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Empathy in Online Mental Health Communities

Abstract: Empathy is usually separated into two major components: affective or emotional (the capacity to share the emotional experience felt by others) and cognitive (the recognition of the other person's emotions, a process that likely requires perspective taking). The focus of the present contribution is how empathy is conversationally managed in two mental health online communities: a chat room and a forum for recovery from an eating disorder (ED). The analysis revealed that in the ED chat room participants resorted to primal responses, formulations of understanding, and parallel assessments to claim understanding and display emotional empathy when responding to a troubles-telling. In contrast, ED forum members tended to produce complex discursive operations to persuade recipients to modify their ED thoughts, feelings and behaviours. This goal called for cognitive empathy displays, such as echoic formulations and resolutive second stories, by which the empathizer echoed the other person's mental representations and offered alternative epistemic and emotional stances.

Keywords: *eating disorders* , *empathy* , *emotions* , *online support groups* , *e-mental health interventions*.

1 Introduction

In the last decades, a growing body of research has been dedicated to understanding empathy from a wide range of disciplines (evolutionary psychology, cognitive psychology, clinical and abnormal psychology, neuroscience, psychology of development, philosophy of mind, linguistics, sociology, etc.). The burgeoning interest in empathy has given rise to an array of empirical and interdisciplinary methods of analysis to account for this multifaceted phenomenon (Brunsteins 2018). Relatedly, the complexity of the empathic experience has sparked a longstanding debate about the limits and interfaces of this psychological construct with other associated intersubjective phenomena (e.g., mindreading, perspective taking, sympathy or emotional contagion). Some authors have opted to differentiate empathy as a distinctive construct (e.g., Batson 2011), whereas others have argued in favour of an overarching category, empathy, that includes other mental processes, such as emotional contagion, sympathy or compassion (Preston and de Waal 2002).

Beyond the particular issue of its boundaries and relations, the ability of empathy usually incorporates two aspects, according to the extant literature in neuroscience: cognitive and affective (emotional) (Shamay-Tsoory 2011; Walter 2012). The former refers to the subject's capabilities to recognise and to understand the mental and emotional states of another person, an operation that requires taking her/his perspective; Baron-Cohen and Wheelwright 2004); the latter, instead, points to the subject's emotional response to the affective state displayed by the recipient (Eisenberg and Fabes 1990). Whereas emotional empathy alludes to the automatic capacity to react and to respond with stimulation to the perceived emotional states of the other, cognitive empathy engages more complex cognitive processes and triggering mechanisms (Barlińska et al. 2018).

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Against this backdrop, the main goal of the present chapter is to reflect on the repertoire of discursive resources to construe empathy when interacting in online mental health groups. This work fits into the fruitful line of research on empathy in social interaction, developed in recent years in the areas of discourse and conversation analysis. Proof of the interest in this subject is the investigation on the role of empathy as related to claiming experiential knowledge in conversation (Heritage 2011), and to responding to affective-laden stories in everyday interaction (Kupetz 2014, 2019), as well as the efforts to systematise the characteristic empathy displays arranged in institutional talks (Hepburn and Potter 2007; Pudlinski 2005; Ruusuvuori 2005, 2007; Stommel and Te Molder 2018; Voutilainen et al. 2011).

While it is true that the study of empathy in institutional interactions has gained some traction in the field of discourse analysis, there is still little attention being paid to the role of empathy in computer mediated communication. Specifically, the question of how empathy is construed and communicated in online mental health communities should be further explored, due to the exponential increase in searches of these online platforms in the last decade (Prescott et al. 2020). So far, the few studies tackling the issue of digital empathy (e.g., Grondin et al. 2019; Hargreaves et al. 2018; Pfeil and Zhaphiris 2007; Preece and Gozhati 2001) have noted that the specific features of computer mediated communication tend to shape the empathic interaction. Factors such as the type of digital medium used for the exchange, its synchronic or asynchronic nature, its distinctive technological affordances, or its own rules to post on the site might affect how the interpersonal communication is perceived by the empathizer and the target of empathy (Grondin et al. 2019). Compared to the embodied practices of doing empathy in face-to-face interaction (cf. Kupetz 2014, 2019), the only markers of empathy in computer mediated communications are textual

and graphic elements (such as emoticons, emojis and other visual elements; cf. Grondin et al. 2019).

Despite the limitations of the medium, empathic communication is extraordinarily high in online support groups (Preece and Ghozati 2001: 254). As a matter of fact, one key gratification from the use of these communities is the perceived empathy their members report when interacting with similar others (Hodges et al. 2010; Nambisan 2011). The importance of perceived empathy is such that it can affect the success of the treatment and the chances of recovery (Nambisan 2011: 298). On that account, peer empathy could eventually supplement the empathy provided by caregivers, which is expensive and time consuming (Nambisan 2011). This potential to deliver more integral mental health interventions justifies the need to better understand the singular and distinctive ways of doing empathy in online peer-to-peer communication. The present study seeks to contribute to this discussion.

Applying discourse and conversational analysis methods, my specific goals are twofold: to discern the differences in empathic responses according to the communicative setting, and to investigate some of the linguistic resources used to communicate emotional and cognitive empathy in interaction. It is not my purpose, though, to compile a comprehensive list of empathic resources. Instead, I narrow the analysis to the diverse methods and resources assembled by empathizers when negotiating the meanings of mental illness and recovery in two different online platforms: a chat room and a forum dedicated to eating disorders (EDs). In this study, I am only concerned with empathic responses in online mental health settings. The interactional construction of empathy in these particular contexts will be the topic of another study.

