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The Best of Both Worlds: An Online Self-Help Group Hosted by a Mental Health Professional

ROBERT C. HSIUNG, M.D.

ABSTRACT

Online mental health groups can be classified as autonomous self-help groups or support groups led by mental health professionals. An online self-help group hosted by a mental health professional, in which the mental health professional focuses on maintaining the supportive milieu and the members of the group focus on providing the support for each other, is hypothesized to combine the best of both worlds. Psycho-Babble, a group of this type hosted by the author (http://www.dr-bob.org/babble/) serves as an example. Between January and August 2000, 1,516 members posted 21,230 messages in 3,028 discussion threads. Forty-eight percent of posters posted just once. Thirteen percent of threads consisted of only the initial post. In July 2000, 534,219 Psycho-Babble pages were served. Samples of educational and supportive posts, misinformation, "Internet addiction," help-rejecting, limit-setting, and member feedback are given. The usage statistics and the anecdotal evidence of the posts themselves support the effectiveness of the group. The hypothesized key ingredients are discussed. The asynchronous online (message board) format is highly usable and makes the group accessible and safe. Drawbacks, however, are the potential for "multiple identities" and the technical difficulty of effectively preventing determined individuals from gaining at least temporary entry into the group. This hybrid type of group combines the best of the two worlds of self-help (empowerment) and leadership by a mental health professional (maintenance of the supportive milieu).

INTRODUCTION

ONLINE MENTAL HEALTH GROUPS can be classified as autonomous "self-help" groups or "support" groups led by mental health professionals.[1] Each has its advantages and disadvantages. An online self-help group hosted by a mental health professional is hypothesized to combine the best of both worlds.

In this hybrid type of group, the "administrative" and "therapeutic" functions are split between the host and the members. This split, first discussed long before there was an Internet,[2] allows the administrator to focus on maintaining the "therapeutic milieu" and the therapist to focus on providing the therapy.[3] In the current context, "hosting" refers to managing the structure and boundaries of the group. Of the 12 dimensions of "facilitation" of computer-mediated groups in the business environment that have been identified,[4] "hosting" encompasses providing structure, creating a participatory environment, clarifying roles, selecting the technology, understanding the technology, and creating comfort with the technology, while "supporting" includes providing support, developing relationships, building rapport, using individual differences, emphasizing outcome, and demonstrating self-awareness.

University of Chicago, Chicago, IL.

Psycho-Babble,[5] an online group hosted by the author, serves as an example. The design of the website and the management of the group are described, usage data and samples of group process are presented, and the key ingredients and advantages and disadvantages of this type of group are discussed.

MATERIALS AND METHODS

Structure

Mailing list vs. message board vs. chat room. Online groups take three basic forms: mailing list, message board, or chat room. The message board format was chosen because it was considered a "happy medium." Compared to a mailing list, a message board is more efficient because members do not have to download messages they have no interest in. A message board selects for more motivated members because they have to initiate each connection and do not simply receive messages passively. Compared to a chat room, a message board is easier to use because no premium is put on thinking and typing quickly (though spontaneity may suffer), members do not have to connect at the same time, messages can be threaded, and asynchronicity promotes reflection.[6,7] A message board with a registration system and passwords requires a level of technical sophistication intermediate between a mailing list and a chat room. Finally, the archiving of messages, whereas possible with both mailing lists and chat rooms, is an inherent step of posting on a message board, and archives are valuable both as an introduction to the concerns and culture of a group and as an informational resource that serves educational and promotional functions.

Design of the site. The design philosophy underlying Psycho-Babble emphasizes usability[8]: minimal requirements and plentiful features. The main page uses only the reader's default font and four graphics and does not assume the browser window is of any particular width. Navigational links are displayed horizontally to use the window most efficiently. The site functions—though fewer features are available—without cookies, frames, or JavaScript; and there are no advertisements.

Messages are previewed before being posted. Messages posted since their last visit are flagged for readers. Posters can be notified by email of follow-up posts. Frames can be used to simplify navigation. The archives can be searched. And posts can be translated automatically (though somewhat crudely) into other languages.

Psycho-Babble was developed from the WWWBoard script from Matt's Script Archive.[9] Additional features were incorporated from other sources.[10–13] Accommodations were made for the idiosyncrasies of Internet Explorer and WebTV. All modifications and other additions have been the author's.

The total cash expenditures to date have been $40 for the Fluid Dynamics Search Engine and $349 for a secure web server certificate. There is no charge to join Psycho-Babble. Since July 1999, dr-bob.org has generated $743 in donations and $337 in referral fees from Amazon.com.[14] The time that has gone into developing Psycho-Babble has been the author's.

Members have also contributed to the site. There happens to be a song called Psychobabble,[15] by the Alan Parsons Project, and one member located a MIDI version[16] which is now used as (optional) background music. In July 2000, an ancillary website, Psycho-Babble-Tips, was started at eGroups.[17] There, members have created "folders" of links to Psycho-Babble threads and other web pages relevant to children and adolescents, Effexor (venlafaxine), psychiatric disability, Remeron (mirtazapine), social issues, thyroid and depression, and Wellbutrin (bupropion). In addition, members have started two eGroups of their own, AsThePsychoBabbles and ASafeHaven.

