particularly big problem when she stands up after having been lying down. People are expected to be able to get up without experiencing dizziness ordinarily, and thus, the example works to point to the experience of dizziness as out of the ordinary and problematic. The dots ("…"), which are also used in line 1 and line 4 may indicate omission of unnecessary text or denote a pause (see Ong (2011:213) on the use of dots in quasi-synchronous chats)[36].

[35] The Danish verbal construction is "kende til" and can also be translated as "know about".

[36] In asynchronous interactions, the use of dots may have special functions. At least I have noticed that dots are recurrently placed after certain types of actions (for example after greetings, see line 1). Dots may be used (by some participants in certain contexts) to indicate writers' indications of sequence or action completions, in cases in which other resources such as question marks are not relevant, i.e. some participants might use several dots placed after each other to indicate something similar to a turn transition relevant place (see section 3.2 on conversation analytic terms), which cannot be exploited sequentially in asynchronous interactions.
Dots are in my data also used after descriptions (see line 2-4). Another function dots might be used to do is to display writers' expectations that the descriptions they provide should be sufficient for readers in order to recognize what the writer is has intended to index with his or her description.

In line 4-5 another problem is described; fatigue. This problem is introduced in a similar manner as the problem with dizziness in line 2-3; WR1 first announces suffering from fatigue ("Er også enormt træt" (Am also extremely tired), line 4), and then demonstrates with a description how the fatigue makes her feel ("føler at jeg bare kan smide mig på gulvet af træthed..." (feel that I can just throw myself on the floor because of fatigue ...)).
In line 7 WR1 poses the question "Er der nogen der kender til de symptomer?" (Is there anyone who is familiar with those symptoms?), a yes/no interrogative formally requesting for a yes/no typed response (Raymond 2003). This question, which follows directly after a description of a problem constructed as a telling about an experienced problem, makes it relevant for other participants to indicate and demonstrate their experience (or knowledge) if they in fact have relevant experiences (or knowledge) to contribute with. Through indicating descriptions of bodily experiences which are categorized by using (medical) categories and inviting people to respond, WR1 indicates expectations of categories respondents should indicate to be members of and/or otherwise deal with. WR1 shows that she understands it to be relevant to describe problems by using specific (medical) categories, and thus this provides respondents with a resource about how to indicate recognition. We may also note here that in the request WR1 formulates the problems she has described as symptoms.

The design of the text in Example A4 thus, resembles the design in Example A1; problems are indicated as personally experienced, and aspects of the actual experience with the problems are demonstrated. A yes/no interrogative is chosen towards the end of the message to invite to sharing of personal experiences with a problem.

The 1st posting in Example A4 is responded to in the first response (Example A5) in quite another way than in the first response in Example A2 (see above):

Example A5: First response, "For lavt stofskifte- Svimmel og træt":

WR2 Tilmeldt: 03-03-2009 16:08	Den 06-03-2009 15:33 **Re: For lavt stofskifte- Svimmel og træt**	

1 Hej Xxxxx.
2
3 Det lyder som noget jeg ku' ha' skrevet...
4
5 *Xxx

English translation:

WR2 Joined: 03-03-2009 16:08	On 06-03-2009 15:33 **Re: Too low metabolsim– Dizzy and tired**	

Hi Xxxxx.
It sounds like something I could have written ...
*Xxx

In the first response to the 1st message with the title "For lavt stofskifte- Svimmel og træt" (Too low metabolsim– Dizzy and tired) (Example A5) the text entails a personal greeting ("Hi Xxxxx.", line 1), a

description that acknowledges recognition (“Det lyder som noget jeg ku' ha' skrevet...” (It sounds like something I could have written ...”), line 3, and a closing (“*Xxx”, line 5).

In the description in line 3 WR2 acknowledges that from what has been written by WR1, WR2 recognizes to have experienced something similar to a degree that she could have used to same words to describe it. In this way WR2 acknowledges recognition of the problem, i.e. acknowledges membership of the group of people who has the experiences WR1 has described, but does not demonstrate personal experience, and does not add any aspects of the problem or the condition described by WR1 as relevant. We may say that, contrary to what we saw in Example A1-A3, WR2 here does not orient to sharing experiences as a method to collaborate on characterizing an illness in terms of indicating personally experienced problems. Instead WR2 validates the experiences described by WR1 by claiming recognition to the degree that WR2 indicates that the first description could just as well have been authored by her, possibly implying that WR2 has nothing new to add and thus that the description provided by WR1 is spot-on.

The second response to the 1st message with the title “For lavt stofskifte- Svimmel og træt “ (Too low metabolism– Dizzy and tired) (Example A6) looks as follows:

Example A6: 2nd response, “For lavt stofskifte- Svimmel og træt”:

WR3 Tilmeldt: 01-02-2009 21:59	Den 09-03-2009 01:30 **Re: For lavt stofskifte- Svimmel og træt**

1 Jeg bliver også træt-bare jeg sidder ned. Har fået medicin i 38 år!!! Er ved at blive
2 reguleret-endnu engang, MEN trætheden og svimmelheden , kan også skyldes et
3 lavt blodtryk! Har du mon fået tjekket det?
4 Godt vi kan læse om lidelsesfæller her, så føler man ikke, at man er helt alene om at
5 have det dårligt , indimellem.
6 Mine største gener er muskelsmerter og hjerteuro, som lægen IKKE mener er fra
7 hjertet, men det står og ryster, især om natten. Jeg kan mærke at det kommer , når
8 min medicin er for "høj". Jeg får 100 dgl nu, men mit tsh er i den høje ende, så
9 lægen ville sætte eltroxinen op. Prøvede med 50 mere pr uge-men så begynder
10 svedeture-hurtig mave-og rysteturene.
11 Vi må bare holde ud og skrive til hinanden.
12 God bedring-snart til dig og knus fra xxxxxxxxxx

English translation:

WR3 Joined: 01-02-2009 21:59	On 09-03-2009 01:30 **Re: Too low metabolsim– Dizzy and tired**

I become tired too, simply from sitting down. Have taken medicine for 38 years!!! Am being regulated - once again, BUT the fatigue and dizziness can also be caused by a low blood pressure! Did you perhaps have that checked?
Good that we can read about fellow sufferers here, so that one does not feel that one is completely alone in feeling bad, once in a while.
My biggest nuisances are muscle pain and disturbances in the heart, which the doctor does NOT believe is from the heart, but it is shaking, especially at night. I can feel that it starts when my medication is too "high". I get 100 mic daily now, but my tsh is at the high end, so the doctor wants to increase the eltroxin. Tried with 50 more per week-but then sweating, stomach upsets and shaking start.
We just have to keep going and write to each other.
Good recovery, soon to you and hugs from xxxxxxxxxx

The second response does not deal with the first response (which is the sequentially preceding posting) in any recognizable way. It deals with issues made relevant in the 1st posting, though; it initiates with acknowledging identification with fatigue: “Jeg bliver også træt-bare jeg sidder ned” (I become tired too, simply from sitting down) (line 1). WR3 builds in a demonstration, an example, of how fatigue is experienced (“bare jeg sidder ned“ (simply from sitting down)). Then WR3 makes information about the extent to which she has experiences with medication relevant: “Har fået medicin i 38 år!!!” (Have taken medicine for 38 years!!!), (line 1). WR3 furthermore mentions that she is in the process of being regulated in her medication (“Er ved at blive reguleret-endnu engang “ (Am being regulated - once again) (line 1-2)). Making regulation of medication relevant displays an understanding that this might be a relevant factor when dealing with the problems described. She also introduces another possible cause for the problems categorized and described by WR1: “MEN trætheden og svimmelheden , kan også skyldes et lavt blodtryk! Har du mon fået tjekket det?” (BUT the fatigue and dizziness can also be caused by low blood pressure! Did you perhaps have that checked?”) (line 2-3). Here WR3 indicates as a request for information a concern to know whether WR1 has already had that checked out. This might be understood as a suggestion for WR1 to check this possibility out as a next step. As we saw in the first series of messages I showed, Example A1, A2 and A3, WR2 in Example A6 goes on from having established that the participants share experiences to dealing with medical issues such as causes and treatment.

WR3 acknowledges the positive effect of reading about other participants in the forum and elaborates that reading other participants’ stories occasionally (“indimellem” (once in a while)) makes one feel less alone when feeling bad (line 4-5). A similar practice was seen in example A3, in which WR1* initiated her response with an acknowledgement that sharing experiences made her feel reassured, that is, this statement in fact works to acknowledge the accomplishment of the activity of sharing experiences. In parentheses, we may notice that in the example we are investigating here, Example A6, the writer is not the author of the 1st message (Example A4), which was the case in Example A3. This may suggest that every participant involved in the activity of sharing experiences may provide acknowledgements of the effects of doing that. However, it seems that only participants who have invited to action expresses direct appreciation or “thanks” as a response to responses (see chapter 6.4).

Similar to what we saw WR2 and WR1* to be doing in Example A2, line 4-5, and Example A3, line 3-4 respectively, WR3 adds problems that have not been mentioned so far in the thread in this example, Example A6, line 6-9. This is done by providing descriptions about how the problems (“Mine største gener er muskelsmerter og hjerteuro” (My biggest nuisances are muscle pain and disturbances in the heart)) are experienced (“men det står og ryster, især om natten” (but it is shaking, especially at night)).
Contrary to the development we saw in Example A1-A3, here the interaction moves on from having shared similar stories in a series and from having indicated medical “candidate” “facts” to actually bringing in a perspective that counters these “facts” (for more examples, see chapter 6.2 on explaining illness).
The experiences, and their suggested causes, are then constructed as being in opposition to a health professional’s opinion (“som lægen IKKE mener er fra hjertet” (which the doctor does NOT believe is from the heart) (Example A6)).

This example informs us about some of the obstacles that some participants face besides the experience of bodily problems, namely that clients may experience that health professionals do not acknowledge or align with the patient's perspective and experiences.
WR3 indicates that she associates the cause for her experienced problems with a too high dosage of medication and argues for this in terms of her experience that this is in fact the case ("Jeg kan mærke at det kommer , når min medicin er for "høj" (I can feel that it starts when my medication is too "high"), line 7-8)). She also indicates her current dosage of medication in line 8 as well as an assessment of a relevant hormone level and the doctor's recommendation to increase the dosage of medication on the basis of this ("så lægen ville sætte eltroxinen op" (so the doctor wants to increase the eltroxin), line 8-9). WR3 rejects this as an optimal solution on the basis of experiences that this has negative effects ("Prøvede med 50 mere pr uge-men så begynder svedeture-hurtig mave-og rysteturene. (Tried with 50 more per week-but then sweating, stomach upsets and shaking start"), line 9-10). As mentioned, the activity has now turned into something other than simply sharing experiences or sharing medical knowledge. The telling of experiences here is used as elements in an argument sequence (Antaki 1994:159). WR3 argues that her medicine intake should not be increased although this is what the doctor recommends on the basis of a blood test result.
In order to argue for her case she refers to how she feels (line 7), and she refers to previous experiences in which the increase of medication led to discomfort (line 9-10). The doctor's arguments on the other hand are categorized as based on believes (line 6) and wants (line 9).

In line 11 WR3 acknowledges as a relevant and positive way of acting to keep going and write to one another. This acknowledgement thus differs in its function compared to the acknowledgements we saw in Example A3 (line 2) and previously in Example A6 (line 4-5). These acknowledgements were used to acknowledge the accomplishment of sharing experiences, including formulating in some terms the beneficial effects this activity was perceived to have. The acknowledgement as it is formulated and placed in Example A6, line 10, can be understood as an appeal or suggestion as to how to deal with doctors (that do not seem to base recommendations on patients' experiences) and/or how to deal with the fact that the recommended treatment is known to cause discomfort instead of recovery. Inviting others to indicate recognition of indicated problems in first postings may then lead to various trajectories, for example it may be used to 1) support and validate the perspective of the participants as experiencers of bodily problems (Example A5), a task that health professionals may not take on. It may also lead to 2) an activity of sharing experiences by demonstrating experiences in descriptions of problems. This activity, as Example A2, A3, and A6 shows, is often followed by exchanges about medical information and experiences with (medical) treatment.
Responses that acknowledge or claim experiences without telling stories about them may provide participants with a feeling that they are not alone with their experiences, but as they don't entail descriptions of problems as they were experienced, they don't contribute to the characterization of how a problem may be experienced with *additional* or *new* descriptions. The fact that WR2's contribution is not recognizably responded to may point to an orientation participants may have towards continuity in the sense of providing contributions that moves the interaction forward by contributing with additional or new issues. Possibly related to this may be the fact that providing a contribution that claims recognition does not make responses (conditionally) relevant, especially not on the part of other respondents.

In the second response, Example A6, we see that WR3 orients to the relevance of demonstrating her personal experience with the problems WR1 has indicated. Furthermore WR3 makes it relevant to indicate causes for her problems and validating these indications with descriptions of personal experiences. WR3 in this example did more than this in fact. She also introduced as a problem the fact that her doctor did not share her understanding of the cause for experienced problems and recommended treatment that she had bad experiences with (see chapter 6.3 on advice giving for further examples of indications of problems related to communication with doctors).

6.1.3.4 Alternative causes

Indicating recognition of a problem in responses is not only done in responses in cases in which metabolic disturbances are acknowledged as the most likely cause for described problems. Indication of recognition by describing experiences that demonstrate personal experience also occur in cases in which alternative causes for problems are suggested by respondents. Example A8 which is the first response to the 1st message shown in Example A7 is an example of this. Before looking at the first response in which WR2 displays an orientation to acknowledging recognition we will look at the 1st message to which it responds:

Example A7: 1st posting, "Træthed kronisk?":

WR1 Tilmeldt: 06-08-2010 11:37	Den 09-08-2010 12:18 **Træthed kronisk?**	

1 Hej
2
3 Jeg er en pige på 20 år, jeg fik for to år tilbage konstateret struma og for lavt stofskifte
4 og har lige siden fået medicin, eltroxin.
5 mit problem er bare at jeg konstant er træt, og det rigtig meget!
6 Jeg har dagligt kun lidt overskud til fritidsinteresser, da arbejdet er ret fysisk krævende.
7 i perioder kan jeg endda blive så træt at jeg knap kan hænge sammen og må gå i seng kl
8 20. og dette kan da ikke være rigtigt når jeg er så ung?
9
10 Jeg ved slet ikke hvad jeg skal gøre, og om det da skal være rigtigt at jeg skal have det
11 sådan resten af livet.
12 Er der andre i same siuation, og hvad har i gjort? og kan det blive bedre?
13
14 Hilsen den fortvivlede

English translation:

WR1	On 09-08-2010 12:18
Joined: 06-08-2010 11:37	**Tiredness chronically?**

Hello

I am a girl of 20 years, two years ago I got diagnosed with hypothyroidism
and have ever since taken medication, Eltroxin.
my problem is simply that I am constantly tired, and that very much
I have daily only a little energy for hobbies because work is quite physically demanding.
at times I can even get so tired that I can barely hang together and have to go to bed at
8. and this cannot be right when I'm so young?

I do not know what to do, and if it should be right that I should have feel like
this for the rest of my life.
Are there others in the same situation, and what have you done? and can it become better?

Regards, the despaired

The 1st message in Example A7 with the title "Træthed kronisk?" (Tiredness chronically?) entails elements that are similar to the elements in other 1st messages presented in this chapter (see for example Example A1), including a (candidate) categorization of a medical problem in the title. WR1 has put a question mark after the categorization of her problem, which might work to indicate an uncertainty on WR1's part as to whether the categorization accurately denotes her problem. Furthermore, in line with the previously shown examples, the text initiates with a greeting (line 1) followed by descriptions that identifies the writer, here as a girl who is 20 years old and has a metabolic diagnosis. Medication is also indicated (line 3-4). She also indicates having been diagnosed with the condition for two years and indicates that she had been medicated ever since. Hence, WR1 indicates as she describes herself that she belongs within the category of people who suffer from a metabolic illness. This illness has been diagnosed by a medical professional and she is in medical treatment. Because readers are presented with these categories initially and these ways of presenting herself, they work as a kind of guide in terms how to understand the problem that WR1 describes in what follows.

What follows is an announcement of a problem: "mit problem er bare at jeg konstant er træt, og det rigtig meget!" (my problem is simply that I am constantly tired, and that very much!) (line 5). This is a different way of indicating a problem than how it was done in Example A1 and A4. In Example A1 and A4 WR1 indicated suffering from a metabolic condition and then invited others to indicate recognition of a specific experienced problem. By constructing the posting in this way, the implied concern was indicated as establishing possible connections between a metabolic condition (or side effects from treatment) and a bodily experience.

In *this* first posting, Example A6, however WR1 indicates by specifically announcing an experienced problem as the problem she has, that it is the experience of a problem and what she can do about it that concerns her, not establishing a connection to her medical diagnosis per se. This way of constructing a first posting, thus, makes it relevant and possible for respondents to deal with the described problem as such, without acknowledging the problem as a candidate symptom of a metabolic disorder first.

This announcement is followed by descriptions of instances in which her problem affects her everyday life. These instances are constructed as currently ("Jeg har dagligt" (I have daily", line 6) and recurrently ("i perioder" (at times), line 7) occurring, similar to what we have seen in previous examples.
In this way she demonstrates how she experiences the problem and how it is actually experienced as a problem worth dealing with.
She indicates an assertion "og dette kan da ikke være rigtigt når jeg er så ung?" (and this surely cannot be right when I'm so young?) (line 8). This utterance is grammatically formulated as an assertion, but is ended with a question mark, i.e. WR1 uses typography to mark this as a question. There are also indications that the utterance should be understood as an exclamation. This is done by including the particle "da" which means underlines WR1's understanding that something is not right. The utterance works to imply that her young age is a factor that points to the fact that her problem cannot be explained by referring to a state of being tired as we all do occasionally as part of everyday life. Here WR1 explicitly demonstrates how she understands one of the categories mentioned initially, her age, to be relevant for her problem; according to her she feels abnormally tired for her age, i.e. WR1 is unable to find any natural explanation for her experiences of being tired.
The next thing WR1 makes relevant is how to act on the problem (see chapter 6.3 on advice giving), as she expresses lack of competence in knowing what to do and expresses some frustration with the situation and whether or not she should work on accepting that situation ("Jeg ved slet ikke hvad jeg skal gøre, og om det da skal være rigtigt at jeg skal have det sådan resten af livet." (I do not know what to do, and if it should be right that I should have feel like this for the rest of my life.), line 10-11).

Then, as we have also seen in the previous examples, WR1 invites other forum participants to respond by posing questions. In this case, WR1 invites other participants to indicate recognition and provide descriptions of their experiences with dealing with the problem: "Er der andre i same siuation, og hvad har i gjort? (Are there others in the same situation, and what have you done?) (line 12). WR1 also poses the question "og kan det blive bedre?" (and can it become better?") (line 12). This way of formulating questions in a list in a specific order might reveal to us one of the purposes participants might have when they invite other participants to indicate recognition of personal experiences. Here, the order of the questions posed has to do with first establishing whether or not there are others with similar experiences. The next question makes relevant that participants who might have similar experiences not only indicate that they do so but also indicate what they have done in order to deal with the problems. The third question is in some sense ambiguous, but very informing as well. WR1 uses an indexical expression, "det" (it) ("og kan det blive bedre?" (and can it become better?") (line 12)). But what does "det" really refer to? Does it refer to WR1's current situation? Or does it refer to such a situation that more participants than WR1 might indicate to be in or have been in? The questions WR1 have lined up seems to suggest that WR1 might be writing the posting in order to get insight about what she can expect of her own current situation by collecting descriptions of the outcome of similar situations. It can be noted that WR1 seems to be particularly concerned with experiences with a positive outcome (rather than asking something like "what can I expect?", WR1 poses the question "and can it become better?"). Revisiting the previous examples, we can notice that WR1 in example A1 and A4 only inquired about indications of recognition, however they also received responses doing more than that (apart from Example A5). In most cases participants understand it to be relevant to indicate their understandings of possible causes for problems and also about ways of dealing with it, when invited to indicate recognition of an experienced problem.

WR1 signs of with “Hilsen den fortvivlede” (Regards, the despaired) in line 14. Identifying as “the despaired” might be understood as a way for WR1 to show anticipation that other participants might interpret her actions provided in the 1st message as such.

WR1 describes her problem as a constant problem (line 5), and she constructs it as abnormal according to her young age. In example A1 and A4 the writers constructed their descriptions to demonstrate how particular categorized problems or symptoms were indication of personal experiences they related to a metabolic condition, and they invited others to share their experiences. In Example A7 WR1 invites to the sharing of experiences (see line 12), and she explicitly requests for responses that deal with what can be done, not with whether or not the problem could be acknowledged as a relevant problem in the forum.

The 1st message is responded to in the following way:

Example A8: 1st response, “Træthed kronisk?”:

WR2 Tilmeldt: 19-08-2008 11:30	Den 09-08-2010 19:00 **Re: Træthed kronisk?**

1 Hej..
2 Har du fået målt og du mangler B12 og evt d-vitamin??
3 Jeg har også lavt stofskifte og havde det præcis som dig, var træt hele tiden og følte
4 aldrig at jeg var frisk..
5
6 jeg var hos en læge på hamlet som fandt ud af at jeg manglede B12, jeg får det som
7 en sprøjte hver 3 måned men skal måske have det hver 2 måned og det er helt
8 fantastisk, nu er jeg frisk og har overskud igen..
9
10 Hilsen Xxxxx

English translation:

WR2 Joined: 19-08-2008 11:30	On 09-08-2010 19:00 **Re: Tiredness chronically?**

Hello..
Have you had measured and do you lack B12 and possibly vitamin D??
I also have hypothyroidism and felt exactly like you, was tired all the time and never felt that I was well ..

I was at a doctor at [name of hospital] who found out that I was low in B12, I get it as an injection every 3 months but may have to get it every 2 months and it is absolutely fantastic, now I'm well and have energy again ..

Greetings Xxxxx

Example A8 shows the first response to the 1st message provided in Example A7. The first response initiates with a greeting (“Hej..” (Hello ..) in line 1, which can be understand as a second pair part to the

greeting in the 1st message (see Example A7). In this case the first thing done is to suggest[37] the possibility of specific causes, B12 and vitamin D deficiency, by asking whether they have already been excluded.
WR2 provides a telling in which WR2 accounts for making B12 and vitamin D deficiency relevant as a cause. This telling can be understood as an account that deals with WR2's reasons for indicating vitamin-deficiency as a possible cause, because it sequentially follows right after WR2 having indicated vitamin-deficiency as a possible cause as the first thing after greeting, and thus, in a sense, as the topic (Example A8, line 2).
The work of accounting is done by first identifying as a person suffering from hypothyroidism and acknowledging and displaying recognition of the problem WR1 experiences: "Jeg har også lavt stofskifte og havde det præcis som dig, var træt hele tiden og følte aldrig at jeg var frisk.." (I also have hypothyroidism and felt exactly like you, was tired all the time and never felt that I was well ..) (line 3-4). Then she provides a description that she dealt with her problem by consulting a doctor who discovered that WR2 suffered from B12-deficiency (line 6), and that the solution in her case was regular injections. WR2 assesses the outcome as "helt fantastisk" (absolutely fantastic) and provides a description of her present state as "nu er jeg frisk og har overskud igen.." (now I'm well and have energy again ..) (line 8). The first response ends with a closing in line 10. Notice how nicely WR2's actions in line 3-8 are fitted to the actions made relevant in the first posting written by WR1. Revisiting the first posting in Example A7 we can see that indicating recognition of WR1's problem, indicating actions that had been pursued to deal with the problem, and indicating whether it could become better was exactly the three inquiries indicated by WR1 in that order (Example A7 line 12).
The explanation for WR1's problems, lack of B12 and possibly vitamin D, suggested by WR2 is new, i.e. has not been mentioned by WR1. As WR2 demonstrates in her response, however, this suggestion meets the criteria made relevant in WR1's first message, in which WR1 indicates that she is not able to make sense of why she should experience fatigue. WR2 demonstrates that her suggest would fit the criteria made relevant by WR1 by indicating that she does have similar experiences as WR1, that she acted on the problem by consulting a doctor who discovered that she suffered from vitamin B12 deficiency, and that she is now better.

6.1.3.5 Questioning metabolism as a relevant category based on knowledge

We just looked at a response, Example A8, in which WR2 used the sharing of experiences, i.e. indicating recognition and demonstrating having personal experience with a problem by telling about them, to account for indicating a specific possible cause WR1 could investigate in order to deal with her problem. Hence, the sharing of experiences was not used to acknowledge someone's experiences as possibly being caused by the metabolism per se, which we saw in example A1-A3, and A4-A6. In the Examples shown in Example A7-A8, questioning or acknowledging the relevance of whether the problem described could be understood as metabolic in nature was not an issue per se but rather WR1's metabolic diagnosis was

[37] The respondent, WR2, does not initiate with any kind of indications of recognition, which we have seen in the previous examples (Example A2, A5 and A6). WR2 formulates a request for information as the first thing after greeting; "Har du fået målt og du mangler B12 og evt d-vitamin??" (Have you had measured and do you lack B12 and possibly vitamin D??) (line 2). This might be understood as a "pre-". When something is recognizably "pre-" it is preliminary to something else, which often is quite specific; a first pair part of a particular pair type (Schegloff 2007c:28)). Here the action may be understood as a pre-suggestion, and thus work to project a suggestion to check whether the vitamins B12 and vitamin D are low, if she has not done that already. This pre-suggestion also indicates an understanding that lack of vitamins may be the cause for WR1's problems with tiredness.

indicated before announcing an experienced problem allowing respondents to suggest possible specific connections between the diagnosis and the problem or not.

In the next example it is questioned whether metabolism is the underlying cause for some trouble in the 1st posting. This is an example of how participants who initiate threads may problematize metabolism as causal explanation.
The 1st posting in the thread "Træt efter måltider !" (Tired after meals !), Example A9, and it's first response, Example A10, shows a case in which metabolism as a relevant category is questioned in the 1st message and how this is dealt with in the first response:

Example A9: 1st posting, "Træt efter måltider !":

WR1 Tilmeldt: 12-01-2011 18:04	Den 12-01-2011 19:13 **Træt efter måltider !**	

1 Hej.
2
3 Jeg aner ikke om det her har noget med ens stofskifte af gøre, men synes det var
4 det som lød nærmest.
5 Men det seneste stykke tid er jeg blevet ualmindelig træt efter at have spist (Frokost
6 / Aftensmad).
7 Jeg bliver så udmattet at jeg ikke ved hvad jeg skal gøre af mig selv.
8 Ligge ned, sidde ned, gå rundt, bliver næsten forvirret af så udmattet jeg bliver. Får
9 også kvalme efter måltiderne.
10 Er der nogen som ved hvad det kan skyldes ?
11
12 Tak på forhånd ..
13
14 Vh Xxx

English translation:

WR1 Joined: 12-01-2011 18:04	On 12-01-2011 19:13 **Tired after meals !**	

Hi.

I have no idea whether this has something to do with one's metabolism, but it seems
it was what sounded closest.
But lately I have become unusually tired after eating (Lunch / Dinner).
I get so exhausted that I did not know what to do with myself.
Lie down, sit down, walk around, almost become confused by becoming so
exhausted. Also get nausea after meals.
Is there anyone who knows what it may be due to?

Thanks in advance ..

Regards Xxx

The 1st message with the title “Træt efter måltider !” (Tired after meals !) provided in Example A9 initiates with a greeting (“Hej.” (Hi.), line 1). In line 3-4 WR1 disclaims knowledge about whether “det her” (this), (i.e. his problem which he implicitly announces an unfolding of by using the indexical expression “det her” to which no obvious referent can be expected to be recognizable to readers) is connected with the metabolism. However, WR1 indicates that metabolism was the category (of which he could choose from) that seemed most relevant (“men synes det var det som lød nærmest“ (but it seems it was what sounded closest)). Hence, WR1 indicates that he has, based on a subjective estimate, chosen metabolism as the most relevant category, and that other categories (i.e. causes) might turn out to be more relevant.

A problem is indicated in a telling in line 5-9. The problem, as indicated in the title, is that WR1 has lately felt unusually tired after eating meals. He unfolds the problem in terms how it is experienced (“Jeg bliver så udmattet at jeg ikke ved hvad jeg skal gøre af mig selv. Ligge ned, sidde ned, gå rundt, bliver næsten forvirret af så udmattet jeg bliver. Får også kvalme efter måltiderne.” (I get so exhausted that I did not know what to do with myself. Lie down, sit down, walk around, almost become confused by becoming so exhausted. Also get nausea after meals.) (line 7-9)). A similar design of how problems were announced and how experience with the problem was demonstrated was found in the other 1st messages shown in this chapter (see Example A1, A4, A7).

Similar to previous first postings shown (Example A1, line 3-4 and line 7, Example A4, line 6, and to some extend Example A7 line 12), WR1 invites to action on the part of respondents by posing a question. In this case, WR1 requests for information about causes for his problem: “Er der nogen som ved hvad det kan skyldes ?” (Is there anyone who knows what it may be due to?) (line 10). The request is posed as a yes/no interrogative requesting for participants to provide their knowledge of causes. The formulation used here differs from the invitations to respond we have seen so far in that what is requested for here is information, or knowledge, about causes, and not indications of recognition of experiences. Sacks (1992d) makes an interesting observation about the distinction between knowledge and experience. He suggests that people in ordinary interaction may treat knowledge and experience differently in interaction. As mentioned above, Sacks has suggested a “search procedure” people use when telling stories in interaction, namely that the recipient of a first story often chooses to tell second stories in which his or her role in the telling is similar to the role the teller of the first story had in the story. Failure to do this, Sacks notes, may imply to participants in interaction that the recipient of the first story does not have similar experiences to tell. Sacks notes that an indication of knowledge apparently does not suffice as a return to a first story. He mentions the following example: “Suppose, for example, your buddy tells you a story about how he went out last night and got laid. Then it’s apparently not a sufficient return to tell about how some other friend of yours did the same” (Sacks 1992d:782).

In the question formulation in Example A9, line 10, an assumption that metabolism is the cause for WR1’s problems is not embedded in the same sense as it is in questions that invite to indications of recognition. Rather than making it relevant that respondents deal with the problem as a possible metabolic problem, WR1 asks an open question. Furthermore, WR1 asks for respondents to indicate knowledge, not experiences. The distinction that seems to be made relevant here is that people may know about causes for problems, which they do not have personal experiences with. Hence, it is not implied as an assumption that only participants suffering from tiredness after meals could contribute with relevant responses. Furthermore, he makes it relevant that people (who may experience metabolic problems) who may have

knowledge of possible causes for WR1's problems, not related to metabolic conditions, to indicate this knowledge.

In line 12 WR1 expresses his gratitude, and in line 14 he closes with regards.

In the 1st message shown in Example A9 WR1, in contrast to the previous examples shown of 1st messages in this chapter, expresses uncertainty as to whether metabolism is a relevant category under which to understand and with which to categorize his experienced problem. In the request which is posed in the 1st message, WR1 does not indicate an anticipation that other forum participants might provide similar stories about their *experiences*, but instead he requests for their expertise in terms of *knowledge* about potential causes for his problems, which does not necessarily require personal experience.

In the first response to the 1st posting in Example A9, Example A10, WR2 initiates with an acknowledgement – and demonstration - of recognition and then indicates knowledge:

Example A10: 1st response, "Træt efter måltider !":

WR1 Tilmeldt: 11-01-2011 16:50	Den 12-01-2011 19:57 **Re: Træt efter måltider !**	

1 Kender det alt for godt!! Fryser endda også, får iskolde fingre og min næse bliver en
2 istap.
3
4 Men har dog fornylig hørt at:
5
6 Sukker eller kulhydrater gør os døsige og åndsfraværende, hvilket skyldes, at disse
7 fødevarer påvirker dannelsen af serotonin, som er en søvnfremkaldende
8 neurotransmitter. Selv en kop te eller kaffe med sukker vil have den effekt.
9
10 Det siges derfor at, hvis du indtager protein samtidig - fx lidt mælk i din te/kaffe –
11 så kan det neutralisere sukkerets søvndyssende effekt.
12
13 Så husk lidt protein fx. kød eller fisk til pastaen, lidt tun eller ost på det hvide brød,
14 mælk til kiksen osv. Især til frokost - så kan du måske gemme indtagelsen af de
15 mange kulhydrater til om aftenen, hvor du formentlig alligevel skal i seng og sove
16 snart.
17
18 Gode kilder til protein er kød, fisk, æg, sojabønner, bælgplanter og
19 fuldkornsprodukter.
20
21 Men måske er du syg, så få lige lægen til at tjekke dig..
22
23 Held og lykke!

English translation:

WR2	On 12-01-2011 19:57
Joined: 11-01-2011 16:50	**Re: Tired after meals !**

I know it all too well! Am even cold, get icy fingers and my nose is an icicle.

But have recently heard that:

Sugar or carbohydrates make us drowsy and distracted, which is because these foods affect the formation of serotonin, a sleep-inducing neurotransmitter. Even a cup of tea or coffee with sugar will have that effect.

It is said, therefore, that if you consume protein at the same time - for example, a little milk in your tea / coffee - it can neutralize the soporific effect of the sugar.

So remember a little protein, for example meat or fish with the pasta, a little tuna or cheese on the white bread, milk with the biscuit etc. Especially for lunch - so you might save the intake of carbohydrates for the evening, where you will probably are going to bed and sleep soon anyway.

Good sources of protein are meat, fish, eggs, soy beans, legumes and whole grains.

But maybe you're sick, so you better get the doctor to check you ..

Good luck!

In the first response in Example A10, WR2 orients to it as relevant to acknowledge recognition of WR1's described problem, "Kender det alt for godt!! " (I know it all too well!), and to demonstrate how she experiences the problem herself: "Fryser endda også, får iskolde fingre og min næse bliver en istap" (Am even cold, get icy fingers and my nose is an icicle). In line 4 she announces that information (categorized as having the character of information that can be passed on, i.e. implicitly categorized as knowledge as opposed to experience) will follow that contrasts (indicated with the conjunction "Men" (But) in line 4) with the action she has just made relevant, that is, identifying with the problem. In line 6-8 nutrition as a cause of WR1's problem is suggested by providing descriptions (constructed as general facts) of how certain nutrient sources have sleep-inducing effects (line 8). In line 10-18 WR2 provides suggestions (i.e. advice (see chapter 6.3)) as to how WR1 can eat accordingly to that knowledge. In line 19 WR2 contrasts this with a statement that indicates that the possibility that WR1 is sick should not be excluded, and that he should see a doctor (suggestions to see a health professional is very common in the forum, see chapter 6.3).
Hence, WR2 displays an understanding that her suggestion as to the causes of WR1's problems (and the advice that is displayed as being in accordance with the suggested cause) should be understood as a suggestion or one possibility, not as a the only possibility, that is, it should not be understood as telling WR1 what the cause for his experienced problem is (see chapter 6.2).
In Example A10 we see that acknowledgement and identification of recognition of an experienced problem is oriented to as relevant to do first in the first response. We also see that identifying with the problem is contrasted with a suggestion based on knowledge that the cause for the experienced problem might be caused by something not related to a metabolic condition. Indication of recognition, then, is oriented to as accomplishing to recognize the problem as a problem and to acknowlegde the relevance of bringing up a specific problem in the forum. In this case, work is done in order to show that the display of recognition should not be understood as implying an acknowledgement of the problem as a metabolic problem.

6.1.4 Conclusion

This chapter started out with pointing to the complexity of postings. Various actions such as greetings, closings, problem descriptions and invitations to respond is organized in a text, which is posted as a unit in a thread. Each thread has been given a title by the writer of the first posting in the thread.
I presented examples from 4 different threads in order to point to a phenomenon that postings recurrently deal with, namely "sharing experiences".

I showed examples of first postings (Example A1 and A4) in which participants, who had indicate a suffering from a metabolic condition indicated (in the title or in the text) indicated suffering from a yet unexplained problem categorized as specific types of pain or disturbances in the body. Participants invited respondents to indicate recognition of a specific bodily experience, understood to be yet unexplained.
Hence, the first postings entail a) indications of bodily experiences and b) invitations to indicate recognition.
Overwhelmingly, such postings are responded to with c) an acknowledgement and d) a demonstration of recognition. By drawing on responses to these first postings (Example A2-A3 and A5-A6) I showed how postings which indicate bodily experiences and invite to indication of recognition make particular understandings and, thus, responses relevant. Responses to postings in which an unexplained problem is indicated and in which indication of recognition is invited to recurrently are initiated by acknowledging recognition. The unexplained problems indicated by WR1 are recurrently referred to by using the same (medical) categories as WR1 and/or by referring to them as symptoms. Acknowledging recognition might be understood as a sufficient response to the invitation to indicating recognition. Such an understanding was displayed in the response in Example A5. Overwhelmingly, however, respondents proceed to demonstrate *how* they recognize indicated problems. They indicate personal bodily experiences and also indicate medical information and/or diagnoses they have. When "shared experiences" – and similar diagnoses - have been established, participants recurrently understand the next step in the interaction to be sharing views on possible causes for the unexplained problems and experiences with medical treatment.

Indicating problems by telling about how they are experienced, and demonstrating recognition by indicating how they are experienced does not simply mean to exchange stories about experiences with bodily pain and disturbances. Participants indicate various medical categories including metabolic diagnoses, and they make it relevant that respondents deal with these categories.

Participants who indicate recognition of experiences acknowledge recognition and recurrently also tell about their experiences by constructing so-called second stories (Arminen 2004; Sacks 1992b). They construct these stories as similar to the experiences told in a previous posting, and thereby indicate understanding of that posting (See Sacks 1992b:768).
Furthermore, as participants overwhelmingly proceed after having "shared experiences" to exchanging views on possible causes and bodily as well as social experiences with treatment (such as descriptions of interactions with health professionals about treatment options), we can see that the activity of sharing experiences has an important function for forum participants. Forum participants orient to establishing specific shared experiences and a shared understanding of particular experienced problems before making it relevant to discuss issues related to how to understand and eventually treat yet unexplained problems.

The shared understanding which is established among participants is that specific bodily experiences correlate with specific metabolic conditions or metabolic treatment.

The activity of establishing shared experiences does not always have the purpose or outcome of establishing a shared understanding that a yet unexplained problem is correlated with a metabolic condition or treatment.
I showed examples from two threads in which "sharing experiences" was done differently and with another function. In Example A7-A8 WR1 organized her first posting to indicate that her main concern was with the experience of a problem, fatigue, and how to act on it, not establishing whether or it was connected to the metabolic diagnosis she had. The response she got differed in structure from the other responses shown previously. It highly oriented to the actions made relevant in the first posting, but it was organized to suggest a specific cause (B12 and vitamin D deficiency), and show how this suggestion could match the information and actions provided by WR1. Shared experiences were used in that process. In the final sequence shown, Example A9-A10, I showed how WR1 in the first posting questioned "metabolism" as a relevant category to explain his problem, when introducing it. In that case rather that inviting to indications of recognition, indications of knowledge of what could cause his problem was invited to, not restricting the possible causes to problems related to metabolism.
The responses shown in this chapter point to the fact that participants not only orient to the sequential organization of first postings when they respond. They also orient to the details provided in previous postings to which they respond. Participants orient to question formulations when responding, but are also highly attentive to the details provided in problem descriptions. This was pointed out in terms of how participants indicated recognition, as they indicated recognition of experiences by using similar categories and by demonstrating experiences that were constructed as recognizably similar to the experiences told in first messages.

6.1.5 Discussion

Investigating a public online forum on a health website with a pre-established topic, metabolism, in terms of how participants accomplish action collaboratively in them, informs us about participants' perspectives and understandings about bodily and social experiences with health problems and possible ways to deal with them.

As this chapter has pointed to, the forum is used to share experiences about yet unexplained problems. Participants indicate experiences with bodily pain or disturbances which they describe and categorize. They invite others to indicate recognition, which is overwhelmingly done by acknowledging recognition and demonstrating recognition by telling about similar bodily experiences.

This activity has specific functions in the forum. Arminen's study of AA-meetings (2004) shows that participants at AA-meetings by telling "second stories" accomplish to establish that they have similar experiences. Wootton (1977) pointed to something similar in his study of therapy; establishing similarity is an interactional accomplishment. Veen and te Molder (2010) in a study of an online forum on celiac disease (a disorder of the small intestine caused by abnormal gluten proteins) also focused on the use of second stories, and showed that second stories in their material was used to negotiate understandings, not

about what celiac disease means, but on how to follow the recommended diet when suffering from celiac disease.

Veen and te Molder point to how the activity of telling second stories, i.e. telling similar stories in a series, in their material not only establishes that participants have similar bodily and social experiences and negotiate understandings, but that this process had a specific outcome: "[T]he abundance of similar second stories establish their account of the diet as the dominant one" (2010:36).

In this investigation I pointed to something of a similar sort, namely that participants not only accomplish to establish that they have similar experiences, but also accomplish to make a shared characterization of specific unexplained problems.

Apart from having functions that can be compared with functions described in AA-meetings (Arminen 2004) and another online forum on health (Veen & te Molder 2010), in the forum the accomplishment of sharing of experiences has a specific purpose, which participants orient to. I pointed to the fact that in cases in which shared experiences was acknowledged and demonstrated by telling details about them, participants often continue to exchange perceived correlations between metabolic disorders explicitly and bodily and social experiences with treatment, also in cases in which only indications of recognition has been made relevant through questions.

This organization of activities in postings shows how participants take (the details of) their own and others' experiences seriously when dealing with yet unexplained problems with other non-professionals in a forum. This supports the challenge made by Stommels and Koole (2010) based on an investigation of an online support group on eating disorders based on CA and MCA (see section 3) of a general assumption that online support groups are seen low-threshold services. In fact, when investigating members' practices, we see how members of online groups negotiate the social norms of what counts as bodily experiences related to metabolism, including how to describe, categorize and understand bodily experiences.

In this forum participants indicate particular categories when describing problems. This includes medical diagnoses, medical information, descriptions and categorizations of bodily experiences and possible experienced correlations between them. Participants treat the sharing of experiences as a possibility for understanding their own yet unexplained problems.

These conclusions and implications are based on an investigation of how people actually use the resources available to them in an online forum. This includes the resources of written language that are organized in complex postings constrained and made possible by the affordances of the medium. As noted, such resources are increasingly used by citizens to deal with health issues and such activities are predicted to have big possibilities in the attempts to develop healthcare (see section 2.1).

The findings in this investigation are based on investigations of how participants themselves construct and accomplish activities and by pointing to and using the categories that participants themselves use and orient to as relevant. Hence, the categories are participants' categories, which indicate their understanding of their problems and their possibilities for action. Hence, the categories are not generated from interviews based on researchers' pre-established questions and categories, i.e. from what researchers anticipate is relevant in order to understand and describe this type of health issues. With such an approach the danger is that researchers might overlook participants' understandings and perspectives. Insight about

participants' understandings and perspectives are crucial in order for health services to provide relevant and useful care and treatment for participants, i.e. patients.

Furthermore, the phenomenon described in this chapter, "sharing experiences" is described as a social activity on the basis of sequences in which this occurs as something participants do in collaboration. The phenomenon is described in terms of how participants do it, what participants accomplish with it and in terms of what this accomplishment of this activity makes relevant for participants. This focus on the sequential organization of resources as a resource reveals important insight that other methods in social sciences and humanities focusing mainly on content, such as for example content analysis (Stemler 2001) does not bring into analysis.

6.2. Explaining illness: Diagnosing descriptions of problems

6.2.1 Introduction

In the data I present in this chapter participants, as in the previous chapter, indicate or imply bodily experiences with health problems. Further, as we will see, participants make use of resources and orient to membership categories which have been described in chapter 6.1.

For one, the sequential organization of the postings in this chapter resembles the structure that has already been described. Postings shown in this chapter also have a complex structure and accomplish various action. Participants for example also categorize themselves and the intended recipients for their postings, and use questions to make specific types of understandings and responses relevant. Hence, this chapter further demonstrates how participants orient to membership categories.

This chapter, though, addresses the issue of how postings about causes for experienced problems is occasioned, invited to and dealt with by participants. Hence, this chapter investigates threads in which causes for problems are dealt with as the primary concern, or topic. Specific methods, in particular specific ways of presenting problems, orientations to specific categories and specific question formats participants make use of within the possibilities that the forum affords will be outlined.

Sacks (1992a) in a lecture addressed the issue of topic as a phenomenon. He stated that the interest for him, when dealing with topics, was not content considerations per se, but the accomplishment of "doing topical talk" (Sacks 1992a:753). Schegloff (1990) makes the case that sequence organization is analytically distinct from the notion of topic. He argues and shows that participants in talk-in-interaction orient to constructing and finding coherence. In doing so sequence organization is oriented to as a source. Topic, however, is more vulnerable as a resource for finding coherence in talk, for example because determining "what the topic is" may be negotiated at any time (also see a list og six arguments that the notion of "topic" as an analytical tool is problematic in Schegloff (1990: 51 f.).
Acknowledging these points, in this chapter it will be outlined how participants accomplish to indicate causes for problems as the topic that respondents should take as the topic to deal with, and it will be pointed out how respondents show that they deal with causes for problems on the basis of what has been made relevant in 1st postings.

This chapter provides four excerpts with 1st postings (Example B1, B3, B5, and B7) in which WR1 indicate as a concern to establish a cause for experienced problems. Ways this is done will be pointed to in the analyses. Furthermore, analyses will outline practices in 1st postings that project action on recipients' part. The first responses to the 1st postings are also provided and analyzed (Example B2, B4, B6, and B8). The analyses of the first responses focus on how respondents indicate their understandings of the actions in the 1st postings and how they treat these actions. As the analysis shows, respondents orient to the details in the 1st postings when they respond, and a pattern can be pointed to in terms of how 1st postings are constructed and responded to. In particular it will be noticed how participants orient to and treat indications of medical information when they construct responses. This type of information seems to be crucial for how respondents treat 1st postings, i.e. whether they treat the problems indicated by WR1 as a

candidate of problems caused by a metabolic disorder, or whether they treat it as a candidate of medical problems which should be investigated further by medical professionals. When analyzing participants' practices then, we see that they in fact in a sense diagnose descriptions based on the type of indications provided in such descriptions. However they do not establish a final medical diagnosis based on other participants' indicated problems. Other postings in which participants deal with causes for illness and orient to medical categories as described and analyzed here can be found in the appendix (Example BB1-BB9).

6.2.2 Dealing with diagnoses in medical encounters

In Denmark, the institution that we usually turn to when we experience a health problem and we want to know what caused it and how we can treat it, is the health care system (Ministeriet for Sundhed og Forebyggelse 2008). In fact, in postings on the topic metabolism, participants frequently refer to visits at the doctor (in all postings provided in this chapter involvement of medical professionals in the process of finding a cause for problems and/or treating problems is either indicated or implied). As we will see, participants display an understanding that their experienced problems are medical in nature, and recurrently metabolism is indicated as a candidate diagnosis. However, participants do not indicate an expectation that interacting in the forum will provide them with a final diagnosis or with medical treatment recommendations. Rather, indications of personal experiences with specific problems are indicated and used as a resource and method for investigating hypotheses about possible causes "empirically".
Although the setting of doctor-patient or provider-patient interaction is different from online discussions between lay people, and although participants have different resources available to them in face-to-face communication and in online discussions respectively, I will shortly mention some of the significant conversation analytic studies of doctor patient interaction, which are concerned with outlining patients' strategies for presenting their problem and explaining their illness. These findings, and their implications, are used as an analytic resource for this study in order to understand participants' practices for presenting problems, constructed as being medical problems, and explaining illness in online discussions in which they interact with other lay persons.
A wide number of studies have been carried out to investigate doctor-patient interaction in a conversation analytic framework. This has resulted in a number of collections (for example Heritage and Maynard 2006; Pilnick et al. 2010), and in a number of analytical findings in terms of fundamental organizational features and interactional processes within medical encounters (Heritage and Maynard 2006b:14). A body of conversation analytical studies have investigated patients' practices for presenting problems (for example Heritage and Robinson 2006; Stivers 2002) and patients' explanations for illness (for example Gill 1998; Peräkylä 2006; ten Have 2001).

Heritage and Robinson (2006) describe recurrent practices patients use to describe problems, and they suggest that the practices are bound up with concerns to justify the visit at the doctor (in acute primary care interactions). Stivers (2002) focuses on a particular aspect of problem presentation; she outlines two practices that are used by parents to present childrens' problems to their paediatricians in acute care encounters; one practice, which she calls "symptoms-only problem presentations" and another practice, which she calls "candidate diagnosis presentations". Stivers suggests that the two practices imply a

difference in stance towards the doctorability[38] and treatability of the child's problem. In cases, in which parents only present symptoms, parents display a concern to seek an evaluation, whereas in cases in which parents mention candidate diagnoses, parents display a concern to get a medical judgement and they adopt a stance that medical treatment (overwhelmingly antibiotics) is needed.

