



The Reintegration Journey Following A Psychiatric Hospitalization: Examining the Role of Social Technologies

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For people diagnosed with mental health conditions, psychiatric hospitalization is a major life transition, involving clinical treatment, crisis stabilization and loss of access of social networks and technology. The period after hospitalization involves not only management of the condition and clinical recovery but also re-establishing social connections and getting back to social and vocational roles for successful reintegration – a significant portion of which is mediated by social technology. However, little is known about how people get back to social lives after psychiatric hospitalization and the role social technology plays during the reintegration process. We address this gap through an interview study with 19 individuals who experienced psychiatric hospitalization in the recent past. Our findings shed light on how people’s offline and online social lives are deeply intertwined with management of the mental health condition after hospitalization. We find that social technology supports reintegration journeys after hospitalization as well as presents certain obstacles. We discuss the role of social technology in significant life transitions such as reintegration and conclude with implications for social computing research, platform design and clinical care.

CCS Concepts: • **Human-centered computing** → **Social networks; Social networking sites.**

Additional Key Words and Phrases: social networking sites, mental health, social reintegration, recovery, psychiatric hospitalization, social technology

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1 INTRODUCTION

“I joined a whole bunch of new groups [after psychiatric hospitalization] to try to make sure that my Facebook feed was nourishing me, and not strangling me.” [P1]

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For mental health, both clinical recovery and social reintegration need to go hand in hand for the overall well-being of individuals [65, 116, 119]. Particularly, for individuals who have experienced a psychiatric hospitalization, recovery is viewed as “*a personal journey rather than a set outcome*” [44], and involves not only removal of symptoms and restoration of functioning but also social reintegration, referring to “*the degree to which an individual’s social network reflects adequate size and multiple social roles (e.g., as friend, family member, coworker) and the extent to which an individual engages in mutual exchange, or reciprocity, in social relationships*” [122]. Reintegration is therefore viewed as a journey, during which the focus shifts from institutionalized treatment and medication to self-management of illness. It is accompanied by mechanisms to break inhibitions and stigma around mental health, open up about an individual’s experiences with intimate others, reach out for social support, re-enter educational or occupational roles, and improve overall well-being. Successful reintegration across these dimensions is a crucial marker for recovery and an important goal for mental health policy, more broadly [22, 52]. However, stigma, negative consequences, and lack of access to resources for support and care present challenges to individuals trying to get back to their social lives after a psychiatric hospitalization.

Despite the central role of social reintegration, the topic has received relatively less attention in mental health research and practice. From a clinical perspective, after discharge from the hospital, clinicians often lose timely contact with their patients which present challenges for continued care and support [72]. Even when patients adhere to clinical follow-up appointments, the emphasis is on reduction of symptoms via continued therapy or medication management, rather than on improvement of other aspects such as social relationships, employment, education, and leisure [71]. This emphasis on clinical recovery alone has received criticism from scholars, as it tends to objectify the person with mental illness [89], disregards their sufferings and identity outside of the clinical definition of the illness [68], reduces patients’ participation in recovery [55], and fails to consider the challenges people need to overcome beyond symptom management to get back to life following hospitalizations [103]. Furthermore, recovery journeys are known to have a high likelihood of re-hospitalization if reintegrating back to social life and roles becomes challenging. Thus, the guiding principle of mental health policy in many countries – the recovery model [6] and patient-centered model of healthcare [45] – posit keeping the patient at the center of decision-making in recovery. Along these lines, we argue that adopting such a “whole-person perspective” and developing a holistic understanding of clinical recovery and social reintegration can provide a person more agency and control in the management of their condition, following a psychiatric hospitalization.

A significant portion of people’s social lives is now technology-mediated through the use of social networking sites, online communities, messaging applications, and so on. Especially for young adults, a demographic most susceptible to onset of mental health conditions [70], technology and online presence form an integral part of their identity and social lives [14]. Furthermore, social technologies have emerged to play an important role in mental health – as spaces for disclosure [5], social support [94], raising awareness [108], fighting stigma [3], and enabling clinical interventions [36]. A growing body of literature in human-computer interaction (HCI) and computer-supported cooperative work and social computing (CSCW) identifies the role of social technologies in recovery and management of health conditions [67, 78, 81]. In parallel, HCI/CSCW researchers have studied how social technology play an important role during major life transitions and help individuals establish a “new normal” [61, 62, 85], conduct identity work [39, 87] and reach out to similar others [111]. However, health transitions like psychiatric hospitalizations are less explored under this lens, and little work has been done to understand how technology-mediated social interactions impact reintegration and recovery journeys in mental health. As noted in P1’s quote above, like other major life transitions [10, 62, 107], people often turn to social technologies during reintegration after hospitalization to navigate shifting mental health goals

and social networks and to access support resources. Understanding the role of social technology in this particular life transition, mental health reintegration, can improve our understanding on how platforms support or hinder people's social lives and health management after events like psychiatric hospitalizations.

In this paper, we examine the role of social technology as people get back to their social lives and negotiate the transition they experience due to the psychiatric hospitalization. Specifically, we ask:

RQ1. How do people get back to their social lives after experiencing a psychiatric hospitalization?

RQ2. What is the role of social technologies in people's reintegration journeys after experiencing a psychiatric hospitalization?

To answer these questions, we conducted semi-structured interviews, spanning over nine months, with 19 adults who had experienced a psychiatric hospitalization for schizophrenia spectrum disorder, mood disorder, bipolar, borderline personality or anxiety disorder in the recent past. Participants actively used at least one social technology platform like Facebook, Twitter, Reddit, Snapchat, Whatsapp, Tumblr, etc. We examined the data adopting a hybrid inductive and deductive approach to thematic analysis. In doing so, we contribute an understanding of people's offline and online social lives after psychiatric hospitalization in the context of managing the illness.

We found that participants' social lives after hospitalization were deeply intertwined with factors linked to self-management of the mental health condition, such as stigma, inhibitions, and over reliance on others after the psychiatric hospitalization [34]. We identified different approaches participants adopted to re-establish social connections immediately after discharge from the hospital, often driven by a sense of urgency, obligation and stigma. Social technology platforms mediated people's interactions after the hospitalization, providing spaces for disclosure, social support, and sources for positive behavioral change. While participants drew several social benefits from social technology use, some felt that their use of these platforms hindered their path to reintegration, due to feelings of social comparison, negative interactions, and emotional triggers to their mental health symptoms. We discuss the theoretical implications of social technology use/non-use for reintegration in an individual's recovery journey. Finally, we highlight clinical implications for post-discharge care and design suggestions for social technology to support reintegration following a major life transition like a psychiatric hospitalization.

Privacy and Ethics. This research was conducted with approval from the Institutional Review Boards of the authors' institutions. Further information on approaches taken to protect participant privacy, safety, and accurately represent the lived experiences of participants without compromising anonymity can be found in Section 3.2. Since the topic of this paper concerns mental health and psychiatric hospitalizations, some quotes and descriptions of participants' lived experiences may be triggering to readers. We suggest caution while reading, printing, or disseminating this paper.

2 BACKGROUND

2.1 Reintegration in Mental Health

The recovery model, emerging from the deinstitutionalization movement in the late 20th century, is the guiding principle of mental health policy in many countries [6]. Per this model, the hospital is no longer considered an institution for long-term stay but is seen as a community-based system of care focused on overall well-being of individual and community integration [112]. Corey Keyes, who advocates adopting the model of mental health as a "complete state" [103] suggests viewing recovery as flourishing in life despite having a mental illness and relying on two complementary reintegration experiences: the restoration from mental illness and the optimization of positive

mental health [103]. These perspectives put the individual in the center and highlight the importance of the relationship between clinical recovery and social reintegration in mental health.

Clinical researchers and scholars in social work and nursing have focused attention on social reintegration and rehabilitation in mental health, alongside the well-established area of clinical recovery. Based on a systematic review and narrative synthesis of 366 papers on personal recovery in mental health, Leamy et al. [73] provide five categories (CHIME): connectedness, hope and optimism about the future, identity, meaning in life, and empowerment to engender recovery processes. Newman et al. point out that dimensions of reintegration like hope, agency (a sense of control over their lives), opportunity for purposeful activity, and social inclusion are in fact, outcomes of recovery in mental health [91]. Silva et al. found a 20% lower risk of re-hospitalisation for patients referred to community-based psychosocial support units following inpatient care compared to patients referred to the usual formats of outpatient care [114]. Adnanes et al. emphasized the importance of meaningful social activities and community participation as well as support from peers and family members in reducing psychiatric re-hospitalizations [1]. Successful social reintegration, often defined as resuming “age, gender, and culture appropriated roles, statuses and activities” [40], is also known to help reduce stigma and improve overall well-being [119].

The current emphasis on reintegration outcomes in existing work over-weighs the understanding of processes and transformations that people undergo after psychiatric hospitalization. Furthermore, today, a significant portion of social activities and community participation happen over technology-mediated channels. However, our current understanding of reintegration and the measurement of social functioning as a clinical outcome only focuses on face-to-face interactions in the offline world. To realize opportunities and challenges in reintegration in mental health, we argue that it is crucial to also consider people’s online social lives. By examining people’s first hand experiences after psychiatric hospitalization, in this paper we contribute insights into people’s reintegration journeys in the offline and online context, furthering the understanding of aspects that support or hinder reintegration in mental health.

2.2 Study of Mental Health Experiences in the Social Computing Literature

In the last decade, social technologies have transformed how individuals, researchers, and clinicians consider mental health. Supported by anonymity and connections to large audiences, online social platforms are increasingly adopted by individuals to share personal, sensitive stories about mental health [5]. Social computing researchers have studied people’s motivations, goals, and practices in using adopting social technology platforms for support and help-seeking behaviors, often outside of clinical treatment. Researchers have focused on identification, modeling and characterizing differences in multimodal (textual, visual) forms of self disclosure on social media [24, 82]. Here, scholars have investigated the unique design affordances of social media like “throwaway” accounts, in providing context-specific anonymity for first-time disclosures on abuse related posts on Reddit [3]. Similarly, prior work examined disclosures of mental health conditions on these platforms and the related social capital and social support goals and outcomes [3, 38, 88, 94, 129]. Although these disclosure behaviors have positive benefits [48], exposure to other high-risk content related to self-harm, suicidal ideation, eating disorders, etc. has dangerous contagion effects [28]. For instance, Chancellor et al. investigated how pro-eating disorder communities on Instagram use non-standard lexical variations of moderated tags to circumvent platform content restrictions [26]. Lastly, digital traces on these platforms have allowed clinical as well as computational researchers to observe individuals’ mental health attributes in a non-invasive, longitudinal fashion that was previously unimaginable for mental health care [12]. Applying computational approaches on digital traces from social technology platforms, researchers have inferred peoples’ mental health, targeting different conditions [12, 25, 33, 106], platforms [25, 37, 113], and disciplines [13, 15, 32, 59].

We draw on this body of work that suggests potential mechanisms through which people with mental health conditions share their experiences and interact with others on social platforms.

2.3 Social Technologies, Health Management and Major Life Transitions

2.3.1 Role of social technologies in health management. CSCW and Health Informatics researchers have paid extensive attention to social technologies, particularly online health communities, to investigate their role in caregiving, informational exchange and peer support for health conditions. Researchers have investigated the role of online health communities and social technologies like Tumblr [100], Facebook [90], Wechat [41], and Instagram [30] in various health conditions including eating disorders [99, 100], fertility [98], and vulvodynia [128].

Significant work in this area focuses on studying people's behaviors on social technologies, i.e. seeking and providing social support, learning about coping mechanisms, and building peer networks, etc., to better understand health trajectories and outcomes. Researchers have conducted qualitative and participatory research to understand how people with health conditions use online health communities [74]. For instance Hayes et al. [64] defined the concept of a "personal cancer journey" drawing from an in-depth study of cancer communities. Jacobs et al. [69] presented a holistic framework describing the cancer journey from patient-centered perspectives (also see Levonian et al. [76]). Focusing specifically on eating disorders, Pater et al. investigated how people suffering from eating disorders reveal their conditions on different social technologies (Twitter, Tumblr, and Instagram) [99] and provided evidence that eating disorder-related content can negatively affect people suffering from eating disorders even if they do not actively consume such content [100]. Huh and Ackerman studied how diabetes patient support groups help one another find individualized strategies and coping mechanisms for managing diabetes [67]. From a quantitative perspective, Wen and Rose [121] developed machine learning methods to extract cancer event trajectories from messages in online breast cancer support groups. Yang et al. investigated how communication on online health communities affected commitment and tenure of participants [125], and modeled different social roles like seekers, providers, storytellers, etc., they take up in online health communities [126]. Closely relevant to our focus on social reintegration, Feuston et al. studied how people get back to their social lives following traumatic brain injury. They introduced the concept of social re-emergence as "a non-linear process of developing a new social identity that involves withdrawing from social life, developing goals for social participation, disclosing health information for social support and acceptance, and attaining social independence" [51]. Burgess et al. examined how people with depression connect with others for support, largely via interactions mediated through locations and communication channels, and highlight the importance of sociality for self-management of depression [17].