Orientation to the group. Readers are introduced to the group at the Psycho-Babble home page.[5] The orientation is brief, but covers the goals of the group (support and education), its values (giving as well as receiving), its limitations (in a crisis, please also get help in-person), its one rule (please be civil), the copyright policy (submitting a message gives the host permission to use it as he wishes), and short, eas-

ily understood disclaimers (don't necessarily believe everything you hear, your mileage may vary, and what you say may conceivably be used against you). The registration process is explained, and there are links to more privacy and copyright information in the orientation and also next to the "submit" button. Also on the main page are links to other areas of dr-bob.org, including pages with information on the quality of online information and at pages that recognize donors (Figure 1).

A separate Frequently Asked Questions (FAQ) page contains more detailed information about features, potential problems, privacy (an overview, how to tell if a web page is secure, the use of encryption, and who has access to registration information and web server logs), copyright policies (posters retain the copyright to their posts and no one should post anything they don't have the right to), and the sources of the scripts.

Boundaries

Membership. Psycho-Babble is not advertised. It is linked to from other dr-bob.org pages, and popular "search engines" such as AltaVista[18] and Google[19] have indexed it. Anyone who learns of it and has access to email and the World Wide Web can join, free of charge.

Setting limits. The author monitors the group by eventually at least skimming every post. The FAQ makes it clear that there is no guarantee that every post will be read. The author also responds to questions, either posted

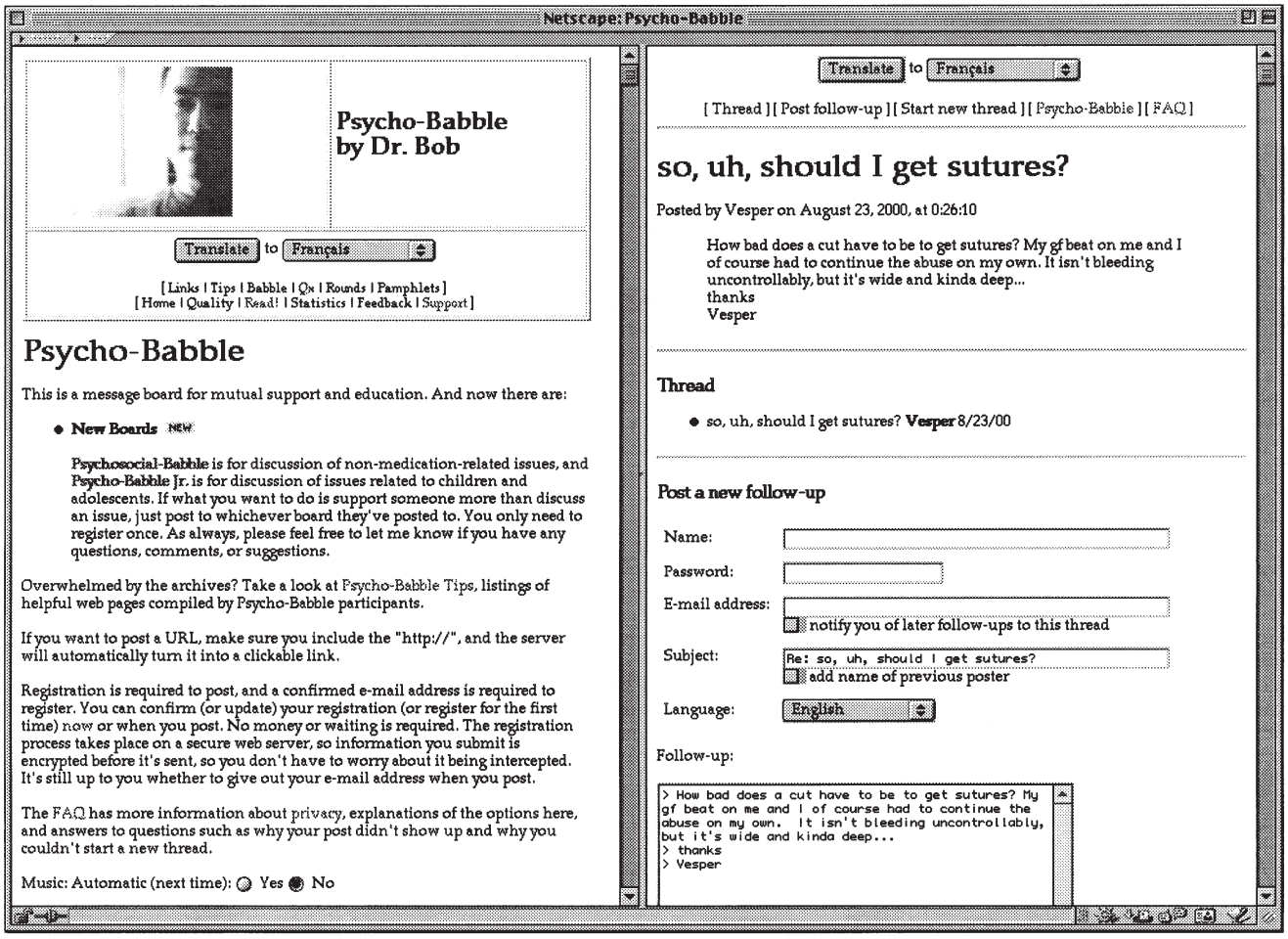

FIG. 1. Psycho-Babble, viewed with frames. The home page is on the left and a recent post is on the right.

or emailed, about the group, but not about mental health.

One of the primary functions of a group therapist, and one shared by a group host, is to manage the boundaries of the group.[20] The primary boundary is who may stay and who must leave. In the case of Psycho-Babble, this is determined by whether the one rule, to be civil, is followed.

