Monitoring and normalising a lack of appetite and weight loss: a discursive analysis of an online support group for bariatric surgery

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Abstract

A significant adjustment in eating practices is required before and after bariatric surgery, yet we know relatively little about how patients manage these changes. In this paper, we explored how members of an online bariatric support group constructed their appetite and weight loss. 284 online posts were collected, covering a period of just over a year, and analysed using discursive psychology. We found that a lack of appetite post-surgery was oriented to as something that was positively evaluated yet a cause for concern. Indeed, members monitored their food intake and marked out food consumption as a necessary activity in line with notions of healthy eating. Through monitoring members also normalised periods of weight stabilisation and were inducted into a group philosophy which encouraged a more holistic approach to post-surgery ‘success’. Our analysis also highlights how monitoring and policing work as social support mechanisms which help to maintain weight management. Thus we argue, in line with others, that weight management, typically depicted as an individual responsibility, is bound up with the social practices of the online support group. We suggest that clinical advice about a loss of appetite and periods of weight stabilisation post-surgery perhaps need further explanation to patients.

Keywords

Online support group; monitoring appetite and weight; bariatric surgery; discourse
Introduction

According to the World Health Organisation (WHO, 2006), approximately 2.5 million deaths worldwide are attributed to obesity per year. Obesity has been labeled as a substantive public health issue and has led to the medicalisation of obesity (Batsis, Clark, Grothe, Lopez-Jimenez, Collazo-Clavell, Somers & Sarr, 2009). When lifestyle, educational, psychological and pharmaceutical interventions fail, bariatric surgery (a term used to describe the various methods used in weight loss surgery) may be recommended as a ‘last choice’ option (Glinski, Wetzler & Goodman, 2001). All methods of surgery work by restricting the volume of food intake (Ogden, 2003). Bariatric surgery is increasingly regarded as an approved treatment for obesity (Buchwald, Avidor, Braunald, Jensen, Pories, Fairbach, & Schoells, 2004; National Institute of Health, 2000). In the UK the National Health Service (NHS) approves bariatric surgery when all previous interventions have failed, employing similar criteria to the U.S. Studies into the effectiveness of weight loss surgery have shown promising results in terms of initial weight loss, further maintenance of weight loss and associated health benefits (Peluso and Vanek, 2007; Torgerson & Sjostrom, 2001).

Surgery requires substantial adjustment in eating practices both before and after surgery. Throsby (2008) noted that the process post-surgery patients go through parallels the process that infants go through when weaning. After surgery the patient initially starts with a liquid diet, but when a solids food diet begins they must chew their food well and slow down the eating process to avoid vomiting or discomfort (Elliot, 2003). Furthermore, patients typically experience an initial rapid weight loss followed by a slower weight loss period (McMahon, Sarr, Clark, Gall, Knoetgen,
Service, Laskowski & Hurley, 2006). Patients often experience early satiety (meaning that they feel full earlier than they would have prior to surgery), and a loss of appetite. Findings from long-term studies of post-bariatric surgery patients suggest that a substantial loss of weight is linked to a greater eating self-efficacy, which appears to weaken over time (Batsis et al, 2009). As such, it is important to consider the behavioural changes in eating practices and provide ongoing psychosocial care (Batsis et al., 2009). Long-term success requires the patient to monitor and sustain nutritional changes and physical activity (McMahon et al. 2006), yet little is known about how patients cope with psychological changes associated with having had bariatric surgery (Batsis et al., 2009).

As the demand for bariatric surgery is growing so too is the prevalence of online support groups, offering people the opportunity to share experiences and to seek advice and support. Whilst Throsby (2008) drew upon online discussion forums as a backdrop for information in her study, there has been no systematic study- that we know of, that analyses online forums for weight loss surgery. Yet, this environment is one of the best places to study how people make sense of, support, or challenge understandings of appropriate eating practices associated with bariatric surgery. Discursive psychology has developed a systematic approach to focus on such practices: it considers the ways that descriptions are put together and the actions they are involved in (Hepburn & Wiggins, 2007). For example, previous discursive research has usefully outlined how people on an Internet forum for veganism allocate blame for failure towards individual practices rather than the nature of a vegan diet (Sneijder & te Molder, 2004). Similarly, Veen, te Molder, Gremmen and van
Woerkum (2010) considered how celiac disease patients managed occasional diet lapses without ‘quitting’ the diet.

Since our focus is on diet, discursive studies on weight loss in other environments are also relevant. Debates involving weight management typically depict the individual as responsible for behaving in appropriate ways. However, discursive and conversation analytic studies focusing on weight loss, diets and exercise (Mycroft, 2008, Webb, 2009, Wiggins, 2009) have been useful in identifying how issues of morality and accountability are collectively produced and bound up with social practices. For example, both group leaders and members of a commercial weight loss management group perpetuated moral discourses about ‘good’ and ‘bad’ food rather than focusing on healthy eating (Mycroft, 2008). The normative practice of attributing moral accountability for weight loss can be seen in the ways that patients manage blame in both NHS weight management treatment services (Wiggins, 2009) and obesity clinics (Webb, 2009). Wiggins (2009) demonstrated how patients resisted responsibility for weight gain by denying the blameworthy activity or locating the blame outside their individual control. Similarly, Webb (2009) found that patients emphasized their own agency by documenting their exercise and improved health when achieving success but minimized their agency with mitigating factors, such as difficulty in exercising or reactions to drugs, when they gained weight.

