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THE AFRICAN FAMILY AS A CLINICAL SETTING: A DISCUSS

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ABSTRACT: This paper reconsiders the African family as a potential clinical setting where distress is perceived, understood, managed and referred, and is examined as a social unit and background to health behaviour. Based upon the World Health Organization's (WHO) holistic view of health, as well as literature on African family systems, mental health care, caregiving, traditional healing and social support, the paper explores the role of extended kin networks in the physical, psychological and social health of individuals. It theorises that the family has a number of roles similar to those of formal clinical settings, such as informal assessment, explanatory formulation, support for treatment, regulation of behaviour, identity reconstruction, social protection, navigating resources and linkage with the professional community care system. The facts in sub-Saharan Africa provide empirical support for the consequential, but ambivalent nature of such functions. Families can also help identify the problem early, adhere to treatment, provide financial and emotional support, provide coping strategies that are culturally relevant, also transfer stigma, and discourage professional help, while also being a source of significant caregiver burden. The paper thus proposes a unique concept of the African family as clinical infrastructure to describe a longitudinal, relational structure that mediates the movement between the experience of illness, cultural interpretation of the illness, informal care, and formal care. This formulation is not a substitute for professional diagnosis or treatment. Instead, it facilitates culturally responsive, rights-based partnerships with families, thereby ensuring that clinical competence, autonomy, safeguarding, and evidence-based care are sustained. The argument has relevance in psychology, primary care, mental health policy, and for future research and practice in Africa.

Keywords: African Family, Clinical Setting, Family Caregiving, Mental Health, Community-Based Care, Africa

INTRODUCTION

When the word "clinic" is mentioned, the mind instinctively travels to a hospital ward where a professional in a white coat receives a patient and prescribes a remedy. This picture, borrowed wholesale from the Western medical tradition, has come to monopolise our understanding of what a clinical setting truly is. Yet, long before the first psychiatric hospital was established on African soil, and long before psychology found its way into African university curricula, the African family had already been performing the very functions that define a clinic. It received the troubled member,

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examined the trouble and gave the trouble a name (Muhlbauer, 2002). It did this while simultaneously applying a remedy consistent with the identified issue.

It is important, from the outset, to be clear about what is meant by "clinical". A clinical setting is a place where problems are brought, examined by a competent authority, given a name, and resolved by an accepted process (Gale, 2022). The World Health Organization's (WHO) constitutional definition of health, adopted in 1948, revolutionised global health discourse by framing health not as the mere absence of disease but as "a state of complete physical, mental and social well-being" (WHO, 1948). This tripartite framework, encompassing physical, mental, and social dimensions, challenges biomedical reductionism and calls for holistic approaches to well-being that account for interpersonal, cultural, and community contexts (WHO, 1948). Health is fundamentally relational, shaped by social norms, group memberships, interpersonal dynamics, and cultural meaning systems (Kirmayer, 2012).

In African societies, the family, particularly the extended family system, has historically functioned as the primary locus of health promotion, illness management, and psychosocial support (Kwabena-Adade, 2018; Ojo et al., 2024). Rooted in Ubuntu philosophy ("a person is a person through persons"), African family structures embody collectivist values that prioritise interdependence, reciprocity, and communal responsibility for well-being (Mugumbate & Nyanguru, 2013). From the perspective of social psychology, a clinical setting should not be restricted to hospitals, psychiatric clinics, counselling centres, or consulting rooms; providing healthcare services like medical checkups, diagnosis, treatment, and disease prevention. Clinical experiences also occur in the everyday social environments in which people interpret distress, seek assistance, receive support, and negotiate treatment. In many African societies, the family is one such environment. This paper argues that the African family operates as a de-facto clinical setting, apart from performing the roles of check-up, diagnosis and treatment, also fulfils some roles identified for clinics: (i) providing social context for behaviour change, (ii) serving as a site of identity reconstruction and resocialisation, (iii) mediating social support and belonging, (iv) addressing stigma and power dynamics, (v) linking individuals to community resources, and (vi) functioning as a laboratory for observing and applying social influence processes.

By analysing the African family through this clinical lens and the WHO's health framework, this discussion illuminates how indigenous family systems promote physical, mental, and social well-being while also identifying gaps that require integration with formal healthcare services. This analysis is particularly relevant for psychologists, public health practitioners, and policymakers working in African contexts such as Nigeria, where family-based care remains the cornerstone of health support amid limited formal mental health infrastructure (Adegboye & Ogunniran, 2021).

