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Collective Efficacy and Community Mental Health: A Psychology Study in Kishanganj

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Abstract

This study examines the relationship between collective efficacy and community mental health in Kishanganj district of Bihar, with particular focus on psychological distress, coping strategies, stigma perception, and social support. A cross-sectional, empirical design was employed, incorporating both quantitative and qualitative approaches. Data were collected from 88 participants (46 male, 42 female) representing rural and urban communities, using standardized tools such as the Kessler Psychological Distress Scale (K10), a coping strategies checklist, a stigma index, and a collective efficascy scale. Descriptive statistics provided an overview of psychological variables, while independent samples t-tests were conducted to compare group differences across gender and residence. Results indicated that women reported slightly higher psychological distress and greater use of emotion-focused coping, whereas men demonstrated stronger problem-focused coping. Rural participants tended to report higher distress and stigma and lower levels of social support and collective efficacy than their urban counterparts. However, none of these differences reached statistical significance at $p < 0.05$, though trends suggested moderate effect sizes that warrant attention. Qualitative interviews further revealed barriers such as stigma, gendered expectations, and rural health inaccessibility. The findings underscore the importance of strengthening collective efficacy and community support structures to mitigate distress and reduce stigma. Implications extend to clinical psychology practice and TB management programs, where integrating community-based interventions can enhance mental health outcomes and improve treatment adherence.

Keywords: *collective efficacy, psychological distress, coping strategies, stigma, community mental health*

Introduction

Community mental health has emerged as a critical concern in India, particularly in underserved districts such as Kishanganj, where poverty, stigma, and limited healthcare access intersect to heighten psychological vulnerability. Mental health is not only an individual concern but also a collective phenomenon shaped by social cohesion, informal control, and trust within communities. The concept of *collective efficacy*, developed in neighborhood studies by Sampson and colleagues, provides a useful framework for understanding how communities regulate behavior, promote support, and buffer distress.

In rural and semi-urban Indian settings, stigma around mental illness and tuberculosis (TB) often deters individuals from seeking care, while coping strategies vary widely depending on gender roles and socio-cultural expectations. Previous studies have highlighted that women tend to experience higher distress levels and rely more on emotion-focused coping, whereas men often employ problem-focused approaches. Similarly, rural residents typically face greater barriers to support than their urban counterparts.

The present study investigates these dynamics in Kishanganj through an empirical, cross-sectional design. By employing standardized measures and independent samples t-tests, the research compares male and female participants, as well as rural and urban residents, on indicators of psychological distress, coping, stigma, and social support. In doing so, it seeks to provide insights for both clinical psychology practice and public health interventions, especially TB management programs, where community engagement and stigma reduction remain crucial.

Methodology

Research Design

The present study adopts an empirical, cross-sectional research design with a focus on exploring the relationship between collective efficacy and community mental health in Kishanganj district. The design is grounded in a quantitative framework but incorporates qualitative insights where necessary to enhance contextual understanding. This dual emphasis ensures that both statistical patterns and lived experiences are considered. Since the research seeks to identify differences in psychological distress and coping strategies between specific groups within the community, a comparative design is integrated. In particular, the study includes an independent samples *t*-test to assess whether male and female participants, as well as rural and urban residents, demonstrate significant differences in psychological distress and coping responses. The mixed strategy of quantitative measures with structured interviews provides a comprehensive framework suitable for assessing both measurable constructs and the nuanced community realities that underpin mental health outcomes.

Participants

The sample for the study consisted of 88 participants drawn from diverse communities across Kishanganj district in Bihar. The population of interest included adult residents aged between 18 and 60 years, representing both genders and varying socio-economic backgrounds. Participants were recruited through random sampling to minimize bias and ensure representativeness of the wider community population. Randomization was achieved by creating a list of households in selected areas and approaching every fifth household for participation, supplemented by online recruitment from verified community groups.

The demographic composition was carefully monitored to maintain proportional representation from rural and urban areas of Kishanganj. Out of the 88 participants, 46 were male and 42 were female, and approximately half were from rural areas while the remainder belonged to urban settlements. This distribution allowed meaningful group comparisons. Inclusion criteria required participants to be residents of Kishanganj for at least five years, fluent in Hindi, Urdu, or English, and willing to provide informed consent. Exclusion criteria included individuals with diagnosed severe mental illnesses (such as schizophrenia or bipolar disorder), as these could confound general measures of distress and coping.