When posters are considered by the author not to have been civil, messages to that effect are posted. Others would do this privately, by email, and that would have the advantage of being less embarrassing. If done with sensitivity, however, posting offers the advantages of clarifying the limits for others, modeling conflict resolution, diminishing any paranoia about activity "behind the scenes," and allowing others to contribute to the process.

When members continue not to be civil despite warnings, they are blocked from posting further (but allowed to continue to read). The initial hope was that enforcement would not be necessary, but that was naïve. As one antiauthoritarian member posted, "Can't censor a quarter-million monthly hits: You can whisper in the corner for a while, but sooner or later the rest of us will become concerned."

Effectively blocking individuals has been technically difficult, and even the current mechanism is not completely satisfactory. At first, the IP address from which a problematic post was submitted was determined from the web server logs and the posting script rejected further posts from that IP address, but the web server logs were unwieldy and members with dial-up Internet services were usually assigned different IP addresses each time they connected. Next, the script was modified to keep its own log and to block entire ranges of IP addresses, but "innocent" members were then affected. It was possible to "moderate" (review and selectively approve) posts, but that was both time-consuming and delayed those posts. Finally, a registration system that required passwords and confirmed email addresses was incorporated, and now would-be posters can be blocked no matter what their IP addresses are. Still, it is possible for individuals who have been blocked just to re-register under different names and with different email addresses.

RESULTS

Usage statistics

Psycho-Babble was started in June 1998. Registration was required starting in April, 2000, and valid email addresses were required for use in June, 2000. As of June 30, 2000, 922 names had been registered, 537 (58%) had posted, 232 (25%) had not, and 153 (17%) were awaiting validation of the email address.

As of August 13, 2000, 36,329 messages had been posted. Between January and August 2000, there were 21,230 (an average of 94 per day) posts by 1,516 members. Forty-eight percent of posters posted just once. The median number of posts per poster was 2, the average was 14. One percent of posters posted 35% of all posts. The most active poster posted 1,526 (an average of 6.8 per day) times. Three thousand twenty-eight new discussion threads were started. Three hundred eighty-seven (13%) consisted of only the initial post. The median length was 4 posts, the average was 6.7. The longest thread was 169 posts.

In July 2000, 534,219 Psycho-Babble pages were served. An exponential approximation of the cumulative pages-served data gave an R-squared of 0.87 and an estimated doubling time of 5.1 months.

Samples of group process

Names of posters have been deleted or replaced by letters, and some posts have been lightly edited for length.

Education. The quality of information provided can be outstanding. An example of such a post is:

> Recently, my aunt overdosed on lithium. The doctors told us that your Li blood level is supposed to be between a .5 & 1. Her level when they brought her in was a 9.

Hi K,

First, I am sorry to hear about your aunt's serious condition. I hope that she overcomes this and returns to her former health.

Lithium level of 0.5 to 1.0 (0.8 to 1.2) is the generally accepted therapeutic level. However, this is not etched in stone. Some people such as the elderly and those with concurrent

neurological conditions are more sensitive to lithium toxicity and therefore, require lower lithium levels for stabilization. FYI, it is the clinical signs and symptoms that dictate severity of lithium toxicity and the decision to lower the dose or stop lithium treatment. In short, the clinical picture is primary, lithium level is secondary.

Lithium level of 9 is an extremely high level. In fact, I would consider it beyond the extreme (4.0–7.0). Chances of survival or returning to former health after a massive lithium overdose depends on several factors which may include but not limited to: 1) the lapse of time between the overdose and medical intervention, 2) the amount of drug taken, 3) the blood level of lithium, 4) person's overall health status, 5) state of hydration, 6) co-existing neurological conditions, 7) concomitant medications, 8) age, 9) coexisting alcohol problem, 10) idiosyncrasies (individual differences).

If your aunt survives this condition, I sincerely hope that she does not experience permanent residual effects from the lithium overdose. I don't want to sound harsh or uncaring, but irreversible brain damage with residual neurological effects have been reported in cases of lithium overdose. My intention is to inform you of these potential residual effects so that you will be more emotionally prepared to cope with them in case they develop.

Most of the irreversible effects from lithium overdose are centered on the cerebellar functions. These symptoms may include gait and sitting ataxia (unsteadiness while walking and sitting), which are common; clumsiness of motor movement, resulting from inability to control accurately the range and precision of movement; difficulty articulating with scanning or slurring of speech; dysdiadochokinesis is common (performance of rapid alternating movements of the limbs is jerky and uncoordinated). Other residual effects include neuropathy (nerve pain); hyperactive reflexes; increased depression; and intermittent convulsions . . .

If symptoms of brain damage occur and persist, physical therapy, general rehabilitation, speech therapy, and other supportive therapies are helpful. Improvement can continue over the first 6–12 months although speech problems lessen more than does the unsteadiness of body and limbs.

Again, hoping the best for you and your aunt.

Reference:

Irreversible lithium neurotoxicity: An overview. Clinical Neuropsychopharmacology 1997;20:283–299.

Rarely is misinformation provided and not corrected by another member, but at times the author posts corrections. For example:

> It is not uncommon to mix an ssri and maoi (under close supervision).

I think that is in fact uncommon. SSRIs, are you sure? If you have a reference (online or off), I'd be interested . . .

A special case was a rumor that proved to be unfounded:

> New info from psychopharm guru Stephen Stahl, MD says that if a person is gaining weight from Remeron and increasing the dose to therapeutic level (30–45 mg) doesn't reverse it, Zantac or Pepcid may help . . .

