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Foreign report

Coconuts and conduct disorder

Child psychiatry in Kerala?

LATHA HACKETT, Senior Registrar, Department of Child and Adolescent Psychiatry, University of Manchester, Jesson House, Manchester Road, Swinton, Manchester M27 1FG; and RICHARD HACKETT, Registrar, Withington Hospital, Manchester

A large crowd throngs the out-patient hall and all 300 children cry in unison. The father of an eight year-old girl pushes her through the crowd until she reaches a partitioned cubicle where four doctors sit round a table. He puts her in front of the first doctor and tells him about the chest pain she has had for months. The doctor, struggling to hear above the din, takes a brief history and examines the girl standing up. The history is inconclusive and there are no signs; he cannot understand why her parents have bothered to make the 30 mile bus ride that morning; why didn't they accept the advice of the paediatricians they had consulted nearer their home? Usually he would have written a prescription for a tonic costing the father two days' wages, but this time he directs the girl and her father back through the crowd to where I sit, alone in my cubicle, separated from the gaze of the attenders by a saloon bar door.

I invite father and daughter to sit down. They come from an interior village that I have often passed through, consisting of 50 or so huts, two shops and, by far the biggest building, a mosque. The girl, Nazeema, eyes me anxiously. What sort of doctor invites children to sit down and doesn't carry a stethoscope? I ask about the family. Nazeema is the youngest of six daughters and one son. Her grandmother recently started treatment for pulmonary TB following episodes of chest pain and haemoptysis, the same two symptoms that preceded her grandfather's death a year ago. I ask about her daily routine. She rises early and goes with her brother and sisters to the Mudrassa (Islamic school) before 7 a.m. For the next two-and-a-half hours she recites the Koran with her classmates, after which she snatches breakfast before starting ordinary school at 10 a.m. There are 70 children in her class and despite it being a rural school, competition is fierce and there are important exams to be faced, even at her age. At 4 p.m. she goes back to the Mudrassa to read the Koran for the next three hours and then she goes home to do her homework. Her life makes no concession to childhood. Fearing her grandmother might die, she expresses her distress in the only language allowed. Chest pain serves as the way out of her predicament, physical illness being the only excuse the Mudrassa would countenance. Indeed the first person her father consulted had been the Unani (Muslim folk healer) physician, but even his medicine had not helped.

In the developing world, illness and death in childhood constitute one of the main yardsticks by which development is measured. The unquestioned assumption has been that only when physical morbidity and mortality have been reduced to Western levels can resources be spared to service the psychological needs of a developing country's children, although the parent of a disturbed child might not agree. Physical disorder in a child, although accompanied by great anxiety, elicits sympathy and an entitlement to medical care. Psychological disorder, on the other hand, elicits stigma and rejection for both the affected child and his family. This preference of overtly physical disorder influences both the provision of health care for children and priorities for research. Pioneers, peering down brass microscopes, made immense contributions to tropical medicine, defining the ecology of the arthropod-borne infections and the syndromes of malnutrition. But, perhaps due to a fond belief in the noble savage, psychological disorder went unnoticed.

After six years of psychiatric training in Britain we returned to my home town in Kerala, South India. Despite settling in Britain, my background had influenced my research interests. Like most developing countries, India is bursting at the seams with children. Five minutes walk in any coconut plantation in Kerala and you will pass dozens of them. The health service staggers along under this vast population never able to meet the demands made upon it, let alone ameliorate the causes of illness. Not only is there no provision for psychologically

disturbed children, there is no undergraduate or postgraduate teaching in child psychiatry.

The construct of psychiatric disturbance in children is culturally alien to both doctors and lay population. Deviant behaviour must either be possession or willful. Despite this, Nazeema's father's search for help illustrates a need.

Our aim on this journey home was to find the first bricks of information needed to build a service that could provide psychiatric care for these children. To ask the basic questions concerning morbidity we had chosen Rutter's two famous scales (Rutter, 1970) which we now planned to validate.

To translate the questionnaires into Malayalam we enlisted the help of a venerable old lady who had not only been a journalist and a teacher but had interpreted for Nehru on numerous occasions at the time of the freedom struggle and for his daughter, Indira Gandhi, since. Her one time trusteeship of the Government Childrens' Home proved useful to us later. Independent back-translation ensured that the meaning of the questionnaires was retained.

We now had to find samples of normal, conduct disordered and emotionally disturbed children. The absence of a child psychiatry service denied us the opportunity to tap into existing clinics for a sample of disturbed children. Instead we chose the daily self-referral paediatric clinic at the Medical College despite the possibility that children with somatic presentations might be over-represented. The oft-reported Asian propensity for somatising distress could stem from a popular lack of psychological mindedness as well as the available service shaping the presenting symptoms; you must have physical complaints if the only source of help is a physical illness sevice.

