

***Ogbanjelabiku* and cultural conceptualizations of psychopathology in Nigeria**

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Abstract

Ogbanje/abiku refer to people who are believed to cycle rapidly and repeatedly through birth and death. A consecutive familial sequence of births and deaths of infants is construed as the same child dying and being born over and over again. The Igbos believe that *ogbanje* results from subversion of human destiny by willful alliance of the newborn with deities who guard the postulated interface between birth and pre-birth (spirit) existence, while the Yoruba attribute many *abiku* to possession of a pregnancy by spirit pranksters most often referred to as *emere*. Surviving persons manifest abnormalities of psychological life with vivid fantasy life or dreams characterized by the presence of water, orgiastic play with unfamiliar children, and frightening contact with a water goddess—mammy water. Labeled children and adolescents often exhibit manipulative, histrionic dissociative, and other maladaptive behavior. They may also be gifted. Contradictory and facultative practices of excessive indulgence of and ostentatious hostility towards *ogbanje/abiku* children are described but are better understood as exhibitions of acceptance of life and rejection of death. This paper reports one study of the deployment of cultural cosmology in shaping individual and group adaptive responses to high infant mortality in Nigeria.

Introduction

Ogbanje is an Igbo (Nigeria) expression meaning a repeater or one who comes and goes (Ilechukwu, 1990/1991). It is a term commonly used to describe a child or adolescent that is said to repeatedly die and be repeatedly born by the same mother. The child is said to die before the next one is born in serial sequence. *Ogbanje* may also be used to refer to a living child, adolescent, or adult who was preceded in birth order by a child or children that died early in life and is thought to have this potential to “come and go”. This is a malignant form

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of reincarnation. The Igbo believe that an *ogbanje* has ties with deities or agents of deities who are said to guard the interface between birth and a postulated pre-birth state and who are believed to mediate life processes. Achebe (1986) synthesized an Igbo cosmology consisting of: *Elu-Igwe* (Sky or Heavens) ruled by *Chiukwu* (Great God); *Ala mmadu* (the human or physical world); and *Ala mmuo* (world of spirits or the dead). Five entities are intimately involved in the *ogbanje* myth: (1) *Chiukwu* (Great God); (2) *Mmadu*, the human or physical person; (3) *Chi*, the human personal spirit; (4) *Nne-mmiri* (Water mother); and (5) *Onabulurwa* (“he who shortchanges destiny”). The most frequently mentioned of these entities is *Nne-mmiri* (also referred to as mammy water, mami wota, or mami wata) who is said to control the water entry port into the human world. Less often mentioned is *Onabulurwa*, who is said to control the alternative overland (earth) portal. Before they are born, humans are thought to enter into a life contract with the Great God, *Chiukwu*, spelling out their life chart or destiny on earth. They then enter the human world at a point where the heavens (*Elu Igwe*) meet the physical world (firm land or water), and in doing so, they encounter the portal deities. Also, deities by their very nature crave worship, faithful devotion, and sacrifice. The entry portals therefore serve as their recruiting stations. These deities are said to test the resolve of transiting humans and attempt to alter their destiny or “life contract” previously agreed upon with *Chiukwu*. The Igbo believe that these contracts (destiny) are negotiated ab initio between the human and *Chiukwu* with the support of the *chi* (personal spirit). Humans in harmony with their *chi* are morally strong and are able to survive the challenges of the portal deities, entering the world with their destiny intact. Those in conflict with their *chi* are morally weak and succumb to the hazing, ridicule, allure, flattery, or enticement of the portal deities or their agents. In so doing, they have their life destinies altered to purposes considered less worthy by the culture. *Mammy water* is said to be bewitchingly beautiful and supremely indulgent, showering riches and extraordinary physical endowments, mental and artistic abilities on her devotees. Artist impressions of *mammy water* show a dark oriental looking woman entwined with two large serpents. She is also described as very temperamental, demanding perpetual worship, and extremely jealous of inter-human attachments, especially as occurs in marriage or married families. Any relationship with *mammy water* is understood as a commitment to a short life span, the single status or a life-long relationship—just as if they were married to *mammy water* or any of her agents. This commitment is said to bring desirable physical appearance, rapid and often phenomenal personal success in business, or some outstanding artistic or psychic talents but at the expense of human relationships. An equally problematic relationship is a putative linkage to other humans who happen to make a commitment to the portal deities at the same time, and therefore are also *ogbanje*. These companions or peer group (*ndi otu* in Igbo) are said to communicate supernaturally, often contacting each other through hallucinatory experiences or dreams. They are said to use such media to socialize, share group largesse, indulge sexual and other appetites, or impose group discipline and punishment which manifest as strange illnesses. They are also said to arrange to die at an agreed time

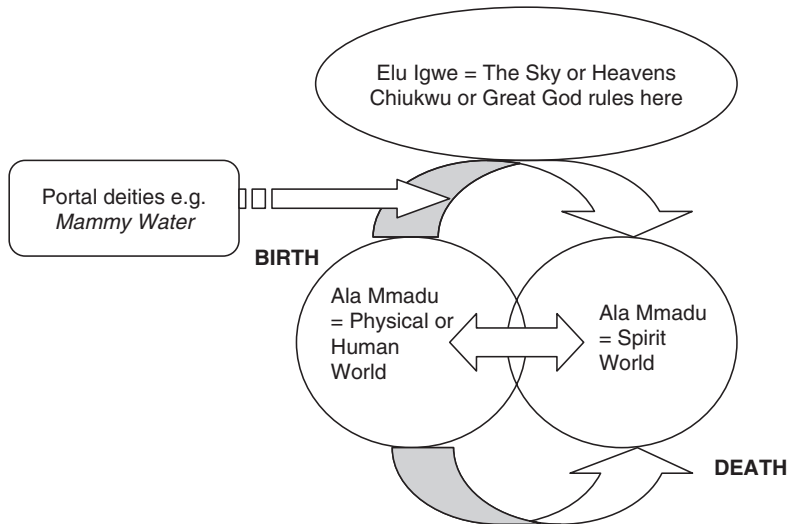


Figure 1. Igbo cosmology: Normal death-life cycle. The Ogbanje life cycle is conceptualized as a short circuit of the normal cycle that does not involve the Great God after the initial contract.