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CONCEPTUAL DEFINITIONS: THE FAMILY AND THE CLINIC

The African Family

The African family is a culturally constituted and socially interconnected network of individuals related through blood, marriage, adoption, fosterage, shared ancestry, common identity, or fictive kinship, whose members are bound by reciprocal responsibilities for one another's physical care, psychological support, socialisation, moral development, economic survival, and collective well-being. Family in the African context often refers to what in western terms would be the extended family. A family is generally constituted by three processes, which are blood relations, sexual unions or adoption. Societally sanctioned sexual unions between (two and in cases of polygamous unions, which are not uncommon in Africa, more than two) adults, and on the other hand, blood relations in Africa typically constitute wider relationship than those that are characteristically in western nuclear families.

African families are typically extended to aunts, uncles, grandparents, cousins and other relatives that form a family that functions in unison. The broad concept of family in many African societies is illustrated in Mandela's autobiography "Long Walk to Freedom" where he states, "My mother presided over three huts at Qunu, which as I remember, were always filled with babies and children of my relations. In fact, I hardly recall any occasion as a child when I was alone. In African culture, the sons and daughters of one's aunts and uncles are considered brothers and sisters, not cousins" (Mandela, 1994). In several African communities, family is not limited to space and time, thus, it cuts across generations, relatives living far and near, the living and those who have joined the ancestors, as well as the ancestors themselves who continue to play a role in the lives of the living (Lugira, 2009). This may be viewed as a very inclusive family system, which models the broader inclusive nature and type of African communities, creating a family-like lens through which several social actors are included and relationships interpreted. Obligations to wider kin vary with time, and are typically more widely invoked during times of crises, or during certain life cycle events such as funerals and this remains a common practice in extended families on the continent, despite social change.

The African family, however humble, maintains structures that mirror this clinical process. The extended family comprising parents, children, grandparents, uncles, aunts and cousins operates as a standing tribunal and consulting body rolled into one (Nukunya, 2003). The African family does not draw a line, disputes and disorders are brought before the same forum, examined with the same seriousness, and settled through the same deliberative process. The African family is best understood as an institution vested typically in the eldest male or female, or in a council of elders. It has a clear and established process for receiving complaints, and an accepted repertoire of outcomes ranging from reconciliation to ritual cleansing to referral to a specialist outside the family. Nwoye (2000) has described the African family system as "a therapeutic community in its own right, one whose members are bound not by contract but by an inherited obligation of mutual care that persists across generations. It is this therapeutic architecture, built into the ordinary fabric of family life, which this paper defines as a clinical setting.

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The Clinic

The word "clinic" is derived from the Greek word klinē (bed) and klinikos (pertaining to the bed), describing bedside medical attendance. Over time, it became a commonly used English term. A clinical encounter is one where a person in distress is examined by someone recognised as competent to examine them, for the purpose of naming the distress and applying a remedy (Schattner, 2014). Nothing in that definition signifies a rigorous medical process. It only requires empathy, competence, a structured process of inquiry and a publicly acceptable outcome.

THE AFRICAN FAMILY AS A CLINICAL SETTING: ALIGNMENT WITH WHO'S HEALTH FRAMEWORK

Physical Well-Being: The Family as Primary Caregiver

The WHO defines physical well-being as "bodily function, freedom from disease, and the capacity to perform daily activities" (WHO, 1948). In African contexts, the extended family assumes primary responsibility for physical care across the lifespan, particularly for children, older adults, and individuals with chronic illnesses or disabilities. Research from rural Ghana demonstrates that families provide comprehensive domiciliary care for older people living with chronic, life-limiting illnesses, with support extending beyond immediate relatives to include distant kin such as grandchildren, cousins, uncles, and aunties (Daliri et al., 2024a; Ojo et al., 2024). This caregiving model encompasses practical assistance (meal preparation, medication management, mobility support) and aligns with traditional norms of reciprocity and intergenerational solidarity (Mobolaji, 2024). Similarly, in sub-Saharan Africa, family networks traditionally assume responsibility for geriatric care, ensuring that older adults remain integrated into social networks while receiving instrumental support as they age (WHO, 2022).

