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## Digital Biocommunities: Solidarity and Lay Expertise About Bipolar Disorder

I had already taken the anxiolytics...

But I've managed to ask someone to help me on a forum because I couldn't take it anymore. Someone reacted and we're talking via private messages. I think this will help me a bit. Thanks. (*Derek21*, March 18, 2013)

Through their online activities, people diagnosed with bipolar disorder often engage in solidaristic behaviors, providing help and support to similar others in need, as the quote above illustrates. This draws attention to another important aspect of expertise, which is not only shaped by the means through which it is acquired and performed and by the goals it aims to achieve, but also by the values that motivate and support such processes. In recent years, expertise about bipolar disorder has been shaped by the rise of personalized and precision medicine (Evers, 2009; Ozomaro et al., 2013; Shin et al., 2016), which many believe will lead to highly individualized approaches to health and will thus have important moral consequences. Whereas autonomy has featured prominently in these debates, in recent years scholars have started to investigate how personalized and precision medicine might affect solidaristic practices. In so doing, influential commentators have challenged the dominant belief

that these approaches would necessarily lead to radical forms of individualism, arguing, instead, that they could also prompt solidaristic approaches to healthcare (Prainsack & Buyx, 2017). In this chapter, I join this group of researchers by studying the tensions between the appeals to solidarity and individualization in mental healthcare triggered by personalized and precision medicine and by considering how these tensions are taken up and reflected in the online exchanges of American and French contributors diagnosed with bipolar disorder. In so doing, I engage in the exploration of the one remaining aspect of the conceptualization of expertise that I put forward in this book, namely its collective nature and the role of affective labor. Based on the analysis of the empirical materials, I argue that solidaristic practices underlie numerous online interactions among people diagnosed with bipolar disorder, thereby contributing to the development of a new type of collectivity—what I have called “digital biocommunities”—and promoting the development of lay expertise.

## The Individualization of Healthcare: Solidarity Under Threat

The rise of personalized and precision medicine has taken place in a context marked by the demise of national welfare systems and by the growing dominance of neoliberal tendencies, which have introduced a market logic in the provision of healthcare and have focused on individual empowerment as a means to achieve collective well-being. Personalized and precision medicine has been fueled by insights from genomics and related fields and has profited from the availability and accessibility of a great number of online applications through which people can keep track of their health. Thus, health-related data have been expanded under precision medicine (Hedgecoe, 2004) to include a vast array of elements (Hogle, 2016; Weber et al., 2014), and individuals have been encouraged to engage in the self-tracking of a growing number of biological, environmental, and lifestyle elements (Lupton, 2018; Prainsack, 2017). While such practices address individuals as autonomous and self-interested beings, even in their most narrow or radical understanding, personalized

and precision medicine relies on collectives for the comparison and interpretation of data. This renders the relationship between autonomy and solidarity at the same time important and problematic for researchers and policy makers alike. A good illustration in this sense comes from the Precision Medicine Initiative, whose name—All of Us—conveys a vision of healthcare meant to bring collective benefits, yet on whose website individual readers are interpellated by being told that “the future of health begins with you” (June, 2018). While for proponents of the Precision Medicine Initiative, individual autonomy appears to be needed to achieve solidarity, in France solidarity seems to be the means through which individual autonomy can be achieved, as the French version of the name of the National Fund for Solidarity and Autonomy (*La Caisse Nationale de Solidarité Pour L'Autonomie*<sup>1</sup>) suggests.

How the individualizing tendencies underlying personalized and precision medicine affect solidarity has also been the object of vigorous debates among scholars. Supporters have welcomed these tendencies as leading to better and more efficient ways to provide healthcare, which they claimed would ultimately benefit both the individual *and* society at large. Thus, by tailoring clinical investigations and therapeutic approaches to the specific needs and circumstances of every person (Wium-Andersen et al., 2017), people would be spared unnecessary tests or therapeutic approaches less likely to be successful. This would enable the more effective attribution of funds in healthcare, thereby addressing and redressing a state of precarity triggered by a growing number of people diagnosed with (mental) health conditions and insufficient funds. Proponents of personalized and precision medicine have also invoked the language of empowerment, arguing that the widespread adoption of digital technologies and self-tracking enable people to gain more knowledge and control over their health (Knoppers & Chadwick, 2005; Steinhubl et al., 2013). In turn, this could contribute to the democratization of the relations between individuals and medical professionals or even to a hierarchical reversal thereof, as titles such as “Patient-Driven Health Care Models” (Swan, 2009) or *The Patient Will See You Now* (Topol, 2015) suggest.

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<sup>1</sup> This institution was established in 2005 to distribute and oversee the national provision of financial help and assistance to people with disabilities and the elderly.

In contrast, critics have argued that by addressing individuals as unique from certain points of view, people may end up focusing more on what distinguishes them from others rather than on what binds them together, which may lead to “radical” differences. According to Dickenson (2013), such approaches could bring about a shift from “We Medicine” to “Me Medicine,” a concern which is eloquently echoed by Prainsack and Buyx (2017:127):

Because every patient is different, as this new version of personalized medicine assumes, their health and their diseases are different as well: individual differences in our genetic makeup, in our gene expression, in the microorganisms inhabiting our guts and bodies, in our lifestyles, diets and so forth render each of us, as well as our physiologies and pathologies, a unique expression of a particular state of health and disease in any given moment in time. (Prainsack & Buyx, 2017:127)

These approaches thus threaten solidarity and may lead to new forms of inequality and discrimination (Prainsack & Buyx, 2012), as people engaging in seemingly preventable individual behaviors, such as smoking or the consumption of sugar and fats, may be required to pay higher insurance rates, and/or may be denied access to some medical treatment and social provisions. These critics warn this way that individual freedom and responsibility can be invoked in such instances to mask systemic forms of economic and social inequality, and may even help to perpetuate them. Challenging what they consider to be the “tyranny of autonomy” (Foster, 2009) in Western healthcare and the understanding of individuals as autonomous, rational, self-interested beings, such commentators (Baylis et al., 2008; Prainsack & Buyx, 2012) have argued instead in favor of a relational approach. From this point of view, individual identities, values, needs, and perspectives are not dictated by self-interest alone, but importantly shaped by the other people in one’s life and by the socio-political context in which one lives. There are indications that such perspectives are supported by practices on the ground, as exemplified by the shift from “The Quantified Self” to “The Quantified Us” (Lupton, 2016) among proponents of health endeavors generally thought to be highly

individualistic and individualizing, and by empirical studies that have identified solidaristic practices at the heart of self-tracking (Sharon, 2017).

