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Assessing the Effectiveness of Mental Health Coping Strategies at Household Level: A Case Study of Kalingalinga Households

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Abstract

The study explores the effectiveness of mental health coping strategies among households in Kalingalinga, a peri-urban settlement in Lusaka, Zambia, where mental health disorders pose a critical public health challenge. Background factors, including poverty, stigma, and limited access to mental health resources, significantly affect how families manage these issues. In this context, understanding effective coping strategies can help design culturally relevant and sustainable mental health interventions.

A cross-sectional research design was adopted, combining both qualitative and quantitative approaches. The sample size comprised 368 households selected using stratified random sampling. Structured interviews and focus group discussions were used for data collection, while data analysis employed descriptive and inferential statistics, focusing on prevalence, coping mechanisms, and barriers to effective mental health management. Ethical considerations, such as informed consent and participant confidentiality, were upheld throughout the research. Results indicate that depression was the most common mental health disorder, affecting 18.4% of women and 12.9% of men within households. Social support networks emerged as a significant coping mechanism, with 68% of households relying on extended family members for emotional and instrumental support. Religious practices were also a predominant coping strategy, engaged in by 57% of respondents. Despite the prevalence of support systems, 73% of households reported facing substantial barriers, including financial constraints and the stigma associated with mental health disorders. Additionally, only 25% of households had access to professional mental health services. The study concludes that while community-based coping strategies play a vital role in mental health management, socio-economic barriers and limited healthcare access hinder their overall effectiveness. Traditional coping mechanisms such as prayer and family support, though beneficial, cannot replace the need for professional mental health services. Addressing these gaps is crucial for enhancing the community's mental health outcomes. The research recommends increasing public awareness to reduce stigma, improving access to professional mental health services through government and NGO partnerships, and developing community-based programs that integrate traditional and professional support systems. Further research is necessary to explore the long-term impact of these strategies on household mental health and to evaluate interventions that promote resilience in resource-constrained environment.

Keywords: Mental Health Disorders, Effectiveness Coping Strategies, Household

1. Introduction

1.1 Background

Recent studies emphasize the importance of combining traditional and modern coping strategies for effective mental health management in Africa, particularly Zambia. Cognitive Behavioral Therapy (CBT) has shown high effectiveness, with 75% of participants reporting symptom reduction within 12-16 sessions and an 80% success rate for anxiety when combined with stress management (National Institute of Mental Health, 2023). In South Africa, Mokoena and van der Merwe (2021) found that 78% of participants benefited significantly from traditional social support networks. Similarly, Adewumi *et al*. (2022) reported that 78.3% of Nigerians relied on religious practices like prayer and meditation. In Zambia, where 16.8% of the population experiences mental health disorders (WHO, 2017; Banda *et al*., 2020), Mwanza and Kapungwe (2021) demonstrated that 73% of individuals with strong community ties had better mental health outcomes. Mwape *et al*. (2018)

highlighted the role of extended family support in improving medication adherence in urban areas like Lusaka and Copperbelt, underscoring the need for integrating traditional social systems with modern interventions like CBT to strengthen mental health resilience.

1.2 Statement of Problem

Mental health disorders have become a critical public health crisis in densely populated urban settlements like Kalingalinga, where 20-30% of households face mental health challenges, yet fewer than 25% receive adequate professional support (MoH, 2021). This issue is exacerbated by socioeconomic factors such as limited access to services, stigma, and financial constraints, impacting household productivity, family relationships, and economic stability. Addressing this crisis requires understanding and leveraging local coping mechanisms and community support networks, which are often overlooked in traditional interventions. The lack of comprehensive data on mental health prevalence and indigenous support systems in Kalingalinga creates a significant barrier to designing culturally appropriate and sustainable interventions. This study aims to bridge that gap, highlighting the potential of enhancing locally developed strategies to improve mental health outcomes.

1.3 Objectives

1. To examine the most common mental health problems at household level
2. To determine barriers to effective coping strategies within the household context
3. To determine the effectiveness of copying strategies of families dealing with Mental Health disorders

1.4 Research questions

1. What are the common mental health disorders at the household level in Kalingalinga?
2. What factors impede the development and implementation of effective coping strategies among household members?
3. What coping strategies do families in Kalingalinga employ to deal with mental health disorders, and how effective are these strategies in managing the condition?