The aim in this study was to examine posts from an Internet support group for bariatric surgery in order to examine how patients themselves constructed their appetite, diet and weight loss. Through a focus on members’ orientations, we also considered the kind of support mechanisms used to regulate eating practices that
emerge within this community. In particular we consider how members performed practices glossed as ‘monitoring’ and ‘policing’ appetite and weight loss. To do this we drew upon Stommel and Koole’s (2010) argument that online forums are not static communities; rather, they are a product of practice whereby membership norms are constructed, negotiated, and as we argue, regulated. We also drew upon research about the way that non-professional peers offered advice in an Internet forum for depression (Morrow, 2006). Providing advice created an asymmetry in relationship between the giver and receiver which peers seek to avoid (Morrow, 2006). Therefore, members tended to construct ‘advice messages’ in ways that both limited the threat to the self-image of those on the receiving end of their advice whilst simultaneously attending to their own legitimacy in being able to offer the advice. Similarly, Vayreda and Antaki (2010) found that unsolicited advice functioned at an ideological level to induct new members to the group stance.

**Methods**

*The data*

A total of 284 wall posts from a weight loss surgery online support group discussion wall on a social networking site were examined. All posts submitted to the site between 30th June 2008 and 13th July 2009 formed the data set. The online networking site under study was set up in the United States and had no official moderator. The characteristics of the participants are impossible to determine completely due to the difficulty of verifying the authenticity of online identities. However, based on the members’ descriptions of their location, the majority were indeed based in the United States, with a number of contributions from members living in other countries. Whilst there may be variation in locations, the discourse of the members seemed to be similar
in most aspects apart from a noticeable difference with regards to the way that US members discussed choice of medical services (which is not part of our focus). The purpose of the discussion wall, as described by the group’s opening page, was to provide limited “information for those who may be interested in having this procedure, or already have had the surgery. Stories of what you’re going through, have gone through, and pictures of your transformation. Questions and answers about Gastric Bypass in general. Support for those who have had or are thinking of having this procedure done.”

All messages on the site were displayed in order according to the time and date they were posted. Whilst it was possible to determine threads of interactions, whether or not posts and their responses were placed consecutively was dependant on the time that each ‘reply’ was written, meaning that at times responses were interspersed with posts unrelated to a first post of a thread. The lengths of the messages ranged from one line per message to around seventeen lines, although most messages were around six or seven lines in length. All data extracts show the text with the original grammar and spelling.

The online support group was open to the public but it was not our intention to draw attention to specific individuals or the specific forum. Therefore, all participant names were replaced with pseudonyms, and place names were deleted. In addition, the online forum has been kept anonymous. Furthermore, we checked the traceability of participant quotes through a number of search engines and were unable to find the source material, thus anonymity was deemed to be suitably protected. Our study was approved by the relevant university ethics committee.
The data were analysed using discursive psychology (Edwards & Potter, 1992), where discourse is viewed as the central medium for action. Our focus is on the way that appetite and weight loss were constructed and the practices of social support employed by participants. For a more detailed description of the method of analysis, please see the appendix.

Results

Our first two analytic sections focus on how members oriented to two concerns that are routinely made relevant whilst discussing post-surgery diets: a lack of appetite and periods of weight stabilisation. Within these two sections we examined how members employ self-regulating and other regulating practices glossed as ‘monitoring’, and how members sought advice about their own eating practices and related behaviour, and co-constructed periods of stability. In the final analytic section we move on to consider the less successful strategy of offering unsolicited advice, or ‘policing’, particular interactions in an attempt to induct members into the group philosophy.

Monitoring and advice-seeking about a lack of appetite and appropriate food intake

Members’ initial posts occurred after varying time periods post-surgery. What was common though is how the posts made relevant a lack of appetite and a concern about appropriate eating practices. Members often marked out a lack of appetite as something new to them, as in the extract below.

Extract 1: post 6, Arietta

1. Hey everyone! I just wanted to let you all know and to share
2. with you the exciting news that I have lost 251bs since my
3. surgery 9 days ago. I just got my staples out and I’m doing
4. very well. I am mush foods now and loving it. I love never
5. being hungry or having cravings. I eat because I have to and
6. thats it. Anways, thanks for all the support so far.

The way that Arietta formulated her progress as “exciting” and “doing very well”
attends to this as an achievement. Arietta made appetite relevant with the construction
of the extreme case formulation (Pomerantz, 1986) “I love never being hungry or
having cravings”. Pomerantz (1986) argued that extreme case formulations (ECFs)
justify a description or assessment. Edwards (2000) further argued that ECFs work as
devices that display a stance towards some state of affairs. Arietta’s stance here was
thus worked up as positive and hence this built up her identity as a successful surgery
patient. As Edwards (2000) argued, ECFs work up “nonliteral” formulations which
are not accountably accurate descriptions. The use of the ECF marks this construction
out as newsworthy and, possibly, distinct from her pre-surgery appetite. The
following idiomatic expression of “I eat because I have to and thats it” gives more
analytic purchase to this point as it bluntly documents food consumption as a
necessary activity for survival rather than, say, an overriding desire to eat, which
could arguably be a moral concern for those who are overweight. The employment of
an idiomatic expression to conclude the action makes it difficult to challenge (Holt &
Drew, 1988). Arietta’s post worked up her identity as a responsible person through
monitoring her lack of appetite appropriately.
Other members oriented to a lack of appetite post-surgery and monitored concerns over appropriate food consumption. The following two extracts, part of a sequence, further document this practice.