(through accidents or very brief illness). The Igbo believe that this agreement, referred to as *Iyiuwa* (literally: life contract), has a concrete representation in the form of a stone but could be any concrete object. Chinua Achebe (1958), defines *Iyiuwa* as a special kind of stone (“boundstone”) which forms the link between an *ogbanje* and the spiritual “companions” and narrates that “only if the *Iyiuwa* were discovered and destroyed would the child not die”. This complicated cosmological scheme is diagrammed in Figure 1.

On the other hand, Chinwe Achebe (1986), depicts the other portal deity, *Onabulawa*, as “more crude, dramatic or coercive”. This deity employs bullying, ridicule, and straightforward hazing instead of temptation or indulgence, unlike *mammy water*, to force individuals to change their destiny. Key targets for change include commitment to marriage, family, or children, presumably because these threaten the relationship to the deity or *ndi otu* (companions). Once committed, violations are punished with unusual illnesses, deformities, misfortune, or mysterious death. *Onabulawa* is also said to confer disagreeable characteristics associated with certain animals. Examples are the slyness and withdrawal behavior of a python; stubbornness and reticence but unusual agility of a chimpanzee; rodents wreaking havoc on farm crops; the brightness but disagreeable sharpness of a monkey; or the laziness of a sloth. *Ogbanje* are, at times, even said to become these animals, not just like them—very much like the Greek and Roman gods sometimes take on the likeness of men or animals. Also, in recent Igbo traditional medical practice, children with silky curly (Rastafarian type) hair generically named *dada* in Yoruba (Nigeria) language have been included in the *ogbanje* category (Ilechukwu, 1990/1991). Those traditional healers who subscribe to this classification regard the *dada* as *ogbanje* with a good prognosis. They postulate that the *dada* have “opted” to give early warning to

their parents (through their silky hair) about their *ogbanje* status so that the parents could, if they chose, initiate protective ritual measures.

Abiku

This literally means “born to die” in Yoruba. It is a concept similar to *ogbanje* among the Yoruba of Nigeria and Benin republic. A typical characterization is that they are “a cycle of wicked spirits who of their own volition enter the wombs of pregnant women and are born to die shortly after” (Awolalu & Dopamu, 1979). Cultural mechanisms presented to account for the phenomenon include “that some children come into the world after a pact with their heavenly playmates to return after a specified period” (Adegbola, 1983) and that “there are companies of wandering spirits (*elere*, *elegbe*, *emere*) given to the prank of entering into pregnant women for the sheer relish of the mischief... [and each]... must covenant with his companions that on a named date, he would return to his normal life” (Idowu, 1965). *Emere* refers to one who belongs to such a group and may be compared to *ndi otu* of the Igbo. The Yoruba believe that *emere* cause the *abiku* phenomenon, but not all *emere* are *abiku*. The impact of *abiku* related beliefs on the health behavior of modern Yoruba women still attracts much interest (Ogunjuyigbe, 2004). Soyinka (1980) and Clarke (1963) have been most responsible for popularizing *abiku* through his literary works.

Reason for study

The case of patient OGB forced attention to *ogbanje* that, until then, was regarded as of literary and sociocultural rather than clinical interest.

OGB, a 13-year-old male, Ishan, Nigerian, student resident in Lagos, was admitted via the emergency room, following deliberate self-poisoning. He had drunk a mixture of liquid soap, tobacco snuff (about 1.4 kg), and powdered mineral potash, leaving a suicide note blaming his younger sister who had repeatedly squealed on him. OGB had five younger siblings, all of whom lived with their parents in two rooms in a slum area of Lagos, Nigeria. His father was a clerical officer in a large commercial organization. He abused alcohol and was away from home most of the time. His mother had a very low budget corner store from which money and merchandise were often missing.

OGB's problems became noticeable in his first year in high school. He often returned very late from school with his school uniform torn or dirty. He claimed to be unaware of how these things happened. At midyear, his mother responded to a letter summoning both parents to OGB's school. The school principal informed her about OGB's perpetual absenteeism and the recovery of weapons from his school bag. The weapons included a knife, razor blades, and sharp-edged broken glasses. OGB denied ownership of the weapons or awareness of how the weapons got into his bag. He claimed that sometimes he found himself being repelled from school in a mysterious manner. Suspicions also fell on him for the losses from the corner store.

After consulting with neighbors, OGB's mother decided to take her son to a widely acclaimed open air Christian revival and spiritual healing service. After listening to a large number of testimonies, they decided on a consultation with the religious counselor. A 5-day fast was recommended for mother and son, at the end of which they were to see the counselor again. During the follow-up consultation, OGB confessed to being an *ogbanje*. He claimed to have been introduced to the *ogbanje* group by his sister (the same sister who was named in the suicide note) and detailed the feasting and carousing that allegedly occurred during their rendezvous by the beach and in the dead of the night. He, thus, implied his sister was also *ogbanje*.