Please see the appended disclaimer from Dr. Stahl.

This illustrates what I say at the top: don't (necessarily) believe everything you hear. OTOH, this shouldn't be seen as invalidating other posts T has made on this board.

Date: Wed, 1 Sep 1999 11:36:48 -0400

From: Stephen M. Stahl

A quote was wrongly attributed to me on your website and I would like your help in correcting this. Recently, I learned that your website posted information that I suggested that weight gain from Remeron (mirtazapine) could be mitigated by various H2 antagonists (e.g., Pepcid, Zantac, Tagamet). This is not true and I would kindly request that you correct the record.

If H2 antagonists help this problem, it would be news to me and whoever really had this idea should be appropriately credited. However, I believe this in fact not to be true, as I can think of no rationale for it. Also, since I have been getting questions about it for several months now, I have been asking my audiences whether anyone has ever observed this to work. Numerous clinicians in fact have anecdotally tried and failed. I have seen nothing in the literature and no case reports on this phenomenon . . .

My own strategy for mitigating mirtazapine

weight gain is to monitor it closely by weighing patients and adding SSRIs, venlafaxine, or occasionally diethylpropion, phentermine, or pramipexole. Nevertheless it remains a vexing problem for some patients . . .

Support. A typical example of a supportive post is:

Hi L

I really admire your courage in being open to yourself (& all of us here) about your drinking problem. I find that just being able to "talk" about my problems & know people care, helps me. I have "in person" people, therapy-type people, & people here, who I talk with & that combination sure works for me.

Yesterday I was at my "women's group." It was only the second time I've been there, but even the first time I realized it's going to be helpful for me. The women in the group have various problems they're dealing with—alcoholism, drug addiction, co-dependence (that's mine), family members abusing drugs and/or alcohol (my 16-yr old son does). Yesterday, a woman was there for the first time & she had just finished a 3 week alcohol treatment. She was just back at work & was dealing with the fact that it had "gotten around" work that she had just been in alcohol-treatment program. She was very uncomfortable with that. During the conversation, one person said, "Remember, you're only as 'sick' as the secrets you keep." It was pointed out that we often think people will judge us negatively for something that we are ashamed of. Often people don't. Often people are way more understanding & compassionate than we expect. It sounds like your husband knows you drink; simply doesn't know that it's getting out-of-hand. Please be compassionate with yourself . . . you have undergone a terrible experience. So what if it was 1.5 or so years ago. It was a shock; it was terrifying; it haunts you. It is perfectly natural and normal in my opinion, that it would haunt you and even paralyze you from doing certain things. It's quite possible that you're suffering from "Post Traumatic Stress Disorder." I have a friend who suffers from that, and she is on a government pension, so PTSD is a real and recognized condition. (Believe me, our . . . government would NOT give money to someone unless it was a definite medical reason!!) It seems to me (in my sometimes not too humble opinion) that you are ashamed of the drinking, but the drinking is just how you're dealing with how you are FEELING as a result of something awful that happened to you. To me, if people love you realize how traumatized you still are from what happened, it's pretty likely they'd be supportive of you.

People who have had an accident & have had to take narcotics for the intense pain sometimes get addicted to those pain-killers, and over-use the pain-killers. It's just something that sometimes happens; it doesn't mean they're bad people. In your case, you have probably been "self-medicating" . . . using alcohol to help you live with your pain from that experience (& maybe other pain in your life also). It seems like your use has gotten out-of-hand & you need some help with that problem. But just taking the pain-killing medicine out of the picture won't be the solution. You still have your mental & emotional pain to deal with. You have been carrying on with your life while dealing with a tremendously stressful situation. Please try to find someone who can help you with this pain & fear. Perhaps a place to start would be your family doctor . . . you don't even need to talk about the alcohol part, if you don't feel like it, although once that's out in the open you can get help & support with it. It takes a tremendous amount of energy to keep that a secret. You probably won't believe this, but you have NOTHING to be ashamed of in this, L. Nothing. Please keep posting. We all care about you. Everyone has their own way of suggesting how to deal with your problem, but the one thing we all have in common is we care about you & have only your best interests in our hearts.

Take care of yourself—you're definitely worth it.

Love, K

In addition, "old hands" do much to help "newbies" get oriented and acculturated, both by setting examples and by explaining.

Spectrum of posts. A broad range of subjects is addressed. The focus has been on medication, including indications, side effects, interactions, dosages, and pharmacology, but there have also been other topics: "alternative" treatments, books and movies, cutting, disability issues, ECT, feeling attracted to one's therapist, having a child die, ordering medication from overseas, sexual dysfunction, substance abuse,

what to tell one's partner or employer about one's problems, etc.