Tools

Demographic Information Schedule

A demographic schedule was prepared to gather essential background data such as age, gender, marital status, education level, occupation, monthly income, family type, and rural or urban residence. This information enabled the classification of participants into relevant subgroups for comparative analysis.

Collective Efficacy Scale

Collective efficacy was assessed using a standardized scale adapted for community contexts. The scale contained two dimensions: (a) **social cohesion and trust**—measuring the extent to which members of a community share trust and norms, and (b) **informal social control**—evaluating perceived willingness of community members to intervene in problem situations. Responses were recorded on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicated stronger perceptions of collective efficacy. The internal consistency of the scale has been reported to be satisfactory (Cronbach's alpha above 0.80 in previous studies).

Psychological Distress Scale

Psychological distress was measured using a short version of the Kessler Psychological Distress Scale (K10), which assesses symptoms of anxiety and depression experienced in the past four weeks. Items were scored on a five-point Likert scale, with higher scores reflecting greater levels of distress. The instrument is widely validated and has been employed in community-based mental health research in India.

Coping Strategies Inventory

Coping responses were evaluated using a brief coping strategies checklist derived from Lazarus and Folkman's model of coping. It measured two broad dimensions: (a) **problem-focused coping** (e.g., seeking solutions, planning), and (b) **emotion-focused coping** (e.g., avoidance, denial, emotional venting). Participants rated the frequency of each coping strategy on a five-point scale ranging from "never" to "always." Subscale scores were calculated to allow group comparisons in terms of coping orientation.

Social Support Scale

Perceived social support was also assessed using a community support index comprising items on family support, peer support, and neighborhood support. This tool provided context for interpreting differences in coping and distress levels.

Procedure

Data collection was conducted over a period of six weeks. Prior to initiating the study, necessary ethical clearance was obtained from the institutional ethics committee. The research was introduced to participants through a written information sheet in both Hindi and Urdu, clearly stating the objectives, procedures, and voluntary nature of participation. Informed consent was obtained prior to inclusion in the study.

The process of data collection combined **in-person interviews** and **online surveys** to ensure inclusivity. In rural regions with limited internet access, trained field researchers conducted face-to-face structured interviews in community centers, primary health units, and households. For urban participants and younger respondents with internet familiarity, structured questionnaires were distributed electronically via secure online forms. Both methods adhered to standardized instructions to maintain uniformity across data collection modes.

Interviews were semi-structured, allowing for elaboration on sensitive topics, particularly when discussing stigma, coping, or mental health barriers. Field researchers were trained in basic counseling skills to manage distress that might arise during questioning. On average, in-person interviews lasted 45 minutes, while online participants took 25–30 minutes to complete the form. All responses were anonymized, coded, and securely stored for analysis.

Data Analysis

Collected data were first cleaned and screened for missing values, outliers, or inconsistencies. Descriptive statistics were calculated to provide an overview of demographic variables and main constructs such as collective efficacy, psychological distress, and coping strategies. Means, standard deviations, and frequency distributions were tabulated.

The central inferential analysis employed in this study was the **independent samples *t*-test**, designed to evaluate mean differences between groups. Specifically, the following comparisons were undertaken:

1. **Male vs. Female participants** – to determine whether gender differences exist in psychological distress levels and coping strategies.
2. **Rural vs. Urban participants** – to assess whether geographical background affects collective efficacy perceptions, distress, and coping.

For each comparison, assumptions of normality and homogeneity of variances were tested. Effect sizes (Cohen's *d*) were also reported to provide additional insight into the magnitude of differences. Significance was determined at $p < 0.05$.

In addition, Pearson's correlation coefficients were computed to examine the association between collective efficacy and psychological distress, as well as between collective efficacy and coping strategies. Regression analysis was also considered to determine the predictive value of collective efficacy on mental health outcomes, though the main focus remained on group comparisons through *t*-tests.

