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A Comparative Study of Mental Health among Tribal Adolescents of Two Districts

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Abstract: Mental health is an important aspect of healthy adolescent development as this stage is considered to involve significant emotional, social and psychological, physical changes. Adolescents belonging to tribal communities may experience various social, educational, cultural and environmental circumstances that can influence their mental health. The present study was undertaken to assess and compare the mental health of tribal adolescents belong to two selected districts that is Dungarpur and Basnwara. A quantitative cross sectional comparative research design was adopted for the study. The sample consists of 60 tribal adolescents, with 30 each from two districts. Mental Health was assessed using a standardized psychological assessment tool. Descriptive Statistics, including mean and standard deviation, were used to describe the mental health scores of the participants. An independent t test was used to examine the difference in mental heath between the two district groups. The findings indicated differences in the mental health scores of tribal adolescents form the two districts, also the statistical significance of this difference was determined through the test. The study highlights the importance of understanding the mental health experiences of tribal adolescents within their specific social and geographical contexts.
Keywords: Mental health, tribal adolescents, comparative study, districts, psychological wellbeing.

Introduction

Mental Health: Most of us think about that when something goes wrong, when someone feels low, anxious or unable to cope then it can be defined as mentally unhealthy, but mental health is actually much bigger than the absence of illness. The World Health Organization describes "mental health as a state of wellbeing in which a person can realize their own abilities, cope with the normal stresses of life, work productively and contribute something meaningful to their community. In simple words, mental health is not just about not being sick." It is about feeling steady enough inside yourself to handle whatever life throws at you, to keep learning and growing and to still have something left over to give to the people around you. It includes things like emotional stability, a healthy sense of self-worth, the ability to bounce back after a setback, workable coping skills, relationships that feel safe and the confidence to make decisions about one's own life.

This every day, wellbeing-based way of thinking about mental health matters because it shifts the focus away from just treating problems and toward building a life that actually feels good to live. A person can be free of any diagnosed disorder and still not be mentally healthy in this fuller sense, just as a person managing a mental health condition can still lead a full and meaningful life. Mental health, then, sits on a spectrum. It moves depending on what is happening in a person's life, their relationships, their environment and the pressures they are under at any given point in time.

Mental Health Among Adolescents: Adolescence is one of the most important stretches of this spectrum, because it is when so much of a person's mental health foundation gets built, for better or worse. This is the stage between childhood and adulthood, roughly between the ages of ten and nineteen according to the World Health Organization, though many researchers now argue this window should stretch closer to twenty-four given how much longer young people take to settle into adult roles today. During these years the brain is still developing, especially the parts responsible for emotional regulation and decision making, while at the same time adolescents are dealing with new academic pressure, changing friendships, questions about identity and, for many, their first real taste of independence. It is a lot to handle all at once, and it is exactly why adolescence is considered such a sensitive window for mental health.

The numbers make this clear. Mental health conditions are now recognized as one of the biggest contributors to the overall disease burden among young people worldwide. Estimates from UNICEF and the World Health Organization suggest that around one in seven adolescents globally lives with a diagnosable mental health condition, which works out to well over one hundred and fifty million young people.

Anxiety and depression alone make up roughly forty percent of these cases, followed by conduct disorders and attention-related difficulties. Global studies tracking the burden of mental disorders from 1990 onward have also found that these numbers have kept climbing rather than levelling off, with the COVID-19 pandemic adding further strain through school closures, disrupted routines and reduced access to support systems. In India specifically, adolescents make up a very large share of the population, and mental health difficulties are known to account for a significant portion of the country's overall disease burden among young people, with a large share of these problems first showing up before the age of fourteen.

A teenager going through anxiety or low mood might just look moody, withdrawn or unmotivated, and these signs are easy to write off as a normal part of growing up. Left unnoticed, though, these patterns can carry forward into adulthood, affecting everything from academic performance to relationships to long-term physical health. This is part of why researchers keep pushing for early identification and support during these years specifically, rather than waiting until problems become more serious later on.

How Mental Health Looks Different in Tribal Areas: If adolescence is already a sensitive period for mental health, growing up in a tribal community adds another layer entirely, one shaped by geography, culture and access rather than just age and biology. Tribal communities in India, which make up roughly eight and a half percent of the country's population, often live in remote and geographically isolated areas with limited infrastructure, weaker healthcare access and lower rates of formal education. These are not small details. They directly shape how mental health difficulties show up, how often they get noticed and whether anyone is around to help when they do.

