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The discourse of comforting: The case of online health support groups

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ABSTRACT

Individuals sharing similar illness experiences nowadays have the opportunity of joining online health support groups to receive comfort from fellow sufferers. This situated practice represents an alternative to the pending issue of integrating patient narratives in a therapeutic approach to illness. The aim of this research is to investigate how discourse is mediated to comfort peers in an online condition-specific support group managed by laypeople. Corpus-based discourse analysis was conducted using a mixed-method design to disclose discourse functions and lexicogrammatical features which construe meanings of comforting in a corpus of online text-based messages. Results highlight how comforters organise their 'talking cures' through different epistemic and affective stance processes enhancing peer self-management, and how their sociocultural constructs serve multiple communicative functions. Results further shed light on how these 'talking cures' can benefit remote peers emotionally, inform the biomedical doctor-dominant relationship, besides challenging physicians as gatekeepers of medical knowledge to become 'physician-healers'.

1. Introduction

Medicine 2.0 is known to strongly promote patient participation in interactive online activities in the clinical area of self-management (Murray 2012), which is made up of the combination of medical, emotional and role management (Corbin – Strauss 1988). These web-based interventions challenge the traditional doctor-dominant relationship in which physicians appear to be solely concerned with their patients' medical management. Due to their biomedical focus on *disease,* physicians allow little, if any, room for patients' personal and social experience of *illness.* Patients are thus left without the

possibility of engaging in emotional management, which involves processing and elaborating negative emotions accompanying health conditions, and in role management, which is featured by learning to adapt to new social relationships due to these conditions. Chronic pain sufferers are faced even more with this unbalanced state of self-management as they are seen by physicians to "threaten the normal routine of biomedical treatments and the expectations governing ordinary face-to-face interactions" (Jackson 2005: 332).

In this light, an effective therapeutic approach to chronic illness has been advocated, whereby doctors are called to act as "physician-healers [who] help patients discover or create new illness narratives with fresh meanings that reconnect them to the world and to others and thereby transcend suffering and experience healing" (Egnew 2009: 170). Central to this approach is the notion of the healing potential of talk as "therapy is constituted, first and foremost, by talk entailing certain discourse types, thus it is frequently referred to as a 'talking cure'" (Pawelczyk 2011: 61). The therapeutic approach therefore assumes that the patient's illness story "is never just the story of disease" (Hunter 1991: 13), and that "the central importance of discourse in our experience of illness cannot be underestimated" (Harvey 2013: 5).

Research studies have, however, found that medical interviews commonly underestimate the value of information sharing even if better outcomes are achieved when patients are able to fully share their experience of illness (Haidet – Paterniti 2003). Morris (2008) notes that this long-standing resistance is due to the cultural influence of the biomedical model of treatment on both physicians and patients. On the one hand, doctors fear losing the professional authority they hold in medical encounters, and they now report undesired behaviours from patients in disease management following their web-based interventions (Hughes 2010). On the other hand, patients themselves are frequently dissatisfied with their doctor-patient relationship (Seckin 2010), and are therefore less willing to accept any medical outreach resembling intimacy or paternalism (Morris 2008).

Against this cultural backdrop, Medicine 2.0 represents a revolutionary alternative to the pending issue of integrating patient narratives in a therapeutic approach to illness. Web-based social networks, such as online health support groups, now allow people experiencing similar health problems to construct and consume personal narratives. The key features of online anonymity and social distance strongly contribute to turning online health support groups into non-threatening environments as they have been found to reduce participants' distress, enhance their coping skills, and improve health outcomes (Neuhauser – Kreps 2010).

From a sociocultural standpoint, patients' online stories of illness thus acquire a new status, allowing them to compete with the authority of doctors' offline stories of disease. However, it is still difficult to determine their clinical outcomes due to the limited amount of quantitative research data still currently available (Ziebland – Wyke 2012). Nonetheless, supportive communication has been found to improve emotional and behavioural outcomes, which, in turn, are likely to lead to improvements in clinical outcomes (Murray et al. 2005). Thus, online text-based messages offering fellow sufferers comfort may be seen as a valuable resource for medical training in the Medicine 2.0 era (Plastina 2016). They may further stimulate physicians to cast aside their traditional role as gatekeepers of medical knowledge, and become 'physician-healers' (Hughes 2010), actively engaged in the practice of 'talking cures'.