Stivers shows that doctors treat symptoms-only problems presentations as making relevant an investigation of the child's problem, whereas doctors treat candidate diagnosis presentations as inviting to uptake in terms of confirmation or disconfirmation (2002: 331). The findings of this study, thus, imply that the particular practices patients employ when they present a problem is consequential for how it is treated.

Gill's (1998) investigation of patients' practices for explaining illness in an outpatient general internal medicine clinic also points at a pattern between patients' practices for offering explanations for health problems and doctors' responses; Gill shows that patients typically downplay their knowledge when they offer explanations for their health problems, and that this practice of exhibiting "tentativeness and uncertainty about the knowledge they are displaying in their explanations […] also tentatively invite doctor's assessments" (1998:356). On the other hand when patients display certainty about relevant explanations they are constructed in ways that do not restrict the doctors to respond to that by evaluating the action as a suggestion.

In sum, Stivers' (2002) and Gills' (1998) investigations point at the sensitivity participants display to entitlements to knowledge, and they also point at the importance of investigating participants' social practices in medical encounters in order to understand the communicational processes and the outcome of doctor-patient interaction.

The findings of these studies have great resemblance to the analytical points I will make in this chapter. First and foremost, participants initiating threads that are constructed to be about causes for illness have various ways for doing that. However, the methods they use can be seen to guide how participants deal with the topic of causes for problems. Secondly, the analyses of this data also show that participants display sensitivity to entitlements to knowledge. When they address issues of finding causes for experienced problems they do so by inquiring about "possible" causes for experienced problems instead of for example implying an expectation that forum participants can establish a final diagnosis, and they project indications of personal experiences as relevant knowledge respondents could provide, not medical knowledge, information or medical assessments or judgements as such.

6.2.3 Dealing with moral issues in relation to health in online discussions

Another set of relevant studies is research conducted on social practices in various online forums on health issues from a discursive psychological perspective. These studies provide this study with important insight on a general level (see section 4.2 for a review of studies conducted on online forums from a discursive psychological perspective).

Hedwig te Molder and her colleagues have dealt with accountability in online discussions of health issues such as veganism (Sneijder & te Molder 2004; Sneijder & te Molder 2005), celiac disease (Veen et al. 2010) and depression (Lamerichs and te Molder 2003).

[38] Heritage and Robinson (2006:58) describe a doctorable problem for patients from the outset of a medical visit as a problem "…worthy of medical attention, worthy of evaluation as a potentially significant medical condition and worthy of advice and, where necessary, medical treatment".

These studies point out how specific linguistic constructions (for example modal constructions and conditional structures) work to deal with moral issues.
Sneijder and te Molder (2005) for example note in a study on online discourse on veganism that the use of modals in the "then" part of a "if-then" structure presents the inference as less robust than if a declarative had been used, and they show that participants use constructions with a combination of "if-then" structures and modals to indicate an understanding that health problems are "sequentially and logically connected to particular individual practices", and thus not to veganism as such (2005: 692). Sneijder and te Molder in another paper (2004) present various related practices that participants from the same corpus of interactions in online discussions on veganism use to ascribe responsibility for health problems like vitamin deficiency to individual recipients.
As noted in the previous chapter, Veen et al. (2010) point at how participants' interpretations of a person's experiences of following a particular diet are negotiated in a posting and its responses. They suggest that "second stories" are used in the forum not only to achieve the establishment of identification, recognition, and membership, but to establish and negotiate what membership amounts to in the forum (for further points on how participants orient to characterizing what membership consists of in the forum though their use of indications of personal experiences, see chapter 6.1 and chapter 6.4 in this thesis). Similarly, the pattern found in this data is that indications of bodily xperiences are in fact used to characterize metabolic disorders, for example by listing and characterizing the typical and recurrent bodily experiences that participants with metabolic disorders have.

6.2.4 Analysis

6.2.4.1 Validating inquiries about possible connections with indications of personal experiences

Participants, who experience problems that have not yet been explained and have not yet been diagnosed, use the forum to deal with that. In particular participants inquire about possible connections between the experience of specific problems and metabolic disorders. One of the ways this is done can be seen in Example B1, a 1st posting with the title "Unrest/sweating ???":

Example B1: 1st posting, "Uro/svedture ???"

WR1 Tilmeldt: 02-08-2008 21:37	Den 17-11-2009 10:52 **Uro/svedture ???**	

1 Mit spørgsmål lyder kort og godt - kan man ha meget uro i kroppen, stive/spændte
2 muskler og svedture hvis stofskiftet ligger i den lave ende ??
3 Kh XX

English translation:

WR1 Joined: 02-08-2008 21:37	On 17-11-2009 10:52 **Unrest/sweating ???**	

My question is short and sweet – can one have a lot of unrest in the body, stiff/tense muscles and sweating if the metabolism is at the low end ??
Kind regards, XX

Example B1 shows a 1st posting with the title "Uro/svedture ??? (Unrest/sweating ???). The title indicates two categories. Both categories, unrest and sweating, point to bodily experiences. The slash put between the two categories may indicate that the bodily experiences indicated should be understood as alternatives, or it may indicate that both categories are – potentially - relevant. The question marks work to question something about the categories (either to question whether the categories chosen are appropriate, to inquire about which of the two categories to use, to inquire about how to understand the categories, or to inquire about what to do when one experiences unrest and/or sweating). WR1 uses not one question mark, but three. This is a non-standardized use of punctuation marks, and the repetitions of the question mark may have a rhetorical function such as indicating emotional involvement or stance. From merely reading the title several interpretations of how the title should be understood are possible, but either way the categories that have been indicated are understandable as referring to bodily experiences.

The text consists of only three lines. However, the text informs us about how the title should be understood; WR1 provides a formulation that she is posing a question, short and sweet. The question is then formulated after a dash as: "kan man ha meget uro i kroppen, stive/spændte muskler og svedture hvis stofskiftet ligger i den lave ende ??" (can one have a lot of unrest in the body, stiff/tense muscles and sweating if the metabolism is at the low end ??), (line 1-2). This is followed by a closing in line 3. The question is formulated by using a version of an "if X, then Y" construction (Sneijder & te Molder 2005), that is, a conditional formulation. Sneijder & te Molder note that "conditional structures such as these can be used to describe circumstances or activities as having particular consequences" (2005:682). The conditional element in this example, "hvis stofskiftet ligger i den lave ende ??" (if the metabolism is at the low end), indicates the condition as being low metabolism, or metabolism at the low end. The "then"-clause, "kan man ha meget uro i kroppen, stive/spændte muskler og svedture" (can one have much unrest in the body, stiff/tense muscles and sweating), entails a list of three elements (Jefferson 1991) readable as all pointing to uncomfortable bodily reactions, or (candidate) symptoms. This question, thus, inquires about whether there is a possibility (this is indicated by the use of the modal verb "kan" (can)) that "man" (one) (that is, potentially not only the person asking) can experience ("ha" (have)) these bodily reactions based on the condition that a metabolism at the low end has been established. This question, then, can be read as a hypothetical question inquiring about the possibilities that specific bodily experiences and metabolism at the low end could correlate.

WR1 does not explicitly state that the bodily experiences she indicates refer to experiences that she has. In the first response in Example B2 WR2 in fact initially answers the question WR1 posed in a format that treats it as possibly hypothetical:

Example B2: First response, "Uro/svedture ???:

WR2 Tilmeldt: 12-06-2008 12:07	Den 17-11-2009 12:28 **Re: Uro/svedture ???**	

1 Hej Xxxxx.
2 Jeg har lige læst dit indlæg, og kan bekræfte dig i ,at man godt kan have
3 alle de symptomer du beskriver til for lavt stofskifte.
4 Da jeg fik for lavt stofskifte svede jeg meget og havde også meget stive
5 muskler og led hvilket jeg stadig har trods behandling.Jeg oplevede også,
6 uro i kroppen,jeg er meget generet af at min krop er tit meget oppustet og
7 især maven er det noget du har prøvet ?
8 Venlig Hilsen XX.

English translation:

WR2 Joined: 12-06-2008 12:07	On 17-11-2009 12:28 **Re: Unrest/sweating ???**	

Hello Xxxxx.
I just read your posting and can confirm that one may well have
all the symptoms you describe at low metabolism.
When I first got low metabolism I was sweating very much and also had very stiff
muscles and joints which I still have, despite treatment. I also experienced
unrest in the body, I am very bothered by my body being very bloated often and
especially the stomach, is it something you have tried?
Best Regards XX.

In the first response in Example B2, WR2 initiates by greeting WR1 personally ("Hej Xxxxx" (Hello Xxxxx) (line 1)). We may simply notice that WR1 in the 1st posting did not initiate by greeting. WR2 then indicates having just read WR1's posting and provides what she categorizes as a confirmation: "Jeg har lige læst dit indlæg, og kan bekræfte dig i ,at man godt kan have alle de symptomer du beskriver til for lavt stofskifte. (I just read your posting and can confirm that one may well have all the symptoms you describe at low metabolism) (line 2-3). By describing courses of action in this way WR2 indicates reacting upon reading WR1's posting with the provision of a confirmation; she indicates a confirmation as the relevant thing to do in a response to WR1's posting. The confirmation is formulated by referring to terms and categories used in WR1's posting in which she inquires about the possibility for whether specific symptoms may be connected to metabolism at the low end. In the 1st posting WR1 used the pronoun one to refer to the agent of the question (Example B1, line 1). Similarly, WR2 uses "man" (one) in her confirmation (Example B2, line 2). Furthermore WR2 refers to symptoms by indicating explicitly that the symptoms she refers to are the ones WR1 described: "alle de symptomer du beskriver" (all the symptoms you describe) (Example B2, line 2-3). By doing this, using the same categories as WR1 did in her inquiry when WR2 formulates a confirmation, she constructs what she is doing as a confirmation, and the issue she confirms is that it is possible, or even likely ("man godt kan have" (one may well have), line 2), to have the symptoms described by WR1 when metabolism is low.

As we have also seen in chapter 6.1 and as is overwhelmingly the case in these data, also in this case indications of personal experiences follow the confirmation from line 4. The personal experiences are indicated as courses of action following upon each other. This is done by using what we can call a "when-then"-construction. WR2 describes bodily experiences at the time when she first got the condition low metabolism, experiences she indicates still having despite treatment: "Da jeg fik for lavt stofskifte svede jeg meget og havde også meget stive muskler og led hvilket jeg stadig har trods behandling." (When I first got low metabolism I was sweating very much and also had very stiff muscles and joints which I still have, despite treatment.), (line 4-5). We can notice that the bodily experiences mentioned by WR2 have also been mentioned by WR1 in her posting. Here, in the response, however, WR1 indicates "bodily experiences" as personal bodily experiences. She tells a story about when the bodily experiences were noticed, she indicates the present situation, and she qualifies how much she experienced the bodily "symptoms" ("meget" (very)). Although WR2 refers to the same categories as WR1 in terms of bodily experiences here she does not refer to the experiences as "the same" as the ones mentioned by WR1. She indicates them as "her" experiences. Linguistically this is done by constructing utterances about what she ("Jeg" (I)) has experienced (which is indicated by the use of the verbs "fik" (got); "svede" (was sweating); "havde" (had); "har"(have); "oplevede" (experienced)", line 4-6). Here we can notice that WR2 treats it as relevant to indicate that she has personal bodily experiences as indicated by WR1 in a list as a response to WR1s inquiry about the possibility that the indicated bodily experiences could be present at a metabolism at the low end.

Also notice the order in which bodily experiences are indicated by WR2 compared to the order in which WR1 indicated experiences. WR2 in fact mentions the last bodily experience WR1 has indicated first in her response (sweating), then the second last (stiff muscles and joints), and then the first thing WR1 indicated (unrest in the body). The order, in which the categories are mentioned, then, is reversed. Furthermore, all three bodily experiences indicated by WR1 are mentioned by WR2 and treated as separate, distinct experiences she indicates to have had.

In line 6-7 WR2 indicates an experience that has not yet been mentioned: "jeg er meget generet af at min krop er tit meget oppustet og især maven" (I am very bothered by my body being very bloated often and especially the stomach). The experience is described as a bother, i.e. as a problem, it is qualified ("meget" (very)) and it is specified that the experience concerns the stomach especially. WR2 then requests for indications of whether WR1 (or possibly other readers) has tried it by posing a question: "er det noget du har prøvet ?" (is it something you have tried?) (line 7). Through this request she makes it a next relevant thing to do to 'talk' about (specific) personal bodily experiences instead of simply "bodily experiences".

In sum, WR2 indicates her experiences with bodily experiences (which had been categorized by WR1) after she has confirmed that a possibility exists that there is a correlation between the mentioned bodily experiences and a metabolism at the low end. Furthermore, WR2 adds bothersome experiences not mentioned by WR1, which she invites WR1 (and possibly others) to indicate recognition of. WR2 orients to the details in WR1's 1st posting by first treating WR1's question as possibly a hypothetical question. She treats it as relevant to indicate personal experiences as a way of demonstrating or proving grounds for providing a confirmation of WR1's inquiry. By doing this she shows that she understands WR1's posting to inquire about whether WR1's personal experiences may be caused by a low metabolism, which she validates with a confirmation and then indications of personal experiences. This is different from the practices described in the previous chapter in which WR1's invited to the sharing of experiences. Responses

to such invitations are recurrently initiated with acknowledgements of recognition of personal experiences or demonstrations of personal experiences.

6.2.4.2 Acknowledging the existence of a problem and facilitating a diagnosing process

Inquiring about whether metabolism can be the cause for bodily experienced problems occurs recurrently in the forum. In the next example, Example B3, WR1 poses a request in the title that inquires about the possibility of whether WR1 can have a metabolic disorder, when her blood tests show numbers within the normal range. In the text WR1 describes her medical history including her symptoms and formulates what we can call an indirect question about whether someone in the forum can tell her whether the symptoms may be derived from the metabolism:

Example B3: 1st posting, "kan jeg have en stofskiftesygdom trods "normale tal"?":

WR1 Tilmeldt: 18-10-2010 09:44	Den 18-10-2010 11:03 **kan jeg have en stofskiftesygdom trods "normale tal"?**	

1 Hej Alle. Har tidligere i min ungdom fået konstatret en betændelse i kirtlen, som blev
2 behandlet med binyrebarkhormon. Journalen fra dengang findes ikke mere. Har
3 diagnosen Kronisk Trærhedssyndrom. Mine tal ligger indenfor normalen, men på et
4 tidspunkt var TSH lidt forhøjet, hvilket ikke skulle betyde noget, sidste gang lå den
5 på2.23.
6 Mine symptomer: Konstant træt, har overhovedet ingen energi, manglende kræfter i
7 arme og ben, mit syn er helt godnat, tørre øjne synsforstyrrelser, føler at jeg er
8 blevet meget dårlig til at huske og koncentrer mig, er stoppet i venstre side af
9 hovedet - ikke forkølet. bliver i perioder hæs. Føler at det strammer på halsen. Har
10 nattesved og hjertebanken. I det hele taget er jeg ikke helt mig selv mere.
11 venter på at få fortaget en scintigrafi af skjoldbryskkirtlen.
12 Har fået taget mange blodprøver, som viser normale værdier.
13 Jeg håber nogen kan fortælle mig om disse symptomer kan stamme fra stofskiftet?
14 Hilsen xxxxxx

English translation:

WR1 Joined: 18-10-2010 09:44	On 18-10-2010 11:03 **Can I have a metabolic disorder despite "normal numbers"?**	

Hi All. Have previously in my youth been diagnosed with an inflammation in the gland, which was treated with corticosteroids. Records from that time no longer exists. Have the diagnosis Chronic Fatigue Syndrome. My numbers are within the normal range, but at one time TSH was slightly elevated, which shouldn't mean anything, the last time was at 2.23.
My symptoms: Constantly tired, have no energy at all, lacked strength in arms and legs, my vision is completely bad, dry eyes, blurred vision, feel that I have become very bad at remembering and concentrating, is clogged in the left side of the head – do not have a cold. Become hoarse at times. Feel tension in my neck. Have night sweats and palpitations. On the whole, I'm not quite myself anymore.
Am waiting to have a scintigraphy of the thyroid carried out.
Have had many blood tests taken showing normal values.
I hope someone can tell me whether these symptoms may be derived from the metabolism?
Greetings xxxxxx

The overall structure of the text in Example B3 looks as follows: A greeting (line 1), indications of medical categories and information which may be understood as a summary of WR1's medical history (line 1-5), a problem description (line 6-10), indications of actions understood to be relevant to deal with the problem (line 11-12), and an indirect question (line 13). This overall structure is very recognizable and resembles the structure of postings found in the data. We can also briefly notice that the problems described by WR1 are referred to as symptoms, thereby indicating an understanding that there should be a medical cause for the problems.

As already noted, the 1st posting in this example, as the 1st posting in Example B1, inquires about whether specific experiences can be caused by the metabolism. We can notice that in both cases the writer uses question marks in the title, however whereas WR1 in Example B1 indicated bodily experiences followed by question marks ("Uro/svedture ???" (Unrest/sweating ???)), here, in the title in Example B3, WR1 has formulated a question: "kan jeg have en stofskiftesygdom trods "normale tal"?" (Can I have a metabolic disorder despite "normal numbers"?). In the formulation WR1 is pointed out as the person the question concerns ("jeg" (I)), and the use of the modal construction "kan…have" (can…have) points to the fact that WR1 inquires about whether it is possible that she suffers from a metabolic disorder, when her blood test numbers are normal. In this case the conjunction "trods" (despite) is used instead of an "if X, then Y construction" to point to possible correlations between states of affairs.

In the text in Example B3 there is an invitation for respondents to respond. The invitation is formulated as an indirect question in line 11-12 following, among other things, a problem description. We may notice how WR1 constructs her indirect question in terms of the actions she makes relevant for other forum participants to deal with or perform: "Jeg håber nogen kan fortælle mig om disse symptomer kan stamme fra stofskiftet?" (I hope someone can tell me whether these symptoms may be derived from the metabolism?). The question is formulated with a clause initiated with "om" (whether). This formulation makes a "yes" or "no" typed response the type-confirming one, and "yes" is implied as the preferred response (Raymond 2003:943). Similarly in Example B1 above WR1 had formulated a question in her text. The question was formulated by using modal constructions and formulating the question to make a "yes" or "no" typed response the type-confirming one. In such a construction a possibility could have been to use what we could call a "whether X or Y"-construction such as "I hope someone can tell me whether these symptoms may be derived from the metabolism or whether it may be derived from something else?". WR1 does not formulate the question in such a way. In the way she formulates her question she makes it relevant that participants deal with her problems as possibly caused by a metabolic disorder (despite normal blood tests). WR1 invites respondents to deal with her inbuilt candidate suggestion in terms of possibilities, indicated with the modal construction "kan stamme" (may be derived).
The text in Example B3 entails identifications in terms of certain medical categories and information and an unfolded problem description, which the text in Example B1 did not. In Example B3 as opposed to the 1st messages in Example B1 (and Example B8), WR1 does not indicate that she already has a metabolic diagnosis or in other ways accounts for why a metabolic disorder should be considered a possible cause, for example by indicating results of medical examinations (blood tests) that point at a metabolic disorder as a possible cause. This, as we shall see, is oriented to in the first response to the message.

In regard to the specific categories mentioned, and thus oriented to as relevant, we may notice that WR1 in fact has a medical diagnosis, (“Kronisk Trærhedssyndrom “ (Chronic Fatigue Syndrome)), and that she has previously had an inflammation in the gland (line 1-2). Furthermore, WR1 is waiting to have an examination of the thyroid carried out (line 11).
After providing this information in a telling, which involves a medical history in terms of WR1’s diagnosis and information about a coming examination, WR1 provides the information that her blood test measurements show normal numbers. Hence, she provides information about normal numbers twice (line 3-5 and line 12).

The first response to the posting in Example B3 is shown in Example B4:

Example B4: 1st response, “kan jeg have en stofskiftesygdom trods "normale tal"?:

WR1 Tilmeldt: 07-07-2009 21:01	Den 20-10-2010 20:04 **Re: kan jeg have en stofskiftesygdom trods "normale tal"?**	

1 Ja jeg synes da godt nok at det lyder som om der er noget galt og ja man kan være
2 stofskiftesyg selv om tallene er indenfor normalområdet, så bare kløp på med at blive
3 undersøgt ordentligt og få undersøgt om du har antistoffer også. vh Xxxxx

English translation:

WR2 Joined: 07-07-2009 21:01	On 20-10-2010 20:04 **Re: Can I have a metabolic disorder despite ”normal numbers”?**	

Yes I really think it sounds like something is wrong and yes you can be sick from a metabolic disorder although the figures are within the normal range, so keep pushing to get investigated properly and get tested if you have antibodies also. Regards Xxxxx

The text in the first response in Example E6 initiates with ”Ja jeg synes da godt nok at det lyder som om der er noget galt og ja man kan være stofskiftesyg selv om tallene er indenfor normalområdet “ (Yes I really think it sounds like something is wrong and yes you can be sick from a metabolic disorder although the figures are within the normal range) (line 1-2). This acknowledgement sequence consists of two clauses, which are both initiated with “Ja” (Yes). “Ja” is thus used as an acknowledgement token (Drummond & Hopper 1993a; 1993b), which is one of the resources to make us recognize this as doing acknowledgement. Initiating a response with “Ja” can furthermore be seen as responding in a manner that is formally type-conforming (Raymond 2003) in regard to the indirect question posed by WR1. The first thing WR2 acknowledges is that “jeg synes da godt nok at det lyder som om der er noget galt” (I really think it sounds like something is wrong). Hence WR2 acknowledges the problems, as WR1 describes them, as something that should be considered problematic and implicitly as something that should be acted on. The second thing WR2 acknowledges is that “man kan være stofskiftesyg selv om tallene er indenfor normalområdet” (you can be sick from a metabolic disorder although the figures are within the normal range). This can be understood as a response to the question posed in the title of the 1st posting in Example B3 (“kan jeg have en stofskiftesygdom trods "normale tal"?” (Can I have a metabolic disorder despite ”normal numbers”?)).

The acknowledgement sequence as a whole deals with the question WR1 indicated in the text, "Jeg håber nogen kan fortælle mig om disse symptomer kan stamme fra stofskiftet?" (I hope someone can tell me whether these symptoms may be derived from the metabolism?) (See Example B3, line 13), by first acknowledging the problems as implicitly something that should be dealt with ("something is wrong", line 1) and then acknowledging the possibility that a metabolic disorder can be the cause for problems although blood test measurements are within the normal range. In this way she orients to the details of the 1st posting, as she treats the problem as a medical problem, but doesn't completely align with WR1's suggestion that the problem is caused by the metabolism. Rather she acknowledges the possibility.
As opposed to other example described above (Example B2), WR2 in this example provides a recommendation, or advice (see chapter 6.3 on advice giving), that WR1 should push to have further medical examinations ("så bare kløø på med at blive 3 undersøgt ordentligt" (so keep pushing to get investigated properly)) and that a specific test should be carried out ("og få undersøgt om du har antistoffer også" (and get tested if you have antibodies also.)). Thus in contrast to the response shown in Example B2 (and in contrast to the practice we will see in Example B6), here WR2 does not make any indications that she has any specific competences or premises for acknowledging or rejecting the possibility that WR1 has a metabolic disorder despite the fact that her blood test results do not show indications of it. Hence, she does not tell a personal story which would testify to this as a part of the activity of responding. She simply confirms that WR1 can have a disorder and hence aligns with WR1's description of a possible – or candidate - diagnosis. As in other cases (Example B2 (and Example B6 which will be analyzed in the following), but also chapter 6.1 on sharing experiences)) respondents use tellings of personal experience with a problem and sometimes their knowledge about other peoples' personal experiences (Example B6) to either demonstrate that connections between specific bodily experiences and specific illnesses can be empirically validated, and/or to account for why they have specific believes about the causes for their problems. In this example, however, the respondent does not engage in an interactional process of establishing a final diagnosis of some metabolic disorder of WR1's. She instead facilitates a further diagnosing process which involves health professionals. Orienting to the details of WR1's 1st posting, she confirms as mentioned the possibility of such a disorder but then proceeds by facilitating the process of a final one.

6.2.4.3 Indications of personal bodily experiences as "empirical evidence"

So far we have seen examples of 1st postings in which WR1 provided a(n indirect) question which was formally inquiring about whether a metabolic disorder could be a possible cause for indicated problems. We saw that respondents provided acknowledgements and we also saw that they oriented to the details in the 1st postings by either providing a personal telling of experiences that worked to document their acknowledgements with inbuilt claims that metabolism may well be an underlying cause for specific problems (Example B2) or refrain from providing a personal story and instead provide suggestions for ways to act in order to investigate possible causes further (Example B4). In the case in which personal experiences were not indicated in the response, WR1 did not indicate to have been diagnosed with a metabolic disorder, she reported to have normal blood test results, and she indicated suffering from other disorders. Hence, she did not indicate medical diagnoses or medical facts that could be used to validate a metabolic disorder as a possible cause.

In the following examples of 1st postings (Example B5 and B7) finding a cause for an experienced problem is also an indicated concern for the participants. However, in these postings WR1 does not inquire about

the possibility that a metabolic disorder could be the cause for certain problems, which we saw in the examples above (Example B1 and B3). In the 1st postings in Example B5 and B7 WR1 formulates a question about whether or not respondents have particular experiences.

In the 1st posting in Example B5 unexplained problems are indicated. In this case a health professional has rejected metabolism as an underlying cause for experienced problems, i.e. telling of personal experiences is suggested as a source of argumentation. WR1 indicates having a metabolic diagnosis, which might explain his experienced problems that are still present despite treatment for the metabolic problem, but a specialist does not share that opinion (for other examples in which participants indicate problems in regard to communication with the doctor, see chapter 6.3 on advice giving):

Example B5: 1st posting, "Symptomer ved lavt stofskifte?":

WR1 Tilmeldt: 20-07-2009 07:30	Den 07-08-2009 09:39 **Symptomer ved lavt stofskifte?**	

1 Hej med jer.
2 Jeg fik diagnostiseret lavt stofskifte i foråret og har været på eltroxin lige siden, min
3 THS er faldet pænt fra 20 til 4.5 og min t3,t4 har stort set hele tiden ligget i
4 normalområdet.
5 Problemet er at jeg stadig har en masse sygdomssymptomer. Jeg er meget svimmel,
6 ukoncentreret, glemsom, ondt i muskler, hovedpine, sviende øjne. Jeg har skiftet til
7 euthyrox for at se om det gjorde en forskel, men det gjorde det ikke. Efter at have
8 læst her i forum kan jeg se at de symptomer som jeg har er almindelige hos
9 stofskifte patienter. Men min speciallæge mener at jeg ikke skal have symptomer
10 når min t3,t4 ligger helt inden for normalområdet og mener at mine symptomer må
11 skyldes noget andet. Hvad er jeres erfaring? Har nogen af jer oplevet disse
12 symptomer på stofskiftesygdomme til trods for normale tal? Tak

English translation:

WR1 Joined: 20-07-2009 07:30	On 07-08-2009 09:39 **Symptoms at low metabolism??**	

Hi there.
I was diagnosed with hypothyroidism in the spring and have been taking Eltroxin ever since, my TSH has dropped nicely from 20 to 4.5 and my t3, t4 has almost always been in the normal range.
The problem is that I still have a lot of disease symptoms. I am very dizzy, distracted, forgetful, pain in muscles, headaches, stinging eyes. I have switched to Euthyrox to see if it made a difference, but it did not. After reading in this forum I can see that the symptoms I have are common for metabolic patients. But my specialist thinks that I should not have symptoms when my t3, t4 are well within the normal range and believe that my symptoms may be caused by something else. What is your experience? Have any of you experienced these symptoms of metabolic diseases in spite of normal numbers? Thanks.

In the 1st posting presented in Example B5 the title is "Symptomer ved lavt stofskifte?" (Symptoms at low metabolism?). WR1 hereby introduces the topic of the posting as being about possible symptoms at low metabolism. The categories chosen, "symptoms" and "low metabolism", are recognizable as medical and

they imply a particular connection; particular symptoms are connected to a particular illness. As in Example B1 and B3, also in this example the question mark put after the statement works to show that some aspect of the utterance is questioned.

The text initiates with a greeting addressing forum participants that is, presupposing more than one recipient ("Hej med jer." (Hi there.)). In line 2-4 WR1 describes his history in regard to hypothyroidism; he identifies as someone having been diagnosed with hypothyroidism since the spring (that is, for a couple of months). He furthermore describes how he is being treated for this condition ("har været på eltroxin lige siden" (have been taking Eltroxin ever since)). Also, he provides a description with an inbuilt assessment of the development in some measured blood test numbers referring to TSH hormone levels ("min 3 THS er faldet pænt fra 20 til 4.5" (my TSH has dropped nicely from 20 to 4.5)), and he mentions that other hormones, t3 and t4, have been measured to be "almost always" within the normal range. WR1 thus indicates having a diagnose, being treated with medication, documents measured hormone levels and provides assessments of the measurements in comparison with normal ranges, and thereby orients to this as relevant for the activity he is engaged in.

In line 5 WR1 introduces a problem: "Problemet er at jeg stadig har en masse sygdomssymptomer." (The problem is that I still have a lot of disease symptoms.). By announcing this problem grammatically in a definite form, "Problemet" (The problem), WR1 shows that he understands indications of a problem as being anticipated and relevant there. WR1 then provides a list of six elements readable as referring to disease symptoms; "Jeg er meget svimmel, ukoncentreret, glemsom, ondt i muskler, hovedpine, sviende øjne." (I am very dizzy, distracted, forgetful, pain in muscles, headaches, stinging eyes.), line 5-6. The text continues with indications that WR1 has done something to deal with the problem: "Jeg har skiftet til euthyrox for at se om det gjorde en forskel, men det gjorde det ikke." (I have switched to Euthyrox to see if it made a difference, but it did not.). WR1 here also reports that his attempt to deal with his problem did not have an effect. Hence, WR1 implies that a specific drug, Eltroxin, could be rejected as the cause for his experienced problems.

In line 7-9 WR1 establishes that a correlation exists between common experiences reported by the group of people with metabolic conditions and the experience of the symptoms WR1 describes. He also indicates that this has been established on the basis of reading in the forum: "Efter at have æst her i forum kan jeg se at de symptomer som jeg har er almindelige hos stofskifte patienter." (After reading in this forum I can see that the symptoms I have are common for metabolic patients.). Although WR1 does not explicitly suggest his metabolic condition as a cause, his statement in line 7-8 works to introduce a possible cause for WR1's problems, namely his metabolic condition. This is inferable because WR1 points at an "empirical" correlation between symptoms and causes after he has indicated having a metabolic condition that is being treated successfully (indicated by the fact that blood test results are within the normal ranges) (line 2-4), experiencing problems (line 5-6) and having indicated an attempt to act on it, which was not successful (line 6-7).

In line 9-11 WR1 refers to a third party's opinion, namely a specialist's opinion: "Men min speciallæge mener at jeg ikke skal have symptomer når min t3,t4 ligger helt inden for normalområdet og mener at mine symptomer må skyldes noget andet." (But my specialist thinks that I should not have symptoms when my t3, t4 are well within the normal range and believe that my symptoms may be caused by something else.). The description is initiated with "Men" (But), thereby indicating the description as contrastive to the suggestion implied about possible causes previous to the description (see line 5-8). Furthermore, WR1 constructs the reported action accomplished by the specialist as stating his opinion by using the verb

“mener” (think). The opinion s/he is reported to have expressed is that symptoms should not be present when the metabolic numbers measured for the hormones t3 and t4 are within the normal range. It is formulated as what could be referred to as a “when X then Y”-construction. Such a construction was also used in Example B2 to indicate that the time of becoming diagnosed and experiencing particular bodily problems correlated. As opposed to an “if X then Y” construction in a so called “when X then Y”-construction a clause initiated with “when” indicates certainty that the state of affairs expressed in the “when”-clause, “når min t3,t4 ligger helt inden for normalområdet ” (when my t3, t4 are well within the normal range) (line 9-10), is in fact the case, but as a “if X then Y”-construction also indicates that the state of affairs expressed are not necessarily the case in other cases. The “then”-clause (“jeg ikke skal have symptomer” (I should not have symptoms)), here without “then”, is formulated with a modal construction, “skal have” (should have), which points to a high degree of probability that the statement should hold (Nuyts 2006:6), according to the specialist.

WR1 addresses the forum participants with two questions (line 11-12). The first question, “Hvad er jeres erfaring?” (What is your experience?), is formulated as an “wh-question”, which means it does not indicate formal linguistic restrictions in the format respondents are expected to formulate a response, but does project a specific type of information to be included in a response (Lee 2012:420), here tellings about experience. The second question formulated by WR1 specifies what kind of responses he seeks: ”Har nogen af jer oplevet disse symptomer på stofskiftesygdomme til trods for normale tal? (Have any of you experienced these symptoms of metabolic diseases in spite of normal numbers?) This question puts further restrictions on projected responses: Responses should address experiences of having symptoms while also having normal blood test results. The request is formulated as a “yes/no interrogative”, and thus a “yes/no response” would be type conforming (Raymond 2003).

In this 1st posting, Example B5, WR2 suggests metabolism as a possible cause for his illness symptoms based on reading in the forum. He also indicates that his doctor disagrees with this suggestion. After having established finding the cause for his symptoms as the topic, and in particular whether metabolism may still be the cause in spite of a blood test result indicating normal values, WR1 inquires about experiences, linguistically formulated with yes/no interrogatives.

In this example, as in the previous examples shown in this chapter, establishing a cause for indicated problems is indicated as a concern. Contrary to the examples shown in Example B1 and B3, in which WR1 invited participants to acknowledge whether there was a possibility that certain experiences were connected with a metabolic disorder, in this example WR1 inquires about experiences occurring under certain conditions (normal blood test results). We also saw that WR1 in this example started off by indicating having a metabolic diagnosis (“et lavt stofskifte ” (hypothyroidism), line 1).

This example shows how WR1 orients to inquiring about others’ experiences as a method to establish whether a metabolic disorder could be a possible cause, or, alternatively, to possibly *question a doctor’s assessment,* or thought (line 9), that hypothyroidism as a cause is not probable when blood test numbers are normal.

In the first response to the 1st message provided in Example B5, shown in Example B6, WR2 picks up on WR1’s noticing that many forum participants experience the same problems as WR1. WR2 uses this as grounds for acknowledging her suggestion that his problems could be caused by his metabolic condition. Furthermore WR2 orients to WR1’s inquiry about experiences by providing a personal narrative (as did WR2 in Example B2, which was a response to a 1st posting in which WR1 inquired about possible

correlations between bodily experiences and low metabolism). WR2 also provides a suggestion for a specific cause for WR1's experienced problems in her response:

Example B6: 1st response, "Symptomer ved lavt stofskifte?":

WR2 Tilmeldt: 15-06-2009 08:07	Den 07-08-2009 14:58 **Re: Symptomer ved lavt stofskifte?**

1 Hej Xxxxxx.
2
3 Ja, det lyder da helt klart som stofskiftesymptomer, du har.
4 Det var jo sådan vi andre havde det med ny Eltroxin, trods normale tal. Og for mit
5 eget vedkommende har jeg ikke kunnet skifte lige over til Euthyrox. Symptomerne
6 kom igen. Så var jeg pillefri i 2 dage og gik på halv dosis, men efter et par uger,
7 kom symptomerne igen, men i mildere grad. Igen holdt jeg 2 dage pillefri og tog 1/4
8 pille fra, så jeg nu er langt under min normaldosis. Men jeg kender ikke mine blodtal
9 før i næste uge.
10
11 I går havde jeg en skidt dag i hovedet, men i dag er jeg frisk igen. Så jeg håber, at
12 jeg nu kan få mange almindelige dage på denne dosis og så langsomt hæve dosis
13 med 1/4 pille ad gangen - jeg er jo ligesom 5 kvarte piller bagud. Men igen, det
14 kommer jo også til at afhænge af mine blodtal.
15
16 Jeg tror, at din krop ikke har kunnet følge med pilledoseringen og pilleændringen.
17 Det siger alle herinde er helt almindeligt.
18
19 Hilsen Xxxxx

English translation:

WR2 Joined: 15-06-2009 08:07	On 07-08-2009 14:58 **Re: Symptoms at low metabolism??**

Hello Xxxxxx.

Yes, clearly it sounds like metabolic symptoms you have, sure.
It was how the rest of us[39] felt with the new Eltroxin, despite normal numbers. And

for my part, I have not been able to switch straight over to Euthyrox. The symptoms came back. Then I was without pills for 2 days and went on half dose, but after a few weeks the symptoms came back again, but to a lesser degree. Again I took 2 days without pills and took 1/4 pill away, so I am now far below my normal dose. But I do not know my blood counts before next week.

Yesterday I had a bad day in the head, but today I'm fine again. So I hope I can now get many ordinary days at this dose and slowly increase the dose by 1/4 pill at a time - I'm like 5 quarters of pills behind. But again, it will also depend on my blood counts.

I think your body hasn't been able to keep up with the pill dosage and pill change.
Everyone in here say that is quite common.
Regards Xxxxx

The posting shown in Example B6, which is the first response to the 1st posting with the title "Symptomer ved lavt stofskifte?" (Symptoms of low metabolism??), the first thing done after greeting (line 1) is

[39] In the Danish original the term "os andre" was used which means "us others".

acknowledging the symptoms described by WR1 as metabolic symptoms; “Ja, det lyder da helt klart som stofskiftesymptomer, du har.” (Yes, clearly it sounds like metabolic symptoms you have, sure.). The acknowledgement initiates with “Ja” (Yes), which can be a way to respond type-conforming to a yes/no interrogative, and which was also used in Example B4. Initiating with “Ja”, then, can be a way of constructing the utterance as a response (i.e. a second pair part) to something that has been made relevant by another participant (in a first pair part). The acknowledgement is not performed with “Ja” in itself, which we also saw in Example B4, as WR2 provided a specification of what the acknowledgement performed with “Ja” should be understood to acknowledge. Here there is also a description of what “Ja” should be understood to do following it: “det lyder da helt klart som stofskiftesymptomer, du har.” (clearly it sounds like metabolic symptoms you have, sure) (line 3). With this utterance WR2 acknowledges the symptoms described by WR1 as metabolic symptoms based on WR1’s presentation of them (this is indicated by the use of the formulation “it sounds like”). With “clearly” WR2 indicates her understanding about the likelihood and certainty that it could be the case that WR1’s problems could be connected to a metabolic condition; she expresses a high degree of certainty. The particles “da helt klart” (translated with “clearly” and “sure”) in the unfolded acknowledgement (line 3) indicates the acknowledgement as being in agreement with the understandings WR1 has made relevant. With this acknowledgement WR2 treats it as the relevant thing to do first in her response to acknowledge WR1’s problems as likely to be caused by a metabolic condition. If we revisit the 1st message (in Example B5), the explicit requests did not address this specifically; instead other participants were requested to provide indications of their own experiences with specific problems despite normal blood tests. If we further look into the sequential organization of the 1st posting in Example B5 we can recognize that WR1 displays to be concerned with whether his problems can be caused by a metabolic condition despite normal blood tests and despite a doctor’s opinion that WR1’s problems are not caused by a metabolic condition, and WR1 suggests the sharing of experiences as a method for investigating his “hypothesis”.

In the first response (Example B6) WR2 uses descriptions of her experiences in exactly this way, that is she formulates her knowledge about other metabolic patients’ experiences with problems despite of normal blood tests as grounds for acknowledging WR1’s hypothesis as likely (“Det var jo sådan vi andre havde det med ny Eltroxin, trods normale tal.” (It was how the rest of us felt with the new Eltroxin, despite normal numbers.), line 4). We can see that she includes herself as a member of the forum, and thus she orients to herself as representing the group of people whom WR1 has alluded to in the 1st posting. This means WR2 is also orienting to WR1 as treating forum participants as a group.

WR2 provides a narrative about personal problems with changing drugs (line 4-9) and considerations in regard to dosages of medication (line 11-14). She presents a case, her own case, in which symptoms persisted despite of taking medication. This “empirical” example works as documentation against the assessment which a doctor is reported to have made in Example B5 that symptoms should not be present when blood test results are within the normal value. In that way WR2 orients to the structure and actions of the 1st posting.

In line 16 WR2 provides a suggestion as to specific causes for WR1’s experienced problems, namely challenges with the regulation of dosages of medication and transitions of drug. WR2 refers to her knowledge about what other forum participants have expressed about the issue: “Det siger alle herinde er helt almindeligt” (Everyone in here say that is quite common), line 17. WR2 in this way shows that her suggestion is not only grounded in a personal opinion (“Jeg tror” (I think), line 16) based on personal

experiences (see narrative, line 4-14) but on accumulated knowledge based on many cases. Commonality of the symptoms for metabolic patients was pointed to by WR1 in Example B5 (line 8), and thus we can see how commonality of experiences is oriented to, implicitly acknowledged and used by WR2 as an argument or resource for validation. Here WR2 uses an extreme case formulation (Edwards 2000), "alle" (everyone, to indicate that the opinion expressed is assumed to be generally shared among the forum participants. In line 19 WR2 expresses her regards.

6.2.4.4 No medical indications – no acknowledgment of metabolism as a possible cause

The following examples, Example B7 and Example B8, shows a case in which low metabolism as a relevant category to explain WR1's problems turns out to be questioned by WR2.

In contrast to the 1st postings in example B1 and B5 described above, in the 1st posting in this example WR1 does not 1) indicate that she has a metabolic diagnosis in her problem description (Example B5) and/or 2) indicate or imply medical evidence that a metabolic condition could be a possible cause (Example B1). In contrast to the 1st posting in Example B3 above, in this example, Example B8, WR1 does not request for an assessment regarding the possibility that a metabolic disorder could be the cause for indicated problems. Rather, WR1 invites respondents to indicate experiences (as in Example B5). As we shall see in the response to this posting this seems to have structural consequences. Also in the response to Example B7, presented as Example B8, WR2 seems to orient to the possibilities and resources for interaction provided for in 1st messages in constructing a response. In Examples B7 and B8 an indication of a metabolic disorder or an indication of medical evidence is not one of them.

The 1st posting in Example B7 has the title "Excessively bloated and heavy weight gain"; in this title two categories readable as referring to problems are indicated, being "bloated" and "weight gain". Both problems are qualified ("Excessevely"; "heavy"), which indicates an understanding that the problems mentioned should not be taken to be ordinary, everyday or trivial problems, but instead should be taken as problems that need to be dealt with. Notice that, contrary to the construction of the title in Example B5, in this title WR1 does not indicate a (candidate) cause or diagnose, but problems only.

Example B7: 1st posting, "Voldsom oppustet og kraftig vægtøgning.":

WR1 Tilmeldt: 12-06-2008 12:07	Den 16-02-2011 17:16 **Voldsom oppustet og kraftig vægtøgning.**	

1 Hej alle.
2 Jeg har indenfor de sidste stykke tid taget meget på ,og jeg er voldsom
3 oppustet i hele kroppen, især maven som puster op som en højgravid
4 Jeg er dødtræt af at ligne en elefant og både ben og fødder hæver meget op .
5 Sidste gang jeg fik taget mine stofskifteprøver ,sagde han at prøverne var
6 normale og jeg orkede ikke denne gang at diskutere stofskiftetal med ham ,
7 da han sidste gang blev sur, og spurgte mig om jeg ikke troede på ham.
8 Er der andre som har oplevet dette med lavt stofskifte og normale tal?
9 Er der nogle som kender en god Endokrinolog, i STED, der har privat klinik,
10 hvor man selv betaler, og derfor ikke behøver en henvisning fra egen læge.?
11 Jeg vil blive rigtig glad forsvar
12 Venlig Hilsen XX.

English translation:

WR1 Joined: 12-06-2008 12:07	On 16-02-2011 17:16 **Excessively bloated and heavy weight gain**	

Hi all.
I have within the last period of time gained a lot of weight and I am severely bloated in the entire body, especially the stomach which blows up like someone who is pregnant.
I am sick of looking like an elephant and both legs and feet raise very much.
The last time I got my metabolic tests he said that the tests were normal and I didn't bother this time to discuss metabolic numbers with him, since he was upset the last time and asked me if I didn't believe him.
Is there anyone who has experienced this with low metabolism and normal numbers?
Is there anyone who knows a good endocrinologist in PLACE who has a private clinic, where one pays oneself and therefor don't need a referral from one's own doctor.
I would appreciate response

The text initiates with a greeting ("Hej alle." (Hi all.)); this greeting includes all participants in the forum as its recipients. As mentioned in chapter 5 participants cannot know who will read their postings and who will respond. As mentioned in chapter 6.1 various actions are accomplished in a posting without adjacent responses on a turn-by-turn level. However, as Example A1 and A3 demonstrate (as well as various examples which follow), participants may initiate with a greeting. Thereby they orient to the activity they engage in as a social activity which involve recipients. In activities such as greetings in which recipients are addressed, they are also categorized. This will be further touched upon in chapter 6.4 in which I focus on methods for initiating and closing interaction with recipients and groups of recipients.

In line 2-3 WR1 introduces her problem in a telling: "Jeg har indenfor de sidste stykke tid taget meget på ,og jeg er voldsom oppustet i hele kroppen, især maven som puster op som en højgravid." (I have within the last period of time gained a lot of weight and I am severely bloated in the entire body, especially the stomach which blows up like someone who is pregnant.). In this telling WR1 unfolds, or describes in more detail, her problems which were also indicated in the title. The details include information about duration ("Jeg har indenfor de sidste stykke tid" (I have within the last period of time)), and about the location of the problem in the body ("i hele kroppen, især maven som puster op som en højgravid." (in the entire body, especially the stomach which blows up like someone who is pregnant.)). In Example B3 and B5 WR1 provided a kind of summary of his/her medical history before indicating a problem. In line 4 WR1 describes some emotional distress experienced as a consequence of the physical appearance of her problem ("Jeg er dødtræt af at ligne en elefant og både ben og fødder hæver meget op ." (I am sick of looking like an elephant and both legs and feet raise very much .)). WR1 provides a narrative about what happened the last time she was at the doctor and got the results of her metabolic tests (line 5-7); the doctor informed WR1 that the results showed numbers within the normal range ("Sidste gang jeg fik taget mine stofskifteprøver ,sagde han at prøverne var normale" (The last time I got my metabolic tests he said that the tests were normal)), and WR1 did not inquire further about this or object ("og jeg orkede ikke denne gang at diskutere stofskiftetal med ham" (and I didn't bother this time to discuss metabolic numbers with him)) which she accounts for not doing on this basis of having bad experiences with doing that; "da han

sidste gang blev sur, og spurgte mig om jeg ikke troede på ham" (he was upset the last time and asked me if I didn't believe him).
In line 8-10 WR2 poses two questions: "Er der andre som har oplevet dette med lavt stofskifte og normale tal? Er der nogle som kender en god Endokrinolog, i STED, der har privat klinik, hvor man selv betaler, og derfor ikke behøver en henvisning fra egen læge.?" (Is there anyone who has experienced this with low metabolism and normal numbers? Is there anyone who knows a good endocrinologist in PLACE who has a private clinic, where one pays oneself and therefor don't need a referral from one's own doctor.). The first question is formulated in a way similar to one of the questions in Example B5 ("Hvad er jeres erfaring? Har nogen af jer oplevet disse symptomer på stofskiftesygdomme til trods for normale tal?" (What is your experience? Have any of you experienced these symptoms of metabolic diseases in spite of normal numbers?), line 11-12), which was treated by WR2 as a request for indications of personal experiences. In this case tellings of experiences might work to document empirical correlations between having low metabolism (or symptoms of low metabolism) and having normal blood test results. The second question may be treated as a request for specific information ("Er der nogle som kender en god Endokrinolog, i STED, der har privat klinik, hvor man selv betaler, og derfor ikke behøver en henvisning fra egen læge.?" (Is there anyone who knows a good endocrinologist in PLACE who has a private clinic, where one pays oneself and therefor don't need a referral from one's own doctor)). The text ends with a statement that expresses appreciation for a response ("Jeg vil blive rigtig glad forsvar" (I would appreciate response)).

In this 1st message WR1 does not identify as someone with an established metabolic diagnose by indicating having a metabolic diagnosis. Neither, does she indicate results of medical examinations (for example blood test results) that point at metabolism as a possible cause. Instead she identifies as someone with a problem.
At the least a suspicion that WR1 may be suffering from a metabolic disorder might be implied from WR1's description of having blood tests done and assessed by a doctor, but the blood test results are normal (line 5-6). In the question, line 8, WR1 indicates low metabolism as a relevant category, but the relevance of this category for WR1 is not "validated" as it is in Examples B5 and B1 in which WR1 either indicates a metabolic diagnosis in her problem description (Example B5) or indicates or implies medical evidence that a metabolic condition could be a possible cause (Example B1). It is simply presupposed or taken for granted in Example B7.

