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Cultural Influences on Mental Health: Development, Expression, Prevalence, and Help-Seeking in the Democratic Republic of Congo

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Abstract

Mental health is a critical issue for public health today globally. However, despite the increasing awareness of mental health and advances in mental health practices, cultural barriers still limit people's understanding of mental health and care-seeking in many parts of the world including the Democratic Republic of Congo (DRC). The objective of this study, therefore, was to examine the role of culture in development, expression, prevalence of mental health issues and help-seeking behaviors in the DRC. The study used a systematic review of extant literature on the subject drawn from various online databases where a total of 16 studies were analyzed. The methodology adhered to the PRISMA guidelines to ensure transparency and rigor, and only peer-reviewed articles, including empirical studies, reviews, and meta-analyses focusing on mental health were included in the study. The study found that in the DRC, cultural views on mental health pervade. Culture had both positive and negative influences of mental health and mental illness perceptions. Cultural beliefs and familial bonds provided a sense of belonging and resilience and could serve as protective factors. However, uninformed cultural dispositions can also be a source of stigma. Further, cultural barriers, including stigma and a preference for traditional healing, hindered mental health treatment-seeking behavior. The study concluded that cultural factors significantly influence mental health and mental illness perceptions and treatment-seeking behaviors. There is a need to promote culturally sensitive, community-based mental health care through inclusive policies, practitioner training, and public engagement to reduce stigma and encourage timely help-seeking behaviors.

Keywords: Mental Health, Positive and Negative Impacts, Culture, Treatment-seeking

Introduction

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act (Okafor et al., 2022). It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is a basic human right and is crucial to personal,

community and socio-economic development (WHO, 2022). Mental health is more than the absence of mental disorders and exists on a complex continuum, which is experienced differently by each individual. Mental health is also experienced with varying degrees of difficulty and distress and potentially very different social and clinical outcomes (Westerhof & Keyes, 2008). Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always the case (Zhao & Tay, 2023).

Mental health is a critical issue for public health today. Mental health is a global problem, affecting virtually all societies and countries and its prevalence has been increasing (Moitra et al., 2023). Mental health disorders represent one of the most common problems facing adults: within a twelve-month period, nearly 30 per cent of the world's population experiences some diagnosable mental health disorder (Buunk & Dijkstra, 2017). Mental disorders are among the top 10 leading causes of health loss worldwide, with anxiety and depressive disorders ranked as the most common across all age groups and locations (Institute for Health Metrics and Evaluation [IHME], 2021).

The global burden of mental health conditions is immense: more than 1 billion people are living with mental, neurological and substance use disorders, according to World Health Organization (WHO) 2023 estimates (WHO, 2023). The global burden of mental illness accounts for 32.4% of years lived with disability (YLDs) and 13.0% of disability-adjusted life-years (DALYs) (Effatpanah et al., 2024; Vigo, Thornicroft & Atun, 2016). Between 1990 and 2019, the global number of disability-adjusted life-years (DALYS) due to mental disorders increased from 80·8 million to 125·3 million, and the proportion of global DALYs attributed to mental disorders increased from 3·1% to 4·9% GBD 2019 Mental Disorders Collaborators, 2022). YLDs contributed to most of the mental disorder burden, with 125·3 million YLDs globally in 2019 attributable to mental disorders (GBD 2019).

Of the global burden, almost three-quarters of the burden lies in low- and middle-income countries (LMICS) (Moitra et al., 2023). According to WHO (2022), across the African Region, more than 116 million people were already estimated to be living with mental health conditions pre-COVID-

19 pandemic. Despite the high prevalence of mental illnesses across the continent, mental health remains underprioritized in many African countries. Mental healthcare for people living in sub-Saharan Africa is inefficient, inadequate and inequitable. Poor access to mental health care in many African countries is due to low government investment is one of the major hurdles to prevention and care services (Nicholas, Joshua & Elizabeth, 2022). Mental healthcare, therefore, is severely underfunded in low-income countries and approximately 85% of people in these contexts receive no professional treatment (WHO, 2022).

