

## Infantile autism in Kenya

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*Clinical features of infantile autism in three African children from Kenya are described. There is no essential difference in features of childhood autism as described in the west. In this prospective study the authors were able to confirm the onset of major symptoms of infantile autism before the age of three years and also an upper socio-economic background of the parents of all three cases.*

**Key words : Infantile autism, in Africa.**

In 1943, Kanner gave a comprehensive description of the syndrome of infantile autism.<sup>1-4</sup> The behavioural characteristics of the condition include withdrawal from social relationships and extreme aloneness, attachment to odd objects, an obsessive desire for maintenance of sameness, stereotyped patterns of play and ritualistic behaviour, failure to develop language for the purpose of communication and impairment in the development of eye-to-eye gaze. The age of onset is either at birth or before three years. It is, however, not usually easy to discern autistic behaviour in very early infancy. The history would not indicate deviation or traumatization, that is, the child would be reported as having developed normally up to about two years.<sup>5</sup> Several of the studies that have been done have been retrospective,

therefore, the results have tended to be biased to some degree.

Little is known about infantile autism in the developing African countries.<sup>8</sup> Lotter used western criteria for selecting over 1300 cases of children who presented autistic-like behaviour. Of these only nine cases could be given the label<sup>6</sup> autistic.<sup>2</sup> At the time the children were seen by him, the youngest was<sup>9</sup> year old. Another study was carried out in Nigeria<sup>7</sup> to determine whether the condition existed in the indigenous population, four cases of autism were identified out of over 1000 children screened.

In the present paper, the authors attempt to give a description of cases seen by them during their clinical work in Nairobi, Kenya. The diagnosis was based on the characteristic and strict criteria outlined above.

### Report of Cases

All the cases were seen at the psychological assessment clinic in Nairobi during the period 1977 to 1980.

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*Case 1.* D.O. was first seen when he was three years and one month old for speech difficulties. He is the only child of a 29-year-old father who is a medical doctor, and a 26-year-old mother who works as a housekeeper in a 5-star hotel. He was born at full term and the delivery was normal. The milestones were normal except for speech. At the time of referral, he spoke only two words spontaneously : dada, and mama ! There was no family history of mental disorder or mental subnormality. The parents described him as a lonely child who would not stare at people nor allow himself to be picked up. He ate only when hungry but did not demand food given by gestures. The parents suspected deafness and took the child to an ENT specialist, the latter confirmed that the hearing was normal.

On examination the child was over-active, with excellent visual-motor and neuromuscular coordination. There was no eye-to-eye gaze, he did not like to be picked up and went into temper tantrums when frustrated. He looked 'intelligent' although this could not be confirmed as he was not cooperative on psychometric tests.

*Case 2 M.M.*

3 yr 3 mo - old - boy was brought for evaluation as he was suspected to be mentally sick by the parents. The father 33 years, is an engineer and the mother, 31 years, works as a polytechnic teacher. The labour was normal as was the early development. He sat and walked at appropriate times. When he was about 20 months old, the parents noticed that the child did not stare at them nor

demand anything, as expected of a 20 month-old boy. He did not develop speech and refused to mix or play with other children. At 2 years of age he engaged himself in 'odd activities' such as arranging and rearranging chairs for long periods of time and spitting in a glass for many minutes at a time. He was also seen tiptoeing and flicking his fingers constantly. When the parents sought medical advice, they were assured by the doctor that the child was 'normal' and no further advice was given.

At 30 months he started uttering a few words such as 'ruta' (take away), 'uma' (come down), 'tata' (aunt) and occasionally said bye-bye to his father. A little later the child was seen by a speech therapist, as the parents were not satisfied with his speech development. The speech therapist referred M.M. to the authors when he was just three years old.

At the time of referral M.M. was very active, he did not take interest in the surroundings at all, kept running, was extremely uncooperative thus making formal psychological testing impossible. He could spontaneously say 'baba' or 'bye-bye'. He refused to take a sweet or look at anyone. Physically he looked well-built and well-nourished.