Similarly, in Nigeria, the care-giving role of the family is shown in comparable evidence. The role of family caregivers in the care of older adults with chronic conditions, especially diabetes, is still a vital aspect of healthcare, and Ojo et al. (2024) created a health promotion guideline aimed specifically at older adults and their family caregivers. This kind of evidence helps to inform a more specific formulation: families can be a platform for formal clinical recommendations to become the local practice of care, rather than just a source for care.

The African family also serves as the first line of response to acute illness and injury. Studies indicate that approximately 80% of Black South Africans consult traditional healers, often family-embedded practitioners, as their primary source of healthcare, particularly for conditions perceived to have spiritual or social dimensions (Galvin et al., 2023). This pluralistic health-seeking behaviour reflects pragmatic adaptation to limited biomedical access and cultural congruence with indigenous explanatory models of illness (Galvin et al., 2023; Kirmayer, 2012).

In a systematic review of 51 studies across sub-Saharan Africa from 2024, however, traditional healing including faith-based, diviner and herbal is revealed to also be a significant route to mental

health care, with also significant variations by context and serious risks linked in some cases with the practices of traditional healers. Evidence therefore suggests the use of a traditional healing practice as an important part of pluralistic care, but not a percentage for the continent as a whole (Berhe et al., 2024).

Mental Well-Being: The Family as Psychological Support System

The WHO defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community" (WHO, 2022). This positive, strengths-based definition emphasises functioning and flourishing rather than mere absence of psychopathology; a perspective that resonates with African communal worldviews.

Ubuntu philosophy offers a culturally grounded framework for understanding mental health in African contexts. Ubuntu, expressed in the Nguni phrase "umuntu ngumuntu ngabantu" ("a person is a person through persons"), emphasises interconnectedness, collective identity, and relational well-being (Mugumbate & Nyanguru, 2013; Gwagwa, 2022). Fukiau's model positions Ubuntu as foundational to positive mental health, critiquing Western psychological models for their individualistic limitations and advocating for culturally inclusive approaches that incorporate connectedness, competency, and consciousness (Mugumbate & Nyanguru, 2013). Within this framework, mental well-being is not an individual achievement but a collective accomplishment sustained through family and community relationships.

Adeponle et al. (2023) in Nigeria demonstrated that caregivers' interpretations of behavioural change, sources of support, stigma, perceived risk, and culturally negotiated illness perceptions highlighted in the literature influenced help-seeking for moderate to severe perinatal depression. This is in line with the current argument as it demonstrates that the family is not passive in terms of its involvement in defining distress, its timing and when it becomes a problem, and the pathway it is deemed legitimate to follow.

Social Well-Being: The Family as Community Integrator

The WHO's inclusion of social well-being in its health definition acknowledges that "relationships, community connections, and sense of belonging shape health just as much as biology" (WHO, 1948). Social well-being encompasses social functioning, community integration, and the quality of interpersonal relationships (WHO, 1948). The African family is the primary architect of social well-being, functioning as the bridge between individuals and broader community ecologies. Several mechanisms illustrate this role:

Socialisation and Norm Transmission: Families socialise children into cultural norms, values, and behavioural expectations that facilitate social acceptance and community participation (Mugumbate & Nyanguru, 2013).

Social Capital and Network Access: Extended family networks provide access to resources (employment opportunities, housing, financial assistance) and social capital that enhance individuals' capacity to participate fully in community life (Adeyeye, 2026). The proverb "It takes a whole village to raise a child" reflects the distributed responsibility for child-rearing and social integration across kin networks (Mugumbate & Nyanguru, 2013).

Conflict Resolution and Social Harmony: Families mediate interpersonal conflicts, restore relationships after transgressions, and maintain social harmony through culturally sanctioned practices (e.g., family meetings, elder mediation, restorative rituals) (Turner, 1969; Nwoye, 2000). These processes prevent social isolation and preserve individuals' standing within the community.

Collective Celebrations and Mourning: Family-organised ceremonies (naming rituals, marriages, funerals) reinforce social bonds, affirm collective identity, and provide structured opportunities for community gathering and mutual support (Galvin et al., 2023; Kirmayer, 2012).