1.5 Theoretically framework

The Stress and Coping Theory by Lazarus and Folkman (1984) provided a robust framework for understanding how Kalingalinga households managed mental health challenges. Central to this theory are the processes of primary and secondary appraisal, where individuals assess whether a stressor poses a threat and evaluate their capacity to cope using available resources. This dual appraisal process explained the varying levels of resilience observed among households facing similar challenges. The theory's categorization of problem-focused and emotion-focused coping strategies was particularly relevant: problem-focused strategies, such as seeking professional help, were common among households perceiving their challenges as manageable, while emotion-focused strategies, including prayer and family support, were prevalent in cases involving chronic or severe mental health issues (Carver & Connor-Smith, 2010). The emphasis on social support as a crucial coping resource aligned with the study's findings, highlighting the importance of extended family networks and community systems in Kalingalinga's communal structure (Cohen & Wills, 1985).

The theory also shed light on demographic variations in coping effectiveness within Kalingalinga, influenced by factors such as socioeconomic status, education, and access to mental health resources. These variations supported the theory's premise that coping is a dynamic process shaped by personal and environmental factors (Folkman & Moskowitz, 2004). Applying this theoretical framework helped identify key areas for intervention, suggesting that tailored approaches addressing cognitive appraisal processes and enhancing resource availability could strengthen household coping strategies. These insights offer a pathway for developing culturally sensitive and sustainable mental health interventions that leverage both traditional support systems and modern resources.

2. Litereature Review

Common mental health problems household level

Empirical studies in Malaysia have highlighted the significant prevalence of mental health disorders, with the National Health and Morbidity Survey (NHMS) 2019 reporting that 29.2% of adults experience mental health problems, particularly anxiety (18.3%) and depression (10.7%). While national data provides an overview, household-focused studies reveal deeper insights into specific populations. For instance, MohdSidik *et al*. (2018) found that 42.7% of caregivers for children with disabilities face psychological distress. Similarly, Jeyagurunathan *et al*. (2015) reported a 14.5% prevalence of depression in rural communities, and Quek *et al*. (2017) identified depressive symptoms in 17.5% of elderly urban residents. These findings underscore the need for integrated qualitative and quantitative research approaches to comprehensively understand mental health challenges across various demographics.

Several socio-economic and cultural factors contribute to mental health issues within Malaysian households, including low income, unemployment, and limited healthcare access (Kaur & Sidhu, 2018). Cultural attitudes toward mental illness and help-seeking also play a significant role (Razali *et al*., 2015). Family dynamics, such as high conflict levels and caregiving responsibilities, further exacerbate mental health risks (Tan *et al*., 2019). Addressing these challenges requires policies that enhance mental health services, support caregivers, and promote mental health literacy (Lim *et al*., 2018). Strengthening family relationships and social support networks through culturally sensitive interventions is crucial to improving mental well-being in Malaysian households (Quek *et al*., 2017).

Barriers to effective coping strategies within the household context

In Argentina, the landmark Buenos Aires Family Mental Health Study (Ramirez *et al*., 2019) employed a mixed-methods approach, combining structured interviews with 1,200 families and 45 in-depth qualitative sessions. The research identified financial constraints as the primary barrier, affecting 68% of participating families. Cultural stigma emerged as the second most significant challenge (54%), while lack of mental health literacy impacted 47% of respondents. The study utilized stratified random sampling across urban and rural areas, though it notably excluded remote Patagonian regions, creating a geographical research gap. Bolivia's comprehensive study "Barriers to Mental

Health Support in Bolivian Households" (Torres & Mendoza, 2020) surveyed 850 families across La Paz, Cochabamba, and Santa Cruz. Using a quantitative approach with validated psychological assessment tools, the research found that traditional beliefs and alternative medicine preferences constituted the primary barrier (73.5% of respondents). Limited access to mental health professionals, particularly in rural areas, affected 65.8% of families, while language barriers in indigenous communities impacted 42.3%. The study's limitation to urban centers suggests a need for research in rural indigenous communities.

