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Utilizing social media platforms to promote mental health awareness and help seeking in underserved communities during the COVID-19 pandemic

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Abstract:

BACKGROUND: COVID-19 virus has resulted in significant psychological distress for many individuals, particularly, those in underserved communities. Social media have the potential to be one of the most effective tools for mental health campaigns, reaching wide audiences in the shortest amount of time. In this paper, the potential of harnessing social media platforms to address mental health needs in underserved populations is presented. In addition, description of the preliminary implementation of a social media mental health campaign, the 5 × 5 campaign, is described as an example of the feasibility and benefits of such efforts. Key implications gleaned from the implementation process are also presented.

MATERIALS AND METHODS: Utilizing a participatory approach, the 5 × 5 campaign aimed to improve recognition of mental health symptoms, promote help seeking, and provide immediate strategies for self-care for individuals experiencing psychological distress related to the COVID-19 pandemic in low-income, high-risk communities in and around Guatemala City. Campaign content was promoted on Facebook, Instagram, and WhatsApp from April 2020 to June 2020.

RESULTS: Preliminary analysis of the 5 × 5 campaign demonstrated feasibility and substantial impact with over 84,000 individuals reached by the campaigns through initial messaging and shares.

CONCLUSION: The 5 × 5 highlights the feasibility of using social media campaigns for mental health promotion and key factors that should be incorporated in the planning of social media mental health campaigns aimed at promoting awareness, engaging underserved communities, and encouraging help seeking.

Keywords:

COVID_19, feasibility, implementation, mental health campaigns, social media, underserved communities

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Introduction

Health communications, such as brief public service announcements (PSAs), are a quick way to provide essential messaging to the public in times of crisis. At no such time has the need been greater than during the current global COVID-19 pandemic. Health communications informing the general public on evidence-informed strategies to curb the spread of the virus including the importance of maintaining physical distance, hand washing, and mask wearing have proliferated TV and print news, radio, and social media. Research has examined the benefits of these campaigns at increasing positive health behaviors related to public health.

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The COVID-19 virus has affected individuals from all age groups, across genders, and ethnicities, albeit some with greater prevalence than others (i.e., Blacks in the US have disproportionately high rates of infection), and reaches across the globe. Social media have the potential to be one of the most effective tools for mass media mental health campaigns, reaching wide audiences in the shortest amount of time. Internet-based social networking services (i.e., WhatsApp, Facebook, and Instragram), in particular, offer easy, cost-effective access to large numbers of people across geographic distances and are increasingly being harnessed for enabling and empowering individuals in their healthcare-related decisions.[1] For example, one study found that social media platforms were used to obtain information about health and wellness by 34% of online health information seekers.[2] Other research indicates that 70% of adolescents and young adults use general social networking platforms as sources of health information.[3]

While most research exploring the effectiveness of mass media health campaigns has focused on television, radio, and print media, research now shows that some online communications media, such as social media platforms, are more effective than others at improving knowledge and understanding of specific health topics.[4-7] Studies have also found that social media can successfully encourage health improvement and behavior change.[8-10]

However, the potential for communications focused on recognizing mental health symptoms during this time of crisis; offering self-care strategies for managing psychological distress resulting from contagion fears, shelter-in-place, and lockdown restrictions; and promoting mental health-care help seeking, has received less attention. This is not necessarily surprising as efforts to curb the spread of the deadly coronavirus are clearly of utmost importance. However, the constant media coverage highlighting death and infection rates, loss of employment, changes in work and childcare routines, school closures, social isolation due to extended quarantines all take a significant toll on mental health. For those populations in which stigma around mental illness is high, mental healthcare services are low, and awareness and understanding of mental health symptoms is lacking, the impact of the COVID pandemic on the mental health functioning also merits attention.

Social media offer a promising avenue for mental health communications in underrecognized, underserved populations such as low-income Latin American countries. Social media can widen access to those who may not easily access health information through traditional methods such as younger people, ethnic minorities, and lower socioeconomic groups.[11-17] Social media for health communication can promote and provide invaluable social and emotional support, thereby reducing stigma; disseminate important mental health information to targeted communities where formal services are not available;[15,18] and spread word in areas where mental health outreach in the community is lacking.[15,19]

Mental health context in Guatemala

Rates of mental illness in Guatemala are quite high with approximately 1 in 4 Guatemalans experiencing a mental illness in their lifetime.[20] Prevalence estimates of 40.7% for depression, 23.3% for alcohol-related disorders, and 50% for posttraumatic stress disorder (PTSD) have been reported in Guatemala.[21] Rates are even higher among particularly vulnerable groups such as women, indigenous groups, those directly affected by the country's 36-year armed conflict, and the urban poor.[22,23]

This is especially concerning as mental health treatment utilization is particularly low in Guatemala, with only 2%–15% of those with a mental illness receiving needed psychiatric treatment.[24] Contributing to the limited utilization rates of mental health services is a dearth of resources for mental health care in, especially outside of Guatemala City.[25] The few organized mental health services that do exist in the country are not readily accessible to the majority of the population and most often are inadequate.[25] In low-income areas where risk of mental illness is highest, the minimal charge for a therapist is 50 quetzales per hour (approximately $6 USD), a rate equivalent to 2 days of work. Experienced mental health providers in wealthier areas charge the equivalent of close to a week's pay for a laborer, farm worker, or maid,[25] thereby rendering mental health care cost-prohibitive above and beyond other structural barriers such as having to travel long distances to find a mental health-care provider.