Since I have argued that expertise is a collective notion, requiring the concerted efforts of numerous stakeholders, the expectation of “radical” individualization in healthcare raised important questions about its future and the new shapes that it may take. This was particularly the case for lay expertise, a collective notion whose meaning and relevance are rendered uncertain in a healthcare context marked by a focus on individual differences. The data used in this chapter were therefore initially approached with the expectation of encountering numerous instances confirming the idea that individual needs, preferences, and approaches in mental healthcare have become dominant to the detriment of more collective challenges and concerns. Yet, on many blogs and fora people diagnosed with bipolar disorder continued to seek to understand their condition collectively and displayed substantial concern for others. For instance, they tried to make sense of the symptoms they experienced by placing them in the broader context of their lives, by considering how their behaviors affected their families, friends, and colleagues, and by comparing their experiences with those of others with the same diagnosis. It thus became obvious that solidarity is a value that online contributors diagnosed with bipolar disorder perform online, which shifted the analytical focus onto its relation to lay expertise, thereby turning this chapter into a contribution to calls made by scholars to study how values manifest themselves in practice (Swierstra, 2013; van de Werff, 2018).

## The Meaning of Solidarity

Despite solidarity’s re-appearance in debates about health policy, the meaning of this concept remains evasive. While it is often defined as “the glue that keeps people together” (Komter, 2005:2), different perspectives have been put forward to explain how such social cohesion is achieved. Thus, some scholars approach solidarity as a particular set of feelings and emotions (Mayhew, 1971), as moral (Etzioni, 1988) and “affective ties” (Parsons, 1952:157) which inform people’s commitment to others. In such cases, solidarity is intertwined with the human capacity to

experience and express sympathy, care, and concern for people in their immediate surroundings. It is thus thought to spring into being rather automatically, informed by common attachments (instead of rational considerations) among a relatively small number of people. Others understand solidarity as a characteristic of groups and societies (Durkheim, 1964; Weber, 1947), regulating the interactions between the individual and the community (Bayertz, 1998), and potentially furthering the common good. Van Oorschot and Komter noted in this sense that “[t]he main source of solidarity is a mutual sharing of each other’s fate” (1998, 8), thereby largely conceiving of solidarity as a result of rational choices and calculations (Hechter, 1987), of the acknowledgment of “shared identity” and “shared utility” (Van Oorschot & Komter, 1998). Yet other scholars approach solidarity as a moral, universal, “inclusive” ideal (Dean, 1995), prescribing specific sets of orientations and behaviors which people should take up in order to increase social bonds in the heterogeneous societies we currently live in.

The study of solidarity in this chapter is based, however, on the conceptualization put forward by Prainsack and Buyx (2012, 2017), which has the advantage of being concrete and practice-oriented. In their view (2012:346), “[s]olidarity signifies shared practices reflecting a collective commitment to carry ‘costs’ (financial, social, emotional, or otherwise) to assist others,” and this conceptualization is underpinned by three important elements. First, it relies upon a relational understanding of personhood, as these scholars see the individuals’ concerns, values, and preferences as emerging in interaction with those surrounding them and as shaped by the socio-cultural environment in which they find themselves. This allows for solidarity to be distinguished from altruism, as people are approached as simultaneously self-interested and concerned for the well-being of others. Second, solidarity is based upon the recognition of a relevant similarity, upon people’s acknowledgment that they share a commonality with others in respect of interest. This makes it possible to distinguish it from charity, as solidaristic practices are understood to emerge among individuals or groups in symmetrical relations to each other in regard to the similarity that is relevant in a given context. Third, while feelings and emotions may play an important role in its development, solidarity is something that is done, performed. It is manifested

through “enacted commitments” (Prainsack & Buyx, 2017:42), which may vary in scope and impact, ranging from a document or piece of policy to individual actions undertaken by private citizens. Attention to these three dimensions made it possible to study the provision of online texts as informed by solidarity and to focus on how online contributors diagnosed with bipolar disorder relate to or distinguish themselves from others rather than approach them as a homogeneous group. As this involves inclusions and exclusions, this conceptualization also has the advantage of precluding an approach to solidarity as something exclusively positive (Dean, 1995) and encourages a focus on how the affordances of online platforms may be implicated in such practices.

## Solidarity and Idioms of Practice

In studying how solidarity relates to lay expertise online, I build upon multiple studies which have shown that a common diagnosis (Epstein, 2007; Rabeharisoa & Callon, 2002) and similarities in one’s genetic profile and potential health risks facilitate the formation of collectives (Rabeharisoa et al., 2013) and can even contribute to “genomic solidarity” (Van Hoyweghen & Rebert, 2012). The analysis is particularly indebted to Rabinow’s (1996) view that developments in genetics have led to the emergence of biosociality; that is, they have enabled the formation of new group and individual identities based on genetic and molecular insights. While new types of knowledge transform the ways in which people understand their condition and relate to others, online interactions are importantly shaped by the digital technologies they use, by the affordances of the social media where they seek and provide information. Thus “its [the internet’s] interactivity and the interaction it allows for can facilitate the formation of specific points of view and new ways of articulating individual experience to collective positions” (Akrich et al., 2008:2). Online exchanges may therefore contribute to “fostering community and mutual support, and negotiating medical relationships” (Sosnowy, 2014:325). They may also prompt transformations in the very meaning and practice of sociality (van Dijck, 2013), as people figure out what aspects of a technology they use and how they use it in practice, by

tinkering with it as they interact with others. Thus, not only do people use such technologies for social activities, but their very use is social, in that people “develop their beliefs about media and ways of using media within *idioms of practice*” (Gershon, 2010: loc 117). According to Gershon, “[i]dioms of practice point to how people have implicit and explicit intuitions about using different technologies, which they have developed with their friends, family members, and coworkers” (ibid.) and which “emerge out of collective discussions and shared practices” (ibid.).

The concept of idiom of practice underlines the multiple meanings that a technology can have, depending on its users and on the context of their engagement with it, on the ways in which those around them use it, and on the prevailing social norms and values that delineate what it should and should not be used for. In this sense, Gershon describes how the development of social media led to the development of various idioms of practice regarding acceptable forms of breakup. While some people considered breaking up via an e-mail a more acceptable approach, because it was more personal and private, others found that it resembled too much a monologue, and preferred being notified about such an occurrence on social media, where turn-taking could unfold faster and dynamic exchanges could easily occur. While in the early days of a technology, multiple idioms of practice can exist, in time certain practices may “solidify,” as some uses become widespread in specific contexts. The analysis described in this chapter is based upon a theoretical framework where this concept is combined with the understanding of solidarity developed by Prainsack and Buyx (2017). This framework allowed for a better understanding of the roles that online platforms and their affordances play in the performance of this value, of the new forms of sociality that can thus be developed, and of how they relate to lay expertise.