THE AFRICAN FAMILY AS A CLINICAL SITE

The philosophy of Ubuntu supports this assertion. Desmond Tutu once said, "I am because we are, and since we are, therefore I am" (Tutu, 1999). This statement notes that in the African setting, personhood is not an individual achievement but a communal one, realised only through relationships. Where Western clinical psychology begins with the individual as the foundation of its analysis, the African worldview begins with the lineage, community and the family as the true seat of both affliction and healing. A disorder that affects one member in this sense affects all other members.

The African Family as a Site of Assessment, Diagnosis and Treatment

The family may identify that an individual is behaving unusually, determine whether the behaviour constitutes illness, decide where help should be sought, provide financial resources, supervise medication, accompany the individual to treatment, and provide long-term care.

The African Family as a Site of Assessment

Assessment begins with observation and history-taking. The African family performs assessment continuously, informally, and with a degree of intimacy no hospital could replicate. Because family members live, eat and labour together, they are positioned to notice the slightest departures from a person's behaviour. This continuous surveillance, though never termed "assessment" by the family, performs the function that a clinician will perform in a clinical setting.

The vocabulary used to register these observations is rich in itself, even where it does not fit neatly into Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) categories. Expressions such as "he is carried away by deep thoughts", "her mind has travelled," or "the child is not himself again" are culturally coded shorthand for identifiable

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symptoms such as depression, withdrawal, dissociation or behavioural regression that family members can easily recognise. They recognise in a similar way to that of a psychologist who recognises a complaint by listening to his patient (Ilechukwu, 1988). When symptoms are identified to be a point of concern, the family typically convenes a meeting. This is similar to a case conference. The African family arrived at this method by custom long before it was formalised worldwide as a best practice.

The African Family as a Site of Diagnosis

Diagnosis is the act of naming a condition and attributing a cause to it. In the African family setting, the function of diagnosis is performed principally by the family head or the council of elders, whose authority to pronounce upon the meaning of a member's condition is revered and binding. The diagnostic process typically proceeds from an inquiry, since among many African peoples, illness of the mind or emotions is rarely accepted as a random biological event; it is understood to have a reason, often spiritual in character (Mbiti, 1969). Possible causes include a broken taboo, the scheming of an ill-wisher, transgressions, or the psychological aftershock of an unresolved family dispute, such as a contested affair or an unpaid obligation.

Where the problem cannot be solved by the family, the diagnostic process does not end. Under the supervision of family members, a Pastor, Imam, Mallam, or Diviner is consulted (Odejide et al., 1989). This referral, far from being a bypass of the family's clinical role, is better understood as an extension of it, comparable to a practitioner referring a patient to a specialist while remaining the coordinating authority over the patient's care. The diagnosis rendered by the outside specialist is typically reported back to the family and integrated into the family's own understanding of the case before any treatment proceeds.

The African Family as a Site of Treatment and Resolution

Once a diagnosis has been obtained, the African family moves immediately into treatment. Treatment may take several forms. It may be religious and reconciliatory; where a solution is gotten the Islamic, Christian or Traditional way. The family typically identifies the religious authority to be consulted, accompanies the afflicted member to consultations, and monitors compliance with any prescribed spiritual rule, functioning as what a Western clinic would call a treatment adherence support system (WHO, 2022). Under the traditional system, cleansing rites, sacrifices, and formal apologies are exchanged amongst estranged relatives, all intended to repair the breach that is believed to be the source of the affliction (Turner, 1969).

It may also take the form of correction of behaviour. Where a child exhibits persistent disobedience, aggression or withdrawal, the family's response typically combines firm discipline, increased supervision, and assigning responsibilities to adjust the child's behaviour. It may also take the form of sustained caregiving. Where a condition is not resolved, the family absorbs the long-term burden of care that, in societies with better infrastructure, will fall to state institutions. It reflects a deliberate

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philosophy that a troubled member is never to be permanently excised from the family but is to be held by it, however long the trouble persists (Nukunya, 2003).

The African Family Fulfilling Clinic Roles

Social Context for Behaviour Change

Clinics provide structured environments where health behaviours are modelled, reinforced, and normalised through therapist-client interactions, group therapy, and psychoeducation (Bandura, 1977; Cialdini, 2009). The African family fulfils this role through:

Modelling and Observational Learning: Children and younger family members learn health-related behaviours (hygiene practices, help-seeking, coping strategies) by observing elders and peers within the family system. Multigenerational living arrangements facilitate intergenerational transmission of adaptive behaviours and cultural health practices (Bandura, 1977; Nwoye, 2000).