In another line of work, researchers focused on improving the design of online health communities to better facilitate people's interactions and goals. Hartzler et al. developed prototypes that provide a health interest summary extracted from users' profiles to facilitate peer matching processes on these platforms [63]. O'Leary et al. designed a peer support chat system to enable peers to chat online using effective principles of talk therapy [95].

We situate our study in this body of work and the varied ways social technologies have supported or hindered people's health goals and management. While previous research has provided rich insights related to social technologies and how people with health conditions utilize such technologies, the topic has been under-explored in cases where people suffering from the health conditions are socially isolated (both online and offline), which is a common experience in people who are suffering from mental illnesses requiring intensive care. This paper expands these efforts by providing empirical evidence concerning mental health patients' use of social technologies focusing on psychiatric hospitalization and the period after discharge from in-patient care settings.

2.3.2 Social Technology Use Following Major Life Transitions. Social technologies play an important role around major life transitions by helping individuals establish a “new normal” [60, 85], conduct identity work [39, 87] and reach out to similar others [111]. For instance, Semaan et al. [111] found that in the context of veterans returning to civilian life, technologies like social media enable people to re-integrate into society by developing identity awareness and connecting to similar others to understand post-military life and receive support. Prior research has examined several life transitions such as engagement [39], marriage [86], parenthood [54], job loss [19], divorce [127], loss of a loved one [16, 53, 66, 84], and transition to college [115] in the context of different social technology use [19, 39, 60]. These works show that people actively shape their digital footprints on these platforms by curating the self-presentation signals in the context of shifting identities [60] and show changes in language use [16] and behaviors surrounding transitions [35, 36].

Psychiatric hospitalization, that is characterized by institutionalized rituals and rules set by the hospital, and the shift from one’s role as a patient in the hospital to home can also be considered as a major life transition. In contrast to other life transitions described above, psychiatric hospitalization is also cyclical and potentially recurring due to the high likelihood of relapse. How does social technology use change during psychiatric hospitalization? What are the ways in which these technologies are appropriated during reintegration periods during which people re-establish social connections? Our work contributes to this literature by examining psychiatric hospitalizations, an unexplored event under the lens of life transitions. We extend prior literature by identifying shifts in individuals’ social technology use during reintegration after psychiatric hospitalization, relative to a previous ‘normal’ in their lives.

3 METHODS

Table 1. Participant demographics, including self-reported diagnosis of mental health condition, duration and place of their last psychiatric hospitalization.

ID	Gender	Age	Education	Race	Self-reported diagnosis	Time	Place
P1	W	46	some college	White	Bipolar Disorder	9 d	SC
P2	M	30	bachelor’s	Black or African American	Anxiety Disorder	1 wk	CA
P3	W	24	some college	Middle Eastern or North African	Anxiety Disorder	2 mo	NY
P4	W	24	some college	Black or African American	Anxiety Disorder	1 wk	NY
P5	M	27	bachelor’s	Black or African American	Borderline Personality Disorder	2 mo	CA
P6	W	25	some college	Black or African American	Anxiety Disorder	3 wk	GA
P7	W	25	bachelor’s	Black or African American	Anxiety Disorder	2 wk	TX
P8	M	25	bachelor’s	Native Hawaiian or Other Pacific Islander	Anxiety Disorder	3 mo	TX
P9	W	37	Master’s	Some other race, ethnicity or origin	Depression and Anxiety Disorder	3 wk	TX
P10	W	25	bachelor’s	Black or African American	Depression and Anxiety Disorder	4 mo	CA
P11	M	25	bachelor’s	Black or African American	Mood Disorder	6 mo	TX
P12	W	27	bachelor’s	White	Depression and Anxiety Disorder	4 wk	NY
P13	M	30	bachelor’s	Black or African American	Borderline Personality Disorder	1 wk	TX
P14	W	28	bachelor’s	Black or African American	Anxiety Disorder	1 d	VA
P15	W	21	some college	Black or African American	Schizophrenia	1 mo	NY
P16	W	22	bachelor’s	White	Schizophrenia	15 d	NY
P17	M	38	bachelor’s	Black or African American	Depression and Anxiety Disorder	2 wk	AL
P18	W	34	bachelor’s	Black or African American	Postpartum Psychosis	1 mo	NC
P19	M	37	master’s	Some other race, ethnicity or origin	Schizophrenia	1 wk	GA

We designed an interview study to investigate how people who experienced a psychiatric hospitalization got back to their social lives post-hospitalization (RQ1) and the role of social technologies in this process of reintegration (RQ2). We conducted semi-structured interviews with 19 adults (ages 21-46 years; $M = 28.9$ years, 63% women) who have experienced a psychiatric

hospitalization between 2009 and 2020. In this section, we describe our recruitment methodology, analysis process and the ethics of our work.

3.1 Recruitment and Participants

We used four channels to recruit participants for the interview study: 1) clinician referrals within a large health care system, 2) local Craigslist ads, 3) online social media platforms, 4) online mental health support communities. We collaborated with clinician researchers and practitioners in a large healthcare organization in the north-east of the United States who posted recruitment flyers around their centers and contacted potential participants regarding the research study. We also posted recruitment ads on Craigslist, shared the call for participation on Twitter and online mental health support communities on Reddit with moderator approval. We recruited from all four channels in parallel until we had reached a point of theoretical saturation [105]. Participants were eligible if they were adults between the ages 18 and 65 who experienced a psychiatric hospitalization for a diagnosis of schizophrenia spectrum disorder, mood disorder, bipolar, borderline personality or anxiety disorder and who had an active account on at least one social technology platform (e.g., Facebook, Twitter, Reddit, Snapchat, Tumblr.) We chose these mental health conditions because of the significant importance of social functioning and reintegration for clinical recovery, the lifelong management of the condition and the high likelihood of relapse.

We sent out a brief screening survey with the recruitment call for eligible participants to sign up for participation in the study. Participants self-reported their hospitalization, diagnosis of mental health condition and social technology use via the screening survey. Participants were also required to provide an email address so that they could be contacted for scheduling and compensation. We offered participants a \$25 Amazon gift card as a token of appreciation.

The screening survey was active September to November 2020 and we received a total of 138 responses. Among survey respondents, 42 were eligible for participation and they were contacted via email with study information and an online consent form. The first author conducted remote interviews with 19 consented adults within the U.S who experienced at least one psychiatric hospitalization. The average age of participants was 28.9 and 63% identified as women 11 participants reported a diagnosis of anxiety disorders, 2 reported borderline personality disorders, one participant reported a diagnosis of bipolar disorder and 4 participants reported schizophrenia form disorders. Participants had experienced psychiatric hospitalization (in-patient or emergency room facilities) for time periods ranging from 1 week to 6 months (average = 38 days, std = 46 days, median = 21 days) between 2014 to 2020 across the United States including Alabama (1), California (3), Georgia (2), New York (5), North Carolina (1), South Carolina (1), Texas (5), and Virginia (1) (Refer Table 1.) Participants' reported reasons for the psychiatric hospitalization included escalation of symptoms related to their mental health condition, management of medication, as well as high risk adverse experiences related to self-harm, suicidal ideation, trauma and postpartum psychosis. All participants reported using at least one social platform, with Facebook, Instagram and Whatsapp being the most commonly used ones.

3.2 Participant Safety and Risk Mitigation Measures

The study was conducted following Institutional Review Board (IRB) approval from the authors' institutions, and informed consent from the participants. To ensure participant safety, as a part of the consent process, participants were clearly told that they are free to end the interview at any time, and to let the interviewer know if there are parts of their disclosure that felt too sensitive or deanonymizing for publication. Additionally, following Draucker et al. [42], after particularly overwhelming questions (e.g., those on past suicidal ideation or self-harm), participants were briefly asked after answering if they felt okay and wanted to continue the interview. Further, our consent

form included links to prominent mental health resources like 7 Cups of Tea¹, Crisis Hotline¹, Crisis Text Line¹, and National Suicide Prevention Lifeline¹, which we encouraged our participants to use if the interview left them emotionally overwhelmed. To protect privacy, all personally identifiable information have been deidentified or obfuscated in our reporting of the findings.

3.3 Data Collection

Following our approved IRB protocol, we collected data for this study from October–November 2020. We conducted semi-structured, remote interviews via video or phone call based on the participant’s preference. We incorporated remote interviews to extend the reach of the study and for safety concerns during the COVID-19 pandemic. We developed guiding interview questions by drawing from literature on clinical recovery and social reintegration and input from the mental health clinician co-authors of this paper. The primary author conducted the interviews using a video-conferencing software approved by the IRB and the author’s academic institution, including for the local participants, due to the ongoing COVID-19 pandemic at the time. The interviewer began the session by informing participants the study goals, the risks and benefits of participation and asking for their permission to record the session. Then participants were asked to walk through the day they were discharged from psychiatric hospitalization and what followed next. In cases where participants experienced more than one psychiatric hospitalization, we asked them to pick a hospitalization experience that they considered prominent and to answer all subsequent questions around that hospitalization. Follow up questions focused on getting back to social lives, disclosure of experiences related to mental illness, social support, general social technology use and changes in use surrounding hospitalization. When possible, we asked for specific examples and probed participants to understand the role of social technologies during their reintegration journeys after hospitalization. Each interview lasted approximately 60 minutes. Only audio was recorded and then transcribed for analysis using Otter.ai software for transcription services.

3.4 Qualitative Data Analysis

To analyze the interview data, we followed an integrated inductive and deductive approach to thematic analysis to combine data-driven codes with theory-driven ones [50]. The analysis began with the inductive part – open coding of the transcripts independently by three co-authors to identify patterns in data and establish a thematic framework. The themes were then organized into an initial codebook. The team met frequently to resolve disagreements, discuss emerging concepts, and refine the themes. This coding process resulted in the formation of 10 themes such as “transitioning from hospital to home,” and “online social support.” We consolidated and organized these themes to highlight the social lives of people after psychiatric hospitalization and how management of a mental illness and technology use intertwines with people’s social lives during the reintegration process.

3.5 Limitations

As with other qualitative work with similar research goals and methodological orientation, our findings are limited in their generalizability. While, we sought for a diverse pool of participants with four different recruitment channels and involving people with different mental health conditions, our study sample is not representative of individuals in the U.S. who have experienced psychiatric hospitalization. Similarly, we only included participants who have been diagnosed with schizophrenia form disorders, anxiety, mood, bipolar, and borderline personality disorders, and did not identify experiential differences based on diagnostic type. Future work can evaluate and extend our findings with other populations, including people with different mental health conditions, people who have

¹www.7cupsoftea.com, www.imalive.com, www.crisistextline.org/, suicidepreventionlifeline.org

experienced very long hospitalization periods, and people in different countries and cultures. All of our participants mentioned using at least one social technology platform actively. Therefore, our results on the role of social technology in reintegration after psychiatric hospitalization are not representative of people who do not use them actively or at all. Despite these limitations, our work presents first insights into how social technologies support and hinder people's social lives after psychiatric hospitalization.

3.6 Positionality

This research has been conducted by a team diverse in many ways. In terms of academic, disciplinary, and professional backgrounds, our team includes social computing and human-computer interaction (HCI) researchers, as well as clinical psychologists and psychiatrists. Our team is also demographically diverse, including people of color, those holding LGBTQ+ identities, and immigrants. Notably, the team includes members with lived experience of mental illness as well as those who interact with such individuals on an everyday basis as part of their (clinical) profession. Together, our team holds a profound commitment to mental health research and practice, critically considering the potential offered by technology and computational artifacts in mental health, whether from the perspective of benefits or from that of harms. Therefore, we collectively recognize the emotional labor it takes on the part of a researcher to conduct research that involves a marginalized population, that centers around a highly sensitive topic, and whose social interpretations are shaped by demographics and culture. These personal and professional experiences have influenced both the questions we ask and the analytic lens we have adopted in this work.

4 FINDINGS

In this section, we present findings on the social lives of people after psychiatric hospitalization and their social technology use during reintegration. Section 4.1 is organized to present contextual information on people's lives immediately after discharge from the hospital, including the ways people re-gain access to social connections and technology post-hospitalization. Section 4.2 focuses on how social lives of people after the hospitalization are intertwined with management of the illness, highlighting the intersection of clinical and social aspects of mental health care. Lastly, in section 4.3, we present findings on people's social technology use during the post-hospitalization period and its relation to self-management of the mental illness.

4.1 Social lives of individuals after psychiatric hospitalization

4.1.1 Transitioning from hospital to home. Psychiatric hospitalizations are considered life-altering experiences, as the admission often implies that individuals are unequipped to manage their psychiatric needs and require removal from their existing environment to receive appropriate, urgent care [31]. While admitted in the hospital, an individual's role as a patient is often defined by the many rules and rituals set by the hospital that they have to follow. Importantly, in many cases, there is a lack of access to technology, social support, and offline connections [31, 97]. Participants' transition from the restrictions of the hospital and their role as a patient to their own home was often described as a significant social re-adjustment.