Example B8, the first response to the 1st posting shown in Example B7, shows a case in which metabolism is not acknowledged as a possible cause and in which personal experiences are not indicated as a relevant thing to do. This response, as mentioned, follows a 1st posting (Example B7) in which a metabolic diagnosis has not been indicated and in which medical evidence pointing to the possibility that a metabolic disorder could be the cause for indicated problems has not been provided either:

Example B8: 1st response, "Voldsom oppustet og kraftig vægtøgning.":

WR2 Tilmeldt: 14-03-2010 18:29	Den 16-02-2011 17:27 **Re: Voldsom oppustet og kraftig vægtøgning.**

1 Vægtøgningen må være pga. vand i kroppen. Det giver god mening når du "hæver
2 op".
3
4 Se at komme til lægen igenigenigen. Og bed om at blive udredt - lægen har jo
5 formodentlig ret når han siger, at stofskiftetallene er som de skal være! Men så må
6 han henvise dig til andre undersøgelser.

English translation:

WR2 Joined: 14-03-2010 18:29	On 16-02-2011 17:27 **Re: Excessively bloated and heavy weight gain.**

The weight gain must be due to water in the body. It makes sense when you "raise".

See the doctor againagainagain. And ask to get examined – the doctor is probably right when he says the metabolic numbers are as they should be! But then he must refer you to other examinations.

The first response, Example B8, to the 1st message provided in Example B7 does not initiate with a greeting as WR1 did in Example B7[40], instead it initiates with an assessment: "Vægtøgningen må være pga. vand i kroppen." (The weight gain must be due to water in the body.). WR2 here constructs a suggestion for a cause for WR1's weight gain as a logical inference by the use of a modal construction ("må være" (must be)) and further accounts for the suggestion as logical and as a rational inference that is based on "facts" with the comment that follows; "Det giver god mening når du "hæver op"." (It makes sense when you "raise"). The "fact" that is being referred to is the observation that WR1 indicated that her body "raises". Here, then, an element from WR1's telling of personal experiences is used as grounds for indicating a particular cause (water in the body) as likely and logical. Similar to Example B4 WR2 in this example does not refer to or indicate his personal experiences as relevant for making an assessment about the possible causes for WR1's problems. As in Example B4 WR2's response follows a 1st posting in which WR1 has not indicated a medical diagnosis or medical evidence pointing at metabolism as a possible cause.

In Example B8 WR2 then does not indicate personal experience with the problems described by WR1 in Example B7. In the first response, Example B8, line 4-6, WR2 provides recommendations for WR1 to see a doctor again ("Se at komme til lægen igenigenigen.[41]" (See the doctor againagainagain)), and she provides

[40] In two other responses presented in this chapter respondents initiate with a greeting (Example B2 and B6). In Example B4, WR2 initiates with "Ja" (Yes).

[41] WR1 by repeating "igen" (again) three times without space in between indicates an expectation that WR1 has already seen the doctor repeatedly. This might be a way of indicating an iterative aspect, that works to indicate the action as scripted (Edwards 1994), and in this particular case works to show that WR2 knows WR1 has already attempted to do the actions she suggests, i.e. shows that WR2 knows she is not telling WR1 something she does not already know herself or has not attempted to do. Furthermore "igenigenigen" has the effect of implying an understanding that seeing the doctor repeatedly (and in particular without any positive outcome) is a bothersome process.

specific advice (see chapter 6.3 on advice giving) as to what WR1 should ask from the doctor ("Og bed om at blive udredt" (And ask to get examined)). As in Example B4, in which WR2 does not align with WR1 by indicating personal experiences in her response, WR2 provides advice on what WR1 could do. In this sense WR2 also in this example as in Example B4 facilitates a diagnosing process.
Furthermore WR2 expresses an understanding that 1) the doctor has an obligation to help WR1, and 2) other causes than the causes suggested by WR1 as possible should be taken into consideration since the metabolic numbers did not provide the "proof" needed; "- the doctor is probably right when he says the metabolic numbers are as they should be! But then he must refer you to other examinations". Although WR1 in the 1st message (Example B7) poses two questions ("Er der andre som har oplevet dette med lavt stofskifte og normale tal?" (Is there anyone who have experienced this with low metabolism and normal numbers?), line 8 and "Er der nogle som kender en god Endokrinolog, i STED, der har privat klinik" (Is there anyone who knows a good endocrinologist in PLACE who has a private clinic), line 9), these questions are not recognizably responded to in the first response, i.e. WR2 does not provide recognizable answers. Furthermore, the questions are not treated as requests for indications of personal experiences (as in Example B6) and/or as making acknowledgements or information (or knowledge) about medical experts within the area of metabolism relevant. Instead WR2 provides an assessment of an aspect of WR1's problem, recommendations to see the doctor again, as well as assessments of the doctor's assessment of some blood test results as well as a logical inference based on this assessment, that other causes might be found than the candidate suggested by WR1. Also similar to the first response in Example B4, WR2 in her response in Example B8 does not reject WR1's described problem as a problem. Neither does WR2 reject it as a medical one.

Although complex, there seems to be a pattern and a logic behind how postings that address the possibility that a metabolic condition could be a cause for experienced problems are constructed and responded to.

First postings may indicate a concern to establish a metabolic disorder as a possible cause for experienced problems in various ways, for example by indicating this as a suggestion, or by formulating questions addressing this issue, either in the title or in the posting itself. Questions may also be posed inviting respondents to indicate experiences that validate suggestions about possible connections.
In responses to such first postings respondents initiate with acknowledgements of suggestions of possible causes or with indicating possible causes. Thereby, they treat this as WR1's main concern. After this, respondents recurrently indicate personal experiences or facilitate a further diagnosing process. In some cases the question formats used by WR1's are nicely oriented to and aligned with. In responses, however, respondents not only orient to the question formats used by WR1's. They also deal with details of how categories and descriptions of medical histories and experiences are indicated in first postings. We see that respondents in particular treat indications of medical diagnoses and medical information as relevant for how they acknowledge a suggestion for a possible cause and how they validate it. In cases in which WR1's have not indicated any metabolic diagnoses and/or medical information that might suggest a metabolic disorder as a possible cause, participants recurrently facilitate a further diagnosing process rather than completely aligning with and validating suggestions that a metabolic disorder is a possible cause. This suggests that respondents treat problems as possibly medical and metabolism as a medical category.

In Example B8 alternative causes to the cause suggested by WR1 (low metabolism) is indicated (water in the body) as based on WR1's telling. Low metabolism was thus not acknowledged as a possible cause for WR1's problems, contrary to Example B4, in which WR2 did indicate low metabolism as a possible cause. This might be connected to the fact that WR1 in Example B3 indicated to have recently been diagnosed with low metabolism, whereas WR1 did not account for suggesting a connection between her experienced problems and low metabolism in Example B7. Furthermore, we may speculate whether the differences in the quality of the symptoms described may affect how respondents treat and understand them. In Example B3 WR1 provided the following list of symptoms (line 6-10):

> 6 Mine symptomer: Konstant træt, har overhovedet ingen energi, manglende kræfter i
> 7 arme og ben, mit syn er helt godnat, tørre øjne synsforstyrrelser, føler at jeg er
> 8 blevet meget dårlig til at huske og koncentrer mig, er stoppet i venstre side af
> 9 hovedet - ikke forkølet. bliver i perioder hæs. Føler at det strammer på halsen. Har
> 10 nattesved og hjertebanken. I det hele taget er jeg ikke helt mig selv mere.

> 6 My symptoms: Constantly tired, have no energy at all, lacked strength in arms and
> 7 legs, my vision is completely bad, dry eyes, blurred vision, feel that I have become
> 8 very bad at remembering and concentrating, is clogged in the left side of the head –
> 9 I do not have a cold. Become hoarse at times. Feel tension in my neck. Have night
> 10 sweats and palpitations. On the whole, I'm not quite myself anymore.

In Example B7 WR1 describes her problems in the following way: "Jeg har indenfor de sidste stykke tid taget meget på ,og jeg er voldsom oppustet i hele kroppen, især maven som puster op som en højgravid Jeg er dødtræt af at ligne en elefant og både ben og fødder hæver meget op." (I have within the last period of time gained a lot of weight and I am severely bloated in the entire body, especially the stomach which blows up like I am pregnant. I am sick of looking like an elephant and both legs and feet raise very much.) (line 2-4). Despite from the significant fact that some problems may be known to be more common than others for people suffering from metabolic conditions, there is a possibility that certain problems have certain connotations for people and that that has an effect on how the problems are treated. As causation is the issue people deal with in the threads presented in this chapter, the issue of whether a problem is in fact self-inflicted may be an issue that people have to deal with (Brooks 2009:361). People might expect that some problems may have emerged on the basis of certain behavior, and may disappear again if the behavior is changed. People may treat overweight as a candidate of self-inflicted problems (Brooks 2009 361; Cordell & Ronai 1999), and since overweight could be a candidate of problems that are caused by specific behavior (ingesting more food than the body burns), this might influence the way that forum participants deal with overweight as a candidate symptom of a metabolic condition (Brooks 2009).

Overweight as a problem was not acknowledged to be a possible effect from suffering from low metabolism in Example B8. Nevertheless WR2 did recommend WR1 to deal with her problem by seeking medical help, and nowhere did she suggest that WR1's problem was self-inflicted. This practice points to the fact that described problems are acknowledged as problems that medical professionals should deal with (which may be compared to the practices described in Heritage and Robinson 2006, in which patients account for seeing their doctor as part of describing their problem, and which was also pointed out in chapter 6.1 about sharing experiences). Furthermore it points to the fact that, at least this participant, WR2, does not raise issues about different ways of understanding and dealing with particular weight

problems that are experienced, i.e. WR2 focuses on dealing with strictly medical aspects of WR1's problem in terms of causation and treatability. In the following chapter, chapter 6.3 about advice, practices of how participants deal will personal responsibility for dealing with problems will be touched upon. Similar to the practice just described here, people describing problems, and who furthermore request for help, are recurrently advised to see a health professional.

6.2.5 Conclusion

This chapter has outlined practices participants in the online forum use to interact about unexplained problems, and in particular about whether metabolism may be a possible and/or likely cause for the bodily problems.
As described in chapter 6.1, also in the postings in which participants discuss possible causes for problems, the structure of postings is complex. Participants make use of the resources available to them. They interact via written language and typography, and they post postings as complex units of actions, including descriptions of problems and invitations to provide responses by posing questions.
However, when interacting about possible causes for problems, participants make use of specific methods.
I have provided four excerpts of 1st postings (Example B1, Example B3, Example B5, and Example B7) in which participants inquire about whether metabolism can be a possible cause (B1, B3, (B5 a possible reading from the title) and/or indicate in the problem description a concern to establish a cause for experienced problems followed by a question inquiring others about their experiences.

As mentioned, the 1st postings in this chapter do not only indicate unexplained problems as a concern, they also inquire about or indicate whether metabolism could be the cause. Metabolism is thus indicated as a candidate diagnosis.
This is done by a variety of methods, including

1) Only suggesting a metabolic condition as a possible cause, (Example B1, B3[42], B5, B7), that is, not suggesting possible alternatives.
2) Constructing questions that inquire about the possibility that metabolism could be a cause in a yes/no format, and indicating a preference for a yes response (Example B1, Example B3).
3) Constructing questions that inquire about whether other forum participants have experiences in a yes/no format, and indicating a preference for a yes response[43] (Example B5, B7).
4) Referring to problems or implicitly constructing problems as symptoms (Example B1, Example B3, Example B5, Example B7).
5) Making use of conditional formulations to imply causal connections between experienced problems and a metabolic condition (Example B1, Example B5).
6) Indicating a metabolic diagnosis (Example B5 ("Jeg fik diagnostiseret lavt stofskifte i foråret" (I was diagnosed with hypothyroidism in the spring))).
7) Indicating results of medical examinations pointing at metabolism as a possible cause (Example B1 ("stofskiftet ligger i den lave ende" (metabolism is at the low end)).

[42] Although WR1 indicates that she has other diagnoses, she only inquires about whether her problems may be derived fom the metabolism.
[43] These questions were analyzed as methods for possibly gathering "empirical proof" that certain experiences could be explained by a metabolic disorder.

In most cases, however, participants indicate challenges in establishing a metabolic diagnosis as a cause for experienced problems. Overwhelmingly, this seems to be why they interact in the forum in the first place! Many participants indicate results of medical examination that show normal blood tests values and thus cannot be used as indications of a medical disorder as the problem. Both Example B3 ("Har fået taget mange blodprøver, som viser normale værdier." (Have had many blood tests taken showing normal values .), line 12), Example B5 ("min THS er faldet pænt fra 20 til 4.5 og min t3,t4 har stort set hele tiden ligget i normalområdet." (my TSH has dropped nicely from 20 to 4.5 and my t3, t4 has almost always been in the normal range.), line 3-4) and Example B7 ("Sidste gang jeg fik taget mine stofskifteprøver ,sagde han at prøverne var normale og jeg orkede ikke denne gang at diskutere stofskiftetal med ham ,da han sidste gang blev sur, og spurgte mig om jeg ikke troede på ham." (The last time I got my metabolic tests he said that the tests were normal and I didn't bother this time to discuss metabolic numbers with him, since he was upset the last time and asked me if I didn't believe him.), line 5-7) entail such information. Such information, however, is treated very differently depending on other details of the postings, in particular whether a participant has a metabolic diagnosis already seems to be critical for how responses are designed.

Two methods for inviting to responses in 1st postings are outlined. One way WR1's are inviting to responses is by inquiring about the possibility that metabolism could be the cause for indicated problems. Examples of this practice are shown in Example B1 and B3. Another way WR1's invite to responses in postings in which it is indicated as a concern to find the cause for unexplained problems is by posing a question about whether respondents have particular experiences. Questions of this type may be understood to project acknowledgements and tellings about experiences, i.e. as requests to indicate experiences, which was the how such questions was shown to be treated in chapter 6.1. Examples of this practice are shown in Example B5 and B7.

How do respondents then respond to such invitations? The analyses in this chapter indicate that respondents orient to the details of 1st postings when they respond. In particular information about medical diagnoses and results of medical examination that may or may not point at metabolism as a possible cause seem to be critical for how respondents design their responses.
This chapter has outlined three ways of responding in ways that systematically correlates with 1) how WR1's invite to responses and 2) whether or not and which medical diagnoses are indicated and whether or not results of medical examinations point at metabolism as a possible cause.

Firstly, responses to 1st postings concerned with establishing a cause for unexplained problems recurrently initiate with (a greeting and) an acknowledgement; either WR2 acknowledges the experiences indicated by WR1 as a problem (Example B4) and/or WR2 acknowledges the experiences as possibly caused by the metabolism (Example B2, B4, and B6). After WR2 has provided an acknowledgement the examples indicate that one out of two options may occur: Either WR2 indicates personal experiences (Example B2 and B6) or WR2 facilitates a final diagnosis by suggesting WR1 to consult a health professional (Example B4 (and B8)). In the choice of what to do we see that WR2 orients to the details of the 1st posting, not so much in terms of how the invitation to respond is formulated (i.e. whether or not indications of experiences can be understood to be projected (as in Example B6 and B8) or not (as in Example B2 and B4)), but rather WR2 orients to the details of how the problem is indicated in terms of medical information (diagnosis and results of medical examinations). Thus, in Example B2 and B6 WR2 indicates personal bodily experiences, whereas

in Example B4 and B8 WR2 does not. In example B4 and B8 WR2 facilitates a final diagnosing process with a medical professional instead.

In fact, Example B8 is a special case in this collection in the sense that WR2 does not initiate her posting by acknowledging the experiences as a problem or by acknowledging metabolism as a possible cause. What happens instead is that WR2 suggests alternative causes and backs the suggestions up with logical inferences based on "facts" from WR1's telling of personal experiences. As noted, this is then followed by suggestions to see a doctor, i.e. facilitating a further diagnosing process.

6.2.6 Discussion

A whole body of conversation analytic studies have investigated doctor-patient interaction in health care settings (for example Gill 1998; Heritage and Maynard 2006; Peräkylä 2006; Pilnick et al. 2010; Stivers 2002; ten Have 2001), as mentioned, among other things by focusing on sequences in which patients present problems to the doctor and by investigating how they explain illness in medical encounters.

This chapter has focused on how participants in an online forum interact about possible explanations for their bodily experienced problems with other non-professionals through the use of so-called postings organized in threads. As I have pointed out, participants through their actions can be said to "diagnose" other participants' descriptions of problems, but they stay away from providing final medical diagnoses of other participants problems based on their descriptions.

Through analyses of first postings and responses that deal with possible explanations for problems, we learn that participants recurrently provide acknowledgements in responses. Participants acknowledge the experiences described by others by acknowledging the described experiences as problematic and/or as possibly caused by metabolic conditions.

Looking at the organization of postings has showed that participants indicate the basis they ground these acknowledgements on. They orient to 1) medical information and 2) the bodily experiences described and categorized as relevant for providing acknowledgements.

Hence, the analyses in this chapter have pointed at important and recurrent aspects of how participants understand and explain certain bodily experiences when interacting with other non-professionals. This may be referred to as doing "lay- diagnosis" (Beach 2001). As Beach stresses (2001:15), lay-diagnosis is not about how non-professionals diagnose themselves or others, but about how they understand and make sense of diagnosis (Beach 2001:15). This understanding of the concept is in alignment with what participants orient to through their actions in the forum.

Some health professionals and some researchers express a lack of knowledge about or even concern in terms of how lay persons use and understand information about health and illness which they encounter in online settings (Greene, Choudhry, Kilabuk & Shrank 2011; Stuart 2013). However, in the forum investigated we see that participants treat their problems as medical problems. Thereby they orient to specific membership categories, in particular they orient to themselves as people who suffer from medical problems (rather than for example psychological issues). They do so by indicating medical information,

including blood test results, previous diagnoses, medical treatment etc. They also do so by advising others to consult medical professionals in order to diagnose problems. Medical information and medical professionals are thus treated as crucial in order to understand, explain and deal with the problems that participants indicate in this forum. By treating medical information and medical professionals as key to dealing with and treating experienced bodily problems, participants also orient to themselves as competent and knowledgeable lay-persons who take medical knowledge and expertise seriously, when dealing with their problems (for further points on how participants do that, see chapter 6.3).

6.3 Advice giving fellow sufferers: Acting on problems

6.3.1 Introduction

In this chapter threads that rather directly deal with advice giving as a category is investigated in terms of how participants deal with initiating an advice giving process and how participants provide advice. I.e. advice giving processes are investigated in terms of how they are constructed, oriented to and dealt with. Participants who invite to advice, as in postings inviting to other types of action (see chapter 6.1 and 6.2), also categorize themselves and/as they describe problems, and they use questions to make responses relevant. However, when it comes to advice sequences, some specific methods and structures have been identified, which will be outlined. For example, when participants explicitly invite to advice giving, advice giving recurrently relates to treatment of an established medical problem.

Advice giving has been studied by conversation analysts in face to face interactions (probably the most foundational being Heritage and Sefi 1992; Jefferson & Lee 1992), and there are studies on advice giving in online message boards inspired by conversation analysis that investigates the construction of advice accomplished by linguistic and structural resources (Morrow 2006; Ruble 2011). In this investigation I will specifically focus on outlining participants' methods for initiating an advice process – and not something else, such as a process of sharing experiences or a process of searching for relevant possible diagnoses or causes for a problem – as well as participants' methods for dealing with providing advice. Particularly I will be concerned with what kinds of advice giving processes participants orient to as relevant, that is, which kinds of actions advice initiating actions make relevant.

It has been demonstrated that responses in online forums recurrently entail actions which are recognizable as advice although advice has not been explicitly invited to (See Morrow 2006; Ruble 2001). Advice may be defined, understood and made recognizable as "…directives, opinions, or suggestions about how to solve a particular problem" (Ruble 2011:401, see below). In this chapter I argue that in cases when participants in 1st messages in this data explicitly invite to advice and/or help, they imply an understanding that they have a problem that has been established as medical, that (likely) causes have been established and that they need help in terms of how to act on the problem.

This and previous analysis in this thesis suggest that participants in this forum with the topic metabolism in and through the actions they make relevant and in and though the sequential order of messages display to concerned with various issued related to the experience of problems, including how to categorize them (see the chapter on sharing experiences), how to explain problems (see chapter 6.2 on explaining illness), and how to act on problems. Participants orient to an understanding of metabolic problems as medical. Accordingly, we see participants orienting to treating the problems as medical problems. Participants indicate and search for medical knowledge, they are concerned with indicating or finding a fitting medical diagnosis to their experienced problems, and they are concerned with acting on the problems in accordance with this knowledge and understanding. In fact, as will be pointed to, when participants explicitly invite to advice, they often indicate a problem related to medical treatment, i.e. a problem that has been established and/or diagnosed as medical. Hence, participants orient to an understanding that advice is a relevant category to use to invite to responses, when problems have been "diagnosed".

This chapter will show how advice is invited to and provided. However, this chapter will also focus on ways in which participants treat indications of complex problems, which are not always presented as clear instances of specifically medical problems although problems are indicated to involve treatment. As will be shown, responses are recurrently packaged as "advice" on how to act. Furthermore respondents recurrently refrain from engaging in possibly complainable matters indicated in texts as complaints in cases in which advice has been invited to. Participants, however, do deal with details of problem presentations by for example not providing acknowlegdements that experienced problems may be metabolic, by not indicating personal bodily experiences that are constructed to be in essence the same as the experiences in the first story etc., in cases in which metabolic diagnosis or medical evidence pointing towards metabolism as a cause have not been indicated or in cases in which the problem indicated is not presented as strictly medical.

6.3.2 Conversation analytical studies on advice processes

Interactions involving advice in institutional settings have as mentioned above been investigated within the framework of conversation analysis (Heritage & Sefi 1992; Hutchby 1995; Jefferson & Lee 1992[44]; Hepburn & Potter 2011; Pudlinski 2002 among others). Conversation analytical studies of interactions involving advice giving focus on exploring and grounding researchers' "…analytical categories, [their] descriptions and formulations of procedure, upon the observable orientations of the co-participants themselves" (Jefferson & Lee 1992: 521).

As also mentioned Two studies of advice giving stand out, as they have presented findings and terms that other CA studies concerned with advice giving build on, that is Heritage & Sefi (1992) and Jefferson & Lee (1992). In these studies the authors note that advice giving processes recurrently are oriented to by participants as a service encounter.

Noticeably, both Heritage and Sefi's study and Jefferson and Lee's study have a particular focus on dilemmas in advice giving processes. Recurrently, then, initiating and providing advice seem to cause participants some interactional "trouble". The studies suggest that this interactional trouble may be bound up with the local relevant categories that follow from providing and seeking advice, the participants then being in the roles of advice seekers and advice givers, including the presumptions about knowledge and competence that is implied or oriented to with that.

Jefferson and Lee's "basic concern is the ways in which "troubles" are talked about in the everyday world, in ordinary interaction" (1992:521). On the basis of inductive investigation they introduce the notion of a troubles telling and specify how they understand the concept of troubles telling: "…it is not the "content" per se, but the organization of the talk which provides for a troubles telling; the same "content" may also be talked of in ways in which provide for other specifiable activities" (1992:525 f.).
Jefferson and Lee's analysis suggests that interactional trouble will recurrently arise when an "asynchrony" is present between an ongoing activity and the categories participants orient to. In particular, they describe a practice among friends or relatives in terms of trouble management in interaction; advice is recurrently

[44] Jefferson and Lee use data of "tape-recorded conversations in "ordinary" settings plus a small collection of "institutional" settings" (1992:521).

rejected if the giving of advice occurs early in talk about a "trouble". They suggest that the relevant local categories in terms of the roles participants orient to in a troubles telling are "troubles teller" and "troubles recipient", whereas the categories that are oriented to when delivering advice would be categories such as an "advice giver" and an "advice seeker". This means that when advice is provided in the course of a troubles telling at an early stage, the business of the talk changes with the rights and obligations that come with it. Jefferson and Lee suggest the following: "The recurrently found rejection of advice in talk about a trouble may, then, be accomplice to an attempt by a troubles teller to preserve the status of the talk as a troubles telling, with its particular structural and interactional properties, and to maintain incumbency in the category troubles teller with its particular and general perquisites" (1992:535). Conversely, Jefferson and Lee note that emotional reciprocity may not be well-fitted in service encounters in which categories such as advice seeker and advice giver are relevant.

They conclude:

> In short, it appears that it is from appropriate troubles recipients, in the environment of a troubles telling, that a troubles teller properly receives and accepts emotionally reciprocity, and from appropriate advice givers, in the environment of a service encounter, that an advice seeker properly receives and accepts advice (1992:546).

These membership categorizations (see section 3.3 on MCA), practices and methods that participants can be observed to orient to in the local accomplishment of actions is assumed to reflect "presumed common sense knowledge of social structures" (Hester & Eglin 1997:3).

Heritage and Sefi who investigated "aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers" (1992:359), note that both first time mothers and health visitors treat the initial visit as a service encounter in which the health visitors are oriented to as "baby experts" and not as "befrienders" (with whom sharing problems might have been relevant) (1992:365).

Heritage and Sefi's analyses show that health visitors often provide advice based on assumptions about mothers' doubtful knowledge or competence, rather than based on a clear establishment of a problem or based on an inquiry sequence (1992:389). They further point out that there are good interactional reasons for why health visitors "…tend to act on a presumption of systematic doubt about the mothers' abilities" (1992:413). In fact, they note that there is a central dilemma involved in advice giving. The authors describe a precondition for advice giving: "…advice giving must ordinarily constitute the advice recipient as being of at least doubtful knowledge or competence". (1992:413). However, if health visitors' inquiries establish that mothers are specifically knowledgeable and competent, there would be no basis for providing advice. On the other hand, inquiries might also be thought to expose and humiliate mothers. This dilemma may explain why health visitors often provide advice based on assumptions about mothers' doubtful knowledge or competence, rather than based on a clear establishment of a problem or based on an inquiry sequence.

6.3.3 Advice processes studied in online forums

Advice giving has also been studied as a phenomenon in online discussion forum, for example from linguistic perspectives that are inspired by the conversation analytic focus on talk as action.
Morrow (2006) for instance has investigated an online discussion forum on depressions and shows that postings that present a problem are often responded to with "advice" packaged in various ways.
Hence, the fact that participants respond by providing advice to postings in which a problem is presented points to the fact that not only is the problem, which is indicated, understood to be the topic, responses recurrently provide suggestions as to have to deal with this problem, and thus advice is understood by respondents as being projected or relevant as a response.

Morrow suggests that the methods participants use to request for advice are bound up with participants' concerns to present themselves as having competence in dealing with their own problems (2006:546). Similarly, he suggests that methods to provide advice are bound up with participants' concerns to minimize the potential threat to the one receiving advice, since, it is argued, providing advice implies that the person receiving advice is less knowledgeable than the one giving it (2006:541 f.).
In the data I show in this chapter participants recurrently indicate and make relevant a specific kind of knowledge about their problems, namely in particular knowledge about symptoms and medical information. Recurrently in the threads in which advice is invited to, participants indicate that they have a medical diagnosis related to the metabolism, and they request for medical information and aim at gaining knowledge about what to do. In this way they indicate lack of (knowledge about) practical experience with the outcome of action, i.e. treatment options and outcome.
In another study of online interaction, Ruble (2011) investigated aspects of social support in an online message board for English speaking individuals working as language assistants in French schools on short term contracts. The online message board focused on aspects of intercultural adaptation. The investigation focused on "advice, defined as messages that provide recipients with directives, opinions, or suggestions about how to solve a particular problem" (2011:401). The research interests in this study were to investigate how advice topics were initiated, and how the methods for initiating advice influence responses similar to the approach in this thesis. Another research interest was to investigate the strategies used in advice-giving postings in terms of "their appropriateness, utility, and face protection" (2011:403). The data material was coded on the basis of pre-established categories from an advice model (Goldsmith 2004) and from categories identified as relevant in previous studies (Morrow 2006; Harrison & Barlow 2009). In the corpus used, 29 topic threads were found to contain at least one advice message. The initial posts to the 29 advice topics were then coded, firstly for whether advice was sought directly or indirectly, next the responses that followed were coded for directness, solidarity and deference based on Goldsmith's advice model (2004). Furthermore, messages were coded in terms of the components of problem messages. This for example included descriptions of problems, expressions of feelings, requests for advice, personal experiences and expressions of solidarity or regard (Ruble 2011:406).
Ruble found that advice could be either unsolicited, directly solicited, or indirectly solicited. Unsolicited advice was described as forum participants who started new advice topics (which I suppose correspond to what I have termed "1st messages" or "1st postings") with the purpose of providing advice to whoever may be in need of it (2011:406). Indirectly solicited advice was when participants began a new topic and described a problematic situation but did not directly ask for advice (2011:407). Directly solicited advice

was advice topics in which advice was directly requested for. This happened in 23 out of 29 cases. Ruble notes that the responses to directly solicited advice varied greatly, and indicates two characteristics of the advice-seeking messages that appear to influence the responses: the *"specificity"* of the problem indicated and the *"emotionality"* of the post (2011:409). Responses following requests about a specific problematic situation tended to be indirect, while some responses entailed direct advice about the situation (2011:410). Responses following general requests also tended to be indirect and mostly entailed descriptions of the problem and personal experience rather than suggestions for how to act (2011:411). Responses following emotional requests usually entail direct advice about how to solve the problem described or exhibit high solidarity with the advice seeker (2011:414).
The study, according to Ruble, shows that advice givers seem to orient to an understanding that "visitors to the site are seeking advice, even when they do not directly ask for it" (2011:415). Ruble suggests that participants use other clues such as the specificity and emotionality of advice-seeking postings to make advice giving relevant, and in Ruble's terms, appropriate, useful and face protecting (2011:415). However, Ruble notes in conclusion that "the current coding categories available for examining supportive communication, and specifically advice communication, are insufficient for describing the complex context of online communication" (2011:415).

Morrow and Ruble refer to "advice" as a rather broad analytic category, in Ruble's terms as "messages that provide recipients with directives, opinions, or suggestions about how to solve a particular problem" (Ruble 2011:401, see above). The studies both point to the fact that respondents often provide advice, even when advice has not been solicited directly, but also that advice is often indirect, for example advice may amount to descriptions of problems and indications of personal experiences. In both studies they explain variations in linguistic strategies in terms of politeness theory (Brown & Levinson 1987) and suggest that participants have concerns to avoid an unequal relationship and concerns to mitigate potential threats to recipients' self-image (Morrow 2006), and to formulate responses that are appropriate, useful and face protecting (Ruble 2011:409).

Although recognizing that advice can be accomplished in many ways, the present study differs from the studies described above in that I specifically focus on instances in which respondents indicate suggestions for how WR1's can act, i.e. this chapter focuses on instances of what we may call direct advice. Furthermore, apart from the last set of examples shown (Example C11 and C12) the advice giving described in this chapter has been explicitly invited to. Practices for doing that is outlined in the analytical sections. The postings in this chapter differ in the methods participants recurrently use in for example activities in which participants share experiences (see chapter 6.1) and activities in which people are concerned with understanding their problems or finding an appropriate diagnoses to denote particular experienced problems (see chapter 6.2). The differences are particularly apparent when analyzing the sequential organization of actions, which is the focus in this thesis.
This implies that "advice processes" in this investigation are to be understood as a rather restricted term with recognizable and recurrent interactional features oriented to by the participants.
Rather than drawing on politeness theory for understanding the practices participants use in advice sequences I attempt to investigate advice giving as an interactional process. In particular I will draw on the CA-perspective on advice giving as I will aim at describing participants' understandings of their problems and of relevant actions related to their problems. Specifically I will draw on categories described by

Jefferson and Lee's (1992), namely "service encounter" and "troubles telling" as participants in my data seem to display an orientation towards what they do when they invite to and provide advice as a service encounter.

I will analyze four 1st postings and their first responses. I will initiate the analysis with a look at their titles. Then I will analyze the text and their first responses. The postings chosen work as examples of a recurrent pattern in how participants invite to and provide advice in the forum (see appendix, Example CC1-CC10, for more examples).

6.3.4 Analysis

6.3.4.1 The use of titles: Requesting for help

Here I will elaborate a bit on the use of titles in threads in which advice giving is oriented to as relevant. It turns out these titles often include some indication of a medical problem as well as an explicit indication of what respondents are expected to do, namely provide help.

I will analyze these titles as well as the 1st message and the first response, among other things in order to understand what kind of help WR1's might invite to. As indicated in chapter 5 in which I introduced to the data, each posting entails specific information placed in a square above the text. This information includes information about the time for posting the posting. Readers thereby may take this information into consideration when responding. The fact that the forum is asynchronous and provides readers with information about time for posting etc., does not mean that participants do not orient to the here and now when they write. On the contrary, as described in chapter 6.1, participants recurrently describe their problems as current and recurrent. However, they do not orient to getting responses from forum participants in the "here and now". This is obvious from the fact that they do not post single-turn postings such as for example greetings and wait for responses. Also, the problems participants indicate and the responses they make relevant are not understandable as acute problems requiring immediate actions from respondents. The way titles are constructed also points to this.

Example C1 looks as follows:

EX) C1 Title

hjælp mig mine stft. tal er hvist helt forkerte...

help me my metabolic numbers are all wrong I think…

In this title WR1 uses an imperative ("hjælp mig" (help me)) to express a desire to get help, and thereby displays an orientation to other forum participants as potentially being in a position to provide help. Expressions such as "hjælp mig" (help me)" would in emergency settings (for example emergency calls in which urgency and seriousness of a problem as well as the timing of help provision are oriented to as relevant (Edwards 2007:3)) ordinarily be understood as a plea for help, a cry for help, that is, as a way to get recipients to act in a relevant way immediately. In this case the expression "hjælp mig" (help me) occurs

in writing in a title on a discussion forum and is followed by a noticing or claim: “mine stft. tal er hvist helt forkerte...” (my metabolic numbers are all wrong I think…). The claim concerns WR1’s metabolic numbers, which are categorized by her as “all wrong”. However, WR1 also indicates that this categorization is just a claim (indicated with the Danish particle “vist”, here spelled “hvist” and translated with “I think”). If this claim turns out to hold, having metabolic blood test results that are all wrong, i.e. deviate very much from the normal range, this constitutes a medical problem. This is inferred from the fact that making assessments of blood test results are one of the basic methods medical professionals’ have for establishing medical problems and diagnoses.
In this title a (candidate) problem[45] is indicated as being apparent on the basis of medical indications (“stft. Tal” (metabolic numbers)). However, WR1 does not request for emergency aid and she does not address recipients as medical professionals. Rather she constructs her problem as a subjective assessment about medical indications that could suggest a problem. Furthermore, she constructs the (candidate) problem as a serious or extreme issue (by using an extreme case formulation (Edwards 2000), “helt” (all), and by using a category that explicitly refers to a problem (“forkerte” (wrong)), which can also be seen as resources used to indicate the statement in the title as a subjective assessment.

The title in Example C1 can be read as a first pair part in that help is requested for followed by an assessment of a (candicate) medical problem (too high blood test results compared to the normal range). Personal involvement is indicated, as it is stated in the title that the blood test results assessed are WR1’s blood test results and as the assessment is indicated as a subjective one. However, it is not specified what the problem is and how respondents could help deal with or solve the problem.

In Example C2 “help” is also invited to in the title:

EX) C2 Title

Hjælp - masser af symptomer men ingen behandling.
Help – lots of symptoms but no treatment.

As we saw in Example C1, the title in Example C2 initiates with an imperative, “Hjælp” (Help). The imperative works to indicate what respondents are expected to do, namely provide help. This imperative might work as a first pair part in its own right, especially in other settings, but in this case, and as we saw in Example C1, an indication of the nature of the problem requested help for occurs in combination with the request to provide help. The problem indicated is constructed as relevant to the request for help, and this

[45] Stivers (2002), as mentioned in chapter 6.2, describes two practices of presenting problems in pediatric encounters. One practice is characterized by parents only presenting symptoms, and the other practice is characterized by parents also including a candidate diagnosis. In the example presented here WR1 does not present symptoms that may point at a problem, and she does not present a candidate diagnosis. Rather she points at medical evidence that – she thinks – suggests that something is wrong. Pomerantz (1988) describes a strategy to seek information from co-participants in interaction. The strategy involves incorporating a “candidate answer” in a query. The formulation used in this example may be seen as an example of such a strategy. Furthermore, as Pomerantz points at, by using such a strategy the participant indicates knowledge and familiarity with a circumstance. This circumstance, however, is indicated as in need for verification (indicated with “I think”).

is accomplished by putting a dash between the request for help and the specification of the problem to which help is relevant: "- masser af symptomer men ingen behandling." (– lots of symptoms but no treatment.). In this example the problem is constructed as serious, but not acute, with the use of extreme case formulations ("masser" (lots); "ingen" (no)) and as a problem, which is readable as a problem the writer should logically and morally not have been faced with. This is accomplished by indicating a contrast (indicated with "men" (but)) between having lots of symptoms and not getting a treatment for the symptoms. Thereby the writer may point to a normative expectation that people who experience symptoms should be offered medical treatment (see Sneijder & te Molder 2005 on the use of specific kinds of script formulations used in combination with modal expressions to blend morality with logic). Again, as in Example C1 the problem indicated is recognizable as a medical problem as WR1 uses categories recognizable as medical categories ("symptomer" (symptoms); "behandling" (treatment)) and furthermore the problem is indicated as a problem with medical treatment specifically. As in Example C1, the formulation used in Example C2 also implies personal involvement. In this case WR1 indicates a view that her problem is not being handled in the way one would logically and morally expect such a problem to be treated.

The title in Example C3 initiates with a statement indicating a problem, also readable as being a medical problem related to treatment:

EX) C3 title

Stadig for højt TSH efter medicinøgning :(Hjælp

Still too high TSH after medicine increase :(Help

In the statement "Stadig for højt TSH efter medicinøgning" (Still too high TSH after medicine increase) it is suggested that an increase of medicine intake has not led to a normalization of a hormone referred to as "TSH". The statement indicating a problem is followed by an emoticon[46] (":(") illustrating a face with the corners of the mouth turning downwards. Then an invitation to provide help follows, which is indicated by using an imperative: "Hjælp" (Help). WR1 implies having acted on a medical problem (having a TSH that is above the normal range) by increasing the dosage of medicine with no success in her description of her problem, and she uses an emoticon to display some dissatisfaction with this. After having done this she displays herself as someone who is concerned with acting on her problems by addressing forum participants and requesting that they help her. This is accomplished with the imperative "Hjælp" (Help).

The title in Example C3 works to provide recipients with information about the nature of a medical problem, information about some emotional state related to this and information about what actions would be relevant for recipients to perform, namely providing help that is relevant in relation to the indicated problem.

[46]In the entry on emoticon in the Oxford dictionaries "emoticon" is defined as: "A representation of a facial expression such as a smile or frown, formed by various combinations of keyboard characters and used in electronic communications to convey the writer's feelings or intended tone" (emoticon n.d.).

The examples shown so far (Example C1-C3) of titles have in common that they state a problem indicated as medical and which they are personally involved in. The titles also have in common that they invite recipients to provide "help". Example C4 entails a statements about problems, but it does not express what actions recipients are expected to perform next. As we will see later, in Example C11 (in which the 1st posting text is presented) and in Example C12 (in which the first response is shown), WR1 does not explicitly request for advice in the text either, but nevertheless she receives, besides from expressions of sympathy that can be seen as responsive to WR1's expressions of being in shock etc., something we can recognize as advice from WR2. This may inform us further about how participants in the forum understand how they can relevantly and maybe even conventionally deal with descriptions of problems in responses, specifically with problems that involve treatment, which is the case for Example C4, C11 and C12.
In Example C4 the title is initiated with a description followed by an expression of an emotional state related to this instead:

EX C4

TSH lidt MEGET for højt! Dybt chokeret!

TSH a little A LOT too high! Deeply in shock!

The description initiating the title, "TSH lidt MEGET for højt!" (TSH a little A LOT too high!), indicates that WR1's TSH-level is far above the normal range. The writer has chosen to use a colloquial term to describe the degree to which the TSH level is above the normal range ("lidt MEGET" (a little A LOT)), which displays an understanding that the TSH level is or was very high compared to the normal range. The term used to describe the TSH level ("lidt MEGET") is to my knowledge a colloquial term not used in formal Danish. However, "lidt meget" is an expression that is used in everyday interaction in Danish, but I don't know of any studies that have investigated how the expression is used and responded to. I found some examples of how the expression is used in various online media[47]. This combination of "lidt" (a little) and "meget" ("a lot" or "much") seems to create several possible meanings and interpretations, as "lidt" seems both to downgrade and upgrade the meaning of "meget". "Lidt" understood in a literal sense works to downgrade the expression, whereas "lidt" put before "meget" also creates a meaning similar to the English expressions "more than enough" or "ample". The examples I found of uses of this expression also pointed to the fact that the term can have different connotations and meanings depending on the context in which it is said.

[47] Examples of occurrences of "lidt meget" in online media:

In a headline in a newspaper: "Meget lidt - og lidt meget: Om kunsten at snakke. Og kunsten at holde sin kæft" (English: "Very little – and a little a lot: About the art of talking. And the art of shutting up") (Munch 2005, January 1).

As part of the name of a facebook profile: "Hej, jeg synes du er lidt meget sød" (English: "Hi, I think you are a little very nice"). (https://www.facebook.com/pages/Hej-jeg-synes-du-er-lidt-meget-s%C3%A8d/374971182045962, visited 13th March 2014).

As citation in an online news article: "Vi havde derefter to dage, hvor der var lidt meget krise, hvor der skulle kæmpes" (English: "We had two days after that where there was a little much of a crisis where a fight was needed") Poulsen: 2013, October 18)

As part of the title in an online forum: "Er lidt meget offline" (English: "Am a little much offline") (Er lidt meget offline: 2013, December 21).

However, the term seems to imply a sense of subjectivity and accountability. The expression is recurrently used as part of assessments or descriptions, which imply opinions or evaluations.
WR1 makes use of capital letters when she uses the expression, "lidt MEGET". The use of capital letters might underline astonishment about the measured level. An exclamation mark ("!") is used which contributes to the construction of the TSH level as indeed surprisingly high. These elements, the use of colloquial terms to describe the degree to which the TSH level was too high, the use of capital letters, and the use of an exclamation mark, construct this description as a subjective one, as an assessment[48] and not merely as a statement. The assessment is followed by an expression of an emotional state ("Dybt chokeret!" (Deeply in shock!")), which is constructed as quite acute (with "chokeret!" (in shock!)) and serious or extreme (with "Dybt" (Deeply)). In this example there are no explicit indications of which actions would be relevant next, but the elements in the title signal acuteness or astonishment by means of using exclamation marks, using an assessment and expressions of unbalanced emotional states. In this way responses that deal with that are – implicitly - made relevant. Jefferson & Lee's study (1992) of talk about trouble in ordinary interaction points to the fact that in a troubles telling emotional reciprocity is expected rather than advice (see above). Later in this chapter I will analyze how WR1 constructs her 1st posting (see Example C11) as a troubles telling and how this is responded to in the first response (see Example C12).

Titles from this collection are used in different ways to make actions on the part of recipients relevant. In some titles (Example C1-C3) participants indicate explicitly which actions they orient to as relevant (i.e. getting help), and in another title (Example C4) the participant does not indicate which actions would be relevant next, but instead constructs the problems as acute and serious by describing a problem and indicating an unbalanced emotional state associated with the problem. These features were not recurrently found in titles of threads in which sharing experiences (chapter 6.1) or explanations for problems (chapter 6.2) was oriented to as the relevant thing to do or deal with.
In Example C1-C3 participants display an understanding that they know or have a candidate suggestion for the nature of their problem, it is medical, and know what would be relevant in order for them to solve or deal with their problems, namely getting help from forum participants, that is, getting help that relates to their described problem. In Example C4 a medical problem is also indicated, but no relevant actions are explicitly invited to, that is, the writer does not display an understanding that she knows or has a suggestion as to how to proceed in the title. Instead she displays emotional distress.

6.3.4.2 Treating a problem as medical

In the following sections I will show four 1st postings (Example C5, C7, C9 and C11) and four first responses (Example C6, C8, C10 and C12) that correspond with the four titles already shown (Example C1-C4).

As we will see, although the writers in three cases presented have initiated these threads and have invited to help (C5, C7 and C9), the problems they describe in their 1st postings and thus the kind of help that they invite to may be different and may thus make different responses relevant. I show a fourth case, Example C11, in which WR1 indicates a psychological (and social) problem rather than a strictly medical problem in

[48] Pomerantz (1984:57) for example notes "…that assessments are produced as products of participation; with an assessment, a speaker claims knowledge of that which he or she is assessing, and she notes on connections between participation and assessments".

order to show how this 1st message is treated by respondents compared to messages in which help is explicitly invited to.
vv
The focus of the analysis will be on showing 1) how problems are described and treated, 2) what kind of knowledge is indicated and oriented to, and 3) on how writers invite to and provide responses.
The 1st posting in Example C5 entails a greeting (line 1), some information regarding medicine and blood test results (line 3-9), a statement regarding how WR1's doctor deals with her treatment in terms of medicine intake (line 11), a question (line 13) and a closing (line 16). Overall, this structure is very recognizable, i.e. 1st postings recurrently initiate with a greeting following some sort of indications of medical or personal information and/or presentation of problems, some sort of action that specifically invite to action on the part of readers and a closing.

In previous analytical chapters I described practices for (inviting to) sharing experiences and practices for interacting about possible causes for experienced problems. After having analyzed examples from various collections, we can now begin to recognize that the overall structure of many 1st postings regardless of the specific business or topic is similar and recognizable.

However, we can also recognize differences in the details of how postings are constructed. If we focus on Example C5, we can notice that WR1 presents her problem in a specific way, that she indicates specific details of her medical history and that she makes specific action relevant on the part of readers.

Example C5: 1st postsing, "hjælp mig mine stft. tal er hvist helt forkerte...":

WR1 Tilmeldt: 09-11-2011 11:42	Den 09-11-2011 19:08 **hjælp mig mine stft. tal er hvist helt forkerte...**	

1 hej alle
2
3 jeg får 50mik. euthyrox om dagen, og mine tal er
4
5 tsh 3,9
6
7 t4 12
8
9 t3 1,32
10
11 min læge vil ikke regulere i min medicin,
12
13 er der en som vil skrive hvor jeg bør ligge.
14
15
16 mvh. Xxxxxxx

English translation:

WR1 Joined: 09-11-2011 11:42	On 09-11-2011 19:08 **help me my metabolic numbers are all wrong I think…**

hi all

I get 50 mic. Euthyrox a day, and my numbers

tsh 3,9

t4 12

t3 1,32

my doctor will not regulate in my medicine,

is there someone who will write where I should be.

regards xxxxxxx

Focusing on the details indicated in the 1st message above, we can notice that WR1 indicates the name of the medication she takes, the dosage of medication (line 3) and specific blood test results (line 3-9). From this information it can be inferred that WR1 has a medical diagnosis which is treated with medication. In line 11 WR1 states that her doctor will not regulate in her medication. This statement confirms that WR1's doctor is involved in her treatment.

However, stating that her doctor will not regulate her medication also recognizably constitutes a problem for WR1, i.e. a reason for writing, since WR1 has indicated in her title that her metabolic numbers, to her knowledge, are all wrong. Having wrong metabolic numbers (see title) is not WR1's only problem. The problem that makes it relevant for her to initiate a thread in the forum is the fact that her doctor will not regulate her medication (line 11).

In line 13 WR1 addresses readers with a question: "er der en som vil skrive hvor jeg bør ligge." (is there someone who will write where I should be.). We can notice that the question is constructed as having some coherence with the statement that the doctor will not regulate in WR1's medication by separating the question from the statement with a comma (and not for example with a punctuation mark), and we can notice that the question does not have a question mark. We can also notice that the question is formatted as a yes/no-typed interrogative, which literally asks if someone would indicate the normal values for the blood tests she has indicated. Hence, WR1 asks readers of the 1st posting for medical knowledge.

Let us look at the response she gets:

Example C6: 1st response, "hjælp mig mine stft. tal er hvist helt forkerte...":

WR2 Tilmeldt: 20-08-2009 12:24	Den 11-11-2011 12:13 **Re: hjælp mig mine stft. tal er hvist helt forkerte...**	

1 Hej Xxxxx,
2
3 Du får ikke nok stofskiftehormon. Din tsh er for høj, den skal ned på omkring 1, men
4 selvfølgelig skal man også selv mærke efter hvor man har det bedst. De andre tal er
5 for lave og vil stige, når din tsh falder. Nogle mennesker omdanner dog ikke selv t4
6 særlig godt til t3, og derfor kan man tale med lægen om at få t3 tilskud. Men prøv
7 først at tale med lægen om dosis-forøgelse. Du bør have en specialist og ikke egen
8 læge til at behandle dig. En tsh allerede over 2,5 anses for at være for høj og give
9 symptomer, selvom referenceværdierne siger noget andet. Det bør du konfrontere
10 lægen med, hvis han/hun ikke lytter. På Rigshospitalet anvender man en tsh på 1
11 som normal vejledning, så det kan du eventuelt referere til.
12
13 Kh.