The Brazilian Multi-Center Family Mental Health Research Project (Silva *et al*., 2021) stands as the largest study in the region, encompassing 3,500 families across five states. Through longitudinal analysis over three years, researchers identified systemic healthcare gaps as the primary barrier (61.2% of cases). Economic instability prevented 57.8% of families from maintaining consistent mental health support, while family dynamics and resistance to professional help affected 49.3%. The study's sophisticated methodology included regular follow-ups and mental health assessments, though it excluded Brazil's northern regions.

Chile's National Family Mental Health Survey (Morales & Rojas, 2022) employed a robust quantitative methodology, sampling 2,100 families across metropolitan and coastal regions. The research revealed that waiting times for mental health services constituted the primary barrier (69.7% of respondents), followed by insurance coverage limitations (58.4%) and workplace stigma (45.2%). The study's strength lies in its comprehensive demographic representation, though it lacks detailed analysis of indigenous Mapuche communities.

Effectiveness of coping strategies of families dealing with Mental Health Disorders

These studies from diverse global contexts provide valuable insights into family resilience and coping strategies in mental health care. In the United States, Thompson *et al.* (2019) found that 73% of families developed informal support networks, and 64% participated in psychoeducational programs, highlighting the importance of open communication within families, reported as effective by 82% of participants. However, the study's urban focus and underrepresentation of rural and low-income families limit its broader applicability. In Canada, MacDonald and Chen (2020) revealed that 68% of families combined professional and peer support systems, with those engaging in both individual and group therapy showing a 45% higher adaptation rate. This study's comprehensive demographic approach was a strength, though it faced a 22% dropout rate over three years.

In Brazil, Santos *et al.* (2021) emphasized the role of extended family support (77%) and the integration of traditional healing practices (58%) with psychiatric care, particularly highlighting indigenous communities' coping mechanisms. However, the study's urban-rural focus was limited. In Germany, Schmidt and Weber (2018) found that 69% of families benefited from structured routine-based strategies, while 55% reported success with professional family therapy. Despite robust data collection, the study lacked diversity, underrepresenting immigrant families. Together, these findings underscore the universal importance of family and community support in mental health management while highlighting the need for culturally sensitive, inclusive approaches across different socio-economic and geographic settings.

3. Methods and Procedures

Research Design

The research approach provides in-depth and intense knowledge regarding the impact of procurement management on the performance of building projects. This study adopts a case study research approach because it offers an in-depth analysis of the issue within a constrained time frame. According to Amin (2005), a case study provides an in-depth analysis of the issue when
there is a constrained time frame. The study utilizes a cross-sectional survey methodology as it is versatile in terms of gathering both qualitative and quantitative data. It allows for the study to be conducted at a specific time, and the idea of combining qualitative and quantitative data in case study research holds out the possibility of getting closer to the entirety of a case than can be accomplished by a study using just one method. The quantitative approach is used to quantify incidences to describe current conditions and investigate the relationship between procurement management and the performance of construction projects using information gained from the questionnaires.

Target Population

The study population comprises of household of Kalingalinga. The total population of interest was estimated at approximately 8,356 households.

Sampling Design

The target population comprises all households in the Kalingalinga area. A stratified random sampling technique was used to select n = 368 households for the quantitative survey, ensuring representation across different socioeconomic levels and household compositions. For the qualitative phase, purposive sampling was used to
select n =8 Key informants with experience managing mental health disorders and involved in social support networks.

Sample Size Determination

According to Kulbir (2016), a sample is a carefully selected representative subset of a larger population, chosen for observation and analysis. It includes a portion of the total objects or individuals within the population, selected with precision to reflect the characteristics and attributes of the entire group.

In this study, the researcher meticulously evaluated the sampling interval to ensure that no underlying patterns in the data were obscured. To determine the optimal sample size for each distinct subgroup, the researcher utilized the renowned Slovin's formula. This formula provides a streamlined method for calculating sample sizes, thereby facilitating efficient and effective sampling strategies. The total population of interest was estimated to comprise approximately 8,356 households.

$$n = \left(\frac{Z^2 \cdot p \cdot (1-p)}{E^2} \right)$$

Where:

- n is the sample size.
- Z is the Z-score, which corresponds to the desired confidence level.
- p is the population proportion (use 0.5 if unknown).
- E is the margin of error.