Some participants expressed feeling a sense of freedom as they transitioned from the hospital back to their home. This was indicating everyday mundane activities like *'sleeping in my own bed'* (P1, P2, P16) or *'having a cigarette,'* (P1) but also a shift in power and control over other activities and interactions. For example, P1 notes that after leaving the hospital, she was not being told what to do by others anymore and this was a sudden transition back to social relationships where she had equal power. Similarly, P2 shared feeling an immediate *'feeling of freedom'* and being *'back in control'* as soon as he was discharged. P2 said he felt this way because he disliked hospitals and the in-patient experience and was waiting to get back home.

“The first thing that came through my mind even just before the tests and after I was discharged. I don’t know, that feeling of freedom.” [P2]

However, this sense of increased control and freedom was not shared by all participants. The transition from the hospital to home was drastic for some participants. P12 shared how factors at home contributed to her hospitalization. She expressed fear that interacting with people at home would make it challenging for her to manage and cope with the mental health condition. P12 said,

“The first thing that came to my mind was, how do I cope? How do I get back to the reality that I left at home? Because there’s no escaping the reality that was at home. There was no escaping the people. I was scared that I’d get depressed, all over again. But somehow, somehow, sticking it out a minute at a time, a day at a time, I was able to cope.” [P12]

P18 shared that she did not have anyone to pick her up after the discharge, so she reached home in a hospital van. Upon reaching home, her family kept her from living in the same house and she found herself homeless for a bit after the hospitalization. She said,

“And I was homeless for a little bit because my own husband has kicked me out. And so, you know, it was just really frustrating. And, yes, it’s this frustrating because it’s a lot going on, and happening, kind of fast. Things that I wasn’t really prepared for.” [P18]

Some of our participants experienced the hospitalization during the COVID-19 pandemic [96], which made their transition to home and their reintegration journey further challenging. P16 noted *“I went from like having a very busy schedule of work, school, volunteering, seeing friends, having a social life, going out all those things to having a psychotic episode and then coming out of that going to a wedding the week after and then being in quarantine [due to the COVID-19 pandemic.]”*

Assessing patients’ capacity for management of the illness and self care, their clinical needs and their socioeconomic and cultural needs including where the patient would stay after the discharge, the levels of support available and needed, the wishes and decisions of the patient and the family, etc., are an integral part of discharge planning for patients hospitalized for a mental health condition [1, 2]. Our findings suggest the preparedness that participants might feel at the time of discharge might change as they immediately transition to home due to unforeseen conditions that happen while they were in the hospital.

4.1.2 Re-gaining access to social connections. Consistent with prior work, we found two distinct approaches participants took to re-establish their social connections immediately after discharge from the hospital [46, 51].

For some participants, after the hospitalization, we found that a sense of urgency and prioritization determined how they interacted with others in their lives – either because they were missing out on social interactions while they were in the hospital, or because they felt obligated to get back to people who couldn’t reach them while they were hospitalized. One of the immediate social interactions participants had after discharge from the hospital was letting people in their lives know that they were back home. This communication happened most often via technology-mediated channels and rarely in person. Some participants shared feeling a sense of overwhelm and urgency in reaching out to people and described how they prioritized whom to contact in their lives. We found that being able to re-establish social connections and draw upon benefits from social circles depended on whether people in participant’s lives knew about their psychiatric hospitalization. P16 shared that since she had not seen their friends in a while, one of the first things on her mind was getting back to them. However, she said, *“My parents made sure not to tell people, not because they’re ashamed, but because they didn’t want me to feel like I had to go and explain myself to other people.”* P16 mentioned how it was only after a period of time that she opened up to her close friends about her hospitalization experiences.

Other participants shared that they did not immediately re-establish their social connections because they were worried or skeptical about how their family/friends might react to the news about their psychiatric hospitalization or because they considered slowing down the reintegration process as a coping mechanism to manage their condition. As P8 shared,

“I don’t know what I’m expecting and [how] people may react to the news that I’m back, and then, bearing in mind that it was difficult for them to understand me.” [P8]

P13 echoed a similar withdrawn approach to re-gaining access to their social network. He said,

“I mean, you know, just trying to stay away from many things, just like keeping a low profile...I meant to just relax [...] It makes me have a good plan. Yeah, just like no pressure at all.” [P13]

Clinical literature suggests that social functioning, i.e. re-establishing social connections and interactions after hospitalization is an essential marker for recovery in mental health [11]. Importantly, problems with social functioning can lead to long-term social difficulties, such as withdrawal, isolation, and lack of integration into the community [120]. In relation to our finding, this body of work suggests that while people might not feel immediately ready for social interactions, waiting too long to re-establish social connections is not beneficial for recovery and reintegration.

4.1.3 Regaining access to technology and re-establishing online presence. A common experience during psychiatric hospitalization is loss of access to personal devices like mobile phones and limited use of technology and the internet [31, 97]. Participants expressed a wide range of emotions including feelings of anxiety, overwhelm and the fear of missing out, when they re-gained access to their phones at the time of discharge. For instance, P17 shared that he felt anxious about missing work-related emails while he was in the hospital. P13 mentioned how he missed his phone and online interactions while he was in the hospital. He mentioned that the first thing he did after discharge was catching up with online interactions and notifications.

“I wasn’t allowed to have my phone. So, I felt like I missed a lot of things online. When I got back home, it was so hard to catch up with everything on like like on Instagram, Facebook, the forums that I’m always in. I’m in [different] groups, so I just felt left out. I mean, everything was behind me. Yeah, so I had to catch up, to get to get updated.” [P13]

However, not all participants expressed positive feelings towards re-gaining access to their devices. One of the major reason noted by participants was the overwhelming volume of mobile push notifications they received when they turned on their phones after the discharge. P1 shared that the volume of mobile notifications *“ruined [her] experience of returning home”*, and she would strongly advise others to not immediately turn to their phones and calls or read the notifications they have missed right after discharge from the hospital.

“The first thing you want to do is turn your phone on, because gosh you missed your phone so much, and it won’t stop making noise at you because you’ve missed, you know, a week’s worth of texts, and emails and any other notification. And, you know, so you’re trying really hard not to be overwhelmed by anything. So eventually, you know, I just, I just turned it on and put it down, because, I knew that there were people I wanted to let them know that I was home and all that. But, that was too much all at once, so I try to just, you know, put the phone down, enjoy the car ride with my mom.” [P1]

P2 also echoed this feeling of overwhelm, saying, *“there’s a lot of notifications...people are chatting chatting always. When you go offline and come back online or leave your phone. So many notifications.”* In Social Computing and HCI literature, prior work has studied various forms of technology non-use [7, 109, 124] in the context of people who actively choose to stop their online presence and interactions or people who were never able to access a technology [109]. In contrast, in the context of our participants who have experienced a psychiatric hospitalization, the institutional rules and

guidelines do not permit them to use technology while admitted in the hospital. Situating this finding in technology non-use literature, we find that our participants feelings about their break with technology extend beyond existing categories and conceptualizations of non-use [109].

4.2 Social lives intertwined with management of the illness after hospitalization

4.2.1 Self-reliance. The deinstitutionalization movement shifted the role of the psychiatric hospital from a place of long-term stay and treatment to emphasizing reducing feelings of dependence and supporting community integration [6]. This model encouraged rapid discharge from the hospital once patients' symptoms stabilized, so they may continue care in outpatient settings. We found that not all participants felt like they were ready to get back to their normal routine and social lives after discharge from the hospital. P16 mentioned difficulty with focusing and paying attention and fine motor skills after the hospitalization. She also spoke about how receiving accommodations at school was helpful to navigate life after the hospitalization.

“I was still like frazzled coming out of it like you’re not like I was recovered enough to go home, but not enough to like be back to normal routine... my fine motor skills were, I’m not gonna say depleted but I’m gonna say like, not as refined as what they typically were. like I was having like I was getting dizzy from walking in the hospital so even just like light exercise was difficult for me because I found myself getting dizzy from walking.” [P16]

Participants shared how their recovery journey outside of the hospital affected their self-perception and self-reliance. P19 experienced problems with his memory after discharge from the hospital and needed people in his life to help him remember things. P12 mentioned being heavily dependent on her mother for coping skill and managing her symptoms because her mother also experienced the same condition. The reliance on others for everyday activities was particularly challenging for those who experienced their first psychiatric hospitalization. P16 who was diagnosed and hospitalized for schizophrenia form disorder for the first time noted, *“Prior to that like I had been such like an able person. Like even coming out of the hospital I wasn’t allowed to drive, because I was still gonna adjust to medication so I wasn’t allowed to drive so I had to Uber everywhere.”* This reliance on others during the recovery period and a change in self-perception impacted how participants described their social interactions immediately following the psychiatric hospitalization.

4.2.2 Stigma. Extensive research establishes the challenges associated with stigma around mental health conditions globally [49, 56, 77, 79]. We found that the post-discharge period is particularly challenging due to stigma as participants re-established their social connections and opened up about their psychiatric hospitalization experiences with others. On the one hand, the stigma manifested as a hindrance to self-disclosure, obtaining social support and reintegrating back to social lives. As P16 notes, *“I think there’s a huge disconnect. In between what people know about... what they think they know about mental illness and what it actually looks like, and what leads people to have it.”* P2 also expressed the difficulty in feeling they could not tell friends they had been in the hospital because they wouldn’t be accepting. P18 shared,

“It’s something that I guess from an outsider’s perspective, people don’t really understand and they might say, you know, ‘you’re just being lazy,’ you know, when you’re, you know, really depressed, you know, and you legit can’t function, you know, and them not understanding that or empathizing with that.” [P18]

On the other hand, participants also noted the societal level stigma associated with mental illness that led them to unwillingly lie about their condition and hospitalization. P1 shared that she had to lie about the hospitalization to people at her workplace due to the stigma and negative consequences she might face. She noted:

“if I’m not telling them that I’m going into the hospital that I tell them that, Oh, my, my aunt is having surgery, and I’m going to stay with her for a week...and, the cell..you know, reception is, you know, not always great out there. But yeah, unfortunately, we’re still at a point in this country in the world that if you say that you are in a behavioral health center, you know, to fancy it up.” [P1]

These effects of stigma on people’s social lives obstructed their path to successful reintegration after psychiatric hospitalization. Participants noted cutting family members and friends off their life because they were ‘scared’ (P11) or could not handle what the person was going through with management of the mental illness. P11 says *“Some people think maybe you are not okay. So they’ll be a bit scared of how you’re going to react.”* These obstacles resulting from stigma highlight a re-assessment of pathways to social reintegration (due to loss of previous social connections) and self-management of the illness (due to lack of social support resources, perceived or actual.)

4.2.3 Shift in goals. The period after discharge from psychiatric hospitalization is characterized by a shift from institutional, clinical treatment to self-management of the mental health condition by individuals. We found that several participants identified this shift and created new goals to manage their condition outside the hospital, often noting that the hospital was only one step in their journey with mental illness.

“The hospital is a temporary thing, you know I’m saying, whatever problem or situation is going on with you. That is still going on with you. You know, none of that changes. You change, your environment changes, your perspective changes, but, they don’t change anything. So yeah, most of my managing definitely came from when I was outside.” [P18]

Participants noted several strategies to cope with their symptoms and manage their condition after the hospitalization, most commonly identifying these mechanisms as part of self-care. Some participants shared how they stopped adhering to their prescription medication or choosing alternative forms of medication to manage their condition. For instance, P19 mentioned that he started taking natural medications such as activated charcoal to *“clear [his] gut of all those medications”* [P19]. P18 also shared her negative perceptions towards medication she received at the hospital and how she chose to stop it and focus on changes to her lifestyle. She described her approach as, *“taking care of myself is just being more aware of what’s going on with me.”*

“To this day, and even in the hospital they forced me to take pills, I wouldn’t, I don’t take medication now. So, to me it was just a lot of self care and making sure that I pay attention to me, make sure I eat and sleep, which again, somehow [I] wasn’t getting because I just had a baby and making sure that I just pay attention to, you know what’s going on with me...if I’m feeling, you know, emotional or whatever, I just choose not to do certain activities that day.” [P18]

Other participants revealed how they made changes to their lifestyle to maintain their health outside the hospital and how this was a significant change to their lives post-hospitalization. P19 spoke about how he started eating healthy, exercising, meditating, and noticed a significant improvement in managing his symptoms: *“Instead of just saying, you know, go to your therapist and all that... no, we need to, people need to be teaching people about healthy food...Suicidal thoughts, or like voices, or whatever, it’s so low now. It’s like it almost doesn’t exist because I started changing a diet.”* Similarly, P2 spoke about making major decisions in his life after the hospitalization such as quitting a stressful job and ending bad friendships to maintain his health and well-being.

“I had to quit my job. I was under a lot of pressure. I don’t know...my eating habits changed. Even friends, I stopped talking to some of my friends, putting a little pressure and all that...so I had to drop my friends and the job.” [P2]

P19 shared how he changed his self-presentation to symbolize the new beginning he was marking after the hospitalization.