Normative Influence: Family expectations and sanctions shape individual behaviour through mechanisms of conformity and compliance. For example, family pressure to marry, have children, or pursue certain occupations reflects normative influence that can promote socially valued behaviours but may also constrain individual autonomy (Cialdini, 2009).

Reinforcement and Feedback: Family members provide immediate positive reinforcement (praise, material rewards) or negative feedback (criticism, withdrawal of support) that shapes behaviour over time. This operant conditioning occurs naturally within daily family interactions (Bandura, 1977; Cialdini, 2009).

Identity Reconstruction and Resocialisation

Clinics function as spaces for resocialisation, helping individuals reconstruct identities disrupted by illness, trauma, or marginalisation (Nwoye, 2000). The African family performs this function through:

Role Assignment and Validation: Families assign and validate social roles (caregiver, breadwinner, elder, mediator) that provide individuals with purpose, structure, and identity continuity even amid adversity (Mugumbate & Nyanguru, 2013; Nwoye, 2000).

Narrative Reconstruction: Family storytelling and collective memory help individuals integrate difficult experiences (illness, loss, failure) into coherent life narratives that preserve dignity and meaning (Nwoye, 2000).

Mediator of Social Support and Belonging

Clinics facilitate social support networks through group sessions, family therapy, and peer support programmes that buffer against isolation (WHO, 2022). The African family is the archetypal social support system:

Emotional Support: Family members provide empathy, love, and reassurance during times of stress, illness, or loss. This emotional scaffolding is critical for mental health and resilience (Daliri et al., 2024a; Ojo et al., 2024; Mobolaji, 2024).

Instrumental Support: Families provide tangible assistance (financial aid, childcare, transportation, meal preparation) that enables individuals to cope with practical challenges and maintain functioning (Yuan et al., 2022; Zgierska et al., 2024).

Informational Support: Families share health-related knowledge, advice, and guidance that inform decision-making and problem-solving (WHO, 2006).

Belongingness: Family membership provides a fundamental sense of belonging and social identity that protects against loneliness and existential isolation (Mugumbate & Nyanguru, 2013; Gwagwa, 2022). Studies consistently show that family involvement in care is associated with improved engagement, enhanced communication, and increased caregiver competence (WHO, 2022). Among Black sub-Saharan African immigrants, religion and social support within family networks are primary coping strategies for depression, compensating for low formal service utilisation (Iheduru-Anderson, 2026).

Arena for Addressing Stigma and Power Dynamics

Clinics are key sites for confronting stigma and navigating power imbalances between providers and clients (Corrigan & Watson, 2002; Kirmayer, 2012). The African family both reproduces and challenges stigma and power hierarchies:

Stigma Management: Families buffer members against external stigma by reframing stigmatised identities (e.g., "mentally ill person" becomes "person going through spiritual testing") and advocating for their inclusion in family and community activities (Thoits, 2011; WHO, 2022). Ubuntu-informed research with university students raised by caregivers who misused alcohol in Lesotho found that Ubuntu philosophy enabled resilient outcomes by emphasising interdependence, communal belonging, and shared identity ("I am their child. They are my parents too") (Mushonga et al., 2026). This illustrates the family's role in identity reconstruction amid adversity.

Power Negotiation: While traditional African families are often hierarchical (elders hold authority over youth, men over women), contemporary families increasingly negotiate power more democratically, especially in urban, educated contexts (Nwoye, 2000; Thoits, 2011). This evolution can empower marginalised family members (women, youth) to voice needs and access resources.

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Community Linkage and Cultural Brokerage

Clinics act as bridges between individuals and their broader social ecologies, translating cultural norms and advocating for marginalised groups (WHO, 2021; Brown, 2026). The African family is the original cultural broker:

Resource Navigation: Families connect members to external resources (schools, employers, healthcare facilities, religious institutions) and advocate on their behalf (Daliri et al., 2024a; Ojo et al., 2024).

Cultural Translation: Families interpret biomedical information through cultural frameworks, making health information comprehensible and actionable within indigenous meaning systems (Kirmayer, 2012; Galvin et al., 2023).

Collective Advocacy: Families mobilise collective action to address community-level challenges (e.g., lobbying for improved healthcare infrastructure, organising mutual aid networks) (WHO, 2021; Adeleke et al., 2025; Mugumbate, 2026). This demonstrates the family's role in linking individuals to culturally congruent care systems.