**Extract 2: post 16, Jenny**

1. Hey!!! I just had surgery on the 8th!!!! I am SO Sore!!!!!!!!!!
2. But I am excited!!!!!! And I am never hungry!!! Should I eat
3. just to eat, or don’t worry about it?!?!?

**Extract 3: post 17, Liz**

1. Hey Jenny congrats!! YES you have to eat!!! I know it’s a fight I am having
2. aswell, but what the doctors told me was even if I just take a couple of bits of
3. my protein food, but NEVER miss a meal completely..

Jenny (extract 2) produced a similar ECF to Arietta of never being hungry. However, instead of the self-regulating account produced by Arietta, Jenny categorised herself as a novice or help seeker with her request for advice about whether she should eat or not be concerned about her lack of appetite. Her formulation of “Should I just eat to eat” echoes Arietta’s production of food consumption as a requirement.

Liz’s response (extract 3) initially congratulated Jenny but then attended to Jenny’s question. The advice offered is an imperative and marked out in capital letters (line 1) which works to stress the message that Jenny has to eat. Morrow (2006) also noted this stylistic feature of using capitals for emphasis. Liz produced an empathetic response which acknowledges the “fight” (line 1) whilst simultaneously referencing a
similar experience. Studies of empathy and sympathy (Pudlinski 2005; Staske, 1998) have considered how the employment of such ‘me too’ responses (Staske, 1998:71) normalise problematic feelings and attend to these experiences as reasonable and expectable. Liz aligned herself with the construction of never feeling hungry but provided some advice, effectively categorising this as one of the struggles post-surgery. Furthermore, Veen et al. (2010) found that second stories (cf. Sacks, 1992) normalise group views and can be used to correct deviant cases. Second stories are designed to align with a previous initial story and function to display an understanding and stance towards the initial story (Arminien, 2000). Liz’s response thus worked up the ‘correct’ strategy of having to eat. However, in addition to this, Liz invoked her doctor’s advice to “NEVER miss a meal completely”. Drawing upon the ECF (Pomerantz, 1986) of “NEVER”, and this appeal to professional advice, bolsters the importance and factuality of her advice (Potter, 1996). Morrow (2006) argued that advice givers need to present themselves as credible advisors. In the Internet forum that he analysed, Morrow found that nearly all the advice givers established their competence by discussing their own experiences before offering advice. He argued that this also demonstrated solidarity within the group. The minimised (Pomerantz, 1986) “even if I just take a couple of bits of my protein food” highlighted the importance of maintaining some food intake. The reference to an approved food group also works up the description as clinical and a pragmatic response to her own lack of appetite. Liz’s construction thus also offered a strategy of what type of food is useful in such situations. The minimisation also possibly works to demonstrate that whilst one must eat, the amount and food group is in accordance with a restricted diet.
Our final thread illustrates further this pattern of monitoring.

Extract 4: post 124, Delores
1. hi my name is Delores…I had my gb on (date) and in less than 9 months now
2. lost 172 lbs and still going. People ask me when I’m going to stop and my
3. answer is I don’t know, I feel like I have no control over it anymore. Glad to
4. be smaller but dealing with low blood sugar issues and somedays I feel like
5. I’m becoming anorexic. Anyone else feel this way?

Extract 5: post 127, Sally
1. Hi Delores I had my bypass ion the same day as you & I think what is
2. happening to you is exactly the same as Me, I have no appetite at all & I have
3. to force myself to eat & I can only eat dried biscuits, I have nausea constantly,
4. the food I have tried to eat gives Me tummy ache & that is even fater [after]
5. chewing it to a pulp, I hope things settle down as I know it is not good to not
6. eat at all, I can go 5 days without eating a thing, let me know how you get on
7. & keep taking the vitamins and calcium good luck

Whilst Delores did not mention a lack of appetite per se, she did infer a decreased appetite through the detailing of her weight loss. The inclusion of the indirectly reported speech of “people” asking her when she is going to stop also marked out this construction as potentially troubling to others. Delores cited a lack of control over weight loss, low blood sugar, and at times a feeling of becoming anorexic (lines 3-5). Note how ‘becoming anorexic’ lacks an account of agency, hearable as not choosing to withhold food. However, if we consider the concept of next-turn-proof procedure
(Hutchby & Woffitt, 1998), Sally’s response demonstrates that she treated (rightly or wrongly) Delores’ concerns as including a lack of appetite. Sally’s employment of a ‘me too’ response also incorporates complaints of nausea, tummy ache, and an ability to not eat for five days. Sally’s response invoked the notion that “it is not good to not eat at all” in a similar way to Arietta (extract 1) and Liz (extract 3). Thus whilst in some ways Sally’s construction of five days without eating could be heard as newsworthy, she nonetheless oriented to this as a problem that she hoped would “settle down”.