Further contributing to the low rates of utilization is the role of stigma. Although limited, evidence does suggest that mental health stigma is a negative predictor of help seeking among Latinos.[26,27] Latino cultural values also may serve as a disincentive toward formal mental health treatment given the cultural belief that psychological issues should be resolved by oneself or within one's family. As such, a Latino individual experiencing symptoms of psychological distress may feel that seeking treatment for their problems could bring shame or embarrassment to the family,[28,29] or that he or she is unworthy of dignity and respect.[26] For example, a study of Latino families in which a family members has a severe mental illnesses found that stigma was the most commonly reported barrier to seeking treatment, with formal treatment being associated with shame about one's mental health and how it reflects upon the family.[30]

The 5 × 5 campaign is a social media-based mental health campaign aimed targeting underserved communities in and around Guatemala City. From the preliminary rollout, we gather feasibility and reach data and glean key strategies that should be included in the planning and design of social media mental health campaigns to increase their effectiveness in underserved populations and present them here.

Materials and Methods

This study used a participatory approach to develop and implement the 5 × 5 campaign. The study was conducted over 3 months (April–June, 2020) in 11 high-risk, low-income communities in Guatemala.

5 × 5 campaign components

As a social media mental health campaign, the 5 × 5 program consists of 5 aims to: (1) increase awareness and understanding of mental health symptoms; (2) provide evidence-informed activities to support self-care through five simple activities of five steps each; (3) encourage help seeking; (4) provide concrete information where help can be sought in the community (i.e., phone numbers, websites, etc.); and (5) normalizing and validating the experience of psychological distress (i.e., anxiety, stress, and depression, burnout) during shelter-in-place and lockdown restrictions. The nature of the campaign was primarily educational, with its immediate purpose being to raise awareness and understanding of mental health symptoms, while promoting self-care. As such, no evident risks were identified for this population. Ethical considerations regarding access to care were addressed by including links to relevant information and services people could use during the pandemic.

The five activities of five steps each are completed independently and do not require assistance from others. They do not require equipment, supplies, a special setting, or any financial investment. The activities provide simple steps for controlling anxious thoughts, guided imagery for de-stressing and relaxation, breathing for calmness and focus, controlling overwhelming emotions, and mindful moving meditation. Full description of the five activities is provided in the appendix. In addition, a series of brief, one-line PSAs were pushed to the communities with the goal of reducing stigma, normalizing psychological distress related to the pandemic, and encouraging helping. The PSAs included such messages as, "You can't be heard if you don't speak out," "You don't have to go it alone," "Help yourself so you can help others," "Don't suffer in silence," and "We are stronger together." In addition, a series of "Know the Signs" PSAs were utilized, which were followed by a list of key symptoms of anxiety, stress, and depression. Finally, a PSA of "Need help? We are listening" was utilized, which included the phone number, E-mail contact, and website for the community-based organizations that implemented the campaign in Guatemala.

Conceptual framework

The campaign used a participatory action framework,[31,32] engaging with communities and health care and social work professionals in the communities, to present information that can lead to actionable changes. This framework is anchored in the Social Capital theory, and the importance of social networks,[33,34] particularly considering networks of care as a resource for nonprofit organizations, addressing gaps in services.[35]

The activities comprising the 5 × 5 campaign are guided by Beck's Cognitive Model.[36,37] They incorporate key strategies of cognitive behavior therapy (CBT)[38] and principles of mindfulness and emotion regulation [Table 1].

Cognitive theory and cognitive behavior therapy

The general cognitive model represents a set of common principles that, although originally conceived as a way of understanding the development and maintenance of depression, can effectively be used to address a wide range of psychological disorders including, depression, suicide, anxiety disorders, substance abuse, interpersonal problems, personality disorders, schizophrenia, and bipolar disorder.[39] Although the original model has been refined over the past 50 years, the core features have endured, specifically, the model's emphasis on the influence of distorted thinking and unrealistic cognitive appraisals of events on an individual's feelings and behavior.[36] Simply stated, the cognitive model suggests that human beings are disturbed by the meanings they attach to situations, not by situations themselves.

Based on this underlying cognitive theory, current CBT approaches share in common the defining feature that psychological distress and dysfunctional behaviors are cognitively mediated and therefore, relief can be achieved by modifying dysfunctional thoughts and beliefs.[38] CBT emphasizes that the individual is an active agent in his/her treatment.

Core to CBT is the concept that there are thoughts that occur spontaneously and rapidly and serve as an immediate interpretation of any given situation, called automatic thoughts.[36,38,39] They are generally accepted as true and accurate and serve as the basis for resulting feelings and behaviors. Most individuals are not aware of the their automatic thoughts and one key goal of CBT is to train individuals to monitor, identify, and challenge them to arrive at a more adaptive, rational interpretation that results in less distress and/or