“You got to create, like a whole new person, you know, you can go back to the old ways or you’ll probably, you’ll probably go back to to bad mental health issues, so basically try to create a new person...and even dressing different, you know, people see me now and I’d have hoop earrings on, like, I never did that. Just creating a whole new human being, that’s what I’m about.” [P19]

A common theme across these goals that people set for themselves was that they were actively identifying and addressing daily stressors in their lives and making positive behavioral changes to better manage their condition. P18 summarizes this accurately speaking about how reintegration is more than just treating symptoms, particularly, focusing on the everyday stressors with social relationship, finances, jobs, etc., that people face in their lives outside the hospital.

“A lot of people just have a lot of issues that are not being addressed. They’re, again, so focused on, you know, the pills and things. But like I say, maybe there was something that was stressing them out, like, hey, I don’t have enough money to feed myself, you know, I don’t have a license. which means I can’t get services, you know, like food stamps or housing or whatever. I think that [clinicians and hospital staff] don’t really help people in their everyday lives, to kind of cope with that stress a little bit to help what’s inside. which I really feel like puts people in a place where they’re just constantly in this fight or flight response and survival mode.” [P18]

4.2.4 It takes a village. Beyond the individual’s role in managing their mental health condition outside the hospital, we found that family members, friends and online social connections together played an important role in supporting participants’ reintegration after psychiatric hospitalization. We found that the role of others is important not only after discharge but also during in-patient hospitalization experience. Particularly among participants who were hospitalized for a longer duration ranging from weeks to months, we found the importance of close friends visited them during the hospitalization or sending cards thinking of them (P5, P19).

After discharge, participants spoke about how their family made them ‘feel welcome’ (P5) to be back to their home. They shared how feelings of acceptance after the hospitalization experience and normalizing mental health challenges played a crucial role in their recovery and reintegration journeys. P12 spoke about how her family treated her the same after hospitalization, due to their own experiences with depression and anxiety.

“They didn’t change the way that they view me for having a mental illness. That meant a lot to me.” [P16]

Participants’ friends and family also helped them with managing their symptoms and cope with their mental health condition after the hospitalization. P11 mentioned receiving a lot of support from both family and friends; they visited him frequently after discharge and helped him get back to a normal routine. P19, who faced challenges with his memory after hospitalization, spoke about how his sister showed him pictures on his phone to recollect past memories. Similarly, he spoke about watching old videos with his friends and to remember those he had lost memory of. P19 also mentioned how his family recorded moments during which he faced suicidal thoughts and walked him through those videos as a way to give structure to his experience with schizophrenia. This form of confronting inhibited thoughts and giving an experience structure and meaning is known to help self-management of mental health conditions and facilitate a sense of resolution [101]. P12 shared how her mother, who also experienced mental health challenges, helped her with coping mechanisms during the reintegration period.

Another role that participants' social connections played was as a source of informational support. P2 mentioned that his girlfriend shared links related to mental health support with him, even when he was not seeking such informational support. He expressed the important role this played in his recovery after the hospitalization.

“Actually my girlfriend used to give me links. So, personally, I wasn't like looking for such content, but my girlfriend sent me links to read about being in the hospital.” [P2]

P2 shared how having at least one supportive person during the reintegration journey plays a significant role.

“I don't have many friends. I think I spoke to one of my friends, and it is very different. And so when we went to hospital because of my issues. They might end up, I don't know, may be they couldn't take me for who I am. So, I would just keep it myself apart from one friend or didn't even tell them exactly where I was...in the hospital. But for my girlfriend she knew everything. Because to her it doesn't matter. With my girlfriend on my side I think things were not bad...she was really there for me.” [P2]

Apart from close friends and family members, participants spoke about the role other social connections and in-person support groups played during reintegration. For instance, P12 spoke about how her boss at work was extremely supportive and understanding of her hospitalization experiences and allowed her to take time off and slowly get back to a normal work routine.

“my boss give me a break, and allowed me to work at home more because part of the pressure at work was triggering my depression. but he cut work time for me and eventually went back to working full time. but he helped me gradually, gradually, ease into work. that helped a lot.” [P12]

The role of social connections was also emphasized by participants who felt like they did not have such a social circle supporting their recovery and reintegration. P18 expressed feeling a lack of support from family and friends. She came back home after discharge from the hospital by herself and had negative experiences of rejection from her family. She shared that she made new friends while she was admitted in the hospital and joined a support group, albeit unenthusiastically, and this played an important role in recovery after hospitalization.

“I don't feel like I got a lot of support, I was kind of forced into a support group, and actually really enjoyed that. Because of people that I felt like it kind of surprised with what I was going through. And then I made some friends in the hospital so I think that really kind of helped my overall recovery talking to them and you know getting their perspective on what happened.” [P18]

Prior literature on mental health supports that emotional and informational support, coping and management of symptoms are associated with successful recovery and overall well-being [73]. We found that the social context of the individual, either a single person or a community of people, involving family members, friends, colleagues, 'sympathetic others', together shared the labor involved in navigating reintegration after psychiatric hospitalization. Furthermore, we found that both pre-existing social relationships as well as newly established connections have a role in supporting reintegration journeys.

4.3 Online social lives intertwined with self-management of the mental illness

4.3.1 Online spaces for self-disclosure. Confirming findings in prior literature, our participants also appropriated social technology platforms for mental health disclosures [5, 48]. We identified three different approaches to how participants considered disclosing about their mental health challenges on social technologies like Facebook, Instagram, Youtube, and others. Some participants noted being very private on online spaces and they mentioned that they would never consider posting about

their mental health experiences on online social platforms (P2, P6, P13). The stigma around mental health and the uncertainty in how others might perceive them inhibited participants from disclosing to those outside their close friends and family circles (P11). For example, P12 shared that she only disclosed to people who needed to know about her condition, but that she would also tell others if they asked. The second approach to online disclosures of psychiatric hospitalizations involved participants who felt comfortable to post about their mental health experiences on personal social media platforms or online support groups. Among reasons that made participants feel comfortable with their posting decisions, one frequently noted reason was other people's prior knowledge of the participant's condition (P1, P11). P11 said, *"Most of my friends knew about my situation. So, I did not have any challenge posting it because they are aware I was in hospital."* In contrast to face to face disclosures, P18 expressed that it was easier for her to disclose in online support groups because she felt it was easier to say everything she wanted to say without any interruptions. P18 also mentioned that with online support groups, there is no fear of therapist mandatory reports. She said, on the benefit of disclosing in online support groups compared to offline groups:

"I think online, you're a little bit more receptive to open up and you are not under like a time constraint, like in group in person, you may have a certain amount of time. And because again there's other people there, you can't talk over people or whatever. when you're by yourself online, you can really say everything you have to say and get it all out. Some people's posts are very very long I don't know if everybody reads through the entire thing or not. But you do feel like, again I'm being heard. I'm not being interrupted, I'm not under constraint, I can really just say everything that I have to say. Whereas in person, you may not necessarily get to do that and again because they can put a face, you know with the name. we may be a little bit more hesitant to say certain things, especially since it's facilitated by, you know, therapists and they're mandatory reporters. So there are certain things, you're probably not going to say to them." [P18]

The third approach participants adopted for online self-disclosures involved public broadcasting disclosures to those outside their social circles. P19 used YouTube and Facebook live streaming to tell his story with mental illness to followers and discuss his recovery process, especially following the hospitalization. P5 shared that he posted on Facebook and Instagram about his experiences with mental illness and gained a significant number of followers because of their stories. P15, who had a YouTube channel where she posted videos on Christianity and music, spoke about opening up about her hospitalization experiences:

"I'll probably open with my hospitalization experienced probably on YouTube because I do gain a lot of views on YouTube. So I might put it on YouTube. I might not really say it by posting on Instagram or posting on Tumblr." [P15]

When asked about what she would share on YouTube, P15 said she wanted people to know that, *"life will get better. things can get better like right now you might be going through something, but it takes time for, for you to get better."* P15 also noted that she would feel more comfortable opening up to her followers on YouTube than people in her life because she did not like waiting for people's response and the lack of reciprocation from her friends. She said by posting on YouTube, she would be able to help a larger group of people:

"I think sharing it on YouTube is meaningful because of your experience, what you've gone through and then, you can probably help someone. And that's how I feel, I feel like it's more meaningful than talking to your friend about it, because that's just one person, and compare this with many other people." [P15]

While most participants experienced positive feedback and support when they opened up about their condition online, one participant (P17), who had a public Facebook profile for both his personal

and business use, shared experiencing negative interactions and harassment that made him skeptical to share more about their illness.

“People harassed me over the phone, I have like my business phone number up on my website. But I have been harassed and I blocked people on Facebook, yes. I have been attacked emotionally by people on Facebook. They [people who attacked] were people from high school, that, you know, people will add you on Facebook based on connections from school or church or whatever. And that doesn’t mean I was personally connected with them.” [P17]

4.3.2 Online spaces for support. Most commonly, we found that participants adopted social technologies for reaching out and accessing social support. Majority of our participants shared about finding and accessing support via technology only after their first psychiatric hospitalization. Two mechanisms were predominant in the ways participants found social support via social technology platforms after hospitalization.

First, majority of the participants mentioned belonging to an online support group, most commonly on Facebook or Whatsapp. On Facebook, participants mentioned large groups formed by organizations like Mental Health America (MHA), National Alliance on Mental Illness (NAMI), as well as smaller, local mental health awareness and support groups. Some participants mentioned being part of WhatsApp groups, with several hundred people, that facilitating sharing about mental health experiences, coping mechanisms and supportive resources.

When we asked participants how they learned about these groups, we found several points of entry through which participants entered online support groups. Most commonly, participants shared that someone else in their lives introduced them to the groups (P2, P7, P8) or pointed to them as a support resource. For instance, P2 spoke about how his girlfriend shared a link with him through which we could join a local mental health support group on WhatsApp. Other participants mentioned actively seeking out for support groups after their hospitalization using features such as Facebook search. P12 spoke about seeking out mental health groups on Facebook after hospitalization because she was more aware of her problems and how these groups could benefit her. Once participants joined a Facebook group, they revealed how they subsequently found more support groups through the auto-generated suggested groups on Facebook (P1).

We probed into the structure of these online support groups and how participants participated and found meaningful support during their reintegration journeys. On Facebook, most groups that participants belonged to were private Facebook groups that required moderator approval to join. Participants shared how this enabled them to feel like these groups were safe spaces and made them feel comfortable speaking about mental illness (P1, P18). In contrast to the structure and moderation of Facebook groups, the WhatsApp groups that participants belonged to were largely not moderated. P2 spoke about how the chatting interface on Whatsapp and constant push notifications made it difficult for him to follow content on the group.

“There’s a lot of notifications...people are chatting. Chatting always. When you go offline and come back online or or leave your phone. So many notifications.” [P2]

One participant (P2) shared that he thought a member of his WhatsApp group might be a licensed therapist because they frequently answered others’ questions. But, the lack of affordances to archive roles and norms on WhatsApp groups made P2 unsure about recommendations on the group. Across Facebook and WhatsApp support groups, participants described how members introduced themselves, shared stories about their mental health condition and hospitalization experiences, as well as coping mechanisms. As also evidenced in prior work [3, 4, 47], reciprocity, informational support, reducing inhibitions and stigma and normalizing mental health experiences contributed to the value our participants drew from these groups. P5 spoke about how there were

so many people with many different experiences on these groups that they were always able to relate to some content or person on the group.

“I’m in there, talking about you know my experience being chronically in and out... recently, and for the extended period of time. And they all say the same thing you know it’s like it’s like coming into a new world, like being born again.” [P19]

P10 shared about feeling inspired by others’ stories on the Facebook group she was participated. She started sharing stories of people’s recovery and reintegration journeys from the Facebook support group on her own timeline (with the individual’s consent), to raise mental health awareness among her social circle.

While not all participants actively participated in these online support groups by posting or commenting, they noting benefiting from reading advice on coping with mental illness and making positive life changes based on information shared in online groups (P2). The second predominant mechanism through which participants drew benefits via social technologies was by passively consuming supportive content on these platforms. Sometimes this included posts made by other individuals in an online support group. But, more commonly participants mentioned following content on inspirational quotes, positive life changes, positive behavioral changes, spirituality, etc. For instance, P4 spoke about following a Twitter account that posted motivation quotes and how this content helped her.

“There’s a page on Twitter that usually shares motivational quotes. I go through the articles they post. you know, get inspired and that really help me to deal with my with my inner self. So I was able to be happy again.” [P4]

P8 also spoke about following Facebook pages that post inspirational quotes and spiritual videos. He said, *“[I get] the ups and the inspiration and that one would let me recover, very quickly. Yes. And, yeah, most of them did they have the Facebook pages so just follow the pages and get the posts and inspiration on a daily basis. And with that, it has helped me to get the mental illness in control.”* Lastly, apart from the popular social technology platforms, some participants also mentioned finding online meetings (P1, P3) and webinars (P6) related to mental health via social technologies. Participants spoke about how these interactive meetings helped them during the COVID-19 pandemic as they could not access resources and care in-person.

4.3.3 Negative aspects of social technology use that hinder management of mental illness. So far, we discussed how participants found that social technologies supported their reintegration journeys after the hospitalization. Alongside these benefits, participants also identified aspects of social technology use that they found harmful or not beneficial to their recovery and reintegration.

Some participants found that spending too much time online on social technology platforms was replacing the time they spent on social interactions in-person (P16).