Poems written by members are even shared. For example:

> Abyss Edge
>
> Teetering on the brink
> of the mournful abyss.
> Tormenting my own soul.
> Insanity
> driven to the edge . . .
> the abyss opens wide
> gaping
> calling me inside.
>
> I almost fell
> tippy toes
> unbalanced spirit . . . beckoned by the voice within.
>
> No reason.
> Too much reasoning.
> With who?
> No, not tears . . . even worse.
> For with myself I did converse.
> The more I asked myself to stop . . .
> the faster it whirred throughout my brain.
> So close I viewed the word . . . insane.
>
> Stop!
> wrestle, torment, tangle
> Stop!
> annoying grating verse
> Stop!
> The more I begged it made it worse.
>
> One grasp for help,
> clinging to a thread of hope
> the voice upon the other end
> taught me this is how I cope.
>
> And only for a little while
> would I need to linger here
> teetering on the edge of the abyss.
>
> Now comes the time
> slowly retreat
> step by cautious step
> to safer ground.
> Abyss defeat.
>
> Once lost, now found.
> His love will surround . . . if only I wait.
> Be still. Old self be gone.
> The lesson . . . so profound.
>
> Tammy
> In memory of my Tanner Jason Tobac
> 2-14-00

Feedback. Positive feedback is common. Four examples:

> I have received several responses to my postings that have either provided needed information or simple words of kindness and compassion . . . This site is far better than many others that I have visited. Many people are taking the time to hear AND respond to calls for help. Birds of a feather do seem to flock together. But isn't that how they survive?

> I found this board a few weeks back while trying to find out if my 30 lb weight gain was due to the Effexor XR I was on. I have been very impressed by the quality of information and the helpfulness of members of this board. Based on information I found here and some tracing of my weight gains/losses over the past few years, I talked to my doctor and he agreed to let me try Wellbutrin . . . Thanks to all of you that post your experiences! It really helped me to make informed decisions and have a good dialog with my internist.

> When I got home today, a wreck, I came right to my computer. You guys are too good. After reading these posts and taking in the sharing, and honesty, and good advice . . . I feel really calmed down, able to think, not nearly as scared—or ashamed. Thank you so much, I'm very glad you took the time . . .

> You mean the world to me and I want to thank you all for the love and support you've shown me over the last few months. You are the best group of people I have ever known . . .

Not everyone's experience is always positive, however. For example:

> No one except for K wished me well, for either going into the hospital or getting out of the hospital . . . Maybe it's me. But I guess if I have to pick people responding to me in real life rather than cyberspace, I'll put my energy in real life. Still it would have been nice to feel that people on the board cared; I've been sharing information and support now with others

> on the board for about three months. Maybe I should have asked, "should I go into the hospital?" to get more responses, but those are the kind of things I tend to decide for myself . . . Maybe you can tell me the secret I'm missing. I really don't get it.

But even negative experiences can be followed by reflection:

> It made it feel really weird, sort of sad and angry—like why am I at all involved in this board. I still think I need to take time and figure how to get what I need on this board. Maybe it is just information. That is how I started. I've been thinking about this board tonight and I think it is "good" to either come across as very very vulnerable or as extremely knowledgeable . . .

Sometimes there can be too much of a good thing. From N:

> I am addicted . . . I find myself checking in here at work, which isn't good, and keeps me from doing what I am supposed to do.

Follow-ups:

> Yeh, but isn't it great to stop in once in a while and warm ourselves by the campfire?

Follow-up:

> I find I'm sucked in sometimes . . . and it's tough to pull away. I've stopped checking during work hours, and I try not to go online after certain hours b/c it's just another insomnia enabler . . . It's weird. Just slip out of the cycle of checking/reward/more checking for less reward, the desire just kind of goes away, or falls to a healthy level. Behavioral therapy has taught me well.

Later, from N again:

> I am totally addicted to this place. It has become a very real community, even though I don't know you guys for real . . .

Follow-up:

> It's because you empathize so much and you care and we are all grateful.

Follow-up:

> I have only been here for about two weeks, but already check every day . . . this is my lifeline! So I guess I'm addicted, too. But I suspect as I feel better and get my life back, I won't feel the need to be here so much . . .

Follow-up:

> Hi, my name is C, and I'm a psycho-babbleoholic. Is that in poor taste? I'm sorry, it's meant to be funny. I have a really bad inner censor, I've had my foot in my mouth so many times, I'm thinking about swallowing some odor-eaters!

Perhaps it will be no surprise that the above poster was the one who was posting an average of 6.8 messages per day.

Setting limits. Almost all posts of a religious nature have been considered acceptable. For example:

> Jesus came to heal the sick, the blind, the broken-hearted. His kingdom was not born of this material world, but of the spiritual. Any Christian church with the heart, spirit and love of Christ should welcome you, even if you don't buy the dogma, doctrine, rituals, or traditions. Who is Christ, if not the Son of God born of flesh, and who is God, if not the Father, and who is the Spirit, if not the Comforter. Every aspect, the three profiles, of God reflect healing, love, nurturing, and life.
>
> I wage an inner battle, a battle of mind against my heart and against my spiritual soul. I feel like a failure as a follower of Christ, in large part, due to my depression. I'm afraid to share my beliefs because my life doesn't display this neat/clean, content/happy scrupulous morality. I know God heals the broken-hearted, the depressed, but I'm still here struggling. I would never dream of placing those same values on someone else. I would explain that Christ gave us doctors, chemicals, minds, in order to heal. But, in regard to myself, I always feel like I've somehow failed, and my walk is so bumpy how can anyone follow where it leads? . . .

At times, however, the subject becomes touchy. From P:

> Christians believe that the Bible is the inspired word of God. Your books are men's ideas. I choose to get my information as close to the source as I can . . .

From D:

> All books are written by men, interpreting their narrow slice of the universe. Yours is narrower than most because you revel in your dogmatic, simplistic beliefs. I believe Christianity has just as much to offer as any other philosophical set of principles, all of which have good and bad points NONE of which is superior to any other. The superiority comes in the practice of core principles not the mealy mouthed, sanctimonious crap that hypocrites spew, while crucifying those who disagree with them . . .