“It’s just a blip”: monitoring problems with weight loss

After the ‘honeymoon’ weight loss period post-surgery, members routinely oriented to a period when their weight loss either stopped or slowed down. It is not surprising that issues of accomplishment and accountability are key concerns when monitoring weight loss (see also Mycroft, 2008; Webb, 2009; Wiggins, 2009), but perhaps this is especially true in the context of bariatric surgery, it being a potential ‘last chance’ option.

Extract 6: post 202, Joy

1. Hi all, I had my gastric bypass 6 weeks ago and so far lost 3 stone, did anyone
2. have where they didn’t lose for a couple of weeks coz ive just stopped or is it
3. just a blip, x x

Extract 7: post 203, Mark

1. Joy, it’s just a blip. You’ve lost 42 1lbs (if I did my math correctly) in
2. 6 weeks! That’s fantastic. Your body will make adjustments on the way down,
3. and you’ll see the scale stop temporarily. It happened to me several times, and
4. happens to a lot of people. It’s just temporary. You should keep track of your
5. body measurements. Often, when the scale doesn’t move, you will still lose
6. size. This is especially true if you are exercising and building muscle mass.
7. Congrats and good luck!

Joy (extract 6 above) sought advice about a period where she stopped losing weight and sought confirmation and advice as to whether this was “just a blip”. Mark’s response (extract 7) supported her construction by recycling her formulation of this as “just a blip”. The use of “just” in both these posts is pertinent as it minimises (Pomerantz, 1986) the issue, downplaying the problem. Mark’s response did not simply offer the required advice; he also provided support in the form of acknowledging the achievement she has already made with regards to weight loss (lines 1-2). What follows is a normalisation of the ‘temporary’ period of weight stabilisation. As in extracts 3 and 5, a ‘me too’ response (Staske, 1998:71) is employed to build up the credibility of his stance on this issue and to demonstrate that he is knowledgeable about the topic. Mark’s ‘me too’ response incorporated the ECF (Pomerantz, 1986) of “it happened to me several times”. Furthermore, he constructed this as happening to “a lot of people” (line 4). The action here then is of reassurance that what is happening is normal.

Mark also produced some advice and offered a different focus for Joy to consider (lines 4-6), urging Joy to keep track of her body measurements. Here then, weight loss is constructed as only part of the equation in a post-surgery body – size too is made relevant. His advice oriented to broader notions about changing body shapes, echoing
the clinical management advice typically provided post-surgery (McMahon et al. 2006). The use of “often” (line 5) normalised a decrease in size even when weight loss was not evident. Thus, he neatly switched the focus away from a preoccupation with weight loss towards a more holistic version of success. This is further established by the introduction of exercise and muscle mass.

The reassurance that ‘slow periods’ are normal was also attended to in the posts that form a sequence, below.

**Extract 8: post 73, Sally**

1. Hi, went to see surgeon on thursday & when He weighrhd Me
2. I had lost only 6 lbs in 2 weeks, did anybody else have a time
3. when they lost only a little, I had op on (date) & until now
4. the weight has been dropping off & I have not been eating
5. anything I should not & I am not eating anymore!!!!! What is
6. going on I have been very upset & worried, but the Doc said
7. it is normal

**Extract 9: post 77, Mandy**

1. Sally, don’t worry you will have many times that you hit a
2. plateau but u will get past it…it is normal and we have all
3. had them at the same time u r probably losing inches … i
4. was like u and sooooo upset but now I know I am just one of
5. the slower losers but I still do lose and that is the main thing…..
In extract 8 Sally constructed herself as seeking help in relation to what she presented as a problem of “only 61bs in 2 weeks”. Sally’s addition of “& I have not been eating anything I should not” attends to issues of accountability, warding off any criticism that it was her fault that her weight loss has slowed down (Potter, 1996; Webb, 2009, Wiggins, 2009). The intake of food is often a matter of public surveillance when a person is overweight (Mycroft, 2008; Webb, 2009, Wiggins, 2009), but a gastric bypass surgery support group member presumably has more at stake. By warding off any claims that her weight loss could be attributed to her eating practices, Sally’s identity as a responsible member of the support group is validated. Sally’s documentation of seeking advice from her doctor also worked to further support her ‘responsible persona’. However, even with her doctor’s reassurance, she still constructed herself with the ECF (Pomerantz, 1986) of being “very upset & worried”. Mandy’s response (extract 9), worked up a reassurance of the normality of this weight loss pattern by stating that “you will have many times that you hit a plateau but u will get past it”. Mandy also employed an ECF of all members experiencing this. Furthermore, Mandy reassured Sally in a similar way to Mark (extract 6) by invoking the notion of losing inches. In lines 3 to 4 we see here another ‘me too’ response (Staske, 1998:71), which validated Sally’s fears, provided support, and worked up Mandy’s competence to offer advice. Mandy also attended to issues of accountability of her own slow weight loss by constructing herself as “one of the slow losers”. However, Mandy’s take-home point was that she was still losing weight and with the idiomatic expression “that is the main thing” she neatly attended to a decreased weight loss period in a positive way which reinforced the continuation of the dieting process.
**Policing other’s weight loss and eating practices**

In the above two sections the monitoring of another member’s lack of appetite and weight loss was either self-induced or as a response to solicited advice-seeking. In this section we considered unsolicited advice glossed as ‘policing’ others’ interactions about weight loss and eating practices. However, initially we considered one thread where members responded to a plea for “powerful support”, and an invitation for admonishment, which could be categorised as a solicited request for policing of particular behaviours.