From a linguistic perspective, these discourses of social concerns deserve major interest from discourse analysts as condition-specific support groups currently hold a prominent position in online health communication (Harvey 2013). In fact, these groups "[r]epresent significant contexts in which individuals can interactively produce and consume discourse in the process of adjusting to perceived physical impairment and psychological distress" (Hunt – Harvey 2015: 135-136).

Against this backdrop, the current paper focuses on the therapeutic potential of comforting discourse, which is produced and consumed by chronic sufferers of the New Daily Persistent Headache disorder in an online group managed by volunteers and subjects with personal experience. Broadly-speaking, the investigation attempts to make a contribution in the under-researched area of healing talk, seeking to disclose how peer practice may inform the doctor-patient relationship in terms of patient self-management. More specifically, the study analyses the discourse functions and lexico-grammatical features which construe the meaning of comforting in a collected corpus of online messages and their socio-cultural values for different stakeholders.

2. Theoretical framework

Besides having their own websites, many online health support groups have dedicated discussion forums, where a sense of *groupness* is created among participants through the verbal cues of comforting messages. While it can be argued that this asynchronous text-based communication may not facilitate effective support due to the absence of nonverbal cues, this constraint is

compensated by the cues available through the content and style of verbal messages. Online support groups are thus governed by the key features of *verbal behaviour* and *message-centredness.* The former is "produced with the intention of providing assistance to others perceived as needing that aid" (MacGeorge et al. 2011: 317); the latter shapes "social interaction centred on the processes of producing and interpreting messages" (Burleson 2010: 151) with the main functional purpose of giving and receiving emotional and/or informational support. According to Biyani et al. (2014: 827), "emotional support comprises of seeking or providing caring/concern, understanding, empathy, sympathy, encouragement", and is thus related to the emotional dimension of self-management; informational support, instead, refers to giving advice, providing referrals and instructional information (Bambina 2007), and is therefore connected to the spheres of medical and role self-management.

From this perspective, the current study is theoretically framed by Burleson's (2003) comforting model of supportive message skills at the macro-level of comforting messages, and by the principles of corpus-based discourse analysis at their micro-level. The comforting model is designed to cover five core message skills for effective support, and is referenced to introduce the communicative functions and their related semantic fields as the analytical framework as shown in Table 1.

Table 1. The analytical framework for corpus-based discourse analysis

Supportive Message Skills (based on Burleson 2003)	Major Communicative Functions served by Discourse Units	Semantic fields
1. Clarify supportive intentions	1. State desire to help	helpfulness
2. Show sympathy	2. Express feelings of concern, care or sorrow	sorrow
3. Emphasise Other-centredness	3. Express encouragement and/or empathy	encouragement
4. Express availability	4. Offer help	support
5. Give advice	5. Provide relevant suggestions and/or information	knowledge

In detail, the first communicative function involves *stating the desire to help* peers who require support. It is likely that fewer discourse units serve this function as members tacitly share the understanding that mutual aid is key

to online health groups. On the other hand, the next three communicative functions are key to the discourse of comforting. *Expressing feelings of concern, care or sorrow* is the basic function to communicate sympathy (from the Greek *syn-* "together" + *pathos* "feeling"), or fellow-feeling. *Expressing encouragement and/or empathy* (from the Greek *en* "in" + *pathos* "feeling") is another crucial communicative function to comfort fellow sufferers by placing oneself in the situation of the Other (Other-centredness). Likewise, the communicative function of *offering help* legitimates the discourse of comforting by expressing the provider's availability. While all these four functions contribute to building emotional support, the fifth function involves *providing relevant suggestions and/or information* with the intent of offering informational support.

Furthermore, the study is informed by the principles of corpus-based discourse analysis, whereby "corpus analysis can also serve as a lens through which to examine wider sociocultural concerns. Indeed, recurrent discursive phenomena that are revealed in […] corpora in the form of keywords […] offer an observable record of the unconscious behaviours through which dominant meanings are discursively reproduced" (Hunt – Harvey 2015: 135). Moreover, the corpus-driven method is likely to reveal the most characteristic fixed strings, or "lexical bundles [which] provide interpretive frames for the developing discourse" (Biber – Barbieri 2007: 270). Concordance analysis of lexical bundles therefore assists in yielding quantitative evidence of the qualitative discourse features of comforting discourse, and helps disclose traces of this social phenomenon.