From the author:

> I'm afraid I'm going to have to try to block D from posting any further. For this to be a supportive forum, people need to be civil. There aren't many rules here, but that's one of them. And D was warned before . . .

From D:

> Sorry there, Dr. Bob but religious dogma is a flash point for me, not to mention the source of many 'civil' wars.

There have been other, more heated, exchanges. *Flame war* would be too strong a term, but dealing with one can, in fact, feel like trying to put out a fire. From A:

> I want to mention that E must have the multiple personality disorder. I read some of his posts on alt.depression.medication that are supportive, even compassionate, whereas the other posts are like that above.

From E:

> Hmmmmm that's funny. None of my doctors think I have multiple personality disorder. I just get irritated when I read stupid stuff is all. I let people know that I think their ideas are STUPID. Like your idea about me having multiple personality disorder is stupid. All I do is tell the truth and am very direct and frank. Some people hate me cause of that. Big deal . . . do you think I care?

From the author:

> Please be civil. If that means keeping what you consider to be the truth to yourself, then please do that. Thanks . . .

From P:

> while there may be a few similarities between e's and whatever-his/her-name-is's [B's] writing style, there's one HUGE difference. e made a suggestion a long while back re: sleep and vitamins which made a substantial improvement in the quality of my sleep. in other words, he helped someone—me—out. all i have ever seen WHOOZIT do is be an abrasive, three-or-four faced waste of time whose posts come from a place i am tearfully glad i'll never understand. i have yet to see b or whoever educate, inform, or support. i HAVE seen him/her email me veiled, toothless, and ridiculous threats, asinine assertions and other comments that kept me in stitches for hours and generally do his/her damnedest to lower the quality of an otherwise stellar group. indeed—i have NO IDEE why he/she even posts here. does anyone??

From the author:

> > all i have ever seen WHOOZIT do is be an abrasive, three-or-four faced waste of time whose posts come from a place i am tearfully glad i'll never understand . . .
>
> Please be civil, even when provoked. Thanks . . .

From C:

> E - Actually, I do think you care; I just think that you are a very lonely person. It's not about other people's stupid ideas, it's about your vulgar, derogatory, demeaning writing style and your egocentricity. Pseudo-intellectualism cannot replace the work it takes to acquire knowledge.
>
> It seems that you have learned that the only way you can get people to listen to you, is to get them mad and have them react to you; not unlike a spoiled child at a cocktail party. Most of us can rein these emotions when we become adults. This has nothing to do with multiple

personalities, it has to do with your level of maturity . . .

From the author:

> your egocentricity [and] Pseudo-intellectualism . . .

> not unlike a spoiled child at a cocktail party . . .

Please be civil. Maybe when responding to the style, rather than the substance, of someone's post, it would be a good idea to count to 10? Thanks . . .

From B:

Dr. Bob's refereeing in this thread is somewhat balanced, though he still fails to consistently call every foul committed against his self-imposed standard of civility. To his credit, in other threads he has mentioned the limited time he has available to referee the site, and the tendency for others to say what needs to be said . . .

E incorrectly presumed that I posted because I disagree with him. Rather, I posted because generalizations coupled with obscenities failed to inform me why e opined that the named therapies did not work. I expect discussion of the particular merits, contraindications and fallacies related to various therapies. Such information provides substance for thought. An object of consideration that does not present substantive material for more detailed analysis tends to frustrate cerebral processes. Frustrated cerebral processes sometimes seem to causally correlate with emotional excitation . . .

From E:

B, what does the above mean in plain English? You can't write worth a shit.

From the author:

That's not civil. I'm going to block this handle.

There has been a fair amount of discussion of civility. The setting of limits is inevitably to some extent either subjective or arbitrary, depending on one's point of view. On a more humorous note, a piece on "Conversational Terrorism" was also posted:

All of the techniques listed in this document have actually been witnessed, told to us by someone else, or dreamed up. They are described in first person for clarity of motive . . .

It is hoped that exposing these tactics will help muzzle the burgeoning terrorism in our conversational landscape. Give copies to both perpetrators and victims . . .

First, we have the Ad Hominem Variants where you attack the person as a way to avoid truth, science, or logic which might otherwise prove you wrong. Next are the Sleight of Mind Fallacies, which act as "mental magic" to make sure the unwanted subject disappears. Then, we move on to Delay Tactics, which are subtle means to buy time when put on the spot. Then, the ever popular Question as Opportunity ploys, where any question can be deftly averted. Finally, we have the General Cheap-Shot Tactics and Irritants, which are basically "below the belt" punches.

Ad Hominem Variants

Over Your Head: "I'd like to respond to that, but taking into account your background, education, and intelligence, I am quite sure that you would not be able to understand." . . .

Even You: "My next point will be so cogent that even you will be able to understand it." . . .

You'll Get Over It: "As you mature emotionally (or mentally, or spiritually), you will grow out of your present way of thinking, and you will eventually come around to my point of view." . . .

"Cries for help" are common and have included, as has been found at other message boards, suicidal ideation and attempts.[21–24] There has been one apparent case of a "help-rejecter."[25] From V:

They say if I don't do certain things they won't treat me anymore, but I'm not sure I can do these things, and if they won't see me anymore, there's nothing else I can do. Anyway my therapist is leaving for several months at least anyway, I don't know what I'm trying to say, sorry for the ramble. Hey, does anyone know how many stories one must fall to be certain of death?