2 Methods

2.1 Corpus

The corpus for the present investigation comprised messages gathered from two different English-speaking digital platforms: a real time chat channel with the hashtag *#eating_disorders*, and an asynchronic online forum for EDs that is part of a large social news aggregation and discussion website.[1] The rationale

1 Both sites are public, so that anyone can get access to the repository of threads and posts and read the message boards online. Users resort to 'throwaway accounts' and pseudonyms, which are practices that facilitate anonymous discourse and help to shield individuals with stigmatized conditions, such as EDs (van der Nagel and Frith 2015). In order to further ensure that participants are protected and that their anonymity is

to select these two sites was to examine whether empathic practices in mental health communities were distinctively different or shared some key aspects. In fact, each site has specific affordances that shape the kind of interaction being developed. The ED chat room is regulated by moderators, whose role is basically to promote and to engage users in discussions on topics related to EDs, whilst simultaneously banning any content that might be harmful to participants or distressing for them. The ED forum for its part belongs to an extensive social networking platform with different topical moderated forums that has become increasingly popular with young adults.

I collected two samples of messages, one for each online mental health community. I included opening posts that explicitly posed a problem (troubles-telling), requested advice, or asked for information. The sample from the ED chat room included conversations from May 9th of 2018 to January 2nd of 2019, and from January 1st to February 18th of 2021 (total number of words: 61,971). Both time periods were selected to detect potential differences in empathy displays between the first and the latest interactional activity in the channel. The sample from the ED forum, in turn, contained 50 threads published during the month of February of 2021 (total number of words: 64,020 words).

2.2 Procedure and Analysis

Instances of empathic expressions were identified by going through the data. Empathic moves were broadly understood as a verbal display of understanding, affiliation, compassion or alignment with the emitter's troubles-telling. The codification of these empathy displays was conducted taking into account the list of forms of communication identified as empathy, support or affiliation in the previous literature (Burleson 2003; Burleson et al. 2002; Couper-Kuhlen 2012; Fiehler 2002; Figueras 2021; Heritage 2011; Kupetz 2014; Pudlinski 2005; Sanahuges and Curell 2020).

All representative instances of empathy were subjected to a fine-grained, small-scale and local qualitative analysis with the methods of discourse analysis, in the specific version of discursive psychology (Edwards and Potter 1992).

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secured, the names of the sites have been concealed. Likewise, I removed any individual identifiers and those specific details that might identify individuals or organizations. Finally, I entered random phrases from the personal profiles collected for the present study into Google and I checked to see if they could be traced back to the personal profiles in the two sites investigated. Results of these searches did not return to the original post or to the site.

This analytic perspective is concerned about the ways psychological states are displayed in talk. Rather than regarding mental processes as the primary explanations for human action, discursive psychology focuses on conversation to scrutinise the actions and practices that the talk is doing, how it is constructed, and what resources are available to perform this activity. Taking this approach, empathy displays were not investigated in terms of changes of inner states but more in conversational terms, as social practices construed with and within discourse.

3 Results and Discussion

3.1 Types of Understanding and Types of Empathy

As Meneses and Larkin (2017) reason, empathy is a form of interpersonal or social understanding that connects to the exercise of reaching a substantial insight into another person's experience while, at the same time, being cognizant of the difference between the self and the other. Three prevailing ways of knowing what other people are feeling can be differentiated: intuiting, sharing and imagining (Meneses and Larkin 2017). Although all three have experiential validity, only sharing and imagining are common modes of understanding in the psychological definitions of 'empathy'. While sharing is a common mode of empathic understanding in the two online mental health communities examined here, imagining has a more prominent presence in the ED forum. Imagining is closely associated with the intellectual understanding (perspective taking) characteristic of cognitive empathy processes.

In reality, the empathic responses in both support groups are contingent on the discursive construction of two different insights into the other's ED experience: shared emotions and shared understandings. The ED operated as the binding or collective experience that all members had in common, which meant that participants in both platforms were personally implicated and emotionally invested in the business of sharing those ED insights. This personal involvement sometimes was more emotional (shared emotions), as for the ED chat room exchanges, and sometimes was more reasoned (shared understandings), as in the ED forum, when responders opposed two mental and emotional models of the illness experience: the ED and the recovery mindset (Figueras 2020, 2021). In any case, what is relevant in this discussion is the ways to discursively construe understanding in both online communities, and how they relate to two kinds of empathy displays: emotional and cognitive.

Following Sacks (1992), a contrast should be established between claiming understanding and demonstrating understanding. These two types of displays are connected to the specific ways of asserting membership categories, epistemic (a)symmetries, and particular rights and obligations (Mondada 2011). In both the ED chat room and the ED forum all their members were entitled to experience, given that they had a common epistemic access to the sensations, behaviours, body perceptions, feelings and thoughts associated with the ED. Hence, they all owned a collective network of meanings resulting from their personal firsthand experiences. However, not all of the experiential knowledge circulating in either group was uniformly distributed among its members. Some posters (the moderators, for instance) had more experiential rights than others, mainly because they were more advanced in the process of recovery from an ED (Figueras 2021). This differential expertise was made available in discourse through a variety of manifestations of emotional and intellectual understandings. In other words, the interplay of epistemic symmetries and asymmetries in online mental health support groups revealed fundamental differences in the types of empathy displays that interactants produced.