## Lay Expertise and Affective Labor

Lay expertise is typically developed as people diagnosed become better informed about the medical knowledge available about their condition, by learning to interpret their own embodied experiences in light of this knowledge and by engaging in various tinkering practices to better



manage their symptoms in their daily lives. While acquiring medical knowledge is an activity that in theory one may conduct individually, the other processes at the heart of lay expertise generally require multiple social interactions, as people diagnosed encounter others with the same condition and start making sense of their experiences by comparing symptoms, treatment reactions, and life circumstances. Importantly, lay expertise is developed in conditions where people who are brought together by virtue of the same diagnosis come to experience feelings of trust, care, and concern for each other. This means that such processes are importantly underpinned by affective practices, by the various strategies through which people diagnosed manage their affects and seek to produce specific affects in those they interact with. Nevertheless, previous studies on lay expertise have mainly focused on the epistemic processes through which people diagnosed become very knowledgeable about their condition, and have generally neglected the affective practices, which support the processes of knowledge acquisition, exchange, and development. While such a lack of attention may be informed by the age-old dichotomy between ratio and affect, it is regrettable in a context where scholars have highlighted the epistemic value of emotions (Nussbaum, 2003). This is especially relevant in regard to online practices, as growing calls have been made to acknowledge them not only as communicative activities, but also as forms of labor, through which particular identities are claimed and networks are developed (Clough, 2008; McCosker, 2018; McCosker & Darcy, 2013).

To determine the role affective practices can play in the development of lay expertise online, it is important to understand how emotions have come to be associated with the sphere of labor. Psychologists have played an important role in this sense, as in the first decades of the twentieth century they highlighted the relevance of emotions for professional practices through their engagements with the army and corporations (Illouz, 2008). Thus, during the First World War, intelligence tests were developed, followed in the decades thereafter by personality tests and experiments on corporate productivity, which came to be increasingly applied in personnel recruitment and management (Lussier, 2018). Under the influence of mental healthcare professionals, the ability to control one's emotions and to manage those of others became the mark of rational and

self-interested individuals and started to be seen as important competences, which could significantly further one's professional career (Illouz, 2008). As Hochschild (2012) showed in her studies on emotional labor, this trend has become all the more pronounced with the rise of the service economy, as the display of particular emotions is now an integral part of various jobs. Work on and through emotions has not been reserved, however, only to the professional realm, but has also become integral to the development and management of the successful self in the realm of private life (Illouz, 2008). Illouz (2018:148) importantly remarked in this sense that "the growing focus on emotions in the psy-industries and their rising economic value in corporations and consumer culture (...) are intertwined with the rising cultural value of emotions in the constitution of self-identity, social relations and well-being." Writing and reading have been at the core of such developments, as they allowed individuals to decontextualize and fix what had hitherto been transient emotions, to reflect upon them, and, in so doing, to manage them. This is important for the analysis described in this chapter, because while such practices have generally been reserved for private diaries, online platforms allow these days for "networked public intimacy" (Kitzman, 2004), facilitating new approaches for online contributors to manage their selves and to lay claims to particular identities online.

Since online exchanges involve not only the management of one's emotions, but also those of others, the concept of affective labor is used to study how affective practices contribute to the development of lay expertise. Affective labor is understood as "labor that produces or manipulates affects such as feelings of ease, well-being, satisfaction, excitement, or passion" (Hardt & Negri, 2004:108), which take place at a pre-visceral stage of experience. Particularly relevant here is Hardt's (1999:89) view that affective labor is indicative of "processes whereby our laboring practices produce collective subjectivities, produce sociality, and ultimately produce society itself." This perspective allows me to focus on the personal and social value their online engagements may have for people diagnosed with bipolar disorder. Whereas a growing amount of value is nowadays generated from the cognition, communication, affect, and the immaterial actions of online "prosumers," the debate among scholars about the role of immaterial labor in digital media economics is still

ongoing. Thus, Hardt and Negri (2004) join many others who have criticized users' engagement with digital technologies as a form of free labor (Lupton, 2014; Mitchell & Waldby, 2010; Terranova, 2000; Waldby & Cooper, 2008). More recently, however, a number of scholars (Andersson, 2017; Kneese, 2017; McCosker & Darcy, 2013) have shown that other forms of value or gratification that users of digital technologies may derive by engaging in immaterial labor need to be considered. This chapter builds upon the views of this latter group of researchers, as I argue that affective practices are an important, even though tacit, element of lay expertise, shaping it both directly and indirectly, through the collectives it supports into being.

The data underlying this analysis were collected from one French forum, *Troubles Bipolaires*, hosted on the online platform *Doctissimo*, and from one American forum, *bp Hope*. Two threads were selected from the first two pages of thread titles on the *Troubles Bipolaires*, which means that they had been among the most recently contributed to when the selection occurred. They were initiated in 2013 and 2014, respectively, and by February 20, 2018, one had gathered 1829 replies and the other 17,102. Fifteen threads from the *bp Hope* forum which had received at least 30 comments were selected. This selection criterion was determined by the need for numerous interactions in order to study the development of community. There is a considerable difference between the number of interactions studied on the French forum, which were also atypical for *Troubles Bipolaires*, and the ones on the American forum. Nevertheless, I decided to compare the two, in order to understand whether there was something specific about sociality on these two threads and whether the content, the contributors, and/or particular uses of online affordances explained this difference. While Chap. 4 focused on the treatment experiences of people diagnosed with bipolar disorder, for this chapter data were collected about two other important aspects in their lives—the lived experiences of the symptoms of this condition and personal and social life with/despite bipolar disorder. The data were analyzed using thematic analysis combined with approaches derived from conversation analysis, thus following in the footsteps of researchers who approach online interactions as forms of naturally occurring exchanges, given that they resemble offline dialogue in terms of turn-taking, action, and reaction (Armstrong et al., 2012; Kaufman & Whitehead, 2016).