Table 1: 5×5 activities: Purpose, basis, and components

Activity	Theoretical foundation	Purpose	5 components
Thought challenging	CBT	Controlling and modifying anxious thoughts	Step 1. Consider the thoughts that you are having. Ask yourself: "Is this thought helpful or harmful?" Step 2. If your thoughts are unhelpful, change the story you are telling yourself. Focusing on these thoughts can intensify your anxiety and lead you down a path of worst-case scenarios. Ask yourself: "What can I tell myself instead?" Step 3. Anxiety can drive us to collect as much information as possible but often this means turning to unreliable sources and spending too much searching for information. Limit yourself to reliable sources. Ask yourself: "Where am I getting my information?" Step 4. Stories and images can catch your attention and can draw you into hours of web surfing that only heightens anxiety. Ask yourself: "How much time am I spending watching, reading, or listening to the news?" Step 5. Anxiety is mentally and physically exhausting. Find ways to keep yourself busy with healthy alternatives. By choosing other activities to occupy your mind, there will be less room and energy available for anxiety. Ask yourself: "What can I do to shift my focus?"
Guided imagery	CBT	De-stressing and relaxation	Step 1. Find a quiet place where you spend the next 10-15 min uninterrupted. Sit down comfortably and close your eyes Step 2. Start by just taking a few deep breaths to help you relax, in through the nose and out through the mouth Step 3. Recall a time/place in your life when you felt a sense of peace, security, happiness, or strength. What was happening at that time? Add as much detail as possible. Where were you? Was anyone with you? What were you doing? Was it hot or cold? What time of day was it? What do you hear around? What can you smell? etc., The more detail you can add the better Step 4. When you are deep into your scene and are feeling relaxed, take a few minutes to breathe slowly and experience the peace, security, happiness, or strength. Fully immerse yourself in that feeling Step 5.Think of a simple word or sound that you can use in the future to help you return to this place and feeling. Tell yourself that you will feel relaxed and refreshed and will bring that feeling with you. Then, when you are ready, slowly open your eyes
Deep breathing	Mindfulness	Calmness and focus	Step 1. Breathe in through your nose softly to the count of 4 Step 2. Hold for the count of 7 Step 3. Breathe out loudly to the count of 8 (making a whooshing noise with your mouth) Step 4. Repeat 3-4 times Step 5. Take a minute to notice how your body feels after you complete the exercise. What is different?
The 5 senses	Emotion regulation	Controlling distressing emotions	This "5 senses" exercise guides you through what each one of your senses is experiencing in the moment. This running through your senses will take only a few minutes and will help keep you focused on what is happening right now rather than escalating unhelpful emotions by pulling up similarly distressing moments from the past or catastrophizing the future Step 1. Notice 5 things that you can see. Identify things that you would typically overlook like the wind blowing the leaves of a tree, the color of the cars driving by, the number of people crossing the street, etc. Step 2. Notice 4 things that you can feel. Bring your attention to the things that you're currently feeling, such as the texture of your clothing on your skin or the smooth surface of the table your hands are resting on Step 3. Notice 3 things that you can hear. Listen for and notice things in the background that you typically don't notice like the humming of a machine, the engines of passing cars, or the chirping of birds Step 4. Notice 2 things that you can smell. Bring your attention to scents that you might usually filter out, either pleasant or unpleasant, like food cooking or someone else's breathe Step 5. Notice 1 thing that you can taste. Chew a new piece of gum, take a sip of a drink, take a bite of food, or if nothing is available, notice the taste that is in your mouth or the absence of flavor
Moving meditation	De-stressing and focus	Mindfulness	Step 1. Choose a place to walk in advance to eliminate spending most of your time deciding where we should walk. Choose a spot that provides the space for walking back and forth between two points about 20-30 feet apart, which helps us to let go of "getting somewhere." We practice walking just to walk

Contd...

Table 1: Contd...

Activity	Theoretical foundation	Purpose	5 components
			Step 2. Begin by focusing your attention on one or more sensations that you would normally take for granted while walking (i.e., your foot hitting the ground, swinging of your arms, etc.)
			Step 3. Next, slow down enough so that you notice the lifting of the foot and then the stepping of the foot on the ground. Lifting, stepping—lifting, stepping—lifting, stepping. You may notice that your mind wanders many times. That's to be expected. Just keep bringing your focus back to the sensations of lifting and stepping
			Step 4. Next, add the descriptive words very softly in your minds as you perform the actions of walking meditation. When you are lifting, say, "lifting;" when you are stepping, "stepping". This kind of noting can give you a little extra support in being aware of the walking process and can help keep you focused
			Step 5. Keep your primary focus on the sensations of walking but now also note your distractions. Sometimes you will notice that you are not focused on walking but rather on seeing or hearing—a very common experience. When that happens, just note, "seeing" or "hearing," and come back to walking again. Continue this process for 10-15 min

CBT: Cognitive behavior therapy

dysfunction. Throughout the treatment, a collaborative and psychoeducational approach is utilized, in which individuals learn to: (1) monitor and identify automatic thoughts; (2) recognize the relationships among thoughts, feelings, and behavior; (3) test the accuracy of automatic thoughts and underlying beliefs; (4) correct biased, distorted thoughts by challenging them and identifying more realistic cognitions with which to replace them; and (5) identify and alter beliefs, assumptions, or schemas that underlie faulty thinking patterns.[36-39]

Mindfulness

In recent years, there has been significant interest in the role of mindfulness as a way to reduce stress and emotional distress. Mindfulness has been operationalized as the nonjudgmental, nonreactive acceptance of emotional states.[40,41] Baer *et al*.[41] have proposed a five-element model of mindfulness that includes: (1) observing; (2) describing; (3) acting with awareness; (4) nonjudgment of inner experiences; and (5) nonreactivity to inner experiences.

