Building familiar-looking bridges and reaching familiar-looking outcomes: Information behaviors of recovered mental health patients and their roles in sense-making their mental health

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Abstract

This paper explores the motivations of recovered Filipino mental health patients (RMHPs) for seeking and processing mental health-related information, as well as these information behaviors' roles in helping them make sense of their mental health. The findings show that practical motivators such as the need to alleviate pain and socio-psychological motivators shaped RMHPs' information seeking, information processing, and privacy management. In particular, the pain of enduring symptoms and the expectations to get better increased their intentions to seek information, engage with their concerns more effortfully, and craft lenient privacy boundaries that helped them gain more insights about their mental health. RMHPs labeled these behaviors as guides that helped them achieve an acceptable but not ideal outcome. That is because RMHPs wish to feel "normal" again after having engaged so much with their concerns. This implies that the role of information in sense-making may be that of helping people reach familiar but not ideal outcomes.

Keywords: information behaviors, sense-making, mental health, health communication

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Introduction

In the Philippines, issues related to mental health are often taken for granted. Regina Peralta (2016) observed that in both mediated and actual conversations about mental health, there exists a tendency among Filipinos to downplay mental health problems and describe them as mere "moods" or "rants" (p. 2). Mental health problems such as depression may be perceived by Filipinos as something made up, a belief that Antover Tuliao (2014) attributes to lay and folk conceptualizations of mental health disorders that treat them as mere moods, a lack of strength of character, or even the curse of spiritual entities (Abad et al., 2014; Tan, 2008).

Such attitudes, as well as the shame associated with seeking help for mental health problems and the lack of mental health facilities in the country, leave much to be desired when it comes to the discourse on Filipino mental health (David, 2010; Lagman et al., 2014; Tuliao, 2014). Scholars have attempted to expand the discussion by using the ritualistic lens of communication[1] to understand the experience of going through mental health problems. The lens has brought forward new perspectives on how people deal with mental health problems as disabilities. Studies using the ritualistic lens have found that individuals who live with mental health problems struggle to explain their experience to their immediate social circles (Flood-Grady & Kellas, 2019), resist categorizations of their experiences (Gwinner et al., 2013; Van Lith, 2014), and instead try to find meaning in living life outside the perspective of a person managing a disability (Gowen, 2013; Rasmussen-Pennington et al., 2013). Despite this approach's usefulness, studies on mental health still primarily focus on health information transfer and influence rather than meaning-making (Carey, 2008; Mendez, 2020).

A majority of health communication scholars contribute to health discourse by understanding the processes involved in making informed health-based decisions. They start by identifying the demands of information seekers (Aref-Adib et al., 2016; Gowen, 2013; Mishra et al., 2009), then analyze the motivations for and barriers to information behaviors such as affordances, structural forces, and stigma (Lannin et al., 2016; Tuliao, 2014; Tuliao et al., 2016). They mostly utilize the transmission view of communication, which focuses on the execution and reception of messages (McQuail, 2010). They see information behaviors as the central phenomenon influenced by biological, psychological, social, and cultural factors. As such, they studied the consequent effects of these factors on the intent to seek information and the ways people use it to engage in issues using it (Ho et al., 2014; Kahlor et al., 2006).

The Risk Information Seeking and Processing model (RISP) has been used primarily to explain individuals' information seeking and processing

behaviors for impending but relevant health hazards (Eastin et al., 2015; Johnson, 2005; Kahlor, 2010; Lu, 2015). Typically, scholars who use RISP as a theoretical anchor expect certain variables to stand out as significant predictors of information behaviors; however, they found it difficult to ascertain the most consistent and strongest motivators of information behaviors. For one, a majority of these scholars measured the intent to seek information and not the actual behavior of seeking information. Upon taking a closer look, they examined the influence of socio-psychological variables in several, often impersonal, health contexts using surveys (Eastin et al., 2015; Ho et al., 2014; Willoughby & Myrick, 2016). They also struggled to form a consensus on the predictive power of their theories after having them examined time and time again (Willoughby & Myrick, 2016; Yang et al., 2011). In particular, several scholars struggled to vouch for the reliability of predicting information-related behavior through the "main drive," which was information insufficiency. Information insufficiency has, in several health contexts, failed to reach significant relationships with information-related behaviors in several contexts (Willoughby & Myrick, 2016; Yang et al., 2010, 2011); in times that it did, it was outclassed by other factors (Li, 2015).

Because of their lens, they used to explain only the transmission aspect of communication and overlooked what James Carey (2008) and Samuel Mendez (2020) might term the broader picture: what people get from seeking information and how they use it to navigate their world. Hence, information scholars who utilize the ritualistic lens focus instead on sense-making, which, in a nutshell, is bringing one's self from his current to his desired situation using information (Dervin, 1999). Although sense-making scholars have quite a similar approach to scholars who studied patients' definition of their experiences through meaning-making, which often focused on defining the personal significance of experiences (Brolan et al., 2013; Holmes & Papps, 2018; Van Lith, 2014), sense-making scholars also invest in exploring the processes involved in creating these meanings. The sense-making process also involves identifying the gaps in one's current situation, looking for more desirable outcomes, and bringing oneself to those outcomes with the use of information behaviors (Dervin, 1999). Upon focusing on the importance of the processes, these scholars also become perceptive of the increments of information behaviors and the factors that influence them rather than simply exploring the meanings and definitions of one's life experiences.

This paper bridges the health communication discourses of the scholars who subscribe to the transition and ritual views of communication, although it seeks to capture more of the nuances of the ritual view. This merged approach is particularly suitable for studying mental health problems, which are personal and not easily defined in clinical terms (Ehrlich et al., 2018;

Holmes & Papps, 2018; Van Lith, 2014). While this study acknowledges the importance of exploring the motivations behind information behaviors, it goes beyond that by examining how these behaviors are utilized in the sense-making process, employing a tailored approach that aligns with the information behaviors of recovered mental health patients (RMHPs). Notably, this study recognizes privacy management as a crucial facet of information behaviors, acknowledging the unique rituals of individuals living with mental health problems.