3. Methodology

The study analyses a corpus of 30 threads (30,153 words) containing a total of 226 posts (M=133.42 words), which were uploaded to an online health support group during the years 2013 and 2014. Corpus size was not considered to affect the study as "a small corpus is seen as a body of relevant and reliable evidence" (Sinclair 2001: xi). All postings were downloaded from the discussion forum at www.mdjunction.com/ndph, where the support group is populated by individuals affected by New Daily Persistent Headache (NDPH), i.e. "a rare chronic daily headache of long duration" (Evans – Seifert 2011: 145). This group was purposely selected since individuals affected by this syndrome are more likely to engage in comforting peers who endure this long-term condition. A mixed-method

research design framed the methodology of corpus-based discourse analysis, featured by a top-down procedural approach (Biber et al. 2007) for data validity. Manual searches were performed to discard irrelevant information and all messages were saved as an electronic document in .txt format for subsequent analysis in AntConc 3.4.3 software (Anthony 2014). A concordance search was run for lexemes with the highest levels of keyness, based on log-likelihood statistical measures with a cut-off of the top 100. Results matching at least one of the semantic fields in the analytical framework (cf. Table 1) were classified accordingly. Linguistic-quantitative analysis was conducted with the support of single concordances for each of the top five lexemes classified. KWIC (Key Word in Context) was computed for the keywords with a 5-word window span to the left and right of the search term based on the same statistical measures used for the keyness search. The resulting concordance lines were treated as horizontal texts (Tognini-Bonelli 2001) to interpret linguistic features across the different functional types of discourse units (Biber – Conrad 2009). Wordlist clusters, generated for the most frequent four-word lexical bundles, were classified following Biber et al. (2003, 2004) to disclose the prevailing organisational pattern of comforting discourse.

4. Results and discussion

4.1 Keyness

The concordance search for keyness yielded the highest levels for the five lexemes *think*, *know*, *better*, *helpful* and *sorry* occurring in the corpus (634 word types; 2982 word tokens). These results are useful to trace the broad socio-cultural value of comforting discourse, which appears to be "mobilized and deployed through stance processes" (Du Bois 2007: 141). The lexemes provide clues that these processes are predominantly elaborated as epistemic stances of belief and knowledge (*think*, *know*), and are interwoven with affective stances signalling solidarity (*better*, *helpful*, *sorry*). Keyness thus suggests that comforters act as stance takers, who first position themselves within the condition-specific support group and claim membership. In particular, the lexeme *think* evokes epistemic degrees of confidence in the propositional truth of messages, and thus socially situates comforters as subjective experts of the NDPH experience. They thus hold the socially recognised authority of adopting an epistemic stance of direct,

or experiential knowledge (*know*). Both these stances then lay the ground for placing comforters' subjectivity in relation with that of their peer sufferers in order to structure the affective stances hinted by the lexemes *better*, *helpful*, *sorry.* Additional social values can be captured from these keywords in relation to how intersubjectivity is likely to be realised. The higher ranking of the lexeme *better* is an overt cue that comforters first create intersubjectivity through their orientation toward the NDPH condition as "the shared stance object" (Du Bois 2007: 159). They then shape an intersubjective relationship featured by alignment with sufferers in order to establish the condition of being *helpful*. In turn, this social relationship paves the way to adopting affective stances, which organise the socially recognised feeling of *sorry,* allowing personalised emotional discourse to be then conveyed.

At the linguistic level, the keywords provide insights into the main communicative functions of comforting discourse and its underlying meanings as shown in Table 2.

Table 2. Keyness and semantic fields for *comforting* lexemes

Rank	Keyness (LL)	Keyword	Semantic Field
1.	370.209	*think*	knowledge
2.	327.914	*know*	knowledge
3.	248.240	*better*	encouragement
4.	198.185	*helpful*	helpfulness/support
5.	193.839	*sorry*	sorrow

In detail, *think* and *know* serve the communicative function of *providing relevant suggestions and/or information*, construct meaning within the semantic field of experiential *knowledge*, and thus pertain to the supportive message skill of *giving advice.* The lexeme *better,* instead, connotes meanings of *encouragement,* therefore functioning communicatively to *express encouragement and/or empathy* as part of the supportive message skill of *emphasising Other-centredness*. The keyword *helpful* denotes ambiguity as it is associable with both the semantic fields of *helpfulness* and *support*, and serves the communicative functions of *stating desire to help* and *offering help*, which pertain to the supportive message skills of *clarifying supportive intentions* and *expressing availability.* Finally, the keyword *sorry* is overtly associable with the semantic field of *sorrow*, and serves the communication function of *expressing feelings of concern, care or sorrow*, which are part of the supportive message skill of *showing sympathy*.

