

# Mental Health Research Among Tribal Population in India

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## Abstract

Tribals are the most marginalized social category in the country. There is little and scattered information on the actual burden and pattern of illnesses they suffer from. Tribal communities in general and primitive tribal groups are prone to disease. Also, they do not have required access to basic health facilities. They are most exploited, neglected, and highly vulnerable to diseases with a high degree of malnutrition, morbidity, and mortality. Research on the mental health of tribal people is not much in numbers. Few studies made on them have produced inconsistent results. This study aims to assess the mental health status of tribal communities. It was found that due to a lack of appropriate mental health services in rural areas, the tribal population is unable to access the needful services and treatment. There is a need to develop a psychosocial care program for tribal to promote positive social, physical, psychological, and emotional well-being. This study is the first of its kind to review research on mental health among STs. Mental health research conducted among STs in India is limited and is mostly of low-to-moderate quality. Determinants of poor mental health and interventions for addressing them need to be studied on an urgent basis.

**Keywords:** Mental health, Tribal, Health facilities, Vulnerable, Mental health services, Psychosocial care program.

**Method:** Studies published between, January 1980 and December 2023 were included. Studies on mental disorders were included only when they focused on the Schedule Tribe population. Both qualitative and quantitative studies on mental disorders of the tribal population only were included in the analysis. Studies without any primary data which are merely overviews and commentaries and those not focused on the tribal population were excluded from the analysis.

## Introduction

Mental health is a highly neglected area, particularly in low and middle-income countries (LMIC). Data from community-based studies showed that about 10% of people suffer from common mental disorders (CMDs) such as depression, anxiety, and somatic complaints. A systematic review of epidemiological studies between 1960 and 2009 in India reported that about 20% of the adult population in the community is affected by psychiatric disorders in the community, ranging from 9.5 to 103/1000 population, with differences in case definitions, and methods of data collection, accounting for most of the variation in estimates. The tribal population is a marginalized community and lives in relative social isolation with poorer health indices compared to similar nontribal populations. There are an estimated 90 million STs or Adivasis in India. They constitute 8.6% of the total Indian population. The distribution varies across the states and union territories of India, with the highest percentage in Lakshadweep (94.8%) followed by

Mizoram (94.4%). In northeastern states, they constitute 65% or more of the total population. The ST communities are identified as culturally or ethnographically unique by the Indian Constitution.<sup>[1]</sup> They are populations with poorer health indicators and fewer healthcare facilities compared to non-tribal rural populations, even when within the same state, and often live in demarcated geographical areas known as tribal areas.

As per the National Family Health Survey, 2015–2016, the health indicators such as infant mortality rate (IMR) is 44.4, the under-five mortality rate (U5MR) is 57.2, and anemia in women is 59.8 for STs – one of the most disadvantaged socioeconomic groups in India, which are worse compared to other populations where IMR is 40.7, U5MR is 49.7, and anemia in women among others is 53.0 in the same areas.<sup>[2]</sup> Little research is available on the health of the ST population. Tribal mental health is an ignored and neglected area in the field of healthcare services. Further, little data are available about the burden of mental disorders among the tribal communities. Health research on tribal populations is poor, globally. Irrespective of the data available, they have worse health indicators and less access to health facilities.<sup>[3]</sup> Even less is known about the burden of mental disorders in the tribal population.

It is also found that the traditional livelihood system of the tribes came into conflict with the forces of modernization, resulting not only in the loss of customary rights over the livelihood resources but also in subordination and further, developing low self-esteem, causing great psychological stress. This community has poor health infrastructure and even fewer mental health resources, and the situation is worse when compared to other communities living in similar areas. Only 15%–25% of those affected with mental disorders in LMICs receive any treatment for their mental illness, resulting in a large “treatment gap.”<sup>[4]</sup> Treatment gaps are more in rural populations, especially in tribal communities in India, which have particularly poor infrastructure and resources for healthcare delivery in general, and almost no capacity for providing mental health care.