Mental health is inseparable from the pervasive issue of stigma, which affects societies worldwide. Media scholars have highlighted stigma as one of the most significant barriers to help-seeking (Holman, 2014; Peralta, 2016; Smith, 2015). Specifically, the stigma identified revolves around the perpetuated notion that mentally challenged individuals are violent, homeless, unemployed, and involved with the criminal justice system (McGinty et al., 2016; Smith, 2015). In light of this hostile landscape, efforts to seek mental health information often incorporate privacy management elements.

These aforementioned issues invite scholars to not only explain how information behaviors can be bolstered but also to elaborate on how they contribute to sense-making using an approach that best suits the health context. To fulfill such ends, I explored how recovered mental health patients, or RMHPs, made meanings out of their mental health experiences. To incorporate the dominant mode of explaining information behaviors, I sought to understand the psychological, social, and privacy-management-based factors that influence information behaviors and their emergent interactionsm, as seen in RMHPs' experiences. I thus asked: What are the motivations of RMHPs' information behaviors? And what are the roles of information behaviors in RMHPs' sense-making of their mental health?

Theoretical Framework

To provide a theoretical framework centered on sense-making and its implications for mental health, I applied Brenda Dervin's (1999) sense-making theory to understand RMHPs' information-seeking behaviors. This framework recognizes information-related behaviors as crucial in bridging individuals from their current situations to desired outcomes and takes a qualitative, meaning-making approach to health information behaviors.

Building on the revised Risk Information Seeking and Processing (RISP) model by Robert Griffin et al. (1999) and Janet Yang and Lee Ann Kahlor (2013), this study examines the motivations behind information-seeking and processing among recovered Filipino mental health patients. It acknowledges that information-seeking and processing are driven not only by insufficient information but also by factors such as attitudes and

subjective norms that influence the desire to bridge the gap between current and desired knowledge levels.

To capture the nuances of privacy management in information seeking and processing, the framework also incorporates the Communication Privacy Management (CPM) perspective. The theory states that people believe they have the right to control their information and form mechanisms or strategies regarding its disclosure (Canzona et al., 2015; Petronio, 2002). Private information is conceptualized as health information carefully managed by the owner. Upon sharing it with others who eventually become co-owners, they may inadvertently cause social consequences apart from gaining insights, such as jeopardizing the original owner of information with threats of discrimination (Oldfield et al., 2016) or terminating valuable relationships (Broekema & Weber, 2017). Individuals exercise privacy control by selectively choosing to disclose information or preparing for responses from people who might respond to their disclosures in unexpected ways. This is what Mollie Canzona et al. (2015) call "privacy protection strategies" (p. 9). In this study, I refer to them as privacy management strategies, and they may be applied to the intention to seek information or the intention to engage with mental health-related concerns in a certain manner.

In summary, this theoretical framework, rooted in sense-making theory, highlights the importance of understanding the motivations behind RMHPs' information-seeking behaviors. By recognizing the interplay between information seeking, processing, privacy management strategies, and mental health outcomes, it provides insights for the development of targeted health communication interventions that can bridge the gap between information and patients' well-being.

Methodology

Research design

Following the path of sense-making scholars, I took the qualitative route and conducted interviews with RMHPs using a life history approach. Informants were considered recovered and eligible for interview if they fit the following criteria drawn from Retta Andresen et al.'s (2003) study that aimed to develop a model of recovery and Theresa Van Lith's (2014) preferences for selecting participants:

a) consenting adults who have manageable or less observable symptoms;
b) are seeking counselling if the experience of symptoms is inevitable, and
c) are vocal in sharing their opinions.

Nineteen (19) RMHPs were interviewed for this study. They were given pseudonyms to protect their identities and were grouped according to mental health problem severity. Initially, there were three categories, namely: mild, moderate, and severe (Lux et al., 2010; National Institute for Health and Care Excellence, 2011). The fourth, "combination," was created by the researcher to capture a contingent category of severity that (a) always hovers between two categories, (b) has been downgraded or upgraded after treatment, or (c) exists with other mental health problems whose severities were unclassified.

Of the 19 informants, 8 informants recovered from the contingent "combination" category, while 6 informants recovered from moderate mental health problems. Three (3) people recovered from severe mental health problems, while only two (2) recovered from mild mental health problems. The table below shows informants' profiles.

Table 1.

Informant Matrix

Informant no.	Pseudonym	Age	Sex	Severity
1	Ella	28	F	Severe
2	Alyssa	35	F	Combination
3	Rhian	40	F	Combination
4	Stephanie	26	F	Moderate
5	Kiko	47	M	Moderate
6	Veronica	25	F	Combination
7	May	25	F	Combination
8	Ara	23	F	Severe
9	Kim	24	F	Severe
10	Akira	20	F	Moderate
11	Diana	28	F	Combination
12	Therese	30	F	Moderate
13	Aduke	25	F	Moderate
14	Matteo	22	M	Mild
15	Tina	28	F	Combination
16	Marcus	39	M	Combination
17	Edmond	30	M	Combination
18	Maribel	29	F	Moderate
19	Princess	26	F	Mild

Ethical statement and data gathering

This study took into consideration the sensitive nature of discussions about mental health and its relevant issues. Informed sensitivity guided the conduct of the study, especially during interviews with informants. Before the materials for the interview were used, they were reviewed by a psychologist, Dr. Emy Liwag[2], for potential harm. Before each formal interview, I provided specific guidelines that ensure transparency, safety, confidentiality, and ethical conduct in this study. I communicated with my informants and requested their participation. I also sent a letter of consent that included information about the research. These were explicitly stated:

a. Nature of Research, Purpose, and Funding

   The research is academic, personally funded, and devoid of grants from any private or public institution. It is a face-to-face interview conducted at a mutually agreed-upon place and time that usually lasts 45 minutes to an hour and 30 minutes.