The first distinction to be made is between emotional empathy displays (based on shared emotions) *vs* cognitive empathy displays (built on shared understandings). Following Meneses and Larkin (2017), the more intellectual aspects of empathy are the basis for the phenomenon of shared understanding, whereas its emotional aspects are more closely related to the experience of shared emotions. Reasoning (e.g., generalisation, projection), mindreading and argumentation are operations involved in communicating cognitive empathy, as it will be argued in section 3.2. Reacting with primal responses to the troubles-telling (1), exhibiting alignment with the troubles reported in the opening message (2), taking the same emotional stance as the first poster (3), and/or describing one's own ED practices as proof of understanding (4) are considered in the present study some of the discursive moves to claim understanding. In any of these cases, the responder is doing emotional empathy.

(1) a. 😭 [ED chat room]
b. *that's good!* [ED chat room]

(2) a. *omg this is literally EXACTLY what I do too* [ED forum]
b. *I'm so sorry it is!! You're not alone, though!* [ED forum]
c. *This is my entire existence too* [ED forum]

(3) a. *I feel the same and I'm actually chubby* 😭😭😭 [ED chat room]
b. *I have the same feelings. Disgusted with myself, unable to control yourself and ashamed.* [ED chat room]

(4) *Omg I feel the same way I don't eat for a couple of days except no one notices I just starve myself in secret* [ED forum][2]

The most basic emotional displays that convey empathy are primal responses (Sanahuges and Curell 2020), which equate to non-elaborated reactions that are placed at the beginning of the post to communicate the immediate reply to the troubles-telling message. Primal responses included primary sound objects (onomatopoeias, such as 'awww', 'ugh'; interjections, like 'oops'; or emojis, like the heart ❤, or the raising hands 🙌), and secondary sound objects, corresponding to more substantive lexical forms ('Soooo good!!!', 'That's good', 'YESSSSSSSSS…', 'Oh, yeah'). These elements, more common in the ED chat room than in the forum, could be considered tokens of response cries, that is, "signs meant to be taken to index directly the state of the transmitter" (Goffman 1981: 116).

Response cries represent the most typical and embodied resources to bring about empathic alignments between interlocutors (Heritage 2011). In the case of computer mediated communication, they can be associated with certain textual features of a non-propositional nature (such as emojis), that make them more suitable to convey bare or raw emotional reactions to a reported event. Naturally, they evoke a more primal or basic form of empathic expression. By being part of the into-the-moment communication characteristic of the ED chat room, these textual cues indicated that responders were fully engaged and emotionally connected to any member of the group who was wrestling with the ED.

In both online communities, the significance of 'sharing emotions' was linked to the business of building relationships with other sufferers, participating in another's person story and forming an impression of emotional connectedness with others. Members of each group expressed a feeling of emotional togetherness that stemmed from the similarities, real or presumed, regarding the experience of the illness. Sharing-as-knowing was a powerful tactic to create familiarity and solidarity among strangers. Reporting on personal feelings when responding to the call for support by another member stood as proof of understanding the recipient's emotional condition.

The motivation for empathy, however, might not be necessarily altruistic in the majority of the interactions held in the two online ED communities examined here, but directed toward the ultimate goal of relieving one's own distress (fear, anxiety, guilt). After all, when responders reacted to the troubles-telling, they might not have been led by the distress they experienced by seeing

2 The examples are reproduced with all the errors in grammar and spelling that were present in the original posts.

another person suffering, but by their own struggles with the illness (cf. Batson 2011). This underlying egotistic motivation explains why so many responders in both online communities rendered formulations of understanding and parallel assessments only to claim understanding, but not to demonstrate it.

According to Mondada (2011), formulations of understanding are the most explicit mechanisms to claim understanding, albeit they are commonly used for doing something more than just showing understanding. In the ED chat room, as well as in the ED forum, statements of the kind reproduced in (5–6) were in service of coping with the responder's own strains with the illness, rather than to show that a process of understanding had really taken place:

(5) *Totally understand and personally also feel what you're saying. Eating feels like work almost all the time, so I've started a couple of things in particular (food/mood journaling, cooking larger batches of comfort food, ~daily walks around the block) to help get back on track and kind of guide myself along while tracking progress.* [ED forum]

(6) *I understand what you're going through. I'm like that with most clothes. Shopping makes me depressed a lot of the time too. And I say I can't find my size when it's because I don't want to try a bigger size. So I get what you're going through* [ED chat room]

In the excepts in (5) and (6), ED members resort to an empathic formulation introduced by a verb of acknowledgment ('I understand…'), in order to transform prior talk (the troubles-telling act) and express explicit understanding of the target's feelings and experiences. *Notwithstanding this claim of epistemic rights, no meanings of deep comprehension were delivered in those responses. Resorting to the verb* 'to understand', that denotes the achievement of a mental state (the result or success of a process) does not offer any guarantee that a real move of taking the other person's perspective has occurred. In these replies, the poster is, rather, conveying emotional empathy based on the realisation of two activities: claiming understanding (with the preface containing the verb of acknowledgment) and sharing her/his own emotional state. These two moves result in an affiliative action that matches the evaluative/affective stance of the target. The responders in (5) and (6) do shared feelings and, hence, their posts stand as displays of emotional empathy.

According to Håkansson and Montgomery (2003), both empathizers and targets express their own emotions, although the targets do not usually refer to the empathizers'. The opposite is generally true for empathizers. In this manner, the empathy experience is shared by the participants, but the focus is more on the target's situation than the empathizer's (Håkansson and Montgomery 2003). Yet, emotional empathy displays that appear in both the ED chat room and the ED

forum arose from an epistemic and emotional symmetry between the empathizer and the target. This is emphasised by the fact that responders of (5–6) focused almost exclusively on their own experience when giving feedback. They did not make reference to any other subject's mental or affective state but their own.