The case history of OGB unraveled in a very interesting way. It was one of the earliest cases that strongly recommended *ogbanje* as a phenomenon deserving study. Sometimes, a patient presented in a deteriorated state because relatives had opted to complete *ogbanje* rituals before hospital treatment. At other times, a patient was taken out of hospital against medical advice because relatives thought behavioral problems were due to *ogbanje* and so inappropriate for modern hospital treatment. Could *ogbanje/abiku* problems be a recognizable discrete clinical psychiatric syndrome or group of syndromes? Could psychiatrically informed research of *ogbanje* lead to better treatment of afflicted patients and their families?

Method of study

This is a combination of hospital-based case studies and descriptive fieldwork.

For the period 1984–1987 a register was opened to record all patients at the Lagos University Teaching Hospital (LUTH) outpatients psychiatry clinic who described themselves as *ogbanje* or *abiku* or had been labeled as such. Thereafter, their charts were retrieved to extract socio-demographic data and DSM III-R psychiatric diagnoses (axes I, II and IV) and symptoms.

Fieldwork was done with the help of social workers and research assistants conversant with the language and culture in the parts of Nigeria where the study was being done. The study was done in Lagos state (a Yoruba-speaking area) and Anambra state (an Igbo-speaking area), respective states where the notions of *abiku* and *ogbanje* are indigenous.

The following were done:

- (1) Serial interview of three healers reputed to have special knowledge of *ogbanje* over a 3-year period in Nnewi, Anambra state of Nigeria;
- (2) Establishment of a case register in one of the healers' clinic to record socio-demographic data and problem assessment of visiting clients.
- (3) Accessing and interviewing healing assistants and inmates with problems attributed to *abiku/emere* or *ogbanje* in a Christian healing home in Lagos.
- (4) Personal names assigned to children thought to be *abiku* were inquired into from traditional (native) healers in the Lagos area by the collaborating social worker.

(5) Based on impressions gathered from early inquiries, four questions were formulated and responses sought from three healers in the Lagos area. It had become clear that many healers distinguished between *emere* and *abiku*, and so further clarification had to be sought. The questions were as follows:

- (i) Is it true that *emere* is different from *abiku*? In what ways are they different?
- (ii) Which is more common: *emere* or *abiku*? Is it true that *emere* has increased and *abiku* decreased in recent years?
- (iii) Are there parts of the world or Yoruba land where there are more *emere* or *abiku* than in others? Please explain.
- (iv) Is there anything else you want to tell us about *emere* or *abiku*?

Findings and discussion

For space considerations simplicity and clarity, only information gathered in the hospital setting, from two traditional Igbo healers, and from the responses from Yoruba healers will be presented. The information from the Christian Spiritual Healing home is mostly narrative and will be omitted. Since there is more detailed information about cases seen in the hospital, two cases seen in the hospital setting will be provided to illustrate psychopathology.

Ogbanje psychopathology as seen in hospital (LUTH) (see Table I)

Ogbanje patients seen here are predominantly female (female:male ratio = 5:1) and young (mean age = 20 years). However, the onset of psychological symptoms is at a mean age of 16 years. This represents a delay of 4 years before presentation in hospital. They are socio-economically disadvantaged, and fathers are absent, chronically ill, or dysfunctional. The numbers are few, and so no reliable conclusions can be reached.

The most common psychiatric symptoms are visual hallucinations (67%), but aggressive/destructive behavior (33%), conversion/dissociation disorders (25%), and vivid dreams about water and play (25%) are also noted. The loss of control, unexplained symptoms (conversion), changes in conscious expression (dissociation), and dreams about water (*Mammy Water*) and play (with spiritual companions) suggest *ogbanje* to the patients. Selective dream recall may also be a factor here. Histrionic personality traits are reported in 42%. Possible DSM-IV psychiatric diagnostic considerations here include bipolar disorder, conversion, and dissociative disorders.

Native healer, J2's clinic (Table II)

The population of *ogbanje* appears small ($N = 9$), but this is almost two *ogbanje* per week. Even this small sample shows the female predominance expected (2:1). *Ogbanje* is clearly a problem of young people (mean age = 14.4 years), preadolescent males (mean age = 10.7 years), and adolescent females (mean age = 16.3 years). Concerns about *ogbanje* start even earlier, as seen in the Dada

Table I. Sociodemographic and diagnostic characteristics of patients seen at the Lagos University teaching hospital (Luth).

| |
|---|
| <i>N</i> = 12 |
| Age: Mean at onset = 15.8 years |
| Mean at presentation = 20.2 years |
| Sex ratio (male:female) = 1:5 |
| Social class: Social Class IV/V (i.e., lower class) |
| Religion: Christian |
| Family pattern: Maternal dominance (absent, sick, or dysfunctional fathers) |
| <i>Diagnoses</i> |
| 1. Conversion/dissociative disorders = 3 (25%) |
| 2. Visual hallucinations = 8 (67%) |
| 3. Auditory hallucinations = 2 (16.7%) |
| 4. Vivid dreams (water, play) = 3 (25%) |
| 5. Aggressiveness/destructiveness = 4 (33%) |
| 6. Predominant personality characteristics: |
| • Histrionic = 5 (42%) |
| • Dependent = 2 (17%) |
| • Paranoid = 2 (17%) |
| • Conduct disorder = 1 (8%) |
| • Schizotypal = 1 (8%) |
| • Insufficient data 1 (8%) |