In the Democratic Republic of the Congo (DRC), mental health issues are more prevalent than in many other low- and middle-income countries, largely due to the impacts of armed conflict and poverty (Ngamaba et al., 2024; Seekles et al., 2025; Vaillant et al., 2023). The World Health Organization (2020) reported that the Disability-Adjusted Life Years (DALY) per 100,000 population for mental and substance use disorders in the DRC was 1,557.7, significantly higher than other countries in the region, such as Cameroon (347.7) and Gabon (33.7). Common mental health disorders include schizophrenia (6–15%), anxiety disorders (22%), and mood disorders (13–23%) (Espinoza, 2016). These figures might underestimate the true burden, as barriers to accessing mental health services limit diagnoses. DRC's history of war, disease epidemics, and persistent poverty, compounded by violence and forced ethnic displacement, exacerbates mental health issues (Glass et al., 2018; Mukwege, Mohamed-Ahmed & Fitchett, 2010). Additionally, barriers to seeking mental health care include cultural perceptions, reliance on community-based treatments, and a lack of mental health screening (Espinoza, 2016). These factors contribute to the high prevalence of mental health disorders in the country.

Further, in the DRC, as in the rest of Africa, most data recorded in health management systems do not include mental health, which contributes to an under-appreciation of the disease burden in countries across the continent. Lack of data means that policymakers cannot comprehend the depth of the problem that countries are facing. Moreover, due to high treatment costs, most young people in sub-Saharan Africa are left with no choice but to live with untreated mental disorders or to visit traditional or religious leaders for treatment. Limited mental health education and awareness and shame and stigma are also barriers, and this is the focus of this study as it touches on cultural issues.

The primary objective of this systematic review was to examine the available literature on the influence of cultural factors on mental health in the DRC, with a particular focus on:

a. The positive and negative perceptions of culture on mental health in the DRC.
b. The role of cultural beliefs, practices, and social norms in defining and interpreting mental illness in the DRC.
c. The influence of culture on mental health-seeking behavior in the DRC.

Methodology

This study on "Culture and Mental Health Wellness" employed a rigorous systematic review methodology to synthesize existing literature on the interplay between culture and mental health. The review process followed established Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (O'Dea et al., 2021; Page, & Moher, 2017). These guidelines are widely used to ensure transparency in the review process, comprehensive coverage of relevant studies, rigor and replicability in how systematic reviews and meta-analyses are reported (Parums, 2021; Shamseer, 2015). The systematic review explored how culture influences mental health wellness by synthesizing existing literature on cultural norms, beliefs, and practices, and their implications for mental health outcomes.

This review utilized several academic databases for the search of relevant studies: PubMed, PsycINFO, Scopus, Google Scholar, Web of Science, and ERIC. The search included the following keywords and phrases:

"Culture and mental health"
"Cultural influence on mental health"
"Cultural beliefs and mental illness"
"Mental health stigma in different cultures"
"Enculturation and mental health"
"Cross-cultural mental health wellness"

Boolean operators (AND/OR), truncation (*), and proximity searches were used to refine the results (Alharbi & Stevenson, 2020). Studies published between 2010 and 2024 were included to ensure the review reflects recent research and perspectives on cultural influences on mental health.

Inclusion and Exclusion Criteria

The inclusion criteria for studies in this review were as follows:

a. Study Design: Peer-reviewed articles, including empirical studies, reviews, and meta-analyses.
b. Population: Studies focusing on cultural groups and populations across various countries, including individuals from collectivist and individualist cultures.
c. Mental Health Focus: Articles that specifically address mental health outcomes, including anxiety, depression, schizophrenia, and the role of culture in the diagnosis, perception, and treatment of mental health disorders.
d. Language: Articles published in English and other widely spoken languages (if translated).

The exclusion criteria for studies in this review were as follows:

a. Studies that do not focus on mental health but discuss general cultural factors.
b. Non-peer-reviewed literature (e.g., opinion pieces, blogs, and editorials).
c. Articles published before 2010.
d. Studies conducted in non-human populations.

Data Extraction and Analysis

Data extraction was performed using a structured form to capture essential details from each study, including author(s), publication year, study population, cultural context, and research design, and key findings (Schmidt et al., 2025; Büchter et al., 2020). Thematic synthesis was employed to categorize findings into major themes such as enculturation, stigma, cultural values, and their impacts on mental health. Quantitative studies were analyzed for statistical relationships between cultural variables and mental health indicators, while qualitative studies were assessed for recurring patterns and insights into cultural influences.

Quality Assessment

Each included study underwent a quality appraisal using validated tools such as the Critical Appraisal Skills Programme (CASP) for qualitative research and the Newcastle-Ottawa Scale for quantitative studies. This ensured the reliability and validity of findings by evaluating methodological rigor, sample size, and potential biases.

Synthesis of Findings

The review synthesized data across studies to highlight key insights, including the dual role of culture as both a protective and risk factor for mental health. Themes such as the impact of parental enculturation strategies, cultural stigma, and differing cultural definitions of mental health were integrated into the analysis. Differences between collectivist and individualist cultures were explored, as well as the role of traditional belief systems and community structures in shaping mental health perceptions.