The examples in (5–6) also reveal the role that parallel assessments fulfil in the construction of emotional empathy in mental health support groups. As Heritage (2011) points out, parallel assessments describe similar experiences to the one reported by a first speaker, but without getting into the trouble that was reported. When ED responders resorted to parallel assessments in their replies, they narrowed their interest to the core elements of the original post (the one announcing the troubles-telling) that aligned with their own dealings with the illness. Their messages contained self-references and second stories without any (re)elaboration of the original poster's experience. The second story was usually introduced as a parallel experience that was oriented to prove the responder's understanding of the first story, the troubles-telling, resulting in conversations with different individual voices, each one reporting on its own (similar) circumstances.

Inasmuch as the responses in (5–6) were delivered without problematizing the trouble that was being collectively shared (cf. Arminen 2004), they should be considered instances of claiming, rather than demonstrating understanding. Thereby, the myriad of parallel assessments so often exchanged in both groups (particularly, in the chat room) symbolically represented the stand-alone tales in a collective ED lived experience. Participants in this kind of interaction became both the actors and the audience when enacting their stories, as was the case in the thread with the title "Does anyone else have 'safe clothing"?', posted in the ED forum. The first message is reproduced in (7), and a selection of the 47 responses that were offered to the original post are copied in (8a-g):

(7) *i have specific clothes i always feel safe in but then i have other clothes that i cannot wear bc they make me feel so fat. like i cannot wear sweatpants with an elastic waist band bc it touches me*

(8) a. *i am the same. i only feel 'safe' in elastic waists when they are loose on me even if they fit just fine, my brain perceives it as a sausage casing and it is just the worse.*

b. *yes, exactly! i only wear one brand of leggings consistently and even then, sometimes some batches are just..*

c. *I hate any jeans or slacks with no stretch in the waistband. When I sit and it tugs at my abdomen…..rage fuel. I can't stand it*

d. *i only feel safe in one pair of sweatpants (usually paired with a crop top.) or really tight high waisted shorts with a large hoodie- my safe clothing isn't typical i know :/*

e. *my 'safe' clothing is warm knee high socks and legging under bell bottom jeans*

f. *Yes. I can't wear jeans because I'm afraid of seeing my legs.*

g. *I have a weird flip flop between safe clothes. I either want a lot showing or none at all*

The private ED practice disclosed in (7) opens a response space that has to be fulfilled by other members. The specific emotions described in this troubles-telling sequence (feeling 'safe' with certain clothes, as opposed to feeling 'so fat' with others) constitute a relatable ED episode to which other sufferers can align. The personal tribulations exposed by the emitter of (7) set the stage for the audience to react with emotional empathy. The particular strategy to enact empathy in this case was issuing responses that contained parallel assessments. Responders in (8a-g) shift the focus from the experiential world of the first poster to their own experiential worlds (Kupetz 2014). Telling their side means not only describing recognizable ED habits and behaviours (such as wearing certain kinds of clothes) but also verbalizing those feelings and emotions that are triggered by the illness (e.g., 'I always feel safe', 'I hate', 'rage fuel', 'I'm afraid'). By doing so, that is, by showing shared feelings (emotional involvement), ED members sought to legitimise and normalise their private labours coping with the ailment.

The display of emotional empathy was more prevalent in the ED chat room, due to the particular affordances of the site. Chat rooms are designated virtual channels in which messages are spontaneous and instantly visible and readable, which means that subscribers of the ED channel could have conversations in real time. The messages were, in general, shorter and with a sharp focus on the trouble at hand (chiefly, issues with food intake). Forums, in contrast, are better suited for asynchronic interactions, a feature that allows participants to discuss pressing issues in more depth. This fundamental distinction accounts for the orientation of each of the two platforms explored in this chapter. While subscribers of the ED chat room leaned towards dealing conversationally with the emotional stresses caused by the illness, members of the ED forum were more inclined to manage and to negotiate the workings of recovery in their interactions.

These different orientations translate into distinct ways of talking about EDs with other members, as it has been underscored in the literature (Figueras 2018, 2021; Wolf et al. 2013). Members of the ED chat room seemed to be more self-focused (although they sustained high levels of sympathy and concern for others in similar situations) and gravitated more around their own preoccupations, feelings of distress, and arduous efforts to control eating. Instead, the space of the ED forum was populated by several recovered individuals who actively promoted and advocated for a life without the disorder. As a result of these positionings toward the ED, distinguishable ways of doing empathy can be found in each site, as it is argued in the next section, dedicated to the speech act of advice.

3.2 Empathy and Advice

One of the main features of online mental health communities is the fundamental role that advice solicitation and advice provision play in users' interactions (cf. Figueras 2020, 2021; Kouper 2010; Morrow 2006; Stommel and Lamerichs 2014). It comes as no surprise that advice exchange constitutes one of the main activities in the two support groups explored in the present study. Focusing on the advice-giving act, its realisation involves transferring information, recommendations and a proposed course of action (Kouper 2010). On the one hand, offering advice seems to be based on an asymmetric epistemic relationship, an imbalance in power and expertise between the interactants (Feng and MacGeorge 2006). On the other hand, it might be received as an imposition by the part on the advisor and, as a result, regarded as face threatening, particularly among peers (Kouper 2010; Locher 2006; Locher and Limberg 2012). To make the advice more acceptable to the recipient, advisors in online mental health communities often resort to empathy moves (Figueras 2020, 2021).