“I felt as if I was spending too much time on my phone, to the point where I was not physically present in the conversation or like I just needed time that I wasn’t being bombarded by, you know, advertisements, friends from high school doing this, friends and colleagues doing this, comparing yourself to other people.” [P16]

The most commonly noted negative aspect of social technology use was related to feelings of social comparison [18]. Participants described how seeing other people’s posts about doing well in life made them feel less accomplished (P12) or bad about themselves (P1). As P16 explained, *“Well, look, there’s a fitness Instagram model and like I just feel like it creates so much of distress in a lot of ways that it’s kind of unnecessary. like as much as it is entertaining it causes a lot of like, low key distress. to put it.”* We found that feelings of social comparison were particularly significant when they acted as triggers to people’s mental health conditions. P12, who mentioned feeling left behind seeing other people’s posts on Facebook said:

“I’ve been trying to avoid Facebook ever since because I will admit that some of my triggers come from seeing how other people are doing so well and I feel like I’m stuck.” [P12]

While P12 also participated in online support groups on Facebook as we described above, she noted how these support groups have been helpful in managing her condition, but, she viewed them as short-term solutions. Specifically, P12 spoke about the content on these support groups reminded her of her old experiences with mental illness that she wished to move away from. From P12 (on negative aspect of support groups): *“I wouldn’t want to keep replaying my experience over and over and over again. I’d like to move on from that.”* Another participant spoke about the negative effects of consuming information that was not helping their recovery and reintegration. P17, who was hospitalized in 2020, shared that he deactivated his social media accounts after the hospitalization because he did not wish to see posts about the California wildfires, and COVID-19 related deaths as that affected his moods and mental state.

“That was kind of intense I didn’t want to say too much about that [mental health], or the wildfires and COVID, which is kind of sad. I didn’t want to. I didn’t want to see much about that. Yeah. Even though I wanted to be mindful of people that are suffering I just did. It was kind of sad to hear about it.” [P17]

Prior experiences on the platform also affected P17’s decision to deactivate his Facebook account after the hospitalization. He mentioned being bullied online, where someone used profanity and hateful language on his posts. P17 also shared that a family member posted hurtful comments about being hospitalized for mental health. Due to these past experiences, P17 said he commonly deactivated his account when he decided to take a break and focus on his mental well-being. As people navigate the complexities of recovery and reintegration in their social lives, these findings show that negative feelings related to social comparison, negative interactions and emotional triggers presented additional hindrances to management of the illness.

4.3.4 Transformation in digital habits and routines. Finally, we asked participants if their use of social technologies changed after the hospitalization, compared to how they used these platforms prior to the hospitalization. For many participants, we found no active changes to time spent, digital habits and posting behaviors on social technologies. These participants were already using these platforms in a specific, limited manner and their use did not change due to the hospitalization (P2). For instance, P18 shared about always being private and that she prefers to directly call or send messages to her friends as opposed to interactions on social media. She mentioned that she did not like the idea of having information about her available to anyone other than people who already knew her background.

Other participants actively made changes to their online social lives, digital routines and posting behaviors on social technologies after the psychiatric hospitalization. For example, P16 shared about spending less time on Facebook and Instagram after the hospitalization because she felt it was beneficial to limit screen time for her mental health. She mentioned using a logging app on her phone to track her screen time. In contrast, some participants increased their screen time and social technology use because they believed these platforms mediated their offline social reintegration, i.e., they helped re-establish social connections that they missed while they were hospitalized. P11, who had been in the hospital for four months, shared that after discharge he got back on social media to re-establish his online presence. He mentioned that social media was the only medium through which he could share with friends his experiences and plan social interactions since his discharge. Similarly, P5 spoke about always being active on WhatsApp and using it more frequently after the hospitalization as he was not seeing his friends in-person due to the COVID-19 pandemic.

A few participants spoke about re-configuring their digital habits and social technology use to better facilitate their reintegration journeys after the hospitalization. P1, who only had a few

high school friends on her Facebook friends list, spoke about actively joining five Facebook groups for mental health support. She also mentioned restructuring her Facebook feed by unfriending toxic acquaintances and strangers, and following health-related pages, and joining mental health support groups: *“I joined a whole bunch of new groups to try to make sure that my Facebook feed was nourishing me and not, and not strangling me.”* [P1]

“[I recommend] anybody struggling with any of these issues, to try to find some groups on Facebook, especially if they use Facebook, that help increase your support chances, the support system, your chances of staying mentally healthy, because you’ve got all these extra people to interact with. Find online meetings, or, you know, NAMI or any of the other mental health support places out there. Because, they’re out there! your people are out there, no matter who you are, especially if you’re struggling with mental health. And you can be in these groups, and you’re going to get affirmation statements, you’re going to get really good quotes. You’re going to have people talking about their issues. And you can be like, oh, wow, those are my issues here. So I helped with that. I would definitely that would be the first thing I would encourage people to do. Like, drop all of your friends from high school, pare your list down to people you actually care about and are interested in, and definitely find a group or two or five. I mean, you can make technology and social media, you can make that work for you.” [P1]

P17 whose past experiences on Facebook included negative interactions and frequent de-activation, spoke about how he blocked people who were hurtful, and started following funny videos on Facebook Watch. He found light-hearted content online relaxing and helpful after the hospitalization.

“Yeah, some of the videos that people post. I guess they are like bloopers or just pranks, without hurting someone, but just kind of quirky, funny videos, those help me...just seeing people make this video so I guess even like dance videos and videos of people making different food from across the world. That kind of helps.” [P17]

P17 also highlighted how social technology platforms differ from one another, and how one might be better for him after the hospitalization experience. He mentioned that he continued using Instagram (and not Facebook as much), because he does not have to see other people’s status updates and interact with them: *“You can just follow, post, and like pictures, and you don’t have all these status updates all the time.”*

P19 who did not share personal details on Facebook prior to the hospitalization shared how he transformed his profile to a public-facing account. He continued using Facebook and YouTube to stream a fitness series he had started before hospitalization. After the hospitalization, he used these platforms to start a mental health series that benefited both him and his subscribers. From P19 (on how getting back to created a Facebook series helped him): *“You know, regain your mental health, you know just doing stuff that helps other people, versus focusing on yourself often.”*

5 DISCUSSION

5.1 Interpreting our findings

By investigating the social lives of individuals after psychiatric hospitalization, this paper presents people’s shifting goals, priorities and challenges during the process of reintegration and unpacks how social lives are intertwined with management of illness. Our findings on people’s reintegration journeys after psychiatric hospitalization corroborate that both clinical recovery (i.e. reduction in symptoms) and social reintegration (resuming social roles) need to go hand-in-hand for overall well-being of those with mental illness [6, 71]. Further, we lay out details on the intersection between clinical and social factors affecting people’s lives after psychiatric hospitalization. During the period after discharge, we identified participants’ goals and responsibilities such as re-establishing social connections, resuming social roles, and management of the illness outside the hospital. However,

stigma related to mental illness, over-reliance on others, lack of support and change in living circumstances presented challenges to achieving these post-hospitalization goals. The interplay between people's goals and challenges due to mental health impacted both clinical recovery and social reintegration. On one hand, we identified how social factors impacted management of illness. We found that perceptions of stigma, at both an individual and societal level, affected how participants viewed themselves and accessed pathways to care. For instance, participants most affected by stigma perceptions mentioned cutting social ties with family members and friends, online and offline, because they were unsure how they would react to mental health experiences, presenting obstacles to successful recovery [1]. On the other hand, clinical aspects like aberrations in mental health symptoms during the recovery period also impacted people's social lives. Some participants distanced themselves from social interactions either because they were still recovering from mental health symptoms and did not feel comfortable being around others, or because reducing interactions was perceived as beneficial for their recovery.

The intersection of clinical recovery and social reintegration especially impacted people's online social lives after the hospitalization. Participants mentioned that it was mostly after the psychiatric hospitalization that they considered disclosure and support resources on online social technology platforms. We found that social technologies supported participants recovery and reintegration journeys by mediating social interactions, providing spaces for disclosure and support and sources for positive health changes. However, negative feelings related to social comparison, emotional triggers from content seen online and negative online interactions caused distress to some participants and presented hindrances to their efforts towards recovery and reintegration journeys.

Examining these factors together calls attention to people's shifting goals and priorities and the transformations in their social lives during the periods after hospitalization. In the following subsections, we reflect on how these findings inform researchers, clinicians and designers of social technologies invested in improving mental health care.

5.2 Digital breaks in the context of mental health experiences

Research in CSCW and HCI has focused on articulating and classifying different types of technology use and non-use including framings such as digital divide [75], and dimensions like volitionality [124], disenchantment or disinterest [109], resistance [124], among others. In the context of psychiatric hospitalization and social technology use, the period of digital break is due to institutionalized mandates that do not permit individuals to access their devices and online sources during the period of hospitalization. As we discussed in section 4.1.3, participants' feelings about their digital breaks extended beyond existing categories and conceptualizations of non-use. Initially, the relationship between technology and use in our participant sample might relate to the "limiting use" category of non-use – people who systematically limited their use of a platform due to social, professional or institutional pressures [7]. However, in contrast to institutional pressures at, say, a workplace, individuals hospitalized at a psychiatric facility do not have the power to negotiate technology access and use until they are discharged. How can we understand participant's feelings of anxiety, overwhelm and the fear of missing out in relation to digital breaks and re-gaining access to technology? What, then, are the nuances in digital breaks in the context of reintegration for mental health – circumstances when digital breaks can both be nourishing as well as alienating?

Our findings help to triangulate and confirm results from prior work on people returning to social media after a break. We find that un-friending practices and updating friends lists is a common practice across both contexts [8, 110]. Consistent with prior work, we also note concerns about boundary regulation and privacy as people get back online after periods of digital breaks, observed in our findings about disclosure and the segregation of public and private online profiles [8].

However, there are a few characteristics of mental health experiences and psychiatric hospitalizations as periods of digital break that separate our results from other work. First, participants had no agency or choice in taking digital breaks during hospitalization. Also, the period of digital break in this context is unknown, because it is often unclear when one is ready to be discharged from the hospital. The periods of hospitalization in our study ranged from one week to several months. While our findings do not let us disentangle the effects of hospitalization duration on how participants re-established online presence, we anticipate this duration to be an important variable affecting getting back online after digital breaks. Second, more so than in other contexts [7, 58], social surveillance [83] (i.e. by people gathering information about other people) and identity management during re-entry periods online can play a bigger role in populations experiencing psychiatric hospitalization due to the societal stigma around mental illness. Lastly, reversion to online social platforms in the context of our participants can be perceived as a need or necessity due to the post-hospitalization goals of reintegration and re-gaining social connections. Future work on mental health and technology use can pay attention to such nuances, idiosyncrasies, and uniqueness in different people's digital breaks in the context of mental illness hospitalization.

5.3 Social technology affordances and their role in mental health support

Our study shows that social technology affordances such as visibility [117], pseudo-/anonymity [80], broadcasting communication [29, 104], one-on-one interactions [20, 21], etc. have enabled participants to use these platforms towards their mental health recovery and reintegration, by participating in online support groups [3], making disclosures about their experiences [47], seeking informational support, sources for positive behavioral changes and re-connecting with people in their lives. Outside of "active" [118] interactions with people and content online, participants also mentioned the benefits they drew from scrolling, viewing videos, and passive consumption of online content. The benefits people draw from the latter practices are often invisible to researchers when we focus on archived digital trace data or "active" use of social media.

Recent work has highlighted the importance of understanding and incorporating these invisible practices such as passive browsing of social media postings, or non-clicking into experiences on social media platforms [43]. Situating our findings in this body of work draws attention to the concept of engaged lurking, a "strategic and idiosyncratic activity" that lets users meet their needs online while avoiding other concerns [43, 92, 93]. Scrolling and non-clicking practices are also viewed by this literature as privacy-protecting activities [27, 123]. This is particularly important in the case of mental health experiences in the aftermath of a socially stigmatizing experience like a hospitalization, as users may fear revealing their health status to online audience by leaving behind visible digital traces. While we did not further investigate participants' motivations for passively consuming online content in this study, it is likely that they do so as for privacy reasons or to circumvent online advertisements and algorithmic content curation.

Furthermore, these invisible practices might also differentiate the social benefits that people draw from social technology use for reintegration. While our participants mentioned drawing certain benefits from passively consuming content online, how to do the social benefits and negative feelings of social comparison play out when people adopt these invisible practices of viewing content? How does the role of social technology in reintegration for mental health vary among groups that "actively" engage with people and content online vs. groups that adopt invisible engagement practices online. Future work can examine these differences and the differentiating use of social technology use for mental health.

5.4 Clinical Implications

Reintegration and self-management of mental health symptoms outside the hospital and institutionalized clinical treatment strongly impact future clinical outcomes and overall well-being of individuals [65, 71]. Clinical literature highlights the importance of social reintegration and community participation in avoiding re-hospitalizations and supporting the clinical goals of recovery [1, 114]. However, reintegration is a complicated phenomenon to identify and existing instruments and validated measurements are limited; often they are specific to the domain are such as incarceration [57], refugee migration [23] etc.). Our empirical findings and narratives on people's reintegration trajectories can inform clinical practices along two directions.

