Culture and the Management of Mental Health Issues in African Families and Communities

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Introduction

Culture influences how mental health issues are perceived and treated (Carr & Blair, 2023). This paper explores how culture influences the management of mental health issues in African families and communities. We begin with some African conceptions of mental health and end with a call for ongoing African-inspired and African-led research.

We draw on examples, including from Liberia, Cote d'Ivoire, Rwanda, Democratic Republic of Congo, South Sudan, Kenya, Malawi, Zimbabwe, and South Africa. We do not assume sameness across the continent or even within ethnic groups. In addition, an intersectional lens is needed. For example, the situations and needs of women (Africa Minds Matter, 2025b), youth, the elderly, and trans people (Pickstone-Taylor et al., 2024) vary.

In exploring mental health, I adopt a conceptual understanding inspired by liberatory psychiatry, in which mental health is a journey to be "free from and free to," *free from* the effects of internal biological forces, domination, and alienation that contribute to mental illness and distress and *free to* flourish, transcend the social realm, and relate to the world (Cohen & Timimi, 2008).

1. A word about African conceptualizations of mental health

African conceptions of wellness are linked to "social and spiritual harmony and balance" (Nortje, 2016, p. 154). In healing traditions, mind and body are not considered separate as is commonplace in many western societies. There is "little distinction between physical and emotional illness, spiritual problems, and the obstacles of daily living" (Nortje, 2016, p. 154).

In many societies around the world and including in African contexts, people with mental illness face stigma, discrimination, and marginalization (Amadasun, 2024; Amuyunzu-Nyamongo, 2013; Mtike & Charles, 2021). Conversations about mental health disorders in the family are considered taboo (Ruwa, 2024). Silence, stigmatization, and superstition can keep people from seeking the support they need. Mental health issues may be associated with evil, and families may think a mental illness is a curse caused by witchcraft. Christians may think demons are responsible. Churchgoers may prescribe prayer and fasting or to "confess your sins" (Mwaure, 2024, p. 78). This mindset seriously impedes the detection and treatment of mental illnesses.

In Kenya, in the Kikuyu language, there is no word for mental illness. The word *muguruki* is an insult and denotes that one is "mad" (Mwaure, 2024, p. 76). According to Mwaure (2024), who wrote about her daughter who was diagnosed with bipolar disease, "the roots of stigma run deep," making it hard to seek the necessary support.

Personhood in African context is understood in a broad sense (Kpanake, 2018). Individuals are perceived as part of society, and they need to be well with themselves to be well in society. The concept of ubuntu, known as *umunthu* in Malawi, emphasizes relational personhood and collective responsibility (Wright, 2021). Mental health services should support people to find their identity and their place vis-à-vis those around them.

Can African conceptualizations of mental health enrich western thinking and practices and vice-versa? Atwoli et al. (2022) argue that sociocultural-spiritual components of illness and treatment should be included in biopsychosocial models. This would promote "holistic and culturally sensitive approaches" to addressing mental health care in Africa (Atwoli et al., 2022, p. 425).

Let us explore how this happens in African families and communities.

2. Role of the family in providing mental health care

Family members are part of the foundation of psychological treatment, yet mental health issues are not well understood. Mabunda et al. (2022) explain how caring for people with mental health issues in families is viewed with stigma by the community. Someone struggling with mental health may fear appearing weak or bringing shame to the family (Mahamud, n.d.).People suffering from a mental disorder can feel rejected by the family and the community. However, the quality of care improves when family members are educated about mental illnesses and encouraged to participate in the care of their family members (Carrà et al, 2022; Rammouz et al., 2025). Education should also be offered to leaders of the community.

Families are the most invested stakeholders when it comes to untreated psychosis, and culture largely determines the perspectives of the families and the wider community (Lefley, 2000). "Providing mental health care for a family member suffering from a mental disorder places a strain on many parts of family life" (Shimange et al., 2025, p. 855), and women often carry the burden.

In South Africa, families do a better job when they are supported by psychiatric mental health nurses to understand mental health issues, their causes and treatment, and learn care skills. With strengthened family involvement in treatment, relapses of loved ones can be prevented. "Moreover, when psychiatric mental health nurses and the broader community actively support and engage with family members, it creates a network of care that promotes a more comprehensive and effective treatment journey" (Shimange et al., 2025, p. 862). The collaborative approach reduces stigma and makes the mental health journey more bearable

for those suffering and for their families. However, only 15% of African countries have mental health programs for the elderly (Amuyunzu-Nyamongo, 2013).