Research indicates that developing a more mindful way of being is associated with less emotional distress, more positive states of mind, and better quality of life.[42] Mindfulness practice has been linked to positive changes in the brain, the autonomic nervous system, stress hormones, the immune system, and health behaviors including eating, sleeping, and substance use. Mindfulness practice has been further linked to reducing the symptoms of mental illness, promoting mental health, reducing negative affect, and enhancing positive emotional experience.[43-45] Mindfulness has been noted to play a substantial role in helping individuals free themselves from automatic thoughts, habits, and unhealthy behaviors and in enhancing self-regulated behavior.[42,46] As such, it can serve as a natural compliment to CBT and was incorporated into the 5 × 5 activities.

Emotion regulation

Gratz and Roemer[47] have proposed that emotion regulation includes several strategies. They specifically identify (1) awareness and understanding of emotions; (2) acceptance of emotions; (3) ability to control impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions; and (4) the ability to use emotion regulation strategies in a flexible manner that are situation specific to modulate emotional responses as needed to meet individual goals and situational demands.

Research indicates that deficits in emotion regulation are associated with the development and maintenance of various psychiatric disorders including depression, anxiety disorders, PTSD, social dysfunction, borderline personality disorder, substance-use disorders, and eating disorders, to name a few.[48-51] The manner in which individuals are able to manage their emotional experiences in response to a given situation is related to impaired mental health functioning, particularly, in respect to an inability to suppress emotions, inability to understand and communicate emotions, and the tendency to exaggerate emotional experiences.[50-54]

One proposed pathway for the psychological benefits of mindfulness has been through its facilitation of adaptive emotion regulation.[55,56] Research indicates that the practice of mindfulness is associated with healthy emotion regulation including reduced intensity of distress; enhanced emotional recovery; reduced negative self-referential processing; and enhanced ability to engage in goal-directed behaviors.[56] In addition, emotion regulation research has traditionally proposed that cognitive reappraisal (considered an engaging ER strategy in which one attends to emotional information while changing its meaning in order to modify its emotional impact) leads to healthier outcomes

and greater psychological well-being than other, less engaging emotion regulation strategies.[52,56-58] Therefore, emotion regulation strategies were incorporated into the 5 × 5 campaign as a means of enhancing the impact and benefits of the cognitive reappraisal-based approach of CBT.

Implementation

Target communities

The campaign targeted 11 "Red Zone" districts in and around Guatemala City. These districts are characterized by overcrowding, pollution, violent crime (i.e., armed robbery and murder), gang activity (i.e., extortion), and narcotics trafficking. Child abuse and neglect, domestic violence, alcohol and substance abuse, and teen pregnancy occur at high rates. Unemployment is high and resources for health and mental health care are scare. Access to electricity and water is limited and at time, unavailable.

The participatory design of the campaign

The 5 × 5 development process was based on a participatory approach,[32] in which researchers, community-based mental health providers, university counseling center staff, and individuals from the high-risk communities actively participated in designing the aims and content of the social media mental health. The stakeholders involved in the process were selected based on previous participation in a community capacity building suicide prevention and intervention training program. Particular attention was paid to involvement of representatives from organizations based directly in the at-risk communities being targeted by the program who face firsthand the challenges and struggles of daily life in the community of focus. On the ground collaborators were three target community-based organizations with strong footholds in each of the targeted communities, respected by community members and well known for the services they provide. In addition to this ground-up identification of stressors, evidence-informed strategies for self-care and for the promotion of help-seeking were reviewed and discussed for their relevance to the target population and modified as needed according to local culture, values, attitudes, and beliefs regarding mental illness and mental health care.

Social media sites

Based on the existing networks of care established by the three target community-based organizations, we identified additional ten "community partners," key care providers well known and respected in each community, to share the mental health campaign material on their respective their social media platforms, extending the reach of the material. The sites utilized included WhatsApp, Facebook, and Instagram.

Results

Audience reach

Due to the time constraints involved with developing the campaign quickly enough to be disseminated at the height of the pandemic and to have an immediate impact on the target population, we were not able to build in a systematic process of evaluation for its effectiveness in terms of its long-term impact. This type of limitation is common with social communication campaigns launched during a crisis periods such as the current pandemic.[59] Furthermore, for the communities included in this study, the pandemic manifested itself as a complex emergency, triggering higher levels of uncertainty and affecting all kinds of communication. Under these circumstances, to provide preliminary proof of concept for the campaign, we tracked audience-reach and engagement in the first period of the campaign launch (April to June) specifically, number of people reached and number of shares, which are considered indicators of reach and engagement for social media marketing campaigns.[60,61] These indicators were collected with the metrics released from the social media platforms utilized for the campaign.

Number of people reached and number of shares

The 5 × 5 campaign material was initially shared with the WhatsApp groups of the three target community organizations consisting of 5145 members. In addition, the material was shared with the WhatsApp groups of the community collaborators consisting of an additional 3246 members across the organizations. The campaign material was also posted to the Facebook and Instagram pages of the three target community organizations. Analytics from Facebook and Instagram show 646 unique visits to the 5 × 5 campaign material pages. Analytics ascertained from the WhatsApp indicated that one out of every five users shared the 5 × 5 campaign material and for every person sharing, an estimated of fifty additional users viewed the material for a total number of 83,900 individuals. We estimate a total reach of 84,546 individuals reached by the 5 × 5 campaign.

