The state of the Mental Health related conditions among the Scheduled Tribes and the Culture-Specific approaches and methods they apply for the Management of such conditions: A Bibliographic essay catering to the contemporary trends in Mental Health research in India.

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ABSTRACT

The World Health Organization has defined 'Health' as "a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity". The concept of mental health includes subjective well-being, perception of self-efficacy, autonomy, competence, and recognition of one's ability to realize one's intellectual and emotional potential. It is also defined as a state of well-being in which individuals realize their abilities or are able to cope with the stresses of normal life, be productive at work, and contribute effectively to their communities.

India is home to the largest tribal populations in the world with 8.6% of the total population belonging to Scheduled Tribes forming 705 tribal groups across India, a signifiacant section of which are suffering from a multitude of mental health issues. This article narrates the state of the mental health conditions pervading inside the tribal groups across India and their ability to cope with the emerging trends and issues responsible for the increase in cases of mental health problems. Tribal communities are not immune from the clutches of mental illness and the unique cultures of each tribal society have shaped their own understanding of mental illness and the strategies for its treatment/management. Further, it is observed that the decisions and choices taken by the authorities catering to the wider arena of mental health issues, which were imposed on the tribal groups without consulting their prerogatives and social proclivities, have led to a state of social-emotional distress and lethargy in terms of the treatment seeking behaviour.

Keywords: *Mental Health, Scheduled Tribe, Management, Treatment, Disease, Distress, Culture.*

Introduction

The diversity of India's population and its social and cultural practices continually influence people's perceptions of mental health issues. Over time, these social and cultural practices have insinuated how the public perceives the need for mental health treatment by emphasizing or minimizing over mental health concerns. Mental health is defined as a state of well-being rather than the absence of mental illness. The ability to create healthy relationships, emotionally balanced, free from severe anxiety or other debilitating symptoms, and the ability to cope with daily demands and obstacles are all signs of steady mental health condition (Bhagi, 1992).

Mental health in India is one of the biggest causes of disability and huge economic burden. According to the recent National Mental Health Survey (2016), one in ten Indians suffers from a mental illness. Especially between the ages of 20 and 40, when people are most productive, mental health problems are quite common. India, which has 705 distinct tribes and 8.6% of the population is made up of Scheduled Tribes, has the highest tribal population. Indigenous people are more prone to mental health problems for a number of reasons. Rapid social changes have adverse effects on people's behaviour, beliefs and social interactions. Due to the pressures of acculturation from living in urban areas and abusing alcohol and other drugs, they are more likely to suffer from a range of mental health problems. Mental health studies in general have been done in India, but unfortunate as it may, so far little has been done to address the mental health of the indigenous groups.

According to the World Health Organization, health "is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity". The idea of mental health encompasses one's subjective well-being as well as the perception of one's self-efficacy, autonomy, competence; and recognition of one's ability to achieve one's full intellectual and emotional potential person. It has also been described as a state of well-being in which people are aware of their abilities, can handle daily stress, be productive, and can make meaningful contributions to their communities (Agarwal, 2007).

Rationale behind the Study

Mental health in India is one of the biggest causes of disability and huge economic burden. According to the recent National Mental Health Survey (2016), one in every ten Indians suffers from a mental illness. Especially between the ages of 20 and 40, when people are most productive, mental health problems are quite common. Indigenous people are more prone to mental health problems for a number of reasons. Due to rapid social changes in their lifestyle, changes in belief system and community life, cross-cultural background of moving to urban areas and their use of alcohol and other drugs exposes them to a variety of mental health problems.

The Indian Psychiatric Association believes that data on Indigenous mental health is lacking and further research is needed to fill the knowledge gap. They added that very little is known about disease burden and inter-tribal patterns in terms of health dynamics (Janakiram et al., 2016). Indigenous peoples are more vulnerable to mental health problems than other parts of society because they are subject to more oppression and vulnerability. Despite its popularity in public health discourse, mental health research lacks the usual human resources and healthcare infrastructure (NHRSC, 2013).

Complex lifestyles, urbanization, acculturation, isolation and resettlement cause serious health and other socioeconomic problems among the tribes (Banerjee et al., 1986; Mishra, 2015). Epidemiological studies in many developing countries (including urbanization) show that the most common mental disorders are depression and anxiety disorders (Foster and Mayer, 1966). Mental health issues, till now are poorly researched and under-recognized by a section researchers and policymakers. Studies in Canada and Australia defined mental health more broadly than the WHO definition, which recognizes the factor of the state of mental illness (Foster and Mayer, 1966). They reflect the individual's healthy interests in relation to the community and the spiritual world where the understanding of disease rooted in culture, tradition, spirit, etc. They also have centuries of unique collective know-how to deal with it.