Results

Table 1 shows the summary of the search results.

Table 1: Search Results

Category	Frequency
Databases	Five (PubMed, PsycINFO, Scopus, Google Scholar, Web of Science, and ERIC)
Total hits	138
Excluded after abstract	79
Included after title & abstract	68
Excluded after full text	57
Included after full text	41
Quality assessment	High

The Role of Cultural Beliefs and Practices in Mental Health Seeking Behavior

Culture plays a foundational role in shaping how mental health issues are understood, expressed, and addressed, particularly in the Democratic Republic of Congo (DRC), where deeply embedded cultural norms influence the entire trajectory of mental illness, from its perceived origins to the decision to seek help. According to Kirmayer and Bhugra (2009) and Lewis-Fernández, R., & Kirmayer (2019), culture influences what individuals bring into the clinical setting, including how they communicate symptoms, what they choose to report, and the explanatory models they apply to mental distress. These cultural frameworks can underlie variations in symptom expression and even give rise to culture-bound syndromes, clusters of symptoms more prevalent in specific societies (Kyolo et al., 2023). This highlights how cultural beliefs do not merely shape the expression of mental disorders but also contribute to their perceived development and prevalence within communities.

More importantly, cultural values critically determine whether individuals seek mental health support, the kind of support they consider appropriate, and the degree of stigma they associate with mental illness. In the DRC, these cultural determinants manifest in diverse ways. For example, in some communities, emotional restraint is valued, limiting open expressions of psychological distress and affecting coping mechanisms and resilience (Lawry et al., 2021). In others, supernatural interpretations of mental illness and the use of traditional healers are dominant, which profoundly impacts help-seeking behavior (Espinoza, 2016).

Table 2. Culture and Mental Health Seeking Behavior in the DRC

Study	Focus	Methodology	Key Findings	Strengths	Limitations
Dossa et al. (2015)	Mental health disorders among women victims of conflict-related sexual violence in the DRC	Cross-sectional survey	Women affected by sexual violence showed high rates of depression, PTSD, and anxiety. Stigma and shame acted as barriers to seeking care.	Provides statistical data on the mental health outcomes of sexual violence victims.	Cross-sectional design limits causal inference. Focus on sexual violence victims may not generalize to the broader population.
Kohli et al. (2014)	Family rejection and mental health outcomes in conflict-affected women in rural DRC	Quantitative surveys and regression analysis	Family rejection negatively impacted mental health outcomes, with stigma and social rejection being key barriers.	Statistical analysis offers clear insights into the relationship between family rejection and mental health outcomes.	Limited generalizability beyond women in rural DRC. Does not explore deeper cultural beliefs.
Espinoza, S. (2016)	Barriers to mental health treatment in the Congolese population	Qualitative analysis (interviews)	Identified stigma and traditional beliefs as key barriers to seeking mental health care, with preference for traditional medicine.	Provides rich cultural context and insight into traditional beliefs affecting mental health care.	Lack of statistical data limits generalizability. Focus on the Congolese diaspora may not reflect all cultural contexts.
Scott et al. (2015)	Mental health outcomes, stigma, and acceptance among women raising children born from sexual violence-related pregnancies	Mixed-methods (respondent-driven sampling, interviews)	Found high stigma and social exclusion linked to children born from sexual violence, worsening mental health outcomes.	Combines quantitative and qualitative data to provide a well-rounded view of mental health outcomes.	Focus on a specific subgroup (women with children born from sexual violence) limits broader applicability.
Kyolo et al. (2022)	Use of medicinal plants for mental illness in Goma City, DRC	Ethnobotanical survey (qualitative)	Found that traditional medicinal plants were widely used for treating mental health disorders, reflecting strong cultural beliefs.	Provides a unique cultural perspective on mental health treatment using traditional medicine.	Lacks statistical data, limiting generalizability. Focus on one city in the DRC may not reflect national practices.
Lawry et al. (2021)	Health and mental health characteristics and barriers to healthcare for Ebola survivors in DRC	Mixed-methods (surveys and interviews)	Cultural beliefs about supernatural causes of disease and stigma were major barriers to healthcare access among Ebola survivors.	Mixed-methods approach offers comprehensive insights into mental health and barriers to care.	Focus on Ebola survivors may not be generalizable to the general population. Limited cultural analysis beyond disease context.