English translation:

WR2 Joined: 20-08-2009 12:24	On 11-11-2011 12:13 **Re: help me my metabolic numbers are all wrong I think…**	

Hi Xxxxx,

You don't get enough metabolic hormone. Your tsh is too high, it should be down at around 1, but of course one should also feel where one feels the best. The other numbers are too low and will increase when your ths falls. Some people don't transform t4 to t3 very well themselves, though, and therefore one can speak to the doctor about getting a t3 supplement. But try first speaking with the doctor about a dosage increase. You should have a specialist and not your GP treating you. A tsh even at 2,5 is considered too high and giving symptoms, even though the reference values say something else. You should confront the doctor with this if he/she does not listen. At Rigshospitalet [one of Denmarks' biggest and most specialized hospitals] one uses a tsh at around 1 as normal guidance, so you can possibly refer to that.

Regards.

The first response in Example C6 initiates with a personal greeting (line 1), and a complex response, or answer (in the analytical chapter 6.4 ,on "responses to responses", one of the main focuses is how responses are formulated as responses or answers), occurs in line 3-11 before signing of in line 13.
The answer is initiated with a statement in line 3: "Du får ikke nok stofskiftehormon." (You don't get enough metabolic hormone.). This statement is readable as a response to the problem and expressed desire to get help indicated in the title of the 1st posting written by WR1 ("hjælp mig mine stft. tal er hvist helt forkerte..." (help me my metabolic numbers are all wrong I think…))., because the statement is readable as providing the[49] reason for why WR1's metabolic numbers are all wrong. By providing a reason as the first thing after greeting WR2 orients to the details in the title and the 1st posting, namely that WR1 has indicated a problem with all wrong blood test results (which are also listed for the readers), she has indicated having a doctor that will not regulate in the medication, and has invited to help and information about normal blood test ranges.

[49] This statement is constructed as a fact and does not entail markers working to indicate a subjective character of this statement.

In providing a reason this statement also implies agreement with the statement indicating a problem in the title by WR1. Here, this is not done by using acknowledgement tokens or by formulating agreement in explicit terms (see chapter 6.2 on explaining illness). Rather, WR2 orients to providing help invited to by WR1 (see title) by providing a medical reason for why WR1's blood test results are all wrong; the amount of hormones she gets. Agreement is implied on the basis of providing a reason for why the statement holds. We may say that WR2 treats the problem WR1 has indicated as an established medical fact.

WR2 treats the problem as a medical problem. She does that by treating the medical information provided by WR1 as relevant to deal with. In line 3 – 5 she provides assessments ("Din tsh er for høj," (Your tsh is too high); "De andre tal er for lave" (The other numbers are too low))) of the metabolic rates provided by WR1 in her 1st posting. WR2 includes in the assessment information about optimal values ("den skal ned på omkring 1" (it should be down at around 1)), she indicates experiences (see chapter 6.1 on sharing experiences) as relevant ("men selvfølgelig skal man også selv mærke efter hvor man har det bedst" (but of course one should also feel where one feels the best)), and she also indicates knowledge about correlations between metabolic hormones ("De andre tal er for lave og vil stige, når din tsh falder" (The other numbers are too low and will increase when your ths falls")). Providing assessments of WR1's measured hormone values provided in the 1st posting in relation to optimal values has been made relevant by WR1 in her 1st posting in which she poses the question "er der en som vil skrive hvor jeg bør ligge" (is there someone who will write where I should be). (Example C7, line 13). Hence, these assessments are understandable as providing WR1 with the knowledge she has requested for, i.e. we can understand the assessments as providing answers.

WR2 accomplishes with her assessments to display knowledge about normal ranges for hormone values (orienting to optimal hormone values made relevant by WR1 by using a modal construction ("bør ligge" (should be))) and to demonstrate an ability to apply this knowledge on specific measured values (thereby also orienting to the availability of WR1's specific measured numbers as relevant as well as orienting to the indication by WR1 that a response should address her specific case). Furthermore, by not only assessing WR1's measured values but also displaying her knowledge and referring to experiences as relevant, she displays an orientation to providing a basis for making medical assessments of a fellow sufferer's measured hormone values as a relevant thing to do in the forum and specifically as a response to the 1st posting written by WR1 (Example C5). Thus, she shows that she understands knowledge of how to understand medical information to be relevant for how to deal with WR1's problem, and she also shows that she recognizes personal experiences as the basis for assessing whether something is wrong.

In the remaining part of the posting, from line 5 onwards, WR2 displays an orientation to suggesting relevant actions on WR1's part. The first suggestion, "og derfor kan man tale med lægen om at få t3 tilskud." (and therefore one can speak to the doctor about getting a t3 supplement) (line 6) is constructed as being based on knowledge: "Nogle mennesker omdanner dog ikke selv t4 6 særlig godt til t3," (Some people don't transform t4 to t3 very well themselves, though,) (line 4-5). It is constructed as applying to some people, and thus not necessarily to WR1. WR1 is implied as the recipient in line 6-7 in which an imperative is used: "Men prøv først at tale med lægen om dosis-forøgelse." (But try first speaking with the doctor about a dosage increase). A suggestion for an action for WR1 to perform is thus formulated, and it is indicated that this should be the "first" action to perform. WR1's statement that her doctor will not participate in the regulation of her medicine (Example C5, line 11), is thus not accepted as a reason for not consulting health professionals on the matter concerning regulation of medication, as WR2 indicates

consulting health professionals as the first step. Furthermore, WR2 does not challenge the validity of the statement made by WR1 either. In fact, what we see is that WR2 does not deal with the possibly complainable matter[50] concerning the doctor's resistance to regulate WR1's medication brought up by WR1 as a complaint. Traverso (2009) investigated third party complaints in conversation between friends and notes that an affiliative response to a complaint would be "to pity or express that they feel sorry for him/her" (2009:2385). We see that WR2 does not treat WR1's initiative as making expressions of pity relevant.

Medical treatment is an issue that WR2 deals with, as she addresses the issue of treatment by health professionals by telling WR1 that a specialist should treat her instead of her GP ("Du bør have en specialist og ikke egen læge til at behandle dig. (You should have a specialist and not your GP treating you.), line 7-8). WR1 is addressed directly ("Du" You), and WR2 provides a description of the preferred state of affairs in regard to treatment by health professionals by using a modal construction ("bør have" (should have). These features makes the statement readable as doing instructing and makes it understandable as "doing advising"; instead of for example treating WR1's statement about the doctor's resistance to regulate WR1's medication as a complaint by expressing pity, WR1 is addressed as the agent, and WR2 provides WR1 with a basis (i.e. knowledge about health professionals) for acting on her problems.

Furthermore WR2 displays herself as being knowledgeable about preferable state of affairs in terms of medical experts and treatment options. WR2 continues to display herself as knowledgeable in line 8-10 in which she refers to a specific hormone value ("En tsh allerede over 2,5 anses for at være for høj og give symptomer, selvom referenceværdierne siger noget andet. Det bør du konfrontere lægen med, hvis han/hun ikke lytter." (A tsh even at 2,5 is considered too high and giving symptoms, even though the reference values say something else. You should confront the doctor with this if he/she does not listen"), and constructs this value as being a limit value that is generally used. Indicating an assessment of the value as a general fact is accomplished with a passive construction with the verb "anses" (is considered), which means that WR2 does not specify which agents are behind the statement. She is also suggesting, or rather telling, WR1 that this is a fact she can confront her GP with in case he or she doesn't listen. In this way WR2 is offering WR1 some knowledge and advising her to use this knowledge in a hypothetical future conversation with her GP as a tool to make him or her listen. WR2 displays an understanding that medical knowledge, or more specifically knowledge of general practice in regard to interpretations of blood test results, is relevant when discussing treatment with health professionals. She might also be seen to orient to the request made by WR1 ("er der en som vil skrive hvor jeg bør ligge." (is there someone who will write where I should be., Example C7, line 13)) about optimal hormone values as well as the displayed insecurity WR1 constructs in the title of the 1st posting ("hjælp mig mine stft. tal er hvist helt forkerte..." (help me my metabolic numbers are all wrong I think…)). In that sense WR2 shows that she understands it to be an issue, a problem that should be dealt with, that WR1 displays and expresses a lack of medical knowledge.

WR2 describes a general practice of using a TSH of 1 as normal guidance and refers to "Rigshospitalet" as the source in line 8-9, and she then suggests WR1 to refer to that as a possibility. Implied here is an understanding that "Rigshospitalet", as one of Denmark's biggest and most specialized hospitals, is an authoritative source that health professionals are expected to conform to. WR2 here invokes her knowledge about general, and best, practice as relevant and offers this to WR1 as a resource in dealing

[50] See for example Ruusuvuori & Lindfors (2008) on complaints as an interactional accomplishment in health care institutions.

with her described problem, that is, WR2 both deals with the request made by WR1 about optimal hormone values and with her account for writing, namely that her doctor will not regulate in her medication. She does this by invoking medical knowledge as relevant and by telling WR1 how she can act on the lack of participation on the part of her GP. In sum, WR2 treats WR1's initiative not as a complaint but as an invitation to provide advice that makes suggestions for how to act relevant.

6.3.4.3 Treating a problem as a candidate metabolic problem

The following 1st posting has an overall structure similar to the structure in Example C5. It consists of a greeting (line 1), a telling, including medical information (line 2-20), actions that invite to responses (line 32-42) and a closing (line 44). In the text in Example C7 WR1 makes medical information relevant, resembling what we saw in Example C5. However, as we shall see, WR1's problem in Example C7, as opposed to the problem described in example C5, is that WR1 in Example C7 has not been offered medical treatment for the problems she experiences by the doctor. The problem, though, calls for action according to WR1 (see line 38-40):

Example C7: 1st posting, "Hjælp - masser af symptomer men ingen behandling.":

WR1 Tilmeldt: 12-10-2010 23:30	Den 13-10-2010 00:35 **Hjælp - masser af symptomer men ingen behandling.**	

1 Hej alle sammen.
2 Jeg har lige meldt mig til netdoktor fordi jeg har brug for hjælp fra nogen der kan
3 sætte sig ind i hvordan jeg har det. Jeg har læst lidt i debatterne og det ser ud til at
4 der er en del herinde der ved en hel del om stofskiftet.
5
6 Jeg er pga. en anden sygdom ofte på hospitalet og får taget diverse blodprøver og
7 det er også helt fint.
8 De sidste 4-6 mdr. er jeg begyndt at have mange smerter i mine led, jeg bliver nemt
9 forvirret og kan ikke koncentrere mig om mit arbejde eller en samtale med venner,
10 min hukommelse er helt væk og min vægt er støt stigende. Generelt føler jeg mig
11 som en kvinde på 80 og ikke 27. Skal måske lige tilføje at jeg har haft store
12 humørsvingninger og faktisk er i behandling med anti-depressiv.
13
14 Alle disse symptomer fik en af de sygeplejersker jeg normalt taler med til at foreslå
15 at jeg fik tjekket mit stofskifte - derfor var jeg hos min læge i torsdags.
16
17 Idag fik jeg så følgende mail fra min læge:
18
19 Prøverne viser let forskudte tal . Ikke brug for behandling men
20 kontrol igen om 2 måneder,
21
22 Med venlig hilsen
23
24 xxxxxx xxxxxxxx
25 Læge
26
27 07 10 2010 TSH;P 4.7 miu/l GV.: 0.30 - 4.5
28 07 10 2010 T3,total;P 4.2 nmol/l GV.: 1.1 - 2.5
29 07 10 2010 T4,total;P 201 nmol/l GV.: 60 - 140
30 07 10 2010 P-Thyreoidea-screening Udført GV.:
31
32 Disse tal siger absolut ikke mig nogen ting så håber at der måske er en herinde der

33 kan hjælpe. Min læge kan jeg ikke komme til at tale med før næste uge og vil
34 gerne vide noget nu.
35 Beklager hvis jeg ikke har forklaret mig godt nok, hvis der er noget I har brug for
36 at vide spørger I bare.
37
38 Jeg er selvfølgelig glad for at han ikke mener jeg har brug for behandling, men jeg
39 kan ikke blive ved med at have det så skidt som jeg har det, så der skal gøres et
40 eller andet - jeg aner bare ikke hvad.
41
42 Håber der er nogen herinde der kan give mig et råd.
43
44 Mange hilsner Xxxx

English translation:

WR1 Joined: 12-10-2010 23:30	On 13-10-2010 00:35 **Help – lots of symptoms but no treatment.**

Hi to all of you.
I just joined netdoktor because I need help from someone who can relate to how I feel.
I have read a little in the discussions and it seems there are quite a few in here who know a great deal about the metabolism.

Because of another medical condition I am often at the hospital and get various blood tests and that is just fine. The last 4-6 months I have started having many pains in my joins, I easily get confused and cannot concentrate on my work or a conversation with my friends, my memory is all gone and my weight steadily going up. Generally I feel like a woman at the age of 80 and not 27. Maybe I should add that I have had significant mood swings and am actually in treatment with anti-depressives.

All these symptoms made one of the nurses I normally speak to suggest that I got my metabolism checked – therefore I had an appointment at my doctor this Thursday.

Today I saw the following mail from my doctor:

The tests show slightly displaced numbers. No need for treatment but a control check up again in 2 months,

Sincerely yours

xxxxxx xxxxxxxx
Doctor

07 10 2010 TSH;P 4.7 miu/l GV.: 0.30 - 4.5
07 10 2010 T3,total;P 4.2 nmol/l GV.: 1.1 - 2.5
07 10 2010 T4,total;P 201 nmol/l GV.: 60 - 140
07 10 2010 P-Thyreoidea-screening Done GV.:

These numbers do not mean anything to me at all so I hope that there might be someone in here who can help. I can't get in touch with my doctor before next week and I want to know something now.
I apologize if I haven't explained myself well enough, if there is anything you need to know just ask.

Of course I am happy that he doesn't think I need treatment, but I cannot keep feeling as bad as I do now, so something must be done – I just have no idea what.

Hope someone in here can give me an advice.

Many regards Xxxx

As I noted on in the section about the use of titles, WR1 requests for help in the title, and she indicates in the title that her problem in a nutshell is that she is not being treated for the symptoms she has. She

implies, by referring to her problems as “symptoms”, that she understands her problems to have a particular medical cause. Thus parallel to Example C5, WR1 uses categories to indicate an understanding of her problem as medical and related to treatment.
In the text in Example C7 WR1 initiates with a greeting addressing “alle sammen (all of you) (line 1), and in line 2 she presents herself as someone who is new in the forum (see Benwell & Stokoe (2006) on “newbie” as a virtual identity). She also indicates as a reason for writing that she needs help from someone who can relate to how she feels. WR1 thus makes common membership (see section 3.3 on MCA) of people who share particular experiences a relevant category. This was not done in Example C5.
Then WR1 states her impression about other forum participants’ knowledge about metabolism (“Jeg har læst lidt i debatterne og det ser ud til at der er en del herinde der ved en hel del om stofskiftet.” (I have read a little in the discussions and it seems there are quite a few in here who know a great deal about the metabolism.), line 3-4). This is not merely a statement, it works to account for addressing other forum participants by expressing an understanding of their competences and thus implicitly what they can contribute with.

Whereas WR1 in Example C5 indicated already being treated medically for a metabolic disorder and requested for specific medical information (information about optimal blood test values), in the 1st posting in this example, Example C7, knowledge about metabolism as such is indicated as potentially relevant for *recipients* to provide. The type of knowledge WR1 anticipates recipients to have is not specified, and may thus refer to different types of knowledge acquired through experiences with having a metabolic disorder. Other forum participants are thus constructed as having some expertise acquired through experiences from suffering from a metabolic disorder that might help WR1.

WR1 presents her problem as a medical problem as she presents a kind of medical history in line 6-30. It is built to account for why and how metabolism had been suggested as a possible cause for various symptoms experienced by WR1 (line 8-12); WR1 describes how an authoritative source, a nurse, had initially suggested that WR1 had her metabolism checked on the basis of the experience of various symptoms. In line 6-15 WR1 embeds a suggestion for a candidate explanation for her problem which is medical possibly caused by a metabolic condition, and she provides an extensive list of symptoms, understood as pointing to a medical cause. Furthermore she indicates that she has actually acted on the nurse’s suggestion to get the metabolism checked and has seen her doctor to address this issue (line 14). In this way WR1 displays herself as someone who takes action. By presenting her medical history in this way she shows that she – and other medical professionals – have treated her problem as a candidate medical and candidate metabolic problem.

WR1 treats her problem as medical in other ways too, for example by indicating information she has received by her doctor. In line 17 WR1 announces that an insertion of an email she has received from her doctor will follow. It is mentioned that the email was received on the same day as writing the posting (“Idag” (Today), line 17). This information both works to account for addressing forum participants at that particular day, and it works to display WR1 as a person who acts on her problems quickly. This also signals that WR1 understands her problem to be requiring immediate action.

The text provided in line 19-30 is readable as an insertion of the email authored by the doctor with slight changes such as anonymization of the doctor's name (line 25). Through this action, WR1 seems to orient to posting her message in a public forum. The email initiates with an assessment of the blood test results ("Prøverne viser let forskudte tal. " (The tests show slightly displaced numbers.), line19), recommendations for treatment ("Ikke brug for behandling men kontrol igen om 2 måneder" (No need for treatment but a control check up again in 2 months), line 19-20), a closing (line 22-25), and a table which seems to entail dates of taking the blood tests, measured values of specific hormones and normal ranges of the hormones measured (line 27-30). WR1 makes a blood test measurement, specific measured values, and a professionals' assessment and recommendations for treatment relevant by inserting most parts of the original email received by the doctor into her posting. Thereby she makes a medical approach to her problems relevant. She also orients to an "objective", "medical" approach to her problem by inserting what was actually written literally by the doctor instead of providing some other formulation of it. Furthermore, the doctor does deal with whether actions, that is treatment, should be initiated on the basis of the measured blood test values. The email is constructed in such a way that (the assessment of) the blood test results make out the basis for declining further action. In this way the doctor is orienting to an understanding that it is relevant to address treatment as a topic as such regardless of whether treatment is recommended or declined. In the doctor's email we, then, also see an orientation towards the relevance of the question about whether or how to act on problems.

WR1 in this example is very much concerned with presenting her problem as a candidate metabolic problem. This was not the concern for WR1 in example C5, in which a doctor's resistance to provide instructions as how to regulate medicine was presented as the problem for WR1. In Example C7 WR1 refers to medical experts' opinions, and we see her listing "symptoms". She orients to other forum participants as having expertise that might help her in dealing with her problem.

These issues are also built on as WR1 invites recipients to respond. In line 30-37 WR1 in various ways addresses forum participants and provides cues to her expectations about which actions would be relevant on the part of recipients. WR1 states "Disse tal siger absolut ikke mig nogen ting" (These numbers do not mean anything to me at all) (line 32). The category "Disse tal" (These numbers) is recognizable as referring to the blood test results provided in the table above the statement. The fact that WR1 is not able to make sense of the blood test results is constructed as the reason for addressing forum participants (accomplished with the conjunction so) and for inviting them to help; "så håber at der måske er en herinde der kan hjælpe " (so I hope that there might be someone in here who can help) (line 32-33). Notice also that it aligns with the view she has expressed about forum participants knowledge in line 3-5. WR1 constructs her invitation as an expression of a hope, that is, as an indirect request. She does not express an expectation that help will be provided; in fact she constructs the provision of help as a possibility (accomplished with "måske" (might))[51].

Indications as to how the invitation to provide help should be understood are provided in line 33-34 as WR1 accounts for addressing forum participants at the present time ("Min læge kan jeg ikke komme til at tale

[51] In the request there is also an indication that help from "someone" is sufficient, that is, one response providing help might be enough. In her opening WR1 addresses "all of you" (line 1), and these different ways of addressing and referring to forum participants as a group or as individuals when performing different actions might be a way of dealing with entitlement to requesting as well as a way of dealing with possible contingencies implied in the request (see Curl & Drew 2008).

med før næste uge og vil gerne vide noget nu." I can't get in touch with my doctor before next week and I want to know something now.)). WR1 explains that the kind of help she is inviting to includes knowledge ("vil gerne vide noget" (I want to know something)) provided immediately ("nu" (now)). Requesting for "Help" is thus not constructed as a call for emergency aid in the sense that WR1 is inviting forum participants to treat her problem as an emergency, to which immediate professional medical interference is required. Instead she is treating her problem as a problem that could be solved with the provision of relevant information.

WR1 shows that she is concerned with providing forum participants with information that is formulated in a particular way as relevant in line 35, in which she apologizes if the information she has provided is not sufficient to provide a relevant response. She also encourages forum participants to ask if they need specific information. This, again, shows her orientation to the importance of providing appropriate ("well enough") information. WR1 indicates that she knows that an adequate problem presentation is necessary in order for respondents to deal with her request. Also, she displays an understanding that she might not have been competent enough herself in providing the medical information required to provide the help needed. In a sense, by indicating this she is displaying herself as someone who is dealing competently with being incompetent on this matter – she knows what she doesn't know, is one way of putting it.
In line 38-40 WR1 deals with the fact that her doctor has recommended that she should not be treated medically. She initiates with an admission of relief regarding the doctor's recommendation: "Jeg er selvfølgelig glad for at han ikke mener jeg har brug for behandling" (Of course I am happy that he doesn't think I need treatment) (line 38) which is constructed as being an obvious fact ("selvfølgelig (Of course)). The admission is continued with a statement that is constructed as contrastive to the admission of relief (this is accomplished with the conjunction "men" (but)). In this statement ("men jeg kan ikke blive ved med at have det så skidt som jeg har det, så der skal gøres et eller andet - jeg aner bare ikke hvad." (but I cannot keep feeling as bad as I do now, so something must be done – I just have no idea what")) WR1 rejects that not acting on her current well-being is an option. In fact, she states: "så der skal gøres et eller andet - jeg aner bare ikke hvad." (so something must be done – I just have no idea what). Here she makes her experience of her problem relevant as well as her disposition that action is required.

Announcing that she knows action is relevant, but does not know what to do makes it relevant for forum participants to provide relevant suggestions as how to act and is recognizable as a way of inviting to advice understood exactly as providing instructions or suggestions on how to act. As this statement is placed in a posting in which WR1 has made common membership with other forum participants relevant based on their experiences (line 2), suggestions based on experiences are made relevant.
WR1 makes a formulation that summarizes what the actions in her 1st posting attempt to invite to: "Håber der er nogen herinde der kan give mig et råd" (Hope someone in here can give me an advice) (line 42). In this statement WR1 explicitly refers to "advice" as relevant[52]. WR1 displays an understanding that providing help (line 32-33) should be understood as providing advice (line 42), and that "advice" should be understood as providing suggestions as how to act (line 39-40). WR1 deals with the issue of taking action on the basis of blood test results although her doctor has not recommended treatment.

[52]We can also notice that the formulation is formatted in a way that orients to entitlements in a similar way as the indirect request in line 32-33.

The overall structure of the 1st postings in Example C5 and C7 is similar in that both examples entail a greeting, a problem presentation, invitation to response, and a closing. The problems presented in both cases relate to medical treatment and in both cases WR1 had requested for help in the title. However, details in how the problems are constructed and in how responses are invited to indicate that the problems the writers are faced with and the responses they invited to are different. We saw in Example C5 that WR1 is being treated for a metabolic condition, whereas WR1 in Example C7 has just been declined treatment by her doctor, while still experiencing problems. The kind of help WR1 is inviting to in Example C7 is not specific medical knowledge as in Example C5, but rather knowledge or expertise that forum participants who have experiences with metabolic conditions can contribute with. Importantly, in both cases, participants treat the problems as medical problems. They do so by indicating medical information, and by inviting to responses that includes and/or considers this knowledge.

The following example, Example C8, is the first response to the 1st posting in Example C7. In the first response in Example C8, which I will analyze in the following, hormone values are assessed before "advice" is provided, just as we saw that WR2 provided assessments of WR1 blood test results before providing advice in Example C6. Thus, assessing, or dealing with, medical information before indicating advice can be seen as a practice respondents use in order to treat an indicated problem as a medical problem. However, as opposed to the previous example, here WR2 acknowledges that results of medical tests look a little strange, but does not acknowledge a metabolic disorder as an established final diagnosis:

Example C8: 1st response, "Hjælp - masser af symptomer men ingen behandling.":

WR2 Tilmeldt: 28-01-2010 17:40	Den 13-10-2010 21:53 **Re: Hjælp - masser af symptomer men ingen behandling.**	

1 Hej Xxxx
2 Det ser lidt mærkeligt ud, med så skæve t3 og t4 men en mindre skæv tsh.
3 Selvom den også er en smule for høj (altså lidt for lavt stofskifte) jeg kan ikke
4 huske referencerne, men går ud fra det er dem der står efter prøvesvar.
5 Jeg tænker at du skulle ringe til den afd. du er tilknyttet og tale med dem om dine
6 sympt. og tallene.
7 Jeg ville insistere på en henvisning til en endokrinolog, og spørg evt. om at få
8 tjekket tpo (antistoffer)
9 Kan din nuværende sygdom evt. påvirke din skjoldbruskkirtel?
10 Jeg har selv Hashimotos og havde også en tsh der ikke svarede overens med t3 og
11 t4.
12 Igen ring til din afd. på hosp.
13
14 Held og lykke og god bedring
15 Hilsen Xxxxx

English translation:

WR2 Joined: 28-01-2010 17:40	On 13-10-2010 21:53 **Re: Help – lots of symptoms but no treatment.**

Hi Xxxx
It does look a little strange with that skewed t3 and t4's but a less skewed tsh.
Even though it is also a little too high (that is a little too low metabolism) and I cannot remember the references, but
assume they are the numbers after the test results.
I am thinking you should call the department you are affiliated with and speak to them about your sympt. and the numbers.
I would insist on getting a referral to an endocrinologist and possibly ask to get tpo (antibodies) checked.
Can your current illness possibly affect your thyroid?
I have Hashimoto myself and also had a tsh that didn't accord with t3 and t4.
Again, call your dep. at hosp.

Good luck and a speedy recovery
Regards Xxxxx

As in the first response shown in Example C6, this first response is initiated with a greeting (line 1), and closed with a closing (line 15).
From the sequential organization of the response we see how WR2, as WR2s in every other example analyzed above, orients to the actions made relevant by WR1, who in her 1st posting expresses lack of knowledge in interpreting the blood test results as an account for requesting for help, and who also expresses that acting on her problems is necessary, but that she does not know what to do (see Example C7). WR2 does that by first providing an assessment of WR1's blood test results (Example C8, line 2-4) and then by pointing to actions WR1 can pursue (line 5-6).
The response in Example C8 furthermore entails indications of personal information about a metabolic disorder WR2 has and expressions of positive regard (line 14), which Example C6 did not.

WR2 orients to an understanding that WR1's problem is medical by constructing an assessment of WR1's blood test results as the first thing after greeting. Furthermore, she constructs the assessment she provides as being in agreement with a health professional's assessment, and she orients to providing the basis on which her assessment is made as being medical.
WR2 suggests WR1 to consult the health professionals she is affiliated with to discuss symptoms and blood test results ("Jeg tænker at du skulle ringe til den afd. du er tilknyttet og tale med dem om dine sympt. og tallene." (I am thinking you should call the department you are affiliated with and speak to them about your sympt. and the numbers.), line 5-6). WR2 also suggests WR1 to get a referral to an expert in endocrinology and points to a potential investigation that might explain why WR1 experiences problems ("Jeg ville insistere på en henvisning til en endokrinolog, og spørg evt. om at få tjekket tpo (antistoffer)" (I would insist on getting a referral to an endocrinologist and possibly ask to get tpo (antibodies) checked.), line 7-8). Hence, WR2 is pointing to actions WR1 can pursue, and the actions, similar to the case of the advice-giving in Example C6, involve consulting health professionals, stressing a potential difference between health professionals, and pointing to a benefit in getting treatment from experts in metabolism. WR2 thus orients to advising WR1 on how she can act in the future in relation to medical related problem and in accordance with general acceptable norms for how patients should deal with their medical problems, that is, they should consult health professionals. The formulations, specifically the choices of

verb constructions, the modal constructions "skulle ringe" (should call) and "ville insistere på" (would insist), display an understanding that the actions suggested for WR1 to pursue (i.e. the advice provided) have a normative character, and in both cases refer to aspects of communication with the doctor. A consequence of the implied normative character of the actions accomplished by using modals in this way and in this sequential context is that the actions come across as instructive and thus as "advice". Revisiting the 1st posting which this is a response to (Example C7), we see that what WR1 in fact invited to was advice ("Håber der er nogen herinde der kan give mig et råd." (Hope someone in here can give me an advice.), line 42), and we then see that WR2 understands it to be relevant to treat WR1's problem as a medical problem by assessing the medical information (line 2-4) and by providing instructions on how to act (line 5-6).
WR2 uses formulations in the advice giving in line 5-6 to mitigate the implied entitlements to telling[53] other people what to do – establishing the advice giver as an expert relatively to the advice receiver[54]. The mitigation devices includes the formulation "Jeg tænker" (I am thinking) (line 5) which implies an understanding that the advice giving is based on "subjective" activity, and in line 7-8 the advice giving is formulated as a description of what WR2 would do if she was in WR1's shoes ("Jeg ville insistere på en henvisning til en endokrinolog, og spørg evt. om at få tjekket tpo (antistoffer)" (I would insist on getting a referral to an endocrinologist and possibly ask to get tpo (antibodies) checked)). In this way she makes relevant the fact that forum participants generally are expected to be experiencers of metabolic problems and *not* medical professionals (see chapter 6.1), and thus have the possibility of sharing as fellow sufferers and in and through demonstrating empathy by indicating what WR2 would do in WR1's place. WR2 shows that this is how the advice giving is to be understood, that is, that the advice should be understood to be formulated by someone with personal experiences with a similar problem (also see chapter 6.1).
WR2 recurrently makes relevant her membership category as a fellow sufferer by using constructions that "put her in WR1's shoes", by referring to her own medical condition and by constructing personal information regarding her medical condition as similar to the information WR1 has provided ("Jeg har selv Hashimotos og havde også en tsh der ikke svarede overens med t3 og t4" (I have Hashimoto myself and also had a tsh that didn't accord with t3 and t4), line 10-11)[55]. In these ways WR2 mitigates the implied entitlements indicated in and through providing advice. This way of orienting to entitlement and mitigating the provision of advice we see in Example C8 is different from the methods used in Example C6 in which WR1 did not indicate personal experiences in order to respond relevantly.

If we, again, revisit the 1st postings, Example C5 and Example C7 we see that whereas WR1 in Example C5 (to which Example C6 is a response) invites others to provide medical knowledge, WR1 in Example C7 to which Example C8 is a response besides for inviting others to help her understand the blood test results, indicates that she has joined the forum "fordi jeg har brug for hjælp fra nogen der kan sætte sig ind i hvordan jeg har det." (because I need help from someone who can relate to how I feel.) (Example C7, line 2-3). We may, thus, understand the methods, resources and understandings used by WR2 in Example C6

[53] See Craven & Potter (2010) on different orientations to requests and directives in UK family mealtime settings. Craven & Potter suggest that by using directives the speaker in a sense claims entitlement to tell rather than to ask.

[54] See Heritage & Sefi (1992); Lee & Jefferson (1992); Morrow (2006); Ruble (2011) who in various ways deal with "dilemmas" of advice. See also Drew and Curl (2008) on entitlements.
[55] However, notice that WR2 does not construct the medical category, the diagnosis Hashimoto, as a category that she shares with WR1.

and C8 as in a sense responsive to the methods, resources and understandings indicated by WR1 in the 1st posting.

We may also notice that although WR2 in Example C8 does use strategies that displays empathy with WR1, the problem WR2 is concerned with dealing with is a medical problem and she thus treats the activity as a kind of service encounter rather than as a troubles telling in which emotional reciprocity might be done as the main activity rather than as a resource for providing understanding of a medical problem and for providing advice.

In line 12 WR2 reformulates[56] the gist of her advice-giving: "Igen ring til din afd. på hosp." (Again, call your dep. at hosp.). The function of this as a reformulation[57], that is, as formulating the gist of what has already been expressed, is pointed to by WR2 who uses abbreviations when referring to the department she is suggesting WR1 to call, and who uses an imperative ("ring" (call)) instead of a modal construction as previously in her response. The fact that WR2 chooses to make a reformulation of her advice indicates an understanding that the advice is to be understood as possibly the gist or essence of the posting. This may thus be another way WR2 orients to the actions made relevant by WR1 who invited to advice (Example C7, line 42).

6.3.4.4 Treating a problem as something for medical professionals to deal with

Problems with getting an effective medical treatment is a recurrent issue dealt with in threads in which participants indicate that what they are after is "help".

In the following example, Example C9, WR1 initiates with a description of her medical history in regard to metabolism. She formulates it as a "Kort resume" (Short summary) (line 3) and notes having written on the discussion forum before (line 1). As we are led through WR1's "medical history" in regard to her problem via her narrative we learn that WR1's problem is not only a matter of whether a certain drug is effective, it is also a matter of not getting the right information needed in order to deal with problems.

Hence, the following example shows another problem related to treatment, namely that blood test results used to assess and monitor metabolic disorders are apparently inconsistent (line 24-25), that medication apparently is ineffective (line 29-30) and that doctors don't listen to WR1 (line 29). In this example, like in example C5 and C7, WR1 invites to help in the title, and she expresses being in need of help and good advice in the text (line 32). However, the way the problem is presented and the way advice and help are invited to are in important ways different from Example C5 and C7, as participants' specific medical knowledge (Example C5) or participants' knowledge based on their experiences with metabolic disorders (Example C7) were made relevant in these cases. As we will see WR1 in Example C9 does not make medical knowledge or knowledge related to the experience of having a metabolic disorder relevant for recipients to provide:

[56] WR2's understanding of this as a reformulation is displayed with "Igen" (Again).

[57] See for example Heritage & Watson (1979) and Antaki 2008 on the use of the term "formulation" in conversation analytic studies.

Example C9: 1st posting, "Stadig for højt TSH efter medicinøgning :(Hjælp":

WR1 Tilmeldt: 20-02-2010 14:05	Den 16-06-2011 22:59 **Stadig for højt TSH efter medicinøgning :(Hjælp**	

1 Har skrevet før.
2
3 Kort resume.
4
5 Fik i februar 2010 konstateret for lavt stofskifte. Startede med 50 mkg eltroxin dagligt
6 og blev øget til 100 mkg efter kort tid.
7
8 Havde i starten af 2011 stadig symptomer og fik derfor taget nye blodprøver.
9 T3 og T4 lå fint, men Tsh var for højt (15, noget)
10
11 Egen læge mente at det var normalt med for højt TSH når man led af for lavt stofskifte
12 også selvom man fik medicin.
13
14 Fik hende dog til sidst til at henvise mig til endo.
15
16 Ved endo fik jeg at vide at TSH var for højt og at jeg danner antistoffer mod min
17 skjoldbruskkirtel. Jeg blev øget til 150 mkg eltroxin.
18 En måned senere fik jeg taget blodprøver igen og her skrev endoen i et brev til mig, at
19 nu var tallene inden for normalen.
20
21 Idag, en måned efter at jeg fik svar på at alt nu så normalt ud, har jeg været på
22 sygehuset og fået taget mange prøver i anden forbindelse.
23
24 De har også taget stofskifteprøver og nu er mit TSH på 19! Altså kan det umuligt have
25 set fint ud for en måned siden :(
26
27 Jeg er altså virkelig ked af det, for hvad skal jeg lige stille op?
28
29 Der er tilsyneladende ingen der lytter til mig og det lader jo ikke til at eltroxinen har
30 den mindste virkning på TSH tallene..
31
32 Trænger virkelig til hjælp og gode råd..
33
34 Selv hæmatologisk afdeling sagde idag, at mit TSH er alt for højt...

English translation:

WR1 Joined: 20-02-2010 14:05	On 16-06-2011 22:59 **Still too high TSH after medicine increase :(Help**

Have written before.

Short summary.

In February 2010 I got diagnosed with too low metabolism. Started out with 50 mcg eltroxin daily and got it increased to 100 mcg after a short period of time.

Had in the beginning of 2011 still symptoms and got new blood tests done.
T3 and T4 were fine, but TSH was too high (15, something)

The GP thought it was normal with a too high TSH when you suffered from too low metabolism, even when one was medicated.

However, at last I got her to refer me to endo.

At the endo I was told that TSH was too high and that I produce antibodies against my thyroid. I was increased to 150 mcg eltroxin.
One month later I got blood tests taken again and here the endo wrote in a letter to me that now the numbers were within the normal range.

Today, one month after getting the reply that everything looked normal now, I have been to the hospital and gotton many blood tests done in another connection.

They also took metabolism tests and now my TSH is at 19! So it couldn't possibly have looked fine one month ago :(

I am really sad, because what can I do?

No one apparently listens to me and it does not seem that eltroxin has the least effect on the TSH numbers.

Really need help and good advice..

Even the hematology department said today that my TSH is way too high…

The posting in Example C9 is long and entails a complex description of WR1's medical history. For the purpose of the current analysis and as I have already presented detailed analysis of how postings are recurrently constructed, I will only focus on presenting and summarizing resources used to present a problem and resources used to make particular responses relevant.
WR1 initiates her 1st posting with an announcement that she has written before (line 1) and that the information she supplies should be read as a "Kort resume" (short summary) (line 3). WR1 displays a competence in assessing blood test values herself (line 9, line 24) and she displays a competence in acting on her experienced problems (line 14) and in dealing with and making use of health professionals (line 11, 14, 35). By demonstrating competences with these issues, knowing how to understand and deal with medical information, and knowing that you should consult experts in metabolism, WR1 displays an understanding that advice within these topics is not relevant. Instead WR1 in her narrative establishes that there must be a discrepancy between information she has received from two different kinds of health experts ("De har også taget stofskifteprøver og nu er mit TSH på 19! Altså kan det umuligt have set fint ud for en måned siden :(" (They also took metabolism tests and now my TSH is at 19! So it couldn't possibly have looked fine one month ago :() (line 24-25)), and provides a description of her emotional state along with a (rhetorical) question: "Jeg er altså virkelig ked af det, for hvad skal jeg lige stille op?" (I am really sad, because what can I do?") (line 27). WR1 also complaints about having the feeling that she is not being listened to (line 29), and she complaints that the medication apparently has no effect (line 29-30). Then, she expresses a need for help and advice (line 32).

The first response, in Example C10, to the posting in Example C9 is significantly shorter than the first responses we have looked at so far. Nevertheless, we recognize what is being done as being constructed as a type of giving advice. Here we thus see that WR2 treats the 1st posting as making advice relevant, which is interesting, since, as already indicated, respondents might have treated the posting in Example C9 as a complaint:

Example C10: 1st response, "Stadig for højt TSH efter medicinøgning :(Hjælp":

WR2 Tilmeldt: 23-06-2009 18:37	Den 17-06-2011 01:25 **Re: Stadig for højt TSH efter medicinøgning :(Hjælp**

1 Du må tilbage til din endokrinolog og fortælle om din nye blodprøve- det er dem der
2 har ekspertisen- god vind

English translation:

WR2 Joined: 23-06-2009 18:37	On 17-06-2011 01:25 **Re Still too high TSH after medicin increase :(Help**

You should go back to your endocrinologist and tell about your new blood test – they are the ones with the expertise – good luck

The posting in Example C10 which is a first response can be analyzed as consisting of a suggestion, or alternatively as an instruction, readable as advice giving ("Du må tilbage til din endokrinolog og fortælle om din nye blodprøve" (You should go back to your endocrinologist and tell about your new blood test)), a statement working to provide reasons, i.e. account, for the specific advice (" - det er dem der 2 har ekspertisen" (– they are the ones with the expertise)) and an expression expressing positive regard (which might be seen to indicate an expectation that the advice will be followed): "- god vind" (– good luck).
WR2 treats a suggestion formulated in an instructive manner as relevant as a first thing in her response. In fact, if we revisit the 1st posting, Example C9, WR1 explicitly states "Trænger virkelig til hjælp og gode råd.." (Really need help and good advice..) (line 32), and thus WR2 can be understood to providing just that. The instructions are provided by WR2 by addressing WR1 directly ("Du" (You)), by using a modal construction ("må" (should)) indicating an understanding that this is the norm and the necessary and only possible next step, and by describing actions for WR1 to perform. The actions suggested by WR2 for WR1 to perform, consulting health professionals, are consistent with what we saw WR2 to be advising in Example C6 and C8. Hence, the examples shown so far point to the fact that when problems are presented as related to treatment, advice and help are recurrently invited to. We also see that, although various medical information and knowledge are often indicated, problems may be of various sorts, for example in terms of medicine regulation (Example C5), lack of medical treatment and knowledge (Example C7), or in terms of inconsistency in (the delivery of) medical results (Example C9). Furthermore, the examples have shown that different kinds of help or advice are invited to: Specific medical knowledge (Example C5), knowledge related to experiences with having a metabolic disorder (Example C7), or the invitation for responses may be understood either as an invitation to provide advice or expressions of pity (Example C9). In the case presented, which might have been treated as a complaint (as it expressed an understanding of health professionals' behavior as complainable) by respondents by expressing pity, understanding or common membership, we see that WR2 chooses to treat the 1st posting as inviting to advice (which was what WR1 explicitly expressed being in need of) understood as medical knowledge, and we see that she indicates an understanding that medical professionals are the ones who have access to the knowledge requested for.

The examples of 1st postings and first responses which relates to treatment and in which advice is invited to point to an apparent distinction that forum participants make in these cases: Participants orient to themselves and other forum participants as having valuable competences, including medical knowledge and experiences, but when it comes to specifically providing advice in terms of medical treatment they are cautious not to challenge the competencies and knowledge of medical professionals. Rather advice involves gathering and consulting medical knowledge and suggesting WR1's to consult a doctor. Furthermore, using this method of providing advice in which health professionals are treated as the medical experts that can "help" participants who indicate problems, which may be understood as related to medical treatment accomplishes to treat an indicated problem as possibly medical and avoiding engaging in complaints or conflict.

Interestingly, although Example C10 in fact is a response to the 1st posting in Example C9 (WR1 did not have to respond at all), and although it actually does provide advice, and even advice that "in essence" is similar to the advice in Example C6 and C8 in terms of the actions WR1 is suggested to pursue, the response in Example C10 comes across as dismissive and curt. This impression might be explained by the fact that the first response in Example C10 does not entail greetings or closings, assessments (for example of blood test results), suggestions for or acknowledgements of candidate explanations (for example for problems), or descriptions of personal experiences, which occurred in the first replies in Example C6 and/or C8. These elements typically include work that demonstrate and negotiate membership and identities. The relevance of these actions is not oriented to by WR2 as relevant here.

If we consider which kinds of options the elements in the 1st posting by WR1 in Example C9 make relevant or displays not to be relevant, we can recognize that WR1 excludes the relevance of the kinds of actions that occurs in other advice giving sequences; WR1 does not invite potential respondents to assess blood tests, deal with the issue of explaining WR1's medical problems or share experiences. Instead emotional distress as a consequence of being unable to act is pointed to as a problem for WR1 and thus provided as one issue WR2's could respond to. Another issue WR1 constructs as relevant for respondents to deal with, having experienced that health professionals apparently supply information that is not consistent, is constructed as a fact, and implies a complaint about the way health professionals have dealt with WR1's medical information. Alternatively, it could have been constructed as a puzzle to WR1 how these apparently inconsistent numbers and assessments provided by different health professionals could be interpreted and understood, and this could then have been dealt with in a response. Given the sparse information in the posting (which is indicated as being a "Kort resume" (short summary)) respondents cannot deal with the particular case in an "objective" way, but could have provided their "subjective" stances on the basis of the information provided and WR1's interpretations of it. WR2 in Example C10 chooses not to provide her own "objective" or "subjective" interpretations of this, but advices WR1 to consult the health professionals instead. In sum, WR2 treats the giving of advice as a relevant thing to do as her actions are recognizable as providing a suggestion for how WR1 should act, but WR2 does not, contrary to what we saw in Example C6 and C8, deal with how she understands WR1's problem by providing acknowledgements, assessments of WR1's problem, indicating recognition by indicating personal experience etc. In fact, WR2 indicates that health professionals, and implicitly not forum members, and not WR1, are in a position to deal with the problem indicated by WR1.

Here we see that it is not only oriented to that advice is understood as acting on one's problems. We also see that the way in which a problem is described in terms of how WR1's problem is characterized and understood is relevant for how responses that provide advice are constructed, and thus how the advice giving is understood. We may say that WR2 resists aligning with WR1 as a fellow sufferer by not dealing with the problem WR1 has indicated, as she (implicitly) rejects that her experience as a fellow sufferer is relevant for dealing with WR1's indicated problem.

6.3.4.5 Focusing on medical issues and possibilities for action

As in the examples previously shown in this chapter, WR1 in the following example, Example C11, describes a problem related to treatment. However in the following example medical aspects are not problematized as such, similar to Example C9. Contrary to Example C9, in this example (and see Example CC5 in the appendix for a comparable example[58]) WR1 does not invite to advice. In fact WR1 does not formulate any questions that can be understood as invitations to responses. Therefore, this case is interesting; it will tell us something about what respondents understand to be a relevant response when no particular actions have been invited to by formulating questions and/or requests.

Example C11: 1st posting, "TSH lidt MEGET for højt! Dybt chokeret!":

WR1 Tilmeldt: 20-02-2010 14:05	Den 07-01-2012 02:10 **TSH lidt MEGET for højt! Dybt chokeret!**	

Nu har jeg jo længe bøvlet med at TSH lå for højt, selvom jeg er medicineret og selvom de andre tal var normale.

Den har det sidste måske år, lagt på mellem 15 og 19..

Jeg fik så taget nye blodprøver i starten af december 2011. Min endo skrev efterfølgende i et brev til mig, at han regnede med at jeg var stoppet med behandlingen, da mine tal var helt hen i vejret. Samtidig skrev han til mig, at jeg skulle kontakte dem og bekræfte om jeg var gravid. Det fortalte jeg at jeg ikke var og endoen svarede tilbage at det var godt, fordi de ellers ville råde mig til at få en abort (Har 4 børn og har fået det fixet så jeg ikke kan få flere, heldigvis).. Jeg fik det total underligt med de mærkelige spørgsmål og svar. I onsdags var jeg så hos endoen og fik svaret på mine blodprøver.. Mit TSH lå der på 73!!! Jeg var simpelthen så chokeret, men fandt jo så samtidig ud af hvorfor jeg har haft det virkelig skidt og på hvorfor de skrev som de gjorde..

Jeg har så altså ikke været stoppet med min medicin på noget tidspunkt og blev faktisk ret ked af at endoen blev ved med at påstå at det måtte jeg have gjort..

Overvejer kraftigt at skifte til en anden endo på et andet sygehus, for jeg kan ikke bruge til noget, at han ikke tror på mig.

Jeg fandt så også ud af at jeg har taget 11 kg på siden Maj 2011.. Det vil sige ca. 30 kg i det hele, siden jeg blev syg... Kan kun lægge hovedet i mine hænder og være fortvivlet over hvad jeg skal gøre...

[58] In Example CC5 in the appendix, WR1 indicates a problem with "fighting" with her health specialist. She does invite to response, which can be recognizable as "help" and/or "advice". The advice she invites to, though, is information about who she can turn to for advice.

English translation:

WR1 Joined: 20-02-2010 14:05	On 07-01-2012 02:10 **TSH a little A LOT too high! Deeply in chok!**	

Now I have hassled for a long time with TSH being too high you see, even though I am medicated and even though the other numbers were normal.

It has the last year or so maybe been between 15 and 19..

Then I got new blood tests done in the beginning of December 2011. My endo wrote to me in a letter subsequently that he expected that I had quit the treatment because my numbers were crazy. At the same time he wrote to me that I should contact them and confirm if I was pregnant. I told them I wasn't and the endo replied me that that was good because they would otherwise advise me to get an abortion (Have 4 children and have taken care that I cannot have anymore, fortunately).. I felt totally weird with the strange questions and answers. This Wednesday I was at the endo and got the results of my blood tests. My TSH was at 73!!! I was simply so choked but at the same time found out why I have felt really bad and why they wrote as they did..

I haven't, then, have quit with my medication at any time and was actually pretty sad that the endo kept claiming that I must have done that..

Seriously consider changing to another endo at another hospital, because it is to no use for me that he doesn't believe me.