Discussion

This paper has argued for employing social media platforms to extend the reach of much needed mental health campaigns to underserved populations, particularly during times of crisis as in the current COVID-19 pandemic. Preliminary analysis of the 5 × 5 campaign in Guatemala demonstrates that significant reach to individuals in underserved, underrepresented communities is feasible through the use of social media-based mental health campaigns.

The feasibility demonstrated by the 5 × 5 campaign is consistent with other research examining physical

health-focused campaigns.[15,62-67] Far less evidence is available regarding implementation and effectiveness of mental health-focused campaigns, even fewer focused on low-income countries or low-income populations within higher income countries.[66] This historically insufficient exposure of health campaigns to high risk, underserved populations has, to date, served as a significant barrier to population level change.[63,66]

Research examining the ability of mass media health campaigns to address disparities in health behaviors and access to care are mixed in their findings.[63,67-73] However, there is general agreement that the likelihood of campaign success is substantially increased by the application of multiple interventions and when the target behavior is one-off or episodic (e.g., screening, vaccination, and medication utilization/adherence) rather than habitual or ongoing (e.g., eating healthy food, increasing physical activity),[66] which makes such campaigns extremely relevant during major public health crises or complex emergencies that require specific immediate behavioral changes, among large population groups. In addition, evaluations of health campaigns indicate that while short-term changes may be gained, long-term effects are much more difficult to sustain once campaigns end.[66,74-77] Therefore, campaigns that consider ease of access to resources in the community to support behavioral changes, promote clear and direct recommendations for change, and are amenable to updates as best practices are modified over time are the most likely to result in long-term changes.[66,74-77]

Implications

In addition to the above suggestions, the design and implementation of the 5 × 5 campaign point to several other critical factors that should be taken into consideration when planning a social media campaign in low-income countries. Three key factors in particular were identified including (1) utilizing a participatory approach; (2) incorporating culturally responsive content; and (3) acknowledging and adjusting for real-time social context.

Participatory approach

The 5 × 5 campaign utilized a participatory approach. The benefits of such an approach were multifold. To begin, by engaging stakeholders from the community representing those being served as well as those receiving or in need of receiving services, we were able to ensure that we targeted relevant symptoms of psychological distress, and labeled them in ways appropriate/easier to decipher by the target communities. This approach also allowed for focused messaging targeting the current experiences of individuals in the community rather than developing more general content based on a wide range of potential mental health reactions to the pandemic, many of which might not have been relevant.

This is particularly important as research has consistently found that in order for a health communication to be effective, the target audience must perceive the message as relevant (Anglechev and Sar, 2011). Further, the more relevant the message is deemed, the more likely it is to result in the desired attitude and/or behavior change.[78]

In addition to facilitating the identification of relevant target symptoms of psychological distress, this participatory process allowed for the identification of available resources in the community for mental health support. This is especially important in low-income underrepresented communities where formal services are lacking and less traditional sources of support (informal networks of care) may be more active and relevant (i.e., schools, churches, etc.). Increasing social capital in general and social networks, in particular, is therefore essential, which is what the 5 × 5 campaign aimed to ultimately do. Reducing stigma and promoting help seeking can only be effective if resources are available to provide support for those who are being encouraged to ask for it. Prior research supports this idea and has demonstrated that, at the macro level, availability of and access to key services in the community that support the target behavior of any given health campaign are essential for persuading individuals receiving the media messages to act on them.[66]

Finally, key to the success of the campaign was the identification of community partners (existing networks of care) who were able to push 5 × 5 campaign messaging to their communities. Without the endorsement of key stakeholders from the three original community-based organizations that served as primary partners for the campaign, these community providers may have been less willing to trust outsiders and take on the 5 × 5 campaign. Even more so, it would have difficult, at best, to identify the providers that were trusted by community members and in the best position to promote the 5 × 5 campaign. These key community allies were well established in their communities with positive reputations. While they may not have been providers of mental health care, specifically, they were regarded as key resources for support and known by community members as trusted providers, which are core elements for building a strong social capital, and sustainably increasing capacity at the community level.[35] Thus, the essential role such partnerships played in the success of the 5 × 5 campaign, particularly in terms of reach, and looking forward, in terms of response.

Culturally responsive content

The 5 × 5 campaign is grounded the cultural values of the target population. The participatory process described

above facilitated the identification of these core values yet another benefit of the approach. This was a key decision in the design of the 5 × 5 campaign intended to increase the impact of the campaign and supported by prior research.

For example, health communication research has largely centered on the role of cognition in making health-related decisions.[66] Through this focus, several factors have been identified that influence the effectiveness of health communications, including, the characteristics of the message (i.e., detection versus prevention), communication mode (i.e., TV, radio, print, and internet), the audience, the behavior of focus, and the nature and amount of interpersonal communication generated by the campaign.[66] However, these factors may be less relevant for mental health focused social media campaigns in low-income, underserved populations where stigma is high, resources are low, and strong cultural values serve as barrier to help seeking. Rather, in this context, ensuring that campaign content is culturally relevant and takes into account the prevailing attitudes toward mental health may have more of an impact on the campaign's effectiveness. The 5 × 5 campaign was designed with consideration of unique characteristics of the target low-income Latino communities.

Influence of real-time social context

The 5 × 5 campaign was intended to promote mental health awareness and help seeking during a unique time in history, the COVID-19 pandemic. At the time, it was introduced, the Guatemalan communities of focus were in week 6 of an extended quarantine and the pandemic had been running rampant for almost 3 months. Individuals were already in significant states of distress, struggling with increased anxiety, stress, and increases in preexisting mental health symptoms.[79] A small body of research has examined the role of mood and affect in the effectiveness of health communications.[78] Overall, this research suggests that preexisting mood can determine the effectiveness of persuasive communications.