Therefore, through a “psychosocial lens”, the level of tribal mental health and related treatments must be assessed. The "psychosocial" prism is a way of diagnosing disease through the interaction between psychology (thoughts, feelings, emotions, behavior of the individual) and the

social world of the community. The most precious thing in the Tribal lives is the "social capital" that empowers them in times of crisis, but in most tribal areas the practice of science and development is radically simplified. Currently, tribes are in transition to adopt the process of cultural change (Mishra, Sinha and Berry, 1996).

Nandi (et al., 1992) states that tribal communities are not exempt from the madness rule. These pressures and the process of "cultural change" lead to mental health problems (Mishra, 2015). "Psychological alienation" affects both physical and mental health (Mishra, 2015). These changes are forced without their consent and cause pain and suffering. Several empirical studies have shown that tribes with better housing, shared family structure and better agricultural power are more prone to mental disorders. Therefore, there is a need to understand the cultural manifestations of epidemiological determinants and their beliefs about the etiology of mental illness in tribal populations. We also need to understand how treatments that address mental health problems can exist as long-term alternatives (Nandi et al., 1992; Berry, 1970).

Objective behind the Research

Mental health remains an important aspect of personal well-being which encompasses a balance of emotional well-being that enables individuals to live effectively and improve their day-to-day lives. Fundamental components of mental health include genetics, physical health, and environment (Lefley, 2010). Mental health encompasses our emotional, psychological and social well-being and affects how we think, feel and act. It also refers to a balanced approach to daily activities. Mental health plays an important role in all stages of life and is an important aspect of health (World Health Organization). Mental health includes subjective well-being, perceived self-efficacy, autonomy, ability to treat self and others, dependence, and self-awareness of one's intellectual and emotional capacity in a group environment.

Based on the above observations, the following bibliographic essay presents a list of the main underlying thematic objectives. a) To examine the ability of the studied population to cope with emerging trends and problems contributing to the increase in mental health problems. b) Identify the accessibility and readiness of the study population to deal with mental health issues. c) The

prevalence of common mental disorders in the study population and their underlying socio-cultural dimensions.

State of Mental Health issues among the Tribal population

The Scheduled Tribe (ST) population of India is 10.4%, out of whom 89.97% live in rural/tribal areas and 10.03% live in urban settlements (Census of India, 2011). The tribal groups are known as the indigenous people of the country. They are forest dependent and have a unique way of life known as tribal culture. But the urban industrial boom destroyed the natural habitats and cultural life of the tribes (Vidyarthi, 1976). They preserve cultural stereotypes, traditional values and beliefs, including traditional treatments to address mental and physical health problems (Subudhi et al., 2020). Complex lifestyles, urbanization, cultural change, displacement and eviction, as well as socioeconomic problems, caused serious health problems for the people of the tribes and mental health became a very important but emerging issue (Banerjee et al., 1986; Mishra, 2015).
Satyanarayana (et. al., 2017) found that the prevalence of anxiety disorders was 26.3% in urban high schools, 23.7% in tribal high schools and 18% in rural high schools. The prevalence of major depressive disorder in this study was highest among urban high school participants at 4.1%, compared with 3.5% rural and tribal 1.6% . The suicide rate among participants in this study was highest among rural high school participants (6.5%) compared with 6.2% in urban areas and lowest among ethnic minorities, numbering 3.2%. In this study, the prevalence of Attention Deficit Hyperactivity Disorder (ADHD) was highest among urban high school students at 4.1%, compared with 2% in rural and tribal at 2.2%. The maturation of children with adolescent ADHD leads to academic failure, low morale and self-esteem, and high rates of injury, substance abuse, and crime (ibid.).
Diwan (2012) found that among tribal school teachers, only ethnicity was associated with mental health. Tribal population was considered to have better mental health status than non-tribal people. This finding is consistent with previous research showing a relationship between human mental health and ethnicity. She also found a small effect of marital status on the mental health of both tribal and non-tribal students, and studies support the current findings (*see*, Dubber, 1999).