I also found out that I have gained 11 kilos since May 2011.. This means approximately 30 kilos in total, since I got sick… Can only put my head in my hands and be devastated about what to do…

We see that the resources made use of here to indicate a problem and invite to responses differ from the resources used by participants in Example C5 and C7 and in part in Example C9. In Example C5 and C7 we saw that WR1's explicitly invited to help and advice, both in the titles and in the message texts, and we saw that participants indicated a problem as medical and related to treatment. In Example C9 WR1 indicated a medical problem in the title, a TSH that was too high compared to normal ranges, and WR1 expressed a need for help and good advice both in the title and in the message text. In the message text, however, which was categorized by WR1 as a short summary, WR1 constructed the problem not to be about how to treat a TSH value measured to be too high but instead the problem was indicated as being how to deal with receiving treatment recommendations from health professionals which did not meet her expectations.

In the current example, Example C11, (and Example C4 in which the title was presented), we see that WR1 indicates a medical problem in the title ("TSH lidt MEGET for højt!" (TSH a little A LOT too high!)) followed by an indication of an emotional state ("Dybt chokeret!" (Deeply in chok!)), and thus not an invitation to provide help or advice as such in the title.

In the posting in Example C11 we see that WR1 indicates her problem as having to do with how health professionals have dealt with the treatment of a medical problem. WR1, though, begins by presenting her problem as a medical problem related to treatment. The posting initiates with a formulation of a problem: "Nu har jeg jo længe bøvlet med at TSH lå for højt, selvom jeg er medicineret og selvom de andre tal var

normale." (Now I have hassled for a long time with TSH being too high you see, even though I am medicated and even though the other numbers were normal.) (line 1-2). The problem is indicated as a problematic experience ("bøvlet" (hassled), line 1) that has stretched over a long time, and it is indicated as being present presently. WR1 constructs her problem as being sustained ("længe" (a long time)) and as persistent even though she has acted on it by getting medical treatment ("selvom jeg er medicineret" (though I am medicated)). Furthermore with this formulation she shows she has knowledge about normal hormone measurement ranges ("og selvom de andre tal var normale" (and even though the other numbers were normal)). WR1's formulation of a problem, which initiates her posting, focuses on hormone value measurements outside the normal area, i.e. a problem that relates to treatment. In Example C9 WR1 indicated a similar sort of problem (see title: "Stadig for højt TSH efter medicinøgning :(Hjælp" (Still too high TSH after medicine increase :(Help))[59].

WR1 then unpacks what is implied in the statement in line 1-2 with the statement: "Den har det sidste måske år, lagt på mellem 15 og 19.." (It has the last year or so maybe been between 15 and 19..) (line 4). It can be read as referring to the hormone TSH. This demonstration also underlines WR1's orientation to providing medical information and to herself as a knowledgeable medical patient as do most other forum members.

In line 6-15 WR1 continues her telling (indicated with "så " (Then), line 6) about her problem as she tells about a correspondence between her endocrinologist and herself. The telling takes its point of departure, as we have seen in the previous examples shown, medical information (line 6), and it includes indirect reporting[60] of what her medical specialist had written to her (line 6-15). Reports of what the endocrinologist have said or done were also included in the previous examples, Example C5, C7 and C9. However, in this example WR1 indicates her understandings and emotional states, which she constructs as connected to the correspondences with the endocrinologist (see for example line 12). In the other examples shown there were either no indications of emotional states (Example C5), or descriptions of an unbalanced well-being or emotions was connected to the experience of medical illness (Example C7 (and to some extend Example C9)).

WR1 further indicates how she understands her problem, as she formulates a version of what her problem amounts: "Jeg har så altså ikke været stoppet med min medicin på noget tidspunkt og blev faktisk ret ked af at endoen blev ved med at påstå at det måtte jeg have gjort.." (I haven't, then, have quit with my medication at any time and was actually pretty sad that the endo kept claiming that I must have done that..) (line 17-18). The formulation initiates with a rejection that WR1 should have had quit her medication at any time, which was what the endocrinologist had anticipated, and a description of an emotional state ("ret ked af" (pretty sad)) connected with the claim made by the endocrinologist that that must have been the case. WR1's problem is thus formulated as being sadness caused by not being believed by a health professional.

We can notice that the issue which the endocrinologist and WR1 deal with, and possibly dispute about, is medical treatment, i.e. medication, but the problem which WR1 indicates as her problem in the posting has to do with emotional issues related to how she understands the endocrinologist to be treating her as a

[59] In fact the postings in Example C9 and Example C11 are written by the same participant. The posting in Example C11, which is written approximately 6 months after the posting in Example C9 is not constructed as being somehow connected to a prior posting (i.e. is not made relevant in Example C11 as it was for example in Example C9), and therefore this information will not be part of my analysis.

[60] For conversation analytic work on reported speech in talk-in-interaction, see for example Holt & Clift 2007.

person, and in that sense the actions and resources typically oriented as relevant in postings involving invitations to advice are not made relevant here.

As in the previous examples WR1 indicates her understandings of relevant ways of dealing with her problem. She provides a suggestion as to how to act on the problem: "Overvejer kraftigt at skifte til en anden endo på et andet sygehus, for jeg kan ikke 21 bruge til noget, at han ikke tror på mig." (Seriously consider changing to another endo at another hospital, because it is to no use for me that he doesn't believe me). Here WR1 formulates one option as to how to act on the problem formulated, but notice that the nature of the problem is not formulated as being a "medical one", but a "personal" one involving a feeling that WR1 is not being treated as being credible. This is different from the previous examples in that these cases specific medical knowledge (Example C5), knowledge connected to the experience of having a metabolic disorder (Example C7), or medical knowledge or expressions of pity (Example C9) were projected as relevant ways of providing help in responses.

WR1 makes measurable medical information relevant again as she in line 23-24 WR1 provides additional ("også" (also), line 23) information about a weight gain and a statement concerning the total weight gain during the period WR1 has been sick. This, of course, might be a way for her to indicate for forum participants that there are in fact visual and measurable indications that she is medically unwell. Finally, WR1 writes: "Kan kun lægge hovedet i mine hænder og være fortvivlet over hvad jeg skal gøre..." (Can only put my head in my hands and be devastated about what to do…) (line 24-25). Here she describes an emotional state[61] (devastation) and provides an illustrative description of what behavior she understands as being the only option for her ("Kan kun lægge hovedet i mine hænder" (Can only put my head in my hands), line 24). This behavior and emotional state are constructed as relevant on the basis that WR1 does not know what to do: "Kan kun lægge hovedet i mine hænder og være fortvivlet over hvad jeg skal gøre..." (Can only put my head in my hands and be devastated about what to do…) (line 24-25). WR1 orients to the relevance of acting on her problem by expressing a devastation about not knowing what to do by displaying an understanding that acting on her problems is relevant, but she displays a lack of competence in knowing how to acting on her problems. WR1 does not explicitly invite forum participants to provide suggestions as to what WR1 could do, and WR1 raises various issues in her posting besides the problem concerning the feeling of not being believed in that might be understood as problems that could be addressed by co-participants.

The posting in Example C12 is the first response to the 1st posting in Example C11, in which a medical problem was indicated, for example in the title ("TSH lidt MEGET for højt! Dybt chokeret!" (TSH a little A LOT too high! Deeply in chok!)) as well as a problem with credibility, that is, WR1 described instances in which she felt her version of specific state of affairs was not believed by her doctor (for example " I haven't, then, have quit with my medication at any time and was actually pretty sad that the endo kept claiming that I must have done that..", Example C11) line 17-18)).

WR1 does not request for advice on the described medical problems in direct ways, for example by requesting for help or advice explicitly, and she does not formulate candidate suggestions as to how to act

[61] Emotions are defined, conceptualized and approached differently within different approaches to language and psychology. Furthermore, emotions are also a topic and/or resource ordinary people use in ordinary interaction, which we also see here. Discursive psychology is concerned with emotions in terms of how emotion categories are used and with their rhetoric design (Edwards 1997:171; also see section 3.4 on discursive psychology). Similarly, here I approach emotion categories in terms of how they are used, what they make relevant, and how they are responded to. This is one way to illuminate participants' everyday understandings of how emotions are relevant for the activities they are engaged in.

on the medical problems expressed. She does not formulate requests formatted as yes/no typed interrogatives (Raymond 2003) either, which I have demonstrated in the two previous chapters to be quite common ways of inviting to responses. Instead she displays an understanding that acting on her problems is relevant, but that she lacks a competence in knowing what to do ("Kan kun lægge hovedet i mine hænder og være fortvivlet over hvad jeg skal gøre..." (Can only put my head in my hands and be devastated about what to do…), Example C11, line 24-25). This is the last thing done in the 1st posting.

If we compare these different strategies with Jefferson and Lee's (1992) distinction between troubles tellings and service encounters in terms of the roles people can be seen to orient to, we may say that in Example C5 and C7 WR1's orient to what they are doing as a service encounter by indicating a medical problem and inviting respondents to provide help or advice on how to act on the problem in accordance with medical information provided and/or in accordance with medical knowledge respondents might have. On the other hand we may say that WR1 in Example C9, while expressing being in need of help and advice, indicates her problem as being a problem related to how medical professionals have dealt with her treatment. Consequently, the expression of being in need of help and advice implies a complaint that health professionals have not provided the help and advice WR1 understands to be expected from them. This may be seen as a type of troubles telling involving a complaint of a third party (or a complaint as such). WR1 expresses being in need of help and good advice ("Trænger virkelig til hjælp og gode råd.." (Really need help and good advice..), Example C9, line 32), but as the problem indicated is not indicated for respondents to deal with in not a strictly medical problem but rather a personal problem, we would expect that this is consequential for how respondents treat it and for how they treat an invitation to provide help and good advice. In fact we saw in the first response, Example C10, that WR2 treated WR1's problem as a medical problem as she advised WR1 to consult her doctor, and she indicated that forum participants did not have the expertise to help WR1. Hence, she provided something recognizable as advice, which WR1's invitation could be seen to make relevant, and she refrained from engaging in a complaint activity or with indicating acknowledgements, medical knowledge or personal experiences, which was the case in the first responses shown in Example C6, C8 and C10.

Example C11 provides us with a case in which WR1 more explicitly orients to what she is doing as a troubles telling rather than as a service encounter than what we have seen in the previous examples; WR1 does not invite to advice or help on how to act on a medical problem; instead she indicates her problem as being problems related to communication with the doctor and she indicates in different ways being emotionally affected by this, which is something respondents might respond to with expressions of empathy or comfort. As Jefferson and Lee (1992:535) express it, "…[w]hile in a troubles telling the focal object is the "teller and his experiences," in the service encounter the focal object is the "problem and its properties"". Thus, the fact that WR1 in Example C9 and C11 focuses on how she experienced doctors' deliveries of information, treatment recommendations in terms of what that makes her feel rather problematizing a medical issue and inviting to advice on how to act make the postings recognizable as the initiation of troubles tellings rather than the initiation of service encounters.
As mentioned, treatment is an issue in the 1st posting we have just focused on (Example C11), although in that case advice or help has not been explicitly invited to in the 1st posting, as was the case in Example C5, C7 and C9. Instead other resources are used to invite to responses, and in the analysis of the following example, Example C12, we will investigate how a 1st posting (Example C11) dealing with treatment and

making emotional distress a relevant issue to deal with is responded to. This may inform us further about how participants understand and do advice giving in the forum (See Example CC6 in the appendix for a comparable example).
WR2 in the posting in Example C12 displays her understanding of relevant things to do:

Example C12: 1st response, "TSH lidt MEGET for højt! Dybt chokeret!":

WR2 Tilmeldt: 20-08-2009 12:24	Den 07-01-2012 20:42 **Re: TSH lidt MEGET for højt! Dybt chokeret!**	

1 Kære du,
2
3 Jeg føler med dig! Du må virkelig have det skidt med så høj en tsh gennem længere tid.
4
5 Der er desværre ingen helbredende kur mod sygdommen, men du vil helt sikkert få det
6 meget bedre, når du (forhåbentlig allerede nu) får justeret din medicin. Det kan endda
7 være at du må skifte mærke. Der er lidt forskel på hvor godt de forskellige mærker
8 optages hos den enkelte. Du må insistere kraftigt på at blive behandlet nu! Din tsh skal
9 helt ned på omkring 1 for at du kan føle dig rimelig "rask". Satte lægen dig slet ikke op i
10 medicin eller talte med dig om din fremtidige behandling?
11
12 Du ved sikkert selv at det er bedst at vente en hel time med at spise morgenmad efter
13 pille-indtag. Husk kun at drikke vand i denne time. Vent desuden 4 timer fra pille-
14 indtag med at indtage al øvrig medicin og kosttilskud. Dette er blot nogle gode
15 tommelfingerregler, som du sikkert allerede kender....men her kom de alligevel ;)
16
17 Held og lykke med det - du skal nok få det bedre igen :)

English translation:

WR2 Joined: 20-08-2009 12:24	On 07-01-2012 20:42 **Re: TSH a little A LOT too high! Deeply in chok!**	

Dear you,

I feel with you! You must feel really bad with that high a tsh for a long time.

There is unfortunately no healing cure for the disease, but you will definitely feel a lot better when you (hopefully now already) get your medication adjusted. It may even be that you have to change label. There is a little difference in how well the different labels is absorbed by the individual. You must insist strongly to get treated now! Your tsh should all the way down at around 1 for you to feel fairly "well". Didn't the doctor increase the medication or speak to you about your future treatment?

You probably know yourself that it is best to wait an entire hour before eating breakfast after taking pills. Remember only to drink water during this hour. Furthermore wait 4 hours from pill intake before taking all other medication and supplements. These are only some good rules of thumb, that you probably already know….but here they were anyway;)

Good luck with it – you will surely feel better again :)

The design of the first response (Example C12) responding to the 1st posting in Example C11 shows orientations to the understandings that have been made relevant in and through the design of the 1st posting. The 1st posting in Example C11 entails numerous expressions of emotional states associated with the experience of medical problems and with experiences of not being believed in by a medical professional. We find several expressions of positive regard in the first response, Example C12, most obviously in the opening (line 3-4) and the closing (line 18). WR2 initiates with a personal – and indexical - greeting, "Kære du" (Dear you), (line 1) followed by an expression of empathy[62] ("Jeg føler med dig" (I feel with you!), line 3) and a formulation that displays WR2's understanding of how WR1 must feel as a consequence of having an increased hormone value for a long time (line 3-4). The posting is ended with an expression of positive regard and an optimistic view on WR1's possibilities of getting better ("Held og lykke med det - du skal nok få det bedre igen :)" (Good luck with it – you will surely feel better again :)), line 17). These are rather conventional expressions (a similar expression was used in Example C8, line 11, and Morrow (2006) also dealt with in his study of online discussions on depression), but by using them, that is, by expressing positive regard and by expressing an expectation that WR1's wellbeing will improve, WR2 displays an understanding that expressions of comfort and optimism are relevant (that is, have been occasioned by elements in WR1's 1st posting).

WR2 treats WR1's problem as a medical problem. She does that by mostly dealing with medical aspects of WR1's described problems by focusing on aspects related to drug intake as an issue WR1 can deal with, and thus as a potential cause for her experienced medical problems (line 5-9). WR2 does not deal with emotional aspects related to WR1's experiences with her medical professional explicitly, but she deals with aspects of how WR1 should approach her medical professional now, with knowledge about optimal blood test results and wellbeing, and she indicates her understandings of what a doctor should have done in a consultation with WR1 (line 9-10). Hence, WR2 deals with medical issues, and specifically she provides advice as to how WR1 can deal with the medical issues she has described.
WR2 also indicates her understanding of what WR1's problem is. In line 6-8 WR2 suggests that the label of the medication used by WR1 may have an impact on her wellbeing. WR2 then accounts for suggesting this by providing a description about differences in absorbation within the labels applying to different people. This is an orientation towards the problem as medical and towards providing medical knowledge as relevant to provide in the response.
Then WR2 provides something which is recognizable as advice. In line 8 she instructs WR1 to insist on getting treatment now. This is marked as advice that WR1 should make sure to follow with the verb "insistere" (insist), the adverb "kraftigt" (strongly) and the exclamation mark ("!"). As in the previous examples of first responses in this chapter, WR2 indicates in her advice to consult a health professional.

WR2 again makes medical knowledge relevant for understanding and dealing with WR2's problem. In line 9 WR2 provides a statement indicating an estimate of the TSH level WR1 should have in order to feel "rimelig "rask"" (fairly "well"). WR2 in this way displays knowledge about connections between blood test values and wellbeing as well as knowledge about a specific reference value. She also implies an assessment of WR1's measured values that they are far from the reference value by describing the path to reaching the optimal value as "helt ned" (all the way down). This is in alignment with the assessment WR1 has provided of the blood test value ("TSH lidt MEGET for højt!" (TSH a little A LOT too high!), see title).

[62] See for example Morrow (2006:543) on expressions of empathy as openers in online discussions on depression.

WR2 does in fact touch upon the endocrinologist's role in the treatment of WR1's problem, which WR1 has complained about. In line 9-10 WR2 writes something recognizable as a request for information directed at WR1: "Satte lægen dig slet ikke op i medicin eller talte med dig om din fremtidige behandling?" (Didn't the doctor increase the medication or speak to you about your future treatment?) This request is formatted as a yes/no interrogative with negative polarity, that is, as an interrogative that formally prefers a negative response ("no") (see Raymond 2003; Heinemann 2005). In this way WR2 formulates a description of events that in WR2's view should have occurred in a normative sense. Notice, though, that WR2 only indicates her understanding of what the doctor should have done, she does not engage in the complaint WR1 has indicated about feeling that she is not being believed by the endocrinologist.

The posting, however, entails instructions in terms of to how to take metabolic medication in line 12-15. These instructions are readable as advice that specify how WR1 should coordinate intake of food and water with intake of medication and how to coordinate intake of other medication and supplements with metabolic medication. The advice sequence is initiated with a formulation that indicates as a possibility and as probable that WR1 already has the knowledge WR2 provides ("Du ved sikkert selv" (You probably know yourself), line 12). The advice sequence is equally ended with formulations about the "newsworthiness" of the knowledge provided: "Dette er blot nogle gode tommelfingerregler, som du sikkert allerede kender....men her kom de alligevel ;)" (These are only some good rules of thumb, that you probably already know….but here they were anyway;)). WR2 here formulates her provision of advice as "only some good rules of thumb". Furthermore WR2 implies in her description an understanding that the advice on how to coordinate intake of metabolic medication with intake of food and other medication that these instructions "exist" as rules of thumb as an objective fact that has not (only) been established on the basis of WR2's personal experiences but could have been "known" to WR1 as a fact gained from other sources. The basis of these instructions is thus implied as going beyond WR2's personal experiences and the advice instructions are constructed as knowledge. This is constructed as advice about what one should know in order to act on one's problems. WR2 indicates that she assumes that WR1 is already familiar with the information she provides, but, at the same time, WR2 also implies in and through providing the information, that WR1 did not indicate that she knows about it.

The choice to provide "rules of thumb" in regard to medicine intake in line 12-15 and the specific constructions of them, in which the rules are constructed as well known, probably also to WR1, might orient to the fact that this kind of knowledge display is not present in the message by WR1 (Example C11). In this way WR2 displays knowledge on how to take medication as a patient as relevant to display here, that is, in regard to the medical problem WR1 has formulated. This may be a way to do advising although it has not explicitly been invited to by WR1, i.e. a way to treat WR1 as an advice seeker instead of a troubles teller (see Jefferson and Lee: 1992).

6.3.5 Concluding remarks

In 1st postings inviting to advice, medical aspects of experienced problems are indicated, frequently by describing symptoms, by providing medical information, or by describing (candidate) medical explanations or medical knowledge. Recurrently too, participants initiating threads display themselves as someone who acts on his or her problems. One obvious way, of cause, is to actually initiate a thread in the forum. These orientations to the nature of their health problem and themselves as a competent acting person respond

well with the methods participants use to invite to advice, and in fact, as I hope to have shown they work as elements of inviting to advice in the forum.

When participants request for advice and/or help, their descriptions of the nature of their problems and of themselves as actors work to display understandings of how help or advice is to be understood. Help and/or advice are recurrently requested for explicitly (in titles and towards the end of posting texts). Furthermore, participants initiating threads invite other forum participants to provide knowledge of relevance to dealing with the established problem, and in various ways indicate that for them suggestions for how to act on their problems would be relevant for respondents to provide.

Respondents to 1st postings inviting to help and/or advice (constructed as inviting to help for self-help) display acknowledgement that the problems described by WR1's are medical problems. This is accomplished in a variety of ways, for example in WR2's formulations of WR1's problems. Respondents recurrently indicate that medical knowledge is relevant for dealing with the problem described, and this is another way of acknowledging a medical perspective as relevant for dealing with the problems. Furthermore respondents provide suggestions for how WR1's could act on the problem described. The ways of acting suggested involve consulting medical professionals, and acting in accordance with the medical knowledge available to WR1. The fact that respondents recurrently deal with the medical knowledge provided by WR1 before providing suggestions for how to act (and in and through that displaying their medical knowledge as advice-givers) can thus be seen as a relevant, or normative, thing to do in order for them to display an orientation to the problem as a medical problem, and in order for them to show that the best way to deal with medical problems is by acting in accordance with the medical "facts".

From the instances in which problems are not presented as strictly medical we may learn quite a bit about how participants understand the activity of seeking and giving advice; the 1st posting in Example C9 and its first response in Example C10 may tell us that 1) the ways in which WR1 indicates what her problem is, is consequential for how advice can be provided, and 2) constructing a response as an advise may be a way for respondents to actually avoid treating a 1st posting as a troubles telling. In Example C9 WR1 indicated as her problem that the medicine she was being treated with apparently didn't have an effect (line 29-30), and she also complained that there was an inconsistency between the information she was given and the actual blood test results she had later received. In Example C10 WR2 advised WR1 to see her doctor. By providing advice, then, WR2 refrains from aligning as a troubles recipient (Jefferson and Lee 1992), who might express empathy, or pity WR1 (Traverso 2009), and thus avoids to take a stance on how to understand or deal with WR1's experienced problems as someone who acknowledges to be an "equal" experiencer of similar problems.

Another 1st posting, (Example C11) and its first response (Example C12) analysed in this chapter deferred from the pattern described, in that the nature of the participant's problem was not only a strictly medical problem in terms of treatment but also a personal problem (of how to deal with lack of credibility), and in that the participant did not invite to advice by making it relevant for respondents to deal with how WR1 could act on her medical problems. Furthermore, in this 1st posting, as an exception to the other 1st postings shown, the participant, WR1, described emotional states connected with her experiences. In the first response to this 1st posting, Example C12, the respondent displayed her empathy in various ways, which was not oriented to as relevant recurrently in replies to the other 1st postings shown here (Example C6, C8 and C10).

The respondent, WR2, in her response (Example C12) furthermore invoked a medical perspective on WR1's problems by suggesting medical causes for the WR1's problems, suggesting and instructing WR1 on how she could act on her problems, and by providing rules of thumb as to how to take medication. By providing this information WR2 not only provided advice for WR1 in terms of how to act on her problems, but she also provides WR1 with a model, or at least an understanding, of which kind of perspective on problems would be seen as relevant in the forum (a medical perspective), what kind of knowledge would be relevant (medical knowledge), and what kind of advice or assistance fellow sufferers can be expected to provide in this forum (help for self-help which is focused on how participants deal with medical aspects of their problem, which they have chosen to put under the category metabolism in the discussion forum).
In sum, the practices for inviting to and providing advice in the forum may be seen as a way for participants to treat themselves and each other as having some competence in dealing with their problems; inviting to and providing advice implies that what they are dealing with is an established problem (which is different from sharing experiences and dealing with causes), and they show that they want to act. It can be added that by inviting to advice the thread initiators actually imply that the problem have been established as metabolic illnesses and that the initiatives do not have as their purpose to discuss how to understand or diagnose the problem she is experiencing. Jefferson and Lee's (1992:535) suggestion may be right on the spot: "And it may be in that environment [of what could be referred to as a service encounter], and not in the environment of a troubles telling, in which the emergence of advice as a logical outcome of description and diagnosis properly and harmoniously resides".

The problems that participants indicated having in postings in which advice or help was invited to, recurrently involved aspects of treatment of an illness. This seems to be different from threads that initiate with indications of personal experience in which sharing of experiences was invited to (chapter 6.1) and also different from threads in which respondents are invited to deal with possible causes for problems (chapter 6.2). When inviting to the sharing of experiences postings are recurrently responded to with acknowledgements of experiences and tellings of experiences. When inviting to deal with possible causes for problems, this is often responded to with acknowlegdements, tellings of experiences and/or knowledge about connections between symptoms and causes. In these cases exchanging and validating understandings of how bodily experiences may be understood, in particular medically, are concerns that partipants orient to.
Explicitly requesting for advice when the problem indicated involves treatment seems to be a well-fitted pair; making advice relevant implies a specific understanding of the nature of the problem (knowing what the problem is but not knowing how to act), and describing a problem as a problem with not knowing how to act (i.e. treat the problem) makes advice on how to act a relevant thing to provide.
As mentioned, Morrow (2006) notes that participants often provide advice in responses although advice has not been solicited in interaction in an online forum on depression. Although it is also pointed out, by Heritage and Sefi (1992) among others that providing advice implies differences in knowledge and competence between advice seeker and advice giver, we can also note that by treating advice as a relevant thing to provide, i.e. to ask for advice explicitly, the business of the talk becomes the business of acting and providing service instead of the business of talking about troubles and pitying (Traverso 2009). Thus, treating the business of the talk as asking for and providing service, i.e. advice, turns the potential troubles teller into an advice seeker. In and through doing this, writers imply an understanding that they have

competence to act on problems and already know how to understand the problem. Furthermore, by inviting to advice in this way they identify as non-medical professionals. These practices may then in fact be understood as reflecting participants' understandings of their social identities rather than reflecting face-protection and/or politeness suggested by other perspectives to explain practices for inviting to and providing advice (for example Morrow 2006; Ruble 2011).

6.4 Responding to responses: (Re-)specifying what counts as a relevant and useful response

6.4.1 Introduction

In this chapter I will focus on participants' use of what has elsewhere been referred to as "thanks messages" (Morrow 2006), namely postings written by a thread initiator, WR1, as a response to the response(s) that have been posted in that thread. Sequentially such postings follow response(s) to postings that initiate threads, which is why I present analyses of such postings after having presented analysis of postings and responses.

In ordinary conversation people organize conversations they engage in in sequences that can entail a number of turns that overwhelmingly can be understood as organized in (adjacency) pairs that go together (see chapter on 3.2 conversation analysis). Conversation analytic studies have dealt with the structure of conversations for example of openings and closings in conversation (Button 1987; Frank 1982; Heath 1981; Schegloff 1968; Schegloff 1979; Schegloff & Sacks 1973; Zimmerman 1992). Findings from such studies indicate that the accomplishment of actions in organized sequences such as for instance greetings and closings is mutual and collaborative, i.e. actions in conversation are mutually ratified and negotiated.

A study done by Rintel and Pittam of opening and closing phases of interactions in Internet Relay Chat (IRC) showed that the interaction management developed "…in some ways that match casual group FTF [face to face] interaction but that quite different strategies and sequences of interaction are also found" (1997:527). They note that the stages in which opening and closing sequences typically occur in IRC is not an exact mirroring of the prototypical opening and closing sequences that have been found in face to face interaction, but they suggest that the functions of these opening and closing phases in IRL and face to face interactions respectively are analogous. They stress that IRL is clearly "…an interpersonal medium (cf. Walther, 1995, 1997), and [that] the opening and closing phase are important for the establishment and maintenance of interpersonal relationships" (Rintel & Pittam 1997:527).

When people communicate in bulletin boards, of which, as mentioned, the discussion forum on metabolism I investigate is one example, they do not have the opportunity to initiate actions in order to obtain stepwise ratifications of actions at a single-turn level as they recurrently do in ordinary conversation and to some extent in chat. Nevertheless postings in bulletin boards for example recurrently include actions recognizable as first pair parts (see section on conversation analysis) such as greetings and closings, respondents may or may not respond to. This was touch upon in chapter 6.1. Similarly, Waldvogel's study (2007) of greetings and closings in workplace emails established that greetings and closings may be present or absent, and she highlighted the affective role greetings and closings have as a linguistic resource in workplace emails. Specifically in regard to closings, she noted: A closing can help consolidate the relationship and establish a relational basis for future encounters (Waldvogel 2007). Waldvogel is concerned with the social role greetings and closings have in workplace emails, and she uses the framework of politeness theory in order to account for variations is usage. She does not deal with the sequential organization of these emails, i.e. their sequential placement in a specific interaction, and she does not deal

with how the structural affordances of the specific medium may play a part in the strategies that people use to greet and close in work place emails explicitly.

Here I intend to investigate the uses of a particular "juncture", responses to responses, in terms of what participants use them for and accomplish with them. The term "responses to responses" should be understood to refer to response(s) posted by WR1 after his or her 1st posting in a thread that has received one or more responses by other participants in the forum[63]. As in previous chapters, I refer to the authors of responses to responses as WR1* since the authors of these third turn responses are the same as the authors of the initial postings. The response to the response(s) he or she received is, of course, posted in the same thread that WR1 initiated. From the outset, then, responses to responses are defined in terms of their placement in space and time, not by the actions they accomplish. Ways in which responses to responses are used will be the topic of this chapter.

As I show, participants use responses to responses in a variety of ways, and in complex ways. Nevertheless, an overall pattern can be identified in terms of how participants organize them. Analysis shows that participants first deal with prior action, and then initiate further interaction in their responses. As it turns out, participants deal with prior action, i.e. prior responses, by indicating thanks and/or a formulation (see for example Heritage & Watson 1979) of the interaction so far in generalizing terms and/or they provide answers. It is argued that these actions that deal with prior responsive actions are closing implicative. In the latter part of the text in responses to responses participants recurrently invite to further talk. Typically "new" information is indicated, and WR1* invites others, and recurrently not WR2 explicitly, to respond.

Analysis will point at how participants within this structure of first responding to responses and then indicating a concern to continue further interaction indicate how or how not they understand responses already received to be relevant and/or useful. We will see that when performing these actions, WR1*'s recurrently treat medical knowledge and specific membership categories as relevant.

As these various practices used in responses to responses display different understandings of the talk so far and project different relevant responses (or none), the term "juncture" (See Button 1991a) seems well-fitted. Practices for displaying a concern to "opening" or "closing" interaction thus become relevant here.

Before I investigate responses to responses specifically I raise some issues related to the structural features of the medium that participants orient to and deal with, and which provide an overall frame, within which I place my analysis. I do this by referring to studies of greetings and closings in different settings conducted by other researchers, and by drawing in examples from greetings and closings from 1st postings in the discussion forum.

[63] The conversation analytic term "third position receipt" (Svennevig & Johansen 2011) was considered as a term to denote this phenomenon. However, as the postings accomplish many actions apart from indicating receipt and possibly could not also be seen or treated as even being consistently in third position, I stick to the term "responses to responses".

6.4.2 Studies of (opening and) closing in interaction

As the phenomenon I want to describe is sequentially organized in a "juncture", in which participants may indicate a concern to close the interaction, deal with specific issues of the interaction or continue or initiate interaction, practices for opening and closing interaction in different settings can work as an analytic resource for understanding, describing and comparing the practices participants orient to as relevant in responses to responses with practices found to be used in other settings. Here I summarize on some of the studies done on closing in telephone calls, chat, and emails respectively.

6.4.2.1 Closing implicative activities in telephone calls

The activity of closing while indicating a concern to continue talk seems to have an inbuilt opposition in itself. On the other hand Button described that in ordinary telephone conversations the organization of junctures within a topic-in-progress can provide a sequential environment that can facilitate either the initiation of closings or of a new topic (Button 1991a:251), i.e. participants accomplish activities that are "closing implicative" collaboratively, and they negotiate whether to close the conversation or initiate a new topic. Button outlines five strategies for initiating closing. The strategies are referred to 1) "Holding over prior activities" (1991a:252), 2)" Formulating summaries" (1991a:254), 3) "Projecting future activities" (1991a:256), 4)" Announcement of closure" (1991a:258), and 5) "Arrangement reintroduction" (1991a:258). He summarizes the commonalities about the strategies participants use to initiate closings:

> All of the sequences and activities […] operate to organize the course of a topic-in-progress "as a whole" by providing for the topic to be understood to be either exhausted, concluded or suspended. They operate in such a way that over the course of a number of turns at talk participants may display to one another that they are not elaborating or continuing a topic-in-progress (1991a:260).

Button shows how participants accomplish to arrive at junctures that are closing implicative collaboratively, and he continues to show that participants organize their talk in these junctures in a topic-in-progress in one of three structures overwhelmingly, namely, (1) "the initiation of a closing", (2) "the initiation of a collaborative development of a new topic", and (3) "the unilateral initiation of the particular topic of arrangements" (1991a:263 f.).

In the telephone calls Button investigated closing initiations recurrently involved arrangements. Button argued that participants in this way oriented to the current conversation as one in a series, which invokes as relevant the relationship between the participants as "standing". Hence, participants oriented to displaying their orientation to the nature of their relationship, when they initiated closing that involved talk about future arrangements.

As mentioned, Button also deals with the possibilities for topic continuation at junctures that are closing implicative as an alternative to closing initiations:

> Continuation may, instead, be done by attempting to provide for the possible initiation of a new topic, done in such a manner as to provide for its initiation to be a collaborative matter, and thus drawing a co-participant along with the speaker. So, should a co-participant decline, closing initiation may be legitimately done. (1991a:270).

Here Button stresses the fact that the initiation of new topics at junctures is done in steps that requires the implied acceptance of the participants in conversation to move into a new topic and thus not close the conversation. He also notes that this method allows for "legitimate" closing, if one of the participants does not collaborate in initiating a new topic. These junctures, in which the negotiation of whether to initiate a new topic or close the conversation is an issue, then, contribute to display and negotiate understandings about participants' interrelationships in and through the methods the participants use, and participants accomplish these negotiations in steps which show an orientation to them as "sensitive" and as activities that normatively should be accomplished collaboratively. Whether or not to close a conversation becomes a negotiation, because participants accomplish the activities in junctures in which this is an issue as such.

6.4.2.2 Closings in chat

Rintel &Pittam (1997) has conducted qualitative research that has focused on "interaction management" (1997:508) of IRC (Internet Relay Chat) interactions (also see Rintel, Mulholland & Pittam 2001). They specifically investigated the opening and closing phases of IRC with a concern to outline recurrent interaction management strategies used to develop interpersonal relationships and communicate socio-emotional content. Rintel & Pittam compared participants' strategies in IRC with face to face (FTF) conversation. They claim that the closest analogy to IRC is casual group FTF interaction, although they also note that IRC has characteristics in common with casual telephone conversations and casual letters (1997:509). In regard to the accomplishment of closing in chats, Rintel and Pittam note as a starting point that participants have a range of choices in order to close, and they specifically mention as a goal to show how the logs become a form of situated practice, i.e. the goal is not to generalize about interactions of IRC as such (1997:512). The authors point out practices that participants use to close interactions. These are exiting the IRC all together, using a series of minimal closing token transmissions without waiting for responses, and undergoing a closing phase similar to that of many face to face interactions (1997:524).

Rintel and Pittam suggest that the affordances of the medium can explain some of the differences in the management strategies they found between IRC and face-to-face interactions. They mention that interaction management strategies on IRC are more overt than in face-to-face interactions, because nothing is "transmitted automatically" in IRC (1997:531). In other words, according to the authors participants have control over exactly what and when they contribute to interactions in IRC. In relation to that, available information is of a specific sort; when joining a channel the server announces the presence to all other channel members, i.e. members of the channel will have available the newcomer's username[64], but no possibility to take non-verbal behavior into account. This means, in some sense, participants are virtually anonymous, since their presence does not amount to physical presence. A consequence of this is that "…no user is expected to interact with every other user, nor would they necessarily want to. Users can, in fact, "lurk" in a channel, not conversing with anyone, and probably avoid the sanctions that are available on IRC" (1997:528). Hence, participants have the opportunity to monitor and observe interactions on IRC without being observed themselves, and thus without being held accountable for it, and they can choose between ongoing interactions. A channel may include multiple participants and many of them may be complete strangers.

[64] Rintel and Pittam mention that the choice of name is the first impression-making device a user has and thus "…becomes significant in the construction of both an IRC persona and for perceptions about other interactants" (1997:530).

In terms of the time variable, (chat is often referred to as quasi-synchronous (Garcia and Jacobs 1999; Zemel 2005)), Rintel and Pittam note how this possibly influences how interaction in IRC's unfolds; IRC's are characterized by distortion of order in message transmission, which generally seems to have an effect on the degree of impersonality of interactions. The affordances of the medium which relates to time allow participants time that exceeds the time frames participants orient to in ordinary conversation to composite and edit their contributions before posting them. This also means that participants may experience time lag as unwanted silence, and may in some ways deal with that (1997:531).

Rintel and Pittam, in sum, provide a framework that takes affordances of chatting into account when analyzing and understanding interpersonal aspects of interactions via IRC´s. They focus specifically on the resources participants have available and they show that openings and closings in chat occur in systematic ways that resembles openings and closings of ordinary interaction, but that participants adapt to the medium they interact in in terms of their strategies for accomplishing action. Raclaw (2008) provides a similar conclusion of his investigation of conversational closings in instant message discourse.

As an example of social and pragmatic variation in the sequential order of talk, Svennevig and Johansen (2011) show how gender is oriented to in closing sequences of chat. The data comes from a collection of 195 chat exchanges between Norwegian youths aged 14 to 15 who are friends and acquaintances, using MSN as their chat program. Therefore, their findings in regard to closings relate to that setting in particular, and in indicated as being connected with displays of affection. Svennevig & Johansen do however also make some tentative conclusions about the structure of closings in chat in more general terms: "It may thus be concluded that closings in chat display a less stepwise and fine-tuned collaboration between the participants in coming to agreement about ending the conversation" (2011). This conclusion seems to be in line with Rintal and Pittams' (1997) and Raclaws' (2008) findings.

6.4.2.3 Closings in email

Using discourse analytic techniques, Waldvogel (2007) investigated greetings[65] and closings[66] in workplace email. Like Rintel and Pittam (1997), Waldvogel was interested in social aspects of computer-mediated communication, which she approached by attempting to identify the influence of the sociolinguistic variables of status, social distance, and gender on the form and use of greetings and closings. The analysis was done on a simple count of the various types of greeting or closing cross-tabulated to the variables (2007:460).

Waldvogel argues that greetings and closings perform an important social role, equally to how greetings and closings work in other forms of interaction. She claims that closings "…can help consolidate the relationship and establish a relational basis for future encounters" (2007). She uses the framework of politeness theory and deals with issues such as status, social distance, and gender in relation to greetings

[65] In the paper defined as "Greeting—the use of a person's name and/or greeting word to initiate the email" (Waldvogel2007:460).

[66] In the paper defined as "Closing – any name sign-off, farewell formula (e.g., Cheers), or phatic comment (e.g., Have a good day) used to end the email. Thanks is counted as a closing when it comes with or without the writer's name at the end of a message. In this article the term "closing" is used interchangeably with sign-off". (Waldvogel 2007:460)

and closings of workplace emails. She shows that different workplaces have different ways of greeting and closing emails, which is based on quantitative analysis in which two workplaces' use of greetings and closings in emails are compared. For example, her study shows that many workplace emails do not initiate with a greeting, and she indicates a quantitative difference between the two workplaces included in her study (2007:462). The "messages" in the emails without greetings could with few exceptions be categorized as specific actions such as "notes", "updates", "follow-up messages" and "messages from information technology staff" (2007:464). Waldvogel notes that closings in the workplace emails studied closely mirrored that of greetings (2007: 465). Waldvogel claims that the strategies for greeting and closing in emails may be related to cultural factors. In the study, email messages are presented and analyzed in terms of politeness. Waldvogel's study did not focus on how available resources of the medium influence the accomplishment of greeting and closing in emails. For example the study does not focus on the fact that a single email message recurrently includes indications in the subject field, greetings, closings and various other actions. However, the study does mention a possible pattern in terms of actions included in the message when the message does not initiate with a greeting (see above).

Studies of greetings and in particular of closings in various settings, telephone calls, chat, and (workplace) email have been summarized here in order to inform my analysis of how participants accomplish to open and close interaction in this setting compared to other settings. In ordinary conversation, such as telephone calls, people can negotiate and ratify actions on a turn by turn level. In chat participants can do something similar. In (workplace) email, and in bulletin boards as I have pointed out in previous chapters, and which will be clear in the following, participants recurrently construct several actions within a posting and do not orient to negotiating and ratifying actions in a sequential organization similar to face to face conversation. Rather several actions are indicated in a posting. Even so they do orient to their actions as elements in an interaction, and they have methods for doing this. Some of them will be pointed out in this chapter.

6.4.3 Making "recipients" a relevant category and categorizing recipients in openings and closings

Before moving to the bulk of the analysis (i.e. the investigation of responses to responses) I will elaborate a bit on some issues related to the affordances of the medium (see Antaki et al 2005; Hutchby 2001a;2001b), and I will demonstrate my points by drawing on examples from greetings and closings in 1st messages from my data. This will be done in order to provide some background and context, both for the data material I present and for the interpretations I make of how to understand responses to responses in this setting.

One of the obvious ways we may notice that actions are accomplished in different ways in face to face conversation and chat compared to bulletin boards is that in bulletin boards participants do not wait for someone to greet them after they have greeted other forum participants. As conversation analytic studies have shown, people do organize their interaction in ordinary conversation in turns, which are recurrently organized in pairs (see section 3.2 on conversation analysis). In bulletin boards participants do not post a greeting as a posting in its own right. Furthermore, in bulletin boards participants initiating a thread rarely greet anyone in particular (see below). In ordinary conversation greeting becomes relevant when someone identifies a person we may wish to greet by sighting (Kendon 1990).

In the discussion forum I investigate writers do not know exactly who their recipients are or will be. They do not have the opportunity to choose or monitor their recipients in real time by visual means, or, as in telephone calls, to dial a specific telephone number, which is usually expected to limit the set of possible recipients. In addition, they cannot see a list of members who have logged on, which is possible in chats (Rintel and Pittam 1997).

This, orienting to not knowing the identity of the people they address, is evident in and through the ways participants usually initiate threads. However, participants who initiate threads do make "recipiency" a relevant category in various ways (see previous analytical chapters on methods to invite to responses, in particular chapter 6.1 on sharing experiences, in which versions of the invitation formulation "Is there anyone who can recognize this?" is analyzed). The following examples of greetings in 1st postings point to some of the ways for making recipiency relevant:

Example D1:

"Hej," (Hi)

(From the thread " Har brug for jeres erfaringer")

Example D2:

"Hej til jer alle." (Hi to all of you)

(From the thread " Lavt stofskifte – hjertebanken – angst")

Example D3:

(From the thread "andre derude")

In Example D1 WR1 uses a general greeting without any specified recipients. However, by indicating a greeting we may say that WR1 presupposes that there are recipients to greet. In the title an expression of a need is formulated "Need your experiences". Recipients are thus addressed directly, but without using personal names. Furthermore, action is made relevant as a greeting is recognizable as a first pair part making a second pair part conditionally relevant (but see the chapter 6.2 for some notes on instances in which responses are initiated with acknowledgement tokens rather than with greetings).

In Example D2 WR1 greets the entire set of recipients ("Hej til jer alle." (Hi to all of you.)). This greeting presupposes that there is not only one recipient, but a whole group of recipients and readers of the message, some of which may respond to it. In the title medical categories are indicated which may be understood to restrict the set of participants this thread might be relevant for and thus restrict the set of relevant respondents.

In Example D3 there is no greeting at all, and the topic specified in the title is ""andre derude" (others out there), which seems to be oriented to the question of whether or not there in fact are relevant recipients available in the forum that can and will respond.

These greetings and titles can be seen to make recipiency a relevant category; Greetings and titles can be seen as recourses to initiate interaction as they make responses relevant. Furthermore, although participants do not indicate the specific identity of the participant(s) they are addressing by using personal names, they do address recipients directly, and they do categorize recipients. In Example D1, people who can indicate relevant experiences are constructed as recipients (see title). In Example D2, specific medical categories are indicated in the title, which may work to delimit the set of recipients who may read or respond. In Example D3, there is no greeting, and the title is used to question whether there are relevant recipients in the forum.

Not only is orienting to and categorizing recipients an issue in the opening phase of 1st message posts, it is also evidently an issue for participants in the closing phase:

Example D4:

"Når jeg læser om forhøjet stofskifte synes jeg også nogle af de symptomer kan passe på mig, men jeg har indenfor det sidste år taget 6 kg på . På forhånd tak håber på nogle meldinger fra jer der har kendskab til lavt stodskifte på egen krop". (From the thread " Har brug for jeres erfaringer").

English translation:
When I read about increased metabolism I also think that some of the symptoms could fit me, but I have within the last year gained 6 kilo. Thank you in advance hope to get some messages from you who have knowledge about low metabolism experienced on your own body.

Example D5:

"Hvordan klarer i andre det med hjertebanken? Er I ikke bange? Desuden havde jeg ingen anelse om, at Eltroxin behandling kunne give depression. Mamma mia!! Ser frem til at høre fra jer. Vh. Xxxx". (From the thread "Lavt stofskifte – hjertebanken – angst").

English translation:

How do you deal with the thing about palpitations? Aren't you scared? Moreover, I didn't have any clue that Eltroxin treatment could cause depression. Mamma mia!! Look forward to hearing from you. Regards, Xxxx

Example D6:

"fik konstateret hashimotos echohalopati sidste efterår(anti stof tal 75000 - nu 4200) og er i højdosis binyrebark hormon behandling vil gerne i kontakt med andre er der nogle derude." (From the thread "andre derude").

English translation:

was diagnosed with hashimotos echohalopati last autumn(antibody number 75000 – now 4200) and am in high dosage corticosteroid treatment would like to get in contact with others are there some out there.

In Example D4 WR1 provides an assessment of how some of her symptoms apply to what she has read about increased metabolism. She then expresses thanks, which orients to an expectation that someone will meet her request, and she formulates an indirect request that expresses that WR1 is interested in responses from people who has personal experiences with low metabolism. Hence, WR1 addresses recipients explicitly ("jer" (you)) and she provides a characterization of the type of recipient she understands to be a relevant respondent.

In Example D5 WR1 addresses recipients explicitly too, as she constructs a request for information that also entails presuppositions about the recipients: "Hvordan klarer i andre det med hjertebanken?" (How do you deal with the thing about palpitations?). This can be understood as a method that works to indicate a concern to include the people who perceive them-selves to be dealing with certain problems, such as palpitations, and exclude the people who do not. WR1 then provides a candidate answer, or a candidate concern in relation to the problem described: "Er I ikke bange?" (Aren't you scared?). This possible reaction to the experience of palpitations is constructed as a problem that respondents can deal with as a relevant issue. In the closing phase she also provides the information that the drug Eltroxin can cause a depression, and she indicates this as new information for her ("Desuden havde jeg ingen anelse om, at Eltroxin behandling kunne give depression." (Moreover, I didn't have any clue that Eltroxin treatment could cause depression.)). She then provides an outcry marked with exclamation marks, "Mamma mia!!", before providing a rather formulaic closing marker, "Ser frem til at høre fra jer." (Look forward to hearing from you.), which indicates an expectation to get responses from some addressed but not explicitly identified particular recipients. Then, WR1 signs of with a personal name, "Vh. Xxxx" (Regards, Xxxx).

In Example D6, which entails the entire text of a first posting, WR1 provides information of his medical history including a diagnosis and a description of present treatment ("fik konstateret hashimotos echohalopati sidste efterår(anti stof tal 75000 - nu 4200) og er i højdosis binyrebark hormon behandling" (was diagnosed with hashimotos echohalopati last autumn(antibody number 75000 – now 4200) and am in high dosage corticosteroid treatment)). He then expresses a wish to get in contact with others with the same diagnosis ("vil gerne i kontakt med andre" (would like to get in contact with others)) and requests for information about whether there are some "out there" ("er der nogle derude" (are there some out there.)), i.e. he formally requests for people with the same diagnoses as WR1 to respond. In the way the request is constructed WR1 does not indicate an expectation that there is in fact anyone who can respond; he constructs it as his concern to find out.

Example D4, D5 and D6 shows some different ways of orienting to the issue of recipiency in the closing phase of 1st postings in the discussion forum. In Example D4 and D5 recipients were explicitly addressed (most obviously by the use of the pronoun "jer" (you)), but in both cases the writer oriented to providing her understanding of some characteristics of a relevant or anticipated recipient. Hence, in Example D4 and D5 WR1 implies an expectation that there are recipients who can be addressed, and the recipients are

addressed not by indicating personal names, but by implying characteristics of the expected group of recipients. Recipients are categorized. In Example D6 the WR1 constructs it as a concern to find out whether or not there are any relevant recipients among the discussion forum participants.