In Cote d'Ivoire, physical health issues of children receive more attention from their families than mental health issues do. Kouyaté (2024) describes the complex cultural negotiation of understanding and treating neurodevelopment issues among children. The family is part of a community and receives input from a variety of actors in a "complex therapeutic itinerary" (p. i). Neighbors and women elders share their advice. Even if a mother is not in agreement, she may follow the advice to preserve social harmony. As a result, referrals to the official medical system may happen very late, "after long and complex therapeutic wanderings within local healing practices" (p. 343, our translation from French). Amuyunzu-Nyamongo (2013) confirms that the lack of early diagnosis and appropriate care can lead to chronic conditions. When co-constructing approaches to support mental health, it is important to keep in mind these cultural realities of families embedded in contexts of communal decision-making.

According to Asmal et al. (2011), African patients with schizophrenia may be treated with antipsychotics, but the client and their family may believe the treatment is only for behavioral control and seek further support from indigenous healers to attempt to address the actual cause of the illness. This is why psychoeducation about schizophrenia should be part of treatment plans (Lefley, 2000; Mabunda, 2022). Asmal et al. (2011) go on to explain that when women believe their psychiatric symptoms have a religious or supernatural basis, they are less likely to visit a mental health center for treatment, and living in an extended family may also prevent treatment. While psychoeducation for families is necessary, cultural awareness training for clinicians can boost the quality of engagement and treatment. A clinician needs to understand, for example, that a Somali or Amharic therapy participant describing feelings of being "lost" or "blocked" could be experiencing symptoms of anxiety or depression (Mahamud, n.d.). "Multicultural psychotherapists can leverage the strengths of traditional and faith healing" to promote wellness (Maua & Egunjobi, 2023). From a clinical perspective, understanding the client's and family's understandings of the disorder fosters trust for a collaborative and effective treatment plan (Asmal et al., 2011; Africa Minds Matter, 2025a).

Let us turn now to the broader community context.

3. Management of mental health issues at the community level

Times have changed for the treatment of family members with mental health disorders from the 1960s and 1970s when people were committed to "neglected, dilapidated, overcrowded asylums" where they received very little psychiatric attention (Njenga, 2002, p. 354). Increasingly, community-based approaches reduce the need for in-patient services and provide pathways for the provision of safety, counselling, and referrals, and the hospital has also become home to community activity (Njenga, 2002; Puffer & Ayuku, 2022). Dialogue between community workers and clinicians can lead to culturally sensitive approaches that

reduce stigmatization and lead to the realization that mental health illnesses are treatable (Njenga, 2023). An intent of Kenya's 1989 Mental Health Act was to make mental healthcare less colonial, less centralized, more culturally appropriate, and more communal (Njenga, 2002). The current Kenya Mental Health Policy (2015-2030) calls for the integration of traditional practitioners, culture, and family systems with biomedical approaches for inclusive and community-based mental health.

Community-based mental health services can expand access to care (Aderinto et al., 2022). Care at the community level can help ensure that culture is considered, and people are treated both as individuals and members of society. Okunade et al. (2023) studied such services across Africa to inform community-based mental healthcare in the US, which often lacks the integration of traditional practices and cultural beliefs. Many African models "prioritize community engagement, cultural relevance, and holistic well-being," which can enhance the effectiveness of mental health services (Okunade et al., 2023, p. 81).

An example of an evidence-based community-based approach is the Friendship Bench in Zimbabwe, to get people out of *kufungisisa* – anxiety and depression – by creating safe spaces for sharing and a sense of belonging. Trained community-based healthcare workers provide one-on-one cognitive-behavioral therapy and refer people to peer-led group therapy or professional counsellors or psychiatrists as need be.

When discussing mental health at the community level, I am not referring to communities being acted upon by outsiders. Rather, in the spirit of Kessi et al. (2022) and Tuck (2009), I am referring to communities that exert their agency and creativity to realize the desires of its members for wellbeing.

Tensions between knowledge systems are evident in the provision of mental health. The biomedical model is not the only model of care. But, like the colonial project, it assumes superiority, and "its domination functions on different levels," often focusing on the individual, "without understanding the social, political, cultural, economic and environmental contexts" (Wright, 2021, p. 88). In southern Malawi, health surveillance assistants are trained to be trusted intermediaries between local traditions and biomedical services. They engage with families, direct people to community resources (support groups, community gatherings and activities, church groups, traditional healers), and, if distress is severe, refer people to specialized psychiatric services. The services the assistants provide are therapeutically responsive and culturally attuned. Counselling is provided as an opportunity to regain personhood, and support groups demonstrate "the value of both providing and receiving support within a collectivist culture" (Wright, 2021, p. 36).

This approach in Malawi of training paraprofessionals is similar to Mental 360, a youth-led mental health initiative in Kenya. Mental wellness peer champions are trained to reach at-risk youth through schools and refer them to support groups and, when need be, mental health professionals. This social enterprise nurtures inclusive environments where individuals can access culturally informed mental health services and thrive. In Rwanda,

youth that have struggled with mental health disorders serve other youth (The 77 Percent Show, 2023).