Two main types of advice-giving acts, with their corresponding differentiate empathy moves, could be distinguished in each site (the ED chat room and the ED forum): giving tips to deal with the symptoms (ED chat room) and providing elaborate and reasoned advice to overcome the illness (ED forum). Regarding the former, the ED chat room, its more synchronic nature facilitated the exchange of pieces of information to manage specific symptoms of the disorder on the spot, such as what to do right after a binge, how to control the imminent urge of purging, or how to overcome the fear of eating the next meal. Thus, for instance, the poster of (9) asked specifically for advice to manage food portions and responders offered different practical tips (10a-c):

(9) *Advisee: I dont know how to have a small portion of 'bad foods', and once i have too much, i say 'may as well keep going' and purge it. Does anyone have advice?*

(10) a. *Eat a little protein with it your body tells u to stop because it has the nutrition*
b. *Have you tried Almond butter or peanut butter for some fat*
c. *I learned in health class and gym class that it's good to eat slowly. When eating fats your brain doesn't register that you are full because you are eating so fast. So if you eat slowly then you won't end up over eating.*

Since other members of the ED chat room usually experienced similar struggles with the ED, tips were often supplemented with a battery of emotional empathy tactics, such as inserting expressions of alignment and affiliation (11a), making formulations of understanding (11b), acknowledging and validating the advisee's feelings (11c), or extending a common experiential ground (with the first person plural) whereby coping strategies could be shared (11d):

(11) a. *I relate. Hang in there. I'm here to talk if you want.*
b. *I understand that. It's the same with me*
c. *It's easy to get overwhelmed with things. […] And, tbh, I'm not too good at coping when I feel overwhelmed. But, the best advice that I have for you is to remember to take deep breaths. Try to clear your thoughts the best you can and try to think logically.*
d. *We can do this though. I ate because I was in a good mood and it made me spiral into a bad one. But we have to remind ourselves that food is not a bad thing.*

The unifying theme in these ED interactions was the management of the behaviours, thoughts, feelings and social pressures of living with an ED. Interactants publicly admitted to performing a set of eating practices labelled as the clinical symptoms of an ED (whether anorexia, bulimia or otherwise). The fact that all of them self-identified as ED sufferers justified why providers of tips positioned themselves in an epistemic and emotional symmetry in relation to the recipient (the initial poster). One way to honour that symmetry was by claiming their inability to dispense practical advice, as was the case in the messages reproduced in (12):

(12) a. *I'm not sure if I can help but I can definitely relate*
b. *I'm sorry if I don't have any advice atm but I'm always here to listen*
c. *I might not have the best advice but I can listen and try my best to help you*
d. *I will be here for you and others too, I can't give advices too, but i hope I can help just a little*

The utterances in (12a-d) pose a dichotomy between advice, understood in practical terms as help to solve particular ED problems ('try my best to help you', 'I hope I can help'), and listening abilities ('I'm always here to listen'). The posters could do the latter but were doubtful about the former, thus constructing themselves more as passive receptors of the troubles-telling than as active givers of sound advice.

The analysis of the corpus made clear that the main interactional activity in the ED chat room revolved around the allocation of emotional resources to support other members and the exchange of small tips to carry on with the daily life of an ED patient. Conversely, this channel was not a discursive space in which participants imagine and collaboratively construe and negotiate the new realities of recovery, as in the ED forum. Given that the orientation of the interactants was more focused on the day-to-day operations of enduring a full-blown ED, it is not surprising that the exhibitions of empathy in the ED chat room were rather emotional than cognitive. In that particular site, then, the responses were aimed at regulating the emotional content of those messages expressing distress, for the most part, as opposed to fulfilling an agenda of long-term recovery from

the ED. However, when enrolled in the process of recovery, ED members of support groups tend to gravitate towards a more disruptive advising exchange (cf. Figueras 2020, 2021), as they seek to modify the mental and emotional states of the advisee, an endeavour that opens up the venue for cognitive empathy displays.

3.3 Cognitive Empathy Displays

A review of the literature suggests that the construct of cognitive empathy encompasses abilities such as knowing another person's emotional and/or cognitive internal state, figuring how another person is thinking and feeling, and/or envisioning how one would think and feel if she/he was in the target's situation (Batson 2011). This exercise of imagining what the mental and emotional contents of the other person's mind are draws on her/his words and her/his actions, as well as the empathizer's knowledge of the target's character, values, and desires.

Conceptualizing the mental states of others has been considered a particular form of perspective taking. Likewise, the capacity to adopt the perspective of the other represents the key component of empathy (Decety 2005). It has been characterised as an 'imagine-self' perspective (imagining how one would personally feel about a situation), as well as an 'imagine other' perspective (imagining what the target of a story might be feeling or experiencing; Batson 2011). To adopt an imagine-self perspective is in some respects similar to the act of projecting oneself into another's situation, which is essentially what an elaborate act of advice giving is (Figueras 2020, 2021). The following posts, taken from the ED forum, are instances of this kind of discursive operation:

(13) *If you didn't specifically tell them that it's your safe food then how would they know? If they tend to forget, I would create a fridge shelf that is only for you and write your name in a sticky note there or something.*

(14) *I wouldn't give up my dream of having children because of your ED*

In both excerpts, the responder delivers her/his advice by impersonating an imagined 'I' that locates her/him in the very centre of the advisee's trouble. By discursively simulating that they can put themselves in the other person's shoes ('I would/wouldn't…'), the posters in (13) and (14) are able to create an impression of empathic understanding that makes the recommendation more suited and tailored to the advisee's needs and expectations.