**Extract 10: post 18, Natalie**

1. 4 years out, tummie tuck and flanks tucked……now alcoholic and gaining
2. weight. I’m looking for powerful support. Day one no alcohol, but eating
3. CRAP! Someone kick me

**Extract 11: post 19, Jenny**

1. *kicking Nicola HARD* You don’t need booze or the junk, come on you can
2. do it and you know you can

**Extract12: post 22, Rachid**

1. If u gain weight back its yourself to blame. Surgery suppose to help u. it’s a
2. tool and if u go and eat junk food again wen your not suppose to then
3. youll gain it back. And if you’re a couch potatoe also…go to the gym do some
4. cardio..and if u are hungry all the time drink a lot of water till your full

**Extract 13: post 23, Rachid**
1. operation march (date) weight 375 today july (same year) weight 255 ad going 
2. to the gym 

Extract 14: post 24, Natalie

1. Oh yeah, its definitely my fault….i used to work at the gym! Lol..its never to 
2. late for me to get back on the horse and work out again… Been 4 years for 
3. me, and its true, alcohol, food and lack of cardio is what adds weight on!

Due to space restriction we have limited our analysis to a few key points that are 
linked to our focus on policing. Natalie’s initial post (extract 10) documented her 
progress, hearable as weight loss through the tummy and flank ‘tuck’, and it focused 
on her construction of herself as “alcoholic and gaining weight”. “Day one no 
alcohol” attended to a categorisation of herself as a member of a new regime of no 
alcohol intake. She documented herself as “eating CRAP” and requested some 
‘policing’ in her jokey plea for someone to kick her. Jenny responded by recycling the 
idea of admonishing by kicking but upgraded this to “hard” in a similarly humorous 
fashion. Jenny’s parting comment urged Natalie to avoid alcohol and “junk” in a 
supportive manner. However, Rachid’s response is more imperative, closer to our 
focus on policing, placing the blame of weight gain firmly on Natalie. He formulated 
an ‘if-then’ structure (Sneijder & te Molder, 2005) as a scripting device (see Edwards 
1994) which effectively categorised the event as routine and thus held Natalie 
accountable for her behaviour (lines 1- and 2). Surgery was constructed as a tool to 
help people lose weight, the implication being that it is not sufficient on its own. 
Indeed, Rachid recycled Jenny’s eating of “junk” food as deviating from the diet. 
However, Rachid also added two more behaviour-related warnings and offered the
advice of attending a gym and to drink water if hungry. In doing so, he firmly placed issues of accountability for weight gain as the responsibility of the individual, in this case Natalie. A minute after his initial response Rachid added a further post (extract 13) which supported his point and built up his legitimacy by demonstrating that he has lost weight and attends a gym. Natalie’s response (extract 14) accepted Rachid’s negative assessment of her, taking the blame for weight gain, possibly because she solicited the advice that he offered.

However, the most common form of policing is through unsolicited advice, and it is to examples of this phenomenon that we now turn. In the extract below, Sophie was responding to the dramatic weight loss documented by James in a previous post (120 lbs in three and a half months).

Extract 15: post 15, Sophie

1. James, that’s amazing. I can’t even believe that’s possible.
2. Does your dr know how much you’re losing? I don’t want to
3. be negative, but it just seems like almost too much too
4. fast…

Sophie’s initial response marked out the significance of James’ weight loss with the surprise token (Wilkinson & Kitzinger, 2006) “amazing”. This response attended to the category-bound activity (Sacks, 1992) of group members as supportive. It may also work to soften what follows. Sophie proceeded with, “I can’t even believe that’s possible” (line 1), which allowed her to accomplish a number of actions. First, Sophie displayed disbelief in a positive sense, after all weight loss is one of the primary goals of having the surgery, so the scale of weight loss is positioned as potentially desirable.
Second, it allowed her to highlight this extreme success as just that - ‘extreme’, as in ‘not normal’, but without jeopardising her supportive stance. Moreover, by saying “I can’t even believe” (emphasis added), Sophie was able to implicitly undermine the success of his weight loss as potentially implausible or troubling.

Once this was achieved Sophie further pursued the delicate matter (see Silverman, 1997 on issues of delicacy) of policing James’ weight loss with an appeal to medical sources of advice: “Does your dr know how much your losing?”. A ‘potential problem’ became the primary focus of attention, but Sophie has shifted the responsibility towards that of the doctor and this indirectly managed the sensitivity of the issue. Sophie attempted to maintain a consistency in her role in lines 2-3. “I don’t want to be negative, but” worked as a disclaimer (Potter, 1996) against her next softened ECF (Edwards, 2000) of “it just seems like almost too much too fast” being heard as a criticism. The idiomatic form also makes this difficult to contest and presents it as a candidate instance of a common sense noticing of ‘something wrong’. Importantly, the positioning of “almost” within this sentence again softened any suggestion that an accusation was coming from her but that she was performing within her role as an ‘advice giver’, therefore, in that category of person who is entitled to offer support and advice in this context (also see Whalen and Zimmerman, 1990). No response to Sophie’s post was found.