Table II. Socio-demographic profile of ogbanje populations in J2's "clinic".

| |
|---|
| Time period: 20 days (= 5 native weeks) |
| <i>N</i> = 96 |
| Number of <i>ogbanje</i> = 9 (9.4%) |
| Number of Dada = 3 (3.1%) |
| Age |
| Overall group mean = 29.4 years |
| <i>Ogbanje</i> group: |
| Range = 6–19 years |
| Mean = 14.4 years |
| Female mean = 16.3 years |
| Male mean = 10.7 years |
| Sex ratio (male:female) = 1:2 |
| Occupation = 70% students |
| Prostitutes = 20% |
| Dada group: |
| Mean age: 7.67 months |
| Sex ratio (male:female) = 2:1 |

group (mean age = 7.7 months). All these figures suggest that initial contact about problems associated with *ogbanje* (and perhaps other problems) is with the native healer.

Recognizing the Ogbanje according to the Igbo healers J1 and J2 (Table III)

These healers describe multiple difficulties in negotiating culturally prescribed phases of the life cycle especially or almost exclusively among women. The

Table III. Characteristics of *ogbanje* according to Igbo healers J1 and J2.

| |
|--|
| 1. Normal women who, upon getting married, begin to exhibit abnormal behavior |
| 2. Usually bright students, especially girls who have study difficulties around examination time (“brain fog”); they are problem-free between examinations |
| 3. Characteristic problem of excessive tears (epiphora) as if they were weeping without appropriate emotional provocation |
| 4. Socially and academically successful women who “bring shame to their family” by exhibiting masculine-typed behavior (smoking, public drinking, hanging out in bars); financial extravagance; repeated refusal of marriage suitors |
| 5. Women who have difficulty with feminine sex roles, e.g., infertility, or difficult pregnancies, frequent miscarriages, marital discord but normal pregnancy and pleasant behavior as soon as they return to parental homestead |
| 6. Persons who have mysterious diseases that are not diagnosable or effectively treatable by modern medical methods |
| 7. Prototypal dreams relating to mammy water, water, masquerades, snakes, dogs |
| 8. Rapidly changing fortunes |
| 9. Rapidly and dramatically changing health status including sudden death |

unstated understanding of these healers is that successes in examinations, marriage, or childbirth threatens the bond with mammy water and/or the spirit companions who therefore induce distress to cause disruption. An alternative viewpoint is that wastage of resources and use of substances of abuse actually “feed” the putative spirit companions. The dreams are regarded as modes of spiritual communication.

The life story of one of these (*Ogbanje/Mammy*) healers, J1, is illustrative. J1 had no formal training as a native or spiritual healer. However, from age 4, he was perceived as specially gifted and often called upon to diagnose and prescribe for people’s problems. He often guided native doctors and *ogbanje* sufferers to discover and dig out their *Iyiuwa* (“boundstone”) as soon as he could talk clearly. He was expected to grow into a gifted diviner and healer.

After primary school, instead of attending to his innate talents, he decided to pursue a retail business, just like his peers. He even consulted other healers to alter his apparent destiny. Unfortunately, after setting up his own retail shop, he was afflicted by mysterious complaints—visual blurring, epiphora, weird dreams of snakes and masquerades, and episodic blindness, which, he claimed, could not be diagnosed or treated in any modern hospital. He eventually went bankrupt and returned to what was thought to be his destined vocation. There was no history of familial childhood deaths.

J1 therefore thought he suffered an “*ogbanje* illness” [very much in the shamanic tradition], because *Mammy Water* had called him, and there was a price to pay for refusal. The only cure for the illness was to return to the service of *Mammy Water* as a healer.

The research assistant who had known J1 for many years described him as a sharp dresser who spent a lot on his personal appearance. His photograph that sat next to his ritual shrine showed him in very high platform shoes, large blown out “Afro” hair, and colorful silken shirt with large collars true to the

Table IV. Characteristics of *abiku* and *emere* obtained from traditional healers in Lagos.A. *Abiku*

- i. Frequent physical illness
- ii. Prevalence reduced by modern medical methods
- iii. Has a "date with death"
- iv. *In utero* detection and treatment of "*abiku* illness" is possible
- v. Parental moral and social transgressions may be contributory

B. *Emere* (contributory to *abiku*)

- i. Visual hallucinations
- ii. Children cults comparable to adult witchcraft cults
- iii. No physical illness
- iv. Rejoices at misfortune of others; often believed to cause bad luck
- v. Fainting and trance-like episodes
- vi. Association with Mammy Water cult
- vii. Social deviance or parental involvement in sorcery may be contributory
- viii. Prevalence reduced in recent years

"psychedelic" fashion of the early 1970s. The shrine itself was full of perfumed powders, mirrors, and beauty items said to be loved by *mammy water*. He was quite friendly. He was not a drug user as far as we knew.

It was not possible to make any retrospective diagnosis without much more information. Histrionic trends were noted.

Abiku and Emere (Table IV)

The native healers consulted, unlike published authors who see *emere* as a cause of *abiku* (Adegbola, 1983, Awolalu & Dopamu, 1979, Idowu, 1965), distinguish clearly between *emere* and *abiku*. Their impressions of *emere* may be summarized as "bad kids from bad parents, who bring bad luck to their parents." Their problems are seen as predominantly behavioral and experiential. There is no "date with death" or physical illness issues as with *abiku*. An additional twist is the notion that medical science has actually reduced the number of *abiku* worldwide, and they boast an ability to diagnose *abiku in utero*, by divination. But since *emere* could cause *abiku*, the *abiku* has the potential both to die on a date or at will and to be associated with psychological problems. The comparison of *emere* with witchcraft is noted.