6.4.4 No responses: An actual concern

Examples D1-D6 show ways in which writers in the opening phase and closing phase of 1st postings orient to recipiency. We saw that writers do address recipients explicitly by using pronouns (for example "jer" (you)), but we didn't see examples of addresses by the use of personal names. We saw that writers provided information about the intended respondent to respond to their initiative. In that way they seemed to orient to increasing the likelihood to get relevant and useful responses, that is, narrowing down what would amount to a useful response by providing characteristics of the ideal respondent, usually in regard to the experience of similar medical problem (for analyses of how participants indicate their problems as medical, see previous analytical chapters).

Writers do not only have a concern to get useful responses. An actual concern for them may also be whether or not they will get a response at all. Participants may orient to a concern with getting responses to their postings. In the appendix one response to a response is initiated with "Endelig et svar :-)" (Finally a response :-)) (See Example DD1).

When participants look at the overview of topics they can choose to click on in order to read a specific thread (see chapter 5 on data), they are also presented with further information about the threads, for example about the amount of views and the amount of responses. In the data material there are threads with between zero and 415 (on December 2nd 2010 at which time I made the count) responses. If one pays attention to the amount of responses in each thread one will notice that it is not uncommon that a first post does not get a response. In fact, about 1 out of 5 first postings in the data material has not received a response.

The 1st posting presented in Example D7 is one example:

Example D7: 1st posting, "væskeophobning/svimmelhed":

WR1 Tilmeldt: 30-06-2008 10:03	Den 26-07-2008 23:11 **væskeophobning/svimmelhed**	

1 Jeg er netop sat op i dosis (Eltroxin) og synes at mærke at jeg har langt mere
2 væskeophobning i kroppen end ellers - særlig i ben,ansigt og hænder. Jeg har i perioder
3 været nød til at tage vandrivende - da jeg ellers er ved at springe (føler jeg). Jeg bliver
4 utrolig svimmel, tror selv det skyldes dosis-ændring.
5 Er der nogen der kan nikke genkendende til dette?

English translation:

WR1 Joined: 30-06-2008 09:03	On 26-07-2008 21:11 **water retention / dizziness**	

I have just been set up in dose (Eltroxin) and think I feel that I have much more fluid in the body than usual - especially in the legs, face and hands. I have at times been forced to take diuretic - because otherwise I am about to explode (I feel). I get incredibly dizzy, I think this is due to dose-modification myself.
Is there anyone who can recognize this?

The first post shown in Example D7 was sent on July 26th 2008. At least until the time for collecting data (March 18th 2012), it has not received a response. The title is "væskeophobning/svimmelhed" (water retention/dizziness); the title thus indicates symptoms or problems. The posting entails a description of experienced medical problems (fluid in the body) that is described as possibly connected to an increase of medication intake. The problem is thus indicated as medical, which previous analyses in this thesis have pointed at to be very common in the forum. The writer provides an invitation for others to share their story, if they have a similar story (see chapter 6.1 on sharing of experiences). This participant seems to be using many of the same resources and address similar issues as posts that receive responses. Hence, in this forum there is no guarantee that initiatives will be responded to or even read.

6.4.5 Responses to responses

In the majority of the 1st postings that receive one or more responses from other participants, authors of 1st postings provide a posting that occurs after this or these (first) response(s) in time in the same thread. Morrow refers to these as "thanks messages" (2006), because in his data participants overwhelmingly expressed gratitude in these postings. These responses can be viewed as responses to responses in terms of sequentiality and time, and I will refer to them as responses to responses. As mentioned, responses to responses indicate participants' understanding of the response(s) "their" initiative (i.e. their prior posting) has received. In some sense they can be understood as formulating their understanding of how the response(s) can be understood to relate to their initiative. I will show how responses to responses do that.

In regard to chat, Nilsen and Mäkitalo (2010) note on the use of reformulations in chat to co-ordinate postings. In this data, i.e. in responses to responses in forum interactions, as I will show, (re-)formulations and summaries of interaction in responses to responses are not only used as strategies to co-ordinate postings and (re-)establish a topic as the topic of the interaction (i.e. a kind of topic preface (Mulkay 1986)), the formulations or summaries as they are used here can be understood to be closing implicative, since they treat the topic as potentially "exhausted, concluded or suspended" (see Button 1991).

Previous analytical chapters showed various practices participants use to make particular responses relevant at to respond in relevant ways. The analyses pointed at recognizable structures postings recurrently have, and also pointed at how participants orient to details of how postings are constructed when responding.

Responses to responses are responses that follow one or more responses by other participants. Participants that provide responses to response(s) orient to this as relevant in their responses, meaning that they show an orientation to whether they deal with a single response or several responses. In the examples that follow I will point to that. Participants responding in a slot that follows responses recurrently deal explicitly with topics that previous respondents have oriented to as relevant, for example by providing information constructed as answers to requests for information. As they are constructed as answers, and thus as second pair parts, this is another way (besides the provision of a summary of the talk so far) for WR1*'s to complete or finish activities without orienting to initiating or continuing further interaction.

Although responses to responses entail closing implicative actions, as they do summarizing, thanking, etc., and as they are constructed as answers, responses to responses may also entail initiatives oriented to continuing interaction or inviting to interaction.

In this chapter as in the previous I will focus on structure. I will show examples of different ways of constructing a response to response(s), pointing to how these responses to responses display understandings of the response(s) received. Specifically I will present and analyze the responses (Example D8a, D8b, D9, D10 below) that occur as responses to the responses of the 1st messages (which I have already presented parts of in Example D1, D2, D3, D4, D5, D6) in order to illuminate how participants organize their responses to responses by first dealing with the interaction so far in ways that implies closing, and then invite to further interaction, i.e. open for the possibility of further interaction. Specifically I will 1) show how participants use responses to responses to answer, summarize, conclude and/or thank other participants for their contributions, and show how these actions can be understood as closing implicative; 2) show how participants in their responses to responses deal with specific actions and understandings understood to be relevant in responses, that is, they construct their responses *as* responses or *answers*, which may also imply closing; 3) show how participants indicate or provide for the possibility to continue interaction or invite to interaction in different ways. Other examples of responses to responses which have similar structures can be found in the appendix (Example DD1-DD6).

It will be pointed out that responses to responses recurrently deal with several of the mentioned issues. It will also be pointed out how participants in and through how they do this indicate and orient to how they understand their problem and the activity they are involved in in the discussion forum. As we will see, also in responses to responses participants orient to medical knowledge and membership categories as relevant for interacting and dealing with their problems. Furthermore, responses to responses as other postings in the forum (see chapter 6.1 – 6.3) recurrently entail various actions which are organized systematically in sequential structures and thus sequential placement makes out a resource for indicating and making sense of actions.

6.4.5.1 Thanks – so far

Example D8a and Example D8b which I will analyze in the following are posting number six and seven in the thread "Need your experiences". They are both written by the author of the 1st posting in that thread. WR1* has chosen to post two postings in the same thread with approximately half an hour between the

time for posting the two responses[67]. As they are posted by the same author in the same thread, i.e. occur in the same immediate context, they are nice illustrations of how differently responses to responses can be organized.

As we will see, one of the differences is that in the posting in Example D8a) WR1* addresses the respondents as a group, whereas in the posting in Example D8b) a particular respondent is addressed.

In Example D8a, which is the sixth post in the thread, WR1* thanks the recipients who have responded and deals with some of the issues that respondents have brought up as responses to WR1*'s initial posting (see Example DD2 and DD3 in the appendix for similar cases):

Example D8a: Posting number six, "Har brug for jeres erfaringer":

WR1* Tilmeldt: 25-10-2010 15:31	Den 26-10-2010 14:28 **Re: Har brug for jeres erfaringer**	

1 Tusind tak for jeres brugbare tilbagemeldinger. Jeg lapper dem i mig og selvom
2 ingen af jer måske helbreder mig så kan jeg da allerede nu sige at jeg finder fornyet
3 håb om, at det kan være stofskiftet der spiller min krop et puds. Jeg må bede om at
4 få målt denne blodprøve der kan vise om det er en form for autoimmun sygdom. og
5 ja det er netop sådan at det hele forværres med 10 - 20 procent omkring
6 menstruation og det har jeg svært ved at tacle når det er så slemt i forvejen.
7 Ja det er rigtig forstået at mit Tsh på en måned faldt fra 7.1 til 4.9 uden medicin og
8 hun siger T3 og T4 var normale og agter ikke at sætte mig i behandling. Ved at jeg
9 ville skulle slå i bordet for at komme i behandling. Ved det fra da jeg havde lavt
10 b 12. Jeg kan ikke mærke at værdierne er faldet altså nogen form for bedring.
11 Tvært imod. Jeg kan forstå at hovedpinen og den der underlige summen-sitren i
12 baghovedet er jeg ikke alene om. Den er meget ubehagelig. Hovedpinen er der
13 altid men varierer i styrke. Oftest tager den til i løbet af eftermiddagen og
14 forsvinder ikke. Jeg ville slet ikke kunne magte et fuldtidsjob og selvom jeg tyer til
15 kodipar for at kunne klare mine aftenvagter så tager de kun toppen. Kan godt høre
16 at det hele er en stor klagesang og netop det er også svært at acceptere. At andre
17 evig og altid skal se og høre man har det elendigt. Derfor har jeg også valgt at
18 skulle på smerteklinik. Men men kunne det hele nu løses ved at få det stofskifte op
19 ville det jo være super og ingen skulle høre mig beklage mig over bagateller.
20 Endnu engang tak til jer der gad ulejlige jer med respons. Hører meget gerne fra
21 andre.
22
23 Sidst rettet af WR1* 26-10-2010 15:38, rettet i alt 1 gang[68].

[67] Indicating reasons for this would be speculative, and I will simply focus on analyzing how the two posts are built and what they work to do.

[68] We may note that this posting has been edited after the time of posting it, but as an analyst and as a reader of the post at this time, i.e. after it has been edited, we have no way of knowing what has been edited, and I will simply analyze the post after it has been edited, since it is also the resource respondents and readers have available after 26th October 2010 at 15:38.

English translation:

WR1*	On 26-10-2010 14:28
Joined: 25-10-2010 15:31	**Re: Need your experiences**

Thanks so much for your useful feedback. I drink it in and even though neither of you may cure me I can say now already that I find renewed hope that it can be metabolism that plays my body tricks. I better ask to get this blood test that can show whether it is a form of autoimmune disease. and yes it's exactly right that it all gets worse by 10 - 20 percent around menstruation and I have a hard time dealing with this when it is so bad already.
Yes it is correctly understood that my Tsh in a month fell from 7.1 to 4.9 without medication and she says T3 and T4 were normal and does not intend to put me in treatment. Know that I should put my foot down to get treatment. Know it from when I had low B12.
I cannot feel that the values have fallen, meaning any improvement. Quite the contrary. I understand that the headache and the weird sum-twitches in the back of my head I am not alone with. It is very unpleasant. The headache is always there but varies in strength. Most often it increases during the afternoon and will not disappear. I would not be able to handle a full time job, and although I resort to [name of analgesic] to manage my evening shifts they cover only the top. Can hear the whole thing is a great lamentation and precisely that is also difficult to accept. That others forever and ever should see and hear that one feels miserable. Therefore, I have chosen to be in a pain clinic. But but could it all now be solved by getting the metabolism up, it would indeed be super and no one would hear me complain about trifles.
Once again thanks to you who bothered to bother with a response. Would very much like to hear from others.

Last edited by WR1* 26/10/2010 15:38, edited a total of 1 time.

As a starting point we can note that in the text in Example D8a) WR1* initiates and closes her posting with an expression of thanks (line 1 and line 22). We can also note that WR1* in the initial part of the posting provides confirmations, and that she in the latter part of the posting provides information about her personal experiences, which is “new”, that is, has not been brought up so far. This information is constructed as relevant in relation to the topics that have been discussed so far. WR1* accomplishes to do far more here than thanking the respondents for posting a response; she displays her understanding of how their responses relate to her problem, she answers specific initiatives, she makes relevant new information and she invites to further responses from others. The methods for doing this will be outlined in the following, while also showing how WR1* displays her understanding of her problem in participating in the activity.

WR1* initiates with expressing gratitude for the responses her 1st posting has generated: “Tusind tak for jeres brugbare tilbagemeldinger.” (Thanks so much for your useful feedback.). She addresses several recipients (“jeres” (your)). WR1* thus addresses the participants who have responded as a group. She categorizes the responses as “tilbagemeldinger” (feedback), and thus shows that she understands the individual responses as all providing feedback on her 1st posting, that is, they are understood to deal with her 1st posting.

WR1* then describes what the responses she has received has contributed with, i.e. she elaborates further on what she expresses her gratitude for. Morrow (2006:545), who investigated "thanks messages" in an online discussion forum on depression notes that expressions of thanks were recurrently followed by elaborations in his data. In this data, Example D8a), WR1* initiates with a statement which implies that she perceives herself as being very responsive and attentive to the feedback from the other participants ("Jeg lapper dem i mig" (I drink it in)) and continues to express that the responses has given her renewed hope that metabolism could be the cause for her bodily problems even though she acknowledges that she cannot expect forum participants to cure her ("og selvom ingen af jer måske helbreder mig så kan jeg da allerede nu sige at jeg finder fornyet håb om, at det kan være stofskiftet der spiller min krop et puds." (and even though neither of you may cure me I can say now already that I find renewed hope that it can be metabolism that plays my body tricks.)). The construction used can be formulated as "Even though not X, then Y". This construction resembles the construction "if X, then Y", which for example Sneijder and te Molder (2005) has described, and which forum participants in this forum recurrently make use of versions of when they deal with causes for problems (see chapter 6.2 on explaining illness). With this formulation WR1* accomplishes to establish that she understands the previous respondents' actions to back her up in her assumptions about possible and likely causes, and that that in itself is valuable for WR1* even though she does not get cured by that[69]. The formulation, then, works to elaborate on why the responses have been helpful to WR1*.

We see that in this Example, a response to responses, the first thing WR1* does is to express her thanks to the respondents as a group. We also see that WR1* indicates her understanding of why the responses have been helpful. WR1* thus indicates the outcome of the responses she received, and we hear this as a kind of positive evaluation, that implies closing of that particular activity which is being evaluated, i.e. some activity has occurred which makes an evaluation possible and relevant.

WR1* does not stop here however. WR1* also deals with previous respondents' actions specifically. In line 3-4 WR1* states "Jeg må bede om at 4 få målt denne blodprøve der kan vise om det er en form for autoimmun sygdom." (I better ask to get this blood test that can show whether it is a form of autoimmune disease.)". This statement indicates a cause of action, (ask to get this blood test) that can indicate whether a specific disease (a form of autoimmune disease) may be the cause for WR1*'s problems, as something WR1* better do. A concern to indicate possible future outcome is displayed. This fits nicely with Button's (1991) observation about conversation that summaries of the talk so far focus on implications for future relevant actions.

This statement is constructed as a response. More specifically, we can read it as a response to an action that WR1* understands and treats as a suggestion for a relevant way WR1 could act, i.e. as an acceptance that implies commitment to doing the action suggested. Commitment and acceptance are implied with the formulation "Jeg må" (I better) and also by indicating what the outcome of acting in the suggested way would be ("bede om at 4 få målt denne blodprøve der kan vise om det er en form for autoimmun sygdom." (ask to get this blood test that can show whether it is a form of autoimmune disease), line 3-4). Here WR1*

[69] In line with this understanding, the previous chapters showed that participants do not orient to the forum as a resource for getting a final diagnosis or as a resource for getting advice on medical treatment as such. Rather, participants orient to an understanding of the forum as a resource to gain various sorts of insights and knowledge that may give them reassurance and provide them with competences that can guide them in terms of how to approach their problem further.

orients to an understanding that she should act in ways that will provide her with indications of specific possible medical causes for her illness. Hence, we see indications that WR1* orients to elements of a previous posting as "advice" understood as relevant ways of acting in order to establish a specific medical cause for the experienced problems. We see that WR1* treats indications of acceptance and commitment to pursuing the actions suggested as a relevant response, and we may say that this action, as the previous, implies closing of that particular activity.

WR1* continues however, in line 4 onwards, to deal with personal experiences. She explicitly shows that the issues she deals with should be understood as a related to an ongoing topic. She makes use of the construction, "og ja" (and yes), to initiate an action. "og" (and) used after a punctuation mark here works to indicate that the action being initiated should be understood as a continuation of something and "ja" (yes), which is used as a type-confirming response to yes/no typed interrogatives in face to face conversation (Raymond 2003), works to indicate the action as a response, and in particular as an acknowledgement or confirmation. "og ja" (and yes) is followed by a statement that explicitly indicates confirmation (indicated with "det er netop sådan" (it's exactly right)) which makes the action recognizable as a confirmation of something a previous respondent has suggested or otherwise made relevant: "og ja det er netop sådan at det hele forværres med 10 - 20 procent omkring menstruation og det har jeg svært ved at tacle når det er så slemt i forvejen." (and yes it's exactly right that it all gets worse by 10 - 20 percent around menstruation and I have a hard time dealing with this when it is so bad already.), (line 4-6).

WR1* initiates the action in line 7-8 with "Ja" (Yes) followed by an unfolded confirmation as well: "Ja det er rigtig forstået at mit Tsh på en måned faldt fra 7.1 til 4.9 uden medicin" (Yes it is correctly understood that my Tsh in a month fell from 7.1 to 4.9 without medication). Here WR1* uses "Ja" (Yes) to acknowledge confirmation (see above) before formulating how "Ja" should be understood as an act of confirmation, i.e. what it should be understood to confirm. The description WR1* confirms to be accurate here involves the development in her metabolic numbers, which she specifies. Medical information is, then, again, oriented to or – and here possibly acknowledged – as relevant in this activity.

WR1* continues to recount an evaluation her doctor has provided in regard to medical investigations and treatment recommendations: "og hun siger T3 og T4 var normale og agter ikke at sætte mig i behandling." (and she says T3 and T4 were normal and does not intend to put me in treatment.), (line 7-9). The statement is constructed as a reporting and/or formulation of what the doctor has said (see chapter 6.3 on advice giving for examples of how such reportings are also indicated in 1st postings). The statement about the doctor's evaluation and recommendation is initiated with the connector "and" (line 7). In this way WR1* indicates that the indication of the doctor's evaluation and recommendation should be read as connected to the prior action in which she confirmed a specific development in the TSH blood test measurements. In that way she indicates that medical facts and the implied interpretations of them which WR1* and the respondents in the thread agree upon are pointing at a medical problem are in contrast with the doctor's evaluation and recommendation.

WR1* indicates statements about her experiences and about medical information and constructs them as confirmations to inquiries or suggestions posed by respondents (line 4-9). This works as demonstrations of how respondents' responses have helped her. They helped her by confirming her understanding.

Furthermore, she accomplishes to indicate that her interpretations about the causes for her problems are in contrast with the doctor's interpretations, and that she is not alone against the doctor with her interpretations, since she indicates the respondents' and her own understandings as being in alignment. In the previous analytical chapters I pointed at ways in which participants also constructed tellings of experiences as "similar" and understandings of problems as being in alignment. We can also notice that the issues dealt with here are recognizable as medically relevant issues similar to what we have seen in previous chapters (chapter 6.1 - 6.3).

WR1* in what she does next builds on this understanding, that the doctor's recommendation is in contrast with her own experiences and the interpretations of them that respondents seem to agree with, as she indicates knowing what she should do in order to get treatment: "Ved at jeg ville skulle slå i bordet for at komme i behandling." (Know that I should put my foot down to get treatment). (line 8-9).

WR1* here then does not indicate a concern to get advice, i.e. suggestions as to what to do (see chapter 6.3 on advice giving). She states that she already knows what to do, which, again, is a way for WR1* to demonstrate that she is (no longer) in a position in which she needs help in that concern. This could be seen as a way of implying closing. WR1* provides the grounds she has for knowing how to act; "Ved det fra da jeg havde lavt b12" (Know it from when I had low B12), (line 9-10), i.e. she bases her knowledge on similar, previous experience she has had with medical problems. Contrary to this, in the chapter about advice giving we saw that participants in 1st postings in which advice was invited to indicated being in need of specific or general medical knowledge in order to deal with their problems. Morrow (2006:545) points out as a finding that in his data the "thanks message writers" never made it clear whether they were following the advice they had received from respondents, when they indicated actions they had pursued. In this sequence in which WR1* expresses thanks and elaborates on it Morrow's point seems to apply as well: WR1* does not explicitly indicate that other respondents' advice in particular has made her act in a particular way. Rather she indicates that responses has confirmed her in her interpretations and provided her with renewed hope.

From line 11 WR1* starts demonstrating how she experiences to have a medical problem (also see chapter 6.1 on sharing experiences in which demonstrations of personal experiences were dealt with). In line 10-11 WR1* indicates that her experiences are not in alignment with what could be expected from the development in her blood test results: "Jeg kan ikke mærke at værdierne er faldet altså nogen form for bedring. Tværtimod." (I cannot feel that the values have fallen, meaning any improvement. Quite the contrary). This works to back up the statement that WR1* should in fact insist to get treatment and to indicate that WR1* still experiences medical problems although respondents have provided helpful responses and although WR1* knows what to do. This is not constructed as being occasioned on any particular action on the part of other respondents, it is readable as descriptions that work to demonstrate the understanding, which there seems to be agreement upon in the tread, but which is not acknowledged by WR1*'s doctor.

In line 11-15 WR1* deals with specific problems, "hovedpinen og den der underlige summen-sitren I baghovedet" (the headache and the weird sum-twitches in the back of my head) (line 11-12). The problems are constructed as known to the participants by using a definite form ("hovedpinen" (the headache); "den

der underlige summen-sitren" (the weird sum-twitches)). The problems she indicates are introduced as relevant on the basis that other participants have also mentioned these problems as personally experienced ("er jeg ikke alene om" (I am not alone with), line 12). She explicitly uses the phrase "Jeg kan forstå" (I understand that) and thereby shows that the action she is performing should be understood as a way of displaying her understanding of elements of the previous interaction; it works as a formulation, a sum up, of what she makes of the previous interaction in the thread about headaches and weird sum-twiches.

She assesses the problems and describes the experiences she has with headache (line 12-15). In that way she makes the quality of the headache a possible relevant factor, as she demonstrates how she experiences headaches. She then rejects being able to work full time, as she resorts to painkillers in order to manage the evening shifts at her present job (line 14-15). These stories accomplish to indicate aspects of how WR1* in fact experiences problems, particularly in regard to pain and how it affects her everyday life. This is another way WR1* demonstrates how her experiences point at a medical problem (see line 2-3), and, again, the demonstration is followed by an action that has pointed at something which is shared or agreed upon with other respondents (here the experience of headaches, line 12-13). Bringing up headaches as a topic here is thus constructed as being occasioned by the fact that that experience is shared among several participants in the interaction, i.e. to point that out as a relevant fact. Here we see an example of how the activity of sharing experiences is oriented to in a response to responses. Hence, WR1* orients to acknowledging the sharing of experiences as an outcome of interactions besides acknowledging confirmation of her own experiences.

Towards the end of the posting WR1* summarizes what her actions of telling about her experiences imply by categorizing them as hearable as "a great lamentation": "Kan godt høre at det hele er en stor klagesang" (Can hear the whole thing is a great lamentation") (line 15-16). Providing a formulation of "the whole thing", a kind of categorization or summary can be a resource to indicate the initiation of closing. However, WR1* uses the categorization for another purpose as well, namely to indicate dissatisfaction with the present situation and to indicate what she has done to deal with it, i.e. the details of how WR1* summarizes indicates how she understands her problem. WR1* states that she has difficulties accepting the fact that her actions are hearable as complaints: "og netop det er også svært at acceptere." (and precisely that is also difficult to accept.), (line 16). She then formulates what it is she has difficulties accepting: "At andre evig og altid skal se og høre man har det elendigt." (That others forever and ever should see and hear that one feels miserable.). She also provides a statement about a choice she has made (being "in a pain clinic", line 18) which is constructed as a consequence (indicated with "Derfor" (Therefore), line 17) of having difficulties with perceiving herself as a "complainer" in the eyes of others. The membership categories WR1* here makes relevant in summarizing are recognizably similar to the membership categories pointed out as relevant in the chapter about advice giving. In that chapter the categories that participants could be seen to orient to with their actions were advice seeker (and advice giver). Most participants could be seen to avoid treating themselves and other participants as troubles tellers and troubles receivers (see the previous chapter on advice giving and Jefferson & Lee (1992)). What WR1* could be seen to be doing in this example is formulating that she knows that she in and through her tellings could be categorized as a "troubles teller" or even as a "complainer". She, however, also indicates that she in fact has taken action, and that she therefore could also be categorized as a competent member, i.e. as someone who seeks medical help and advice and acts on it.

WR1* continues the interaction about being "a complainer" in line 18-19 as she states a case in which she would not complain to others: "Men men kunne det hele nu løses ved at få det stofskifte op ville det jo være super og ingen skulle høre mig beklage mig over bagateller." (But but could it all now be solved by getting the metabolism up, it would indeed be super and no one would hear me complain about trifles). This statement, which describes a hypothetical case, is constructed as being in contrast to the actual and current situation she just described. This is done by initiating with "Men men" (But but)[70]. A version of an if X, then Y construction is used here (see chapter 6.2 on explaining illness); WR1* describes a scenario of solving it all by regulating the metabolism, which is marked as a hypothetical scenario by using the verbal construction "kunne…løses" (could be solved) in a past tense and passive form. This corresponds to the "if X"-element. The "then Y"-element is formulated as "ville det jo være super og ingen skulle høre mig beklage mig over bagateller" (it would indeed be super and no one would hear me complain about trifles)[71]. Here the verbal constructions "ville det jo være super" (would be super) and "skulle høre mig beklage mig" (would hear me complain) are used, also in past tense. "ville" (could or would) and "skulle" (would or should) in a past tense modal are used to talk about wishes for the future ("Wishes and hypotheses": n.d.), and that is what these constructions seem to indicate here. Contrary to the practice I described in chapter 6.2. about explaining illness) in which I described how versions of if X, then Y structures were used to invite to talk about possible or likely connections between experienced problems or medical indications (such as blood test results) and a metabolic condition, here the if X, then Y construction is used to provide an assessment of the outcome if WR1* could succeed in solving her problems by regulated her metabolism. Again, then, we see WR1* orienting to outcome in her response to others' responses.

WR1* with this formulation that indicates as a wish for the future that WR1*'s problems would be solved by regulating her metabolism indicates that she has a hope, and possibly a belief, that problems with the metabolism is the cause for her problems. She also implies that she is not a kind of person who complains about trifles, and that she considers her current problems to be complex and severe (similar descriptions were found in the previous analytical chapters). This is implied because she refers to her problems as "det hele" (it all) (line 18) as opposed to the trifles that would be left to possibly complain about, when her main problems ("det hele" (it all) were solved. Furthermore, by using this category, "det hele", WR1* implies that readers would know that that refers to, i.e. that it is understandable from previous interaction.

WR1* also shows that she knows what the optimal solution to her problems would be, getting the metabolism up (line 18). This implies that WR1* does not expect or invite to talk about explanations for her problems or invite to advice, which participants recurrently do in 1st postings (see chapter 6.2. on explaining illness and 6.3.om advice giving).

[70] The repetition of "but" (Danish "Men men") here may be a typing mistake, or it may be deliberate, since, at least to my knowledge as a speaker of Danish, the use of the Danish equivalent to the English "but", "men", used repetitively is a practice people use in spoken Danish, usually three times after each other, "men, men, men". My sense is that it works to indicate stress or draw attention to whatever follows, i.e. mark it as a point.

[71] Alternatively, "it would indeed be super" could be analyzed as the then Y…-element, and "and no one would hear me complain about trifles.", could be analyzed as an additional effect or consequence. As it is not clear, and as it is not a central point here, I will just note this as an alternative.

In line 20 WR1* repeats the act of thanking in a reformulated way: “Endnu engang tak til jer der gad ulejlige jer med respons.” (Once again thanks to you who bothered to bother[72] with a response.). She indicates this as a repetition (“Endnu engang” (Once again)), and she formulates appreciation for the responses she has received by referring to the act of responding as a bother. This may be a way for WR1* to orient to the fact that participants have no social obligations to respond, i.e. they are not physically present to each other and in that sense respond voluntarily.

She closes by opening up for the possibility of getting responses from participants who have not yet responded: “Hører meget gerne fra andre.” (Would very much like to hear from others.), (line20-21). This statement works explicitly to invite participants who have not yet responded to provide a response. It does not indicate any specifications in terms of what respondents should deal with or respond to. WR1* may be seen to imply that what she is interested in responses to has already been established, i.e. she is still interested in responses that deal with her initial post and the actions made relevant in that post and/or she is still interested in hearing from people who has similar experiences to the experiences WR1* has described (see title). This invitation, which is explicitly addressed at people who have not yet responded does not address respondents who have already responded. As WR1* does not invite to further interaction with the respondents who already responded the invitation explicitly addressed at others may be read as an implicit closing of the interaction with those respondents.

This example, Example D8a), illustrates the complexity of responses to responses. WR1* accomplishes various actions in this posting. However, the actions are accomplished in a particular sequential order.

WR1* treats it as relevant first to thank the people who responded and then indicates how the responses are useful and how she will act. WR1* also deals with issues brought up by respondents, which she responds to by providing confirmations and by indicating her understanding of experiences that are shared between herself and respondents. Hence, WR1* deals with the previous responses in her response 1) by thanking for them, 2) by indicating what an outcome they have had, and 3) by providing responses, for example formulated as confirmations. At the end of the posting WR1* invites people who have not yet responded to do so. WR1* does not invite to further talk with people who already responded. Other examples of responses to responses that initiate with thanks and provide responses can be found in the appendix (Example DD2-DD5).

From the way WR1* constructs these actions, we also see how she understands her problem and what membership categories she understands to be relevant. WR1* indicates that the responses she received gave her renewed hope that it is the metabolism that causes her problems (line 2-3). In the analysis it was pointed at how she demonstrates how she understands the responses to do that. Among other things, the fact that she indicated information as confirmations to suggestions coming from respondents implied alignment, which was then contrasted with a doctor’s opinion.

By constructing respondents’ interpretations as being in alignment with WR1*’s interpretations, WR1* accomplishes to indicate that her interpretations, based on the medical information made public in the postings, have been confirmed, and, thus, that she should continue to act according to that understanding.

[72] The English translation “bothered to bother” corresponds to the Danish “gad ulejlige jer” in the orginal.

In her response WR1* treats previous responses as advice. This is done by indicating committing to actions she should do (line 3-4). In that way WR1* orients to the categories advice seeker and advice giver as relevant. An understanding that WR1*'s problem is medical is further aligned with as WR1* indicates confirmations of specific medical information (line 4-10).

WR1* also indicates personal experiences (line 10-15). WR1* tells about bodily pain and how she deals with that. She orients to this telling as possibly hearable as a complaint (line 15-17). She then indicates what she has done in order to act on her problem, get treatment at a pain clinic (line 18). Again, we see an orientation to acting on problems by seeking (professional) help, i.e. the category advice seeker is again oriented to. An understanding that the problem has a medical cause is also restated, as WR1* indicates that she would not complain about "trifles" if the problem she has could be solved by getting the metabolism up (18-19). WR1* ends her posting by indicating having an interest in hearing from others in the forum.

6.4.5.2 Dealing with knowledge challenges

As mentioned, in the thread "Need your experiences" the participant, WR1, who initiated the thread, has also posted the sixth and seventh postings, that is, postings that I refer to as responses to responses. The sixth posting was shown in Example D8a.The seventh posting in the thread is shown in Example D8b) below. It has been posted on October 26th 2010 at 2.50 pm., 22 minutes later than the sixth post (see Example D8a). In the seventh posting, Example D8b) below, WR1* indicates that the post is intended for at specific recipient (see line 1), which I refer to as "WR3", as WR3 has posted the third posting in the thread. WR1* uses the opportunity to post several postings in order to indicate that she responds to different (sets of) respondents in the two postings. Nilsen and Mäkitalo (2010:100) note that in chat interactions the norm seems to be that one posting is used to respond to one previous contribution. A similar norm does not seem to be followed here, since WR1* in her posting shown in Example D8a) addresses several participants in a posting (also see appendix (Example DD4 and DD5) for more examples of postings in which several respondents are addressed). Instead WR1* shows, by singling out a specific respondent in a posting after having addressed the respondents as a group in the previous response, that WR1* takes it to be relevant to respond to WR3's previous response in the thread specifically.

In the first response to the responses received, WR1* expressed appreciation and indicated that the responses had provided her with renewed hope that metabolism is the cause for her problems. In the response to WR3 in Example D8b), WR1* constructs it as a point that there is in fact a medical cause for her problems. In fact, she treats that understanding as a counter to the understanding indicated by WR3:

Example D8b: Posting number seven, "Har brug for jeres erfaringer":

WR1* Tilmeldt: 25-10-2010 15:31	Den 26-10-2010 14:50 **Re: Har brug for jeres erfaringer**

1 Til WR3: Jeg har fået målt min blodprocent og den var ok, men har også taget jern
2 forebyggende for at udelukke, dette skulle være årsagen. Jeg ved bare at der ER en
3 årsag til, at jeg har det sådan og hvis det er stofskiftet der er synderen, så er det jo
4 foklaring på, at de 10 behandlinger ved privat akupunktør , 7 x akupunktur ved
5 lægen, 25 ganges massage, 5 gange fysioterapi, 10 kiropraktor behandlinger, 2
6 medicinfri måneder og fjernelse af hormonspiral ikke har hjulpet mig

English translation:

WR1* Joined: 25-10-2010 15:31	On 26-10-2010 14:50 **Re: Need your experiences**

For WR3: I have measured my blood percent and it was ok, but have also
taken iron in prevention to exclude that this should be the cause. I just know that
there IS a reason why I feel the way I do and if it is the metabolism that is the
culprit, then it's the explanation that the 10 treatments at private acupuncturist, 7 x
acupuncture at the doctor, 25 times massage, 5 times physiotherapy, 10 chiropractic
treatments, 2 drug free months and removal of IUS has not helped me

In the response in Example D8b) addressed at WR3 (line 1), WR1* initiates with descriptions of actions she has pursued in order to deal with her problems; she has had her blood percent measured and she has taken iron in prevention to exclude iron deficiency as a cause for her problems (line 1-2). Then, in line 2-3, she states that she knows that there is a cause for her problems; "I just know that there IS a reason why I feel the way I do". As a statement we may notice the following characteristics: WR1 explicitly states what she knows, that is, the statement makes a claim about what she knows. The issue she claims to have knowledge about is that there is a cause for her problems. As this knowledge claim is indicated after indications of medical examinations and just before suggesting metabolism as a cause, the cause WR1* seems to be searching for is a medical cause. Knowledge about the "existence" of a cause is constructed as grounds for claiming the existence of a cause ("I just know that…").

As I have only presented you with the response to the response and not the responses themselves (but see appendix, Example ReD8-ReD10)) and as I point at recognizable methods for dealing with prior talk in responses to responses, in some cases that will not be sufficient in order to point out particular practices. Here is a case in which I will refer back to actions in responses prior to the response I analyze here. One of the central issues that is going on here, I will argue, is that WR1* counters WR3 with this knowledge claim. In her response WR3, among other things, writes; "Men du skal vide, at du ikke er alene med din følelse af at "være forandret" og heller ikke med dine hyppige hovedpiner." (But you should know that you are not alone with your feelings of "being changed" and not with your frequent headaches.) (see appendix, Example ReD8_3). Here WR3 tells WR1 what she should know, namely that she is not alone with the feeling of "being changed" and she is not the only one with many headaches. "You skal vide (you should know) is a

construction that, in the sense it is probably intended here, does not simply announce a statement about knowledge that is relevant for WR1, it also offers comfort or reassurance, as the knowledge that is offered by WR3 includes a formulation of WR1's experiences and implies that these experiences are shared by others, including WR3 . The statement offers a particular understanding of WR1's problems and it offers reassurance as a relevant action.

If we then revisit the knowledge claim by WR1* in the response to that response, line 2-3, "Jeg ved bare at der ER en årsag til, at jeg har det sådan" (I just know that there IS a reason why I feel the way I do), we can see that this knowledge claim might work as a counter to the offering of knowledge and reassurance by WR3. In his examination of elementary properties of argument sequences in conversation Coulter (1990) takes up a practice for constructing a counter-assertion to an assertion, namely the contrastively-matched counter (1990:195). He notices about this practice that… "Declaratives are built into Counters in adjacent turns according to the design convention of contrastive matching. Indeed, contrastive matching enables a speaker to produce a symmetrical utterance which accomplished two functions simultaneously, viz., to rebut the prior declarative Assertion's point and to advance an alternative position." Coulter furthermore provides some characterizes of Contrastively-Matched Counters as he mentions that they include "…some turn-initial re-orderings, obligatory pronominal transformations, and critically, one or more major transformations on a category or category-phase occurring in the prior turn which alters it in the paired Counter to its contrastive category" (1990:196).

We can notice that WR1 uses a construction that has some similarities to the construction used by WR3, which makes this recognizable as a contrastively matched counter. Both statements, ""Men du skal vide, at du ikke er alene med din følelse af at "være forandret" og heller ikke med dine hyppige hovedpiner." (But you should know that you are not alone with your feelings of "being changed" and not with your frequent headaches.), (see appendix, Example ReD8_3) and "Jeg ved bare at der ER en 3 årsag til, at jeg har det sådan" (I just know that there IS a reason why I feel the way I do) (Example D8b, line 2-3), is constructed to be about what WR1 knows or should know. The use of pronoun thus changes from "du" (you) to "Jeg" (I). WR1 builds the statement in her response to the response to be symmetrical with the statement in the response as she constructs it to be about the same issue with a "similar" construction. Also, both statements deal with WR1's experiences or sensations in relation to her problem ("din følelse af" (your feelings of); "jeg har det sådan" (I feel the way I feel)).

Crucially, WR1 specifies what she knows already, not what she should know in the statement in the response to the response ("Jeg ved bare at der ER en 3 årsag til, at jeg har det sådan" (I just know that there IS a reason why I feel the way I do), line 2-3). Furthermore, WR1 does not counter the formulation that she has certain experiences, which was formulated in the response by WR3, but she claims that there is a reason for this, thus she makes it a point that she is looking for a cause, not for reassurance or comfort. Notice how WR1* constructs "knowing" as justification for the claim that there is a cause for her problems and how she marks parts of her claim. This is done with the expression "Jeg ved bare" (I just know) and the capital letters used, "ER" (IS), which might work to indicate stress (Darics 2010:138). This shows that WR1* has a concern for pointing this out, and it may imply that WR1* understands WR3's response as not acknowledging that there is a cause for WR1's problems, or that it is relevant to search for a cause or deal with that in the forum. Furthermore WR1 may implicitly dismiss the offer WR3 made about what WR1 should know, since she is stating what she does know and does not acknowledge the offer given. WR1*

thus shows that she does not acknowledge knowledge that others also feel bad as reassurance. We saw in Example D8a WR1* indicates that the responses made her feel reassured that metabolism was the cause for her problems, and she expresses appreciation for that.

WR1* continues (in line 3) with a formulation that indicates that if the metabolism is the cause for her problems, it would explain why her many attempts to get treatment with the help of health professionals have all failed; “og hvis det er stofskiftet der er synderen, så er det jo foklaring på, at de 10 behandlinger ved privat akupunktør , 7 x akupunktur ved lægen, 25 ganges massage, 5 gange fysioterapi, 10 kiropraktor behandlinger, 2 medicinfri måneder og fjernelse af hormonspiral ikke har hjulpet mig” (and if it is the metabolism that is the culprit, then it's the explanation that the 10 treatments at private acupuncturist, 7 x acupuncture at the doctor, 25 times massage, 5 times physiotherapy, 10 chiropractic treatments, 2 drug free months and removal of IUS has not helped me). Here WR1* makes use of an if X, then Y construction to indicate metabolism as a likely and possible cause for her problems that would, in the way it is constructed here, not only explain WR1*’s problems, but also explain why previous attempts to get treatment have failed. Notice also the list WR1* indicates of things she has done to deal with her problem. By indicating this list WR1* points at the fact that she has acted extensively on her problem and that she has treated the problem as a medical and physical problem by getting treatment from various health professionals.

In line with what we saw in WR1*’s first response to received responses, Example D8a), WR1* deals with possible causes and indicates courses of actions she understands to be relevant to act out in order to deal with (previously described) problems.

Contrary to the methods used to describe problems, causes, and relevant actions in the response in Example D8a), in the response in Example D8b) WR1* does not orient to express gratitude, sum up on the topic so far, to show how she understands previous responses to be relevant to her, and/or to show that she aligns with specific action dealt with by previous respondents. Instead here WR1* provides a statement that claims knowledge about the existence of a cause for the experienced problems, constructed as to make out an argument in a discussion that counters another understanding, and she builds in constructions that indicate a certain cause (metabolism) as likely and possible by the logic of exclusion. Again, the actions in this response also reflect particular understandings of how competent people should deal with such problems, namely by actively searching for a medical cause and not simply accepting feeling bad. In terms of membership categories oriented to we may say that WR1* resists aligning as a troubles teller (see chapter 6.3 on advice giving).

The response in Example 8b is constructed as a counter in an argumentation sequence. Also, in Example 8b) WR1* does not invite to further interaction which was done in Example 8a).

6.4.5.3 Closing and opening – answering and adding

In the following response to a response, Example D9, WR1* uses her response to specify issues understood to be relevant and then invites others to indicate experiences with a specific issue, namely experiences with regulation in medication. The example represents cases in which WR1* initially answers WR2, but then approaches other forum members by adding elements to her telling of experiences and by posing a question in which “nogen” (anyone) who recognizes the experiences she describes is invited to respond (also, see chapter 6.1) (see Example DD6 in the appendix for a similar example):

Example D9: Posting number three, "Lavt stofskifte – hjertebanken – angst":

WR1* Tilmeldt: 20-12-2008 12:29	Den 20-12-2008 15:36 **Re: Lavt stofskifte – hjertebanken – angst**

1 Hej WR2,
2 Jeg er 42, så jeg ligger ikke lige i din aldersgruppe. Mht. depression eller "dårligt
3 humør", ked af det symptomer, så har jeg læst det her på debatsiden, og i nogle af
4 de referater som jeg har set inde på thyreoidea landsforeningens hjemmeside.
5 Lige en anden ting som strejfede mig. Selvom jeg får Eltroxin mod for lavt stofskifte,
6 så har jeg alle symptomerne som om at mit stofskifte er for højt. Nu har jeg aftalt
7 som sagt helt at lade være med at tage medicinen 1 måned for så herefter at gå op
8 og få taget blodprøver. Kan det tænkes at kroppen ikke har behov for Eltroxinen
9 mere, og at man derfor får symptomerne for for højt stofskifte?Er der nogen der har
10 prøvet dette? En anden ting der kunne tyde på, at jeg har ret i mine antagelse er,
11 at jeg var inde på Meditalklinikken i København, hvor jeg fik at vide at min
12 forbrændning er al al for høj i øjeblikket (som en 27 årig). Normalt er dette jo godt,
13 men ikke i mit tilfælde da jeg er gået fra 61 kg. Til 57 kg. Min fedtprocent var også
14 for lav. Havde nok med antioxidanter, og mit oxidative stress lå indenfor
15 rammerne. Ellers kan jeg forstå på de andre som skriver i debatten, at de langsomt
16 har ændret deres medicinbehov, og ikke så drastisk som jeg gør det nu?
17 Vh. Xxxx

English translation:

WR1* Joined: 20-12-2008 12:29	On 20-12-2008 15:36 **Re:** *Low metabolism – palpitations – anxiety*

Hi WR2,

I'm 42, so I am not quite in your age group. Regarding depression or "bad mood", sadness symptoms, I read it here on the discussion page, and in some of the reports that I have seen in the thyroid National Association website.
Just another thing that occurred to me. Although I get Eltroxin for low metabolism, I have all the symptoms as if my metabolism is too high. Now I agreed as I said, to stop taking this medicine altogether for 1 month and then go up and have blood tests done. Could it be that the body does not need the Eltroxin anymore, and that one therefore gets the symptoms of hyperthyroidism? Has anyone tried this? Another thing that might indicate that I am right in my assumption is that I was in the [name of clinic] in Copenhagen, where I was told that my burning is way way too high at the moment (as a 27 year old). Usually this is very well, but not in my case because I have gone from 61 kilos to 57 kilos. My body fat percentage was also too low. Had enough antioxidants, and my oxidative stress was within the scope. Otherwise, I can understand from the others who write in the discussion forum that they have slowly changed their medication needs, and not as drastic as I do it now?
Regards, WR1*

The posting that initiated the thread (the 1st posting, see appendix, Example ReD9_1), the first response (see appendix, Example ReD9_2), and the second response (shown in Example D9) are all written on the same day, with a little over 1 hour between them in time.

WR1* does several things in her posting to indicate how her responses can be read as a response to a response. For example she provides answers. She also indicates descriptions of personal experiences as "new", indicates possible causes and invites people to share their experiences. She thus provides

specifications as answers addressed at WR2 and she provides specifications of personal experiences and possible causes and addresses other respondents as she invites to the sharing of experiences. How she does that will be the focus of the following analysis, while I will also point at how specific understandings of the problem and understandings of relevant membership categories are oriented to.

WR1* explicitly greets WR2 (line 1). The text that follows the address is thus recognizably addressed at WR2. WR1* indicates her age and shows that she on that basis rejects to be quite in WR2's age group. Age is constructed as a category that might be relevant for the activities WR1* and WR2 are accomplishing together, i.e. as a category that has been taken up as possibly relevant in the previous talk. This is implied, because WR1* takes it up as a first thing, and because WR1* does not account for taking it up. The information WR1* provides about age and the conclusion she draws about whether or not WR2 and WR1* belong in the same age group is thus recognizable as an answer.

WR1* then addresses another topic, "depression eller "dårligt humør, ked af det symptomer" (depression or "bad mood", sadness symptoms) (line 2-3). She indicates a topic shift by using the term "Regarding" to show that she is introducing talk about another topic than the topic she had just addressed. This is readable as not merely an introduction, but a re-introduction here, since WR1* does not in any way account for, specify (besides providing three different versions of the topic), or demonstrate the relevance of introducing the topic. Instead what she does is providing the sources from which she has information about the topic[73]. She does not "do" anything with it either, by for example making particular action related to the introduction of this topic relevant. WR1*'s action of providing information about a source of information is thus also constructed as an answer.

WR1* addresses issues in the initial part of the text (line 3-5) and constructs them as responses to initiatives made relevant by WR2. WR1* specifies the topics she is addressing (age and depression or "bad mood", sadness symptoms), and she provides personal information and knowledge about them, but she does not orient to being accountable for the relevance of bringing up the topics or for making further talk about these topics relevant, i.e. she does not invite to further talk about these topics. In the answers she provides WR1* indicates an understanding that an issue understood to be relevant, age, is not shared between the respondent WR2 and herself (which relates to a practice described in chapter 6.1 on sharing experiences in which participants invites to the sharing of experiences based on particular similarities). Also

[73] Mulkay (1986) in his conversation analytic study of the organization of agreement and disagreement in letters remarks on differences in the ways topics are organized in letters as opposed to spoken interaction. In his characterizations of the patterns of agreement and disagreement in letters topic preface is mentioned as a feature:
"The need for such additional concepts [i.e. topic preface and third party disagreement] reflects the fact that there are differences in the organization of agreement/disagreement in spoken and written discourse. The most significant difference appears to be due to the way that topics are organized in the two contexts. In the letters, the sequential ordering of topics is a more prominent feature of textual organization. As such, it inevitably affects the form taken by agreements/disagreements. In particular, it means that the 'topic preface' is a recurrent feature of many of the letters and that such prefaces frequently precede and establish the textual referent for subsequent expressions of agreement/disagreement". (1986:313 f.).

On several other occasions Mulkay notes on differences between letters and spoken conversation, for example differences in formality and interpretative work, and the differences are ascribed to differences in turn-taking, topic organization etc., and not to the nature of the activities the participants accomplish:
"…the increased formality of agreements in letters, in comparison with conversations, can be attributed to basic differences in turn-taking and topic-organization in letters, not to any major change in the relationship between prior assessment and subsequent agreement in written texts". (1986:308).
"…the additional interpretative work which accompanies the expression of agreement in the letters is concerned with topic-specification rather than with agreement/disagreement".(1986:308)

WR1*, who as mentioned also initiated the thread, is the one to provide WR2 with information (regarding where to find specific information). We can, thus, see that WR1* as in Example D8a and D8b does not orient to being in a position in which she is an advice seeker or a troubles teller only (although they are often relevant categories when participants initiate threads (see previous chapters). Rather we see that there is an orientation to sharing of experiences and information that can go both ways, and here WR1* is the one to provide the answers.