Qualitative insights gathered during semi-structured interviews were coded thematically and used to contextualize statistical findings. For example, when distress levels were found to be higher among rural respondents, interview excerpts regarding healthcare inaccessibility or community stigma were employed to explain underlying causes. This mixed interpretation enriched the purely statistical findings and highlighted the socio-cultural nuances of Kishanganj.

Ethical Considerations

The research adhered strictly to ethical principles of psychological research. Participation was voluntary, and individuals were informed of their right to withdraw at any stage without penalty. Anonymity was maintained by assigning numeric codes to participants instead of recording identifying information. Sensitive data were stored securely, and only the principal investigator and authorized research assistants had access. Additionally, participants who displayed high distress levels during data collection were provided

with referral contacts of local mental health professionals and helpline services.

Limitations of Methodology

Though the methodology attempted to maintain rigor, certain limitations were acknowledged. First, the reliance on self-report measures could introduce response biases. Second, the mixed-mode data collection (online and offline) may have influenced the level of disclosure, with online participants potentially reporting differently due to perceived anonymity. Third, while the sample size of 88 was adequate for *t*-test analyses, larger samples would enhance the generalizability of results. These limitations were considered while interpreting the findings.

RESULTS AND DISCUSSION

The present study explored the relationship between collective efficacy and community mental health in Kishanganj district, with particular focus on psychological distress, coping strategies, perceived stigma, and social support. Results are presented in two stages: first, the descriptive analysis of demographic and psychological variables, followed by inferential analysis using independent samples t-tests and correlations. Each set of findings is discussed in light of existing psychological theories and previous research on community mental health.

Demographic Characteristics of Participants

Table 1: Demographic Profile of Participants (N = 88)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	46	52.3
	Female	42	47.7
Residence	Rural	44	50.0
	Urban	44	50.0
Age Group	18–29	37	42.0
	30–44	35	39.8
	45–60	16	18.2
Education	Primary	13	14.8
	Secondary	25	28.4
	Higher Secondary	19	21.6
	Graduate	22	25.0
	Postgraduate	9	10.2
Occupation	Unemployed	7	8.0
	Student	16	18.2
	Homemaker	10	11.4
	Skilled Labor	16	18.2
	Clerical/Service	16	18.2
	Professional	12	13.6
	Self-Employed	11	12.5
Income Group	Low (< ₹10k)	19	21.6
	Lower-Middle (₹10–25k)	26	29.6
	Middle (₹25–50k)	23	26.1
	Upper-Middle (₹50k–1L)	15	17.0
	High (> ₹1L)	5	5.7
Marital Status	Single	39	44.3
	Married	44	50.0
	Separated/Widowed	5	5.7
Interview Mode	In-person	53	60.2
	Online	35	39.8
Treatment Status	Treatment	48	54.5
	Non-Treatment	40	45.5

Discussion of Demographics

The demographic profile demonstrates balanced representation across gender and residence, ensuring meaningful comparative analysis. A relatively young to middle-aged population (82% between 18–44 years) dominated the sample, aligning with the district's age distribution trends. Education and occupation data suggest moderate literacy levels, with a significant proportion having completed secondary or graduate education. This is important because educational background often influences health awareness, stigma perception, and access to coping resources.

Income distribution reflects socio-economic diversity, with nearly one-fifth of respondents in the low-income bracket. Poverty and limited income are well-established social determinants of mental health, particularly in rural Bihar where healthcare access is restricted. A balanced marital status distribution provides insights into family-related coping dynamics.

Interestingly, 60% of data collection occurred through in-person interviews. This might have allowed richer contextual insights compared to online participants, who may have reported with greater anonymity but less narrative elaboration.

Descriptive Statistics of Psychological Measures

Table 2: Descriptive Statistics of Psychological Variables

Measure	Mean	SD	Min	Max
Psychological Distress (K10)	21.6	5.9	10	40
Problem-Focused Coping	24.2	5.2	11	36
Emotion-Focused Coping	20.3	4.9	9	35
Stigma Perception	18.7	5.3	9	34
Social Support	26.8	5.5	12	39
Collective Efficacy – Cohesion	16.1	3.9	7	25
Collective Efficacy – Control	15.3	3.8	6	24
Collective Efficacy – Total	31.4	6.7	14	47

Discussion of Descriptive Findings

The average distress score (M = 21.6) falls in the mild-to-moderate range according to Kessler norms, suggesting a notable burden of psychological distress within the community. Coping scores indicate slightly greater reliance on problem-focused strategies (M = 24.2) compared to emotion-focused (M = 20.3). This is encouraging, as problem-focused coping is generally associated with adaptive outcomes, though emotion-focused strategies may still play a role in short-term emotional regulation.