Overall, this campaign introduced a new approach to mental health awareness and support during complex emergencies that promote concrete behavioral changes, using social media to reach large population groups. While further impact data need to be collected, it is relevant that the low-income, high-risk communities largely utilized this campaign, suggesting high feasibility for this model. The lessons learned will be effective in informing future campaigns and possibly, national-level health awareness programs, particularly in the area of mental health.

Conclusion

The 5 × 5 campaign serves as preliminary evidence for the feasibility and substantial reach of a social media-based mental health campaign to create a culture of mental health awareness and promote help seeking in underserved populations. Although the potential to reduce disparities in knowledge, help seeking, and accessing care through the use of such campaigns is supported, it remains critical to acknowledge structural inequalities that may serve as barriers to their effectiveness including stable Internet access. Using a participatory approach to improve mental health care (policies and practice) is crucial as it contributes to creating social networks that are an important asset for these communities. It also ensures sustainability by creating ownership at the community level and building capacity for improved responses. Further research should continue to explore the short-term and long-term impact of social media-based mental health campaigns and issues regarding equity of access and quality of effectiveness for different user groups.

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Conflicts of interest

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References

1. Thackeray R, Neiger BL, Hanson CL, McKenzie JF. Enhancing promotional strategies within social marketing programs: Use of Web 2.0 social media. Health Promot Pract 2008;9:338-43.
2. Lau AY, Siek KA, Fernandez-Luque L, Tange H, Chhanabhai P, Li SY, *et al*. The role of social media for patients and consumer health. Yearb Med Inform 2001;20:131-8.
3. Lenhart A, Rainie L, Lewis O. Teenage Life Online: The Rise of the Instant-Message Generation and the Internet's Impact on Friendships and Family Relationships. Washington, DC: Pew Internet and American Life Project; 2001. Available from: http://www.pewinternet.org/~/media//Files/Reports/2001/PIP_Teens_Report.pdf.pdf. [Last accessed on 2020 Nov 25].
4. Bennett GG, Glasgow RE. The delivery of public health interventions via the Internet: Actualizing their potential. Ann Rev Public Health 2009;30:273-92.
5. Evers CW, Albury K, Byron P, Crawford K. Young people, social media, social network sites and sexual health communication in Australia: "This is funny, you should watch it". Int J Commun 2013;7:18.
6. Lustria ML, Noar SM, Cortese J, Van Stee SK, Glueckauf RL, Lee J. A meta-analysis of web-delivered tailored health behavior change interventions. J Health Commun 2013;18:1039-69.
7. Portnoy DB, Scott-Sheldon LA, Johnson BT, Carey MP. Computer-delivered interventions for health promotion and behavioral risk reduction: A meta-analysis of 75 randomized controlled trials, 1988–2007. Prev Med 2008;47:3-16.
8. Korda H, Itani Z. Harnessing social media for health promotion and behavior change. Health Promot Pract 2013;14:15-23.