5.4.1 Discharge planning and post-discharge care. Our findings showed that psychiatric hospitalization removes individuals from their social lives, both online and offline. On top of that, participants felt overwhelmed by the sudden transition back into their normal lives, as well as triggered by life circumstances that contributed to their initial hospitalization. As a patient reintegrates, they are leaving an environment centered around their mental illness for one that generally stigmatizes it. Our participants said that they may also exit the hospital with additional anxiety regarding the stigma surrounding hospitalizations, as well as personal and professional complexities brought to the fore due to the hospitalization, whether around getting back to an abusive partner or dealing with homelessness. In section 4.2, we discussed how several participants ended unhealthy friendships following hospitalization, both in their personal lives and on social media. It is important that clinicians ensure their patients have some form of a support system to assist them in the reintegration process. Similarly, it is also crucial to identify the negative aspects of their patients' social lives, as some patients may have relationships or life circumstances that contribute to their struggles with mental health. Accordingly, in line with strategies developed by the department of social work at the hospital [102], we suggest that prior to discharge, clinicians (including clinical psychologists, psychiatrists, and social workers) can discuss the process of social reintegration with patients and share resources (including community integration programs and social technology platforms) that might support post-discharge care. They can assist patients in developing a plan that allows them to slowly return to their everyday routine. Our findings suggest that the preparedness patients feel at the time of discharge might not be the same after leaving the hospital. Clinicians could alleviate some of this anxiety by periodically assessing patient's preparedness towards reintegration and getting back to their normal lives. Clinicians can further help patients learn how to disclose their conditions to trusted others, whether online or offline, and share avenues where social technology use could support their reintegration journey outside of the hospital.

5.4.2 Holistic understanding of mental health resources available to patients post-hospitalization. Beyond mediating social interactions after the hospitalization, we found that social technologies played a significant role in participant's self management of their condition. In this work we found a plethora on social technology platforms such as Facebook, Whatsapp, Instagram, Youtube, Reddit, including video-conferencing tools and webinars, that played a role in care pathways after hospitalization. Our findings suggest that better understanding of the sources available to people via social technologies for management of mental illness can inform clinicians in their provision of post-discharge care. We found that after first psychiatric hospitalization experiences, participants appropriated platforms like Facebook, Twitter, Instagram, Youtube and Reddit to disclose about their illness, reach out and provide social support to similar others and share coping mechanisms and challenges to their reintegration online. Online disclosure and social support were particularly helpful for participants who did not feel comfortable disclosing to many people in their life. Majority of our participants shared that they had no prior knowledge about the types of online support groups available to them – most commonly they became aware of such groups' existence after being

informed by another person in their life (Refer section 4.3.3). Patients might benefit from having a compiled set of online resources available to them on different social platforms, and considerations that go into the use of these platforms for overall well-being. While clinicians themselves might not always be aware of all available resources, given that they are aware of their patients' needs and histories, they might be able to use such a resource to recommend which specific ones to use, and which ones patients might want to avoid. Furthermore, the ways participants appropriated social technologies presented positive benefits as well as challenges to their mental health journeys. In collaboration with their clinicians, patients could consider the aspects of their social technology use that may be damaging to their mental health and come up with a plan collaboratively to develop a more positive practices. Such a plan could even be adapted over time and persistently, as an individual pursues their recovery and reintegration journey. Lastly, we note a caveat that the inclusion of social technology platforms as resources for post-discharge care should not exclude opportunities for care for those who do not use such platforms.

5.5 Design implications

Our findings highlight challenges in re-entering online spaces and both positive and negative aspects of social technology use that supported/hindered participants' recovery and reintegration journeys, including social support and informational benefits, as well as feelings of social comparison and emotional triggers to mental health symptoms. To counteract the negative aspects, participants mentioned transforming their digital habits and routines, such as adopting better privacy and access controls, restructuring Facebook feeds and controlling screen time. These findings suggest that while the harms of adopting social technology for reintegration do not necessarily outweigh the benefits for all individuals in all cases [9], there are opportunities for platforms to better facilitate and support people's reintegration trajectories. Drawing on the benefits and harms in adopting social technology for reintegration, we identify design implications for platforms to better facilitate people's reintegration journeys after hospitalization. These design suggestions are inspired by our participants' practices to make social technology platforms work for their unique needs, circumstances and goals.

We, however, note an important caveat in these design suggestions. For psychiatric hospitalization, relapse is exceptionally common and people undergo multiple transitions and periods of lack of access to resources and technology non-use throughout their illness trajectory. Several participants in our study noted how one hospitalization was more prominent in their experience than others. People's reintegration journeys with and without social technologies, additionally, may vary from one hospitalization experience to another. It is therefore not surprising that our findings suggest that a "one size fits all" approach to social technology use does not support the varied ways that people adopt (or do not adopt) these platforms for mental health. Our proposed design suggestions, thus, cannot be uncritically followed without additional context about the specific person's needs, demands, or the broader life situation. Future research is needed to understand digital breaks in the context of psychiatric hospitalizations under the lens of technology use/non-use.

5.5.1 Designing for digital breaks. Drawing on the nuances of digital breaks in the context of psychiatric hospitalization and mental health experiences, we identify design opportunities for social technology platforms to support people getting back online. Platform designers can pay attention to facilitating taking breaks from social technology. In the context of reintegration after psychiatric hospitalization, facilitating breaks would involve a set of closely connected, trusted considerations. First, platforms can begin to consider the design of push notifications after digital breaks or periods of inactivity to reduce feelings of overwhelm and anxiety due to information overload. Second, designs and affordances that provide safe spaces and support self-disclosure and selective sharing, i.e. supporting users to share personal, sensitive content in a way they feel comfortable about the

privacy of their posts, could better facilitate mechanisms for reintegration. Importantly, as has been noted in recent HCI research, platforms need to be sensitive and respectful to people's life circumstances around major events and transitions [107], including psychiatric hospitalization. For instance, special consideration could be given to algorithmic ranking of information feeds, personalized features such as Facebook's "Year in Review" and advertisement recommendations for users who return after long breaks from the platform, including thinking through when and for who are these features appropriate at all.

5.5.2 Controls to manage information feeds. While several participants highlighted the benefits of consuming inspirational content about positive life changes on social technology platforms, others mentioned how the information they consume online was stress-inducing, triggering their mental health symptoms or eliciting feelings of social comparison. However, only a few participants adopted practices like blocking, unfriending, re-configuring Facebook's News Feed settings or deactivating their accounts to counteract the negative effects. Platform designers can better account for these effects by providing users more agency and control in configuring their information feeds and recommendations. This could include features for controlling how much they see a specific type of content on their feeds. For instance, platforms can design "algorithmic marketplaces" providing a suite of content ranking and recommendation algorithms to users, who can select the desired ones based on their life circumstances. A feature like this would support several participants in our study, including who wished to only see funny videos to relax their moods, those who wished to stop seeing content triggering social comparison or mental health symptoms, and those who wished to only see positive, inspirational, or reaffirming quotes. Similarly, existing features for blocking, taking a break from other people's content, un-following, etc., can be made more apparent and easily accessible to users by providing "feature guides", for instance, to recommend their use.

6 CONCLUSION

In this paper, we presented insights from interviews with 19 adults who experienced psychiatric hospitalization in the United States, on reintegration in mental health and the role of social technologies in this process. We found that a strong support network both offline and online played an important role in people getting back to their social lives and managing their mental health condition. On balance, social technologies supported as well as hindered people's reintegration journeys. Our findings suggest that post-discharge care and planning need to account for the transformations that people experience due to psychiatric hospitalization in terms of their self-perception due to stigma, and in terms of shifting rules as they transition from hospital to home. Drawing on the benefits and harms in adopting social technology for reintegration, our work underscores the need for platform designers to provide more controls to people over their information feeds, and to design with non-use and digital breaks in mind, to better facilitate people's social reintegration.

REFERENCES

- [1] M Ādnanes, J Cresswell-Smith, L Melby, H Westerlund, L Šprah, R Sfetcu, C Straßmayr, and V Donisi. 2019. Discharge planning, self-management, and community support: Strategies to avoid psychiatric rehospitalisation from a service user perspective. *Patient Education and Counseling* (2019).
- [2] Helen Altman. 1983. A collaborative approach to discharge planning for chronic mental patients. *Hospital & community psychiatry* (1983).
- [3] Nazanin Andalibi, Oliver L Haimson, Munmun De Choudhury, and Andrea Forte. 2016. Understanding social media disclosures of sexual abuse through the lenses of support seeking and anonymity. In *Proceedings of the 2016 CHI Conference on Human Factors in Computing Systems*. ACM, 3906–3918.
- [4] Nazanin Andalibi, Pinar Ozturk, and Andrea Forte. 2015. Depression-related imagery on instagram. In *CSCW*. ACM, 231–234.
- [5] Nazanin Andalibi, Pinar Öztürk, and Andrea Forte. 2017. Sensitive self-disclosures, responses, and social support on Instagram: The case of #depression.. In *CSCW*. 1485–1500.

- [6] William A Anthony. 1993. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial rehabilitation journal* 16, 4 (1993), 11.
- [7] Eric PS Baumer, Phil Adams, Vera D Khovanskaya, Tony C Liao, Madeline E Smith, Victoria Schwanda Sosik, and Kaiton Williams. 2013. Limiting, leaving, and (re) lapsing: an exploration of facebook non-use practices and experiences. In *Proceedings of the SIGCHI conference on human factors in computing systems*. 3257–3266.
- [8] Eric PS Baumer, Shion Guha, Emily Quan, David Mimno, and Geri K Gay. 2015. Missing photos, suffering withdrawal, or finding freedom? How experiences of social media non-use influence the likelihood of reversion. *Social Media+ Society* 1, 2 (2015), 2056305115614851.
- [9] Eric PS Baumer and M Six Silberman. 2011. When the implication is not to design (technology). In *Proceedings of the SIGCHI Conference on Human Factors in Computing Systems*. 2271–2274.
- [10] Jennifer L Bevan, Ruth Gomez, and Lisa Sparks. 2014. Disclosures about important life events on Facebook: Relationships with stress and quality of life. *Computers in Human Behavior* 39 (2014), 246–253.
- [11] Max Birchwood, JO Smith, Ray Cochrane, Sheila Wetton, and SONJA Copestake. 1990. The social functioning scale the development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *The British Journal of Psychiatry* 157, 6 (1990), 853–859.
- [12] Michael Leo Birnbaum, Sindhu Kiranmai Ernala, AF Rizvi, Elizabeth Arenare, AR Van Meter, M De Choudhury, and John M Kane. 2019. Detecting relapse in youth with psychotic disorders utilizing patient-generated and patient-contributed digital data from Facebook. *NPJ schizophrenia* 5, 1 (2019), 1–9.
- [13] Michael L Birnbaum, Sindhu Kiranmai Ernala, Asra F Rizvi, Munmun De Choudhury, and John M Kane. 2017. A collaborative approach to identifying social media markers of schizophrenia by employing machine learning and clinical appraisals. *J. Med. Internet Res* (2017).
- [14] Michael L Birnbaum, Asra F Rizvi, Christoph U Correll, John M Kane, and Jamie Confino. 2017. Role of social media and the Internet in pathways to care for adolescents and young adults with psychotic disorders and non-psychotic mood disorders. *Early intervention in psychiatry* 11, 4 (2017), 290–295.
- [15] Scott R Braithwaite, Christophe Giraud-Carrier, Josh West, Michael D Barnes, and Carl Lee Hanson. 2016. Validating machine learning algorithms for Twitter data against established measures of suicidality. *JMIR mental health* 3, 2 (2016).
- [16] Jed R Brubaker, Funda Kivran-Swaine, Lee Taber, and Gillian R Hayes. 2012. Grief-stricken in a crowd: The language of bereavement and distress in social media. In *Sixth International AAAI Conference on Weblogs and Social Media*.
- [17] Eleanor R Burgess, Kathryn E Ringland, Jennifer Nicholas, Ashley A Knapp, Jordan Eschler, David C Mohr, and Madhu C Reddy. 2019. "I think people are powerful" The Sociality of Individuals Managing Depression. *Proceedings of the ACM on Human-Computer Interaction* 3, CSCW (2019), 1–29.
- [18] Moira Burke, Justin Cheng, and Bethany de Gant. 2020. Social comparison and Facebook: Feedback, positivity, and opportunities for comparison. In *Proceedings of the 2020 CHI Conference on Human Factors in Computing Systems*. 1–13.
- [19] Moira Burke and Robert Kraut. 2013. Using Facebook after losing a job: Differential benefits of strong and weak ties. In *Proceedings of the 2013 conference on Computer supported cooperative work*. 1419–1430.
- [20] Moira Burke, Robert Kraut, and Cameron Marlow. 2011. Social capital on Facebook: Differentiating uses and users. In *Proceedings of the SIGCHI conference on human factors in computing systems*. 571–580.
- [21] Moira Burke, Cameron Marlow, and Thomas Lento. 2010. Social network activity and social well-being. In *Proceedings of the SIGCHI conference on human factors in computing systems*. 1909–1912.
- [22] PJ Carling. 1996. Emerging approaches to housing and support for people with psychiatric disabilities. *Handbook of mental health economics and health policy* 1 (1996), 239–259.
- [23] Helen Carr. 2014. Returning 'home': Experiences of reintegration for asylum seekers and refugees. *The British Journal of Social Work* 44, suppl_1 (2014), i140–i156.
- [24] Stevie Chancellor, Yannis Kalantidis, Jessica A Pater, Munmun De Choudhury, and David A Shamma. 2017. Multimodal Classification of Moderated Online Pro-Eating Disorder Content. In *Proceedings of the 2017 CHI Conference on Human Factors in Computing Systems*. ACM, 3213–3226.
- [25] Stevie Chancellor, Zhiyuan Lin, Erica L Goodman, Stephanie Zerwas, and Munmun De Choudhury. 2016. Quantifying and predicting mental illness severity in online pro-eating disorder communities. In *Proceedings of the 19th ACM Conference on Computer-Supported Cooperative Work & Social Computing*. ACM, 1171–1184.
- [26] Stevie Chancellor, Jessica Annette Pater, Trustin Clear, Eric Gilbert, and Munmun De Choudhury. 2016. #thyghgap: Instagram Content Moderation and Lexical Variation in Pro-Eating Disorder Communities. In *CSCW*. ACM, 1201–1213.
- [27] Pamara F Chang, Janis Whitlock, and Natalya N Bazarova. 2018. "To respond or not to respond, that is the question": The decision-making process of providing social support to distressed posters on Facebook. *Social Media+ Society* 4, 1 (2018), 2056305118759290.
- [28] Qijin Cheng, Hong Li, Vincent Silenzio, and Eric D Caine. 2014. Suicide contagion: A systematic review of definitions and research utility. *PLoS one* 9, 9 (2014), e108724.