My current team I like better, they seem more willing to discuss things rather than presenting ultimatums re meds. It doesn't matter much anyway, I am close to just killing

myself. I already did some cutting yesterday, and it makes me want to do more, it felt so good.

From A:

Cutting is bad. What *did* they want you to do. It's so hard, because sometimes a reasonable doctor seems awful, and it is because we feel bad at that moment. Rarely, is one party completely "in the right." Perhaps they just wanted you to give the drugs adequate trials. Go to the ER now!

From V:

My current therapist [there] is on staff, and doesn't do research, so she's good, I like her. My current pdoc is not bad either, compared to the one to whom I was referring . . . I have been feeling better physically . . . for the most part, although I am sleeping a lot and I have sudden fits of crying for no apparent reason. I went in for day tx this morning but left because I felt angry and defensive and afraid because they have been putting a certain amount of pressure on me to talk about things I would rather not. I walked by the ip ward and that scared me too. I never want to go back there.

Hey, I just took an od with alcohol and I hope I die. Sorry to waste your time. I don't know what the hell I'm doing so ignore this please if I'm posting something wrong or something . . . sorry, you don't know how sorry I am I wish I could have known some of you you seem so nice dammit I can't take the pain any more. sorry.

From J:

I know his real name, I'll try calling the [police department]. I also have his therapist's names and #s. I will call them too. Can you think of anything else?

I just spoke with his psychiatrist, and she is getting an ambulance right now. So hopefully, V will be okay!

From B:

My God—is he going to be okay? Has this happened before? J/N, please let us know. What can we do?

From N:

I don't know if he has done this before, but earlier he was on the verge and J was terrific, getting in contact with him and his therapist to facilitate his going to the hospital on a voluntary admission. But then he didn't go, when his friend came into town.

I hope he'll be ok, hope that the ambulance got there fast. He needs to be in the hospital.

I don't know what else we can do.

From A:

I've been talking to [the] hospital and apparently he's arrived. I'm glad you all have such sweet feelings for him because frankly I feel manipulated and abused. But V if you get a chance to read this—You're an ace at it. I'm shaking so much I can hardly type. I can't stop crying. Do you think you are the only one who ever lost anyone to suicide?? Would it have been so hard to just go to the hospital yourself? I know you're in pain but why do everything you can to spread it around??

The hospital psych did the usual I can't give you any information routine (after the first doc I talked to had already told me he was alright—that was so kind and human I hope he doesn't go into psych and grow cold and arrogant).

I'm really upset. I don't think these [bulletin boards] are safe for people who already hurt. I can't stand feeling this way. Good night.

From V:

I apologize for last night, it will never happen again. Please just stop talking about me and go on with more important things. I obviously can't seem to control myself when it comes to posting whatever happens to be going on at the time, so I guess I should simply refrain. I am ok, just spaced out and groggy and weak. No, I am not in the hospital, and yes, the [police department] deserves its reputation. As soon as they had me, they would have shown the same brutality that they seem to enjoy. Thank you everyone.

From the author:

> I don't think these [bulletin boards] are safe for people who already hurt.

> This is a really good point. I think there are bound to be people here who will at least occasionally act in ways that evoke the past traumas of others. This might be difficult for those others. In theory, they might also gain something from the experience, but, for them, the risks might outweigh the potential benefits.
>
> I guess there are two other issues:
>
> 1. How people here might deal with this kind of thing.
>
> I think it helps one to help others, but efforts to help unfortunately don't always succeed. That doesn't mean that one shouldn't try to help—that's the whole idea here!—just that one shouldn't always expect, let alone feel responsible for, a good outcome.
>
> 2. What if any general "policy" there might be.
>
> I don't mean to be heartless, but a forum like this *may* in general be better off without people who act in certain ways.
>
> I think we generally accept this when people are hostile. But what if they're "just" unrelentingly depressed and suicidal (and possibly not doing what they "should" about it, either)? Both may be in pain. But both may also, because of the reactions they elicit, make it harder for the forum to serve its purpose. They should be supported, too, but this might not be the place.

That poster did eventually go to the hospital. Although Virtual Munchausen Syndrome has been described,[26] there have not been any apparent cases at Psycho-Babble.

Between January and August 2000, 17 warnings were issued and 8 blocks instituted. At least three of those blocks were of the same person under different names. An advertisement for pornography and some anti-Semitic posts were deleted without discussion.

Warnings and even blocks have been accepted, but have also been resisted. Members have been considered to have the right to complain, however, so threats to do so have not been considered uncivil per se.

DISCUSSION

Effectiveness

As has been also found at a message board for sufferers of painful hand and arm conditions,[27] the messages at Psycho-Babble have been posted by both professionals and nonprofessionals, discussed both conventional and unconventional approaches, and been based on both personal experience and the scientific literature. Contrary to early predictions that "computers will remain on the fringe in patient education,"[28] the Psycho-Babble usage statistics, in fact, demonstrate their popularity.

The effectiveness of a group is a function of the individual member outcomes. The posts at Psycho-Babble do themselves provide ample, though anecdotal, evidence that it has been effective in its goals of support and education. Online dialogues on a message board devoted to the topic of suicide were considered more "sustaining" than "transforming."[22] That distinction has not been explored here, but sustaining others is in any case a worthwhile enterprise.

To our knowledge, no outcome study of Psycho-Babble has been done. Systematic research on this group and others is, however, certainly needed. Methodological challenges would include selecting the sample and operationalizing outcome.