Calicut's paediatric department is the ultimate referral centre for the 10 million people of North Kerala. Parents arrive with desperately ill children after bus rides lasting many hours. Often these journeys are made because a local paediatrician wants to avoid a child dying under his care. To parents the department is a last hope, but their children die of encephalitis, snake bites and tetanus every day. As the parents wail, the medical staff try to look busy. The unrealistic expectations of the parents and the inability of any doctor to explain has led to an increasing misunderstanding and resentment of doctors by the public.

Our approach to the paediatric department received a sympathetic if bemused reaction from the professor. Indian academe mostly subscribes to the view that knowledge consists of memorising Western textbooks. He kindly promised us space in the outpatient department so that we could educate the junior doctors about when to suspect psychiatric disorder. The referrals grew from a trickle to a stream. Case finding means accumulating a case load and raising parents' expectations, denial of which is unthinkable.

Unlike the West where family dislocation usually stems from parental separation, distress in these children often followed illness or death in a close family member. Although Kerala, unlike most of India, has effectively outlawed the obscenities of child labour, the prevailing ideology of childrearing differs markedly from that in Britain. The extended family still offers much security, but children are still seen rather than heard. For many, the mosque or temple dominates the social and intellectual horizons, providing both the comforting certainties of life and an emotional hold to which our encouragement of self expression must have been a threat. None of the disturbed children we saw had ever been encouraged to draw or even seen felt tip pens before.

The Government Childrens' Home provided our conduct disordered sample. This institution comprised a crumbling colonial villa and a concrete barracks set at the end of a winding drive in a large compound full of coconut palms and arecanut trees. When we arrived all 70 children were practising the high jump while big vats of curry were cooking over a fire. As well as accommodation and classrooms, the compound housed the juvenile court which represented a remarkable concession to childhood. Proceedings were carefully designed not to intimidate the child. The room was an ordinary office and the judge, lawyers and police dressed informally and used Malayalam even for legal discussions. Half of the residents came through the court usually convicted of theft or ticketless travel. The rest were abandoned children from destitute families. India lacks child care legislation and almost all social work and most orphanages are in the voluntary sector, usually sponsored by Muslim or Christian institutions.

Our conduct-disordered sample consisted of children convicted in the juvenile court, diagnosis being presumptive because to interview them was 'against government regulations'. Our request to take photographs was refused on grounds of 'security'. I didn't press the matter but it was reminiscent of bizarre Indian regulations forbidding photography on railway stations. Our fleeting impression was of care rather than custody and an atmosphere in no way oppressive. Nothing physically stopped the children from absconding, in marked contrast to India's adult prisons. For many of these children admission would have ensured enough to eat if nothing else.

Our sample of 'normal' children came from two local schools. Kerala is renowned for having achieved the highest literacy rate in India, despite the burgeoning population forcing schools to run two shifts of pupils a day. Christianity took root in Kerala and teaching orders set up in schools that continue to serve every layer of society. Even in

rural areas the morning buses are crammed with uniformed children clutching exercise books (the scent of coconut hair oil and the hair-raising antics of the drivers on the country roads are an abiding memory). The education-mindedness of the population means that competition for the limited work and college places is unnaturally fierce. The mismatch between increasing population and limited educational opportunities means that this competitive ethic appears ever earlier; exams for admission to kindergarten are well established and it is a common sight to see six-year-olds taking a pile of books home every evening. The teachers I approached were unfailingly helpful. Surprisingly, many felt that this competition robbed children of their childhood and reduced education to memorising easily examinable facts. Many regretted that the volume of their work prevented them from taking a pastoral interest in the children. As a group they showed far greater psychological awareness than the doctors, readily recognising many unaddressed psychological problems in school children.

The case for child psychiatry in Kerala starts with the many children with psychological disorder. These children deserve genuine help, not just prescriptions for expensive tonics. A child psychiatry service would also serve to psychologically inform other branches of medicine. When children die, grief is unavoidable, but more empathy from the medical attendants would prepare parents for their loss and help to ease the bitterness that can follow. Finally, child psychiatry presents a challenge to an ideology that forces children to keep their distress to themselves and withstand the brutal pressures of competition. Perhaps subversively, child psychiatry challenges the central place of mosque or temple in the upbringing of children, insisting that children be respected as individuals and not as possessions of their families or their religion.

We intend to extend our small pilot project into a larger epidemiological study so as to provide the essential statements about morbidity needed to design a service. Malayalam versions of basic psychometric tests also need validation. Such a service must be broad, dealing with problems of child psychiatry, subnormality and paediatric neurology. The wider acceptance of paediatrics in India and its more favourable funding position suggests that child psychiatry should be established close to paediatric medicine rather than as a separate speciality.

Reference

RUTTER, M., TIZARD, J. & WHITMORE, K. (1970) *Education, Health and Behaviour*. London: Longman.

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