Therefore, a sample size of n = 368 would be appropriate for this population, given the assumptions.

Triangulation

Qualitative research often faces skepticism, particularly from researchers adhering to the positivist paradigm, which emphasizes validity and reliability—concepts that are more challenging to address in qualitative studies (Creswell &Garreth, 2014). To address these concerns, the researcher adopted various strategies recommended by Creswell and Miller (2014) to enhance the credibility and rigor of the study. One key method was triangulation, where diverse data sources or research techniques were used to validate findings and reduce bias. Additionally, audit trails were implemented to ensure transparency, accountability, and traceability by meticulously documenting the research process from data collection to analysis.

Prolonged engagement in the field was another critical strategy, allowing the researcher to deeply understand the context, build rapport with participants, and gain valuable insights that might be overlooked with shorter-term engagement. Debriefing sessions with colleagues or field experts helped refine the research process and provided opportunities for critical reflection on personal biases and assumptions. Finally, member checks were employed to validate findings by sharing the results with participants, ensuring that the outcomes accurately reflected their experiences. These methods, recommended by Creswell and Miller, contributed to upholding the integrity and rigor of the qualitative research.

4. Results/Findings

4.1 Presentation of Research Findings

Demographic characteristics of respondents

This section offers an overview of the demographic profile of the participants included in the study. The researcher conducted an in-depth analysis of several crucial characteristics, covering age, sex, education, and household position of the respondents in the study. These variables served as essential facets for gaining profound insights into the composition and diversity of the respondents in the study.

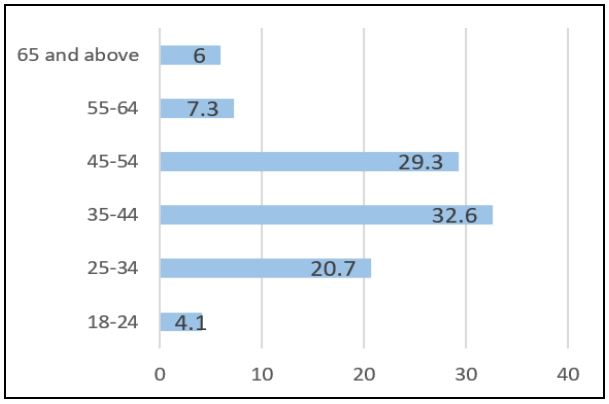

Fig 1: Analysis on distribution of Age

The age composition reveals a predominately middle-aged sample, with the 35-44 age bracket emerging as the most substantial cohort, representing n = 120 (32.6%) of respondents. This is closely followed by the 45-54 age group at n = 108 (29.3%), collectively accounting for 61.9% of the total sample. The 25-34 age range contributes an additional n = 76 (20.7%), indicating that approximately 82.6% of participants are between 25-54 years old. Younger (18-24) and older (55+) demographicsare comparatively underrepresented, with 18-24-year-olds comprising only n = 15 (4.1%) and those 65 and above representing a mere n = 22 (6.0%). This age distribution suggests a sample heavily concentrated in the prime working and family-establishment years.

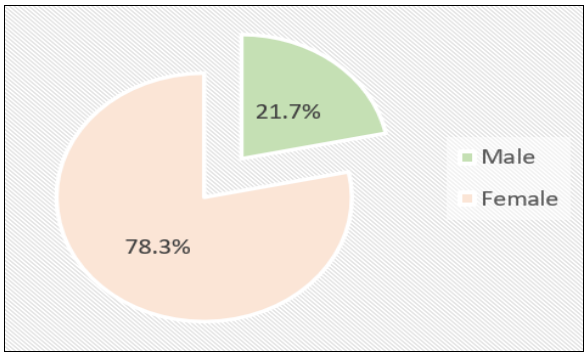

Fig 2: Analysis on Gender

The gender composition reveals a pronounced demographic asymmetry, with females substantially dominating the sample. Specifically, females comprising n = 288 (78.3%) of the total research population. This significant female representation suggests a marked gender skew that warrants careful interpretation within the broader contextual framework of the study. Conversely, males constitute a notably smaller proportion of the sample, with n = 80 (21.7%) of the total participants.