Key ingredients

An online self-help group hosted by a mental health professional combines the advantages of being online, of members helping each other, and of professional oversight.

Online ingredients. The members of asynchronous online groups have the significant advantage of not having to be in the same place[29] at the same time.[30] Another major factor is the feeling of safety that members have because of the anonymity and physical distance involved. This feeling of safety probably underlies increased self-disclosure[6,24,31] and interaction[32] online.

Along with anonymity, there are fewer nonverbal cues. This can protect members from stigmatization and discrimination.[33–35] Their actual contributions can become more important than whether they are liked.[36] This may help explain the findings of increased toler-

ance[31] and support.[6,31] Members can have more difficulty forming impressions of each other, but that diminishes with time.[37,38]

A serious drawback of anonymity, however, is the potential for members to assume "multiple identities." This could be in the context of dissociative identity disorder, but could also just be a way for members to simulate more support for particular sides of issues or to rejoin the group after being blocked. Accountability can be increased by requiring more personal information such as email addresses, but deters others from participating.

Clinicians who assume a helping role complicate the situation further. Online, they may feel safe from charges of malpractice and, therefore, feel free to become "very important posters." As long as they do not practice their profession online, malpractice should not be an issue, but this is why one disclaimer is "what you say may conceivably be used against you." This and the "multiple identity" issue are related in that non-professionals may masquerade as professionals. This is partly why another disclaimer is "don't necessarily believe everything you hear" and the site links to information on the quality of online information. Clinicians could reassure readers about the information they provide by providing also their credentials, but by doing so they would identify themselves and thereby make themselves easier to sue. In the end, it is "caveat lector,"[39] and readers must decide for themselves what to make of posts.

Self-help ingredients. Members in online self-help groups have been shown to receive that help in a variety of forms, from information[40] and advice[22] to sympathy,[22] empathy,[41] increased confidence[42] and hope,[43] to a social identity[42] and a sense of community.[22,35,40,43,44–46] The last can be true even if their participation is not apparent.[42] Some readers at Psycho-Babble have "lurked" for over a year before becoming posters.

Dependency in a group is diffused among the members.[33,34] Even when large, online groups can function effectively.[47]

What most distinguishes self-help groups from groups led by clinicians, however, is the degree of mutuality of support and problem-solving.[48] Online career development groups have been shown to be more effective if moderated than unmoderated, but these groups were small (10–12 members).[49] Research on learning in children has found that a large group of peers can substitute for a teacher.[50] The key may be that being the helpers as well as the "helpees" is empowering.[51] In the current context, the mental health professional empowers the helpers in the group, and the helpers empower the helpees in the outside world—and perhaps they then become helpers themselves.

A "critical mass" is probably required.[52] Psycho-Babble certainly has a relatively small core of "very important posters." These may be mental health professionals or "merely" knowledgeable and caring lay people. A critical mass is vital because of positive feedback: the more posts that there are, the more readers that are attracted; the more readers that are attracted, the more posters—and the more very important posters—that are attracted; and the more posters that are attracted, the more posts there will be. The very important posters are very important not only because they drive this feedback, but also because each is responsible for a significant amount of the total support and education provided.

Clinician ingredients. Online self-help groups also have the potential for destructive interactions.[33,34] Mental health professionals, by virtue of their training in and experience with therapeutic principles (including the setting of limits) and group dynamics, are well-prepared to manage and to minimize the occurrence of such disruptions and thereby maintain the supportive milieu.

In addition, the therapist–administrator split results in both the therapist and the administrator becoming somewhat more detached, which helps diminish not only the transference of the patient to the therapist,[3] but also the countertransference of the administrator to the patient. In the current context, the host and the members would therefore be expected to be even more able to focus on the group as a whole and the individual other members, respectively.

Complications

More is sometimes less. A continuous stream of posts can overwhelm a reader. Markey found that as the size of a chat group increased, it took longer for an individual to receive help.[53] It is not clear what to make of the finding that 48% of posters posted only once. They may not have found the response, if any, to their one post to be helpful. Even at a group as large as Psycho-Babble, however, only 13% of initial posts went unresponded to. In some cases, moreover, that was due to factors such as the poster starting a thread with what should have been a follow-up post or doing so just before the thread analysis was conducted. On the other hand, the response may have been so helpful that additional posts were unnecessary. Markey also found that that effect was virtually eliminated when a bystander was asked for help by name.[53] It certainly is common at Psycho-Babble to name a very important poster on the subject line of a post.

An active online group can promote "Internet addiction."[54,55] Probably any activity that is positively reinforced has the potential to become pathological. Finally, although it can be managed after the fact by the firm setting of limits, the more popular an online group is, the more some individuals will be drawn to acting out there.

CONCLUSION

The usage statistics and the anecdotal evidence of the posts themselves support the effectiveness of this online self-help group hosted by a mental health professional. The asynchronous online (message board) format is highly usable and makes the group accessible and safe. Drawbacks, however, are the potential for "multiple identities" and the technical difficulty of effectively preventing determined individuals from gaining at least temporary entry into the group. This hybrid type of group combines the best of the two worlds of self-help (empowerment) and leadership by a mental health professional (maintenance of the supportive milieu). The "therapist-administrator split" is a division of labor that minimizes (or at least externalizes) the potential conflict between these essential functions.

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Address reprint requests to:
Robert C. Hsiung
University of Chicago
5737 South University Avenue
Chicago, IL 60637–1507

E-mail: dr-bob@uchicago.edu