Research directly comparing tribal and non-tribal adolescents backs this up. An early study by Venu Gopal and Ashok (2012) found a noticeably higher rate of emotional and behavioral difficulties, including anxiety, low mood, withdrawal and attention problems, among tribal adolescents compared to their non-tribal peers. A more recent cross-sectional study conducted among tribal and non-tribal adolescents in a rural block of Jharkhand found a similar pattern, with tribal adolescents reporting higher rates of depression, anxiety and stress than adolescents from the surrounding non-tribal population, despite both groups living in the same broad rural setting. A separate community-based survey conducted among tribal adolescents in a district of West Bengal found that as many as two-thirds of the sample were at meaningful risk of developing a clinically significant mental health problem, with peer-related difficulties standing out as especially common (Basu, Maity, Ghosh & Roy, 2018). These are not isolated findings. Across multiple states and multiple research teams, the same pattern keeps showing up: tribal adolescents tend to carry a heavier mental health burden than their non-tribal counterparts, even when researchers try to hold other factors steady.

What is just as interesting, though, is that this burden is not spread evenly across tribal India either. It depends on which specific district or region a study looks at. A large multi-site study covering tribal adolescents in Gujarat, Tamil Nadu and Meghalaya found statistically significant differences in psychiatric morbidity between the three sites, with one state showing considerably higher rates than the others despite all three populations being tribal (Gharat et al., 2024). Even within a single state, this kind of variation shows up. A study comparing two neighbouring districts of Meghalaya found different patterns of risk between them, despite both falling under the same state government and broadly similar tribal populations (Suting & Ali, 2024). Studies from Ranchi in Jharkhand, Kohima in Nagaland and the Araku Valley in Andhra Pradesh have each reported quite different rates of emotional and behavioural problems among tribal adolescents, suggesting that where exactly a tribal adolescent grows up matters almost as much as the fact that they are tribal in the first place.

Put together, tribal adolescents are not just facing more mental health difficulty on average. They are also facing far fewer resources to deal with it, and how severe that gap feels depends heavily on the specific district or region they happen to call home.

This is exactly why understanding tribal adolescent mental health cannot rely on a single national picture or even a single state-level picture. The evidence consistently points toward real, meaningful differences from one district to the next, shaped by local infrastructure, community attitudes and how isolated or connected that particular region happens to be. Any study of tribal adolescent mental health, including the present one, needs to take this district-level texture seriously rather than treating tribal India as one uniform experience.

India is home to one of the largest tribal populations in the world, numbering in the tens of millions of people. Among the states of India, Rajasthan holds a notable place in this picture, ranking among the top states for tribal population size according to the 2011 Census. Despite this scale, tribal communities in India remain underrepresented in mainstream research, policy discourse and public conversation, which often treat tribal life as peripheral rather than as a population and culture worth understanding in its own right. This gap becomes even more pronounced when the focus narrows to tribal adolescents, a group who sit at the crossing point of two significant transitions at once: the universal developmental shift from childhood to adulthood and the more specific cultural negotiation between tradition and the pressures of modernization.

Before turning to adolescence itself, it is worth pausing on what the term "tribe" actually means, since this word carries a long and somewhat contested history. Historically there has been little consensus on its definition. Early

evolutionary anthropologists viewed tribal life through a technological lens, treating it as a lower and earlier stage of societal development on a path toward the more modern, nuclear and self-sufficient family units associated with Western societies. Morgan (1877) offered a different reading, describing the tribe as a political unit formed by kinship and shared descent. Durkheim (1984) took this further by distinguishing between two forms of solidarity that hold societies together. Stripped of this theoretical framing, a tribe in a simpler and more everyday sense is a community of people who live at the margins of urban, and at times rural, life, close to the natural environment and bound together by shared language, custom and livelihood. Tribal groups tend to practice endogamy and often remain somewhat separate from the broader population, a separation historically tied to relative disadvantage in education, occupation and social standing. In recognition of this disadvantage the Indian Constitution, through Article 342, designates certain tribes as Scheduled Tribes, extending to them reservations intended to support their educational and socioeconomic development (India, 1949). Whether these measures have succeeded in closing the gap they were designed to close remains an open and debated question, complicated further by the fact that regional identities in India, such as being Bengali in Bengal or Gujarati in Gujarat, often carry their own set of rights and privileges that scheduled tribes may not fully share, leaving them at a relative disadvantage even where formal protections exist (Xaxa, 1999).

It is also worth briefly distinguishing tribe from caste, since the two were historically used interchangeably by the British colonial administration despite being conceptually distinct.

Turning to Rajasthan specifically, the state's tribal population makes up close to fourteen percent of its total population according to the 2011 Census, placing Rajasthan sixth nationally in terms of tribal population size, behind Madhya Pradesh, which holds the top position. Within Rajasthan, Udaipur district has the highest concentration of tribal residents while Bikaner has the lowest. The state is home to a range of tribal groups including the Bhils, Minas, Damor, Garasia, Kathodi, Kokna, Koli, Nayaka, Patelia, Sahariya, Kanjar and Sansi, each distinguished by their own customs, trades, fairs and festivals, though the Bhils and Minas together account for the majority of the state's tribal population.