Stigma perception scores (M = 18.7) highlight persistent negative community attitudes toward mental health or TB-related issues, aligning with previous research in Indian rural settings (Raguram et al., 2004). Perceived social support (M = 26.8) was moderately high, suggesting that despite stigma, participants often relied on family and neighbors for assistance.

Collective efficacy scores (M total = 31.4) indicate relatively strong levels of community trust and willingness to intervene, consistent with Sampson's model of collective efficacy. This suggests that Kishanganj communities retain cohesive structures that could be leveraged for health interventions.

Gender Differences in Psychological Measures

Table 3: Group-wise Means by Gender

Measure	Male (n=46) Mean (SD)	Female (n=42) Mean (SD)
Psychological Distress (K10)	20.9 (5.8)	22.3 (6.0)
Problem-Focused Coping	25.0 (5.0)	23.4 (5.3)
Emotion-Focused Coping	19.6 (4.7)	21.1 (5.0)

Discussion of Gender Comparisons

Female participants reported slightly higher distress levels (22.3 vs. 20.9) and greater reliance on emotion-focused coping, while men scored higher on problem-focused coping. These differences mirror global trends where women often report greater psychological burden due to gendered social expectations and caregiving responsibilities (WHO, 2022).

The tendency of men to employ problem-focused coping resonates with gender-role socialization theory, which suggests men are more likely to adopt task-oriented solutions, whereas women are socialized toward emotional expression. While not statistically significant (as shown in Table 5), these patterns hold practical implications for tailoring community-based interventions by gender.

Rural–Urban Differences in Psychological Measures

Table 4: Group-wise Means by Residence

Measure	Rural (n=44) Mean (SD)	Urban (n=44) Mean (SD)
Psychological Distress (K10)	22.7 (6.1)	20.5 (5.6)
Stigma Perception	19.5 (5.2)	17.9 (5.3)
Social Support	25.7 (5.4)	27.9 (5.6)
Collective Efficacy – Total	30.5 (6.5)	32.3 (6.9)

Discussion of Rural–Urban Comparisons

Rural residents reported higher distress and stigma, alongside lower perceived social support and collective efficacy. These findings are consistent with rural disadvantage theories, which argue that geographical remoteness, poor infrastructure, and limited access to mental health resources exacerbate psychological vulnerability.

Urban participants, conversely, demonstrated stronger support networks and higher collective efficacy. This could stem from more structured neighborhood associations, NGOs, and healthcare access in urban centers. Nevertheless, qualitative interviews highlighted that urban stigma often manifests subtly through workplace discrimination rather than overt community exclusion.

Inferential Analysis: Independent Samples t-tests

Table 5: Independent Samples t-test (Selected Comparisons)

Contrast	Measure	Mean A	Mean B	t-value	p-value
Male vs Female	Psychological Distress	20.9	22.3	-1.06	0.292
Male vs Female	Problem-Focused Coping	25.0	23.4	1.42	0.159
Male vs Female	Emotion-Focused Coping	19.6	21.1	-1.43	0.156

Contrast	Measure	Mean A	Mean B	t-value	p-value
Rural vs Urban	Psychological Distress	22.7	20.5	1.76	0.082
Rural vs Urban	Stigma Perception	19.5	17.9	1.43	0.157
Rural vs Urban	Social Support	25.7	27.9	-1.82	0.073
Rural vs Urban	Collective Efficacy Total	30.5	32.3	-1.24	0.218

($p < 0.05$ considered significant)

Discussion of t-test Results

None of the observed differences reached conventional statistical significance ($p < 0.05$). However, several results approached significance:

- **Rural vs Urban Distress** ($p = 0.082$) suggests a trend toward greater psychological burden in rural participants.
- **Social Support differences** ($p = 0.073$) also trended, with urban residents reporting more support.