4.2 Keyword in context

KWIC results of the top 20 concordance lines for each lexeme are presented and discussed to capture salient aspects of comforting discourses. In Fig. 1, concordance lines for the node word *think* show a range of relevant suggestions offered by comfort providers.

1		I think	it is important to get aggressive treatment
2	t to get aggressive treatment in the beginning. I	think	it is important to keep trying. I think it
3	. I think it is important to keep trying. I	think	it is important to try anything. I think it
4	. I think it is important to try anything. I	think	it is important to have the best chance of
5	have the best chance of beating this thing. I	think	it is important to get rest and keep the
6	hot tea than I normally could stand but I	think	it really is helping. I do not think rebound
7	I think it really is helping. I do not	think	rebound would develop that quickly. I tend t
8	ink rebound would develop that quickly. I tend to	think	of anything that reduces the pain without ho
9	even if it is not a full cure. I	think	for many of us one of the things that
10	ped the most was finding a headache specialist. I	think	one of the more important things is quite ge
11	hings is quite general, keep trying something. I	think	that even doctors don't know how a lot
12	't know how a lot of medications work. I	think	that friends who are willing to TRY to under
13	problems of being in pain are worth keeping. I	think	that headaches that start after accidents sh
14	uld really be in their own category altogether. I	think	the pain meds are what is causing most of
15	your sleep problems, or at least contributing. I	think	the procedure will advance though. I think t
16	ing. I think the procedure will advance though. I	think	this is a good option for some people. I
17	this is a good option for some people. I	think	you have a lot of commonalities with a lot
18	commonalities with a lot of us (including me). I	think	you just needed to hear it from people going
19	our current friends are not understanding. If you	think	that there is no cure, your life is over,
20	life is over, that you will never get better.	Think	about substituting soy or almond milk.

Figure 1. KWIC results: *think*

Qualitative analysis reveals three main categories of functional discourse: providing practical suggestions, health-related suggestions, and offering psychological comfort. The first category is illustrated in example (1):

(1) *I think it is important to get rest and keep the stress down* [l. 5]; *I think it* [hot tea] *really is helping* [l. 6]; *Think about substituting soy or almond milk* [l. 20]

Coaxing NDPH sufferers to adapt to new life roles (*get rest*, *keep the stress down*), and new dietary habits (*hot tea*, *soy or almond milk*) builds on their role management. It can also help family/ friends be more aware that their supportive role is to remind and motivate their dear to perform similar self-management tasks.

Example (2), instead, shows how discourse was functionally shaped to provide more health-related suggestions:

(2) *I think it is important to get aggressive treatment in the beginning* [l. 1]*; I do not think rebound would develop that quickly* [l. 7]; *I think the pain meds are what is causing most of your sleep problems* [l. 14]

Here, comforters show strong degrees of confidence in the propositional truth of their messages, inducing their peers to infer their experiential knowledge. For instance, [l. 1] is likely to evoke the irresponsible behaviour of delaying medical self-management, but it can also inform family/friends of the importance of enacting the role of *medical proxy*; [l.7] and [l.14] share medical information, which may help peers reflect more on how to handle their emotional stress. It may also aid family/friends understand that the quality of their relations depends on their being better informed about the medical conditions of their dear.

Example (3) shows the ways in which opinions can generate psychological comfort:

(3) *I think it is important to keep trying* [l. 2]*; I think it is important to try anything* [l. 3]; *I think it is important to have the best chance of beating this thing* [l. 4]

Here, personal beliefs serve the purpose of aligning comforters with sufferers as a premise for conveying fellow-feelings of care and encouragement, shaped by personal affective stances.

KWIC results for the node word *know* are more information-oriented as shown in Fig. 2.