T aken together, these threads point toward a fuller and more balanced understanding of tribal adolescence, one that neither romanticizes hardship nor reduces tribal youth to a list of disadvantages and deficits. The present study sets out to examine tribal adolescents in Rajasthan through this mental health lens, focusing specifically on differences across districts viz Banswara and Dungarpur.

Review of Literature

Gehrat et al. 2024 studied on adolescent mental health across India's tribal belt suggests that prevalence rates vary considerably depending on the district and state in which a study is conducted, even when similar screening tools are used. In one of the more direct comparisons available, a cross-sectional survey of 623 indigenous tribal adolescents conducted across three Indian sites, Valsad in Gujarat, the Nilgiris in Tamil Nadu, and East Khasi Hills in Meghalaya, found statistically significant site-wise differences in psychiatric morbidity, with Gujarat showing the highest prevalence and Meghalaya somewhat lower, and these figures came out considerably higher overall than the prevalence reported for adolescents in India's National Mental Health Survey.

Ali et al. 2024 explicitly noted that the prevalence of emotional and behavioral problems reported in Nagaland was lower than the rates found among tribal adolescents surveyed across five northeastern states including Assam, Meghalaya, Nagaland, Manipur and Arunachal Pradesh reinforcing that even within the same broad region, district of residence appears to shape reported mental health burden.

Suting & Ali, 2024 did a within-state comparison in Meghalaya as well. A study comparing schools in the Ri-Bhoi district and the East Khasi Hills district found an overall mental health problem prevalence of roughly 31% among school-going tribal adolescents, with risk factors such as community disorganization, poor family management and low school commitment differing in their strength of association across the two district settings.

Karuturi & Kandi,2024 did a study of college students in the Araku Valley region of Andhra Pradesh reported very high rates of psychological distress, including disturbing intrusive thoughts in nearly three quarters of students, along with elevated loneliness and depression, figures well above what has been reported in most other district-level Indian studies of tribal youth.

Taken together, this body of literature indicates that district of residence is not incidental to mental health outcomes among Indian tribal adolescents. Differences in geographic isolation, healthcare infrastructure, state-level tribal population share and local socio-cultural context appear to produce meaningfully different prevalence rates from one district to the next, even among populations that share a broadly similar tribal identity. This variation is a central reason the present study treats district and regional context as relevant variables.

Methodology: A quantitative, cross-sectional comparative research design was adopted to examine the difference in mental health among tribal adolescents belonging to two selected districts that is Dungarpur and Banswara.

The total sample of 60 tribal adolescents age range 13 to 19 years, that is 30 adolescents each from Dungarpur and Banswara was taken for the study.

Objective: To compare the mental health of tribal adolescents belonging to two districts that is Dungarpur

and Banswara.

Hypothesis: There will be no significant difference in the mental health scores of tribal adolescents belonging to the two selected districts.

Variables: Independent Variable: Two districts (Dungarpur, Banswara)

Dependent Variable: Mental Health

Tool Used is Mental health battery by Arun Kumar Singh and Alpana Sengupta (1971). It consists of emotional stability, autonomy, security-insecurity, self-concept, intelligence and overall adjustment.

For statistical analysis as the sample size is 30 participants from each group so descriptive analysis and t-test is calculated.

Inclusion Critera: Participants should:

1. Adolescents within the age range defined for the study (13 to 18 years)
2. belong to the tribal population/community
3. residents of the selected district
4. enrolled in the schools from which the sample is drawn
5. willing to participate in the study
6. understand the language in which psychological tool is administered

Exclusion Criteria: Participants may be excluded if they:

1. Outside the specified age range
2. Do not belong to the tribal population
3. are not residents/students of the selected district
4. are unwilling to participate
5. have difficulty understanding the instructions or language
6. are unable to complete the assessment

Result Tables

Table 1: Descriptive Statistics for Mental Health Scores by District

District	N	M	SD
Dungarpur	30	67.70	10.84
Banswara	30	61.90	6.23
Total	60	64.80	9.24

M = mean; SD = standard deviation.

Table 2: Independent Samples t-Test for Mental Health Scores by District

Variable	Variance Assumption	t	df	Sig. (2-tailed)
Mental Health	Equal variances assumed	2.541	58	.014
	Equal variances not assumed	2.541	46.26	.014

Discussion: Adolescents from Dungarpur scored higher on mental health, on average, than adolescents from Banswara. The average score in Dungarpur was 67.70, while in Banswara it was 61.90. The scores in Dungarpur were also more spread out (a standard deviation of 10.84) compared to Banswara, where scores stayed closer together (a standard deviation of 6.23). In simple words, most adolescents in Banswara reported fairly similar experiences, while in Dungarpur some adolescents were doing quite well and others were struggling more, so the district average hides a wider range of individual experiences.