## Solidarity About Bipolar Disorder Online

### Relevant Similarities

Online contributors were initially brought together on the fora studied by one important similarity: they had all been diagnosed with bipolar disorder. Behind this rather obvious commonality, many other similarities were conflated, such as a similar orientation toward bipolar disorder and similar approaches in trying to make sense of it and to address it effectively. Thus, long-lasting interactions developed among people who understood bipolar disorder as a biological condition, determined by genetic and neurological factors, and which could be managed through medication. This shared perspective was apparent, for instance, among online contributors who joked about not having children to prevent the transmission of their “bipolar genes,” or referred to neural activity and faulty circuits in their brain to explain some of their behaviors.

Another commonality online contributors shared was the difficulty to narrow down the meaning and influence of bipolar disorder on other aspects of their health. For instance, while in terrible pain because of trigeminal neuralgia, a chronic pain condition that affects the trigeminal nerve, *Sylvana* confessed to feeling uncertain regarding the source of her pain. Since none of the procedures undertaken had been very successful, she had started doubting whether the pain she was experiencing was solely caused by the trigeminal nerve or whether her diagnosis of bipolar disorder also played a role, either by rendering her more sensitive to the experience of pain or more resistant to the effects of the medications prescribed. In a similar vein, *elaine43*, a contributor on the forum *bp Hope*, confessed to being uncertain whether the loss of memory she was experiencing was due to aging, hormonal changes induced by the menopause, neurological changes bipolar disorder had produced in her brain, or the long-term effect of the medications she had taken for its management. Such common uncertainties were often underlined by similarities in certain aspects of identity, such as age, gender, and level of education.

Online contributors identified additional similarities in the form that certain symptoms took for them or in the adjustments they required,

such as the adaptation to a new location while on holiday, as the exchange below illustrates:

Whether I go far away or not, it's the same. Once I have my bearings, it's ok, but I need to get used to the place.

Sometimes this only happens late .... (georgette393, August 20, 2015)

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Same here, but that's why I often go to places I know. The adaptation can take long for me ... Decidedly the bipo [people diagnosed with bipolar disorder] really tend to function the same way .... (+Vie, August 20, 2015)

The identification of such commonalities contributed to the contributors' feeling part of a community to such an extent that it prompted some of them to make inferences about all people diagnosed with this condition, as +Vie's comment suggests.

The development of a shared idiom of practice further assisted online contributors to identify commonalities. For instance, frequent contributors on one of the *Troubles Bipolaires* threads developed the habit of sharing and updating elaborate personal descriptions on a separate location on the forum. This approach helped them discover similarities in terms of family circumstances, favorite pets, or places where they had lived. It also had the disadvantage, however, of rendering one's newcomer status more obvious, when online contributors did not use these distinct spaces on the forum as was customary. On *bp Hope*, the discovery of additional commonalities was assisted through the development of threads with a playful, socially informative character, such as "where were you when..." or "Sharing quotations." Next to the structured provision of such personal information, online contributors could identify similarities based on their profile photos, their motto, or online signatures, which conveyed through words and/or images their interests, hobbies, or political views.

## Performing Solidarity

Having identified such similarities, online contributors performed solidarity by sharing personal strategies to better manage bipolar disorder in

daily life, by informing others about the results of their self-experiments, and by creating a safe environment where concerns, preferences, and challenges could be expressed. The following exchange is illustrative in this sense:

The part about psychosis resonates with me. People don't understand it and are frightened by it. I find that I can't talk about it with my loves ones because it just creates more worry. It's the most isolating part of my illness.

I would add thoughts of self harm to the list. We all deal with it but it's not something we can talk about. (*beyondblue*, March 7, 2015)

**1 user thanked author for this post: Mary**

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Beyondblue,

Self harm does seem to be a taboo subject, even on here. I understand the trigger it is for most but I think it's important to admit when those feelings are breathing over our shoulders. Not only for our own well being but so others know they are not alone.

MO (*midnightowl*, March 7, 2015)

*beyondblue's* comment shows that he feels comfortable enough to accept the thread initiator's invitation to contribute to a list of less-talked-about symptoms experienced by people diagnosed with bipolar disorder. The first paragraph is important because it highlights the relational way in which this contributor experiences his condition as well as the affective labor he performs, as he takes into account the impact certain topics may have on his family and acts accordingly. The contrast between such avoidance behaviors toward one's family and the openness of one's online contributions highlights the important social function fulfilled by online platforms. The switch from "I" to "we" in the second paragraph indicates that *beyondblue* feels solidarity with the other online contributors based on a common, even though rather taboo, symptom.

*midnightowl's* reply to *beyondblue* confirms the solidaristic ethos underlying such sharing practices, as she encourages him to continue to talk about self-harm as a form of support for others. While she does not dwell upon it, *midnightowl* acknowledges that such sharing practices also further the well-being of the contributor, which supports the view put

forward by Prainsack and Buyx (2017) that people act simultaneously out of self-interest and concern for others when engaging in solidaristic behaviors. Even though it is a light form of participation, *Mary's* appreciation of *beyondblue's* comment suggests that the online affordances on the forum ensured a minimal degree of reciprocity among information providers and information seekers and thus contributed to the development of relationships.

Online contributors also performed solidarity by putting time and effort into identifying reliable sources of information for those with whom they frequently interacted. As *Sylvana* was worried about a surgical procedure she was due to undergo, online contributors answered her invitation to help:

you make me think that I should look for a very specific forum for “people in my case”.

if one of you is willing to do a search for me, I'm interested. (*Sylvana*, April 13, 2015)

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so....

on docti [N.B.link provided]

next

a discussion on vulgaris [N.B.link provided]

then

a forum [N.B.link provided]

and afterwards

a positive testimony [N.B.link provided]

That done, you'll still need to look around...

Right now I got to go pick up my son.... (*Rianne*, April 13, 2015)

*Sylvana's* first sentence highlights the tendency among online contributors to seek interactions with others with whom they share relevant similarities, and indicates that individuals may be simultaneously members of multiple online communities, where they focus on different issues of interest. *Rianne's* reply makes it obvious that she invests time in the context of a busy schedule and uses her online experience and personal knowledge of *Sylvana* to identify online sources of information that she believes would be of help to her online friend. The small description

*Rianne* provides about the online platforms she selected suggests that for these online contributors, interactive online platforms where people can engage in dialogue are important sources of lay expertise, which they find useful in case of doubt or anxiety. The list can also be understood as the result of affective labor, as *Rianne* keeps her list short and easily legible, and includes in it a positive testimony, to further reassure *Sylvana*.