9. Van Genugten L, Dusseldorp E, Webb TL, Van Empelen P. Which combinations of techniques and modes of delivery in internet-based interventions effectively change health behavior? A meta-analysis. J Med Internet Res 2016;18:e155.
10. Webb T, Joseph J, Yardley L, Michie S. Using the internet to promote health behavior change: A systematic review and meta-analysis of the impact of theoretical basis, use of behavior change techniques, and mode of delivery on efficacy. J Med Internet Res 2010;12:e4.
11. Chou WY, Hunt YM, Beckjord EB, Moser RP, Hesse BW. Social media use in the United States: Implications for health communication. J Med Internet Res 2009;11:e48.
12. Frimming RE, Polsgrove MJ, Bower GG. Evaluation of a health and fitness social media experience. Am J Health Educ 2011;42:222-7.
13. Kontos EZ, Emmons KM, Puleo E, Viswanath K. Communication inequalities and public health implications of adult social networking site use in the United States. J Health Commun 2010;15 Suppl 3:216-35.
14. Lariscy RW, Reber BH, Paek HJ. Examination of media channels and types as health information sources for adolescents: Comparisons for black/white, male/female, urban/rural. J Broadcast Electron Media 2010;54:102-20.
15. Moorhead SA, Hazlett DE, Harrison L, Carroll JK, Irwin A, Hoving C. A new dimension of health care: Systematic review of the uses, benefits, and limitations of social media for health communication. J Med Internet Res 2013;15:e85.
16. Ralph LJ, Berglas NF, Schwartz SL, Brindis CD. Finding teens in TheirSpace: Using social networking sites to connect youth to sexual health services. Sex Res Soc Policy 2011;8:38-49.
17. Van Uden-Kraan CF, Drossaert CH, Taal E, Smit WM, Moens HJ, Van de Laar MA. Determinants of engagement in face-to-face and online patient support groups. J Med Internet Res 2011;13:e106.
18. Corley CD, Cook DJ, Mikler AR, Singh KP. Text and structural data mining of influenza mentions in Web and social media. Int J Environ Res Public Health 2010;7:596-615.
19. Adams SA. Revisiting the online health information reliability debate in the wake of "web 2.0": An inter-disciplinary literature and website review. Int J Med Inform 2010;79:391-400.
20. World Health Organization. Preventing Suicide: A Global Imperative; 2014. Available from: https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/[Last accessed on 2020 Oct 15]
21. Branas CC, Dinardo AR, Polanco VD, Harvey MJ, Vassy JL, Bream K. An exploration of violence, mental health and substance abuse in post-conflict Guatemala. Health 2013;5:825.
22. Herrera W, de Jesús Mari J, Ferraz MP. Mental disorders and the internal armed conflict in Guatemala. Actas Esp Psiquiatr 2005;33:238-43.
23. Puac-Polanco VD, Lopez-Soto VA, Kohn R, Xie D, Richmond TS, Branas CC. Previous violent events and mental health outcomes in Guatemala. Am J Public Health 2015;105:764-71.
24. Rissman YZ, Khan CT, Isaac SK, Paiz JA, DeGolia SG. Developing a mental health curriculum to build capacity and improve access to mental health care in rural Guatemala. Acad Psychiatry 2016;40:692-4.
25. Godoy-Paiz P. Obstacles to achieving mental health in post-war Guatemala: The Intersection of Political and Structural. Nexus 2005:18.
26. Abdullah T, Brown TL. Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. Clin Psychol Rev 2011;31:934-48.
27. Brennan M, Vega M, Garcia I, Abad A, Friedman MB. Meeting the mental health needs of elderly Latinos affected by depression: Implications for outreach and service provision. Care Manag J 2005;6:98.
28. Cheng HL, Kwan KL, Sevig T. Racial and ethnic minority college students' stigma associated with seeking psychological help: Examining psychocultural correlates. J Couns Psychol 2013;60:98.
29. Rastogi M, Massey-Hastings N, Wieling E. Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. J Syst Ther 2012;31:1-17.
30. Marquez JA, Ramírez García JI. Family caregivers' narratives of mental health treatment usage processes by their Latino adult relatives with serious and persistent mental illness. J Fam Psychol 2013;27:398.
31. Minkler M, Wallerstein N, editors. Community-Based Participatory Research for Health. San Francisco: Jossey-Bass; 2003.
32. Baum F, MacDougall C, Smith D. Participatory action research. J Epidemiol Community Health 2006;60:854-7.
33. Coleman J. Social capital in the creation of human capital. Am J Soc 1988;94:95-120.
34. Putnam RD. Bowling Alone: The Collapse and Revival of American Community. New York: Simon and Schuster; 2000.
35. Prell C. Social Capital as Network Capital: Looking at the Role of Social Networks among Not-For-Profits. Soc Res Online 2006;11:39-52.
36. Beck AT. Thinking and depression. I. Idiosyncratic content and cognitive distortions. Arch Gen Psychiatry 1963;9:324-33.
37. Beck AT. Thinking and depression: II. Theory and therapy. Arch Gen Psychiatry 1964;10:561-71.
38. Beck AT. Cognitive Therapy and the Emotional Disorders. New York: International Universities Press; 1976.
39. Knapp P, Beck AT. Cognitive therapy: Foundations, conceptual models, applications and research [Fundamentos, modelos conceituais, aplicações e pesquisa da terapia cognitive]. Rev Bras Psiquiatr 2008;30 Suppl II: S54-64.
40. Baer RA. Mindfulness training as a clinical intervention: A conceptual and empirical review. Clin Psychol Sci Pract 2003;10:125-43.
41. Baer RA, Smith GT, Hopkins J, Krietemeyer J, Toney L. Using self-report assessment methods to explore facets of mindfulness. Assessment 2006;13:27-45.
42. Mandal SP, Arya YK, Pandey R. Mental health and mindfulness: Mediational role of positive and negative affect. SIS J Proj Psychol Ment Health 2012;19:150-9.
43. Brown KW, Ryan RM. The benefits of being present: Mindfulness and its role in psychological well- being. J Personal Soc Psychol 2003;84:822-48.
44. Micheal LS, Graham JR. Mindfulness, subjective well-being, and social work: Insight into their interconnection from social work practitioners. Soc Work Educ 2011;30:29-44.
45. Speca M, Carlson L, Goodey E, Angen MA. Randomized wait-list controlled trial: The effects of a mindfulness meditation based stress reduction program on mood and symptoms of stress in cancer outpatients. Psychosom Med 2000;62:613-22.
46. Ryan RM, Deci EL. On happiness and human potentials: A review of research on hedonic and eudemonic well-being. Ann Rev Psychol 2001;52:141-66.
47. Gratz KL, Roemer L. Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. J Psychopathol Behav Assess 2004;26:41-54.
48. Boden MT, Thompson RJ. Facets of emotional awareness and associations with emotion regulation and depression. Emotion 2015;15:399.
49. Berking M, Wupperman P. Emotion regulation and mental health: Recent findings, current challenges, and future directions. Curr Opin Psychiatry 2012;25:128-34.
50. Gross JJ, Jazaieri H. Emotion, emotion regulation, and psychopathology: An affective science perspective. Clin Psychol Sci 2014;2:387-401.
51. Saxena P, Dubey A, Pandey R. Role of emotion regulation