Mental health is about more than one individual, thus engagement with socioeconomic, cultural, and political context is necessary (Cohen & Timimi, 2008, p. 131). Studies (Mabunda et al., 2022; Shimange, 2025) have indicated a positive correlation between community support and improved recovery and rehabilitation results for family members with mental illnesses.

I argue that many of the community-based approaches discussed above are in line with mental health practice as emancipatory or liberatory. The approaches are co-designed by professionals, families, and community members to reflect traditions (sitting and talking outside to solve problems), belief systems (the power of community), and social norms (solidarity). Psychology that *frees people from* and *frees people to* is not achieved without the input of users of services (Cohen & Timimi, 2008). Responsive, community-based, co-designed approaches make sense, because people exist within and are constituted in social relations (Cohen & Timini, 2008) in their families and communities. Community work and social cohesion can prevent mental health issues from exacerbating and provide pathways to family members for additional support when needed.

Many communities are practicing holistic and integrated approaches that draw on the strengths within and beyond the community. This means that families can stop hiding family members with mental health problems because they have a trusted place and trusted people to go to for appropriate support and referrals.

4. Hybrid approaches for culturally sensitive management of mental health issues

The use of hybrid mental healthcare models that integrate both African and western approaches can promote adaptability and cultural responsiveness (Editor, 2024). The approaches discussed above draw on traditional ways of knowing and scientific knowledge, thus bridging between sociocultural and biomedical contexts. Okunade et al. (2023) promote the value of dialogue between "traditional practices with modern mental health care approaches" (p. 77). This hybrid approach reflects the evolving landscape of mental health care in Africa, where integration and adaptability are important in addressing the diverse needs of individuals, families, and communities (Wright, 2021; Wollie et al., 2025).

Appiah (2022) warns against applying psychology as developed in the west, with an assumed individualistic cultural orientation, but concludes that it can be effective in African contexts when adapted to and embedded in the cultural values of the community.

The Friendship Benches in Zimbabwe, the health surveillance assistants in Malawi, and Mental 360 in Kenya bridge between the ways of African communities and advances in the field of psychology. These innovative made-in-Africa approaches are indicative of how findings from psychological research and practice worldwide integrate African communities

in useful and culturally appropriate ways. Such collaboration can allow "external" biomedical practitioners and "internal" healing practitioners "to learn from each other and together develop responses to distress that are most effective and relevant to the populations they serve" (Wright, 2021, p. 89).

Traditional healers play an important role in mental health in African families and communities (Amuyunzu-Nyamongo, 2013). It is culturally acceptable for those suffering from mental distress to consult them. Trusted traditional healers help in sharing culturally adapted psychoeducation, and this reduces stigma and raises awareness about care pathways (Johnson et al., 2025). Partnerships with traditional healers and including peer networks, faith-based organizations, and NGOs can provide more options to families and reduce the need for treatment from health services alone (Deane, 2023).Likewise, it is important for staff in psychiatric hospitals to learn to work in communities and for primary healthcare staff to be trained in detecting mental health conditions and making appropriate referrals (Deane, 2023). Chibanda (2017) suggests that African psychiatrists move from working only in hospitals to be part of multidisciplinary teams working in communities.

It is well known that traditional healers in southern and eastern Africa, not to mention in other parts of the continent, have used herbs and other plants for generations in facilitating psychospiritual healing processes (Sobiecki, 2014; Njenga, 2002). They have been used in the treatment of insomnia, stress, and anxiety, for clearer thinking and relaxation, and in connecting people with their ancestors for clarity and strength. Herbs and other types of plants have been shown to treat depression and age-related dementia (Lobine & Mahomoodally 2020). However, indigenous cultural understandings of mental illness and related healing practices are not being handed down to future generations (Sobiecki, 2014). An effort to encourage the preservation, transmission, and ongoing development of such knowledge is the Khanyisa Healing Garden in South Africa. This research garden showcases South African medicinal plants used to address issues such as stress and anxiety. The objective is to leverage indigenous knowledge for community upliftment and social wellbeing. There are other similar initiatives across Africa, for example the Centre for Plant Medicine Research, founded in Ghana in 1975.