In line 6 WR1* announces the initiation of a telling (see chapter 6.1 on sharing experiences) about another thing: "Lige en anden ting som strejfede mig." (Just another thing that occurred to me). In this way she shows that the action that follows should be understood as entailing information that has *not yet* been addressed, but which adds to the activities that have been performed so far. It is done by accounting for adding the narrative because it "occurred to" WR1*, i.e. the "thing" WR1* establishes as the topic of the following narrative is constructed by WR1* to entail relevant new or additional information that add to the information that has been made relevant so far. The narrative describes WR1*'s medical history by making use of what could be called an "although X, then Y" construction that describes an inconsistency between getting treatment for low metabolism and experiencing symptoms of high metabolism (line 6-7). This is followed by a description of what WR1* is going to do in the coming month, namely stop taking medication and getting a blood test. This is indicated as something WR1* has agreed to (line 7), that is, she is following the advice of someone.

In line 8-9 WR1* provides a candidate answer (Pomerantz 1988) to why there is an inconsistency between her treatment and her symptoms: "Kan det tænkes at kroppen ikke har behov for Eltroxinen mere, og at man derfor får symptomerne for for højt stofskifte?" (Could it be that the body does not need the Eltroxin anymore, and that one therefore gets the symptoms of hyperthyroidism?). We may notice that this candidate answer is constructed by referring to definite, but general categories (the body; one), that might apply to more people than simply to WR1*. Hence, WR1* indicates a candidate answer that is consistent with WR1*'s personal bodily experiences and may be generalizable at the same time. WR1* then invites to sharing of experiences: "Er der nogen der har prøvet dette?" (Has anyone tried this?) (line 9-10). Here WR1* addresses "nogen" (anyone) and thus shows that she orients to the interaction as public and to her recipients as not (only) WR2 who she specifically addressed initially.

In line 10 WR1* initiates action that addresses "En anden ting" (yet another thing); the thing referred to here is a telling about a visit at a health clinic, where WR1* had some tests done, which she refers to, and which according to WR1* can be used to back her assumption up (see line 10-15). In line 15-16 WR1* formulates her understanding of how other forum participants deal with regulation of medication, and she contrasts this with her way of managing changing medication needs; "og ikke så drastisk som jeg gør det nu?" (and not as drastic as I do it now?). She invites other participants to deal with this understanding as she marks the action with a question mark. By indicating the formulation as her understanding of what she has read in the forum, she implies that there may be other understandings and other ways of dealing with regulation of medication. Of cause WR1* also orients to her lack of entitlement to knowing, how other people deal with regulation of medication. Noticeably, WR1* refers to other forum participants' accounts in other threads here as she generalizes on what she recognizes to be a recurrent way of dealing with regulation of medication; she does not refer to actions or understandings as if they had been made relevant by WR2 as such. WR1* signs of with a personal name which ends the posting.

WR1* in the response to a response in Example D9) deals with previous action initiated by WR2, provides new information in a narrative about personal experiences (see chapter 6.1) and invites to further responses from other participants. WR1* first responds to issues that have been made explicitly relevant to deal with (as she constructs the actions as answers this is what she orients to), and she addresses her recipient personally. Then she adds personal medically relevant information and interpretations in a narrative about personal experiences, and she also refers to other forum participants' stories. Furthermore, she invites other forum participants to deal with this additional information and the additional interpretations.

We may say that the provision of a response to a response is constructed as an answer to WR2 as it is initiated, and thus its relevance is accounted for in that way. On the other hand the response is also used to point at, (re-)specify and add to the details of WR1*'s personal experience and address the issue of possible causes and practices for regulating medication in relation to personal experiences. On this matter WR1* clearly addresses forum participants who have similar experiences, which is implicitly NOT WR2, since she is not addressed, since WR1* initiated with rejecting to be in the same category as WR2 in terms of age, and since WR1* nowhere in her response acknowledged the relevance of WR2's response to her 1st posting. In the response to a response that follows below, Example D10, WR1* goes a step further than that as he clearly dismisses the relevance of the response he received.

6.4.5.4 Rejecting a possible shared membership and restating the purpose to find others

In the following example, Example D10 which is the third posting in the thread "andre derude" (others out there), membership of a specific category of people (see section 3.3 on membership categorization analysis) is oriented to as crucial for the continuation of further interaction:

Example D10: Post number three, "andre derude":

WR1* Tilmeldt: 16-09-2008 18:53	Den 05-07-2010 06:41 **Re: andre derude**

1 En sjælden udvikling af hashimoto efter sigende er jeg vist den eneste herhjemme –
2 derfor prøver jeg her om der skulle være andre - vi er vist et par hundrede på
3 verdens plan. Og nej du har den ikke hvis man har er man ikke i tvirvl idet man
4 bliver hundesyg. Er du nysgerrig kan du google den.

English translation:

WR1*	On 05-07-2010 06:41[74]
Joined: 16-09-2008 18:53	**Re: others out there**

A rare development of hashimoto reportedly I'm the only one in the country - that's why I'm trying here if there should be others - we are I think a few hundred at world level. And no you don't have it if you are in doubt because you become sick as a dog. Are you curious you can google it

The response to a response shown in Example D10 is initiated with indicating a description of a category, " En sjælden udvikling af hashimoto" (A rare development of hashimoto) (line 1), and it is continued with a specification that WR1* reportedly is the only one in Denmark who has this illness (this illness is what the description "En sjælden udvikling af hashimoto" (A rare development of hashimoto) can be recognized to refer to). This is indicated as an account for why WR1* is looking for others with the illness by approaching forum participants ("- derfor prøver jeg her om der skulle være andre" (- that's why I'm trying here if there should be others), line 2). WR1* adds that as far as he knows ("vist" (I think), line 2) on a global level the group of people who suffers from this illness consists of a few hundred people, him inclusive ("vi" (we), line 2). Then, in line 3-4, WR1* rejects that WR2 has the illness if she is in doubt about it, i.e. one is not in doubt if one has the illness, "idet man bliver hundesyg." (because you become sick as a dog.). WR1* suggests WR2 to google the illness if she wants to know more about the disease ("Er du nysgerrig kan du google den." (Are you curious you can google it), line 4).

WR1* in his response makes it recognizable that his actions should be understood as a response, and in particular the greatest part of it is constructed as answers. The posting is simply initiated with a description of a medical category, "En sjælden udvikling af hashimoto" (A rare development of hashimoto) (line 1), and thus, what this description refers to and how it should be understood is made recognizable and understandable via its sequential placement as a first thing done in a response (to a response). Hence, this description is readable as an answer; the provision of information about something which has been requested for, invited to, or otherwise made relevant by WR2[75]. We may note, that the response in Example D10 is the shortest of the responses to responses I show here; the text takes up 4 lines of space. We may speculate that the brevity of this text, and possibly of the postings that precede the response (see appendix, Example ReD10_1 and ReD10_2), may afford the use of sequential placement as a resource for making actions recognizable as doing answering. At least here we may note that WR1* does not make use of resources such as reformulations or recycling of parts of others' postings, which we saw in other postings, which Nilsen and Mäkitalo (2010:99) point to as resources participants make use of in chat in order to establish and maintain continuity in chat interactions.

[74] The first posting in the thread is posted on the 29th June 2010 at 15:42, and the first response is posted on the 4th July 2010 at 19:10.

[75] Psathas (1990:14) shows, by means of an example, how an utterance and a bodily action (in ordinary conversation) "…presented in the immediate next position following the first speaker's utterance can be interpreted as a response to the question, i.e., an answer, by virtue of its timing, content and information…".

In line 1-3 WR1* provides information about the medical category he has indicated as relevant ("En sjælden udvikling af hashimoto" (A rare development of hashimoto)) and specifically about membership of the group of people for whom this category is personally relevant, and he provides an account of why he is looking for people who suffers from the illness which the category is a description of. He is indicating, that what he is doing by approaching the forum participants is an attempt to find others (line 2), and he is explicitly indicating that he is expecting to be the only one in Denmark (line 1), and that the total amount of people who suffers from the illness in the world is only a few hundred (line 2-3). By making this information relevant in continuation of answering to what the category he refers to means, WR1* shows that what he is doing by initiating a thread and by bringing a specific illness up (an illness explained in the response to be "En sjælden udvikling af hashimoto" (A rare development of hashimoto)) should not be understood as providing knowledge about a specific illness as such, but should be understood to be "trying here if there should be others" (line 2). He implies that he only wants to hear from people who have personal experiences with this illness. In line 3 WR1* makes it recognizable that he responds to another, but related, initiative by WR2, as he initiates an action with "Og nej" (And no); "Og nej du har den ikke hvis man har er man ikke i tvirvl idet man bliver hundesyg." (And no you don't have it if you are in doubt because you become sick as a dog,) (line 3-4). This way of initiating a response, by making use of the connector "Og (And), and the particle "nej" (no) (which is a particle used to decline offers, invitations etc. in ordinary conversation among other thing, and which is the particle people initiate with in type conforming responses to yes/no type interrogatives if they respond negatively (Raymond 2003)), is a method to make it recognizable that the action should be understood as a response to something to which a yes/no typed response would be appropriate. In Example D8a WR1* made use of a similar device ("Ja" (Yes); "og ja" (and yes)) in order to indicate that the action she was doing should be understood as a response, and in particular in those cases as confirmations. Here, in Example D10 line 3, "Og nej" (And no) is understood to do rejection. WR1 formulates the rejection in words as: "du har den ikke hvis man har er man ikke i tvirvl idet man bliver hundesyg (you don't have it if you are in doubt because you become sick as a dog). WR1* here rejects that WR2 would have the illness if she did not know about it. He also implies something about his own condition of course; that he has a severe illness. WR1* concludes with a suggestion for WR2 if she wants to know more about the illness: "Er du nysgerrig kan du google den" (Are you curious you can google it) (line 4). WR1* in a way refers WR2 to use another source for information gathering and thus implies a rejection to be a source of information about the particular illness. WR1* shows that he is not interested in providing knowledge about his illness, and that he is not interested in continuing his interaction with WR2. His actions thus not simply imply closing, but indicate closing of the interaction with WR2 as such. As was pointed out previously in this chapter, and which was also pointed out in chapter 6.1-6.3, participants who initiate threads use methods to categorize recipients. As WR1* (re-)states an interest in finding others who have the same illness as he does, he shows that his initial initiative, looking for others with the same illness, still stands. His response to a response in that sense works to re-specify, re-actualize and thus re-invite participants with certain characteristics and exclude other participants and other activities for further interaction.

6.4.6 Conclusion

In this chapter the purpose has been to investigate the uses of responses that are positioned sequentially after responses in a thread, hence "responses to responses", i.e. responses by the writer of the 1st posting in a thread, who posts a response in the same thread after someone else has provided a response. In broad terms the purpose of the analysis has been to uncover how participants respond to responses and thus how they display their understanding of the interaction so far. In a more technical sense I identified a certain structure that recurs in the data of responses to responses, namely that the responses are organized in such a way that they first deal with the interaction so far in ways that imply closing and then open up for the possibility of further interaction. By dealing with the interaction so far, so called "WR1*'s" explicitly or implicitly evaluate the relevance of the responses according to their initial initiative and by opening up for further interaction they indicate their understanding of what to be relevant to do next. As will be summarized below, the ways responses to responses are constructed have been analyzed to be particularly reflexive of participants' understandings of their problem and how it has been treated by previous respondents and on how specific membership categories have been oriented to.

As responses are in a sense responses to responses, and as my analysis shows they can be used in that sense, they have a special status sequentially; they organize some kind of "juncture" within a topic in progress (see Button 1991a: 252). How participants use this kind of "juncture" in forum interaction in terms of how they display their orientation to the "status of the talk" and the relevant thing to do next is the overall phenomenon I am trying to capture. I argue that (opening and) closing practices in interaction might contribute to uncovering this phenomenon. I referred to studies of (openings and) closings in interaction, which had outlined recurrent practices for (opening and) closing in telephone calls (Button 1991a), chat (Rintel &Pittam 1997), and workplace email (Waldvogel 2007). The studies, each in their own terms, argued that practices for opening and closing interactions are bound up with social structure, and ultimately the negotiation and display of social relationships.

In the initial part of the analysis in this chapter I presented three examples of greetings (Example D1, D2, and D3) and closings (D4, D5, and D6) in 1st messages, and I showed that greetings and closings in the forum I investigate are performed in such a way as to deal with not knowing who, specifically, will read the posting and who will respond to it, as they don't address named respondents. Instead of addressing specific, named, recipients, they provide characterizations of the intended recipient of the posting. The 1st messages I presented parts of in Example D1, D2, D3, D4, D5 and D6 were responded to (see appendix). I also presented an example of a 1st message that did not get any response at all (Example D7). By showing an example of a 1st message, posted in 2008, which has so far not received any responses although the author makes use of methods recognizable from 1st messages that do get a response, and although the topic seems to be similar to topics that do get responses, I pointed to the fact that authors of 1st messages cannot be guaranteed a response in the online forums.

After having pointed to methods participants use to deal with recipiency from the outset of interactions, I presented and analyzed the responses to the responses to the 1st messages of which example D1, D2, D3, D4, D5, and D6 were part, namely Example D8a, D8b, D9, D10 (as I indicated Example D8a) and Example D8b) are responses to response(s) written by the same participant in the same thread). Here we may

expect some evaluation, or at least some display of understanding of the previous actions, i.e. of the response(s) to the initiative started by WR1 with a 1st message.

The main focus was put on analyzing participants' methods to 1) answer, summarize, conclude and/or thank other participants for their contributions, their methods to 2) deal with specific responses and understandings understood to be relevant in responses, and their methods to 3) continue interaction or invite to further interaction in different ways. Dealing with the topic so far, responding to specific actions, and inviting to further talk are activities participants recurrently perform in responses to responses. In the four examples I have shown participants accomplish this in different ways, and thus orient differently to the relevance and status of the topic so far.

The analysis showed that participants oriented their problems as medical and to details of medical information and knowledge when responding to responses. Furthermore, they oriented to (re-)specifying what kinds of (membership) categories they understood to be relevant. Participants orient towards "shared" membership in terms of experiences and/or medical categories. Furthermore, they oriented to themselves as competent advice seekers (rather than troubles tellers) in the process of acting in ways that were in accordance with available medical knowledge.

It seems that responses to responses in this material have the function of specifying or re-specifying what counts as a relevant and useful response for WR1* in that interaction. This is done by closing and opening interaction. The methods for doing this imply understandings that responses can be evaluated for their relevance and usefulness. Participants orient to an understanding that specific experiences and understandings should be "shared" and in alignment in order for responses to be relevant and useful.

6.4.7 Discussion

As in the previous chapters, the analyses of details of the complex actions accomplished in written postings in the forum despite of recognizable patterns in terms of how responses to responses are build point at how participants orient to details through how they accomplish actions.

In the case of responses to responses, the analyses showed that participants are not only concerned with expressing thanks. In fact, participants treat responses to their first postings as a resource for getting knowledge about how their first posting has been understood. This can be inferred from the fact that responses to first postings in many cases are followed by a response to the responses in which thread initiators specify or respecify categories and understandings based on the understandings displayed in prior responses.

Participants in the forum investigated can write up to 500 characters in a posting, and the posting is not visible before it has been posted as a unit by the author of the posting. They can for example specify and respecify understandings and categories within a posting. They might treat their initial postings as final texts, similar to how books, documents, articles etc. are treated despite from the fact that readers may have and express opinions about them. However, participants in the forum generally don't. Participants engage in complex social interactions with other forum members. They accomplish actions in interactions

in which understandings are negotiated, specified and respecified on based on displayed understandings of other participants.

The analysis of responses to responses confirmed analytical points from previous chapters regarding participants' displayed understandings. In responses to responses participants are in particular concerned with specifying and respecifying particular understandings; through their actions they show that they treat their problem as medical and that they orient to a shared membership with respondents based on particular experiences as crucial for getting the responses sought for.

7. Conclusion

7.1 Members' use of CMC as a topic

This thesis has been concerned with understanding, describing and illuminating member's methods for achieving a mutual understanding in an online discussion forum on the topic metabolism.

I started out by stating that sociology's main concern with CMC is to develop measures and estimate outcome, and that pragmatics, which is concerned with the use of CMC, overwhelmingly describes linguistic, and not social, phenomena in CMC. I claimed that both sociological approaches and approaches in pragmatics are typically concerned with developing theory based on existing approaching in the fields. I argued that research that is concerned with the use of CMC should also, initially and basically, and in order to qualify and substantiate theories and measures, provide knowledge and insight about *how participants use CMC*.

Garfinkel developed the ethnomethodological approach to study society as an accomplishment of its members (see the section 3.1 on ethnomethodology), and Sacks and his colleagues pointed to the sequential organization of talk as a fundamental resource people who converse have for accomplishing and making sense of social actions (see the section 3.2 on conversation analysis). Based on these findings the approach of conversation analysis has developed as an approach to the study of social interaction with rather strict methodological principles. These principles include that the data used to study social interaction should preferably by naturally occurring. The phenomena that conversation analysts are concerned with describing are the practices that are observable and contribute to the practical accomplishment of social actions in their own right, that is, actions that are recognizable as specific social actions by members of society.

Since around the 1960'ies when these approaches started developing, researchers within various fields within the humanities and the social sciences who have been concerned with members' methods for accomplishing social interaction have described recurrent practices for accomplishing action. Some research has been concerned with describing so called mechanisms, techniques, or basic structures that people accomplish social interaction with (see section 3.2 on conversation analysis). These findings have been the basis for studies that describe recurrent practices in various kinds of institutional interaction (see section 4.3 on conversation analysis on healthcare practices). Implications of such studies are, among other things, that "society" and social structures (even at a very local level) can be described and viewed as accomplishments of members of society. Conversation analytic studies point to the fact that people orient to social structures as situated and locally occasioned. Such studies furthermore show that people overwhelmingly accomplish actions in systematic ways and thereby orient to social structures in the accomplishment of action.

The ethnomethodological and conversation analytic perspectives and approaches to social interaction have inspired this thesis on various levels. In fact the research question the thesis should address was formulated as:

How do participants in online discussions achieve a mutual understanding?

I chose to address this question by making use of (primarily) discursive psychological and conversation analytic methods to empirically investigate how participants use, organize and arrange the resources available to them to achieve mutual understanding.

7.2 Sequential organization of resources as a resource

The bulk of this thesis is empirical analysis, which has attempted to point out recurrent practices for accomplishing recognizable social actions with the resources available to the participants. The sequential organization of resources is seen as a fundamental resource for making sense of actions in interaction, and the purpose of the thesis has been to explore how people use this resource with other resources available in forum interactions.

The analytical section consists of four chapters divided into two parts. The first analytical part, part I, consists of three chapters (chapter 6.1 -6.3). The three chapters describe three recurrent practices for initiating threads and recurrent practices for responding to these initiatives. The second analytical part, part II consists of a chapter (chapter 6.4) that focuses on how responses to responses are used in the forum interactions investigated.

The phenomena I described in the first analytical part concern how participants initiate actions and how respondents respond to them in recognizable ways. Focused reading and analysis revealed that although postings are complex texts, they are organized in patterned ways according to "what they do" with the topic they approach. The three analytical chapters in the first analytical part attempt at describing three different recognizable practices for initiating and responding to action in the forum.

Chapter 6.1 focused on participants' methods for initiating and responding to interaction which accomplished the sharing of personal experiences with problems understood to be relevantly placed under the pre-established topic metabolism. Chapter 6.2 focused on participants' methods for initiating and responding to interaction which accomplished to indicate and deal with metabolism as a possible cause for experienced problems as the topic. Chapter 6.3 focused on participants' methods for inviting to and providing "advice".

The choice to focus on practices for initiating a thread by posting a posting and responding to that with a posting was chosen for several reasons. Being concerned with methods for accomplishing social interaction inspired by the approach of conversation analysis, the question of how sequential organization of action works as a resource for participants is an essential topic. I wanted to uncover how it is that participants initiate action that is being recognized as specific action that makes specific responses relevant. I also wanted to know more about how participants construct their postings as postings in an online discussion forum about metabolism, i.e. how they make use of the possibilities to construct a text addressed at unknown recipients that had metabolism as a predefined topic.

On the basis of the empirical analyses of methods to initiate a thread and respond to that initiative (chapter 6.1–6-3) I want to make some more general observations.

We can observe that participants do not accomplish social interaction by orienting to the principles of turn-taking which people can be observed to orient to in ordinary interaction. The resources people have available when there is common physical presence and/or common access to the voicing of spoken

interaction are not available as people interact via texts organized in so called threads (see chapter 5 on data). Nevertheless the participants who post postings in the forum in a variety of ways orient to what it is they are doing as social interaction. For example the analyses that focused on practices for initiating and responding to postings showed that postings that initiate threads are organized in systematic and recognizable ways. The actions that are being done are accomplished by making use of social methods. Furthermore, overwhelmingly 1st postings make actions on the part of respondents relevant.

Recurrently, 1st postings, i.e. postings that initiate a thread, are organized in such a way that they…

1) have a title, which may indicate categories readable as medical categories (either indications of experienced problems or indications of medical illnesses or both), expressions of complaints, requests for help or advice etc.
2) may or may not entail a greeting.
3) entail a description recognizable as a problem description. The problem is indicated as a medical problem that is often related to understanding experienced problems, establishing a cause for an experienced problem or is constructed as inquiries about how to act on a problem.
4) entail an invitation for respondents to deal with the issue which has been indicated as the problem (quite frequently this invitation indicates restrictions on the kinds of responses that is understood to be relevant (for example by specifying which diagnosis or problems a respondent should have), and the format is quite often a yes/no interrogative).
5) may or may not include a closing.

Although 1st postings are complex and accomplish various actions, they can be described as a unit, as an activity organized in a sequence; participants who initiate a 1st posting construct their text as a unit that works to make particular action relevant on the recipient's part. We may say that the particular elements that make out a 1st posting are in service of indicating a problem and inviting respondents to understand and deal with that problem in a particular way (also, see below).

7.3 Dealing with prior action – display of understanding in responses

In 1st postings a recurrent and recognizable structure has been identified (see above). We can observe that people within this structure recurrently orient to displaying orientations towards making what they are doing recognizable, towards identifying specific recipients and towards categorizing themselves and a health problem (see below) to be the topic of interaction. A recurrent structure for first responses that follow 1st postings on the basis of analyses in chapter 6.1 – 6.3 could be formalized in the following way:

First responses recurrently…

1) may or may not entail a greeting (possibly addressed at WR1).
2) indicate the first action, possible after greeting, as a response to something made relevant in the 1st posting (The first action may initiate with "Yes", and is typically constructed as an acknowlegdement).

3a) entail a telling of personal experiences. This telling is understood to be occasioned, made relevant, by participants' display of understand of what the topic of the interaction is and of the resources that have been relevant so far to interact about this. For example a telling of personal experiences in a response may be understood as a demonstration or an account of having provided some acknowledgement.

or

3b) entail suggestions on how to act on a problem which WR1 has described and which WR2 has acknowledged. Respondents orient to medical knowledge as relevant when indicating suggestions on how to act, and they may indicate that they have personal experiences with a problem indicated as "similar" or "the same" as the problem indicated by WR1, and WR2 may indicate or imply that the suggestion provided is based on personal experiences with acting on that problem.

4) may or may not entail expressions of positive regard.
5) may or may not entail a closing.

We can, thus, notice that respondents very often initiate their response with some sort of acknowledgement, that may be initiated with an acknowledgement token (For example "*Yes*", which often is the type confirming (Raymond 2003) response to an invitation provided by WR1 in the initiative to which the response responds). A typical response also entails a specification or elaboration of what is being acknowledged. WR2 in this first action displays his or her understanding of what it is relevant to do first in a particular response, and WR2 thus indicates his or her understanding of what action and topic WR1 has invited respondents to perform and deal with. Respondents, by constructing their initial action as an acknowledgement, accomplish to indicate that their action should be understood as a response, an action that deals with prior action. Furthermore this acknowledgement often acknowledges a problem, and indicates a particular understanding of the nature of that problem. Further action that may follow is understood in terms of, or being in service of, dealing with a problem which has been indicated by WR1 and which WR2 has displayed his or her understanding and acknowledgement of as the first thing done in the response.

7.4 Looking back and looking forward

Writers of 1st postings recurrently respond to responses to their initial posting. In chapter 6.4 I showed that these responses are recurrently organized in such a way that they first deal with the interaction so far, for example by addressing specific respondents, by providing thanks, summaries and/or displaying their understanding of the interaction so far. After having dealt with "the topic so far" responses to responses recurrently open up for the possibility of interacting about issues indicated as relevant with recipients who are not explicitly identified, i.e. may not be the respondents who already provided a response. I suggested that responses to responses can be described as a "juncture" in which understandings of the topic so far is displayed and dealt with, and in which relevant things to do next is also an issue participants deal with. I suggested that the methods participants use to do this resemble methods for closing and opening in conversation. I also suggested that participants use this "juncture" to (re-)specify what counts as a relevant and useful response, which both had the purpose of evaluating interaction that had already occurred and

also work to increase the likelihood of getting relevant and useful responses forward-looking. Participants recurrently (re-)specified an understanding that what counts as a relevant and useful response includes that in order for indications of experiences in responses to be relevant the experiences should be understandable as "shared" as the experiences indicated in 1st postings. Specific criteria for assessing similarity and thus relevance and usefulness are indicated. For example there is an expectation that respondents should present their problem as medical and themselves as having specific physical characteristics and experiencing specific "symptoms".

7.5 Writing to someone

Constructing a posting as a particular recognizable action that makes responses relevant is a way in which participants construct their postings as social interaction. We may notice another way: Writers in fact construct their postings to be read and possibly responded to by someone, i.e. they design their postings to recipients. They do this, although they have no ways of establishing whether anyone will in fact read and/or respond to their posting. Writers indicate that they are writing to someone in several ways. Firstly, we may notice that participants may use greetings and closings. Secondly, participants in fact orient to particular types of categories of recipients as relevant, i.e. they construct their postings to be (relevant) for particular categories of people. In the first analytical chapter, chapter 6.1, we saw how participants dealt with how particular experienced problems could be understood to be relevant under the category "metabolism" by inviting to the sharing of experiences with others. Participants thus indicated an expectation that recipients might have experiences that could be said to be "shared", "similar" or "the same" as the experiences they had indicated. In the second analytical chapter, chapter 6.2, we saw that participants were careful not to diagnose themselves or others; participants discussed diagnoses as possibilities and in that way treated each other as laymen, i.e. as people who should not provide diagnoses. On the other hand they oriented to entitlements provided by "empirical facts" that can be gained from having and sharing personal experiences with medical problems; personal experiences were oriented to as an asset. In the third analytical chapter, chapter 6.3, it was pointed out that participants explicitly invite other participants to provide advice or help. In doing that they made typical roles from a service encounter relevant and thus oriented to their addressees as service providers, not as troubles recipients (Jefferson & Lee 1992). Detailed analysis revealed that participants oriented to a particular type of advice or help as relevant; they invited recipients to provide advice on how to act on a problem that was typically a problem concerning treatment. Participants, then, through their practices for inviting to advice indicated that the type of advice they requested for was advice based on personal experiences with how to deal with experienced problems. Competences and willingness to act on problems were implied, both on the part of the participant inviting to advice, and on the part of the addressees.

Hence, participants construct what they are doing as social, among other things because they design their postings to specific categories of recipients and specific potential categories of respondents. An implication to draw from this is that identity and category ascription can be an issue or a topic of social interaction that can be investigated as such. In fact, in ethnomethodologcal studies it is argued that "…identity category, the characteristics it affords, and what consequences follow, are all knowable to the analyst only through the understandings displayed by the interactants themselves" (Antaki & Widdicombe 1998:2).

7.6 Categorical work

Focusing on how threads are initiated and responded to illuminated another, related, aspect: Participants' displayed indications and understandings of the topic of the interaction per se and of the use of categories understood to be relevant. As noted, participants who initiate threads use the opportunity to indicate a title. Titles typically entail categories, readable as medical categories, they may entail categories readable as indications of personal experiences with physical problems, or they may indicate invitations for others to provide advice or help.

In the first analytical chapter, chapter 6.1 about the sharing of experiences, it was pointed out that participants initiating threads that invite to the sharing of experiences recurrently indicate personal experiences that are understood as problems and may be referred to or indicated as "symptoms". These problems are typically acknowledged as problems and possibly as symptoms of problems with the metabolism by respondents.

In the second analytical chapter 6.2, which described practices for indicating causes for problems as the main concern to be dealt with, it was pointed out that participants dealt with problems and possible causes in ways that seemed to depend on whether participants had indicated having an established medical diagnosis or not.

In the third analytical chapter, chapter 6.3 about advice giving, participants invited others to provide suggestions on how to act on a problem. Participants recurrently indicated that the problems they were concerned with had to do with treatment. Participants often indicted medical knowledge and constructed this knowledge to be relevant for knowing how to act on a problem. Indicating medical knowledge and indicating an understanding that a specific problem had been established and should be treatable can be seen as ways in which participants orient to their problem as medical and ways in which they then orient to metabolism as a medical category. Furthermore, advice may (among other things) consist of WR2 suggesting WR1 to consult a doctor, in particular when a (metabolic) diagnosis is not indicated as already established by a medical professional.

8. Discussion

8.1 Implications

Conducting analysis of forum postings that focuses on resources used to do social actions and to make actions recognizable is time consuming relative to methods that investigate CMC based on pre-specified categories and theories. Content analysis, and approaches within traditional branches of linguistics are examples of such approaches.

However, by focusing on the resources, categories and understandings that participants use and orient to through the actions they accomplish when they interact, which this thesis has attempted to inspired by ethnomethodological conversation analytic methods, we get insight about how participants achieve a common understanding as they use resources available from certain technologies.

We also gain insight about how they understand aspects of society when they interact. In this case, rather than using methods such as interviews with questions formulated by researchers to guide the collection of answers from a collection of selected respondents, I have pointed to how people, who have chosen to participate in an online forum, accomplish activities in a specific naturally occurring setting as part of their everyday lives.

The setting that is focused on is interactions in an online forum about metabolism on a health website (www.netdoktor.dk) about experienced health problems. In the analytical chapter I have pointed out aspects of how participants understand their experienced health problems, including aspects of how to explain and treat them, in online interactions with other forum members.

More traditional methods investigating CMC and also health communication in different settings often attempt to explain expressions of people's believes or even understandings of their own conduct retrospectively. Some studies offer explanations that focus on the structures or affordances of particular technologies or resources used to communicate as discussed by Hutchby (2001a; 2001b). Other studies explain believes or conduct by referring to social norms or discourses, however they do not document how it is that participants orient to them in what they do (Green, Griffiths, Henwood & Wyatt 2006) and may thus miss or misinterpret the social norms that participants orient to in situated interaction.

Although widely used, CMC has only been used for a couple of decades and the possibilities offered in order to use technologies to communicate change continuously and rapidly. Advances within healthcare and society at large may further change ways in which citizens are met in health care services, may change the quality of information, and may have an impact on how citizens understand their health problems and on how they act.

As mentioned, such structural changes happen rapidly. Consequently, updated research on these issues lacks. Since there is so little scientific knowledge focusing on the use of CMC to deal with health issues, basic research that focuses on how CMC is actually used and understood by participants and how participants in fact understand and deal with their health issues outside of the ordinary health care system by using technologies is highly needed before scientific categories and theories can be invoked, developed and used in research.

For the purpose of investigating participants' actual use and understandings of the possibilities to interact with others in online forums about health issues, I focused on some of the resources they use in interaction. In my analyses I pointed at how particular categories are indicated and made relevant in the accomplishment of particular social actions, and I pointed at how sequential organization is crucial for making sense of participants' actions. The analyses were based on insights and methods from ethnomethodological conversation analysis. Further studies are needed, not only to qualify how CMC is used, for example to interact about health issues, but also to qualify how to use the ethnomethodological conversation analytic insights and methods for the analysis of various types of CMC, including forum interactions.

8.2 Methodological issues to consider

The focus in the thesis has been on participants' displayed understandings indicated in and through how they organize social actions in postings and in and through how they organize responses. Displayed understandings of previous actions are not only resources for participants. Displayed understandings work as a resource for analysts in order to ensure that claims about interactional mechanisms are based on the displayed understandings of participants rather than being the analyst's guesses or assumptions (see section 3.2 on next-turn proof procedure).

Common for the analytical chapters are that the analytical "unit" I have chosen to focus on has been "a posting". The concern with "postings" has been for what they accomplish. Throughout the ambition has been to document analytical claims in the recognizability of actions for members. The notion of "next turn proof procedure" has been central for documenting a claim of what an action recognizably accomplishes in how participants display understandings of actions in responses.

Online interaction, such as discussion forum interaction, is, unlike ordinary conversation, not organized on a single turn-by-turn basis. Therefore sequences of interaction are not organized by the principles of turn-taking described for ordinary conversation (see section 3.2 on conversation analysis). Rather, as I have shown, postings are complex as each posting accomplishes various actions. Furthermore, in discussion forum interactions resources may be available for participants, which are not yet identified or well-described in the literature, which many resources used in conversation are at this point (see for example Sidnell and Stivers 2012). Therefore, even defining the unit of analysis suitable for describing a phenomenon (for example a practice participants use for accomplishing an intersubjective understanding) may be a challenge.

If the unit of analysis would be phenomena such as "greetings", "problem descriptions", "closings", etc., it becomes very difficult to document what those actions accomplish without referring to the sequential context, which is, at least, (elements from) the posting in which it occurs, and the posting that follows. If this context is not brought into the analysis, the danger is that the phenomenon which is described is not described as a social phenomenon understood in ethnomethodological conversation analytic terms, but rather something as else. Examples of other approaches can be found in pragmatics on CMC, for example Waldvogel 2007.

The unit of analysis might also be so called discursive phenomena, i.e. it might be linguistics phenomena which are analyzed for what they accomplish rhetorically. Such an approach is used in a bulk of discursive psychological studies on CMC, which I mentioned (for example Lamerichs 2003). While having a concern for describing CMC phenomena as action, this approach does not capture how participants use sequential organization as a resource for making sense of what they do.

In ethnomethodology an analyst's problem of how to make sense of actions can be viewed as a participant's practical problem of making sense as well. However, the ethnomethodological understanding is that participants, or members, do not deal with knowing how to make sense of actions as a topic, they use that knowledge as they act (see section 3.1 on ethnomethodology). Overwhelmingly, then, members solve practical problems of making sense of actions by making use of the resources available to them and by acting in ways that are "…sufficient for all practical purposes" (ten Have 2005:12).

In my analysis I have not touched upon issues of how participants indicate a concern with knowing how to make sense of actions. One of the reasons for this is that participants in the forum did not recurrently treat it as a problem that they did not know how to make sense of the actions that had been accomplished by posting postings. Rather, when problems or troubles arose, they were treated as having to do with social issues, such as issues of having a shared understanding, having shared experiences, and having acted appropriately on an experienced problem (see the empirical analyses).

The challenge of describing methods for accomplishing an intersubjective understanding, in CMC as well as in other kinds of social interaction, is a challenge the researcher has to address in ethnomethodological conversation analytic studies, and a challenge members deal with. Although it is a complex task for the analyst, who for example wants to describe forum interactions as social interaction, forum interactions are being organized, by its users, by posting units, which are referred to as postings. These units are treated, by participants, as having a purpose, as doing something, as making specific responses relevant.

As participants use postings as a unit that can be understood to entails various actions being in service of a specific activity I have chosen to describe and approach the analyses in that way.

Ethnomethodological conversation analytic inspired research on CMC is still sparse and has not yet found its theoretical grounding and has not yet developed a kind of methodology, which can be found in conversation analysis of talk-in-interaction. At present, ways of understanding and analyzing sequential organization as a resource for sense making in bulletin boards is being explored based on terminology and findings from conversation analytic studies of face-to-face interactions or telephone calls (see for example Antaki, Ardévol, Núñez, & Vayreda 2005; Reed 2001).

Just as conversation analysis as a field has contributed with and continues to contribute with findings in terms of how conversation is and can be organized, ethnomethodological conversation analytic inspired studies of CMC might also benefit from developing a research tradition that can describe CMC in terms of its organization of actions, as such studies reveal important insights about participants' understandings of the social norms involved in the social activities they engage in online.

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Appendix

AA) Postings resembling the structure of postings described in chapter 6.1

AA1: First posting, ” Svedeture - hjertebanken”:

WR1 Tilmeldt: 22-12-2008 09:46	Den 05-02-2009 17:30 **Svedeture – hjertebanken**	

Jeg syntes, at jeg har nogle mærkelige symptomer.
Jeg kan fryse. Lige pludselig sveder jeg - selvom jeg ikke har gjort noget fysisk - og så får jeg hjertebanken. Jeg bliver groggy i hovedet med svimmelhed til følge og ingen koncentrationsevne. Somom der ikke kommer ilt nok til hjernen. Det er faktisk ret ubehageligt.
Er der andre, som har disse symptomer?
Jeg kan oplyse, at det er ca. 5 år siden, at mine menstruationer stoppede. (Jeg er 52 år).
Det var efter, at jeg fik konstateret et alt for højt stofskifte. Så overgangsalderen skulle jeg være ovre.

AA2: First response, ” Svedeture - hjertebanken”:

WR2 Tilmeldt: 23-08-2008 21:36	Den 05-02-2009 22:14 **Re: Svedeture – hjertebanken**	

Kære Xxxxxxx.
Jeg kender kun alt for godt til svedeture, for derefter at fryse.
Jeg bliver 52 og min menstuation stoppede også for godt 5 år siden, så det har intet med overgangsalderen at gøre.
Jeg har 7-9-13 dog heldigvis ikke haft svedeture de sidste knap 2 mrd.
Mht. hjertebanken har jeg "kun" haft det, når jeg har været overdoseret med medicin.
Derfor alle mine udregninger, da jeg af bitter erfaring har lært, ar jeg max. skal reguleres med 25 mikrogram om ugen.
Jeg spurgte på et tidspunkt en endokrinolog om "lio".
Han svar var, at har du tendens til hjertebanken så hold dig for din egen skyld langt væk fra det.
Det mangedobler hjertebankenen.
Men omvendt var det ham som satte min Eltroxin op med 25 mikrogram OM DAGEN, så hvor "klog" han var, kan vist diskuteres.
Mange hilsner Xxxx

AA3: Second response, ”Svedeture - hjertebanken”:

WR3 Tilmeldt: 22-12-2008 09:46	Den 06-02-2009 12:27 **Re: Svedeture – hjertebanken**	

Hej
Jeg har også erfaret, at jeg højst skal ændres med 25 mkg Eltroxin ugentligt -hvilket min endokrinolog også har indset/har sagt!!!!!
På trods af dette, satte han mig op med 25 mkg Eltroxin ugentligt samt 35 mkg Lio.

(Dette er taget fra igen). Når vi ved, at Eltroxin skal nedsættes når man får Lio, ser jeg ham slet ikke kompetent m.h.t. doseringer. Det endte også med, at jeg simpelthen blev totalt dårlig.
Mine symptomer for øjeblikket:
Ondt i muskler
Fryser - sveder med hjertebanken til følge og groggy i hovedet.
Jeg kan kun koncentrere mig, meget kort tid af gangen.
Eksem i hovedbund og øregang - som er tiltaget meget.
Ingen energi.
Har svært ved/overskud til at være sammen med andre - så jeg siger gerne fra.
Grådlabil (men det er skú også surt at blive ved med disse symptomer)
Den anden dag besøgte vi lige mine forældre kort. Jeg kunne slet ikke klare snakken. Jeg fik igen svedetur efterfulgt af hjertebanken og svimmelhed - og skulle derefter bare hjem.
Jeg har ikke på ét tidspunkt i min sygdomsperiode (sygemeldt fra 22.12.08) haft en rigtig god dag. Har svært ved at tage med ud af handle - kører træt og det hele forvirrer mig. Min krop har det bedst, når jeg bare sidder derhjemme. Og så tænker jeg selvfølgelig på immobilitetens farer!!!
Jeg er endnu ikke klar over, om alt dette er grundet - et ikke velreguleret stofskifte. Min endokrinolog siger: At jeg ikke skal forvente min gl. energi og kræfter igen.
Den ene dag hvor jeg talte med ham - "forsvandt" ordene igen. Jeg spurgte om min hjerne kunne have taget skade. Han sagde, at den gerne skulle blive bedre, når stofskiftet blev reguleret ind, men det var ikke sikkert, at hjernen kom i "niveau" igen.
Jeg tænker så: Hvad kan vi som stofskiftesyge gøre? Endokrinologerne tager os ikke alvorligt (de fleste). Nu prøver du bare denne dosis!!! Selvom jeg ytrer, at det er alt for meget.
Ja, jeg kan godt forstå, at mange af os simpelthen føler os magtesløse i dette system.
Kærlig hilsen Xxxxxxxx

AA4: 1st posting, "Ømme muskler":

WR1 Tilmeldt: 12-06-2008 14:02	Den 08-02-2009 15:53 **Ømme muskler**	

Hej allesammen

Nej hvor jeg lider af ømme muskler, over det hele, især hvis jeg bare har knoklet en lille smule, føler efterhånden at alt fysisk arbejde er knokkelarbejde.
Og min vægt den stiger, har ellers efter lægens udsagn, et velrreguleret stofskifte med eltroxin.
Så er det jeg tænker om vejret kan spille en rolle, om vi lettere blever syge, i dennne mørke og kolde tid, om det tærer på kræfterne ?
Er der nogen der har erfaring med det.
Kh

AA5: 1st response, "Ømme muskler":

WR2 Tilmeldt: 12-06-2008 12:07	Den 25-02-2009 01:56 **Re: Ømme muskler**	

Hej Xxxxxx(håber jeg har husket rigtig)
Jeg har også tit meget ømme muskler og stive muskler
,samt jeg har taget rigtig meget på sidenjeg fik for lavt stofskifte,sidste gang jeg var hos lægen sagde han også at mit stofskifte så fint ud,men jeg har det fortsat ikke særlig godt b.l.a. hoster jeg en del har du evt også prøvet

det ,samt min mave puster jævneligt op så jeg ligner en der er gravid min krop er langt fra normal som før.
håber du har det bedre.
Venlig Hilsen XXXXXXX,

AA6: 1st posting in the thread ” kuk i stofskiftet”:

WR1 Tilmeldt: 30-06-2008 10:03	Den 25-12-2008 22:27 **kuk i stofskiftet**	

Kære alle - først og fremmest glædelig jul.
Jeg har siden april i år haft diagnosen for lavt stofskifte. Først i august kom jeg i kontakt med en endokrinolog, som jeg så har gået hos hver måned til hveranden måned. For en uge siden fik jeg at vide, at mine tal nu var i den lavere ende. øv. Så jeg skulle nu øges i medicin. Jeg har ellers ligget i den højere ende og dette har jeg helt klart fysisk haft det bedre med. Jeg må sige at min december måned har været hård. Jeg har været så træt i hver en muskel i min krop og har faldet i søvn - så snart mine unger er blevet puttet.... Derudover har humøret ikke været for godt. Intet overskud. Nu er jeg blevet øget og fik det rigtig godt et par dage efter, men nu en uge efter dosis-ændring - er jeg træt som aldrig før, fryser og sidder bare og stirrer med trætte små øjne. Jeg er bare så træt af dette stofskifte.... Håber virkelig at medicinen snart begynder at virke. Jeg skal førtst have taget nye blodprøver om 2 måneder og er kun øget med 25 mikrogram eltroxin om ugen - så det er jo finjustering, men hold da op hvor det kan mærkes..... Jeg har ikke været på den samme dosis i mere end 2 mdr - siden jeg fik konstateret sygdommen.
Hvad med jer andre - hvor lang tid har i været på den samme dosis og hvor tit får i taget blodprøver....????
Det kunne jo være rart - at man fik det lidt bedre - i længere tid af gangen. Føler kun at jeg har det rigtig godt ca. hveranden måned, når der er styr på mit stofskiftet, for så sker der altid noget med det og jeg skal ændres i dosis, bliver svimmel, for mave-problemer, bliver træt m.m.

Jeg er begydt at dyrke sport for første gang i mange mange måneder - men det har ihvertfald ikke øget mit stofskifte, men har da givet mig mere energi lige efter.

Er der nogen der ligesom jeg får det markant dårligere når man har menses?

Sikke en masse spørgsmål. Og sikke en masse brok over kuk i stofskiftet.

AA7: 1st response , ” kuk i stofskiftet”:

WR2 Tilmeldt: 22-12-2008 09:46	Den 26-12-2008 22:02 **Re: kuk i stofskiftet**	

Hej "Xxxxxxx"
Dette bliver kun et lille kort indlæg fra mig i denne omgang. Jeg har ikke rigtigt overskud til at formulere mig.
Men jeg kender alt for godt til dine symptomer.
For øjeblikket for jeg taget blodprøver ca. hver 2. måned. (Jeg fik en total fjernelse af skjoldbruskkirtlen i april 2006). For mit vedkommende har stofskiftet svinget meget. Det har været utroligt svært at regulere.
Sidst jeg havde en total nedtur var i marts 2007. Siden har jeg haft det tåleligt. Der var en periode på nogle måneder, hvor jeg var helt i top efter at havde fået tilført Liothyronin, idet mit T3 altid lå i den øvre ende.
For øjeblikket hvor TSH ligger på 17,9 - har jeg det dårligt. Koncentrationsbesvær, kvalme, svimmelhed, sitren i kroppen, træthed (men for øjeblikket sover jeg ikke særligt godt). Jeg

har lavere stresstærskel og mindre tålmodighed.
Det er meget fornuftigt at der kun bliver tilført 25mkg Eltroxin af gangen. Ellers kan du hurtigt stå i den situation, at stofskiftet vil svinge for meget.
Dette kan du sikkert ikke bruge til særligt meget. Men jeg vil skrive igen, når der kommer lidt mere "power" på.
Held og lykke og god bedring.
Xxxxxxxx

AA8: 1st posting, "Svingende stofskifte":

WR1 Tilmeldt: 22-12-2008 09:46	Den 22-12-2008 11:45 **Svingende stofskifte**	

Jeg fik konstateret forhøjet stofskifte i 2002. Jeg har været i jodbehandling og fik en total fjernelse af skjoldbruskkirtlen i april 2006. Dengang fik jeg at vide, at efter 1/2 år skulle jeg være velreguleret. Eltroxinen var nemmere at regulere!!!!!! Efter ca. 1 år skulle jeg ikke længere kontrolleres fra sygehuset men igennem min egen læge.
Jeg bliver stadig fulgt på sygehuset. Stofskiftet har svinget utroligt meget. Jeg har fundet ud af, at hvis der skal ændres dosering, skal det kun ske med 25mkg - ellers "kører" det bare helt "agurk".
Ved mit sidste blodprøvesvar var TSH 4,54 - T4 136 - T3 1,71. Endokrinologen sagde, at jeg skulle tage 25 mkg Eltroxin mere ugentligt. Jeg ved at TSH tallet viser et lavt stofskifte. Men de øvrige tal ligger jo i den øvre ende. Jeg har ikke fuldt hans ordination, da jeg føler, at stofskiftet er forhøjet.
Jeg fik også at vide ved min sidste kontrol, at jeg hørte til de få, som ikke skulle forvente, at få min "gamle" livskvalitet igen.
Det har gået mig utroligt meget på. Jeg kan sove kl. 19 og føler ikke at der er kræfter og overskud til min mand. Får nemt ondt i led og muskler og føler at kroppen står af.
Men selv om jeg er en garvet stofskiftept., kan det være svært at vurdere om stofskiftet er for højt eller for lavt.
Jeg er skrevet op til en kontrol af binyrerne i januar (har tidl. fået en sådan test), men min endokrinolog mener, at de kan have taget skade grundet svingninger i stofskiftet.
Er der nogle af jer, der til tider kan føle, at nu kan det være nok. Har lyst til at blive dulmet med rødvin eller piller?
Jeg ved, at dette ikke er løsningen. Jeg har jo hverken kræft eller anden livstruende sygdom. Så dette burde jeg istedet påskønne.
Jeg er bare utrolig træt af mig selv for øjeblikket. Dirren, ingen energi og har til tider mange sorte tanker.
Kærlig hilsen Xxxxxxxx

AA9: 1st response, ”Svingende stofskifte”:

WR2 Tilmeldt: 02-10-2008 09:31	Den 22-12-2008 11:56 **Re: Svingende stofskifte**

Hej Xxxxxxx.