Though non-significant, the effect sizes (Cohen's $d \approx 0.4$) suggest moderate differences worth exploring in larger samples. Small sample sizes may have limited statistical power, but patterns are theoretically consistent with prior community psychology findings.

The absence of significant gender differences contrasts with Indian epidemiological surveys showing higher distress in women (Patel et al., 2018). This discrepancy could result from strong informal support among Kishanganj women, buffering distress.

Broader Interpretation

The findings support the **social determinants of health model**, which emphasizes the role of structural factors such as income, education, and geography in shaping mental health outcomes. Collective efficacy, though moderately strong overall, was lower in rural areas, underlining the importance of community-level interventions.

Stigma remains a major barrier, particularly in rural settings. Prior TB-related studies in Bihar and Jharkhand report similar stigma-induced delays in treatment seeking (Courtwright & Turner, 2010). Addressing stigma through psychoeducation and community awareness could enhance coping and collective efficacy.

The **transactional model of stress and coping** (Lazarus & Folkman, 1984) provides a useful framework here. Participants with stronger problem-focused coping and higher perceived support tended to report lower distress, though causality cannot be assumed. Collective efficacy may enhance coping by reinforcing trust and shared responsibility, echoing Bandura's concept of **collective agency**.

Integration with Qualitative Insights

Semi-structured interviews provided context for these statistical patterns. Rural participants often mentioned long travel times to health facilities, lack of mental health professionals, and fear of being labeled "mad" if they sought help. One respondent stated, *"If someone knows you are going to a doctor for stress, they think you have lost your mind."* This illustrates how stigma inflates distress levels.

Urban participants emphasized work-related stress but also noted easier access to informal support through NGOs and peer groups. Women frequently highlighted household burden and lack of decision-making power as sources of distress, whereas men discussed unemployment or unstable work as primary stressors.

Implications for Community Mental Health

The study underscores the importance of strengthening **community-level resources** in mental health promotion. Collective efficacy—particularly social cohesion—can serve as a buffer against distress if effectively harnessed. Programs that encourage community dialogue, peer-support groups, and neighborhood watch-style health initiatives may reduce stigma and promote coping.

Gender-sensitive interventions are also critical. Women may benefit from problem-solving skills training, while men might require spaces to express emotional vulnerability. For rural communities, investment in mental health infrastructure, mobile health clinics, and awareness campaigns are urgent.

Overall, while statistical significance was limited, clear patterns emerged: women and rural residents reported higher distress and stigma, whereas men and urban residents displayed stronger coping and support networks. Collective efficacy, though generally robust, varied by geography. These results align with health psychology frameworks emphasizing the interplay between individual coping and community-level social structures.

The findings provide actionable insights for designing **culturally sensitive, community-based mental health programs** in Kishanganj and similar rural-urban transitional districts of India.

Conclusion

The present study investigated the association between collective efficacy and community mental health in Kishanganj district, with specific focus on distress, coping strategies, stigma, and social support. Results of the independent samples t-tests revealed no statistically significant gender differences in

psychological distress or coping strategies, although women tended to report slightly higher distress and greater reliance on emotion-focused coping, while men leaned toward problem-focused strategies. Similarly, rural participants demonstrated higher distress and stigma and somewhat lower collective efficacy and support compared to their urban counterparts, though these differences did not reach statistical significance. Despite the lack of strong statistical differences, the observed trends are meaningful and consistent with broader literature on community disadvantage and gendered stress experiences.

From a clinical psychology perspective, these findings underscore the need for gender-sensitive mental health interventions that acknowledge women's greater emotional burden and men's limited outlets for emotional expression. For TB management programs, the results highlight the importance of reducing stigma—particularly in rural communities where it remains a major barrier to treatment adherence. Strengthening collective efficacy through community mobilization and enhancing informal support systems may not only reduce psychological distress but also improve health-seeking behavior and treatment outcomes. Ultimately, the study suggests that leveraging social cohesion and trust within communities can serve as a protective factor in addressing both mental health challenges and TB-related stigma.

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