b. Identity of Researcher and Informants

   The research is conducted by a principal investigator, whose contacts are provided. Participant details will be coded to maintain anonymity.

c. Voluntary Participation

   Participation in this research is voluntary. If respondents wish not to participate, they may freely do so without consequence. They may also withdraw from the study at any time they wish. Transportation fees may be compensated.

d. Risk-benefit ratio

   The interview contains risks, such as the uncomfortable disclosure of information about illness experiences. The informant may benefit from the therapeutic value of storytelling. In addition, they are rewarded with tokens for participating. The audio was sent back only once to secure accuracy and let them screen for potentially harmful details. The analysis containing all the results of other informants was not returned to (1) maintain minimal risk by avoiding possible re-traumatization upon reading the texts, (2) avoid burdening the informants during the pandemic, and (3) increase identity protection.

e. Accuracy of Results

   The audio recording of the interview was sent for verification purposes and for additional layers of privacy management that may require censorship of certain details that may reveal their location, participation in certain events, affiliations, and personalities with whom they have had contact.

During the interviews, I informed participants of two main concerns: that of their privacy and that of experiencing discomfort. For privacy, I told them that they are to be given pseudonyms and that they are allowed to censure more information after the interview. For discomfort, I gave them the chance to view the questionnaires beforehand so they could anticipate their responses. They were given breaks during the interview to process their emotions or their decisions to answer the questions more in-depth.

Similar to Flood-Grady and Kellas' (2019) approach, informants were told to only disclose information they felt comfortable sharing. They were not required to recall thoughts about suicide or self-harm unless they spoke about it. At the beginning of the interview, informants were briefed about their freedom to not disclose self-incriminating details about their illness experiences. They were also duly informed about the nature of the research, which is an academic, un-funded, and unsponsored interview that lasts for thirty minutes to an hour. Warm-up questions initiated the interview, where the informant and the researcher tried to find commonalities to have points of reference for the succeeding questions.

Data analysis

The main method I used was a thematic analysis of the psychological, privacy-management-based, and emergent factors that influence RMHPs' information behaviors and sense-making outcomes drawn from their narratives of recovery. It should be noted, however, that these themes were first drawn from a narrative analysis-like method of delineating RMHPs' experiences, as the raw results came from their accounts of their lives pre-and-post diagnosis. As my study advanced, I transitioned to theoretical and axial coding as my primary analytical methods for extracting meaningful patterns and themes from the narratives. Axial coding further refined these categories, shedding light on the motivations, experiences, and sense-making processes of RMHPs.

To produce the major themes, namely, motivations for information seeking, information processing, and roles of information behaviors in sense-making, I made codes each time I observed RMHPs associating their behaviors with certain motivations and meanings. For instance, I made a code each time RMHPs deliberately attributed their information behaviors to their fear or expectations and when they claimed that information behaviors shaped the way they viewed and acted upon their mental health or recovery. The process of creating subthemes may be more visible in parts where RMHPs discuss similar behaviors and motivations but with different narratives (for instance, when RMHPs actively engaged with mental health issues out of trained curiosity or as a sudden reaction to a lack of resources).

Reflexivity

A study of this niche of a topic must have required some sort of introduction to the field before any kind of interest materialized into an article. My research began as a way to help my friends who were experiencing mental health problems. I, too, had to go through their conundrum of searching for information on the internet and making as little sense of what I read.

I looked into this topic in hopes of aiding those with mental health problems. In saying that, I state that I have a particular bias toward writing content that my informants would like to hear. I write *for and with* them. I must say that I have known several people whom I did not know were living with mental health problems before conducting this study. Thus, before conducting this study, I already knew what to say and not to say to the mentally struggling (e.g., "Just pray, and everything will be fine").

As I concluded my study, I also solidified my opinion on seeking help: while it is necessary to relieve pain and prevent the worst scenarios, it is not a ticket to recovery and, therefore, function. "Functioning" in this study has lost its connection with living and making meaning out of one's life. I believe that is what "filters" my writing—the moroseness of living translating into criticism of efforts to live, which at times involves seeking help.

Results and Discussion

Motivations of recovered mental health patients' information seeking

RMHPs reported various motivations for seeking mental health information, including practical and psychological factors. Health communication scholars often study these motivations to inform campaigns and language changes in health messaging. Practical concerns, like pain relief, were the primary motivators, despite the significance of psychological factors. RMHPs' avoidance of information underscores the need for health communication scholars to validate their symptom experiences, legitimizing their help-seeking. Some RMHPs who were already aware of their symptoms refrained from seeking help due to social barriers. While health communication often prioritizes raising awareness, these findings emphasize the importance, especially for individuals like RMHPs, of eliminating barriers and affirming the significance of their experiences for medical attention. RMHPs accessed various sources—professionals, trusted friends, academic journals—to address practical needs. Before being diagnosed, their focus was on symptom relief. Information-seeking occurred sporadically during urgent situations, suggesting their motivation

wasn't merely curiosity but driven by the need for solutions when symptoms persisted (Griffin et al., 2006; Yang & Kahlor, 2013).

Before diagnosis, most RMHPs knew little about mental health, which hindered their perception of their experiences and their ability to seek help. Their fear of mental health problems or being associated with them further deterred them from learning more about their conditions. This fear aligns with research on fear appeal studies (Chae, 2015; Kessels et al., 2014; Taber et al., 2015), which established avoidance of information based on negative emotions like fear. RMHPs also had negative beliefs about seeking mental health information, consistent with Filipino tendencies (Lagman et al., 2014; Tuliao, 2014; Tuliao et al., 2016). RMHPs also expressed curiosity about broader factors affecting mental health, including laws and philosophies around mental illness. These findings are in line with studies by Aref-Adib et al. (2013) and Gowen (2013), underscoring the comprehensive nature of RMHPs' information behaviors.