Rendering advice aimed at changing the advisee's thoughts, feelings and attitudes, as is the case in the ED forum, requires, on the part of the advisor, to come up with a model of the other person's mental and emotional states. She/

he faces two challenging tasks when strategizing her/his advice: a) imagining the advisee's state of mind; and b) making a mental simulation of the model that the advisee is building of the advisor (Martinovski et al. 2004). Both tasks triggered mindreading (theory of mind) processes: the advisor has to be able to represent the mental states of others in terms of intentions, desires and beliefs, as well as to understand and predict others' behaviours (Abu-Akel and Shamay-Tsoory 2013).

In order to persuade the advisee to make significant changes in her/his attitudes and behaviour towards the ED, advisors in the ED forum often resorted to empathy displays that prepared the speech act of advice provision, as the message in (15), posted on the ED chat room, exemplifies:

(15) *Hello @X I am sorry to hear you are struggling so much, just remember that your struggles are valid. It is truly devastating when our eds start affecting aspects of our lives like health, studies and family, but they eventually will, and if they go on too long, they are not going to affect them in a good way.*
Although I do not mainly struggle with restriction, I can advise you to take care of yourself in non-ed related ways, make it a point to give yourself the care and love you oh so crave, then it gets easier to let go of ed, even if it is just a part of it, because the truth is that sometimes we simply need tools to keep our lives afloat, because when we get out of this dark web, it would be nice to have something to get back to. Think about the 80-year old you, what would you want them to remember? what would they tell you to do?
I think it is important to know what your ed replaces, and give it to yourself, love? safety? care? attention? and do it for you!

The response in (15) combines both emotional and cognitive empathy displays. The advisor opens her/his post by replying directly to the advisee's (using the tag @X). With this manoeuvre, she/he frames her/his message as a personal response to the specific query posed by the advisee. Next, she/he inserts an expression of care and concern that prefaces a validating move to acknowledge the legitimacy of the target's struggles ('just remember that your struggles are valid'). Then, she/he claims understanding of the destructive effects of an ED on the person's life by performing an evaluative assertion ('It is truly devastating') and by resorting to the first-person plural to emphasise the reality of the common experience ('our lives'). This battery of strategies instantiates emotional empathy displays that prepare the advice-giving act which is realised in the second paragraph: 'I can advise you…'

Giving advice requires knowledge of the other person's reality. Although the advisor in (15) is well versed on the emotional toll of the ED, based on her/his own personal history, she/he needs to make a disclaimer implying that she/

he might be lacking the experiential knowledge to advise someone struggling with restriction. In spite of her/his insufficient expertise in a specific domain of the ED experience, she/he asserts her/his epistemic rights as an ED patient with the recourse to vivid metaphors to refer to the illness ('this dark web') and the use of the first-person plural to create an emotionally congruent stance with the advisee ('we simply need tools', 'when we get out'; Figueras 2021).

In addition, with the use of the imperative form 'think', the advisor induces the recipient to perform some mental tasks. First, she/he poses a hypothetical question ('Think about the 80-year old you, what would you want them to remember?'), in order to transport the recipient to an imagined future self ('the 80-year old you') who would be judged by others for her/his past self. This exercise of simulating or pretending works in conjunction with another inquiry about the advisee's insight into the symbolic meaning that the ED plays for her/him ('what would they tell you to do?'). In reality, these queries materialise the advisor's claims of knowing the mental state of any ED experiencer, which is why they can work as the preamble to the advice-giving act performed at the end of the post ('do it for you'). All the linguistic devices deployed in (15) constitute the discursive tools to produce cognitive empathy, inasmuch as they bring together the self-perspective and the other-perspective. As Decety (2005: 144) contends, "empathic understanding requires the inclusion of other characteristics within the self". It is, precisely, the process of perspective taking which creates an explicit representation of the other person.

Perspective taking is a major component of mindreading. It represents the complex socio-cognitive process by which speakers are capable of recognizing others' point of view, whether it be the same or different from their own (Healey and Grossman 2019: 59). Consistent with this view, empathy should be considered a representational capacity, a motivated behaviour that can be triggered voluntarily (Decety 2005: 153).

Empathy should not be reduced to a simple resonance of affect between empathizer and target, but rather understood as a complex ability to make second-order representations of the other which are available to consciousness (Decety 2005: 153). When analysing the interactions in the ED chat room, a recurrent response offered by other members to the troubles-telling or advice seeking post was rendering an account based on self-perspective (as in (10a-10g)). Self-perspective facilitated emotion sharing (emotional empathy, to be more precise), but it was not enough for empathic understanding.

In addition to shared emotion and self-awareness, demonstrating understanding requires consciously adopting the perspective of the other. Affective resonance triggers automatic empathic consideration for the target's

emotional state, while perspective taking induces empathic understanding. Empathic understanding entails incorporation of known information about the target in order to imagine her/his emotional and/or mental state (Grondin et al. 2019). The object of understanding may be the other's thoughts, feelings, desires, beliefs, situation, perspective, or experiences (Håkansson and Montgomery 2003), as is the case for many of the interactions in the ED forum.