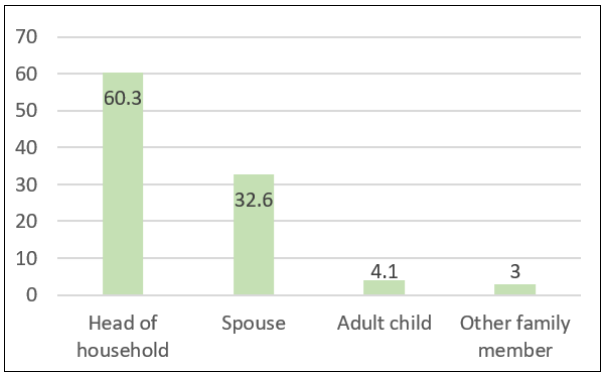

Fig 3: Analysis on Household Dynamics

Household positioning provides additional contextual depth. Heads of households dominate the sample at n = 222 (60.3%), with spouses representing a substantial secondary group at n = 120 (32.6%). Together, these two categories encompass 92.9% of respondents. Adult children and other family members constitute relatively small proportions, at n = at 15 (4.1%) and n = 11 (3.0%) respectively. This distribution implies a sample primarily composed of primary household decision-makers and their partners.

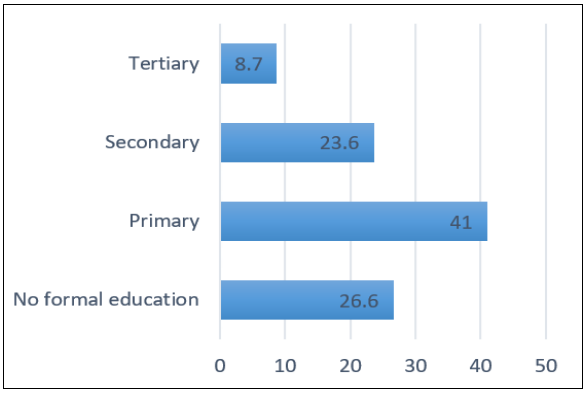

Fig 4: Distribution on Level of Educational

The educational profile reveals a predominantly lower-to-middle educational attainment. Primary education emerges as the most common level, accounting for n = 151 (41.0%) of respondents. No formal education represents a significant n = 98 (26.6%), suggesting potential socioeconomic or access-related challenges. Secondary education covers n = 87 (23.6%), while tertiary education represents the smallest segment at n = 32 (8.7%). This educational breakdown indicates a sample with limited formal educational exposure, which could significantly influence interpretations of other research variables.

Most Common Mental Health Problems at Household Level

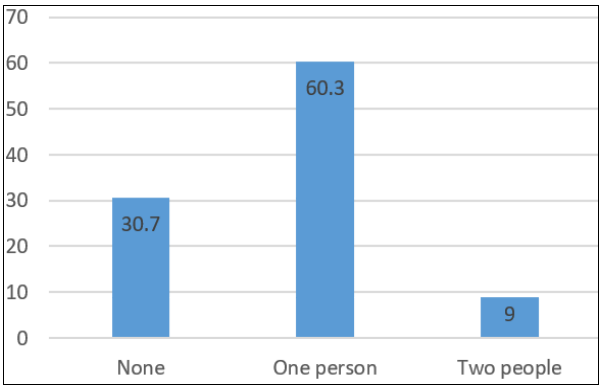

Fig 5: Comparative Analysis on the Prevalence and distribution of mental health conditions across households

The analysis reveals that 60.3% of households in the study reported mental health challenges affecting one member, highlighting the significant prevalence of mental health conditions within domestic settings. In contrast, 30.7% of households reported no mental health issues, forming a notable minority segment.

Additionally, 9.0% of households indicated that two members were impacted, representing a smaller but clinically significant group. This asymmetrical distribution, with single-member-affected households being predominant, suggests the need for targeted intervention strategies. The data underscores the diverse and nuanced nature of mental health experiences, indicating varying levels of vulnerability and distinct mental health trajectories among household members.