Mental illness also affects the emotional climate of the family (Tessler et al., 1987). This indicates that individuals with mental health problems exhibit aggression, confusion, stress, violence, which affect their families and cause tension between each member of the family, fuelling tension, dissatisfaction, stress, and so on in the family as a whole (ibid.). Mental health problems can affect the economic composition of families and reduce productivity as more time is spent caring for the mentally ill. As a result, family income can be affected by who earns or contributes. That being said, other members may also face psychological, behavioral, social, and emotional trauma that are more likely to develop mental illness later in life. Family members with severe mental illness can increase the family's mental health care costs and affect other family expenditures (Subudhi et al., 2020; Gianfransesco et al., 2005).

The roots of psychosis in the villages of *Adivasi* can be understood from a different angle than how people understand mental disorders. A strong belief in the cause of insanity is rooted in past sins. The idea of insanity stems from the belief that a person may have committed a crime in a previous life and will be punished in this life. The idea or concept that not all families have this problem treats mental illness as a personal problem. This is the story of respondents in the study who believed that their problem with someone was due to past deeds; a curse originating from the Supreme Almighty (Subudhi et al., 2020). One of the main things researchers observe in tribal culture is that the family and caregivers don't give up on the client. Prejudice exists in tribal culture, but families try to do all they can to save their patients.

Socio-Cultural aspects behind Mental Disorder

In another study; gender, illiteracy, infant mortality in the household, having less than 3 adults living in the household, large family size with more than four children, morbidity, and having two or more life events in the last year were associated with increased prevalence of Chronic Mental Disease (Singh et al., 2013). Both urban and rural population from the Sikkim’s Bhutia community were examined where it was found that urban residents experienced higher perceived stress than rural residents (Sushila, 2005). Age, current alcohol use, low educational attainment, marital status, social group and co-morbidities were the major determinants of tobacco use and nicotine dependence, found in a study based on Andaman and Nicobar Islands (Janakiram et al., 2016).

A study conducted among adolescents in the schools of rural areas of Ranchi district in Jharkhand revealed that about 5% children from the ST communities had emotional symptoms, 9.6% children had conduct problems, 4.2% had hyperactivity, and 1.4% had significant peer problems (Ali et al., 2019). A study of female teachers in Jharkhand looked at the effects of stress, marital status and ethnicity on female teachers' mental health. Research shows that of the three factors that are stress, marital status and ethnicity; ethnicity has the most impact on teachers' mental health. Study found a positive relationship between mental health and socioeconomic status, with an inverse relationship showing that as incomes increases, rates of depression decrease (Diwan, 2013). 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 (Diwan, 2013; Longkumar, 2013). The prevalence of Down syndrome among the Tribal population of Chikhalia in the Barwani district of Madhya Pradesh, is higher than that reported in the whole of India. Three-quarters of children with Down syndrome had their parents involved in consanguineous marriages or had a history of Down syndrome, intellectual disability or any other neurological disorder such as cerebral palsy and epilepsy in previous generations. Tribes are known to be very impoverished and marginalized in some respects and bear a correspondingly higher burden of nutritional and genetic disorders, which are potential causes of the Down syndrome (Lakhan, 2016).

Association between Substance Abuse & Mental Health Disorders

In an ethnographic study conducted in three districts of western Rajasthan, 200 opium users were interviewed. Opium use is common among young people and the elderly during off-season harvests. Common causes of opiate use are associated with the relief of anxiety, related to crop failure due to drought, stress, ejaculation, and decreased sexual performance (Ganguly et. al., 1995). In a study conducted in Arunachal Pradesh with a population of more than 5000, 30% of the population consumed alcohol and 5% consumed opium (Chaturvedi et al., 2004). In contrast

to this study, in Rajasthan, a higher percentage of women used opium and socioeconomic factors such as occupation, education and marital status were associated with the use of opiates (Ganguly et al., 1995). The prevalence of opiate use increases with age among both sexes, while decreases with gradual attainment of education and improved employment conditions. In the entire Chamlang district of Arunachal Pradesh, drug addicts make up almost half of the male ST population. The substances used are tobacco, alcohol and opium. Among the consumers, oral tobacco consumption is higher than that of cigarettes. Tobacco consumption is higher among men, but alcohol consumption is higher among women, possibly because women generally have easier access to home-cooked rice. This study is unique in terms of finding strong associations between religion, culture and substance use (Chaturvedi et al., 2013). Drinking the Paniyas in the district of Wayanad in Kerala, is seen as a male activity, with more young people consuming than before. One study concluded that their drinking was not a "choice" but rather became “habits” because their conditions have worked through different mechanisms. In the past, drinking was common among older men, but drinking habits have changed as a significant number of young men drink. Alcohol consumption, by and large is concentrated inside families, as fathers and sons drink together. Alcohol is available because the government makes it available. Some employers suggest drinking alcohol to encourage men to work for them (Thresia et al., 2011).