This study's findings align with RISP scholars' focus on subjective norms influencing information-seeking behaviors across health contexts (Ho et al., 2014; Kahlor, 2010; Willoughby & Myrick, 2016). Subjective norms discourage RMHPs from seeking information from formal sources like professionals and journals. These norms, driven by expectations and (dis)approval indicators (Yang & Kahlor, 2013), strongly shaped avoidance behaviors, especially when based on expectations from close social ties that often dismissed mental health issues. Close social ties, such as families and friends, often imposed the reality that mental health conditions can be dealt with by "praying away" or "toughening up," which were things that "truly helped others." Health communication scholars may campaign against the seemingly normalized experience of being "resilient to trauma" or the constant exposure to words of encouragement, which RMHPs label as "toxic positivity." RMHPs followed norms that dismissed the idea of having mental health issues and seeking professional help, which reflected in words like "Kaya namin 'yan" [We can handle it], implying self-reliance. Some even prayed their conditions away. Others conformed to be accepted, as seen in "toxic relationships." Ella, for example, feigned illness to "fit in" and feel accepted.

RMHPs also conformed to norms that expected them to remain vigilant about their mental health, which in turn made them more likely to seek information from formal sources or talk about their mental health. Some felt a certain pressure to remain knowledgeable about mental health for themselves and their social ties. Expectations to seek professional help usually came from deeply concerned friends, partners, or family members. Their expectations made them feel somewhat accountable for their actions,

or lack thereof. Moreover, these individuals' constant "push" to seek information convinced RMHPs such as Therese and Aduke, who would otherwise choose to remain uninformed. In Therese's experience, this constant "push" came from her boyfriend, who constantly reminded her to consult with a psychiatrist.

Aside from societal pressure, the study finds that knowledge-based factors such as current mental health knowledge, defined by RMHPs as what they know about mental health before being diagnosed, and information insufficiency also motivated information seeking among select informants. Those who reported having more knowledge about mental health before being diagnosed were more likely to seek information about it out of their own interest than those who just needed to do so. Select RMHPs' high knowledge threshold about mental health made mental health concerns more relevant, which raised their need to gather more information about mental health. Contrary to the assumptions of Griffin et al. (1999) and Yang and Kahlor (2013), these findings posit that information seeking intentions are also formed when individuals like RMHPs recognize that risk knowledge is relevant and thus worthy of seeking information, not only when there is information insufficiency.

Motivations and variants of RMHPs' information processing

RMHPs mostly processed information heuristically or in a casual manner, only engaging with mental health issues with more rigor during critical situations that may be classified as episodes of mental health problems. Notably, they engaged with mental health issues more systematically when they encountered psychology-related content (DSM-5, self-help books, online accounts of people diagnosed with mental health problems), talked with medical professionals, and interacted with people who recognized their need to be listened to.

Information insufficiency, attitudes, and subjective norms were noted to be the only socio-psychological variables that motivated both routes of information processing. The findings were drawn from RMHPs' diagnosis narratives, where they recalled exerting more efforts to engage with mental health issues after interacting with mental health resources. Some of these narratives come from their stories of "understanding what works," which happened at various points in their lives. Their different reactions and propensities to certain information sources, new learnings, and habits were used as a general guide for coding. These then produced the themes, such as information processing motivated by information insufficiency, attitudes, and subjective norms. Unlike the previous section, the motivations for processing mental health information were not heavily anchored on instances that propelled the need to seek information.

Motivations of systematic information processing

RMHPs systematically processed information to gain a comprehensive understanding of their mental health, involving interactions with various sources, psychological services, and medical professionals. Findings for this major theme can be traced back to RMHPs' narratives of deliberately seeking a diagnosis and not just learning more about their experiences. Although their efforts are usually seen as one of the end goals of health communication campaigns, RMHPs seldom report engaging with their mental health issues exhaustively. While efforts in the field of communication normally seek to make these behaviors more consistent, they should nevertheless be focused on bringing people to legitimate sources of information, as RMHPs often encounter poor-quality information.

The need to address information insufficiency and bridge the gap between their current and desired knowledge levels compelled RMHPs to engage with their mental health issues. While this finding aligns with previous assumptions that information insufficiency drives information processing (Griffin et al., 2006; Li, 2015; Lu, 2015; Yang et al., 2010, 2011), the combination of physical pain and information gaps more closely explains RMHPs' needs to thoroughly address their issues.

Two common forms of systematic processing stem from different types of information insufficiency: organic and reactive. These accounts were derived from the narratives of those who engaged with mental health issues at will and those who reacted to them suddenly and vigorously. Organic processing occurred naturally among RMHPs, driven by curiosity and high information needs. It was also observed by others who were trained to diligently address their mental health inquiries. Reactive processing results from a sudden need for more information, often driven by a desire to relieve symptoms and understand their origins. RMHPs turned to additional sources when their initial ones failed to meet their information needs. For example, select RMHPs rejected guidance counselors' simplistic advice and sought help from mental health professionals due to what they perceived as their own sufficient mental health knowledge. Tina, for instance, digressed from seeking help from her guidance counselors, who once told her to "just go outside" and "eat dark chocolate." She decided to take matters into her own hands (*sasarilihin ko na lang*) because she had sufficient knowledge about the processes of therapy.

RMHPs processed mental health information in a reactive, systematic way to address traumatic instances or emerging but aggressive symptoms. For example, May sought professional help after a peak episode that resulted in "family drama." Similarly, Alyssa consulted her husband when experiencing "cloudy" or suicidal thoughts while walking. Some RMHPs reacted to their need for information without conflicts, such as when Matteo

turned to a psychiatrist after hearing "entrust everything to God" from his family. These findings guide health communication scholars in addressing individuals' unique mental health needs when they seek help for the first time. Help-seeking messages should offer alternatives to confiding in family members in case they are not viable options. Such messages should also suggest professionals who do not impose a certain (in this case, religious) approach to mental healthcare and can diagnose and prescribe medicine to address the issue of receiving low-quality input and directing low-quality remedies.