Laboratory for Observing Social Influence

Clinics offer real-world settings to observe and apply social influence processes; compliance, persuasion, attitude change in therapeutic contexts (Kirmayer, 2012). The African family is a natural laboratory for observing and applying social influence for therapeutic ends.

Conformity and Obedience: Family pressure to conform to norms (e.g., educational aspirations, marriage expectations, religious participation) illustrates conformity and obedience dynamics that shape behaviour (Cialdini, 2009).

Persuasion and Attitude Change: Family members persuade one another to adopt health behaviours (e.g., seeking traditional healing, adhering to medications, attending church) through argumentation, emotional appeals, and social proof (WHO, 2006).

Cognitive Dissonance and Self-Perception: Family feedback shapes self-perception ("You are strong," "You are responsible") that influences behaviour through self-fulfilling prophecies and identity-based motivation (Mugumbate & Nyanguru, 2013). Qualitative research on traditional healing approaches to mental health in rural KwaZulu-Natal found that traditional healers often embedded within family networks, function as spiritual guides and informal therapists, addressing depression, anxiety, grief, and trauma through culturally coherent practices (Galvin et al., 2023).

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THE AFRICAN FAMILY AS CLINICAL INFRASTRUCTURE AND A REFERRAL GATEKEEPER

This indicates a potentially valuable clinical pathway in the field of African Psychology: observe → interpret → negotiate → mobilise → refer → monitor. The first four functions are typically performed by the family, the fifth may be performed by the formal services, and the family is typically involved in the sixth. The model should not be idealised. A gatekeeper can open the door, but can also close it; a cultural interpreter can help make treatment meaningful, yet can also help bring in an incorrect explanatory model. Therefore, partnership, not replacement, is the clinically defensible stance: professionals should engage with family systems while maintaining informed consent, confidentiality, autonomy, safeguarding, and evidence-based treatment.

The gatekeeping aspect becomes more visible, recent evidence shows. In Nigeria, Adeponle et al. (2023) demonstrated that the help seeking behaviours of caregivers in relation to onset of PPD can be modified, such as onset recognition and types of help sought. Qualitative studies in Ghana have reported of the use of prayer, spirituality, acceptance, social support and routinised coping in Ghanaian family care takers, as well as financial, social and psychological strain (Daliri et al., 2024a, 2024b). In Kenya, Obungu et al. (2026) found that there was a significant burden on caregivers of those living with chronic mental illness, indicating that the family has a clinical role and this role is not without costs to the caregiver.

Another contribution of this paper is to conceptualise the African family not only as a "clinical site" but as "clinical infrastructure." We use the term 'clinical infrastructure' to refer to the relational framework in which symptoms show up, meanings are negotiated, decisions are made about care, resources are put together, and informal and formal care are linked together. The distinction is important because an infrastructure is always present, while a clinic typically is found in a sporadic manner. An older sibling when he accompanies a disturbed family member to a hospital, a mother who observes a change in her child's sleep and behaviour, or an extended family that arranges for transport and medicines are engaged in a longitudinal care process which extends beyond the initial clinical encounter and begins before it.

EMPIRICAL EVIDENCE IN AFRICAN CONTEXTS

The Nigerian evidence is especially pertinent to the argument of this paper. The burden of care and psychological stress experienced by family members of persons with mental illness has been documented in Nigeria and the recent literature also indicates that there remains a need for the integration of mental health into other health services and that help-seeking is culturally bound. The accumulating research findings indicate that family engagement should not be considered as a cultural background condition (Adeleke et al., 2025; Adeponle et al., 2023), but rather a clinical variable, a factor to be assessed, supported, and strengthened, if necessary.

Empirical evidence from various parts of Africa bears out the claim that the functions of African families are clinically relevant, albeit unevenly. In Ghana, Daliri et al. (2024a) reported social,

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physical, psychological and financial burden experienced by family caregivers of mental illness patients, and Daliri et al. (2024b) reported coping strategies as spirituality, social support, acceptance and routinisation. Onyia et al. (2024) reported significant caregiver burden in a South African tertiary psychiatric facility among 300 family caregivers of a person with schizophrenia. Obungu et al. (2026) also showed in Kenya that mental-health impacts of care can be measured. All of these studies make it difficult to romanticise the family; same family structure providing care can also be absorbing costs, which are not reflected in the formal health system.