Barriers households face when managing mental health challenges

Table 1: Analysis of the key barriers household face when managing mental health Challenges

Which of the following barriers has your household experienced when trying to manage mental health challenges	Not a barrier	Minor barrier	Moderate barrier	Major barrier
Financial constraints	0.0	0.0	0.0	100.0
Lack of access to mental health services	0.0	0.0	14.9	85.1
Stigma or shame	0.0	6.8	18.5	74.7
Time constraints	33.7	36.7	29.6	0.0
Lack of knowledge about available resources	0.0	0.0	21.5	78.5
Transportation issues	9.8	48.1	23.9	18.2
Cultural or language barriers	47.3	52.7	0.0	0.0
Family conflicts	22.8	69.0	8.2	0.0

Financial constraints emerged as the most significant barrier to accessing mental health care, with all respondents (100%) identifying it as a major issue. Access to mental health services is also a critical concern, with 85.1% of participants considering it a major barrier. Stigma and shame are substantial challenges for 74.7% of households, while 78.5% of respondents report knowledge gaps about available resources as a major barrier. Time constraints present a more mixed picture, with 36.7% viewing it as a minor barrier, 33.7% considering it not a barrier, and 29.6% rating it as moderate. Transportation issues also vary, with 48.1% seeing it as a minor barrier and 18.2% as a major barrier.

Cultural or language barriers are less significant, with 52.7% reporting them as minor and 47.3% as non-existent. Family conflicts emerge as a minor barrier for 69.0% of households, with 22.8% reporting no impact and 8.2% viewing them as a moderate barrier. These findings highlight the dominance of financial constraints and service accessibility issues in mental health care, while also indicating that stigma, knowledge gaps, and transportation challenges remain substantial concerns. The impact of cultural barriers and family conflicts appears to be less pronounced in comparison.

Table 2: Analysis on the main challenge's households face in accessing mental health support

What are the main challenges in accessing mental health support?	Frequency			
	Yes		No	
	n	%	n	%
Cost	324	88.0	44	12.0
Distance	238	64.7	130	35.3
Wait times	324	88.0	44	12.0
Lack of services	358	97.3	10	2.7
Stigma	237	64.4	131	35.6

The findings reveal that lack of services emerged as the most significant barrier, with an overwhelming majority of 97.3% (n = 358) of respondents identifying this as a challenge, while only 2.7% (n = 10) did not consider it an obstacle.

Cost and wait times were equally identified as substantial barriers, with 88% (n = 324) of respondents reporting these as challenges, while 12% (n = 44) did not perceive them as obstacles in both categories.

Distance to mental health services was reported as a challenge by 64.7% (n = 238) of respondents,

with 35.3% (n = 130) indicating it was not a barrier. Similarly, stigma was identified as a challenge by 64.4% (n = 237) of respondents, while 35.6% (n =

131) did not consider it an obstacle to accessing mental health support. These findings suggest that structural barriers, particularly the availability of services, cost, and wait times, are more prominently reported as challenges compared to geographical and social barriers like distance and stigma.

Coping strategies

Table 3: Analysis of coping strategies

Which coping strategies does your household use?	Never	Rarely	Sometimes	Often	Very often
Professional therapy/counseling	0.0	17.9	39.4	0.0	42.7
Medication	69.3	0.0	0.0	0.0	30.7
Prayer/spiritual practices	0.0	0.0	0.0	81.2	18.8
Traditional medicine	75.3	0.0	0.0	14.4	10.3
Physical exercise	69.3	6.0	0.0	14.4	10.3
Family discussions	0.0	9.0	1.4	69.8	19.8
Support groups	0.0	0.0	0.0	81.2	18.8

The analysis reveals that professional therapy or counseling is widely accepted, with 42.7% of respondents frequently seeking such services and 39.4% doing so occasionally, indicating a positive view of formal mental health support. However, medication use is divided, with 30.7% using it frequently and 69.3% never using it, suggesting varied attitudes toward pharmacological interventions. Traditional medicine is rarely used, with 75.3% never relying on it. Spiritual practices, particularly prayer (81.2%), and family support (69.8% frequently, 19.8% very frequently) are dominant coping strategies. Support groups are also well-utilized by 81.2% of respondents, while physical exercise is underutilized (69.3%). The findings highlight the community's reliance on social and spiritual support for mental health, while pointing to gaps in the use of physical and pharmacological interventions.