### **Alcohol and substance use Disorders.**

Five studies reviewed the consumption of alcohol and drugs. In an ethnographic study conducted in three western districts in Rajasthan and the Northeastern States of India, 350 drug users were interviewed. Opium consumption was common among both younger and older males during non-harvest seasons. The common causes for using opium were relief of anxiety related to crop failure due to drought, stress, getting a high, being part of peers, and increased sexual performance.<sup>[3]</sup> In a study conducted in Arunachal Pradesh involving a population of more than 5000 individuals, alcohol use was present in 30% and opium use in about 5% of adults. Contrary to that study, in Rajasthan, the prevalence of opium use was higher in women, and socioeconomic factors such as occupation, education, and marital status were associated with opium use.<sup>[5]</sup> The prevalence of opium use increased with age in both sexes, decreased with increasing education level, and increased with employment. It was observed that wages were used to buy opium. In the entire region of Chamlang district of Arunachal Pradesh, female substance users were almost half of the males among the tribal population. Types of substances used were tobacco, alcohol, and opium. Among tobacco users, oral tobacco use was higher than smoking. The prevalence of tobacco use was higher among males, but the prevalence of alcohol use was higher in females, probably due to increased access to homemade rice brew generally prepared by women.<sup>[6]</sup> This study is unique in terms of finding a strong association between religion and culture with substance use.

Alcohol consumption among tribals in Nagaland and Manipur is perceived as a male activity, with many younger people consuming it than earlier. A study concluded that alcohol consumption among them was

less of a “choice” than a result of their conditions operating through different mechanisms. In the past, drinking was traditionally common among elderly males, however, the consumption pattern has changed as a significant number of younger men are now drinking.<sup>[1]</sup> Drinking was clustered within families as fathers and sons drank together. Alcohol is easily accessible as the government itself provides opportunities. Some employers would provide alcohol as an incentive to attract tribal men to work for them.<sup>[5]</sup>

In a study from Jharkhand, several tribal community members cited reasons associated with social enhancement and coping with distressing emotions rather than individual enhancement, as a reason for consuming alcohol. Societal acceptance of drinking alcohol and peer pressure, as well as high emotional problems, appeared to be the major etiology leading to a higher prevalence of substance dependence in tribal communities. Another study found high lifetime alcohol use prevalence, and the reasons mentioned were increased poverty, illiteracy, increased stress, and peer pressure.<sup>[7]</sup> A household survey from Chamlang district of Arunachal Pradesh revealed that there was a strong association between opium use and age, occupation, marital status, religion, and ethnicity among both sexes of tribals, particularly among Singhpho and Khamti. The average age of onset of tobacco use was found to be 16.4 years for smoked and 17.5 years for smokeless forms in one study.<sup>[8]</sup>

### **Common Mental Disorders and Socio-Cultural Aspects**

Suicide was more common among the tribal population (14.2%) compared to the urban population in general (0.4%–4.2%). Suicides were associated with depression, anxiety, alcoholism, and eating disorders. Of all the factors, depression was significantly high in people who attempted suicide. About 5% out of 5007 people from thirty villages comprising ST suffered from CMDs in a study from Manipur, Meghalaya, Manipur, and Arunachal Pradesh. CMDs were defined as moderate/ severe depression and/or anxiety, stress, and increased suicidal risk.<sup>[9]</sup> Women had a higher prevalence of depression, but this may be due to cultural norms, as men are less likely to express symptoms of depression or anxiety, which leads to underreporting. Marital status, education, and age were prominently associated with CMD. In another study, gender, illiteracy, infant mortality in the household, having adults living in the household, large family size with four children, morbidity, and having two or more life events in the last year were associated with increased prevalence of CMD.<sup>[10]</sup>

Urban and rural STs from the community of Bhutias of Sikkim were examined, and it was found that the urban population experienced higher perceived stress compared to their rural counterparts. Age, current use of alcohol, poor educational status, marital status, social groups, and comorbidities were the main determinants of tobacco use and nicotine dependence in a study from the Andaman and Nicobar Islands.<sup>[11]</sup> A study conducted among adolescents in the schools of the hill districts of North-East revealed that about 5% of children from the tribal communities had emotional symptoms, 9.6% of children had conduct problems, 4.2% had hyperactivity, and 1.4% had significant peer problems. A study conducted among female employees examined the effects of stress, marital status, and ethnicity on mental health. The study found that among the three factors namely stress, marital status, and ethnicity, ethnicity was found to affect the mental health of the female workers most.<sup>[12]</sup> It found a positive relationship between mental health and socioeconomic status, with an inverse relationship showing that as income increased, the prevalence of depression decreased. A study among Ao-Nagas in Nagaland found that 74.6% of the population attributed mental health problems to psycho-social factors and a considerable proportion chose a psychiatrist or psychologist to overcome the problem. However, 15.4% attributed mental disorders to evil