- [29] Yoon Hyung Choi and Natalya N Bazarova. 2015. Self-disclosure characteristics and motivations in social media: Extending the functional model to multiple social network sites. *Human Communication Research* 41, 4 (2015), 480–500.
- [30] Chia-Fang Chung, Elena Agapie, Jessica Schroeder, Sonali Mishra, James Fogarty, and Sean A Munson. 2017. When personal tracking becomes social: Examining the use of Instagram for healthy eating. In *Proceedings of the 2017 CHI Conference on Human Factors in Computing Systems*. 1674–1687.
- [31] Laura J Cohen. 1994. Psychiatric hospitalization as an experience of trauma. *Archives of Psychiatric Nursing* 8, 2 (1994), 78–81.
- [32] Glen Coppersmith, Mark Dredze, and Craig Harman. 2014. Quantifying mental health signals in twitter. In *ACL Workshop on Computational Linguistics and Clinical Psychology*.
- [33] Glen Coppersmith, Mark Dredze, Craig Harman, and Kristy Hollingshead. 2015. From ADHD to SAD: Analyzing the language of mental health on Twitter through self-reported diagnoses. *NAACL HLT 2015* (2015), 1.
- [34] Patrick Corrigan. 2004. How stigma interferes with mental health care. *American Psychologist* 59, 7 (2004), 614.
- [35] Munmun De Choudhury, Scott Counts, and Eric Horvitz. 2013. Major life changes and behavioral markers in social media: case of childbirth. In *CSCW*. ACM, 1431–1442.
- [36] Munmun De Choudhury, Michael Gamon, Scott Counts, and Eric Horvitz. 2013. Predicting depression via social media. In *AAAI Conference on Weblogs and Social Media*.
- [37] Munmun De Choudhury, Michael Gamon, Aaron Hoff, and Asta Roseway. 2013. “Moon Phrases”: A Social Media Facilitated Tool for Emotional Reflection and Wellness. In *Proceedings of the 7th International Conference on Pervasive Computing Technologies for Healthcare (PervasiveHealth '13)*. 41–44.
- [38] Munmun De Choudhury and Emre Kiciman. 2017. The language of social support in social media and its effect on suicidal ideation risk. In *Eleventh International AAAI Conference on Web and Social Media*.
- [39] Munmun De Choudhury and Michael Massimi. 2015. “She said yes”—Liminality and engagement announcements on Twitter. *iConference 2015 Proceedings* (2015).
- [40] Marcel PJM Dijkers, Gale Whiteneck, and Rana El-Jaroudi. 2000. Measures of social outcomes in disability research. *Archives of physical medicine and rehabilitation* 81 (2000), S63–S80.
- [41] Xianghua Ding, Yunan Chen, Zhaofei Ding, and Yiwen Xu. 2019. Boundary Negotiation for Patient-Provider Communication via WeChat in China. *Proceedings of the ACM on Human-Computer Interaction* 3, CSCW (2019), 1–24.
- [42] Claire Burke Draucker, Donna S Martsoff, and Candice Poole. 2009. Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing* 23, 5 (2009), 343–350.
- [43] Nicole B Ellison, Penny Triu, Sarita Schoenebeck, Robin Brewer, and Aarti Israni. 2020. Why we don’t click: Interrogating the relationship between viewing and clicking in social media contexts by exploring the “non-click”. *Journal of Computer-Mediated Communication* 25, 6 (2020), 402–426.
- [44] Jessica HL Elm, Jordan P Lewis, Karina L Walters, and Jen M Self. 2016. “I’m in this world for a reason”: Resilience and recovery among American Indian and Alaska Native two-spirit women. *Journal of lesbian studies* 20, 3-4 (2016), 352–371.
- [45] Ronald M Epstein and Richard L Street. 2011. The values and value of patient-centered care.
- [46] Sindhu Kiranmai Ernala, Kathana H Kashiparekh, Amir Bolous, Asra Ali, John M Kane, Michael L Birnbaum, and Munmun De Choudhury. 2021. A Social Media Study on Mental Health Status Transitions Surrounding Psychiatric Hospitalizations. *Proceedings of the ACM on Human-Computer Interaction* 5, CSCW1 (2021), 1–32.
- [47] Sindhu Kiranmai Ernala, Tristan Labetoulle, Fred Bane, Michael L Birnbaum, Asra F Rizvi, John M Kane, and Munmun De Choudhury. 2018. Characterizing Audience Engagement and Assessing its Impact on Social Media Disclosures of Mental Illnesses. In *International Conference on Web and Social Media*. AAAI.
- [48] Sindhu Kiranmai Ernala, Asra F Rizvi, Michael L Birnbaum, John M Kane, and Munmun De Choudhury. 2017. Linguistic markers indicating therapeutic outcomes of social media disclosures of schizophrenia. *Proc. ACM Hum.-Comput. Interact.* (2017).
- [49] Marianne Farkas. 1996. Recovery, rehabilitation, reintegration: Words vs. meaning. *World Association of Psychosocial Rehabilitation Bulletin* 8, 4 (1996), 6–8.
- [50] Jennifer Fereday and Eimear Muir-Cochrane. 2006. Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods* 5, 1 (2006), 80–92.
- [51] Jessica L Feuston, Charlotte G Marshall-Fricker, and Anne Marie Piper. 2017. The social lives of individuals with traumatic brain injury. In *Proceedings of the 2017 CHI Conference on Human Factors in Computing Systems*. 182–194.
- [52] Robert J Flynn and Raymond Lemay. 1999. *A quarter-century of normalization and social role valorization: Evolution and impact*. University of Ottawa Press.
- [53] Emily Getty, Jessica Cobb, Meryl Gabeler, Christine Nelson, Ellis Weng, and Jeffrey Hancock. 2011. I said your name in an empty room: Grieving and continuing bonds on Facebook. In *Proceedings of the SIGCHI Conference on human factors in computing systems*. 997–1000.

- [54] Lorna Gibson and Vicki L Hanson. 2013. Digital motherhood: How does technology help new mothers?. In *Proceedings of the SIGCHI conference on human factors in computing systems*. ACM, 313–322.
- [55] David Glenister. 1994. Patient participation in psychiatric services: a literature review and proposal for a research strategy. *Journal of Advanced Nursing* 19, 4 (1994), 802–811.
- [56] Walter R Gove and Terry Fain. 1973. The stigma of mental hospitalization: An attempt to evaluate its consequences. *Archives of General Psychiatry* 28, 4 (1973), 494–500.
- [57] Curt Taylor Griffiths, Yvon Dandurand, and Danielle Murdoch. 2007. *The social reintegration of offenders and crime prevention*. Vol. 4. National Crime Prevention Centre Ottawa, Ontario, Canada.
- [58] Shion Guha and Stephen B Wicker. 2015. Do birds of a feather watch each other? homophily and social surveillance in location based social networks. In *Proceedings of the 18th ACM Conference on Computer Supported Cooperative Work & Social Computing*. 1010–1020.
- [59] Sharath Chandra Guntuku, H Andrew Schwartz, Adarsh Kashyap, Jessica S Gaulton, Daniel C Stokes, David A Asch, Lyle H Ungar, and Raina M Merchant. 2020. Variability in Language used on Social Media prior to Hospital Visits. *Scientific Reports* 10, 1 (2020), 1–9.
- [60] Oliver Haimson. 2018. Social media as social transition machinery. *Proceedings of the ACM on Human-Computer Interaction* 2, CSCW (2018), 63.
- [61] Oliver L Haimson, Jed R Brubaker, Lynn Dombrowski, and Gillian R Hayes. 2015. Disclosure, stress, and support during gender transition on Facebook. In *CSCW*. ACM, 1176–1190.
- [62] Oliver L Haimson, Jed R Brubaker, Lynn Dombrowski, and Gillian R Hayes. 2016. Digital footprints and changing networks during online identity transitions. In *Proceedings of the 2016 CHI Conference on Human Factors in Computing Systems*. 2895–2907.
- [63] Andrea L. Hartzler, Bridget Weis, Carly Cahill, Wanda Pratt, Albert Park, Uba Backonja, and David W. McDonald. 2016. Design and usability of interactive user profiles for online health communities. *ACM Transactions on Computer-Human Interaction* 23, 3 (2016). <https://doi.org/10.1145/2903718>
- [64] Gillian R Hayes, Gregory D Abowd, John S Davis, Marion L Blount, Maria Ebling, and Elizabeth D Mynatt. 2008. Opportunities for pervasive computing in chronic cancer care. In *International Conference on Pervasive Computing*. Springer, 262–279.
- [65] John F Helliwell and Robert D Putnam. 2004. The social context of well-being. *Philos. Trans. Royal Soc. B* (2004).
- [66] William R Hobbs and Moira K Burke. 2017. Connective recovery in social networks after the death of a friend. *Nature Human Behaviour* 1, 5 (2017), 0092.
- [67] Jina Huh and Mark S Ackerman. 2012. Collaborative help in chronic disease management: supporting individualized problems. In *Proceedings of the ACM 2012 conference on Computer Supported Cooperative Work*. ACM, 853–862.
- [68] KS Jacob. 2015. Recovery model of mental illness: A complementary approach to psychiatric care. *Indian journal of psychological medicine* 37, 2 (2015), 117.
- [69] Maia Jacobs, James Clawson, and Elizabeth D Mynatt. 2016. A cancer journey framework: guiding the design of holistic health technology. In *Proceedings of the 10th EAI International Conference on Pervasive Computing Technologies for Healthcare*. 114–121.
- [70] Ronald C Kessler, G Paul Amminger, Sergio Aguilar-Gaxiola, Jordi Alonso, Sing Lee, and T Bedirhan Ustun. 2007. Age of onset of mental disorders: a review of recent literature. *Current opinion in psychiatry* 20, 4 (2007), 359.
- [71] Corey LM Keyes. 2005. Mental illness and/or mental health? Investigating axioms of the complete state model of health. *Journal of consulting and clinical psychology* 73, 3 (2005), 539.
- [72] Woorim Kim, Suk-Yong Jang, Tae-Hoon Lee, Joo Eun Lee, and Eun-Cheol Park. 2018. Association between continuity of care and subsequent hospitalization and mortality in patients with mood disorders: Results from the Korea National Health Insurance cohort. *PloS one* 13, 11 (2018), e0207740.
- [73] Mary Leamy, Victoria Bird, Clair Le Boutillier, Julie Williams, and Mike Slade. 2011. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry* 199, 6 (2011), 445–452.
- [74] Katie O Leary, Sean A Munson, Arpita Bhattacharya, Sean A Munson, Jacob O Wobbrock, and Wanda Pratt. 2017. Design Opportunities for Mental Health Peer Support Technologies. *Proceedings of the 2017 ACM Conference on Computer Supported Cooperative Work and Social Computing - CSCW '17* February (2017), 1470–1484. <https://doi.org/10.1145/2998181.2998349>
- [75] Amanda Lenhart and John B Horrigan. 2003. Re-visualizing the digital divide as a digital spectrum. *IT & society* 1, 5 (2003), 23–39.
- [76] Zachary Levonian, Drew Richard Erikson, Wenqi Luo, Saumik Narayanan, Sabirat Rubya, Prateek Vachher, Loren Terveen, and Svetlana Yarosh. 2020. Bridging qualitative and quantitative methods for user modeling: Tracing cancer patient behavior in an online health community. In *ICWSM*.
- [77] Bruce G Link, Elmer L Struening, Sheree Neese-Todd, Sara Asmussen, and Jo C Phelan. 2001. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric services* 52, 12