As already alluded to in some of the examples provided, online contributors also performed solidarity by engaging in affective labor, by displaying emotional availability in their interactions with other people diagnosed with bipolar disorder, and by listening to them with respect and empathy over extended periods of time, judging by the dates and frequency of the comments. At the same time, they showed consideration for the effects their reactions might have upon their interlocutors, or paid attention to the latter's needs and preferences to personalize their advice and render it more appealing. Online contributors also performed solidarity as they sought to motivate people who were going through a difficult time and offered support to those who were experiencing serious mood episodes, as the following exchange illustrates:

I had already taken the anxiolytics...

But I've managed to ask someone to help me on a forum because I couldn't take it anymore. Someone reacted and we're talking via private messages. I think this will help me a bit. Thanks. (*Derek21*, March 18, 2013)

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O.K. If I can also be of any help, it would be my pleasure, even if we haven't talked much.... (*Liane*, March 18, 2013)

The importance of the help online contributors provide each other is highlighted here, as *Derek21* frames the interaction with another person diagnosed with bipolar disorder as an additional therapeutic means to manage anxiety. While *Liane* describes herself as "pathologically pathetic" in her online signature, her reaction suggests that engaging in solidaristic practices online may constitute a way to claim a different identity, that of someone strong and capable enough to support another person with whom she shares an important similarity in a dark moment.



There were, however, also important “costs” to the performance of solidarity. Thus, considerable time was necessary to provide advice and support through well-balanced and carefully considered comments, as was evidenced by replies where contributors acknowledged other people’s requests for input, but mentioned that they needed to reflect before providing them with an answer. The provision of information about the effects and side effects of medications that online contributors had taken at some point along their bipolar trajectories required at times rather painful journeys into their past, a revival of periods marked by pain and suffering. Furthermore, people diagnosed with bipolar disorder shared with others with whom they acknowledged certain similarities strategies to manage their condition at the level of daily life, which were often the result of extensive tinkering. While these “costs” were considerable, online contributors underwent them as the insights they put forward not only benefitted others, but also themselves, as they became better aware of their own behaviors and reactions. The identification of important similarities facilitated the development of a new type of collectivity, what I call “digital biocommunities,” which I discuss below.

## Digital Biocommunities and Their Roles

As the insights provided above illustrated, the online contributors studied here understood their condition in relational terms, by discovering important similarities with others and by making sense of their various experiences through interactions on the fora. The recognition of these commonalities and the performance of solidarity led to an atmosphere of shared intimacy, which made online contributors feel at ease and prompted them to give more detailed and personal information about themselves. This facilitated the development of digital biocommunities, a new type of subgroup that emerged based on increasingly more specific commonalities, including a shared idiom of practice regarding the use of digital technologies. Based on the analysis, it became apparent that the coming into being of this new type of collectivity was underlined by engagements in three types of affective labor: the management of personal affects, the artful display of affective responses, and the careful

orchestration of empathy and distance. This way, relations among a growing number of contributors emerged and were maintained and new knowledge could be produced, as people diagnosed with bipolar disorder were able to further their self-knowledge, to perform lay expertise, and to contribute to its collective development.

The attachments and sharing practices developed among the members of these digital biocommunities enabled them to approach their online engagements as reliable ill-health indicators, as the following excerpt illustrates:

But anyways, I have the feeling that over the last weeks it's been less bad going down [N.B. becoming depressed], so it should be less bad going up [N.B. becoming manic]

Though when I think about it, I was in such bad shape that I didn't come here anymore...

It's crazy how much we forget as time goes by...

What are you up to now? (*Rianne*, February 23, 2015)

Thus, *Rianne* appreciated the severity of her depressive episode by ascribing a considerable weight to her inability to join the forum, as it prompted her to reassess her initial evaluation. For this contributor, participation in this digital biocommunity had become part of how she experienced bipolar disorder, which signals the strength of the social bonds she had developed there.

By developing digital biocommunities, online contributors increasingly related to the digital technologies they used as particular means to act upon disease, as the relative permanence of their posts and the closeness of their interactions with others enabled them to further their self-knowledge and to better manage their condition. This was facilitated by the affordances of fora and by a shared idiom of practice, which allowed for the interpretation of certain online behaviors as markers of particular (ill-health) states. Thus, online contributors could heighten their self-knowledge through their engagements with the posts they had made on the fora over extended periods of time. Since these posts were accompanied by details regarding the time and date when they were made, they functioned as a form of public online diaries, from which people

diagnosed with bipolar disorder discerned specific patterns. This allowed them to identify triggers for certain mood episodes, or to improve their assessment of the mood state they experienced, as the following excerpt illustrates:

it's been the most agonizing thing i've ever experienced. i'd prefer to go through labor and childbirth, because as least when that's over, it's OVER. and besides, it's way less painful than feeling like your soul is being tortured and set on fire.

it will usually begin with a general feeling of anxiety for no discernable reason maybe because i'm bored and don't feel distracted enough from my evil thoughts. OR something extremely minor will make me IRATE, such as getting curly fries when i asked for regular. by then, it's too late, and i'm angrily yelling and/or throwing my food.

my head starts buzzing with a feeling of electricity/energy, and it feels like a fly is zipping around my brain, bouncing off the inside of my skull. there's an unbearable roar in my brain and i cover my ears, shake my head, and scream/cry. i want to jump out of my skin. i curl up in a ball, in a dark, quiet, small room, and i'm paralyzed there, totally unable to function (...). I want to knock myself unconscious to get rid of the pain, when they are REALLY bad (...)

they are very hard to get out of. and now i'm so manic i'm misspelling every other word, so i know those aren't even close to all of what is going on inside, but i will surely upset myself if i try to slow down here and think anymore. :-/” (*noone31*, November 6, 2013)

*noone31* provides a thick description of her experiences of mixed states by mobilizing highly evocative as well as more broadly relatable comparisons, which help make her state intelligible to others. The last part of her post indicates that elements of online communication, such as misspelling, function for this contributor as markers of a severe manic episode. Furthermore, the way in which the evocative description of her states is organized, its rhythm and punctuation suggest that the post can also be understood as a digital enactment of this mood state. Such practices can therefore be seen as important steps toward achieving self-management and self-change, as they allow disease experiences to be “defined, labeled, and categorized” (Illouz, 2008:196).