spirits. About 47% preferred to seek treatment with a psychiatrist and 25% preferred prayers. Nearly 10.6% wanted to seek the help of both the psychiatrist and prayer group and 4.4% preferred traditional healers.<sup>[13]</sup> The prevalence of Down syndrome among the tribals in Chikhalia in Barwani district of Madhya Pradesh was higher than that reported in overall India. Three-fourths of the children were firstborn children. None of the parents of children with Down syndrome had consanguineous marriage or a history of Down syndrome, intellectual disability, or any other neurological disorder such as cerebral palsy and epilepsy in preceding generations. It is known that the tribal population is highly impoverished and disadvantaged in several ways and suffers a proportionately higher burden of nutritional and genetic disorders, which are potential factors for Down syndrome.<sup>[14]</sup>

### **Access to Mental Health-Care Services**

Generally, among the tribals, it was found that most people consulted faith healers rather than qualified medical practitioners and psychologists. There are few mental health services in all the tribal inhabited areas. Among the tribal population, there was less reliance and belief in modern medicine, and it was also not easily accessible, thus the healthcare systems must be more holistic and take care of cultural and local health practices. The Systematic Medical Appraisal, Referral, and Treatment (SMART) Mental Health project was implemented in thirty tribal villages of the North-East Indian States.<sup>[15]</sup> The key objectives were to use task sharing, training of primary health workers, implementing evidence-based clinical decision support tools on a mobile platform, and providing mental health services to rural populations. The study included 238 adults suffering from CMD. During the intervention period, 12.6% visited primary healthcare doctors compared to only 0.8% who had sought any care for their mental disorders before the intervention.<sup>[7,8]</sup> The study also found a significant reduction in depression and anxiety scores at the end of intervention and improvements in stigma perceptions related to mental health. A study in a South Indian tribal region used low-cost task shifting by providing community education and identifying and referring individuals with psychiatric problems as effective strategies for treating mental disorders in tribal communities.<sup>[9]</sup>

Through the program, the health workers established a network within the village, which in turn helped the patients to interact with them freely. Consenting patients volunteered at the educational sessions to discuss their experience with the effectiveness of their treatment. Community awareness programs altered knowledge and attitudes toward mental illness in the community. A study in Nilgiri district, Tamil Nadu, found that the community had been taking responsibility for the patients with the system by providing treatment closer to home without people having to travel long distances to access care.<sup>[16]</sup> Expenses were reduced by subsidizing the costs of medicine and ensuring free hospital admissions and referrals to the people. A study on the impact of gender, socioeconomic status, and age on the mental health of female factory workers in Jharkhand found that tribal women were more likely to face stress and hardship in life due to diverse economic and household responsibilities, which, in turn, severely affected their mental health. Prevalence of mental health morbidity in a study from the Sundarbans delta found a positive relation between psychosocial stressors and poor quality of life.<sup>[17]</sup> The health system in that remote area was largely managed by “quack doctors” and faith healers. Poverty, illiteracy, and detachment from the larger community helped reinforce superstitious beliefs and made them seek both mental and physical health care from faith healers. In a study among students, it was found that children had difficulties in adjusting to both ethnic and mainstream culture. Low family income, inadequate housing, poor sanitation, and unhealthy and unhygienic living conditions were some environmental factors contributing to the poor

physical and mental growth of children.<sup>[11]</sup> It was observed that children who did not have such risk factors maintained more intimate relations with their family members. Children belonging to disadvantaged environments expressed their verbal, and emotional needs, blame, and harm avoidance more freely than their counterparts belonging to less disadvantaged backgrounds. Although disadvantaged children had poor interfamilial interaction, they had better relations with the members outside the family, such as peers, friends, and neighbors.