In a study from Jharkhand, some members of the Tribal community cited reasons related to the lack of social improvement and dealing with distressed emotions rather than personal improvement, as reasons to consume alcohol. Social acceptance of alcohol use and peer pressure, along with increased emotional problems, appear to be the main causes of higher rates of substance addiction in the community (Sreeraj et al., 2012). Another study found a high amount of lifetime alcohol consumption rate and the reasons mentioned were poverty, increased illiteracy, increased stress and peer pressure (Whiteford et al., 2013). A household survey in the Chamlang district of Arunachal Pradesh found a strong association between opium use and age, occupation, marital status, religion and ethnicity in both sexes, especially among the Singhpho and Khamti community (CASP, 2015). The mean age of smoking initiation was found to be 16.4 years for the smoking form and 17.5 years for the smokeless form in one study based on Kerala (Janakiram et al., 2016).

Pattern of HealthCare & Treatment Seeking Behaviour

Each culture has its own system of beliefs, traditions, knowledge and practices related to health and diseases and the tribal cultures across India also have their own health care systems built by their own belief systems. A significant section of tribal population believes that mental illness could be cured with the help of the healers. In the midst of uncertainty, the tribal people's first point of contact is the healer. Stigma also plays an important role in this arena. Even if a person has symptoms of mental illness, seeing a doctor is seen as a stigma, so people often prefer to see a healer. The healer has a special place in the community. Studies have found what people believe about the taking the medication and whether they would make any difference or not. They can tell the difference between serious mental illness and common mental illness in their own words. Healers, on the other hand, have their own networks and if one of the healers is unable to heal the patient, he may refer him to another healer who has treated similar people before. Studies have shown that the treatment of mental illness largely depends on the explanation for the illness for which the patient is suffering (Padmavati et al. 2005).

Over this context, healthcare seeking behavior cannot be considered in isolation. It has evolved with the identity of the family or community, based on the result of social, cultural and experiential factors. In the health system, healthcare seeking behavior can be seen in terms of "social capital" that affects not only the individual but also the community (MacKian, 2002). For example, in the Gond tribe of the Gadchiroli district, there are such traditions as *Korma* and *Gotul.* Korma is a menstrual hut where menstruating women are kept for 5-6 days until their period stops. During that period, women are not allowed inside of the house. Food and drink for their sustenance are provided by their families. Villagers consider *Korma* as a socializing place for women. When talking to people in the village, researchers have observed that there is no discrimination against the mentally ill among the villagers. If a woman has a mental health problem, she can take care of herself by going to *Korma,* if she wants to. *Gotul* is a place where young people can come, socialize, dance, and make new friends and even where they can find their other significant half. Even in *Gotul,* a person with a mental illness can come to observe dances and other activities (ibid.).

Mental health treatment-seeking behavior can also be understood with a common explanatory model in the community. Factors that influence healers' support in the community depend on the

type of illness, local interpretations of mental illness, users' socioeconomic status, and availability of services of mental health. In rural communities, faith healing and traditional healing are the main treatment options for people with mental illness (Thara et al., 1998). However, many processing options are used by the user depending on its availability. Medical treatment methods such as using control therapy or homeopathy are also widely applied by people. Madan (1969), when researching the help-seeking options of rural communities in southern part of India, reported that about 66% of users had used multiple forms of mental illness treatment.

In the decision-making process for mental illness treatment, studies have shown that in most cases family members make the decision (Padmavati et al., 2005). In addition, trust in mental illness treatment options, ease of access to facilities, accessibility, social stigma related to mental illness, affordability of services, belief systems about the causes of mental illness influence the family's decision to choose a particular treatment for mental illness. (Banerjee, 1997)

Jain and Jadhav (2009), noted that community psychiatry is largely dependent on drug induced treatment for mental disorders when the local communities' involvement and psychosocial approaches are neglected. Furthermore, it was also observed that villagers did not consider primary health care a part of their community structure and therefore, did not find primary health care reliable for the treatment of mental illness. Thus, it is argued that villagers' reliability in the health system, accessibility and affordability determine treatment choices for people with mental illness (ibid.).