- (2001), 1621–1626.
- [78] Leslie S Liu, Jina Huh, Tina Neogi, Kori Inkpen, and Wanda Pratt. 2013. Health vlogger-viewer interaction in chronic illness management. In *Proceedings of the SIGCHI conference on Human factors in computing systems*. 49–58.
- [79] Alicia Lucksted and Amy L. Drapalski. 2015. Self-stigma regarding mental illness: Definition, impact, and relationship to societal stigma. *Psychiatric Rehabilitation Journal* 38, 2 (2015), 99–102. Place: US Publisher: Educational Publishing Foundation.
- [80] Xiao Ma, Jeff Hancock, and Mor Naaman. 2016. Anonymity, intimacy and self-disclosure in social media. In *Proceedings of the 2016 CHI conference on human factors in computing systems*. 3857–3869.
- [81] Haley MacLeod, Kim Oakes, Danika Geisler, Kay Connelly, and Katie Siek. 2015. Rare world: Towards technology for rare diseases. In *Proceedings of the 33rd Annual ACM Conference on human factors in computing systems*. 1145–1154.
- [82] Lydia Manikonda and Munmun De Choudhury. 2017. Modeling and Understanding Visual Attributes of Mental Health Disclosures in Social Media. (2017).
- [83] Alice Marwick. 2012. The public domain: Surveillance in everyday life. *Surveillance & Society* 9, 4 (2012), 378–393.
- [84] Michael Massimi and Ronald M Baecker. 2010. A death in the family: opportunities for designing technologies for the bereaved. In *Proceedings of the SIGCHI conference on Human Factors in computing systems*. ACM, 1821–1830.
- [85] Michael Massimi, Jill P Dimond, and Christopher A Le Dantec. 2012. Finding a new normal: the role of technology in life disruptions. In *Proceedings of the acm 2012 conference on computer supported cooperative work*. ACM, 719–728.
- [86] Michael Massimi, Richard Harper, and Abigail J Sellen. 2014. Real, but glossy: technology and the practical pursuit of magic in modern weddings. In *Proceedings of the 17th ACM conference on Computer supported cooperative work & social computing*. ACM, 854–865.
- [87] Tsubasa Morioka, Nicole B Ellison, and Michael Brown. 2016. Identity work on social media sites: Disadvantaged students' college transition processes. In *Proceedings of the 19th ACM conference on computer-supported cooperative work & social computing*. ACM, 848–859.
- [88] JA Naslund, KA Aschbrenner, LA Marsch, and SJ Bartels. 2016. The future of mental health care: peer-to-peer support and social media. *Epidemiology and psychiatric sciences* 25, 2 (2016), 113–122.
- [89] Julia Neuberger and Raymond Tallis. 1999. We do need a new word for patients? *British Medical Journal* 318, 7200 (1999), 1756–1756.
- [90] Mark W Newman, Debra Lauterbach, Sean A Munson, Paul Resnick, and Margaret E Morris. 2011. It's not that I don't have problems, I'm just not putting them on Facebook: challenges and opportunities in using online social networks for health. In *Proceedings of the ACM 2011 conference on Computer supported cooperative work*. ACM, 341–350.
- [91] Katherine Newman-Taylor, Christie Garner, Elizabeth Vernon-Wilson, Karlien HW Paas, Lesley Herbert, and Sheena K Au-Yeung. 2017. Psychometric evaluation of the hope, agency and opportunity (HAO); a brief measure of mental health recovery. *Journal of Mental Health* 26, 6 (2017), 562–568.
- [92] Blair Nonnecke and Jenny Preece. 2000. Lurker demographics: Counting the silent. In *Proceedings of the SIGCHI conference on Human factors in computing systems*. 73–80.
- [93] Blair Nonnecke and Jenny Preece. 2001. Why lurkers lurk. (2001).
- [94] Hyun Jung Oh, Carolyn Lauckner, Jan Boehmer, Ryan Fewins-Bliss, and Kang Li. 2013. Facebooking for health: An examination into the solicitation and effects of health-related social support on social networking sites. *Computers in human behavior* 29, 5 (2013), 2072–2080.
- [95] Katie O'Leary, Stephen M. Schueller, Jacob O. Wobbrock, and Wanda Pratt. 2018. "Suddenly, we got to become therapists for each other": Designing peer support chats for mental health. *Conference on Human Factors in Computing Systems - Proceedings 2018-April* (2018), 1–14. <https://doi.org/10.1145/3173574.3173905>
- [96] Saad B Omer, Preeti Malani, and Carlos Del Rio. 2020. The COVID-19 pandemic in the US: a clinical update. *Jama* 323, 18 (2020), 1767–1768.
- [97] Diana Paksarian, Ramin Mojtabei, Roman Kotov, Bernadette Cullen, Katie L Nugent, and Evelyn J Bromet. 2014. Perceived trauma during hospitalization and treatment participation among individuals with psychotic disorders. *Psychiatric Services* 65, 2 (2014), 266–269.
- [98] Dilisha Patel, Ann Blandford, Mark Warner, Jill Shawe, and Judith Stephenson. 2019. "I Feel like Only Half a Man": Online Forums as a Resource for Finding a "New Normal" for Men Experiencing Fertility Issues. 3, CSCW (nov 2019). <https://doi.org/10.1145/3359184>
- [99] Jessica A. Pater, Brooke Farrington, Alycia Brown, Lauren E. Reining, Tammy Toscos, and Elizabeth D. Mynatt. 2019. Exploring indicators of digital self-harm with eating disorder patients: A case study. *Proceedings of the ACM on Human-Computer Interaction* 3, CSCW (2019). <https://doi.org/10.1145/3359186>
- [100] Jessica A Pater, Oliver L Haimson, Nazanin Andalibi, and Elizabeth D Mynatt. 2016. "Hunger hurts but starving works": characterizing the presentation of eating disorders online. In CSCW. ACM, 1185–1200.
- [101] James W Pennebaker. 1993. Putting stress into words: Health, linguistic, and therapeutic implications. *Behaviour research and therapy* 31, 6 (1993), 539–548.

- [102] Enola Proctor, Nancy Morrow-Howell, Rashid Albaz, and Carol Weir. 1992. Patient and family satisfaction with discharge plans. *Medical care* (1992), 262–275.
- [103] Helene L Provencher and Corey LM Keyes. 2013. Recovery: A complete mental health perspective. In *Mental well-being*. Springer, 277–297.
- [104] Stephen A Rains and Steven R Brunner. 2018. The outcomes of broadcasting self-disclosure using new communication technologies: Responses to disclosure vary across one’s social network. *Communication Research* 45, 5 (2018), 659–687.
- [105] Terry Rowlands, Neal Waddell, and Bernard McKenna. 2016. Are We There Yet? A Technique to Determine Theoretical Saturation. *Journal of Computer Information Systems* 56, 1 (2016), 40–47. <https://doi.org/10.1080/08874417.2015.11645799> arXiv:<https://doi.org/10.1080/08874417.2015.11645799>
- [106] Koustuv Saha, Larry Chan, Kaya De Barbaro, Gregory D Abowd, and Munmun De Choudhury. 2017. Inferring mood instability on social media by leveraging ecological momentary assessments. *Proceedings of the ACM on Interactive, Mobile, Wearable and Ubiquitous Technologies* 1, 3 (2017), 1–27.
- [107] Koustuv Saha, Jordyn Seybolt, Stephen M Mattingly, Talayah Aledavood, Chaitanya Konjeti, Gonzalo J Martinez, Ted Grover, Gloria Mark, and Munmun De Choudhury. 2021. What Life Events are Disclosed on Social Media, How, When, and By Whom?. In *Proceedings of the 2021 CHI Conference on Human Factors in Computing Systems*. 1–22.
- [108] Koustuv Saha, John Torous, Sindhu Kiranmai Ernala, Conor Rizuto, Amanda Stafford, and Munmun De Choudhury. 2019. A computational study of mental health awareness campaigns on social media. *Translational behavioral medicine* 9, 6 (2019), 1197–1207.
- [109] Christine Satchell and Paul Dourish. 2009. Beyond the user: use and non-use in HCI. In *Proceedings of the 21st annual conference of the Australian computer-human interaction special interest group: Design: Open 24/7*. 9–16.
- [110] Sarita Yardi Schoenebeck. 2014. Giving up Twitter for Lent: how and why we take breaks from social media. In *Proceedings of the SIGCHI Conference on Human Factors in Computing Systems*. 773–782.
- [111] Bryan C Semaan, Lauren M Britton, and Bryan Dosono. 2016. Transition resilience with ICTs: Identity awareness’ in veteran re-integration. In *Proceedings of the 2016 CHI Conference on Human Factors in Computing Systems*. ACM, 2882–2894.
- [112] Steven S Sharfstein. 2009. Goals of inpatient treatment for psychiatric disorders. *Annual Review of Medicine* 60 (2009), 393–403.
- [113] Judy Hanwen Shen and Frank Rudzicz. 2017. Detecting anxiety through Reddit. In *Proceedings of the Fourth Workshop on Computational Linguistics and Clinical Psychology—From Linguistic Signal to Clinical Reality*. 58–65.
- [114] Nirma C Silva, Diego G Bassani, and Lilian S Palazzo. 2009. A case-control study of factors associated with multiple psychiatric readmissions. *Psychiatric Services* 60, 6 (2009), 786–791.
- [115] Madeline E Smith, Duyen T Nguyen, Charles Lai, Gilly Leshed, and Eric PS Baumer. 2012. Going to college and staying connected: Communication between college freshmen and their parents. In *Proceedings of the ACM 2012 conference on computer supported cooperative work*. ACM, 789–798.
- [116] Evelina W Sterling, A Silke, Sherry Tucker, Larry Fricks, and Benjamin G Druss. 2010. Integrating wellness, recovery, and self-management for mental health consumers. *Community mental health journal* 46, 2 (2010), 130–138.
- [117] Jeffrey W Treem and Paul M Leonardi. 2013. Social media use in organizations: Exploring the affordances of visibility, editability, persistence, and association. *Annals of the International Communication Association* 36, 1 (2013), 143–189.
- [118] Philippe Verduyn, David Seungjae Lee, Jiyoung Park, Holly Shablack, Ariana Orvell, Joseph Bayer, Oscar Ybarra, John Jonides, and Ethan Kross. 2015. Passive Facebook usage undermines affective well-being: Experimental and longitudinal evidence. *Journal of Experimental Psychology: General* 144, 2 (2015), 480.
- [119] Theresa Viggiano, Harold A Pincus, and Stephen Crystal. 2012. Care transition interventions in mental health. *Current opinion in psychiatry* 25, 6 (2012), 551–558.
- [120] Martin Webber and Meredith Fendt-Newlin. 2017. A review of social participation interventions for people with mental health problems. *Social psychiatry and psychiatric epidemiology* 52, 4 (2017), 369–380.
- [121] Miaomiao Wen and Carolyn Penstein Rosé. 2012. Understanding participant behavior trajectories in online health support groups using automatic extraction methods. In *Proceedings of the 17th ACM international conference on Supporting group work*. 179–188.
- [122] Yin-Ling Irene Wong and Phyllis L Solomon. 2002. Community integration of persons with psychiatric disabilities in supportive independent housing: A conceptual model and methodological considerations. *Mental health services research* 4, 1 (2002), 13–28.
- [123] Tai-Yee Wu, Anne Oeldorf-Hirsch, and David Atkin. 2020. A click is worth a thousand words: Probing the predictors of using click speech for online opinion expression. *International Journal of Communication* 14 (2020), 20.
- [124] Sally ME Wyatt. 2003. Non-users also matter: The construction of users and non-users of the Internet. *Now users matter: The co-construction of users and technology* (2003), 67–79.
- [125] Diyi Yang, Robert Kraut, and John M Levine. 2017. Commitment of newcomers and old-timers to online health support communities. In *Proceedings of the 2017 CHI conference on human factors in computing systems*. 6363–6375.

- [126] Diyi Yang, Robert E Kraut, Tenbroeck Smith, Elijah Mayfield, and Dan Jurafsky. 2019. Seekers, providers, welcomers, and storytellers: Modeling social roles in online health communities. In *Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems*. 1–14.
- [127] Svetlana Yarosh, Yee Chieh, Gregory D Abowd, et al. 2009. Supporting parent–child communication in divorced families. *International Journal of Human-Computer Studies* 67, 2 (2009), 192–203.
- [128] Alyson L Young and Andrew D Miller. 2019. "This Girl is on Fire": Sensemaking in an Online Health Community for Vulvodynia. In *Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems (CHI '19)*. Association for Computing Machinery, New York, NY, USA. <https://doi.org/10.1145/3290605.3300359>
- [129] Renwen Zhang. 2017. The stress-buffering effect of self-disclosure on Facebook: An examination of stressful life events, social support, and mental health among college students. *Comput. Hum. Behav.* (2017).

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