1	think any of us really knows why. As we	know	, a lot of the same meds used for epilepsy
2	epilepsy are used for migraines. As you probably	know	, it is all individual, so its trial and error
3	individual, so its trial and error. I do not	know	a lot about why it works. I do not
4	a lot about why it works. I do not	know	if any over the counter cold medicines help y
5	cold medicines help you at all. I do not	know	if you could find the full article online wit
6	nline without paying for a subscription. I do not	know	if a virologist is actually needed, I do not
7	has seen one of those specifically. I do not	know	what that dose is for different people. I don
8	that dose is for different people. I don't	know	if this med would help at all or not
9	that. I have had it for so long and	know	it so well, that I also feel safe. I
10	it so well, that I also feel safe. I	know	cheese had triggered migraines before but I c
11	before but I could not give it up. I	know	ndph headaches can be both migraine-like and/
12	be both migraine-like and/or tension-like. I	know	of another person, however, who had the surge
13	shortly after the surgery and still is today. I	know	one person around your age did really well wi
14	ound your age did really well with flunarizine. I	know	some people who did really well with that. Ev
15	did really well with that. Even doctors do not	know	how a lot of medications work (or at least
16	d work for headache instead of something else). I	know	there was also a private facebook page on ndp
17	on ndph at one point. I think you will	know	if and when the time is right for childbearin
18	way for everyone of course, and I do not	know	if that is because of their age. NDPH is
19	is known to be quite resistant to treatment. I	know	you should stay away from rebound headache. W
20	you should stay away from rebound headache. We do	know	a bit more than the average population about

Figure 2. KWIC results: *know*

Comfort providers position themselves along an epistemic scale, ranging from ignorance (*I don't know*) to knowledgeability (*I know*) as shown respectively in examples (4) and (5):

(4) *I do not know a lot about why it works* [l. 3]; *I do not know if any over the counter cold medicines help* [l. 4]; *I do not know what the dose is for different people* [l. 7]

(5) *I know cheese had triggered migraines* [l. 10]; *I know ndph can be both migraine-like and/or tension-like* [l. 11]; *I know one person around your age did really well* [l. 13]

By overtly admitting their lack of specialised knowledge about medications and dosages, comforters in example (4) implicitly declare their social status of laypeople. Their epistemic stance of *ignorance* (*I do not know*) further allows to infer that they responsibly refrain from misinforming peers. In turn, this suggests that information shared in online support groups is not likely to generate undesired behaviours in disease management during medical encounters.

This is further confirmed by example (5), where narratives are clearly dependent on popularised sources of knowledge (*cheese had triggered*, *migraine-like and/or tension-like, I know one person*). While physicians' biomedical authority may here appear to be delegitimated, this popularised knowledge reflects "the richness of everyday communication about health care issues" (Brown 2006, cited in Harvey 2013: 2).

1	Glad that you are doing	better	! Hang in there! It is sure got to get
2	! Hang in there! It is sure got to get	better	from here. Hang in there! It is tough, but
3	in there! It is tough, but things will be	better	soon. Hang in there! Positive things will g
4	ter soon. Hang in there! Positive things will get	better	for you. Hang in there, it often gets worse
5	, it often gets worse before it starts to get	better	! I am glad that you are doing so much
6	! I am glad that you are doing so much	better	overall. I am really glad to hear that you
7	glad to hear that you are doing so much	better	! I am so incredibly happy for you that she
8	so incredibly happy for you that she is doing	better	. I hope you feel better soon. I will say
9	that she is doing better. I hope you feel	better	soon. I will say a prayer that things get
10	soon. I will say a prayer that things get	better	for you. I wish no one here had any
11	one here had any health problems and hope for	better	days to come for everyone. It could be wort
12	hough, especially if the headache is consistently	better	during a certain time of the month. It did
13	a certain time of the month. It did get	better	for me, and I hope that it will get
14	, and I hope that it will get a lot	better	for her soon as well. It gets better. You
15	lot better for her soon as well. It gets	better	. You find treatments, learn to cope, and it
16	r respond drastically to a treatment. It will get	better	for you, I am sure! Others had similar symp
17	sure! Others had similar symptoms as you and got	better	, you will feel better. So glad you are doin
18	symptoms as you and got better, you will feel	better	. So glad you are doing better and the pain
19	, you will feel better. So glad you are doing	better	and the pain is more manageable. So, right
20	can do, is convince yourself that things will get	better	. Take it from us, it does get better. Ther

Figure 3. KWIC results: *better*

Results for *better* in Fig. 3 show how encouragement is also mediated through discourses of temporality of the health condition.

Example (6) illustrates how it is sufferers' current state of improvement which generates encouragement in comforters as a positive emotion (*glad*):

(6) *Glad that you are doing better* [l. 1]; *I am glad that you are doing so much better overall* [l. 6]; *So glad you are doing better and the pain is more manageable* [l. 19]

In these cases, comforters position themselves along an affective scale, denoting different degrees of affective stances (*glad* and *so glad)*, which are also intertwined with evaluative stances (*better, so much better overall, more manageable*). These latter markers thus also serve a referential function of relating to sufferers' prior stories. They are, in fact, grounded in a "counterstance", or "what prior stance the current stance is being formulated in response to" (Du Bois 2007: 149). Hence, comforters become encouragingly responsive to the evolving conditions disclosed by their peers, a verbal caring behaviour advocated by the narrative-based approach to illness. This type of care can inform physicians how to act as healers: "rather than 'taking' the biomedical history *from* the patient, [the physician] engages in a mutual activity *with* the patient in which the two work together to 'build' the complete and contextualized history which includes both the biomedical and the patient-defined points of view" (Haidet – Paterniti 2003: 1136; original emphasis).