Cultural Influence on the Development of Mental Health Issues

Across the reviewed literature, culture emerges as a significant factor in the development of mental health conditions, often by mediating exposure to social adversity and shaping individual psychological responses. In the studies by Dossa et al. (2015) and Kohli et al. (2014), the psychological impact of sexual violence and family rejection, respectively, is compounded by culturally rooted beliefs surrounding shame, purity, and familial honor. These cultural norms not only exacerbate trauma but also create hostile environments that foster chronic emotional distress, contributing to the development of conditions such as PTSD, depression, and anxiety. Similarly, Lawry et al. (2021) show that Ebola survivors often develop psychological symptoms not only due to their illness experience but also because of cultural beliefs attributing disease to supernatural causes, leading to isolation and distress. In this context, cultural frameworks function as psychosocial stressors that deepen mental health vulnerabilities following conflict or crisis.

Cultural Framing of Mental Health Expression

Culture in the DRC significantly influences how mental health symptoms are expressed, both linguistically and behaviorally. For instance, Scott et al. (2015) reveal how cultural stigma surrounding children born of sexual violence leads to social exclusion, which in turn intensifies internalized distress, shame, and withdrawal. Mental illness, in these cases, is often expressed not through open articulation of emotional pain but through social silence, isolation, and withdrawal, reflecting culturally sanctioned coping mechanisms. Espinoza (2016) adds that many Congolese individuals interpret symptoms of mental illness, such as hallucinations or depressive states, through spiritual or metaphysical explanations, such as ancestral displeasure or witchcraft, leading to culturally specific forms of symptom expression that may not align with Western diagnostic criteria. These interpretations heavily influence whether symptoms are perceived as medical issues requiring treatment or as spiritual matters necessitating ritual or traditional intervention.

Cultural Determinants of Prevalence Patterns

While all studies highlight mental illness as a significant concern in the DRC, culture affects how and where prevalence is observed. The stigmatization documented by Dossa et al. (2015) and Scott

et al. (2015) suggests that mental health issues may be underreported in formal settings due to fear of social repercussions. Additionally, Kyolo et al. (2022) underscore that many cases of mental illness are managed entirely within traditional medicine systems, never entering formal healthcare records, thereby masking true prevalence rates. Moreover, in rural areas, Kohli et al. (2014) found that cultural pressures around family roles and communal expectations increase psychological strain, particularly for women, potentially resulting in higher prevalence rates in under-resourced and culturally conservative settings. These studies collectively suggest that cultural stigma and alternative explanatory models contribute to hidden prevalence, complicating epidemiological surveillance and public health planning.

Culture and Help-Seeking Behaviors

The impact of culture on help-seeking behaviors is particularly well-documented. In nearly all reviewed studies, cultural beliefs were identified as primary barriers to accessing formal mental health care. Espinoza (2016) found that individuals commonly favored traditional healing practices, often informed by spiritual or communal traditions, over biomedical services. This preference reflects deeply held beliefs that psychological disturbances are not illnesses per se, but spiritual imbalances. Similarly, Kyolo et al. (2022) documented widespread reliance on medicinal plants and indigenous healing systems in Goma City, reinforcing the notion that culturally embedded practices dominate mental health treatment pathways. Even in more formalized research settings, such as Lawry et al. (2021), participants resisted clinical interventions, citing culturally anchored fears of supernatural retribution or social ostracism. Meanwhile, Dossa et al. (2015) and Scott et al. (2015) showed how cultural stigma, particularly surrounding sexual violence, significantly deters women from seeking mental health services, further marginalizing already vulnerable populations.

This joint review reveals that culture in the DRC plays a foundational role across all dimensions of mental health experience. This is from the development of psychological distress shaped by socio-cultural adversity, to the expression and interpretation of symptoms, the perceived prevalence and visibility of illness, and the choice of treatment or avoidance thereof. These studies emphasize that any effective mental health intervention in the DRC must go beyond clinical

frameworks to actively engage with cultural systems. Interventions must consider local beliefs, traditional healing modalities, and culturally sanctioned forms of care, while also addressing the stigma that hinders help-seeking. Moreover, public health efforts must incorporate community leaders, spiritual practitioners, and traditional healers as stakeholders to ensure culturally congruent care models.

Positive and Negative Cultural Beliefs on Mental Health in the DRC

Shojaee (2014) asserts that since cultures set standards or 'norms' for acceptable behaviors of people, mental health is defined in terms of the people's deviation from the social and cultural norms. This deviation from the cultural norms could result in stigma in societies that have a limited understanding of mental health. Thornicroft et al. (2020) observe that while stigma is a universal phenomenon, stigma appears to be a stronger barrier to treatment access within low-resource areas and among vulnerable members of the population including the poor, women, and ethnic minorities. Indeed, family and community play a very important role in an individual's Enculturation process, which in turn has future implications on the individual's mental health (Ward & Szabó, 2023).