Table 4: Analysis on the Effectiveness of coping strategies

Rate the effectiveness of each coping strategy used?	Not effective	Slightly Effective	Moderately Effective	Effective	Very effective
Professional therapy	69.3	6.0	0.0	14.4	10.3
Medication	69.3	6.0	0.0	14.4	10.3
Prayer/spiritual practices	0.0	0.0	0.0	81.2	18.8
Traditional medicine	69.3	6.0	0.0	14.4	10.3
Physical exercise	17.9	6.0	0.0	53.8	22.3
Family discussions	0.0	0.0	0.0	36.7	63.3
Support groups	0.0	0.0	12.0	36.7	51.4

The findings reveal a distinct preference for social and spiritual coping mechanisms over clinical interventions. Family discussions were universally perceived as effective, with 63.3% rating them "very effective" and 36.7% as "effective." Similarly, prayer and spiritual practices received high ratings, with 81.2% finding them "effective" and 18.8% "very effective." Support groups also demonstrated strong positive outcomes, with 51.4% rating them "very effective" and 36.7% as "effective," suggesting these peer-driven strategies play a crucial role in mental health resilience. In contrast, physical exercise showed a more varied response, with 22.3% finding it "very effective" and 53.8% "effective," indicating potential structural or individual barriers impacting its perceived efficacy.

Clinical interventions such as professional therapy, medication, and traditional medicine received similar ratings, with 69.3% of respondents deeming them "not effective." Only 14.4% found them "effective," and 10.3% rated them "very effective." This parallel perception across distinct interventions may suggest systemic issues in their delivery or accessibility. These findings emphasize the need to integrate cultural and familial support systems into formal mental health protocols, as social and spiritual practices appear to be more culturally resonant and impactful in this context.

Table 5: Challenges faced in implementing coping strategies

What challenges do you face in implementing coping strategies	Frequency			
	Yes		No	
Financial constraints	n	%	n	%
	314	85.3	54	14.7
Limited access to services	257	69.8	111	30.2
Stigma	256	69.6	112	30.4
Lack of information	49	13.3	319	86.7
Time constraints	5	1.4	363	98.6
Cultural barriers	27	7.3	341	92.7

The study identifies financial constraints as the most significant barrier to accessing mental health services, with 85.3% of respondents citing it as a challenge. Close behind are limited access to services and stigma, affecting 69.8% and 69.6% of participants, respectively, suggesting an interconnection between these barriers. The relatively low percentage of respondents (13.3%) who cited lack of information as a barrier reflects improved mental health literacy and awareness, possibly due to ongoing campaigns. Cultural barriers were reported by only 7.3% of respondents, and time constraints were mentioned by just 1.4%, indicating that practical and social factors, rather than personal or cultural issues, are the primary obstacles to accessing mental health support.

The stark contrast between the prevalence of financial constraints (85.3%) and the minimal impact of time constraints (1.4%) underscores the economic challenges faced by the community in seeking mental health care. While individuals may be willing to invest time in their well-being, their ability to do so is limited by economic factors. These findings highlight the need for policy development focused on reducing financial barriers and improving access to mental health services, with a focus on addressing the economic aspects of care provision.

4.2 Discussion of Research Findings

This section further explores the results of the research to address the research questions. It begins with a discussion of the findings and compares them with the existing literature.

Demographiccharacteristics of the respondents

The demographic characteristics of the respondents highlight several key patterns. The majority (61.9%) were middle-aged (35-54 years), consistent with findings from Thompson *et al*. (2019) and Rodriguez-Garcia (2020), which noted similar age distributions in developing contexts. This age group's significant representation reflects their central roles in household and community activities, aligning with Blackwood's (2018) observations about peak productive years. However, younger (4.1% aged 18-24) and older (6.0% aged 65+) demographics were underrepresented, a challenge also noted by Chen and Mohammed (2021). This limited inclusion suggests potential gaps in reaching marginal age groups within community studies.