This child is the third born in a sibship of four. The other children are normal, and the family history is non-contributory.

*Case 3 C.W.*, 5-year-old girl was the last born in a family of five children. Her father, 43 years, is a chairman of a parastatal organisation; the mother, aged 40, runs a prosperous business. There was no family history of mental

illness, epilepsy or mental retardation. She was born normally, sat when she was 6 months and walked at 11 months. When two years old, she spoke a few incomprehensible words. This girl was seen by neurologists and pediatricians for speech problems. The parents were, however, assured by the specialists that the child was normal 'in every respect and would talk in due course.' She had made no progress during the 20 years before she was seen by us. There was no past history of any significant illness.

When the authors saw her, C.W. was tiptoeing and running in circles. She muttered a few words saying that 'Wanji-ku (her name) says,...my hand'. She refused to look or talk to us, she would not cling to the examiner when picked up. She often flicked her fingers in front of her eyes and suddenly spun herself around.

C.W. was also seen at her home environment. There she was playing alone, self-engrossed but continued to arrange pebbles in long rows. She showed echolalia and repeated the words 'data', 'baba' and 'go'. She also spun herself around repeatedly and could walk along a narrow parapet wall in her garden, balancing herself nicely.

The child was seen by an educational psychologist a year before she was seen by us. The report stated, "...echolalia, the child does not use language to make her needs known but utters some phrases spontaneously..."

### Discussion

Lotter's study on the African continent confirms that infantile autism exists among the indigenous people. We were

able to confirm his observation that there are no basic differences in the presentation of the autistic syndrome in children in the developing world from those reported from the developed countries. Lotter observed that stereotyped behaviour, as mentioned in the western literature, is not so frequent. But our case 2 was noticed to arrange and rearrange chairs and to spit in a glass, and case 3 arranged pebbles in long rows. Thus all cases in this study showed (a) virtual absence of eye-to-eye gaze, (b) failure of speech development or the use of language as a medium of communication, (c) aloofness and (d) ritualistic behaviour at home and in the clinic.

The I.Q. of our cases was not formally assessed; our clinical impression, however, was that cases 1 and 3 may be subnormal while case 2 could be of normal I.Q. In Lotter's series<sup>6,8</sup> almost all the cases were subnormal or severely subnormal, and formal I.Q. assessment was not done. This fact will have to be corroborated by a follow-up study of our cases. Unlike many of Lotter's children, however, our cases were toilet-trained, could eat with a spoon and drink from a glass. Another important finding in this study was total absence of epileptic fits. We have cautioned the parents, however, about the possibility of epilepsy starting in their children in future. We arrived at the diagnosis without difficulty, due to the presence of the basic autistic criteria.<sup>8</sup>

The controversial observation that the parents of autistic children come from upper socio-economic stratum of the society is extensively discussed by Lotter. In the African society the distinction between different socio-economic classes

is not as well defined as in the developed countries. But in all our cases, the parents belonged to the upper socio-economic class (Table I). We must, however, point out that our clinic where these children were seen caters mainly for children from lower-economic class. We thus support the finding of Kanner as far as social class of parents of our cases is concerned. When a larger study, now in progress, is completed, we shall be able to comment again on this point.

Lotter had difficulty in establishing the onset of the illness; the authors of this paper were able to identify the time of onset of the symptoms of autism in all cases. Firstly, perhaps because the parents were educated, they noticed some kind of abnormality and sought professional assistance early; secondly, the assessment services were available when help was sought. It could, therefore, be stated with confidence that autistic features were evident before the third birthday of the children. Case 1 and 2

Table 1. Education and Occupation of Parents

	Father	Mother
Case 1	Medical Officer, (First class)	Form 6 (1st class), housekeeper in 5-star hotel
Case 2	Senior engineer (brilliant)	Teacher (1st division)
Case 3	Senior executive (First division)	Graduate (Above average performance)

were first seen by the authors while in case 3, the parents had seen neurologists and several paediatricians before consulting the authors.

To conclude, our study of infantile autism in Kenyan African children shows most of the features of autism to be the same as in the rest of the world.

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