Beliefs and attitudes toward information sources also drove systematic processing for RMHPs. Attitudes became more positive as they engaged with mental health sources and verified their beliefs about them. Maribel, for instance, initially found psychiatrists cold, viewing them as "antagonistic." However, she eventually debunked this belief and realized that professionals just wanted to give her new perspectives. Social pressures also pushed RMHPs to understand mental health comprehensively; expectations from friends prompted RMHPs like Veronica to process information in a specific way, while others, like Kim, became the go-to source for mental health information. Interestingly, the study finds that as some RMHPs' control over their information behaviors and risk knowledge grew, their need for more information diminished. Advocates-cum-RMHPs also exerted effort when they felt hopeful about the future of mental health. This contradicts findings by Yang and Kahlor (2013), who noted that people avoid information to maintain a positive attitude toward a risk, and supports the work of Yang et al. (2010), who found that people seek risk information when feeling positive about a risk.

Motivations of heuristic information processing

Motivations for heuristic information processing, characterized by a casual approach to understanding mental health, showed less variety compared to systematic processing. Information insufficiency and affective responses seem to not have motivated RMHPs' heuristic processing. Findings were derived from RMHPs' pre-and-post diagnosis narratives. Habits that helped them "go over their experiences" were a common theme that emerged, as RMHPs were not necessarily aware that they were utilizing pieces of information or certain processes to understand their conditions and manage them as mental health problems. Nevertheless, RMHPs mostly utilized heuristic information processing, seeking information from the most immediate and convenient sources, regardless of their effects. This often involved relying on a single source due to scarcity. Beliefs about the efficiency of these mundane approaches toward understanding mental health also prompted RMHPs to maintain their heuristic stance on information processing. In research, RMHPs remained interested in

exploring treatment options if they thought that reading about them offered information similar to what they received from formal sources. In cases of passive involvement with mental health on social media, RMHPs adopted a "lurking" stance (sharing, liking, without producing content) when they believed this met their information needs and those of others.

Some RMHPs projected and learned through intrapersonal communication, using diary writing, art forms, or other creative outlets. Ella, for instance, had "immense trust issues" and relied on her diary to understand her feelings. Others appeared to be drawn to this mode of information processing because it allowed them to channel their emotions into a safe medium. RMHPs engaged heuristically when they believed their mundane ways of seeking information met their needs and when influenced by the norms of their communities or help groups. Positive beliefs towards personal sources like family members and friends motivated casual engagement with them on mental health issues. RMHPs communicated with approachable, understanding, and non-discriminatory personal sources, believing they offered valuable insights.

In special online and on-ground groups for mental health, RMHPs often engage casually, following the norms of those groups, typically asking surface-level questions. Stephanie, who has been to one of these places, engaged with people in a certain establishment using a common script. Answering the most common questions about their conditions and how they got there usually became the norm of introductions and getting to know one another. RMHPs such as Therese followed these norms by imitating the line of questioning of members without forming one of their own or delving deeper as to why these norms were followed.

Overall, RMHPs' efforts to process mental health issues heuristically still reflect the observation of scholars who noted that Filipinos tend to approach doctors only during critical times because they do not trust the foreign approach to dealing with medical issues (Brolan et al., 2014; David, 2010; Tuliao, 2014). Incidentally, local literature (Brolan et al., 2014; Lagman et al., 2014; Samaco-Zamora & Fernandez, 2016) offers some evidence that this perspective helps individuals see themselves as being healed. RMHPs' experiences strongly suggest that viewing mental health issues from a lay, spiritual, or religious perspective and treating them using this perspective does not help them recover. In part, the findings prompt health communication scholars to engage with individuals' coping strategies and raise awareness among those who utilize them regarding the issues they aim to alleviate. RMHPs' narratives suggest potential areas for these interventions, including artistic platforms, mental health web pages, blog sites for self-reflection, and other online resources. Placing links to mental health services in these locations can enhance both awareness of the concept of seeking help and the accessibility of mental health resources.

Motivations of privacy management strategies when seeking mental health information

RMHPs used privacy management strategies (PMS) to anticipate and mitigate potential stigmatization and discrimination when seeking information from personal sources. Before diagnosis, they often relied on close friends, family, and medical professionals for in-depth mental health information, but uncertainty about these individuals' reactions led to privacy management strategies. The findings for this specific portion can be traced to parts of RMHPs' pre-diagnosis narratives. When coding for this specific portion, several themes were derived from their experiences of discrimination or fear thereof. Thus, PMS were classified as stringent, negotiated, and loose. Stringent strategies were more common and motivated by a need to protect themselves and access private details, such as their diagnosis. Contrary to typical privacy management recommendations, RMHPs had intentions to disclose, but their social environments lacked space for their disclosures. RMHPs were motivated by the need to protect themselves from discrimination and to access information that required the disclosure of private details, such as their diagnosis. These strategies slightly resemble the behaviors of informants in studies where disclosures strained interpersonal relationships (Broekema & Weber, 2017), hindered employment prospects (Oldfield et al., 2016), or challenged one's comfort in publicly discussing specific aspects of their identity (Schrimshaw et al., 2014).