Ogbanje and abiku names (Table V)

These are just a sample of the names. These names are infused with the grief, hopes, prayers, fears, and resignation of mothers who have repeatedly lost their offspring to early death and societies who feel under siege by the death of their young.

Ogbanje-like concepts have been identified in many other West African ethnic groups (Corin & Murphy, 1979; Ilechukwu, 1990/1991; Logmo, 1977; Murphy, 1982; Ortigues et al., 1989; Zempleni & Rabain, 1965). In eastern Nigeria, the Annang/Efik/Ibibio ethnic groups use the expression *amanakpa* (literally, born

Table V. Sample prototypical names.

| | | Literal meaning | Emotional tone |
|-------------------|-------------|--|----------------|
| A. <i>Ogbanje</i> | Igbo name | | |
| | Ozoemezina | May it not happen again | Hope |
| | Onwubiko | Death, I beg you | Supplication |
| | Nonyelum | Please stay with me | Supplication |
| | Ezimma | Genuinely pretty (not that other type) | Denial |
| B. <i>Abiku</i> | Onwuma | Death may please itself | Resignation |
| | Yoruba name | | |
| | Ikudeinde | Death has come back | Dread |
| | Kokumo | Not dying again | Hope |
| | Apara | One who comes and goes | Deadpan |
| | Ikujore | Death leaves him | Hope |
| | Biobaku | If he does not die | Reservation |
| | Durotimi | Stay with me | Supplication |

to die) (Ekpo, 1983). There are mammy water cults all along the West African coast, e.g., in Liberia (Wintrob, 1970) and the Ivory Coast (Ogrizek, 1982). Their relationship to the constructs under discussion here is not clear.

Culture personality and psychopathology

Ogbanje and other schemes discussed below may also be understood as examples of personality (and psychopathology) constructs from Africa (Ilechukwu, 1991) that impinge on modern medical practice.

Chinwe Achebe’s (1986) book provided a psychological profile of the *ogbanje*: trance-like states, “soliloquies”, “tendency to be sickly without scientific medical evidence of disturbance” [conversion symptoms], social withdrawal, acting as if in communication with invisible people, e.g., “sharing food” by “droppings”, and “may opt to die” rather than comply when challenged. A detailed case presentation (MO) will provide perspective.

Miss MO

MO, a 20-year-old maid, lived in Lagos with a distant uncle’s family as a housemaid. Her uncle had rescued her from another family by bringing her to Lagos to live with his own family. She was also apprenticed to a seamstress. Her own family lived 500 km away in the Igbo hinterland. Her father was dead.

MO was reported to be very stubborn, often responding to correction with tantrums, locking herself up in her room, and long spells of mutism. MO was beaten quite often when she lived with the other family. She had frequently run away from home, sleeping in open shrubbery or on top of trees. MO complained of being poorly understood, even in her uncle’s home, being faced with contradictory demands, and being verbally abused by every member of the family. When confronted with such contradictory situations, she would respond

by passive aggressive methods, neither complaining nor complying with demands. She thought she was overworked, but she was often accused of being tardy, slovenly, rude, or sexually provocative with neighborhood artisans. She was even accused of aggravating her uncle's many physical illnesses in the sense that she was always stirring up emotional conflict in the household. Her difficult behavior had been noted in pre-adolescence.

Patient claimed she was "*Ogbanje*" and was being bothered by "*ndi otu*" (spirit mates). She said she concealed her *ogbanje* identity from her uncle's family to avoid being teased. Nonetheless, she could see the machinations of the "mates" by things in the home getting lost and turning up again unexpectedly. The spirit mates were also said to interfere with her memory, making her forget chores or errands in a way that seemed very convenient. She also claimed to have special powers. She could hide in places that could not normally conceal her bulk. This was how she eluded the other family, even though she claimed to have been in plain sight. Another example was that of being able to influence events that affected the welfare or life of either herself or others. For example, she dreamt frequently of swimming or being in water. If she floated, she claimed, she would wake up cheerful, but if she sank or choked, she would wake up tired, moody and irritable. A similar experience occurred with dreams of being in fights. Victory predicted a good day, and defeat meant depression and headaches the next day. Food in the dream meant either she would be ill or someone known to her would die.

She claimed she could avert all the consequences of dreams about water or food by prayers offered in a particular way. In spite of her prayers and special powers, she reported falling so ill that she was hospitalized after a dream surrounded by water and at the same time being forced by an old woman to eat.

MO was very close to her father. She recalled that when her father died about four years before, she hung onto the coffin trying to prevent the father's body from being buried. This was interpreted as being antisocial in the extreme rather than an excessive display of grief.

Patient claimed to have been told by a diviner that she herself would die young. A sibling that preceded her had died in late childhood. She narrated many dream encounters as if they were near-death experiences. In one such dream scene, she was in water surrounded by white objects and people in white. In another, she agreed to marry a very handsome boy who was to take her away. She claimed to have been saved by her prayers during the dream. She understood being taken away in the dream as dying.

This patient's uncle died while she was in therapy. She was assisted through a complicated grief process, at the end of which her behavior had improved considerably. She confessed that therapy times were her best times. She had a solo ride in the family car and spent an hour with the therapist and sometimes with the doctor. This took off more than 2 hours every week from unpleasant chores. Her uncle had insisted on this treatment.