A final example of policing can be seen in the following thread which follows a discussion of pre-operative dieting, in particular, a post from Sandy (not shown here) who categorised her eating practices in the lead up to her operation as to ”stuff my face”.
Extract 16: post 250, Amy

1. Sandy I totally agree…I stuffed myself before liver diet and enjoyed every
2. mouthful…I will still have a treat tmrw even tho im opn detox, (been 3 days
3. so far) been very good, however, just know I have to have a treat to be able to
4. continue …still will have 5 days to be an angel! X

Extract 17: post 257, Susan

1. Hi my name is Susan and I have been reading a few of your comments and I
2. have to say a few things I am sorry if it insults people;e but I am being honest
3. ….I had the operation in (date) and the doctors told me many things to do at
4. the beginning I was thinking I could fool them by eating things I wasn’t
5. suppose top…TRUST ME IT DOESN’T WORK…Gstric bypass is not a
6. miricale and if you have to have a diet for your liver before the operation it’s
7. for a good reason if the liver is too big they will not operate……so by stuffning
8. your face like some people say it’s not a good idea I would think more
9. positive and follow the rules before cause its not easy before, after, and the
10. years following the operation…trust me you will fight everyday at the
11. temptation of not eating junk food…If you start thinking positively before the
12. surgery it will help you during your recovery and the years fallowing. Put in
13. your head that your not on a DIET…your eating HEALTHY

Extract 18: post 259, Amy

1. RE Sandra’s comments – Easier said than done…if I had a *normal*
2. relationship with food then I personally wouldn’t need the bypass, I have been
3. on slopps for almost 3 years, due to an over tight lapband, once it was defiled 2 months ago…I have ate very well and totally enjoyed being able to!! I have the conversion in 5 days..i have had to have the odd treat to be able to be continue on the detox…I feel so ready to get back on the straight and narrow tmrw…I AM NOT SAYING other ppl should stuff ermelves, just being honest about my own situation..You do what works for you and I will do the same, without judgement. Also im well aware of how my liver needs to shrink

10. thankyou. Wishing Everybody continued success in there journey xXxXxXxX

The consumption of food intake and diet in these posts is interesting as it constructed certain practices as more enjoyable yet morally accountable in the context of dieting. Amy’s construction (extract 16) of “stuffed myself before liver diet and enjoyed every minute of it” is hearable as something that is pleasurable yet illicit. Indeed, the projection of “will still have a treat tmr even tho im opn detox” built upon a construction of her food consumption as morally accountable. ‘Treats’ are typically associated with something that doesn’t happen often and as something that people earn for good behaviour (Mycroft, 2008), and contrasts with behaviour that is associated with a detox diet. However, Amy inoculated herself against potential criticism (Potter, 1996) by presenting herself as “very good” thus far, and by justifying her lapse as a strategy employed to continue her diet and to be “an angel”.

Susan took up the construction of “stuffing your face” as problematic (lines 7-8, extract 17). She located her legitimacy to ‘police’ such a practice with the use of a ‘me too’ story about her own deviation from her imposed diet and the formulation in capital letters “TRUST ME IT DOESN’T WORK”. Gastric bypass surgery was
constructed in a similar fashion to Rachid (extract 12) as not a “mirical” (miracle), and dieting was presented as a condition of treatment. The ‘if-then’ structure, “if you start thinking positively before the surgery it will help you during your recovery” strongly suggests that the dieter is morally accountable to the rules (Sneijder & te Molder, 2005) which were worked up as robust by the scripted nature of the formulation (Edwards, 1994). Junk food was categorised as a temptation that had to be fought with the ECF of “everyday”. Mycroft (2008) found similar constructions of ‘good’ and ‘bad’ food in her analysis of group leaders and members of a commercial weight management forum which she argued perpetrated popular moralised discourse surrounding food consumption. Susan’s message urged for a reformulation of the concept of dieting with a positive approach to eating “HEALTHY”. Whilst Susan was directive in her post, she also prefaced her policing with “I am sorry if it insults people; but I am being honest”. This worked to soften the impact of the message somewhat. Susan also used an honesty phrase (Edwards & Faluso, 2006) prior to delivering her assessment, which demonstrated her stance on this assessment.

Amy directed her response to Susan and used the idiomatic expression of “Easier said than done”, making it difficult to challenge. Amy also employed an ‘if-then’ structure in her refuting of Susan’s construction by categorising herself as somebody who did not have a normal relationship with food. Amy proceeded by accounting for her lapse of diet in terms of a long history of eating “slopps” and justified the minimised “odd treat” as a strategy. Amy also invoked the notion of honesty in her account of this strategy, which she argued is not meant to encourage others in this practice. Amy was able to resist the policing by advocating a notion of “what works for you”. Dieting is thus reformulated as a personal pathway and the addition of “without judgement”
criticised Susan’s assessment of her method of critique. Amy also warded off the construction that she was unknowledgeable about the need to shrink her liver with the rather curt “im well aware….thankyou”.

In sum, Amy hearably treated Susan’s policing as un-necessary and unwelcome contribution. Space is too limited to present the rest of the thread, however, Susan’s response was apologetic and Amy accepted her apology.