This "history-building" approach appears to be crucial also in the 'talking cure' of predicting future health improvements as shown in example (7):

(7) *things will be better soon* (l. 3); *things will get better for you* (l. 4); *it will get better for you* (l. 16)

Although the referential identity of the condition is clearly abstract (*things*, *it*) and denotes comforters' low level of certainty, a healing effect is created by the future evaluative predicates *will be better*, *will get better* and the temporal deictic *soon*.

Encouragement is further expressed through other discourse units which functionally soothe peers as shown in example 8:

(8) *it is sure* (l. 1); *hang in there!* (lines 1-4); *I hope* (l. 8); *I will say a prayer* (l. 9); *hope for better days to come* (l.11); *it did get better for me and I hope it will get better for you* (l.13); *I am sure* (l. 16); *convince yourself* (l. 20a); *take it from us it does get better* (l. 20b)

The healing effect in these instances is activated through the use of different stance markers with epistemic stances of certainty (1.1; 1.16) and experiential knowledge (1.13; 1.20b), interwoven with affective stances of emotional involvement (l.8; l.9; l.11; 1.13), and persuasive expressions for encouragement (l. 20a, lines 1-4).

Concordances for the keyword *helpful* confirmed semantic ambiguity as in Fig. 4, where four main functional purposes are at play.

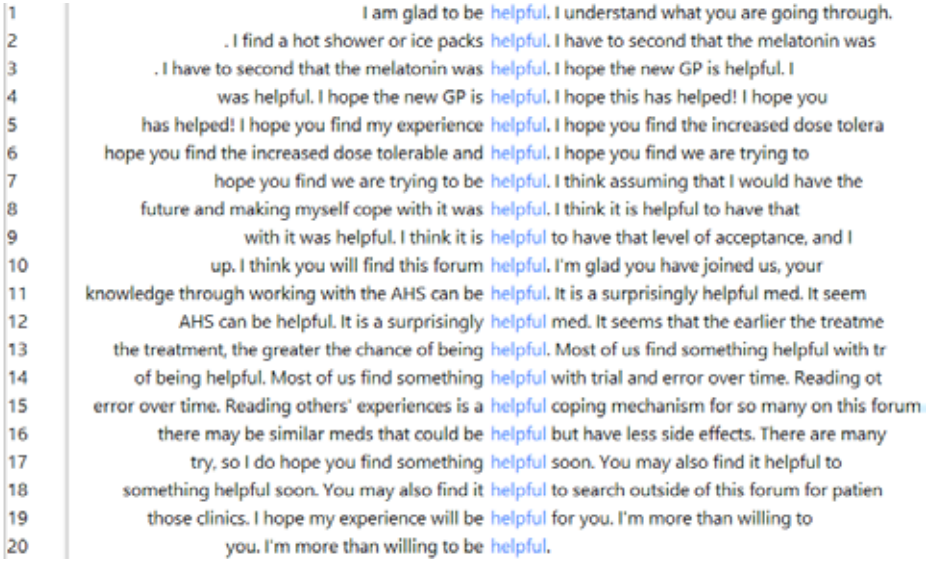

Figure 4. KWIC results: *helpful*

Example (9) indicates the function of stating the desire to provide help both as a single group member (*I*) and as an entire community (*we*):

(9) *I am glad to be helpful* (l. 1); *I hope you find my experience helpful* (l. 5); *hope you find we are trying to be helpful* (l. 7); *I'm more than willing to be helpful* (l. 20)

The second purpose refers to offering support, although in various ways as in example (10):

(10) *you will find this forum helpful* (l. 10); *reading others' experience is a helpful coping mechanism* (l. 15); *you may also find it helpful to search outside this forum* (l. 18)

On the other hand, example (11) shows how the meaning of *helpful* refers to the function of providing relevant suggestions:

(11) *I find a hot shower or ice packs helpful* (l. 2); *working with AHS can be helpful* (l. 11); *it is a surprisingly helpful med* (l. 12); *there may be similar meds that could be helpful but have less side effects* (l. 16)

Example (12), instead, indicates that *helpful* relates to expressing feelings of empathy:

(12) *I hope the new GP is helpful* (l. 4); *hope you find the increased dose tolerable and helpful* (l. 6); *it is helpful to have that level of acceptance* (l. 9); *I do hope you find something helpful soon* (l. 17)

Regardless of the different communicative functions, the sense of helpfulness discursively reproduced in all cases suggests that comfort providers always first *align with* peer sufferers to construct their healing talk. Conversely, physicians enter the medical encounter with their own biomedical perspective, thus disregarding the importance of seeking doctor-patient alignment.