Symptoms of irritability, sub-chronically depressed mood, sleep disturbance, low energy, and social isolation suggested dysthymic disorder. She was placed on

amitryptiline up to a dose of 75 mg at night. Prior designation of a patient as *ogbanje* should alert the clinician or researcher in this West African region to expect any of a range of personality traits and lead to a more sensitive inquiry. Our understanding of *ogbanje* and food dreams (Ilechukwu, 1985) enabled us to avoid over-interpreting her symptoms as delusional or psychotic. Her character traits suggested a schizotypal personality.

Social disadvantage is clearly evident here. MO was in benign servitude when seen at LUTH. She had been in forced servitude before, her father was dead, and she was a scapegoat in her uncle's family. The only love she had from her uncle was filtered through his wife and children who had closest interaction with her. The only power she had in the family system was her capacity to upset it.

Ogbanje, child abuse and dissociation

Many *ogbanje* patients, like MO, experience child labor in the Nigerian nanny system. Their parents send them off at an early age to live with non-relatives in order to earn money for their parents or have access to school in exchange for doing chores or babysitting. Physical and sexual abuse are common. Advance payments are also common. Exhibition of *ogbanje* behavior (hallucinations, dissociation) often terminated such arrangements and forced the return of such children to their parents. The frightening behavior often subsided immediately on return to the parental home. The arrangement is often repeated with another host family, and scamming is frequent. Such scams must be regarded as exploitation of a cultural phenomenon for secondary gain.

There is growing recognition that victimization and maltreatment in childhood precede dissociative manifestations that may be temporary but affect psychological adaptation in adulthood (Barnyard, Williams, & Siegel, 2001). Friedrich, Jaworski, Huxsahl, and Bengston (1997) discussed dissociation as a state of divided consciousness in which elements of experience and self-perception, which are normally integrated, become fragmented. Integrative deficits and phobic avoidance (van der Hart, Nijenhuis, Steele & Brown, 2004) and affective dysregulation (van der Kolk et al., 1996) have all been proposed. Of particular interest to this study is the theory that dissociative phenomena and subsequent trauma-related distress may relate to fears of death and fears about loss or lack of control above and beyond the occurrence of the traumatic event itself (Gershuny & Thayer, 1999). Symptoms being described for the *ogbanje* are the extreme of the continuum of dissociation. There appears to be a failure of awareness of thought process, and feelings so that actions are disconnected from psychological process and appear reasonably attributable to a disembodied psyche.

DSM-IV diagnoses of bipolar mania, brief psychotic disorder, schizophrenia or the schizophreniform psychoses, or the non-DSM diagnosis of *bouffée délirante* of French Psychiatry must always be considered (Ilechukwu, 1991).

Names and the Ogbanje/abiku concepts

The relationship between certain given names and the *ogbanje/abiku* phenomena have been considered to be condensations of parental emotion and cultural defensive attitude in the face of repeated child losses (Ekpo, 1983; Ilechukwu, 1990/1991, 1992; Johnson, 1921). The logic seems to be that the “threat” of these children to die feeds off excessive parental solicitude and the group’s investment in their offspring. Calling their bluff by emotional divestment (or a pretence of it) is expected to cut off this energy and so break the cycle. Unfortunately, the names may further stigmatize the child and serve as a prophecy whose potential for fulfillment has all the potency of cultural validation. Also, the names may be used as predictors of negative tendency and lead to stigmatization, especially at school.

Sickle cell disease and Ogbanje

Sickle cell hemoglobin trait and diseases are widely distributed in the West African sub-region (Brozovic & Davies, 1987). Sickle-cell disease (SCD) is associated with a high mortality (Platt et al., 1994). Frequent painful and hemolytic crises requiring hospitalization often occur several times a year (Belgrave & Molock, 1991; Nadel & Portadin, 1977). There is social disability and psychiatric morbidity (Leavell & Ford, 1983; Whitten & Fischhoff, 1974). They have remarkable physical characteristics (Brozovic & Davies, 1987) and often leave their parents financially and emotionally exhausted (Burlew, Evans, & Oler, 1989). Sickle cell disease patients themselves are subjected to discrimination and face forced minimization of play and career opportunities (Whitten & Fischhoff, 1974). Such a prominent and refillable pool of frequently ill and prematurely dying patients may have triggered these myths in West Africa (Stevenson & Edelstenin, 1980). Attractive as this theory seems, there are few supporting studies. None of the patients seen at all sites of this investigation had SCD. Even the studies of Stevenson and Edelstenin failed to provide support. One study (Nzewi, 2001) found that 70% of children categorized as “malevolent *ogbanje*” had sickle cell disease. Common causes of child mortality and morbidity in Nigeria include diarrhea, acute respiratory infections, measles, and malaria. They are not confined to SCD patients but may precipitate crises in SCD. In fact, malaria, which killed 200,000–300,000 or 5–10% of the 20th-century population in sub-Saharan Africa, especially in children (Carter & Mendis, 2002), may fit the probable cause even better. Malaria is often complicated by delirium (with visual hallucinations, alterations in consciousness, and abnormal behavior) and febrile convulsions, which fit the postulated *ogbanje* features. It is estimated that 100,000 live babies are born with SCD in Nigeria every year (Akinyanju, 1989) compared to 1,000 in the USA. The *ogbanje/abiku* archetypes took root so long ago that it is difficult to imagine that SCD may not have contributed to these archetypes. Anthropological methods may yield more definitive answers.