RMHPs applied stringent strategies when they felt they were at a disadvantage due to their mental health information's disclosure. For example, Matteo and others with uncomfortable family interactions "hid" their feelings from family members. Hiding meant "not telling anything about their mental health" or pretending to be fine. Ella hid information about her hallucinations because she had "severe trust issues." Therese, on the other hand, asked herself to be isolated to protect her relationship with her mother, which is usually at stake when they see each other. Some applied stringent strategies when talking about traumatic past experiences, where disclosure required revisiting painful memories. Rhian, for example, only began to speak about her abuse after processing her trauma and realizing it was "better to be open with it than hide it." Stringent strategies sometimes involved presenting an alternate reality. In the workplace, for instance, RMHPs like Edmond, Maribel, and Stephanie only disclosed details that did not put their employability in jeopardy. With a sense of security, RMHPs negotiated their privacy boundaries, sharing parts of their experiences with trustworthy confidants in exchange for insights. Some disclosed based on an unwritten rule of trust. That said, RMHPs such as Akira, Tina, and Aduke disclosed private information to confidants based on an unwritten rule of trust. Tina, for instance, believed that her confidants

were "*mapagkakatiwalaan*" [trustworthy] because they already "knew what to do" with the information given to them. Others negotiated boundaries when they had enough confidence to discuss their mental health.

Less conservative RMHPs "relativized" the disclosure of information based on confidants' levels of closeness or willingness to listen. Those who exercised a relativized privacy management strategy remained more open to conversations. For Marcus, this meant that only those in his "inner sphere" were told secrets, while others were not. For Matteo, the selection was based on those who reacted positively and understood. Oddly, some RMHPs, such as Diana and Matteo, relativized their boundaries by talking to family members who made the most effort to listen. Said RMHPs took the opportunity to disclose bits of information in exchange for insights. In this light, RMHPs such as Diana found themselves "surprised" that they had conversations with people who simply showed interest in their problems.

Loose privacy management strategies were applied by RMHPs who mostly saw no harm in seeking mental health information from personal sources, even though this involved the disclosure of their private health information. Opening accounts online, advocating for mental health awareness, and being a contact person for mental health issues were classified as "loose" because RMHPs disclosed information without necessarily knowing the kind of response they would receive. Loose privacy management strategies for online media involve the disclosure of information to everyone with access to the site where insights are sought and private information is disclosed. Online-savvy RMHPs loosely applied privacy boundaries in the online space because they believed it offered more confidentiality and security than on-ground. Advocates such as Rhian, Kim, and Akira believed that to share and produce knowledge about mental health, they would have to find a common ground between their audiences, even though the medium in which they share knowledge leaves them vulnerable to discrimination. They noted, however, that it was also a space that could magnify feelings of hate through the very same mechanisms with which privacy is promised. As Kim observed, these people sometimes communicated with RMHPs like her to release their hatred or project their insecurities.

Motivations of privacy management strategies for mental health information processing

The development of various privacy management strategies (inferred, adaptive, and considerate) for processing mental health-related information primarily stemmed from the need to normalize interactions rather than solely acquire information from interpersonal sources. Additionally, they were shaped by RMHPs' beliefs about gaining sufficient information from a preferred method. Such elements gradually evolved as RMHPs adopted

particular approaches to comprehending mental health information. As noted by RISP scholars, RMHPs made inferences from their tendencies towards systematic information processing. These inferences influenced decision-making regarding disclosure during information processing. (Griffin et al., 1999; Kahlor et al., 2006). RMHPs inferred privacy management strategies from instances where they encountered interpersonal conflicts upon disclosing information about their mental health. These strategies were coded from their narratives of rebuilding, healing, and reconstruction, which happened as they underwent treatment and felt stability again or for the first time. From these narratives emerged themes of opening up and adjusting privacy boundaries, which were related to privacy management concepts applied when RMHPs were leaning onto a certain tendency to process information in a certain way.

A few RMHPs inferred from their positive experiences that they learned the benefits of being involved in other people's mental health-related concerns. Learning from efforts to help others seemed to be their point of interest. Most often, discrimination or mismanagement of private health information became inferences to disclose specific sets of information about one's problems, especially when it comes to the workplace. As Veronica affirmed, no one would go about telling their problems in the office in such a casual manner. For this reason, RMHPs only selected one or two coworkers to discuss mental health matters with; at times, they assumed the disadvantages of talking about their mental health problems and withheld information from future employers.

RMHPs applied an adaptive privacy management strategy to balance their needs to tackle mental health-related issues in a certain way and achieve a desired level of privacy. The division of adaptation (being more open or strict) comes from narratives of revisiting previous interactions, from which RMHPs assessed the usefulness of their encounters with certain sources of information who, in their assessments, deserved more or less of their attention. The strategy is often applied to favor certain people, especially family members. For example, RMHPs such as Diana, Kim, and Matteo exercised an adaptive privacy management strategy with their families by discussing mental health issues more in-depth with one member and "hiding" from the rest. Some RMHPs balanced their information needs and privacy by engaging openly with external sources while remaining strict with their inner circle, while others "adapted by" dissolving their previous privacy boundaries and expanding their information sources and mental health discussions. Positive experiences seem to have initiated this effort, as in the case of Alyssa, who received encouraging remarks for letting other people know that she had a mental health problem.

In contrast, select RMHPs adapted to their privacy needs by retracting information from people who provided more conflict than resolution for

their mental health. Experiences of recovery made it possible for RMHPs to generate and enact newfound attitudes toward people. Ella, for instance, blocked her old set of friends because they talked about her with the motivation of feeling better about themselves. Incidentally, RMHPs also considered parting ways with friends who had imparted hurtful messages toward mentally ill people. RMHPs such as Kim "unfriended" these kinds of people and stopped talking to them despite the depth of their former relationships. RMHPs' limiting strategies that bring forth more positive impacts on their mental health suggest that the constant expansion of privacy management is not always necessary for gaining valuable insights. Health communication scholars could utilize these findings to strengthen the claim that sometimes stricter privacy management strategies work for people who have experienced trauma. This should then affect the way reaching out to others is pushed, as it is shown here that introspection sometimes does better for people like RMHPs.