difficulties in predicting mental health and well-being. SIS J Proj Psychol Ment Health 2011;18:147.
52. Gross JJ. Emotion regulation: Affective, cognitive, and social consequences. Psychophysiology 2002;39:281-91.
53. Gross JJ. Emotion regulation: Current status and future prospects. Psychol Inq 2015;26:1-26.
54. Pandey R, Choubey AK. Emotion and health: An overview. SIS J Proj Psychol Ment Health 2010;17:135-52.
55. Alkoby A, Pliskin R, Halperin E, Levit-Binnun N. An eight-week mindfulness-based stress reduction (MBSR) workshop increases regulatory choice flexibility. Emotion 2019;19:593.
56. Roemer L, Williston SK, Rollins LG. Mindfulness and emotion regulation. Curr Opin Psychol 2015;3:52-7.
57. Thiruchselvam R, Blechert J, Sheppes G, Rydstrom A, Gross JJ. The temporal dynamics of emotion regulation: An EEG study of distraction and reappraisal. Biol Psychol 2011;87:84-92.
58. Webb TL, Miles E, Sheeran P. Dealing with feeling: A meta-analysis of the effectiveness of strategies derived from the process model of emotion regulation. Psychol Bull 2012;138:775-808.
59. Firestone R, Rowe CJ, Modi SN, Sievers D. The effectiveness of social marketing in global health: A systematic review. Health Policy Plan 2017;32:110-24.
60. Barger VA, Labrecque L. An integrated marketing communications perspective on social media metrics. Int J Integr Mark Commun 20135 (1);64-76.
61. Hair E, Pitzer L, Bennett M, Halenar M, Rath J, Cantrell J, *et al*. Harnessing youth and young adult culture: Improving the reach and engagement of the truth campaign. J Health Commun 2017;22:568-75.
62. Abu-Omar K, Rütten A, Burlacu I, Schätzlein V, Messing S, Suhrcke M. The cost-effectiveness of physical activity interventions: A systematic review of reviews. Prev Med Rep 2017;8:72-8.
63. Bertrand JT, Anhang R. The effectiveness of mass media in changing HIV/AIDS-related behaviour among young people in developing countries. Tech Rep Series World Health Organ 2006;938:205.
64. Patton G, Bond L, Butler H, Glover S. Changing schools, changing health? Design and implementation of the Gatehouse Project. J Adolesc Health 2003;33:231-9.
65. Rogers EA, Fine S, Handley MA, Davis H, Kass J, Schillinger D. Development and early implementation of the bigger picture, a youth-targeted public health literacy campaign to prevent type 2 diabetes. J Health Commun 2014;19 Suppl 2:144-60.
66. Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behaviour. Lancet 2010;376:1261-71.
67. Yadav RP, Kobayashi MA. Systematic review: Effectiveness of mass media campaigns for reducing alcohol-impaired driving and alcohol-related crashes. BMC Public Health 2015;15:857.
68. Allen LN, Pullar J, Wickramasinghe KK, Williams J, Roberts N, Mikkelsen B, *et al*. Evaluation of research on interventions aligned to WHO 'Best Buys' for NCDs in low-income and lower-middle-income countries: A systematic review from 1990 to 2015. BMJ Global Health 2018;3:e000535.
69. Aminde LN, Takah NF, Zapata-Diomedi B, Veerman JL. Primary and secondary prevention interventions for cardiovascular disease in low-income and middle-income countries: A systematic review of economic evaluations. Cost Eff Resour Alloc 2018;16:22.
70. Graziose MM, Downs SM, O'Brien Q, Fanzo J. Systematic review of the design, implementation and effectiveness of mass media and nutrition education interventions for infant and young child feeding. Public Health Nutr 2018;21:273-287.
71. Naugle DA, Hornik RC. Systematic review of the effectiveness of mass media interventions for child survival in low-and middle-income countries. J Health Commun 2014;19 Suppl 1:190-215.
72. Niederdeppe J, Kuang X, Crock B, Skelton A. Media campaigns to promote smoking cessation among socioeconomically disadvantaged populations: What do we know, what do we need to learn, and what should we do now? Soc Sci Med 2008;67:1343-55.
73. Shea B, Andersson N, Henry D. Increasing the demand for childhood vaccination in developing countries: A systematic review. BMC Int Health Hum Rights 2009;9:S5.
74. Maher CA, Lewis LK, Ferrar K, Marshall S, De Bourdeaudhuij I, Vandelanotte C. Are health behavior change interventions that use online social networks effective? A systematic review. J Med Internet Res 2014;16:e40.
75. Marcus BH, Williams DM, Dubbert PM, Sallis JF, King AC, Yancey AK, *et al*. Physical activity intervention studies: What we know and what we need to know: A scientific statement from the American Heart Association Council on Nutrition, Physical Activity, and Metabolism (Subcommittee on Physical Activity); Council on Cardiovascular Disease in the Young; and the Interdisciplinary Working Group on Quality of Care and Outcomes Research. Circulation 2006;114:2739-52.
76. Randolph W, Viswanath K. Lessons learned from public health mass media campaigns: Marketing health in a crowded media world. Annu Rev Public Health 2004;25:419-37.
77. Noar SM. A 10-year retrospective of research in health mass media campaigns: Where do we go from here? J Health Commun 2006;11:21-42.
78. Anghelcev G, Sar S. The influence of pre-existing audience mood and message relevance on the effectiveness of health PSAs: Differential effects by message type. Journal Mass Commun Q 2011;88:481-501.
79. Alonzo D, Popescu M, Zubaroglu Ioannides P. Mental health impact of the Covid-19 pandemic on parents in high-risk, low income communities. Int J Soc Psychiatry January 2021;EPub 20764021991896.