Culture Specific Approaches in Diagnosing and Managing Mental Health Issues: Road to a Sustainable Alternative

Through the ages, culture has been defined differently and is considered an abstract concept. Despite this fact, it is generally accepted that culture consists of a set of shared beliefs and values. An individual's cultural background plays an important role in understanding health, illness, treatment patterns, and help-seeking behavior (Gopalkrishnan, 2014). Nandi (et al. 1980) mentioned that tribal communities were not spared from the clutches of mental illness, a disease that dates back to humanity. This is a myth that alludes to the fact that the tribes are 'happy primitive people' because they are very close to nature, away from modern technology and lead a

simple life. “Social exclusion” and “Psychological marginalization” affect their physical and mental health. This pressure and process of “cultural change” leads to mental health problems for them (Mishra, 2015). These changes are imposed on them without consulting them and this causes them stress and distress (Berry, 1970). Several empirical studies have revealed that tribes with better housing, shared family structure, and better agricultural power are more susceptible to mental illness (Nandi et al., 1977). Therefore, it is necessary to understand the representation of culture in terms of the determinants of health and wellbeing along with popular beliefs regarding the causes of mental illness in tribal populations (Chiu et al., 2010).

The unique culture of each society has shaped their understanding of mental illness as well as treatment options. Those who believe in the ‘biomedical model’ are more likely to see a psychiatrist for treatment (Srivastava, 2002). Some people still believe that supernatural powers, magical spirits, and possession are the causes of mental illness (Wanger et al., 1999). Others believe that a curse or punishment from a past life also becomes a cause of mental illness. In rural India, it is believed that mental illness is caused by being haunted by an evil or sinful spirit from a past life (Magnier, 2013). Epidemiological studies from various developing countries indicate that the most common mental disorders are depression and anxiety disorders (Foster & Meyer, 1966). Tribal people are known to be indigenous people with unique identity and culture. They have health care methods, formerly known as the "traditional health care system", based mainly on herbs, faith healing, and magical religious rituals (Chiu et al., 2010).

Shankar (et al. 2006), in a study shows various treatment concepts as well as treatment options which are still in practice by the traditional healers. He argues from the research that gaining insight into the local understanding of mental illness will also help medical practitioners use culturally appropriate drugs and treatments. The findings concluded that in ethnic minorities, cultural background plays an important role in understanding mental health problems as well as treatment options (ibid.).

In addition, studies have also shown different views and meanings of "suffering". User-defined distress as a problem does not manifest itself as a "symptom" which resides in the body and reflects itself upon examination. Dawar (2009) in a study by Darghas to understand mental illness from different angles argued that out of 95% of user responses, 85 attributed mental

illness due to witchcraft or black magic. Research continues to link religion and mental health which argues that religion and culture influence the manifestation of suffering.

In a study conducted in a rural tribal community in southern India, it was found that about 56% of the participants associated their illness with supernatural agents such as ghosts, evil spirits, and evil spirits and witch. In addition, the study also investigated the tribal community's understanding of epilepsy and intellectual disability which they consider a brain disorder, but symptoms of depression and psychosis are considered to be due to obsessions (Jiloha et al., 1997).

The symptoms of mental illness are perceived differently by different people based on their cultural, psychological, and spiritual understanding and beliefs (Lefley, 2010). If belief in mental illness is due to supernatural powers then most users prefers to seek out healers. About 70-80% of the Indian population living in rural areas with mental illness will visit a healer for treatment (Thara et al., 2000). Furthermore, in a study it was observed that in 74.7% of the rural population, the first point of contact for mental illness treatment was a healer. (Dawar, 2009)

DISCUSSION & CONCLUSION

One of the aims of this study was to explore tribal populations' perceptions of mental health and mental illness. The study succeeded in understanding tribal perceptions of mental illness by analyzing how a cultural belief affects perceptions of mental illness. In addition, research confirms the relationship between cultural beliefs and the causes of mental illness, as well as the treatment-seeking behavior of the population. The cultural beliefs of the tribes shape their understanding of mental health and mental illness. Understanding mental illness influenced the tribal population to search for the alternative mental illness treatment options and. For example, if a person believes that the cause of mental illness is past sins, they will seek help from a healer. Tribes' cultural beliefs about mental illness also shape their perceptions of mental health treatment options.