Other contributors enhanced their self-knowledge through the substantial knowledge other members of the community had acquired about them, which allowed the latter to mobilize the shared idiom of practice to interpret “deviant” engagements with the technologies of fora as disease markers. For instance, very short replies or the absence of any emoticons across several contributions provided by the same person was seen as a mark of flat affect, and thus indicative of a depressive episode. Similarly, in a context where forum interactions tended to be rather short and to succeed each other quickly, the provision of very long comments, sometimes stretching over the equivalent of six to seven pages, was seen as indicative of a manic episode. The following exchange is illustrative in this sense:

Vana...are you in good shape or is it just an effect of the screen??? (*Rianne*, March 4, 2015)

\*

the optical effect conveys a true reality! I have been in an up [in a manic state] for some time now; I'm even starting to think it's my normal state and nothing will upset it 🚫(😞)... (*Sylvana*, March 4, 2015)

The community-building function of the shared idiom of practice comes into relief here through the use of the euphemism “to be in good shape,” which for the members of this digital community denoted a manic state, and through the emoticons and brackets at the end of *Sylvana*'s post, which were appropriately interpreted by these contributors. It is important to note the distinct functions fulfilled by the two emoticons and brackets. Through the Red Face emoticon, characteristic for *Doctissimo* (Lombart, 2018), *Sylvana* conveys her anger and exasperation at not being able to manage her feelings, whereas the second emoticon fulfills a relational function, as *Sylvana* uses it to connect with *Rianne*, to express regret about the impact the state she finds herself in may have upon her. This illustrates how affective labor can contribute to the maintenance of one's online network.

Self-knowledge was furthered among the members of digital biocommunities also through the consultations they engaged in, as they actively

invited others to help them interpret their experiences and to determine the mood states they were in:

in favor of the up [manic episode]:

I get up every day around 4 pm 🤔

I started to put on a lot of jewels whereas for months I had only been wearing my wedding ring and the one of my deceased mother 🤔

against the up [manic episode]:

I don't feel excited 😊

I don't do compulsive shopping 😊

I am not aggressive 😊 (*Sylvana*, October 1, 2015)

*Sylvana* interpellates the other online contributors as experts, who not only have substantial experiential knowledge on bipolar disorder, but also know her very well. She invites them to perform lay expertise by replicating to a certain extent the activities of medical professionals when seeking to establish a diagnosis. Thus, she describes her online and offline behaviors as clues which they can use toward the correct identification of her state. To assist the other online contributors, she places her behaviors in context, providing information about their frequency and about her own emotions in regard to them. Through intensive online interactions with others, *Sylvana* and other contributors like her could bring in relation to bipolar disorder aspects of their behaviors they had not previously considered to be shaped by it, or to identify certain patterns which in time enabled them to better manage this condition. This allowed online contributors to further their self-knowledge, as aspects of the self which may have been opaque or ambiguous to the individual diagnosed with bipolar disorder were clarified relationally. Furthermore, such exchanges may have (had) performative effects on each contributor in ways similar to the narratives disseminated through other media, as signaled by Illouz (2008:185), who argued that one's public illness account "compels him or her to change and to improve his or her condition (...) It makes one responsible for one's future but not for one's past."

In Chap. 4, I have argued that people diagnosed with bipolar disorder could contribute to the development of new insights about the effects and side effects of medications through their online engagements on

blogs and fora. The findings described above have cast light upon a different dimension of their contributions, as they indicate that fora can be used to enhance the knowledge online contributors acquire about themselves and others in regard to the manifestations of bipolar disorder and how it shapes their personhood. Such exchanges also enable them to perform lay expertise or to contribute to its collective development, which I will discuss in more detail below.

## Solidarity and Lay Expertise

The analysis of the data indicated that lay expertise on bipolar disorder developed as an effect of the solidaristic practices which prompted online contributors to share their embodied, experiential knowledge and the medical insights they had acquired on this condition. The exchange below is a good example in this sense as it illustrates how different contributors came to discover common elements, which moved them to share effective strategies, but also to assume different epistemic positions:

1.Hi everyone, I have bipolar I disorder and

2.have recently experienced being in mixed state the worst I have ever been. It was3.easily the scariest thing I have ever gone through. I was crying uncontrollably at my4.friends house and couldn't stop.

5.I can't explain it to other people very well.

6.My feelings were SO up and down back and forth all at once. The crying wouldn't7.stop.

8.My friends try to be understanding about having bipolar disorder but they struggle to 9.really relate.

10.How can I blame them? I 7.am a bit embarrassed about what happened last week.

11.Does anyone have any tips for me?—Jeanie (*Quickjeanie*, April 5, 2015)

\*

1.Hi Quickjeanie, (and welcome), and Gill, I am diagnosed with BP2, rapid cycling, mixed 2.states,

3.and I've definitely experienced those days with the crying jags that accompany an 4.ordinary or slightly hypomanic day.

5.It's defiantly frustrating and confusing.

6.For me its usually something triggers me or I'm under stress when this happens. Or 7.I'm under a medications change or even hormones can do it.

8.I think the best idea for learning about these shifts is to keep a daily journal. You don't 9.have to write full diary entries, but keeping track of your moods, stressors, triggers, 10.medications, even the weather all help you to establish patterns to help you learn to 11.combat these quick shifts. Its also a good tool to take to your Pdoc to be able to 12.discuss these issues with them. I think coping skills you can learn in therapy are a big 13.help as well. Learning some deep breathing exercises, how to identify those triggers, 14.etc. goes a long way to helping the medications.

15.Just know your not alone, and although it's difficult, try not to be to hard on yourself. MO (*midnightowl*, April 5, 2015)

\*

1.Jeanie,

2.it sounds like the severity of this particular mixed episode was very unexpected.

3.I believe when something this terrible happens, if we're not at all prepared, it's even 4.worse.

5.How could you prepare for such a thing when you've never had this happen before.

6.I need to make a safety plan for the unexpected episode that could put me in harm's 7.way.

8.Anyone of us could experience what happened to you. Bipolar is unpredictable. Meds 9.and therapy and a host of other wellness skills cannot completely protect us. For me 10.this is why a safety plan is so important.

11.When I have a mixed episode (most all of my bipolar is mixed and also rapid cycle) I 12.don't cry. Pretty much I never cry, even when I want to. My symptoms are extreme 13.agitation and irritability combined with depression.14.There are two things that help: #1. Exercise (this is my first line of defense) #2.