Discussion

The advice that is offered by clinicians is obviously an important resource following bariatric surgery. However, the changes pre and post-surgery are challenging. Our study contributes to the limited understanding of how people construct changes post-surgery by studying the issues that they make relevant themselves in an everyday setting, rather than through a researcher-led interview. By doing so, we were able to examine the unstudied ways in which members of a gastric bypass surgery online support group self-regulated and other-regulated, glossed as ‘monitoring’ and ‘policing’, their own and others’ weight loss and eating practices post-surgery.

In our first analytic section we considered how, with little experience of a lack of appetite previously, members responded to this new experience. Our analysis demonstrated how a lack of appetite is paradoxically marked out as something to celebrate, a benefit, but also worked up as an issue that needs addressing. Even though members of the support group should have had information about a loss of appetite, some still constructed this as an issue of uncertainty. However, through self-regulation and advice-seeking members monitored their food intake and marked out
food consumption as a necessary activity in line with notions of healthy eating practices. They displayed an understanding that one should eat regularly notwithstanding a lack of appetite. In doing so, they worked up their identities as ‘responsible’ individuals. For obese individuals, the temptation to refrain from food intake with such a lack of appetite must be high yet members of the support group orient to sensible eating practices in their self-management of this change. Moreover, by demonstrating that you are monitoring (as seen in extract 1) a lack of appetite you can display appropriate behaviour to other forum members. Even when members solicit advice by describing an ‘untoward’ state of affairs (see Heritage & Sefi, 1992), as in extracts 2 and 4, they managed in part to present themselves as acknowledging some basic tenet of the importance of continuing to eat. Heritage and Sefi’s (1992) research about advice giving with first time mothers and health visitors noted a similar pattern in the way that mothers commonly presented their requests in a way that displayed themselves as knowledgeable about the issues that they raised. Responses to solicited advice in our data displayed an adherence to how eating, even small amounts, was crucial.

In our second analytic section we focused on how members often constructed a period of weight stabilisation and sought advice from other members. Our analysis highlighted the co-construction of these periods as a ‘blip’. By generalising periods of weight stabilisation to the wider population, members are able to normalise the process. Veen et al. (2010) found a similar pattern in their analysis of diet talk on a celiac disease online support group. They suggested that orienting to something as routinely encountered by fellow dieters was a device that could be employed in order to dissuade members that it was not a good enough justification to quit. In our study,
the construction of weight stabilisation was normalised and worked to reassure members not to worry and effectively inducted them into treating such ‘blips’ as just that and not something that would continue to impede their diet. Furthermore, members urged others to consider the importance of a holistic approach to their diet. Clinicians such as McMahon et al. (2006) have urged bariatric surgery patients not to focus on weight loss in isolation. Our study highlights that within discussions of weight stabilisation, members also orient to the notion of a holistic approach that also focuses on body measurements.

Across these first two analytic sections we argued that monitoring worked as a support mechanism used to regulate eating practices and normalise weight loss stabilisation periods. Members tended to display some basic understanding of the appropriate ‘rules’ to their post-surgery diet both within posts where advice was sought and in responses to this solicited advice. As others have highlighted, members tended to construct their monitoring or ‘advice messages’ in ways that limited the threat to the self-image of those on the receiving end. Furthermore, advice simultaneously attended to members’ legitimacy in being able to offer the advice (Morrow, 2006). Legitimacy was typically worked up through the employment of ‘me too’ stories (Staske, 1998:71). Sharing a similar experience helped to induct members into treating the activity as something normal that is experienced by others and hence inducts members into treating such problems as part and parcel of the process. Second stories may also include attempts at providing a solution or strategy of how to treat such phenomena (Pudlinski, 2005). The employment of second stories, or ‘me too’ responses, offered an interpretation and resolution to a lack of appetite and ‘blips’, and were thus useful sources of empowerment (Arminen, 2004). As such, the online
support group appears to function as valuable site where post-surgery patients are free to question and make sense of their loss of appetite, not only in line with advice from their clinicians, but with others that have been through a similar experience. In line with Stommel and Koole (2010) we argue that monitoring is a product of practice whereby membership norms are constructed, and negotiated. For example, the reassurance from co-members potentially encouraged others to not lose faith in the process and to continue with their regimes. This is important as studies have documented how self-efficacy weakens over time (Batsis et al., 2009). Through online interactions members have access to a community that provides support through such difficult periods.

In our final analytic section, we focused on a number of instances of ‘policing’ where (with the exception of the first thread) unsolicited advice is offered. We argue that the policing of weight loss and diet is a highly sensitive activity for members, especially in a group without an official moderator, as it could be constructed negatively. In our first example thread (extracts 10-14) the recipient (Nicola) accepted Rachid’s ‘policing’ and construction of her behaviour as problematic. This is possibly because Nicola invited such admonishment (see extract 10). However, face-saving issues were employed in Sophie’s (extract 15) post when she inferred that James should seek medical help. Sophie worked hard to attend to any face-saving issues for James’ successful weight loss identity and, in addition, protected her own identity as a ‘supportive’, albeit ‘concerned’, member of the group. Potter (1996, pp. 110) posited that “the dilemma of stake is that anything that a person (or group) says or does may be discounted as a product of stake or interest”. Sophie could have risked being constructed as jealous, interfering, or judgemental but her post effectively managed
such issues of stake and interest in order to avoid a problematic identity. However, even with her delicate policing Sophie’s post produced no response from James. In the final thread (extracts 16-18) Susan’s policing was actively resisted by Amy, despite some minimal attempts to soften her advice. Susan’s post urged Amy to stick to the guidelines with regards her diet, in doing so she was replicating the group philosophy. However, Amy’s resistance of Susan’s policing is couched in individualist terms of doing what works for her, whilst also attending to the issue of influencing others negatively (“I AM NOT SAYING other pppl should stuff ermselves”).