Reasoning, imagining, simulating, predicting, or inferring another person's experience are central to the empathy process (Meneses and Larkin 2017). This combination of tasks reveals what the advisor is doing with her/his talk in the troubles-telling sequences produced in the ED forum. Since cognitive empathy involves the effort of comprehending the internal world of the other person, the question, from a discursive standpoint, is how the interactants whose intention is to impact and modify the recipient's cognitive and emotional environment, support their conversational activity with cognitive empathy moves. Since careful advice calls for cognitive empathy (Figueras 2021), the issue at hand is to determine the specific strategies that demonstrate understanding when providing advice in an ED support group. For limitations of space, I will focus on only two strategies to demonstrate empathic understanding: echoic formulations and resolutive second stories.

I call 'echoic formulations' those discursive moves oriented to surmise the thoughts and feelings of the recipient. Echoic formulations contain explicit enunciations of the imagined mental representations held by the recipient. Advisors attribute those mental representations to the advisee making ostensively clear, at the same time, that they distance themselves from those beliefs. Initially, the advisor seems to take the advisee's epistemic and evaluative stance, but then she/he makes a move to disaffiliate herself/himself from this perspective and to offer an alternative positioning. An example of this kind of discursive operation can be found in (16):

(16) *Part of the instinctual habit you're describing is the learnt association between ['keep my calories low ---> lose/maintain weight']* THOUGHT ATTRIBUTED TO THE ADVISEE. *In order to break this, you must recognise that this not a perfect association. ['It's all well and good *telling* myself that',]* THOUGHT ATTRIBUTED TO THE ADVISEE *you'll say, and [I get it]* CLAIM OF UNDERSTANDING. *You need to make it experiential in order for it to factor into your habit-making. What would be ideal is if you could force yourself to have a few days 'off' where you eat whatever you want within reason and see for yourself that you wont gain weight. However, [THAT'S EASIER SAID THAN DONE FOR SOMEONE WITH AN ED.]* DEMONSTRATING UNDERSTANDING

*[People who struggle with problems like yours often employ Cognitive Behavioural Therapy. Is this an option for you?]*ADVICE-GIVING ACT

The kind of mental representations that are being echoed in (16) are not all of the advisee's thoughts, but only those that belong to the category of 'ED thoughts'. These particular mental representations are beliefs that are discursively construed as 'wrong' (as is in 16) or 'false' by the ED members themselves. This privileged access to the advisee's ED thoughts comes from the experiential rights claimed by those members in recovery. The fact that the recovering person has lived through analogous situations, and that she/he is now trying to prevail over the ED, legitimises her/his claim to epistemic superiority over the recipient.

The empathic strategy put forward by the advisor in (16) consists of attributing a set of particular assumptions to the advisee but ostensibly indicating that they are part of a more general mindset of distorted beliefs shared by any ED sufferer (including the advisor's past self with the illness). With this tactic, the advisor achieves two goals: a) she/he grants validity for her/his interpretation of what the mental state of a recovering person is; b) she/he demonstrates understanding (she/he does cognitive empathy). Invested with the authority of someone with real insight into the phases of illness and recovery, the advisor is able to produce deontic statements ('you need to') that pose the advisee the challenge of cognitive restructuring, that is, the reorganisation of automatic thoughts and the reorientation of emotional stimuli (Vartanian et al. 2004). This exercise of demonstrating understanding with an elaborate cognitive empathy display paves the way for the indirect advice delivered at the end of the post: 'Is [Cognitive Behavioural Therapy] and option for you?'.

Cognitive empathy seems to be part of the act of advice provision in contexts in which, as the ED forum, there is the need to encourage others to challenge implicit cognitions and to modify maladaptive schemas. The goal sought with the response in (16), as in many other exchanges in the forum, is to change those automatic associations (such as 'keeping calories low' and 'maintaining weight', for instance) that influence feelings and behaviour.[3] From this stance, cognitive empathy in the ED forum invokes an epistemic asymmetry between the empathizer and the target. The grounds for these contrasting epistemic statuses are the differences of knowledge regarding the phases of illness and recovery. These asymmetric experiential rights between the interactants also plays a role in the construction of resolutive second stories.

3 This kind of rationale was probably borrowed from the cognitive-behavioural therapy that many recovering ED patients likely underwent during the time they participated in online support groups.

With resolutive second stories, the responder mirrors the experience of the illness reported by the first poster and makes it the foundation to describe an alternative reality. In the ED forum, this other state of affairs is the conceptual domain of recovery. In a similar fashion as echoic formulations, these second accounts of the ED serve the purpose of overcoming the recipient's resistance to get treatment. One example of this kind of narrative is illustrated in (17):

(17) *I've been there- I went from basically starving myself, to becoming paleo to allow myself to eat, to adding in fear foods (rice, sugar) while calorie counting. It's a prison. You're not going to forget your calorie counting overnight. I frequently redownloaded and deleted my fitness pal for months after saying I wanted to stop counting calories. This isn't a matter of willpower — that's part of what makes eating disorders so horrible — they're MEAN. They tell you something's wrong with you and make you feel bad about yourself. Your BMI, fat percentage, etc, don't matter. Your fear of gaining weight and the coping mechanisms you use to deal with that fear are what matter. The eating disorder is mental. It's hard to navigate all this without a therapist. Before I sought help, I would try to recover, but my thoughts were so disordered that I constantly relapsed. [So number one- get professional help from someone who specializes in this; you don't have to recover alone.]*ADVICE-GIVING ACT
Your therapist will be able to help you break down your fears and learn techniques that will help you cope. When you start spiralling and thinking negative thoughts, it helps me to think of them as something a bully is saying to someone else. Like, it's so easy to tell yourself, 'you're disgusting,' and think it's just a truth. But what if you heard someone say that to your friend?