Another study in the tribal region found that epilepsy was higher among tribal patients compared to non-tribal patients. Most patients among the tribal are irregular and dropout rates are higher among them than the non-tribal patients. Urbanization *per se* exerted no adverse influence on the mental health of a tribal community, provided it allowed the preservation of ethnic and cultural practices. Women in the tribal communities were less vulnerable to mental illness than men. This might reflect their increased responsibilities and enhanced gender roles that are characteristic of women in many tribal communities. Data obtained using culturally relevant scales revealed that relocated Sahariya suffer a lot of mental health problems, which are partially explained by livelihood and poverty-related factors.<sup>[13]</sup> The loss of homes and displacement compromise mental health, especially the positive emotional well-being related to happiness, life satisfaction, optimism for the future, and spiritual contentment. These are often not overcome even with good relocation programs focused on material compensation and livelihood re-establishment.

## Discussion and Conclusion

Mental and substance use disorders contribute majorly to health disparities. To address this, one needs to deliver evidence-based treatments, but it is important to understand how far these interventions for the indigenous populations can incorporate cultural practices, which are essential for the development of mental health services. Evidence has shown a disproportionate burden of suicide among indigenous populations in national and regional studies, and a global and systematic investigation of this topic has not been undertaken to date. Previous reviews of suicide epidemiology among indigenous populations have tended to be less comprehensive or not systematic, and have often focused on subpopulations such as youth, high-income countries, or regions such as Oceania or the Arctic. The only studies in our review that provided data on suicide were in an isolated tribal population of North-East India, and tribal communities from Sunderban delta. Some reasons for suicide in these populations could be the poor identification of existing mental disorders, increased alcohol use, extreme poverty leading to increased debt and hopelessness, and lack of stable employment opportunities. The traditional consumption pattern of alcohol has changed due to the reasons associated with social enhancement and coping with distressing emotions rather than individual enhancement.

Faith healers play a dominant role in treating mental disorders. There is less awareness about mental health and available mental health services and even if such knowledge is available, access is limited due to the remoteness of many of these villages, and often it involves high out-of-pocket expenditure. Practitioners of modern medicine can play a vital role in not only increasing awareness about mental health in the community but also engaging with faith healers and traditional medicine practitioners to help increase their capacity to identify and manage CMDs that do not need medications and can be managed through simple “talk therapy.” Knowledge of symptoms of severe mental disorders can also help faith healers and traditional medicine practitioners refer cases to primary care doctors or mental health professionals. Remote settlements make it difficult for tribal communities to seek mental health care. Access needs to be



increased by using solutions that use training of primary health workers and nonphysician health workers, task sharing, and technology-enabled clinical decision support tools. The SMART Mental Health project was delivered in the tribal areas of Andhra Pradesh using those principles and was found to be beneficial by all stakeholders.

Given the lack of knowledge about mental health problems among these communities, the government and non-governmental organizations should collect and disseminate data on mental disorders among the tribal communities. More research funding needs to be provided and key stakeholders should be involved in creating awareness both in the community and among policymakers to develop more projects for tribal communities around mental health. The Indian Psychiatric Society can play a role in coordinating research activities with the support of the government which can ensure regular monitoring and dissemination of the research impact to the tribal communities. There is a need to understand how mental health symptoms are perceived in different tribal communities and investigate the healing practices associated with distress/disaster/death/loss/disease. This could be done in the form of cross-sectional or cohort studies to generate proper evidence which could also include the information on prevalence, mental health morbidity, and any specific patterns associated with a specific disorder. Future research should estimate the prevalence of mental disorders in different age groups and gender, risk factors, and the influence of modernization. Studies should develop a theoretical model to understand mental disorders and promote positive mental health within tribal communities. Studies should also look at different tribal communities as cultural differences exist across them, and there are also differences in socioeconomic status that impact on ability to access care.

Research has shown that the impact and the benefits are amplified when research is driven by priorities that are identified by indigenous communities and involve their active participation; their knowledge and perspectives are incorporated in processes and findings; reporting of findings is meaningful to the communities; and indigenous groups and other key stakeholders are engaged from the outset. Future research in India on tribal communities should also adhere to these broad principles to ensure relevant and beneficial research, which has a direct impact on the mental health of the tribal communities.

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