As time passed and mental health issues became more salient, RMHPs recognized and responded to the need to spread awareness about mental health issues. To improve the pace at which mental health discourse expands, they considered opening up to more confidants than they had before. At the same time, they considered reconciling with others who once mishandled their private information to see if there were practical motivations behind it. In doing so, they became "considerate" of mental health-related advocacy and engaged with people who showed some willingness to listen to their "mental health journeys." With caution, they disclosed private information about their experiences to anticipate how others might react. They ask, "Are you okay with me talking about my mental health?" before disclosing information about their feelings or experiences.

RMHPs-cum-advocates challenged their privacy boundaries for the sake of advocating mental health awareness, even when confronted by sources of stigma or misinformation. By posting their experiences on social media, they challenged privacy boundaries and gained attention for changing opinions about mental health. Such strategies can be attributed to the desire to learn more or a learned tolerance for potential sources of conflict. The propensity to be tolerant when creating privacy boundaries may also be attributed to the setting of communication—the online space, for example. As observed in Smith and Brunner's (2016) analysis of texts that depict privacy management in a blog, individuals like RMHPs assume the good intentions of the behaviors of co-confidants. Because of this, RMHPs like Kiko, Akira, and Edmond were able to express their dissatisfaction with misinformation about mental health information and extend their efforts in understanding mental health issues.

Roles of information behaviors in recovered mental health patient's sense-making of their mental health

In general, information behaviors played a guiding role in RMHPs' sense-making of their mental health. It has, however, gaps in providing reliable materials for attaining a comprehensive understanding of mental health, which is one of the end goals of health communication. RMHPs' views of their diagnoses and the way they use them to make sense of their world varied from informants in mental health studies (Genuis & Bronstein, 2017; Gwinner et al., 2013; Phillips et al., 2017) in that they still yearn to achieve a certain standard of being "cured," not just recovered. Their ideal and experienced outcomes (cured vs. recovered) were what guided the creation of a theme for the role that information behaviors played in their mental health journeys or recoveries.

The theme of information behaviors bringing them to familiar-looking outcomes emerged when RMHPs recounted their recovery experiences. The space and time to reflect during or post-treatment made them feel as though they were brought back to a time when they were symptom-free or naïve to their symptoms. During these times, they contemplated their ideal outcomes and the reality they were faced with as people with disabilities. RMHPs associated their stability with a familiar feeling of being "like themselves again" as they became more stable. However, after several months of feeling stable, RMHPs like Edmond often asked, "Will I ever be normal?" or "*Makakabalik pa ba ako sa dati?*" [Can I ever be like the person I was before?]. Others asked similar questions even after being in treatment for several years. When asked what their ideal outcomes were, almost all of them responded with "having none of this at all," because it was so rational to them that nobody wanted to have mental health problems or the experiences that cause them. In addition, they had this prevalent belief that mental health professionals would "solve their problems" so that they could function "like they were before" or "make their symptoms disappear." RMHPs, knowing the absence of a cure, also refined their definition of recovery, such that it meant being in a "place to be" and not a "place to function as though they were normal," which is a destination that their treatment usually directs them to be in. The "doing" or functioning was separate from "being" because it was associated with the events that allowed their symptoms to manifest and persist. These ruminations hinted on their desires or ideal outcomes, which were either being "cured" or returning to a "normal state of being." Having lingering questions and ideal outcomes suggested that there was such a difference between recovering and "feeling normal" again. In this case, RMHPs felt that they were brought back to a state where they could feel the least or manage the most of their symptoms. However, their questions as to why they have to manage symptoms or perform the rituals of being a disabled individual (such as taking pills and

going to therapy) suggest that they were simply in a familiar-looking place of stability or naivety.

Their experienced outcomes set them apart from their ideals of being cured, which then further solidified the role of information behaviors as mere guides to achieving familiar-looking outcomes. RMHPs feel as though they are in a familiar-looking place when they feel "stable," but it should be noted that this definition of stability comes with certain compromises that are, to some, very costly. Maribel, for instance, describes the difficulty of accepting the need to make lifestyle compromises. She noted that accepting a diagnosis implied making compromises to her formerly active lifestyle, selecting activities that do not "drain" her, and allotting more time to "listen" to her body. While she claimed that she has recovered to the point of being so different from before [*sobrang layo ko na sa dati*], she believed that she had to make certain sacrifices in order to live life fully. For Aduke, this meant spending money on medications alone. In relation to the reluctance to accept mental illness, the daily cost of living as a person with a mental health problem weighed more than the cost of simply being alive. This was what RMHPs like her struggled to make sense of: the financial distress within psychological distress. To be diagnosed with a mental health problem means to be treated with medicines for its symptoms, which, in Aduke's case, may cost 130 pesos a day. Apart from this, RMHPs had to work for their treatment, maintain a lifestyle, and prepare for eventualities. The economic toll of treating a mental health problem sometimes overweighs the attempt to treat it, which is why accepting mental health problems does not "make sense."

A "familiar-looking outcome" is also one that has been constructed with physicians and medical professionals who also gave them the materials to "achieve their goals." However, as RMHPs noted, the addition of rituals of maintenance made them believe that their information behaviors only led them to a place that their physicians recognize and not a place that they idealize.

With the apparent difference in outcomes, information behaviors' roles appear to be more temporary and relative to one's conditions. Some RMHPs who still vie for a cure see them as alternatives in the sense that they seek other means of explaining their experiences or search for "working labels" to explain their experiences. Information behaviors acted as metaphorical torches, illuminating the path they might pursue. At best, information behaviors can be "relievers," but only when individuals such as RMHPs have practical reasons to accept them.

One of the key reasons for designating information behaviors as guides was RMHPs' aversion to adopting mental health language centered around recovery and accepting one's flaws. Initially, RMHPs resisted the idea of "just recovering," as it imposed certain practices upon them in order to

regain a degree of functionality. Attaining full functionality was intrinsic to their concept of being "normal" and closely aligned with their ideal of returning to a pre-symptomatic state. Consequently, RMHPs like Ella and May often criticized the process of learning about their recovery or expediting the recovery process. Ella's sentiment exemplifies most RMHPs' ruminations about accepting a diagnosis that is arbitrary. In the following lines, she referred to the practice of taking medications prescribed to cure one's illness as an arbitrary, questionable process:

> But there were times that I would be given antidepressants, and the main side effect would be depression. And like, I would be given anti-anxiety (medications) and the main side-effect would be anxiety. So, I'm like, "You're giving me something that would cause the said thing, so... why?"