15.Watching a movie (preferably after I've exercised so I'm calm downed enough to enjoy) (*elaine43*, April 5, 2015)

This exchange follows a two-part sequence often encountered in the interactions of psychotherapists with their patients (Wynn & Bergvik, 2010). Thus, a first “troubles-talk” (Jefferson, 1988) sequence, where

*Quickjeanie* describes her feelings, thoughts, and states to indicate the difficult situation she finds herself in, is followed by a second sequence where *midnightowl* provides a supportive response. Another second sequence is provided, as *elaine43* reacts to *Quickjeanie*'s post before the latter has the opportunity to engage with *midnightowl*'s statement. While *Quickjeanie* opens her sequence in similar ways to other contributors on the thread, a significant feature of this post is the question at the end, which serves as a direct request for advice based on the same diagnosis and similar experiences. It also indicates that *Quickjeanie* positions herself as a non-expert in regard to the management of this group of symptoms, and considers other forum contributors to be more knowledgeable. By reacting to her post and thereby responding to her interpellation, *midnightowl* and *elaine43* situate themselves as experts in this context, and their posts include various elements meant to justify it. Interesting about the way in which *Quickjeanie* organizes her post is the new theme she introduces in the middle of her description of experienced symptoms (lines 2–4 and 6–7). Through it, this contributor both acknowledges her communicational difficulties and suggests that people who lack experiential knowledge of the symptoms she describes may have a hard time properly understanding them. This is further reinforced by her expectation that people on the forum would be able to provide her with advice others in her immediate surroundings were not able to give her, as denoted by her question.

*midnightowl* seeks to convey alignment with the experiences recounted by *Quickjeanie* by mirroring to a large extent the organization the latter opted for in her post. Like *Quickjeanie*, she begins her sequence with a greeting, followed by information about her diagnosis, and a description of her experiences with mixed states. This serves both to legitimate her knowledge and to highlight this as an important element she and *Quickjeanie* have in common. This exchange illustrates the careful orchestration of empathy and distance that online contributors engage in to perform lay expertise, as *midnightowl* responds reassuringly to the latter's expectation of empathy (line 5), but moves on to the provision of knowledge, by showing her awareness of particular triggers and by using medical terms. The next and more extensive part of her reply is the response to *Quickjeanie*'s direct question, and consists of various suggestions on how



the latter could better manage her mixed states. The order of these elements in *midnightowl's* post is important, as the move from personal difficulties to strategies serves to establish her expertise. The authority of her claims thus significantly derives from her ability to successfully, albeit temporarily, address the challenging symptoms she describes and to manage the emotions arising along with them. *midnightowl* concludes her post with a display of solidarity, as she encourages *Quickjeanie* to think of herself as part of a community and provides a caring suggestion in reaction to the latter's statement that she was "a bit embarrassed" by her behavior. The similarity *midnightowl* presumes to exist between her and *Quickjeanie* is further predicated upon common emotions. This is indicated in this part by the preemptive statement "although it's difficult," which signals that *midnightowl* recognizes this affective state, and is aware both of how the contributor might react to this suggestion and of the actual effort required to follow up on it. Such affective labor legitimates the emotions and experiences described by others and lends greater epistemic authority to the advice provided.

*elaine43* organizes her reply to *Quickjeanie* in a different way, dedicating a large part of her contribution to the expression of empathy and the display of solidarity. The first sentence is meant to authenticate *Quickjeanie's* experiences as well as to soothe the feelings of embarrassment the latter described. The switch from "I" to "we" in line 3 is important in relation to solidarity, as it shows that *elaine43* thinks of herself, *Quickjeanie*, and presumably other people experiencing difficulties with the management of their symptoms as part of a community, herewith echoing the last part of *midnightowl's* post. At the same time, *elaine43* distinguishes among people diagnosed with bipolar disorder based on their familiarity with the condition, as she pleads to *Quickjeanie* not to feel guilty by framing her as an inexperienced novice. This is a perspective that she nuances by distinguishing between the agency she ascribes people diagnosed with bipolar disorder and the condition itself, as the understanding of bipolar disorder as "unpredictable" and capable of catching off guard any person diagnosed supports her suggestion of creating a safety plan.

This perspective on bipolar disorder contrasts the one advocated by *midnightowl*, who enumerated various options to manage one's condition

which she considered effective (lines 8–14), as emphasized through the use of the superlative adjective “best” and of qualifying adjectives with a positive (contextual) value in assessments such as “big help,” “good tool,” “long way.” Without directly interpellating *midnighowl*, *elaine43* engages with the elements in her enumeration, resisting the largely optimistic tone of her message. This move suggests that *elaine43* conceives of solidarity in ways which allow one to have distinct individual experiences while still being part of a large community of sufferers. This can be noted in the positioning of “us” and “for me” next to each other in line 9. It is further reinforced in lines 11–13, where even though the mixed states *elaine43* describes are the opposite of those experienced by *Quickjeanie* and *midnighowl*, she still shares her own coping strategies. This contributor thus seems to base her solidaristic practices on the same diagnosis and to consider this a sufficient commonality for the same strategies to be effective, even when the condition manifests itself differently. Since these elements mirror through their position the location of *Quickjeanie*’s request for advice in her post, they also serve to provide a sense of completion.

In the examples provided above, the performance of lay expertise was achieved through the careful combination of empathy and distance, and the efforts the online contributors were making to manage the flow of affects triggered by the experiences described by others were understated. There were, however, also numerous instances, where the intensity of these affects was in full display, as the following quote illustrates:

It is true that you are courageous it's amazing I had tears in my eyes [when reading your account].

I would love to be able to help you but I don't know what to say to you I swear I'm sad for you Vana [N.B.Sylvana]

I have always said that I didn't want anybody else to know the pains I'm experiencing and now it happens to you and it makes me sad and I feel your pain and I don't know what to do.

Know that violent noises, fatigue, fear, sadness, anger, anxiety, panic will accentuate your pain. Also the cold as well as burning things. Unlike them, what is soft will relieve your pain...

Don't take too many analgesics because the sleepier you'll feel, the more your muscles will tense. The brain takes it as a signal, like, saying: "Beware! I won't let go of anything!" Have you been advised to take cortisone in low dosages? On my face it works well but on my legs it never led to any results.

Good and sweet night. (*Lera*, April 5, 2015)

This comment thus highlights the affective labor through which the negative affective reactions triggered by *Sylvana's* post—one of the emotional costs of contributing online for people diagnosed with bipolar disorder—are turned into means through which *Lera* can relate to her, while the memory of the latter's own suffering serves to validate *Sylvana's* experiences. Furthermore, *Lera* engages in "caring work," a key form of affective labor (McCosker & Darcy, 2013), to alleviate *Sylvana's* state by expressing empathy, by encouraging and reassuring her. Building upon these affective practices enables her to perform lay expertise, as she advises *Sylvana* on the emotional and physical states that she should avoid to better manage the pain by combining embodied knowledge with medical information.