Concordances for the node word *sorry* (Fig. 5) show that sympathy was expressed through socially accepted formulas in everyday language as a key feature of online support groups.

1	I am so	sorry	that you've been suffering for so long. I
2	've been suffering for so long. I am so	sorry	to hear this. I know it IS hard to
3	to live with pain day and night. I am	sorry	to hear that you are doing worse. I thought
4	Lyme treatment, is it no longer working? I am	sorry	you are all going through this and pray for
5	for an answer to help us all. I am	sorry	you are going through this. My headache also
6	started with an illness (a sinus infection). I am	sorry	you are having to deal with those scary symp
7	having to deal with those scary symptoms. I am	sorry	you have this headache. Glad you found us th
8	this headache. Glad you found us though. I am	sorry	your daughter is having to deal with this. I
9	so tough for you and your family. I am	sorry	your pain came back. How long has it been
10	has it been since it came back? I am	sorry	your son is suffering so much. Hope he finds
11	so much. Hope he finds relief soon. I am	sorry	you're having to deal with this headache, bu
12	headache, but this is a great support place. So	sorry	for your struggle! Do NOT give up - hang in
13	struggle! Do NOT give up - hang in there. So	sorry	to hear that it is back, or that another
14	aving similarly is here (either way is scary). So	sorry	to hear that your daughter is dealing with t
15	hear that your daughter is dealing with this. So	sorry	to hear what you have to go through. So
16	to hear what you have to go through. So	sorry	your daughter is going through this. I am gl
17	this. I am glad you decided to post. So	sorry	you've had to deal with this headache also.
18	headache also. My start date was close to yours.	Sorry	that you too suffer from this headache. Hang
19	you too suffer from this headache. Hang in there!	sorry	to hear you are having problems with your me
20	ear you are having problems with your medication.	Sorry	you also having this headache. Feel free to

Figure 5. KWIC results: *sorry*

Although the functional purpose of these results appears similar, sympathy is expressed, however, as different degrees of sensitivity. A moderate degree is found in the use of the basic expression *I am sorry* as in example (13):

(13) *I am sorry to hear you are doing worse* (l. 3); *I am sorry you are going through this* (l. 5); *I am sorry you are having to deal with those scary symptoms* (l. 6)

A more intensive degree of sensitivity denoting major emotional involvement is conveyed through the intensifier *so* as indicated in example (14):

(14) *I am so sorry that you've been suffering for so long* (l. 1); *I am so sorry to hear this* (l. 2); *so sorry for your struggle* (l. 12); *so sorry to hear that it is back* (l. 13)

These data point to the importance of sensitivity as a key factor in mediating healing talk, and can thus inform current medical research regarding the condition of the *nocebo response*. Albeit unintentional, physicians' lack of understanding has been recorded to induce anger and distress in patients as a response to this behaviour, thus worsening their health conditions (Greville-Harris – Dieppe 2015).

4.3 Lexical Bundles

Frequency-driven concordance keyword searches yielded 10 top 4-word lexical bundles in the full corpus of 30,153 words of comforting messages as represented in Table 3.

Table 3. Lexical bundles in the comforting corpus

Lexical Bundles	Frequency	N° of Texts (*N*=226)
1. I don't know if	**442**	**223**
2. sorry that you've suffered	**372**	**220**
3. get better for you	**361**	**148**
4. we do know that	**238**	**129**
5. things will get better	**121**	**117**
6. think it is important	103	65
7. was thinking you need	98	57
8. sorry that you too	61	54
9. one of the most helpful	43	25
10. it can be helpful	29	21

Although these lexical bundles are not structurally complete, nor idiomatic in meaning (Biber – Barbieri 2007), they disclose important features of comforting discourse. A striking aspect is given by the conversational-like style mediated through the high proportion of personal stance expressions which hybridise the text-based mode of the comforting messages. Hence,

while plain informal language helps build rapport in comforting, it is still widely undervalued in current pain education and in medical encounters where there is a persistent overuse of specialised jargon (Plastina 2016).