Ogbanje/abiku and witchcraft

Ogbanje/abiku are not usually regarded as witches, but attribution (and claim) of magical power, participation in orgies (Ebigbo & Anyaegbunam, 1988), *Mammy Water* cult activity, and ideas of being possessed by *emere* appear to blur the line. Notions of willfully inflicting emotional pain on mothers, rejoicing at the misfortune of others or bringing bad luck come quite close to witchcraft characteristics. Yet, the same mothers would cajole, indulge and pray for the survival of these children. Perhaps mothers believe that the surviving *ogbanje/abiku* is a different spiritual being, or that their therapeutic efforts have exorcised the evil.

Ogbanje/abiku and grieving

Bonding of a child identified as *ogbanje/abiku* to its mother or extended family is, at best, usually tenuous. The prototypical names, already discussed, attest to this. The names may also serve anticipatory grieving functions. In the pre-Christian era and possibly even now, when such children died, the body was treated differently from usual. The body was not accorded the dignity of a proper coffin; it was buried in a shallow grave or just tossed into the "evil forest" by the father of the child. Sometimes, parts of the body (finger, toe, ear) were nipped off or burnt with fire to facilitate recognition on "return," that is, when it was born again. Weeping, mourning observances, and funeral processions were prohibited. The mother was expected to go about her normal business the next day. All this is an effort to deprive the *ogbanje* of the joy of being missed or mourned.

A case vignette of "the *abiku* mother" is presented. A 32-year-old single Yoruba Nigerian mother of three living children was admitted to LUTH for a fourth episode of a post-partum psychotic disorder. A traditional healer previously treated her. In characteristic Nigerian fashion, she had a large number of relatives involved in her care. These relatives proposed that, since all the patient's previous illness episodes were associated with childbirth, and she had neither skills nor a husband to help with her care and the upkeep of her children, that she be permanently sterilized. Patient agreed to this plan. Following social work counseling and work-up, tubal ligation was scheduled. Before the surgery, however, it was learnt that her only surviving son died while she was in hospital. Being aware of how overvalued male children are in Nigeria, the operation was cancelled, pending further evaluation and grief work. In summing up her feelings, the patient recalled that the child in question (appropriately named Kokumo, literally not dying again) had come to her two previous times. "I thought he had come to stay this time... maybe he should go and rest... I, too, will have some rest". She decided to have the tubal ligation. No untoward responses were reported at followup.

So, in this case, the *abiku* mother employed the *abiku* construct in grief management and treatment planning in a rather surprising manner. This is another illustration of the use of cultural accommodations to facilitate therapy

(Ilechukwu, 1989). Also, a perception of innate defect in the child (Scheper-Hughes, 1885) is deployed with apparent success for grief management.

Conclusion

This study has reported findings that provide perspectives on *ogbanje* (Igbo) and *abiku* (Yoruba) from a Nigerian teaching hospital sample, native healer's clinic sample, and contributions from interviews with native healers in Lagos (Yoruba) and Anambra (Igbo) states of Nigeria. *Ogbanje* and *abiku*, though not identical in their philosophical conceptualization, describe surviving children from families with prior experience of infant deaths. The concepts go beyond the prospects of physical death. They reflect the group assumptions that early mortality is not the design of a Supreme God (Olodumare in Yoruba and Chiukwu in Igbo) but an aberration. Unfortunately, the explanatory myths also end up designating surviving children themselves as potential aberrations.

The major findings for designated persons are a tendency to be histrionic, and display dissociative and conversion symptoms. Traumas of separation (from prolonged and repeated hospitalization), abuse in the Nigerian nanny system, and fear of death are possible disposing factors. Stigmatization with names suggestive of non-human status and implying an innate abnormality may also be important. One important group that must not be overlooked is the mothers who repeatedly suffer from losses from infant mortality, recurrent or not.

References

- Achebe, C. (1958). *Things fall apart*. London: Heinemann.
- Achebe, C. (1986). *The world of ogbanje*. Enugu, Nigeria: Fourth Dimension.
- Adegbola, E. A. A. (1983). *Traditional religion in West Africa*. Ibadan, Nigeria: Onibonoje Press.
- Akinyanju, O. O. (1989). A profile of sickle cell disease in Nigeria. *Annals of the New York Academy of Sciences*, 565, 1126–1136.
- Awolalu, J. O., & Dopamu, P. A. (1979). *West African traditional religion*. Ibadan, Nigeria: Daystar Press.
- Barnyard, V. L., Williams, L. M., & Siegel, J. A. (2001). Understanding links among childhood trauma, dissociation and women's mental health. *American Journal of Orthopsychiatry*, 71, 311–321.
- Belgrave, F. Z., & Molock, S. D. (1991). The role of depression in hospital admissions and emergency treatment of patients with sickle cell disease. *Journal of National Medical Association*, 83, 777–781.
- Brozovic, M., & Davies, S. (1987). Management of sickle cell disease. *Postgraduate Medical Journal*, 63, 605–609.
- Burlew, A. K., Evans, R., & Oler, C. (1989). The impact of a child with sickle cell disease on family dynamics. *Annals of New York Academy of Sciences*, 565, 161–171.
- Carter, R., & Mendis, K. N. (2002). Evolutionary and historical aspects of the burden of malaria. *Clinical Microbiology Reviews*, 15, 564–594.
- Clark, J. P. (1963). Abiku. In G. Moore & U. Beier (Eds.), *Modern poetry from Africa*. London: Penguin, 1963.
- Corin, E., & Murphy, H. B. M. (1979). Psychiatric perspectives in Africa, Part I: The Western viewpoint. *Transcultural Psychiatry Research Review*, 16, 147–178.