In rural settings where people trust healers more rather than doctors; partnering with healers and providing them with training in general mental health, and working with them to identify directions appear to be the best potent strategy available which will significantly contribute to the fight against disease burden. At the same time, there is a need to educate tribes about mental

health issues and provide model treatment options. The District Mental Health Program (DMHP) initiated by MOHFW, GOI along with the respective state agencies are operating successfully in many school districts. However, more community based facilities are needed to provide training for ASHA workers and community health workers and more mental health teams are required to work with tribal populations in rural settings.

Evidence has shown a disproportionate burden of suicidal phenomenon among the indigenous populations in our country. Previous critiques of suicide epidemiology amongst the indigenous populations across the world have tended to be much less complete or now no longer systematic, and their features are centered on subpopulations consisting of youth, high-profits countries, or areas consisting of Oceania or the Arctic (Diwan, 2012). The handiest research in our assessment which supplied facts on suicide are the *Idu Mishmis'*, a tribal populace of North-East India, and some tribal groups from *Sunderban* delta. Some motives for suicide in those populations might be the bad identity of present intellectual problems, accelerated alcohol use, intense poverty to accelerated debt and hopelessness, and shortage of solid employment opportunities (Singh et al., 2013; Chowdhury et al., 2008). The conventional approach considering alcohol as an inducing factor has been modified, because of the motives related to the social enhancement and dealing with distressed feelings in place of character enhancement (Mohindra et al., 2011; Sreeraj et al., 2012).

Religious healers play an important role in the treatment of mental disorders. There is little to no awareness about mental health and mental health services. Whether the knowledge is available but access is limited due to the location of the villages in remote areas and this often involves a high financial burden (Tripathy et al., 2010). In this regard, modern medicine practitioners can play an important role, not only in raising awareness of mental health in the community but also in engaging with religious healers, educators and traditional medicine practitioners to help foster their ability to identify and manage mental health related issues that are manageable within their range of action. Knowledge of the symptoms of serious mental disorders can also help faith and traditional medicine healers to refer cases, if needed, to a primary care physician or mental health professional. Remote location makes it difficult for the Scheduled Tribe community to find affordable mental health care. Access should be increased with solutions that utilize primary care

and non-physician training, task sharing, and technology-based clinical decision support tools (Tewari et al., 2017).

Given the lack of knowledge about mental health issues among the communities, governmental and non-governmental organizations should collect and disseminate data on the potential risk factors and symptoms which leads to serious mental disorders in Scheduled Tribe communities. More research funding is needed and the key stakeholders should be engaged in raising awareness both within the community and among the policymakers. Two recent meetings on Tribal Mental Health Roundtable organized by George Institute of Global Health, India, in 2017 (GIGH, 2017) and National Conference on Tribal Mental Health, first edition, organized by the Psychiatric Association of India in Bhubaneswar, in 2018 – identified several key priority research areas on mental health among the Tribal community. A national policy on the mental health of tribal community is advocated, which should be developed in consultation with key stakeholders. The Indian Psychiatric Association can play a role in coordinating research activities with government support, which can ensure regular monitoring and dissemination of the impact of research among the tribal communities.

According to researchers the impact and benefits of any research are amplified, when the studies are pushed through priorities, identified by the indigenous groups themselves which include their active participation; their understanding and views are included in methods and findings; the reporting of the findings are significant to the groups; and indigenous businesses and other key stakeholders are engaged from the start (Banerjee et al., 1986). Future studies on tribal groups in India must adhere to these ideas in order to produce relevant and useful findings that have a direct impact on the intellectual fitness of the Tribal groups. There is also a desire to continuously supplement the available literature associated with intellectual fitness of the Tribal population, from using culturally appropriate tested units to emphasizing on the degree of intellectual morbidity; and using qualitative studies to know about the perceptions and barriers to help-seeking behaviour among the tribal groups (Leske et al., 2016).

There is a dire need to understand how mental health symptoms are perceived in different Tribal communities and to investigate the possibilities for treatment and management options. This can be done with cross-sectional study or a cohort study with option for a meta-analysis, based on the

wider range of information on morbidity, prevalence of mental illness, and any specific patterns related to a particular disorder. Future research should estimate rates of mental disorders in different age groups and sexes, risk factors and effects of modernization. Studies should develop a theoretical model to understand mental disorders and promote positive mental health approach among the Tribal communities. Studies should also focus on the cultural differences between the tribes and the differences in socioeconomic status that affect access to healthcare.

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