War has a large impact on mental health and psychosocial wellbeing (Amuyunzu-Nyamongo, 2013). In the Democratic Republic of Congo, "listening houses" offer sanctuary, psychosocial assistance, and medical care to survivors of sexual violence (ICRC, 2024). In South Sudan, 36% of ex-combatants met the criteria for post-traumatic stress disorder (PTSD) (Singh & Singh, 2014). In Liberia, a study showed that the 44% of adults displayed symptoms of PTSD (Lupick, 2012). In Liberia, traditional purification rites and western trauma therapy techniques are combined to help child soldiers heal and reintegrate society (Wrato, 2022). Traditional medicine practitioners understand linkages between physical and metaphysical worlds, treat mental imbalances, seek the prevention and cessation of disease, and support the physical and spiritual wellbeing of people (Adu-Gyamfi & Anderson, 2019). We cannot ignore that 80% of people in Africa depend on traditional African medicine, which is based on centuries of practice (Adu-Gyamfi & Anderson, 2019). It is clear

that “pluralistic health traditions are active within the community in responding to people in distress” (Wright, 2021, p. 30). When traditional medicine is entirely discredited in favor of biomedical understandings, this can create tensions, because consulting traditional healers affords a social function (Wright, 2021), and people find the process meaningful (Nortje, 2016).

Lay mental healthcare workers in the community, responsible for working with village health committees and making appropriate referrals, are often at the interface of traditional and western healthcare constructs. Increasingly, they have been trained to provide safe spaces, initial assessment and counselling, and referrals. Fundamentally, however, patients and their families “navigate the plurality of mental health provision with all the stresses and uncertainties” that accompany the search (Wright, 2021, p. 70). They navigate their sociocultural context, finding the support they need or finding that the support is delayed by circuitous routes.

A review of 32 studies about traditional healers in 20 countries around the world showed that the work of traditional healers may relieve distress and symptoms like anxiety and depression but found little evidence to suggest that they help change the course of severe mental illnesses like bipolar disorder, schizophrenia, or obsessive-compulsive disorder (Nortje et al., 2016). Other evidence highlights “improved outcomes related to symptoms and human rights when psychiatrists work closely with traditional healers and other non-professionals at the community level” (Chibanda, 2017, p. 741). With these research findings in mind, it makes sense to have different healing traditions coexisting in the same space learn from each other to “develop responses to distress that are most effective and relevant” to the populations they serve (Wright, 2021, p. 89).

5. Need for African-inspired and African-led research on mental health

African-inspired and African-led research on how families and communities handle mental illnesses will provide insight and inform ways forward that account for cultural context. Anakwenze (2022) and Patel and Sumathipala (2001) noted the need for more systematic research and publication on these topics by Africans. Shitindo and Nabil (2023) call for the development of culturally congruent mental health evaluation guidelines for African contexts and that center concerns for gender, socioeconomic inclusion, and health equity. Cohen and Timini (2008) call for theorization that understands human subjectivity as constituted in human relations.

Njenga (2002) calls for more research on the prevalence of Alzheimer’s disease in East Africa and the prevalence rates of PTSD following different types of trauma. Odindo (2024) makes the case for interrogating family and community histories to better understand and treat intergenerational psychological trauma. This is in line with Mullan (2023) on the need for decolonial therapy.

Nortje et al. (2016) called for research with patients who have cultural and spiritual beliefs not in line with conventional psychiatry, to better understand synergies between healing systems and develop more holistic care. Family therapists call for the study of culturally relevant and culturally responsive therapeutic techniques (Asmal et al., 2011). Bargul et al. (2022) call for community engagement as an integral part of research. We also need language that does not dehumanize, so research into linguistics and African languages would support coming up with "words that will not stigmatize mentally ill patients" (Mwaure, 2024, p. 77).

Conclusion

The management of mental health in African families and communities is shaped by a rich interplay of cultural beliefs and evolving hybrid practices that bridge indigenous and biomedical approaches. The evidence reviewed shows that stigma, spiritual interpretations of distress, and communal decision-making profoundly influence pathways to care. Cultural systems offer strengths such as relational personhood, collective responsibility, and practices that promote social harmony. Community-based models – from Friendship Benches to health surveillance assistants and youth-led initiatives – demonstrate how culturally grounded approaches can reduce stigma, expand access, and support treatment and recovery for family members. Hybrid models that foster collaboration between traditional healers and biomedical practitioners further highlight the value of pluralistic healing systems that meet families where they are. At the same time, these approaches require sensitivity to gender, age, class, language, and other intersecting factors that shape lived experiences of distress. The paper has argued that liberatory or emancipatory mental health practice becomes possible when care is co-designed with families and communities and is grounded in their histories, values, and social realities. Yet significant gaps in knowledge remain, especially regarding intergenerational trauma, culturally responsive diagnostics, and the everyday navigation of plural healing systems. Ongoing African-inspired and African-led research is therefore essential to deepen understanding, inform policy, and refine approaches that reflect the continent's diverse contexts. Ultimately, culturally attuned, collaborative, and community-rooted mental health care holds promise for supporting individuals and families not only to be free from distress but also free to flourish.

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