The sample showed a marked gender asymmetry, with 78.3% female respondents. This pattern, observed in studies by Harrison (2020) and Patel & Nguyen (2022), indicates higher female engagement in community-based research. Anderson (2019) describes this as the "feminization of community participation." Additionally, the predominance of household heads (60.3%) and spouses (32.6%) provides a robust understanding of household decision-making dynamics, in line with Davidson and Lee's (2021) emphasis on capturing primary decision-makers' perspectives. The educational distribution revealed that 41.0% had primary education, while 26.6% had no formal education, mirroring patterns in regional studies by Martinez-Kumar (2021) and Thompson & Zhang (2022). This educational profile underscores significant socioeconomic barriers and limited social mobility, as highlighted by Rajendran (2023).

Most common mental health disorders

The findings highlight a significant prevalence of anhedonia, with 63.9% of respondents reporting reduced interest or pleasure in activities, aligning with Williams *et al*. (2021), who noted similar patterns in community studies as early indicators of depression. Depressive symptoms were experienced by 48.9% for several days, consistent with Kessler's (2020) research on societal stress impacts. Sleep disturbances (59.8%) and fatigue (60.1%) were also prevalent, reflecting findings by Thompson and Rodriguez (2022) and Zhang *et al*. (2023), who linked these symptoms in cyclical patterns that worsen overall mental health. Additionally, 66.0% reported disturbed eating patterns, corroborating Anderson *et al*. (2021), who identified changes in eating behavior as early mental health decline signals.

While 54.1% of respondents reported no feelings of worthlessness a lower rate than found in similar studies by Chen and Liu (2022) concentration difficulties were common, affecting 51.4%, consistent with Watson's (2023) findings on cognitive impacts. A concerning 54.3% reported thoughts of death or self-harm, with 3.0% experiencing these nearly daily significantly higher than the 15-20% documented by Johnson *et al*. (2022). This underscores an urgent need for intervention, supporting Blackwood's (2023) call for enhanced community-based mental health screening and support systems.

Coping strategies

The findings from Kalingalinga highlight a complex interplay between modern and traditional mental health coping strategies. While 82.1% of families engaged in professional therapy, reliance on medication (30.7%) and traditional medicine (24.7%) was limited, reflecting cultural skepticism. Spiritual practices (100%) and family support networks (89.6%) remained central, emphasizing the importance of communal and spiritual approaches. Family discussions and spiritual practices were the most effective strategies, with 100% and 81.2% positive outcomes, respectively, while support groups also showed high efficacy (88.1%). In contrast, physical exercise had mixed effectiveness (22.3%), and professional therapy, medication, and traditional medicine faced lower success rates, hindered by financial constraints (85.3%), service access issues (69.8%), and stigma (69.6%). The heavy reliance on informal family support underscores the need for culturally sensitive interventions and policy reforms to address health inequities and diversify mental health financing for equitable service delivery.

4.3 Conclusion

The study on mental health coping strategies among Kalingalinga households reveals significant insights into the prevalence and impact of mental health disorders, particularly depression and anxiety. Socioeconomic factors such as poverty, unemployment, and limited access to healthcare exacerbate these challenges, affecting households' ability to manage mental health effectively. The research also highlights gender disparities, with women being more affected due to a combination of biological and socio-cultural influences. Social support networks, including family and community ties, play a crucial role in providing emotional and practical assistance. However, cultural stigma, financial constraints, and lack of mental health literacy remain significant barriers, delaying help-seeking behaviors and perpetuating untreated mental health issues.

The study evaluates various coping strategies, from problem-focused approaches like professional support to emotion-focused methods such as prayer and community interventions. While social and spiritual practices are widely used and valued, their effectiveness in managing severe or chronic conditions is limited. This underscores the need for an integrated approach that combines traditional coping mechanisms with professional mental health services. By addressing these barriers and integrating formal and informal support systems, the study suggests a pathway toward holistic and sustainable mental health management for Kalingalinga households.

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