The personal insights people diagnosed with bipolar disorder shared online and the detailed descriptions of their states and behaviors enabled others to increase their knowledge about this condition in regard to aspects that they did not personally experience, as the quote below illustrates:

How the illness transforms a person....

I know the mixed mood state through you Ria....

I could write volumes about it! I had even strongly thought of it as an outlet it's not bad except that you have to stick to it.

And at the moment concentration is not one of my strengths.  
(*georgette393*, January 18, 2016)

While no individual diagnosed with bipolar disorder can have experiential knowledge about all the symptoms of this condition, through their frequent interactions with other people diagnosed, online contributors come to develop lay expertise about it and to enrich their personal knowledge through other people's first-hand accounts. This is important,

because it shows that these contributors are not only interested in grasping the individual manifestations of their condition, but they want to acquire a thorough understanding of bipolar disorder, which is only possible by accumulating different types of knowledge and by relating their experiences to those of others. Overall, the epistemic relevance of these insights was often publicly acknowledged, as the following excerpt illustrates:

Thank you for your personal experiences you have helped me understand a lot more about myself. I only wish my clinical psych was as clear about this as the information I've managed to understand here. (*Polar1, May 18, 2016*)

## Discussion

This chapter has shown that despite individualizing tendencies in personalized and precision medicine, solidarity remains an important value for people diagnosed with bipolar disorder and it underlies the performance and collective development of lay expertise. Thus, rather than focusing on the distinctions between themselves and others, the online contributors studied here identified important similarities with each other, which prompted them to incur personal costs in order to provide others with help and support. To account for this innovative coming together, I put forward the concept of digital biocommunities to denote the development of (sub)groups based on numerous commonalities of experience and similar engagements with the technologies of fora. By developing digital biocommunities, online contributors related to the digital technologies they used as particular means to act upon disease. While such statements are nowadays often made in relation to digital mental health applications, which provide quantified insights or visualizations, this chapter has illustrated that people's ability to manage bipolar disorder is enhanced through the narratives, thick descriptions, and dialogue that fora and similar interactive online platforms allow for. Online contributors can further their self-control and better navigate daily life through the practices of self-revelation/clarification and collective consultation in which they engage. In so doing, they also contribute to the development

of lay expertise about this condition, as a more unified and comprehensive image of bipolar disorder and its manifestations at the personal level emerges through frequent online exchanges.

The development of lay expertise traced here depended not only on epistemic practices, but also on the ability of online contributors to appeal to the considerations, emotions, and perspectives of their interlocutors, and on their display of sympathy and empathy. The sharing of experiential and other types of knowledge required for the development of lay expertise was also informed by the feelings of well-being that online contributors experienced in so doing, as they could temporarily position themselves as knowledgeable, capable, and supportive rather than frail, vulnerable, and in need of help. Thus, for knowledge to be shared, circulated, and produced, it was not enough for people diagnosed to identify relevant similarities, but they also needed to engage in the affective labor required when interacting publicly with multiple individuals. Affective practices and engagements play therefore an important role in the production of knowledge, even though these aspects have been thus far largely neglected in social studies of science. Furthermore, the findings discussed here illustrated that affective labor is more than unpaid work, as, through it, online contributors could perform a value they found important; they acquired self-knowledge and contributed to the development of collective knowledge on the management of bipolar disorder.

The close link between solidarity and lay expertise that these findings illustrated is important in the current context where knowledge is increasingly referred to as a resource that can be privately owned (Newell, 2015) and is thus more often related to other values, such as competitiveness and efficiency. Nevertheless, it is important to bear in mind that solidarity is not in itself a positive value (Dean, 1995). As people come together with others with whom they share important similarities and are willing to incur costs in order to assist them, they also distinguish themselves from those with whom they do not share such similarities. Such tendencies could also be noted in this chapter, as some online contributors distinguished in essential ways between people who were diagnosed with bipolar disorder and those who were not. While such processes of inclusion and exclusion may not be prevented, for digital biocommunities to continue to have positive effects, it is important that their members

reflect upon the criteria they use to include and exclude others and upon the consequences such practices may have.

Digital biocommunities bear some resemblance to self-help groups, which in the past have facilitated the development of a common identity among people diagnosed with contested conditions, such as the fibromyalgia syndrome (Barker, 2002). This is in line with previous findings that have shown that online communities share with their offline predecessors similar objectives, work practices, modes of approach, and orientation toward cognitive resources (Akrich, 2010). The development of digital biocommunities can be interpreted as indicative of a growing need among people diagnosed to come together, share experiences, and support each other in a context marked by the increased deregularization of mental healthcare services. This is supported by the fact that both in the US and in France the number of self-help and support groups, described in more detail in Chap. 2, has been increasing over the last few decades (Fox, 2011; Girard, 2008). Since background conditions can further or deter solidaristic practices (Prainsack & Buyx, 2017), more research is needed to understand how they affect online engagements, and what role the different affordances and designs of fora and other interactive online platforms play in such developments and what types of solidarity are thereby encouraged.

While self-help groups have been historically less influential in France than in the US, solidarity is considered by many to be a national value in France, which might explain the more numerous and frequent exchanges to support others in need on the *Troubles Bipolaires* threads. The role of cultural and social factors in explaining such distinct online behaviors was further reinforced by the fact that on two other American fora, which were consulted to compare the number of participants and their interactions, few threads exceeded 30 comments, let alone reach hundreds or thousands. The distinct online landscape available for both countries may have been another influencing element, as infrastructural, economic, and institutional factors have shaped the development of a dispersed online environment in the US and a more centralized one in France. Future studies are therefore needed to acquire a better understanding of the specific factors that inform such differences in online participation and support between contributors from the US and France.

The solidaristic practices described in this chapter were identified at a time when the pronounced individualization of responsibility brought about by personalized and precision medicine has led many scholars to approach solidarity as a value that is under threat and in need of protection (Aarden et al., 2010). The resilience of solidarity in this context indicates that it is a very important value to people, who find solace in knowing that they are not alone in experiencing specific issues. The concept of digital biocommunities suggests that as people come together based on increasingly more specific commonalities of experience, they might form part of multiple dynamic (sub)groups, depending on the similarities they focus upon and the solidaristic practices they engage in. This has consequences for the ways in which personhood and “personalization” are understood, as it strengthens the idea that they are defined and re-defined through social interactions and practices which are meaningful to people diagnosed. Hopefully, through their multitude and diversity, the development of digital biocommunities will provide people diagnosed with bipolar disorder with safe havens, where they can feel at ease and where they can become better aware of their talents, strengths, and knowledge, and of the important values they uphold as they share them with others.

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