RMHPs only considered their efforts to seek and process mental health information helpful when they gave a name for their concerns; however, they viewed them as processes that simply added labels that described the challenges they needed to face. This is also why some RMHPs' sense-making intended to redefine what recovery meant so as to reclaim power or to have an adaptive preference over the compromise they made in accepting their diagnosis.

The seemingly menial role that information behaviors play in making sense of one's mental health may also be due to the equally menial role that accepting a diagnosis plays in explaining one's experiences. Historically, definitions of recovery from mental health problems remained attached to definitions of physical problems (Andresen et al., 2003; Jacob, 2015). That said, these definitions could only partly explain the nuanced experiences of recovering from mental health problems, which is why seeking mental health information may not make sense of one's experiences. Incidentally, models of recovery maintain that recovery is patient-centered and that functionality still plays a crucial role in living a meaningful life. What these models fail to address is the direction or intention of recovery, which is functioning to be productive and whose pressures fuel mental illness. Arguably, this is why RMHPs blame themselves and seek ways to improve their lifestyles so that they can prove their recovery. At the same time, this is why some RMHPs feel comfortable claiming to have recovered by simply saying that they are "*malayo sa dati,*" or far from before, because this acknowledges their progress in recovering without necessarily claiming to be "fully recovered" or functional, which entailed accepting functionality's stresses.

Health communication's emphasis on predefined notions of recovery may not align with RMHPs' individual journeys, potentially imposing

limiting definitions on their mental health experiences. This is because RMHPS' attempts to reshape their definitions of recovery later on in their lives suggest that the pieces of information they utilized were not aligned with their imagined outcomes—in this case, being "cured" or achieving a state closest to it.

From a critical standpoint, information behaviors tend to perpetuate and legitimize medical discourses surrounding mental health rather than fully capture the experiences of individuals grappling with mental health challenges. This can be attributed to RMHPs' struggle to find suitable definitions that effectively elucidate their mental health-related concerns while trying to align their experiences with established markers of recovery. In this context, medical discourse gains strength through the validation of individuals who recount their recovery narratives, which already align with recognized characteristics in literature. Consequently, a dialogue between RMHPs and their sources of information becomes essential in working towards a shared ideal, such as a state closely resembling a cure, rather than solely pursuing goals set by those in positions of power. What health communication scholars could do to foster or initiate this dialogue is change the way they inquire about the sources of mental health problems, which often focus on patients, not their social environments. However, considering that not all forms of mental health discourse have advanced to a point in which mental health problems are viewed critically, health communication scholars can work on empowering the individual to improve their mental health and "in the way they feel empowered." The findings guide them to a path that "makes sense," which challenges the common notion of seeking health information to achieve better health outcomes. As observed in some instances, RMHPs' efforts to better themselves by engaging with information did not necessarily guide them to a place they desired, which, to them, was "something that made sense."

Implications for theory-building emerge upon exploring RMHPs' sense-making, revealing the activation of information behaviors' roles contingent upon the negotiation or compromise of their goals. Differing from existing sense-making studies, where activation appears natural, RMHPs activate information's role by embracing the recovery processes at the price of relinquishing their ideal of a cure. This negotiation of goals in sense-making challenges Dervin's (1999) theory, suggesting a process absent from current conceptualizations, and underscores that information's influence can lead to compromised outcomes while reinforcing certain discourses.

Conclusion

The motivation for RMHPs to seek information was predominantly driven by feelings of pain and discomfort, which fueled their desire to understand

mental health. They also felt compelled to seek information due to subjective norms or societal expectations placed on them. RMHPs engaged in systematic information processing when they were naturally inclined towards rigorous approaches or when they lacked sufficient information to explain new and unexplained experiences. Conversely, they approached mental health issues casually when resources were scarce and believed that their casual methods were adequate. Privacy concerns, stemming from fear of discrimination, influenced RMHPs to be cautious when seeking information from others. Instances of discrimination served as notable reference points, shaping their intentions to engage more systematically in conversations about mental health.

The role of information behaviors in RMHPs' sense-making processes was found to be somewhat superficial. They served as loose guides, as reflected in RMHPs' struggles to label their experiences as illnesses that they could not fully accept. RMHPs' dissatisfaction with their health outcomes suggests that information behaviors only brought them to a state of relative stability compared to their pre-diagnosis or pre-information-seeking stage. This discrepancy arises from the contrast between their desired outcome of "being cured" and their adaptive preference for recovery and functional improvement.

Acknowledging criticisms about the limitations of information behaviors and the reinforcement of medical discourses, this study underscores the need for a collaborative approach between RMHPs and their information sources, with a focus on giving more power to addressing individuals' needs. As it was observed in RMHPs' experiences, information behaviors are limited to individuals with certain privileges and access to them and are rather focused on achieving certain goals that impose upon them certain procedures in order to feel "okay," which, in this case, is "recovered." RMHPs find it empowering to detach their functionality from their recovery. It is, in fact, having or being in a "place to be" that "makes sense" to them and what they found helpful. This space makes them feel empowered and not pressured to conform to notions of recovery and normalcy, such as being able to function "normally" or as they did before. Thus, future research should look into understanding how individuals may be brought into this space first and other spaces that return some sense of power or agency back to them.

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Notes

[1] Also pertains to the ritual model of communication, where communication fulfills a role but is ultimately not the focus of maintaining a society (Carey, 2008).

[2] Dr. Maria 'Emy' Liwag is a lecturer and a research associate at Work Effectiveness and Leadership Lab (WELL) at the Australian National University.

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