Our study is not without limitations. One notable limitation is that we did not have background details of the networking site and so do not have reliable information about the characteristics of the participants. Furthermore, researching the Internet presents challenges around the ethics of using data that sits on the (currently) blurred boundary line between what is deemed a ‘public’ or ‘private’ space. One obvious ethical issue of debate is that of gaining informed consent. Hookway (2008) argued that ‘blogs’ are firmly located in the public domain and for this reason it can be argued that the necessity of consent should be waived’ and that ‘blogs that are interpreted by bloggers as ‘private’ are made as ‘friends only’. Thus, accessible blogs may be personal but they are not private’ (ibid, 2008:16). Walther and Boyd (2002) similarly suggested that a public space is defined in terms of access: if the forum is defined as ‘open access’ then users should be aware that wall postings are available to anyone and everyone. Indeed, Rodham and Gavin (2006) argued that open access forums are generally understood by users to be public domains that are expected to be
observed by others. It is our position that, in this instance, postings were intended to be ‘broadcast’ widely and thus intended to be highly public.

There is extremely limited qualitative research of how patients cope with the psychological changes associated with having had bariatric surgery. Our study offers some understanding of some keys patient concerns. The key implication of our study is that the focus on ‘monitoring’ and ‘policing’ within the online forum for bariatric surgery further highlights how weight management, typically depicted as an individual responsibility, is actually oriented to by members as a communal responsibility. The forum effectively prevented users from misinterpreting experiences such as a lack of appetite. Furthermore, members normalised weight stabilisation periods which potentially helped others to adhere to their diets instead of giving up. Future research could usefully explore whether or not practices found on this site are replicated in other bariatric surgery online forums. Internet support groups are potentially important sites for patients who have had bariatric surgery as they enable them to find a space to share their concerns and advice about their post-surgery experiences. Furthermore, studying clinician-patient advice giving sessions and face to face support groups would allow us to examine if similar practices occur within these settings. Whilst our analysis demonstrated how clinical recommendations were built into the advice and support offered within this forum, this might not be the case for other forums and future research is needed. However, findings from our study are useful to those who provide clinical advice post-surgery as they illustrate that a loss of appetite and periods of weight stabilisation (and extreme weight loss) are issues which are displayed as worrying and perhaps need further explanation to patients. Furthermore, online support groups allow patients to offer their own expertise through
experiential accounts, which provide a good resource for those undergoing bariatric surgery.

**Appendix**

*Methodology and analytic procedure*

Discursive psychology allows us to understand human conduct in complex situations and is distinct from traditional psychological assumptions that talk represents what people are ‘really thinking’ or what ‘really happened’. Instead, discursive psychology argues that people ‘do’ something with language, that it is ‘action orientated’ in way that performs, for example, requests, accusations and refusals and other sorts of activities. Through a consideration of the rhetorical features of accounts it is possible to examine how people manage issues of their stake and interest in their descriptions. For example, accounts about weight stabilisation might attend to the poster’s own culpability for a decrease in weight loss (Potter, 1996). A further analytic principle of the next-turn proof-procedure (Hutchby & Woffitt, 1998) was applied to the analysis of sequential posts. By examining a response to a post it is possible to elicit how the initial post was understood, grounding the analysis in the interpretations of the members of the support group.

Each of the 284 posts were initially read and coded. During our initial coding we noted any topic related patterns and also paid some attention to the rhetorical organisation of these posts. We then built up data files around emerging patterns: pre-surgery questions; hospital and consultant choices; pro-surgery one-off posts; first posts documenting date of surgery and weight lost, congratulation posts; posts about food choice and diet; lack of appetite; and posts concerning weight loss. We decided
to concentrate on two key concerns: a lack of appetite (9 threads) and weight loss post-surgery (21 threads). Furthermore, we noted that within these concerns (and across other topics) members monitored their own behaviours and also, at times, policed others behaviours. We considered the discursive features of ‘monitoring’ over courses of interaction where such instances took place within our topics in order to shed light on how participants communicated norms to each other through these processes.

Coding and analysis was conducted by both authors independently before we compared our findings and went back to the data to finalise our analysis. Previous research has focused on how newcomers must align with norms that are associated with that particular community to achieve membership of the group. Other discursive studies of Internet forums have noted how a diet management regime is constructed as a collective rather than individual issue with patients managing diet lapses without putting diet itself at stake (Veen et al, 2010). Our analysis was informed by this notion of emerging practices and led us to concentrate on the discursive features associated with ‘monitoring’ and ‘policing’ of appetite and weight loss.

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