CHALLENGES

No honest treatment of this subject can avoid confronting its darker corners, the most serious of which is the risk of harm arising from well-intentioned but medically uninformed interventions, particularly where a genuine psychiatric condition is treated exclusively as a spiritual one, delaying access to potentially life-saving treatment (WHO, 2022). Closely related is the problem of stigma, which, paradoxically, the family itself can both mitigate and entrench. While the family may shield a troubled member from public ridicule, it may equally conceal the condition altogether out of shame, discouraging the member from seeking any outside help at all. The preceding discussion suggests that the family has a dual role. The African family is both a protective and a risk environment, as Table 1 shows.

The evidence also warns about using the word "indigenous" interchangeably with "safe." In Nigeria, for example, people with psychosocial disabilities placed in the care of traditional healers have been chained, physically abused and, in some instances, denied food (Human Rights Watch, 2019). A systematic review of traditional healing in sub-Saharan Africa likewise found that 22% of patients reported physical, emotional and sexual abuse by the healers, alongside evidence of possible benefit from collaborative care (Berhe et al., 2024). So culturally responsive practice must be culturally humane but not culturally relativist; conceptions and behaviours must be interpreted within their context, but harmful conceptions and behaviours must be identified as harmful.

Table 1. Protective and Potential Risk Functions of the African Family

Protective Functions	Potential Risk Functions
Emotional Support	Stigma
Financial Assistance	Blame
Treatment Supervision	Excessive Control
Social Belonging	Social Exclusion
Early Identification	Delayed Professional Help
Cultural Continuity	Harmful Explanatory Beliefs
Advocacy	Family Conflict
Caregiving	Caregiver Burden
Spiritual Support	Potentially Harmful Practices
Rehabilitation	Overdependence

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The social psychological significance of this duality is that the family cannot simply be classified as "good" or "bad". Its effect depends on the interaction between family structure, resources, communication, cultural beliefs, socioeconomic conditions, individual characteristics, and access to professional support. While the African family fulfils many clinical roles, several limitations necessitate integration with formal healthcare systems.

Conclusion

In conclusion, this paper has sought to demonstrate that the African family, properly understood, is not a mere social backdrop to psychological life but a functioning clinical setting in its own right. It is a forum before which disputes over land, marriage and inheritance are settled that also receives, examines and resolves the disorders of the mind and the emotions, because in the African conception, both are simply problems requiring diagnosis and resolution before those recognised as competent to give it.

The African family functions as a comprehensive clinical setting that promotes physical, mental, and social well-being in alignment with the WHO's holistic health definition. By fulfilling the core roles of clinics from a social psychology perspective, the African family demonstrates remarkable resilience and adaptability as a health-promoting system.

The stronger proposition emerging from the evidence is that the family should be understood as clinical infrastructure rather than as an alternative clinic. Observation, interpretation, caregiving, adherence to treatment and mobilisation/referral of resources often rely on a relational platform: the family. This formulation preserves the paper's central insight while avoiding the false equivalence between family care and professional diagnosis.

However, caregiver burden, mental health stigma, resource constraints, and limited integration with formal healthcare systems threaten the sustainability and effectiveness of family-based care. To preserve and strengthen this indigenous clinical system, policymakers, healthcare providers, and psychologists must invest in culturally responsive interventions that support families without pathologising or replacing them. This includes psychoeducation, financial and respite support for caregivers, integration of traditional and biomedical healing systems, anti-stigma campaigns, and family therapy models grounded in African epistemologies.

Ultimately, recognising the African family as a clinical setting validates indigenous knowledge systems, advances decolonial mental health discourse, and points toward integrated care models that honour cultural wisdom while ensuring clinical safety and efficacy. For psychologists working in African contexts such as Nigeria, this perspective calls for collaborative, culturally humble practice that leverages family strengths while addressing systemic gaps.

In Nigeria and similar African contexts, this means a model of family inclusion within a rights-respecting framework: the clinician should ask questions about who is included in care, what the family thinks is going on, what resources they are able to mobilise, what burden they are carrying

and what risks they may face as a result of family decision making. This type of evaluation can transform the family from a background factor to a critical element of the clinical diagnosis.

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