The result came out significant, t (58) = 2.541, p = .014. This means there is only a small chance (about 1.4%) that a difference this large would show up if there were actually no real difference between the two districts. Since this is well below the usual cut-off of 5%, we can say with reasonable confidence that adolescents in Banswara and Dungarpur really do differ in their mental health scores. Both rows of the test, one assuming equal variances and one not, gave the exact same result, which tells us the difference in spread between the two groups was not big enough to cause any problems with the test itself.

This kind of gap between two neighbouring districts might feel surprising at first, but it actually lines up with what other researchers have already found in similar tribal populations across India. Gharat et al. (2024) studied tribal adolescents across three very different Indian states and found that mental health problems were not equally common everywhere, some places showed much higher rates than others, even though all the adolescents came from tribal backgrounds. Suting and Ali (2024) found something similar even within a single state, comparing two districts of Meghalaya and finding different patterns of risk between them. Closer to home, qualitative work carried out with Bhil communities in Banswara itself has pointed out that mental health is rarely spoken about openly in the district and that formal support systems are limited, which may help explain why some adolescents there are doing far better than others depending on the support available to them at home or in their community. Add to this the fact that mental healthcare access varies a lot across rural Rajasthan in general, and it starts to make sense why two districts sitting right next to each other on the map can still produce two quite different pictures of adolescent mental health. In short, this finding is not an isolated result. It fits into a growing pattern researchers keep noticing where a tribal adolescent grows up in India, right down to the specific district, seems to genuinely shape how their mental health turns out.

Implications of the Study:

1. The study can help create greater awareness about the importance of mental health among tribal adolescents. This encourages adolescents to recognize emotional and psychological difficulties and seek appropriate support when needed.
2. The findings may help parents and family members understand the psychological needs of adolescents. This can encourage supportive communication, emotional understanding, and a positive home environment.
3. Teachers and school authorities can provide supportive environments, identify students who may be experiencing difficulties, and facilitate referral to

appropriate psychological services when required.

4. The findings may be useful to psychologists, counsellors, and other mental health professionals in planning culturally appropriate and accessible mental health programmes for tribal adolescents.
5. The study may provide useful information for community-based mental health awareness programmes in tribal areas. Programmes focusing on emotional well-being, coping skills, resilience, interpersonal relationships, and help-seeking behaviour may be developed according to the needs of adolescents.
6. The findings may be useful for educational and social welfare authorities in planning adolescent mental health services in tribal communities. The study can draw attention to the need for accessible, affordable, and culturally sensitive psychological services in tribal areas.

Limitations of the study:

1. The study included only 60 tribal adolescents, with 30 participants from each district. Therefore, the findings may not be generalized to all tribal adolescents.
2. Only two districts were included in the study. Tribal communities in other districts may have different social, cultural, educational, and environmental characteristics.
3. Data were collected at one point in time. Therefore, the study cannot establish how mental health may change over time.
4. Mental health was assessed using a psychological tool, and the responses may have been influenced by participants' willingness to disclose their feelings and experiences.
5. The study focused primarily on mental health and did not comprehensively examine all the factors that may influence the mental health of tribal adolescents.
6. If participants were selected based on accessibility or availability, the sample may not fully represent the wider tribal adolescent population.
7. Some adolescents may have provided socially desirable responses or may have hesitated to report their actual feelings due to concerns about confidentiality or social expectations.

Suggestions for Future Research:

1. It is suggested that the sample size should be large enough to improve the findings.
2. Similar studies can be conducted across more districts and different tribal communities to obtain a broader understanding of tribal adolescents' mental health.
3. Future research can use a longitudinal design to examine changes in mental health across different stages of adolescence.
4. Further studies can examine the role of gender in the mental health of tribal adolescents.
5. Future research may investigate the relationship between mental health and resilience, psychological well-being, character strengths, social support, family environment, and academic achievement.
6. Qualitative studies involving interviews or focus groups may be conducted to understand the lived experiences, concerns, coping strategies, and psychological needs of tribal adolescents in greater depth.
7. Future studies should consider important contextual variables such as socioeconomic status, parental education, family structure, rural/urban residence, school environment, and access to mental health services.
8. Intervention-based studies can be conducted to assess the effectiveness of strength-based, resilience-building, and school-based mental health programmes among tribal adolescents.
9. Future studies may compare tribal and non-tribal adolescents to understand whether differences in mental health are associated with community and sociocultural contexts.
10. Researchers should consider developing or adapting culturally appropriate mental health interventions and assessment approaches that are sensitive to the language, traditions, and social context of tribal communities.

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