- Ebigbo, P. A., & Anyaegbunam, B. (1988). The problem of student involvement in the mermaid cult - a variety of belief in reincarnation (ogbanje) in a Nigerian secondary school. *Journal of African Psychology*, 1, 1-14.
- Ekpo, M. (1983). *The concept of ogbanje*. Paper presented at the Department of Psychiatry Monday Seminar, Lagos University Teaching Hospital, Lagos, Nigeria.
- Friedrich, W. N., Jaworski, T. M., Huxsahl, J. E., & Bengston, B. S. (1997). Dissociative and sexual behaviors in children and adolescents with sexual abuse and psychiatric histories. *Journal of Family Violence*, 14, 151-171.
- Gershuny, B. S., & Thayer, J. F. (1999). Relations among psychological trauma, dissociative phenomena, and trauma-related distress: A review and integration. *Clinical Psychology Review*, 19, 631-657.
- Idowu, B. E. (1965). *Olodumare: God in Yoruba belief*. Ibadan, Nigeria: Longman.
- Ilechukwu, S. T. C. (1985). Food dreams and illness among Nigerians—a pilot study. *Psychiatric Journal of the University of Ottawa*, 10, 89-94.
- Ilechukwu, S. T. C. (1989). Approaches to psychotherapy in Africans: Do they have to be non-medical? *Culture Medicine and Psychiatry*, 13, 419-435.
- Ilechukwu, S. T. C. (1990/1991). Ogbanje/abiku: A culture-bound construct of childhood and family pathology in West Africa. *Psychopathologie Africaine*, 23, 27-51.
- Ilechukwu, S. T. C. (1991). Review of the world of the Ogbanje, C. Achebe; *vide supra*. *Transcultural Psychiatric Research Review*, 28, 141-148.
- Ilechukwu, S. T. C. (1992). Ogbanje (Abiku): A culture-bound construct for coping with high infant mortality in Nigeria. In N. Grizenko, L. Sayegh & P. Migneault (Eds.), *Transcultural issues in child psychiatry* (pp. 87-106). Montreal: Editions Douglas.
- Johnson, S. (1921). *The history of the Yorubas*. Lagos: CMS (Nigeria) Bookshops.
- Leavell, S. R., & Ford, C. V. (1983). Psychopathology in patients with sickle cell disease. *Psychosomatics*, 24, 23-26.
- Logmo, B. (1977). *Cultural forms of psychopathology*. Paper presented at the Pan-African Psychiatric Association Seminar, Yaoundé, Cameroon, September.
- Murphy, H. M. B. (1982). *Comparative psychiatry: The international and intercultural distribution of mental illness*. New York: Springer.
- Nadel, C., & Portadin, G. (1977). Sickle cell crises. *New York State Journal of Medicine*, 6, 1075-1078.
- Nzewi, F. (2001). Malevolent ogbanje: Recurrent reincarnation or sickle cell disease? *Social Science and Medicine*, 52, 1403-1416.
- Ogrizek, M. (1982). Mami Wata, de L'hysterie a la Feminite en Afrique Noire. *Confrontations Psychiatriques*, 21, 213-240.
- Ogunjuyigbe, P. O. (2004). Under-five mortality in Nigeria, perception and attitudes of the Yorubas toward the existence of "abiku." *Demographic Research*, 11, 1-16.
- Ortigues, E., Ortigues, M. C., Zempleni, A., & Zempleni, J. (1989). Clinical psychology and ethnology (Senegal). In K. Peltzer & P. O. Ebigbo (Eds.), *Clinical psychology in Africa*. Enugu, Nigeria: Working Group for African Psychology.
- Platt, O. S., Donald, J. B., Wendell, F. R., Paul, F. M., Oswald, C., Martin, H. S., & Panpit, P. K. (1994). Mortality in sickle cell disease. Life expectancy and risk factors for early death. *New England Journal of Medicine*, 330, 1639-1644.
- Scheper-Hughes, N. (1985). Culture scarcity and maternal thinking: Maternal detachment and infant survival in a Brazilian shantytown. *Ethos*, 13, 291-317.
- Soyinka, W. (1980). *Ake/the years of childhood*. London: Rex Collings.
- Stevenson, I., & Edelstein, S. J. (1980). *Belief in reincarnation among the Igbo of South Eastern Nigeria with particular reference to the connection between ogbanje (repeater babies) and sickle cell anemia*. Paper presented at the twenty-fourth Annual Conference of the Parapsychology Association In Chinwe Achebe, *vide supra*.

- van der Hart, O., Nijenhuis, E., Steele, K., & Brown, D. (2004). Trauma-related dissociation: Conceptual clarity lost and found. *Australian and New Zealand Journal of Psychiatry*, 38, 906–914.
- van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation of trauma. *American Journal of Psychiatry*, 153, 83–93.
- Whitten, C. F., & Fischhoff, J. (1974). Psychosocial effects of sickle cell disease. *Archives of Internal Medicine*, 133, 681–689.
- Wintrob, R. (1970). Mammy water: Folk beliefs and psychotic elaborations. *Canadian Psychiatric Association Journal*, 15, 143.
- Zempleni, A., & Rabain, J. (1965). L'enfant nit ku bon. Un tableau psychopathologique traditionnel chez les Wolof et Lebou du Senegal. *Psychopathologie Africaine*, 1, 324–441.

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