Moreover, results show that bundles 1-5 were more frequently used across group members as highlighted by the bold figures in Table 3; instead, bundles 6-10 occurred across fewer texts in spite of their high frequency. Hence, the former functioned as the main sociocultural constructs of comforting discourse, whereas the latter reflected more individual styles. Hence, comforting discourse was found to be socially constructed through narratives of medical uncertainty (*I don't know if*), *history-building* of illness as a key component of caring (*sorry that you've suffered*; *get better for you*), experiential knowledge (*we do know that*), and through the objectification of the disease (*things will get better*).

The structural categorization of the five key lexical bundles further showed that the main discursive pattern was organised through verb phrase (VP) and dependent clause (DC) fragments, each serving specific functions as shown in Table 4.

Table 4. Structural and functional categorization of lexical bundles

Lexical Bundles	Structure	Function	Sociocultural Construct
1. I don't know if	DC	Personal epistemic stance of uncertainty	Acknowledging subjective lack of medical knowledge
2. sorry that you've suffered	DC	Discourse organiser	Care for past suffering
		Referential	Focus on sufferer
		Affective stance	Fellow-feeling of sorrow
3. get better for you	VP	Discourse organiser	Care for future improvement
		Referential	Focus on NDPH-sufferer relation
4. we do know that	DC	Epistemic stance of certainty	Acknowledging and collective sharing of experiential NDPH knowledge
5. things will get better	VP	Referential	Abstract identification of NDPH
		Affective stance	Care for future improvement

The first bundle is structured as an *if*-clause fragment and operates as an *epistemic stance* bundle denoting uncertainty of medical knowledge. The stance is taken subjectively as marked by the personal pronoun *I*, suggesting that comforters acknowledge their limited medical knowledge so as to boost trust in their peers as a key step in caring. This social construct is further reinforced by the fourth lexical bundle, structured as a *that*-clause and operating as an epistemic stance bundle of experiential knowledge. The personal pronoun *we* signals group members' active participation in sharing experiential knowledge collectively for informational support, but also conveys the strong sense of solidarity built by the group to help peers relieve their emotional distress. As a dependent-clause fragment, the second lexical bundle, instead, operates as a *discourse-organiser* bundle, reflecting "relationships between prior and coming discourse" (Biber et al. 2004: 384), marked by the present perfect tense (*'ve suffered*), which emphasises the long-term chronic condition. The bundle is further imbued with a history-building approach to care, as well as serving the affective stance of fellow-feeling, marked by *you* person-centeredness. The third lexical bundle serves a similar functional purpose, although the temporal reference here changes from the past to the future, and the stance object is covertly placed in relation with the sufferer. The fifth and final lexical bundle is a referential bundle which overtly denotes the abstract identification of the illness (*things*), accompanied by an affective stance of care for future improvement conveyed through the verb-phrase fragment *will get better*.

5. Conclusion

Based on the findings from the present study, Table 5 summarises how the structural organisation of comforting discourse was functionally constructed. Although these results are by no means conclusive as they need to be tested on larger corpora also sourced from synchronous media (e.g. chatrooms), they offer thought-worthy insights into an exponentially expanding social discourse practice, which can inform remote sufferers and other stakeholders, including family/friends, medical educators and physicians alike. In the case of the *asymmetrical* doctor-patient relationship, these results mainly shed light on the crucial importance of integrating patient narratives into the practice of therapeutic talk, featured by a *you-centredness* perspective and implemented through a *history-building* approach, which helps patients refrain from *nocebo responses*.

Table 5. The structural and functional organisation of comforting discourse

Structural Organisation	Discourse Functions supporting Comfort
Epistemic stance	
Personal: uncertainty	Avoid misleading information and beliefs Build trust in interactive relationship
Collective: certainty	Share experiential knowledge for informational support Manifest high degrees of Other-centredness to overcome social isolation
Affective stance	
Personal: emotional	Manifest alignment and involvement to reduce emotional distress
Collective: involvement	Provide non-feeling-centred explanations for emotional support
Referential	
Physical	Exhibit high degree of *You*-centeredness
Temporal	Adopt a history-building approach to care
Abstract	Establish disease-sufferer relation to increase emotional support
Discourse organisers	Show sensitivity to avoid *nocebo responses* Predict improvement to help endure hardship

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