The linking of the advisor's experience to the troubles-telling is crucial to offer mutual support when the advisee is undergoing the difficult process of recovery. By reflecting on the concerns expressed in the first message, empathic responders project a strong alignment with the recipient. Likewise, in tying-up their responses to the initial poster's message (in (17) with expressions such as 'I've been there'), the ordeal of the mental condition (metaphorically described in (17) as 'a prison') is recounted in a thoughtful, knowledgeable, and transformative way (see Arminen 2004). The value of second stories that narrate the transition from the illness state to the successive stages of recovery is that the tale reframes the thoughts, feelings and behaviours characteristic of the ED. As a result, in second stories like (17) the ED reaches, at least symbolically, a resolution.

The empathic component of a response of this kind lies in demonstrating an understanding of the pains caused by the disorder, owning them, and taking the ordeal of the illness as a starting point to rewrite the recipient's story. Both the advisee's and the advisor's ED experiences are blended together by resorting to mechanisms such as the second person singular with generalised reference: 'They

tell you something's wrong with you and make you feel bad about yourself. Your BMI, fat percentage, etc, don't matter. Your fear of gaining weight and the coping mechanisms you use to deal with that fear are what matter'. With this empathy device, deployed to demonstrate understanding, the experience is construed as reciprocally shareable (see Figueras, 2021). The responder exhibits thus deep knowledge of the cognitive and emotional mechanisms developed during the course of the ED, and of the coping strategies that have to be devised and learned in the process of recovery.

Following the advisor's account, the turning point to break the cycle of the ED ('I constantly relapsed') was to find a therapist. Consequently, she/he urges the advisee to 'get professional help'. The acceptance of treatment introduces a new perspective (the recovery mindset), described in the second paragraph of this post, from which emotions and thoughts are questioned, contradicted and reorganised. As illustrated in (17), second stories advocating for recovery may afford the recipient with figurative, symbolic interpretations (such as 'something a bully is saying to someone else') that transvaluate the adaptative meanings that the ED has acquired for the recipient.

4 Conclusions

The present study explored some of the linguistic resources to do empathy in two different online mental health communities: an ED chat room and an ED forum. The analysis of responses to troubles-telling in both sites shed light onto the distinct nature of the empathy displays produced by members of each community. In the chat room, the predominant way of enacting empathy was through displays of shared emotions. In that context, empathy could be read as a type of emotional capital that interactants built and relied on when navigating difficult interactions aimed at releasing the tensions of living with an ED. Primal responses, formulations of understanding, and parallel assessments were three common strategies deployed by responders to claim understanding of the troubles voiced by the first poster (Sacks 1992). The three empathy displays represented the discursive realisation of emotional empathy, understood as the capacity to share the emotional experience felt by others or, more specifically, the ability of appropriating the emotions sustained by the other person. These affective reactions when acknowledging and replying to troubled members created a shared network of mutually recognizable feelings, behaviours and beliefs characteristic of ED rituals and practices.

Emotional empathy is critically different from cognitive empathy. In many cases, the former implies appropriating the other person's feelings (on a gross

level); the latter, instead, refers to the capacity to engage in the cognitive process of adopting another individual's psychological perspective (Dvash and Shamay-Tsoory 2014). Cognitive empathy involves the intellectual recognition of the other person's mental and emotional states. Discursively, it projects onto perspective taking moves, by which the empathizer echoes the other person's mental representations. This is the kind of exercise found in the ED forum through two main discursive strategies: echoic formulations and resolutive second stories. Both empathy displays were realised in the ED forum when delivering advice. Taking into account this specific speech act, a distinction was made in the present study between the interactive tasks of providing tips to manage the symptomatology of the ED *vs* rendering thoughtful advice to overcome the illness and initiate the process of recovery. Exchanging tips was a conversational routine for the members of the ED chat room. It did not require the drawing of elaborate hypotheses about the contents in the recipient's mind, as opposed to the kind of discursive operations that were essential in the ED forum to guide and persuade advisees to modify their ED thoughts and feelings. In this case, advisors had to demonstrate understanding of both the illness and the recovery positionings.

The contrast between the empathy displays (emotional *vs* cognitive) performed in each of these two sites revealed a substantial difference when communicating empathy between self-perspective and other-perspective. The orientation to the self that is the basis of emotional empathy displays seemed to be characteristic of participants who were still deep into the illness experience. The orientation to the other, alternatively, came from a different positioning of the empathizer toward the illness: from the position of self-focus to the position of other-focus of one who has access to the experiences of illness and recovery (Popham 2017).[4] As a result, members of these communities could construe distinguishable levels of empathy in their online communications. Therefore, empathy should be conceived in terms of different levels of understanding that are projected into distinctive discursive operations and moves.

In this regard, and as Kupetz (2014: 28) suggests, displays of empathy can be organised in an apprehension-comprehension continuum. In our data, one end

4 These results could be related to the differences between the cognitive abilities of ED patients compared to non-ED individuals. According to Kerr-Gaffney et al. (2019), the review of the literature indicates that those with anorexia nervosa have lower cognitive empathy abilities. That might explain the self-focus style of the messages in the ED chat room.

is represented entirely by emotional empathy displays (primal responses) and the opposite end by full displays of cognitive comprehension (echoic formulations, resolutive stories). In between these two extremes, there will be more nuanced instances of empathy to be defined and (re)negotiated for each communicative setting. Understanding these differences in the expression of empathy in online mental health communities is essential to better patient 'quality-of-life' in clinical treatments for EDs.

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AQ: Note that no closing single quote for the opening single quote has been provided in the phrase "'Second stories: the salience". Please check and amend necessary.

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