Desværre kender jeg alt for godt til dine tanker. Det er ulideligt at være syg når lægerne siger at alt burde være i skønneste orden. Ja du har ret - dine tal ser lidt skæve ud. Din TSH er jo alt for høj (burde nærme sig 1) men T4 er i top - T3 kunne vel godt komme højere op? REferenceinterevallet på T3 der hvor jeg får taget blodprøver er 1,10-2,50 og hvis man skal op i den øverste ende af referenceintervallet er der jo noget vej endnu for dig? Men jeg er jo ikke læge - og skal ikke kunne sige hvad der er det bedste for dig.
Ja det der med at have lyst til at "bedøve" sig - det tror jeg da vi alle har - men jeg synes bare at jeg får det værre når jeg drikker (og det er vist meget heldigt!).
Ang. piller, så bliver jeg vel "bedøvet" idet jeg er blevet sat i gang med antidepressivt medicin. Jeg synes at jeg har kunne mærke en lille bedring (krydser fingre og banker under bordet!). Jeg tror dog at det er stofskiftet der gør mig deprimeret, men når man ikke kan få lægerne til at acceptere det og finde en behandling der virker, så er man jo nødt til at behandle symptomerne istedet for årsagen - selvom det virker forkert. :o/
Sådan har jeg ihvertfald måttet tænke for at kunne starte behandling med lykkepiller (selvom jeg har hidtil har været ret afvisende overfor disse - "Jeg fejler ihvertfald IKKE noget psykisk - har hidtil været mit motto!").
Håber det bedste for dig - surt at der skal være så lang vej for dig...
Har desværre ikke nogen nem løsning at give.....:o(
Mange hilsner
Xxxxx

BB) Postings resembling the structure of postings described in chapter 6.2

BB1: 1st posting, "Tal i den lave ende af skalaen":

Example of acknowledgement of experiences as symptoms of low metabolism and indications of experiences with another metabolic disorder aftertext with indications of problematic, yet unexplained, experiences, indications of blood test results in the normal area, and an invitation to provide recognition of the experiences. The participant indicated being treated for a metabolic disorder.

WR1 Tilmeldt: 02-08-2008 21:37	Den 27-10-2010 10:18 **Tal i den lave ende af skalaen**	

Hej.
Jeg er i behandling for forhøjet stofskifte igen. Har været uden medicin i en lang periode men kunne ikke undvære.
Jeg er igen ved at blive "kørt ind" med Thycapcol men har de sidste måneder ligget med lavt stofskifte som jo er meget nyt for mig. Der er dukket nogle sære symptomer op som jeg ikke rigtig ved om det kan skyldes lavt stofskifte.
mine tal er lige kommet ind i normel område og ligger på : TSH 3,12 - T4 86 - T3 1,6.
Mine symptomer er - tung, træt og hele kroppen - susen for ørene - træg mave - trætte svage muskler - stramme ømme muskler - syns slet ikke der er "flow" i kroppen - lidt væske i kroppen og hvad mit humør og gå på mod er det bestemt heller ikke som det plejer.
Kan genkende mine "klager".
Kh XX

BB2: 1st response, "Tal i den lave ende af skalaen":

WR2 Tilmeldt: 20-08-2009 12:24	Den 27-10-2010 10:31 **Re: Tal i den lave ende af skalaen**	

Jep;
Det lyder som "normale" symptomer på lavt stofskifte. Jeg har ikke haft for højt stofskifte (så vidt jeg ved), så jeg kommer kun med erfaringen fra det lave stofskifte. Tung, træt, trist...ømme skinneben, spændinger, hovedpine. Manglende "flow" er faktisk en rigtig god beskrivelse.

Alt godt til din behandling fortsat.

BB3: 1st posting, " Ubalance stofskifte på trods af normal blodprøve?":

Example of acknowledgement and advice as response after an inquiry about whether a metabolic inbalance can be the cause for experienced problems despite of normal values. No metabolic diagnosis is indicated.

WR1 Tilmeldt: 27-12-2012 00:54	Den 06-01-2013 20:32 **Ubalance stofskifte på trods af normal blodprøve?**	

Mit spørgsmål går på, om man kan have noget med sit stofskifte selvom den blodprøve lægen har taget, viser normale værdier?

Jeg har det sidste stykke tid haft det dårligt både fysisk og psykisk. Jeg har lidt af nattesved, så jeg 1-2 gange om natten måtte stå op og tage andet nattøj på, eventuelt sengetøj. Jeg har følt jeg har rystet indeni og ofte har mine hænder rystet uden jeg har kunne styre det. Jeg har siddet og været rigtig kuldskær om dagen og alligevel sveder jeg under armene?! Jeg har ikke kunne koncentrere mig om noget, vågnet 10 gange i løbet af natten og har følt jeg skulle græde hele tiden! Jeg har haft meget høj puls ind imellem, ofte omkring 130 og ekstra hjerteslag. Jeg har nu målt mit blodtryk gennem de sidste uger og det er omkring 100-105/60-65. Jeg har ingen appetit haft og har tabt mig cirka 5 kg.
Min læge tog en blodprøve, da jeg var helt sikker på det var mit stofskifte. Der er flere i min familie der har lidt af for højt stofskifte. Den viser normale værdier. Men den dag hun tog den havde jeg det heller ikke så dårligt som jeg ind imellem har.

BB4: 1st response, "Ubalance stofskifte på trods af normal blodprøve?":

WR1* Tilmeldt: 27-12-2012 00:54	Den 06-01-2013 20:34 **Re: Ubalance stofskifte på trods af normal blodprøve?**	

Det skal lige siges jeg er kvinde, slank og i tyverne. Jeg hverken ryger, drikker kun meget lidt og tager ingen medicin.

BB5: 2nd response, "Ubalance stofskifte på trods af normal blodprøve?":

WR3 Tilmeldt: 03-02-2012 22:49	Den 08-01-2013 00:09 **Re: Ubalance stofskifte på trods af normal blodprøve?**	

ja, du kan sagtens have en stofskiftesygdom selvom din blodprøve var normal. Jeg gætter på at din læge har taget TSH, men det er ikke sikkert at han har taget andet end det.

Du skal have taget TSH, T3 ogT4 samt antistoffer mod TPO- og TSH-receptoren.

Nogle få har antifstoffer mod TSH-receptoren uden at TSH bliver påvirket, så den ser helt normalt ud selv om noget er galt.

Hvis du ser i stofskiftetrådene vil du også kunne se, at blodprøverne hos nogle er temmelig luskede, så for nogle få kræver det altså en ekspert at lave den rigtige udredning.

Det er ikke særlig sundt at gå rundt med de symptomer, og når der også i din familie er stofskiftesygdom synes jeg at du skal kræve en henvisning til en endokrinolog og også få taget nye blodprøver hvor du er sikker på at alle stofskifteprøverne er med.

BB6: 1st posting, "normalt stofskifte - men symptomer på stofskifte problemer":

Example of advice after indications of a possible connection between experienced problems and a metabolic disorder and an invitation to provide experiences. No medical examinations done so far points at a metabolic disorder.

WR1 Tilmeldt: 12-11-2011 18:25	Den 12-11-2011 19:40 **normalt stofskifte - men symptomer på stofskifte problemer**	

Hej alle
jeg ville høre om nogen af jer har erfaring med nedenstående:

jeg har i længere tid haft flg symptomer, ikke alle på en gang:
Rysten på hænderne, trykke for brystet (mere som en følelse af begrænset lungefunktion), ondt i halsen, hjertebanken, uro i kroppen, træthed, kraftesløshed, prikken i underarmene, nervøsitet, lyd på vejrtrækningen (periodevis), hæshed og i en periode meget svimmelhed.
jeg har set at alle disse symptomer svarer til stofskifte problemer, og jeg har været til læge flere gange. I starten troede de det var virus på balancenerven, men nu mener de, at det er fordi jeg slog hovedet og nakken for et halvt år siden. De er aldrig kommet ind på at det kunne være mit stofskifte.

Jeg er normalt meget aktiv og i god form, men nu får jeg hjertebanken af bare at gå en tur med hunden....
alle mine prøver er normale også hvad angår stofskiftet, og jeg har ingen hævelse på halsen (skjoldbruskkirtlen).
Mit spørgsmål er : kan jeg have noget med stofskiftet som kræver nogle mere uddybende prøver end en simpel blodprøve og som ikke viser sig i en alm. blodprøve? og hvis ja, hvad kan det så være?
med venlig hilsen Xxxx

BB7: 1st response, "normalt stofskifte - men symptomer på stofskifte problemer":

WR2 Tilmeldt: 14-07-2010 23:34	Den 14-11-2011 00:59 **Re: normalt stofskifte - men symptomer på stofskifte problemer**	

Hej jeg synes du skal bede om at blive undersøgt på syghuset, til en udredning . have tjekket hjertet , skannet hjernen og måske hele kroppen for at se om andet kan være galt, en blodprøve fortæller ikke alt. hvis du stadig ikke får svar ved det kan du blive nød til at få taget en rygmarvsprøve, den kan normal fortælle om der er sygdom i kroppen , hjerneblødning eller andre usynlige ting. de ting du skriver , kan også være

psykisk, med nogle ting, ryger du , hvis eller er sammen med nogen der ryger meget, få tjekket for kol lunger. Sports mennesker kan også blive syge. held og lykke

BB8: 1st posting " Desperat efter svar på træthed":

Example of advice after indications of experiences with being tired. No indications pointing towards a metabolic disorder is indicated.

WR1 Tilmeldt: 08-03-2011 14:58	Den 08-03-2011 16:10 **Desperat efter svar på træthed**	

Jeg ved ikke om det jeg døjer med kan være forstyrrelser i stofskiftet, men det der står i mange af de andre indlæg, kunne tyde på det. Ville være glad for at få jeres mening.

En dag som i dag, vågner jeg efter en god nats søvn på 8 timer, og føler mig total udkørt/træt. Det lykkes mig at komme afsted om svømme, men efterfølgende er jeg om andet mere træt.. Føler at øjenlågene hænger nede om knæene. Prøver forgæves at spise, drikke kaffe (hvilket jeg ikke gøre så tit). Føler ikke jeg kan sove, og hvis jeg gjorde at det ikke ville gøre en forskel.

Jeg har før henvendt mig hos min læge, omkring disse uforklarlige dage med overdrevent træthed. Det har var desværre i mens jeg var i behandling for depression, så følte ikke det blev taget alvorligt. Har haft disse dage tit, nogen gange fra morgenstunden, andre gange føler jeg mig drænet op af dagen. Føler ikke at det er normalt!
Mange gange er det som mit system kører på overarbejde, men jeg er tung i hele kroppen..
Kan det være noget med stofskiftet..?

BB9: 1st response, " Desperat efter svar på træthed":

WR2 Tilmeldt: 14-03-2010 18:29	Den 08-03-2011 16:38 **Re: Desperat efter svar på træthed**	

Til at starte med kan du lige få tjekket din blodprocent... For lav blodprocent kan give træthed og gøre at man hurtigt bliver mørbanket fx. efter motion.

Får du antidepressiv medicin? Eller anden medicin for den sags skyld...?
Mange præparater har træthed som bivirkning. I så fald må du tale med lægen om et eventuelt medicinskifte.

Og så er kosten naturligvis vigtigt. Får man ikke nok at spise - og spiser sundt - er det helt normalt at blive træt. Og hvis man i stedet for at spise ordentligt og regelmæssigt (gerne 4-5 gange om dagen) smider noget sukker indenbords når man er ved at køre ned i trætheden så kører blodsukkeret op og ned hvilket bare fører til endnu mere træthed...

CC) Postings resembling the structure of postings described in chapter 6.3

CC1: 1st posting, "HJÆLP - er der nogen der kan "oversætte" tallene for mig??":

Example of invition to provide advice in terms of medical knowledge responded to with assesments, indications of medical knowledge, personal experience and advice in terms of involving medical professionals and seeking further medical knowledge:

WR1 Tilmeldt: 25-06-2011 15:03	Den 25-06-2011 16:50 **HJÆLP - er der nogen der kan "oversætte" tallene for mig??**	

Helt NY i denne verden og fuldstændigt på bar bund...

Har også spurgt om medicin i anden tråd, men håber der er en der kan oversætte nedennævnte tal for mig???

TSH 13,61
T3 1,01
T4 57

- er det tæt på normalt eller hvordan? Kan det rette sig igen? Fik konstateret lavt D-vitamin i nov og har taget kraftigt D-vitamin tilskud siden (35-70 m om dagen)

Tak tak tak

Xxxxx

CC2: 1st response, "HJÆLP - er der nogen der kan "oversætte" tallene for mig??":

WR2 Tilmeldt: 07-07-2009 21:01	Den 25-06-2011 17:42 **Re: HJÆLP - er der nogen der kan "oversætte" tallene for mig??**	

Ja du har meget lavt stofskifte og det kræver behandling, hvis det skulle vise sig at du har Hashimotos som er den lave stofskiftesygdom som de fleste har så ville jeg passe på med D-vitaminerne, men det er min overbevisning efter at have læst noget som hedder Marshallprotokollen. Og efter at have oplevet det på egen krop at jo mere D-vitamin jeg spiste des lavere blev mit stofskifte og jo mere træls fik jeg det. Du skal bede om at få målt antistoffer for det er vigtigt at vide. vh Xxxxx
p.s men hvis du som i tidligere indlæg skriver at du ikke mener at være mærket af det så lad da være med at få behandling, og hold så godt øje med om du får det dårligere. Tjek stofskifteforeningens hjemmside der er megen information.

CC3: 1st posting, "Mangler jeg T3?!?"

Example of question regarding a possible medical cause for problems in the title. In the text there are an indication of a medical history, including results of medical tests and medication, symptoms, and indications of new knowledge that should possibly have an impact on the treatment. Suggestions are invited to. In response there is an acknowledgement that the medical examinations suggest a medical cause for problems. Then there is indication of medical knowledge and suggestions for how to approach and consult medical professionals in order to deal with the problem.

WR1 Tilmeldt: 26-07-2008 00:25	Den 20-02-2011 12:29 **Mangler jeg T3?!?**	

Jeg har haft problemer med stofskiftet i 7 år nu...men først nu har jeg fået øje på betydningen af T3...selvom jeg LÆNGE har vidst, at en TSH indenfor "normalområdet" er et vidt begreb, har jeg aldrig flyttet fokus over til T3, og den har længe været indenfor normal. Men efter jeg har læst indlæg her de sidste dage, er jeg vågnet op og nu har jeg lige målt gennemsnittet på min T3 over de sidste halvandet år. Den er 1,3. Som regel ligger den på ca 1,2, og den kommer aldrig over 1,5.
Men hvordan får man den op, når man ikke kan tåle større mængder Euthyrox, gammel og ny Eltroxin (ja, jeg har været på dem alle :-) ?
Er det simpelthen Liothyronin, jeg skal begynde at plage min livstrætte læge om? Hold op, hvor blir han træt i hovedet, hver gang han ser mig. Sidste gang sagde han lige ud:
- Hvad er det, du vil ha' jeg skal gøre?
Da sad jeg for gud ved hvilken gang og hang.
Symptomer:
Susen og ringen for ørerne (er ved at gøre mig vanvittig)
muskelsvaghed (svært ved at gå op ad trapper, hænge tøj op, støvsuge, børste hår)
almen træthed (SKAL hvile midt på dagen, ellers løber alting sammen i hovedet på mig)
osv osv
Men som sædvanlig: Tsh er ok
SUK!!!
Nogen forslag?
VH Xxxxxxxx

CC4: 1st response, " Mangler jeg T3?!?":

WR2 Tilmeldt: 23-06-2009 18:37	Den 20-02-2011 18:16 **Re: Mangler jeg T3?!?**	

Hej Xxxxxxxx

Ja du ligger da alt for lavt i T3, så der er ikke noget at sige til at du er træt mm. Nederste referencetal er 1,5 og selv når man ligger lige indenfor, kan man have symptomer. Nogen siger at man ligger bedst på 2.

Egen læge kan ikke, så vidt jeg har forstået, udskrive Liothyronin, det er kun endokrinologen der kan og ikke alle endokrinologer går ind for kombi behandling. Så du må finde en der kan se ideen med at tilføre kroppen T3, når nu din egen krop har svært ved omdannelsen af T4(Euthyrox, ny og gl Eltroxin) til T3.
Så det din egen livstrætte læge kan gøre, er at henvise dig til en endokrinolog, da han ikke selv er i stand til at regulere dit stofskifte så du fungerer ok.
Det var bare lige min vinkel på dit spørgsmål.

God vind og bedring
Hilsen Xxxx

CC5) First posting in the thread "Normalt stofskifte - ØH NEJ :-(":

Example of advice after complaint relevant descriptions and invitations to provide advice.

WR1 Tilmeldt: 22-02-2011 17:11	Den 22-02-2011 18:27 **Normalt stofskifte - ØH NEJ :-(**	

Hejsa

Jeg er ny her på siden, men har fået et problem med mit stofskifte, som jeg søger hjælp til. Jeg er 28 år gammel, blev opereret i 1996 og igen i 2000 for struma og efterfølgende cancer i skjoldbruskkirtlen og har efterfølgende været til de forskellige kontroller med videre undervejs overfor forskellige læger.

Jeg startede min medicinske behandling med eltroxin 250 microgram, og har over de efterfølgende 5 år været fulgt på hals-næse-øre amb. på OUH. Det medførte reduktioner og stigninger af Eltroxinen. Imidlertid begyndte jeg at få problemer med flere symptomer så som træthed, stigende vægt trods nedsat appetit (spiser mellem 1000-1200 kalorier om dagen hvor de 2000 er normalen.) Jeg er træt og irriteret, bider hovedet af folk uden grund. Lider af hårtab, kuldskærhed konstant, ledsmerter (hvor jeg ikke har fået en forklaring) og flere andre ting. Dette har min egen læge ikke kunne finde en løsning på - og hun var selv inde på at det kunne have med stofskiftet at gøre? Hvis det var for lavt imodsætning til tallene, der viste at det var normalt..

I mellemtiden er jeg blevet smidt tilbage til mit lokale sygehus, og henvist til en endokrinolog - fordi jeg ikke skulle være i fare for canceren skulle vende tilbage. Det var såmænd også fint nok, hvis da ellers hun var til at snakke med. Hun lytter slet ikke til at jeg gerne vil have gjort noget ved min medicinering og yderligere da jeg spurgte til mit hårtab og ledsmerter, så afskrev hun det bare med tab dig. Yderligere har jeg oplevet en af hendes kolleger sige direkte til mig "Vil du have mere medicin så ligger du i graven inden du er fyldt 30." (på det tidspunkt var jeg 25)

Jeg skylder at sige, at jeg har forsøgt et år på herbalife - hvor jeg tabte mig 800 gram. Jeg har haft gående og stående arbejde i tre år - med 8-10 timers aktivitet om dagen uden at dette har kunne ses på vægten, der tværtimod er steget væsentligt til jeg nu sidder på 112 kilo. Og hvad angår vægten ved jeg virkelig ikke hvad jeg skal gøre nu for jeg kan stort set ikke leve af mindre end jeg gør....

Det der nu får mig til at skrive, er at jeg slås med min endokrinolog endnu. Hun vil slet ikke høre tale om at ændre min dosis og min d-vitamin er for lav til trods for jeg hele tiden har fået kalk+d tabletter dagligt.

Er der slet ikke noget jeg kan gøre for at få anden rådgivning for det virker som om hun har "afskrevet" mig? Yderligere til trods for jeg ikke overhovedet har det godt - så kontaktede hun mig ikke på telefonen som lovet sidste dag - da jeg måtte melde afbud til en kontrol grundet sygdom og sendte mig bare et svar med øg din d-vitamin og så ses vi om 4 mdr igen?
Den situation kan jeg ikke holde til.... Er der nogen jeg kan kontakte eller spørge til råds for jeg har virkelig brug for hjælp altså...

Ser frem til at høre fra jer og undskyld min store forklaring... Følte bare detaljerne skulle med.

//mig

CC6) 1st response, "Normalt stofskifte - ØH NEJ :-(":

WR1 Tilmeldt: 02-10-2008 09:31	Den 22-02-2011 20:46 **Re: Normalt stofskifte - ØH NEJ :-(**	

jeg synes du skal bede om kopi af dine blodprøvesvar, så du selv kan følge lidt med?
De fleste har det bedst med en TSH på 1 eller derunder og T3 og T4 i den øvre ende af skalaen. Læger har det med at sige at man skal føle sig normal, blot tallene er indenfor normalområdet. De fleste stofskiftesyge føler sig elendige med en TSH oppe på 4 og en lav T3 og T4.
Måske du ikke er velmedicineret eller har brug for et Liothyronin tilskud (hvis din T3 er for lav).
Ring og bed om kopi af dine blodprøvesvar, hvis du ikke har dem allerede
Håber det bedste for dig
mvh Xxxxx

CC7) 1st posting, "Hjælp! ":

Example of invitation to provide help by prodiving medical information, which is responded to with general information and a suggestion to have a medical professional do medical examination.

WR1 Tilmeldt: 30-06-2008 13:43	Den 25-08-2013 11:27 **Hjælp!**	

Hej alle.

Håber I kan hjælpe lidt. Hvad er symptomerne på for lavt og for højt stofskifte?

Jeg er 49 år og vidst nok i overgangsalder, men der er ikke noget der rigtig hjælper på mine hedeture, som heldigvis er den eneste gene jeg har. Jeg har prøvet hormonplaster i 6 uger, det hjalp ikke. Lige nu er jeg ved, at prøve Cetapresan, som skulle kunne hjælpe, det er næsten 5 uger siden jeg startede og der er ingen virkning endnu.

Tænker så, om det kan være mit stofskifte der er noget galt med?
Jeg tager D-vitamin og kalk med magnesium, hver dag + en jerntablet også hver dag.

Håber I kan hjælpe mig, for jeg er ved, at blive skør af at svede sådan hele tiden.

På forhånd tak!

Connie

CC8: 1st response, "Hjælp! ":

WR2 Tilmeldt: 19-08-2013 14:46	Den 25-08-2013 12:12 **Re: Hjælp!**	

Man kan have problemer med stofskoftet på en del forskellige måder og symptomerne er lidt forskellige. Hvis ikke du oplever andre symptomer end at svede, så er det ikke særligt sandsynligt at det skyldes stofskifte problemer. I forbindelse med at man sveder kunne en af de mere almindelige symptomer være vægttab andre symptomer kunne være varmeintolerance, rastløshed, hjertebanken mm (ps. forbundet med forhøjet stofskofte: tyreotoksikose).

Den sikreste måde at få undersøgt om man har problemer med stofskiftet er at få taget en blodprøve hos lægen.

Medicinen som du tager skal normalt virker i løbet af 2-4 uger, der er dog nogen der får sat deres dosis op efter 2 uger. Det bedste er helt sikkert at tale med din læge om det også fordi justering af dosisen på Cetapresan (både op og ned) er en læge beslutning hvis man ikke har aftalt andet. Hvis du skal stoppe med Cetapresan skal du aftale nedtrapning med din læge da man ellers kan opleve bivirkninger.

Ps. jeg var faktisk begyndt at skrive en masse symptomer ned, men slettede dem fordi problemer med stofskiftet er meget svære at selvdiagnosticere og jeg tænkte de måske ville skabe mere usikkerhed end klarhed. Hvis du stadig gerne vil have dem er der her et link.

https://www.sundhed.dk/sundhedsfaglig/l ... rthyreose/

CC9) 1st posting: "Tsh tal...? ":

Example of indication of questions regarding medical tests in the title, and indication of an established medical problem (enlarged thyroid gland) in the text. There is also an indication of medical tests regarding metabolism. Responses that interpret/assess the numbers are invited to, for example by asking for help. The response is initiated with an assessment that the numbers suggest low metabolism. Furthermore, medical information is indicated, and it is suggested that WR1 consults his doctor and seek medical information.

WR1 Tilmeldt: 21-02-2011 14:00	Den 21-02-2011 15:10 **Tsh tal...?**	

Hej. Jeg har en forstørret skjoldbruskkirtel og har fået tjekket mit tsh tal i den forbindelse. Jeg er nu begyndt at få nogle symptomer. som jeg godt kunne forbinde med, at mit stofskifte ikke fungerer som det skal!!! Men det er jo en ren jungle, så jeg håber, at der er nogen der kan hjælpe mig =) Jeg har kun fået målt mit TSH tal, og første gang var det 17,6, og anden gang 17,9 (1 uge siden) Er det som det skal være??? Nu har jeg i dag fået taget nye blodprøver for at tjekke T3 og T4.... Jeg får svar onsdag eller torsdag på de tal... Hilsen Xxxxxx.

CC10) 1st response"Tsh tal…? ":

WR2 Tilmeldt: 02-10-2008 09:31	Den 21-02-2011 21:12 **Re: Tsh tal...?**

Du har lavt stofskifte. Normalområdet er fra 0,4-4,4. Hvad siger din læge? Jeg håber da at han tager hånd om det?
Du kan læse mere on lavt stofskifte på www.thyreoidea.dk eller det norske brugerforum www.sonjas-stoffskifteforum.info.Prøv også at læse lidt her https://www.sundhed.dk/Artikel.aspx?id=13308.871

T3 og T4 vil nok være for lave, når din TSH er så høj. Disse tal skal allerhelst ligge øverst i referenceintervallet.

Lad os håbe at din læge fortæller dig lidt mere når du får prøvesvarene, hvis ikke må du banke i bordet.

mvh Xxxxx

DD) Postings resembling the structure of responses to responses described in chapter 6.4

DD1: Posting number 3 in the thread ” "stofskifte-øjne"” (First response posted more than 3 days after the first posting had been posted):

WR1 * Tilmeldt: 18-10-2012 16:53	Den 09-11-2012 12:49 **Re: "stofskifte-øjne"**	

Endelig et svar:-)
Nej, de er ikke udstående men jeg er meget skel-øjet og har voldsom dobbeltsyn. Min øjenlæge forstår godt min tøven med medrol-beh.. Jeg er ikke synstruet. Det er endokrinologerne, der presser på.
Ang. stimulanser, så drikker jeg 2 kopper kaffe om dagen, ryger ikke, går en tur/cykler hver dag ca 4 km, drikker et glas vin om ugen, ingen chokolade osv, så jeg synes ikke, det kan være det. Mit trap-tal ligger på 6,4 og der har det ligget de sidste 5 mdr. Er bare ved at blive "skør" over, at der ikke er nogen bedring men synes heller ikke jeg tør tage imod medrol-behandling. "Jeg ved, hvad jeg har men ikke hvad jeg får".
Vh Inga

DD2: Posting number 11 in the thread ” ELTROXIN-LEVAXIN-EUTHYROX bivirkninger”:

WR1 * Tilmeldt: 22-02-2014 16:19	Den 15-08-2014 12:22 **Re: ELTROXIN-LEVAXIN-EUTHYROX bivirkninger**	

Kære xxxxxxx
tak for dit svar på mit indlæg. Jeg fornemmer at vi er enige mht. at være med-styrende omkring medicindosis. Min anke går på at det er svært at få lægerne med på ideen. De nærmest klamrer sig til TSH. Mit ønske er, at de i højere grad ville lytte til vores beskrivelse af hvordan man faktisk har det. Jeg skifter ikke læge men kæmper videre, måske er det et spørgsmål om tid og tilstrækkelig mange patienter som os før de ændrer kurs.
venlig hilsen xxxxxxxx

DD3: Posting number 3 in the thread “Nydiagnostiseret med Graves sygdom”

WR1 * Tilmeldt: 08-12-2011 10:34	Den 16-12-2011 18:52 **Re: Nydiagnostiseret med Graves sygdom**	

Hej xxxxxx

Tusind tak for dit svar. Uha hvor lyder det træls alt det du har været igennem.. men glad for at høre det trods alt er blevet meget bedre for dig.

Jeg har fået thycapzol 5mg 6 gange om dagen nu i nu snart 4 uger. Min sidste

blodprøve den 6. dec. viste at t3 og t4 var faldet men at TSH stadig var umålelig (<0,01 det var en fejl at jeg skrev 0,1 i første indlæg). Nu kan jeg ikke huske hvad han sagde t3 og t4 var faldet til. Vil ringe og få en kopi af blodprøverne som du foreslår.

Endokrinologen sagde jeg skulle fortsætte med samme dosis, få taget en ny blodprøve den 19. dec. Så går jeg ud fra han ringer når han ved hvordan det ser ud.

Med hensyn til øjenlæge så har jeg ikke været i kontakt med en sådan, vil høre endokrinologen om det. Synes jo ikke jeg har så slemme øjensymptomer lige nu, andet end at jeg kan mærke et lille trykken bag det venstre øje. Derudover er de begge noget røde, men det kan jo også skyldes kontaktlinserne? :/
Tak for dine links til foreningens side, dem vil jeg prøve og kigge på.

Rart at vide man ikke er alene :)

DD4: Posting number 9 in the thread ” Skifte fra Eltroxin til Euthyrox”.

WR1 * Tilmeldt: 02-10-2008 09:31	Den 17-04-2009 19:28 **Re: Skifte fra Eltroxin til Euthyrox**	

Hej alle
og tak for jeres svar.
Prøver mig lidt frem og ser hvad der fungerer bedst - om morgenen eller om aftenen.
Tak til dig Xxxxxxx - det var jo dig der satte os alle herinde på sporet af den nye medicin.
Godt at høre at du stadig har det godt på den nye medicin. Har du fået taget blodprøver efter du skiftede medicin?
God weekend!
Mange hilsner
Xxxxx

DD5: Posting number 10 in the thread ” stofskifte, stress, depression -hvad er hvad?”

WR1*	Den 29-10-2012 13:37
Tilmeldt: 17-09-2012 09:15	**Re: stofskifte, stress, depression -hvad er hvad?**

Kære Xxxx og xxxxxxx.

Tak for jeres indlæg. Det er trist at I har det som jeg.

Lige nu går det fremad med sygemelding og antiderepssiv medicin - så måske hendler det for mig mest om stress og depression. Jeg har det langt bedre end for en måned siden. Derfor har jeg ikke fået den henvisning til endokrinologen. Synes også at det er svært at finde kræfter til kampen med lægen.

Jeg har dog fået taget en ny blodprøvehvor tSH ligger påå 1,7. I følge rådgiveren i stofskifteforeningen skal TSH være så tæt på 1 som muligt. Umiddelbart synes jeg jo det ser rimelig fint ud så..?

Jeg håber I finder en god vej frem!

KH Xxxx Xxxxx

DD6: Posting number three in the thread ” Desperat efter svar på træthed”:

WR1*	Den 08-03-2011 19:08
Tilmeldt: 08-03-2011 14:58	**Re: Desperat efter svar på træthed**

Har haft taget antidepresiv, er stoppet da jeg tilsidst følte at de drænede mig, og var bange for at det var dem der gjorde mig svimmel. Havde fået tjekket hos høre at det ikke var noget på balancenerven.
Har fået tjekket blodprocent, blodtryk (som godt kan være forhøjet når jeg har det sådanne), men ellers skulle der ikke være noget ud over det normale.
Jeg føler mig ikke deprimeret fortiden, faktisk meget ovenpå psykisk. Har også prøvet hele dagen, at overbevise mig selv om at jeg ikke var træt/drænet og komme i gang med alle de ting jeg har på listen..
Spiser sundt, motionere og lever sundt.
Har altid følt mig mere træt end andre, og ikke kunne klare mere end en ting/oplevelse om dagen.
Bliver hurtig irretabel og kort for hovedet.
Det jeg kunne tænke mig at vide er, om det kan være periodisk værre hvis man lider af forstyrrelser i stofskiftet.?

ReD) Postings that precede the responses to responses presented in chapter 6.4

The first seven postings in the thread "Har brug for jeres erfaringer"

ReD8_1: 1st posting, "Har brug for jeres erfaringer":

WR1 Tilmeldt: 25-10-2010 15:31	Den 25-10-2010 20:15 **Har brug for jeres erfaringer**	

Hej. Efter ca. halvandet år med det primære symptom daglig hovedpine i invaliderende grad samt en tiltagende snurren sitren i baghovedet (ikke ørene) og sovende hænder og ben 1- 3 gange dagligt har jeg brug for jeres råd. Er nærmest desperat efterhånden, men har gennem flere scanninger, fysioterapi, kiropraktor, 25 massage behandlinger, utallige alternative behandlingsforsøg ikke fundet noget der virker. Sagde igen til lægen om nu alle relevante blodprøver var taget, da jeg ikke et eneste sekund er i tvivl om at der er en fysisk grund til min tilstand. Bad om at få målt b 12 som var 100 og dette er jeg blevet tanket op med uden at kunne mærke forskel. Nu kommer vi dertil hvor jeg har et lille håb om at nålen i høstakken måske er fundet ? Mit TSH var på 7,1 og skulle måles igen efter en måned og det har jeg netop fået svar på idag. Nu ligger TSH på 4.9 altså faldet, T3 og T4 var indenfor normal området og lægen mener ikke der skal gøres noget udover ny blodprøve om3 mdr. ??? Kan dette alligevel være årsag til, jeg er så forandret og syg. Skal jeg beskrive min tilstand, så er det som at gå med følelsen af at være forgiftet. Kan ikke koncentrere mig og er lydfølsom især overfor mange der taler samtidig i større forsamlinger. Og kan man få sådan en hovedpine af for lavt stofskifte?
Jeg sover en del, men vågner jeg har jeg utrolig svært ved at falde i søvn igen pga den summen og sitren der er i baghovedet min puls dunker så jeg til enhver tid kan tælle den. Jeg kan dårligt klare at arbejde 28 timer ugentligt og er lykkelig for jeg arbejder aften da jeg slet slet ikke kan komme i gang fra morgenstunden af. Almindelig smertestillende kan ikke dæmpe symptomerne men 2 kodipar tager toppen. Jeg bør nok tilføje, at jeg har været ved neurolog der til sidst (efter 2 mdr uden nogen som helst form for smertestillende for at udelukke medicinsk fremkaldt hovedpine) sagde at jeg desværre må lære at leve med diagnosen kronisk hovedpine. Mit funktionsniveu er generelt faldet med omkring 30 procent på gode dage og 70 procent på de dårlige. Idag blev jeg f. eks forpustet ved blot at gøre rent. Jeg er 40 år og normal vægtig og lever et almindeligt liv med en dejlig og velfungerende familie. Det eneste, men til gengæld også store problem er mit helbred og jeg har næsten ikke flere ressoucer til at lede efter årsagen så derfor er det mit store håb at nogen vil bruge tid til at dele deres erfaringer om dette med mig. Både for min egen men sandelig også for min kæres skyld da det selvfølgelig piner dem at se mig så dårlig og være totalt magtesløse. Når jeg læser om forhøjet stofskifte synes jeg også nogle af de symptomer kan passe på mig, men jeg har indenfor det sidste år taget 6 kg på . På forhånd tak håber på nogle meldinger fra jer der har kendskab til lavt stodskifte på egen krop.

Sidst rettet af WR1 26-10-2010 14:29, rettet i alt 1 gang.

ReD8_2: 1st response, "Har brug for jeres erfaringer":

WR2 Tilmeldt: 17-11-2009 16:11	Den 25-10-2010 20:51 **Re: Har brug for jeres erfaringer**

Jeg er jo ikke læge - men bare en (med)patient... jeg tror dog, det er sandsynligt, at du har det dårligt pga. så høj en tsh... ved du, om du også har fået målt, om du danner antistoffer (en autoimmun form for lavt stofskifte)?

Jeg har næsten lige læst en artikel fra en norsk læge, hvor der står, at han anbefaler behandling allerede ved forhøjet tsh, selvom de øvrige tal er normale.... hvilket kan tyde på, at forhøjet tsh alene kan give problemer...

Jeg håber, du finder ud af det - er sikker på, at du vil få flere svar her på siden. Du skal ikke affinde dig med at have det så dårligt, samtidig med at du har et så skævt tsh....

mh Xxxx

ReD8_3: 2nd response, "Har brug for jeres erfaringer":

WR3 Tilmeldt: 20-08-2009 11:24	Den 26-10-2010 12:19 **Re: Har brug for jeres erfaringer**

Hej,

Det lyder som om du stadig mangler noget behandling.
Men du skal vide, at du ikke er alene med din følelse af at "være forandret" og heller ikke med dine hyppige hovedpiner.

Jeg har selv forhøjet tsh og antistoffer mod skjoldbruskirtlen. Mit tsh har ved blodprøver ikke været højere end omkring 8, men jeg har symptomer allerede ved 2. Jeg får medicin for sygdommen, men tsh svinger og har svært ved at blive stabilt. Og jeg er nu næsten 100% sikker på at mine hyppige migræneagtige hovedpiner skyldes stofskiftesygdommen. Jeg har haft dem i mange år, og har først nu indset sammen retentionhængen med stofskiftet. Jeg havde aldrig hovedpine som barn og teenager.
Jeg har ført hovedpinedagbog gennem lang tid og kan se, at det særligt er omkring ægløsning og menstruation jeg får disse hovedpiner. Ligesom dig kan jeg holde dem nede med kodimagnyl (hvilket i øvrigt ikke spiller så godt sammen med stoskiftemedicin...men noget må man jo ty til, ik´? Panodil virker slet ikke på mig) Men hovedpinen kan fortsætte i 3-4 dage. I slemme perioder har jeg hovedpine ca. 10-15 dage på en måned.
Kroppen skal bruge stofskiftehomon til mange processer. Op til menstruation har kroppen fx. brug for ekstra stofskiftehormon.
Det lyder altså som om, at du skal reguleres i medicin. Anbefalingen er jo på et tsh omkring 1 eller lidt derunder. Mit tsh har kun været på ca. 1 én gang...øv! Men i den periode forsvandt mine hovedpiner fuldkommen. Så¨måske er der håb...jeg vil dog ikke indgyde dig de totale forventninger om helbredelse, da jeg er bange for at skuffe dig med mine erfaringer...så læs det som et velment håb for dig ;)

Desuden bør du få målt blodprocent og jerndepoter (anæmiudredning). Disse kan være små ved lavt stofskifte og bør fyldes op ved at tage jerntabletter. Jernmangel kan forstærke eller fremkalde hovedpiner.
Man kan også få forhøjet blodtryk ved medicinsk behandling for lavt stofskifte. Måske sku´ du lige få det tjekket også?

Håber du får det bedre...jeg ved hvor meget hovedpinerne tærer på kræfterne. De bedste lykkehilsner.

ReD8_4: 3rd response, "Har brug for jeres erfaringer":

WR4 Tilmeldt: 23-08-2008 20:36	Den 26-10-2010 12:28 **Re: Har brug for jeres erfaringer**	

Jeg tror, at den artikel som Anne henviser til er denne
http://www.overgangsalderen.net/forum/s ... php?t=9774
Der står mange nyttige oplysninger.
hilsen Xxxx

ReD8_5: 4th response, "Har brug for jeres erfaringer":

WR5 Tilmeldt: 28-01-2010 16:40	Den 26-10-2010 13:00 **Re: Har brug for jeres erfaringer**	

Jeg tror efterhånden at man kan have alle slags sympt. ved stofskifte sygdomme. Og selvom prøver ikke viser store udsving, så kan man være meget syg.

Har jeg forstået det rigtigt at din tsh er faldet uden medicin? på 1 måned?

Hvorfor svinger den, ville jo være et udgangspunkt, burde man mene.
(Altså for lægerne)

God ide som nævnt, at få tjekket antistoffer (evt. hypofyse)

Jeg har selv haft et atypisk langt forløb, og vil bare sige at man ikke skal affinde sig med at have det skidt. Og 3 måneder er lang tid at vente på svar.

God bedring
Xxxxx

ReD8_6: 5th response, "Har brug for jeres erfaringer":

WR1* Tilmeldt: 25-10-2010 15:31	Den 26-10-2010 14:28 **Re: Har brug for jeres erfaringer**	

Tusind tak for jeres brugbare tilbagemeldinger. Jeg lapper dem i mig og selvom ingen af jer måske helbreder mig så kan jeg da allerede nu sige at jeg finder fornyet håb om, at det kan være stofskiftet der spiller min krop et puds. Jeg må bede om at få målt denne blodprøve der kan vise om det er en form for autoimmun sygdom. og ja det er netop sådan at det hele forværres med 10 - 20 procent omkring menstruation og det har jeg svært ved at tacle når det er så slemt i forvejen.
Ja det er rigtig forstået at mit Tsh på en måned faldt fra 7.1 til 4.9 uden medicin og hun siger T3 og T4 var normale og agter ikke at sætte mig i behandling. Ved at jeg ville skulle slå i bordet for at komme i behandling. Ved det fra da jeg havde lavt b 12. Jeg kan ikke mærke at værdierne er faldet altså nogen form for bedring. Tværtimod.

Jeg kan forstå at hovedpinen og den der underlige summen-sitren i baghovedet er jeg ikke alene om. Den er meget ubehagelig. Hovedpinen er der altid men varierer i styrke. Oftest tager den til i løbet af eftermiddagen og forsvinder ikke. Jeg ville slet ikke kunne magte et fuldtidsjob og selvom jeg tyer til kodipar for at kunne klare mine aftenvagter så tager de kun toppen. Kan godt høre at det hele er en stor klagesang og netop det er også svært at acceptere. At andre evig og altid skal se og høre man har det elendigt. Derfor har jeg også valgt at skulle på smerteklinik. Men men kunne det hele nu løses ved at få det stofskifte op ville det jo være super og ingen skulle høre mig beklage mig over bagateller.
Endnu engang tak til jer der gad ulejlige jer med respons. Hører meget gerne fra andre.

Sidst rettet af WR1 26-10-2010 15:38, rettet i alt 1 gang.

ReD8_7: 6th response, "Har brug for jeres erfaringer":

WR1 Tilmeldt: 25-10-2010 15:31	Den 26-10-2010 14:50 **Re: Har brug for jeres erfaringer**	

Til WR3: Jeg har fået målt min blodprocent og den var ok, men har også taget jern forebyggende for at udelukke, dette skulle være årsagen. Jeg ved bare at der ER en årsag til, at jeg har det sådan og hvis det er stofskiftet der er synderen, så er det jo foklaring på, at de 10 behandlinger ved privat akupunktør , 7 x akupunktur ved lægen, 25 ganges massage, 5 gange fysioterapi, 10 kiropraktor behandlinger, 2 medicinfri måneder og fjernelse af hormonspiral ikke har hjulpet mig

The first three postings in the thread "Lavt stofskifte - hjertebanken – angst":

ReD9_1: 1st posting, "Lavt stofskifte - hjertebanken – angst":

WR1 Tilmeldt: 20-12-2008 12:29	Den 20-12-2008 12:51 **Lavt stofskifte – hjertebanken – angst**	

Hej til jer alle. Jeg var inde på stofskiftedebatterne for første gang i går. Hvor blev jeg dog utrolig glad for, at jeg langt om længe kunne finde personer der rent faktisk kunne forstå hvordan jeg havde det. Jeg har i 4½ år spist Eltroxin 50mg dagligt. Så skete der det, at jeg i juni måned blev puttet i kassen stress. Jeg begyndte at få hjertebanken og blev SÅ bange, for det havde jeg aldrig prøvet før. Hold da op hvor det påvirkede mig psykisk. Jeg blev sygemeldt i 3 mdr. og startede job for 1 måned siden. Problemet er bare at jeg ikke får det bedre. Jeg har symptomer som hjertebanken, hurtig puls, megen uro i kroppen, klump i halsen, hovedpine, svimmelhed, meget sensativ for høje lyde. Nå, men jeg begyndte at få mistanke til mit stofskifte, men lægen afviste da mine tal lå inde for normalværdierne; TSH 2,35, T3 1,4 og T4 15,8. Jeg var overbevist om at det har noget med mit stofskifte at gøre. Jeg gik til endokrinolog, super læge, men han kunne heller ikke se noget på blodprøverne ud over at jeg har forhøjet infektionstal, som er anden gang indenfor 4 mdr. Jeg mangler stadig svar på Anti TPO. Jeg er dog blevet enig med ham i at jeg ikke spiser Eltroxin den næste måned, og så ser om der kommer en forbedring, for alle de symptomer jeg har tyder på at min dosis er for høj. Jeg har bare så mange hjertebankener. Havde 34 forleden dag! Hvordan klarer i andre det med hjertebanken? Er I ikke bange? Desuden havde jeg ingen anelse om, at Eltroxin behandling kunne give depression. Mamma mia!! Ser frem til at høre fra jer.
Vh. Xxxx

ReD9_2: 1st response, "Lavt stofskifte - hjertebanken – angst":

WR2 Tilmeldt: 17-12-2008 17:57	Den 20-12-2008 14:09 **Re: Lavt stofskifte – hjertebanken – angst**	

hej!

Jeg kan udmærket følge dig!! Da jeg startede min behandling for ca. et år siden (nu tager jeg 200 mikg/dag) fik jeg også hjertebanken og uro i hele kroppen og kvælingsfornemmelse. Men jeg har også lidt under panik-angst oven i købet pga den depression jeg fik ud af det alt for lave stofskifte.

Min læge siger så, at jeg slet ikke var vant til at mærke mit hjerte slå så kraftigt, fordi jeg ubevidst har levet med det lave stofskifte i mange år.

Jeg har accepteret at mit hjerte slår så kraftigt og hurtigt. Jeg er oven i købet ikke helt slank, så lige pludseligt skulle hjertet jo også slå efter hvor stor en krop jeg havde, det kunne jeg da godt mærke. Forpustet blev jeg af det hurtige hjertebanken. Indtil jeg blev vant til det. Dog kan jeg stadig få små angst anfald en gang imellem. Dem kan jeg dog takle da jeg har gået til psykolog med det.
Men i starten er det meget foruroligende.
Hvor har du læst/fået at vide at eltroxin kan give depression? Fordi så tror jeg kan have den bivirkning. Selv om jeg også skal passe på om det kun er indbildning. Men jeg føler mig netop nedtrykt lige for tiden.
TPO, den har jeg også meget forhøjet – lyder til at din også driller. Har din læge nævnt noget om Hashimoto? Må jeg desuden spørge om en kvindes alder. Jeg leder sådan efter kvinder i min aldersgruppe….mellem 20 og 30
Håber mine ord kunne hjælpe dig?

Kh
Xxxxxxxxx

ReD9_3: 2nd response, "Lavt stofskifte - hjertebanken – angst":

WR1 * Tilmeldt: 20-12-2008 12:29	Den 20-12-2008 15:36 **Re: Lavt stofskifte – hjertebanken – angst**	

Hej Xxxxxxxxx,
Jeg er 42, så jeg ligger ikke lige i din aldersgruppe. Mht. depression eller "dårligt humør", ked af det symptomer, så har jeg læst det her på debatsiden, og i nogle af de referater som jeg har set inde på thyreoidea landsforeningens hjemmeside.
Lige en anden ting som strejfede mig. Selvom jeg får Eltroxin mod for lavt stofskifte, så har jeg alle symptomerne som om at mit stofskifte er for højt. Nu har jeg aftalt som sagt helt at lade være med at tage medicinen 1 måned for så herefter at gå op og få taget blodprøver. Kan det tænkes at kroppen ikke har behov for Eltroxinen mere, og at man derfor får symptomerne for for højt stofskifte?Er der nogen der har prøvet dette?
En anden ting der kunne tyde på, at jeg har ret i mine antagelse er, at jeg var inde på Meditalklinikken i København, hvor jeg fik at vide at min forbrændning er al al for høj i øjeblikket (som en 27 årig). Normalt er dette jo godt, men ikke i mit tilfælde da jeg er gået fra 61 kg. Til 57 kg. Min fedtprocent var også for lav. Havde nok med antioxidanter, og mit oxidative stress lå indenfor rammerne. Ellers kan jeg forstå på de andre som skriver i debatten, at de langsomt har ændret deres medicinbehov, og ikke så drastisk som jeg gør det nu?
Vh. Xxxx

The first three postings in the thread "Lavt stofskifte - hjertebanken – angst":

ReD10_1: 1st posting, " andre derude":

WR1 Tilmeldt: 16-09-2008 18:53	Den 29-06-2010 15:42 **andre derude**	

fik konstateret hashimotos echohalopati sidste efterår(anti stof tal 75000 - nu 4200) og er i højdosis binyrebark hormon behandling vil gerne i kontakt med andre er der nogle derude.

ReD10_2: 1st response, " andre derude":

WR2 Tilmeldt: 25-10-2009 12:33	Den 04-07-2010 19:10 **Re: andre derude**	

Hejsa!

Hvad er det? syns ikke jeg har hørt det før.... !?
Er det den sygdom som også kaldes Basedow med øjensymptomer?
Det har jeg nemlig... og har også været i behandling med binyrebark!

Mvh. X.

ReD10_3: 2nd response, " andre derude":

WR1* Tilmeldt: 16-09-2008 18:53	Den 05-07-2010 06:41 **Re: andre derude**

En sjælden udvikling af hashimoto efter sigende er jeg vist den eneste herhjemme - derfor prøver jeg her om der skulle være andre - vi er vist et par hundrede på verdens plan. Og nej du har den ikke hvis man har er man ikke i tvirvl idet man bliver hundesyg. Er du nysgerrig kan du google den.