Table 3. Cultural Beliefs and Practices in Mental Health in the DRC

Study	Focus	Methodology	Key Findings	Strengths	Limitations
Cherewick et al. (2016)	Examines the relationship between potentially traumatic events, coping strategies, and mental health among conflict-affected youth in Eastern DRC.	Quantitative cross-sectional survey	Identified that exposure to traumatic events correlates with higher mental health symptoms, with coping strategies impacting well-being.	Clear quantitative approach, large sample size, contributes to understanding trauma and coping.	Cross-sectional design limits causal inference, focuses only on youth without considering broader community context.
Johnson et al. (2010)	Investigates the association between sexual violence, human rights violations, and physical and mental health in Eastern DRC.	Quantitative cross-sectional survey	Found strong associations between sexual violence, human rights violations, and worsened physical and mental health outcomes, particularly in women.	Comprehensive survey of a wide range of human rights violations, large sample size.	Cross-sectional, lacks depth in exploring underlying mechanisms or long-term effects.
Cikuru et al. (2021)	Evaluates the impact of the Healing in Harmony program on women's mental health in rural South Kivu, DRC.	Mixed-methods approach (quantitative and qualitative)	The program improved mental health symptoms, reducing symptoms of depression and anxiety.	Use of mixed-methods provides both quantitative and qualitative insights, focused on an intervention.	Generalizability limited to rural South Kivu, program's long-term impact unclear.
Aldersey et al. (2017)	Explores family quality of life in the DRC, focusing on family dynamics and intellectual disabilities.	Qualitative interviews	Found that families with members with intellectual disabilities faced increased stress, with cultural beliefs shaping caregiving approaches.	In-depth qualitative insights into family dynamics and the role of culture in caregiving.	Focuses only on families with intellectual disabilities, limited sample size.
Emerson et al. (2020)	Investigates the relationship between mental health symptoms, dietary diversity, and nutritional status among mothers in Eastern DRC.	Quantitative cross-sectional survey	Identified that mental health symptoms were associated with poor dietary diversity and nutritional status among mothers.	Combines public health and mental health perspectives, large sample size.	Cross-sectional design, does not establish causality, does not consider broader socio-economic factors.

The studies above collectively explored mental health in the Democratic Republic of Congo (DRC) through diverse methodologies, perspectives, and populations. While they shared commonalities in acknowledging the significance of cultural beliefs, practices, and social norms, they differed in their approaches, specific focus, and conclusions. All studies employed established tools and frameworks to assess mental health outcomes. Cherewick et al. (2016), Johnson et al. (2010), and Emerson et al. (2020) utilized the *Hopkins Symptom Checklist* to measure symptoms like depression and anxiety, ensuring standardized assessment methods. Cikuru et al. (2021) and Aldersey et al. (2017) incorporated culturally relevant qualitative or mixed-method approaches, emphasizing the importance of understanding local contexts. Cherewick et al. (2016) and Johnson et al. (2010) primarily employed cross-sectional survey designs, offering a snapshot of mental

health conditions and their associations with traumatic experiences or human rights violations. In contrast, Cikuru et al. (2021) adopted a pre- and post-intervention design, providing longitudinal insights into the impact of culturally tailored interventions. Aldersey et al. (2017), using a purely qualitative approach, relied on semi-structured interviews to delve into the nuanced interplay between family dynamics and cultural norms. Emerson et al. (2020) uniquely incorporated nutritional assessments, broadening the scope of mental health research by linking dietary diversity to psychological well-being.

The studies consistently found that cultural beliefs, practices, and social norms heavily influenced mental health. Johnson et al. (2010) and Cherewick et al. (2016) agreed that stigma, shaped by cultural attitudes, was a significant barrier to seeking mental health care. Similarly, Aldersey et al. (2017) and Cikuru et al. (2021) emphasized the role of community and family support in shaping mental health outcomes, suggesting that collective caregiving norms acted as protective factors. While Johnson et al. (2010) highlighted the devastating effects of human rights violations and sexual violence on mental health, it lacked the cultural depth present in studies like Cikuru et al. (2021), which showcased the benefits of culturally grounded interventions such as music therapy. Emerson et al. (2020) provided a novel angle by linking mental health symptoms to dietary practices, diverging from other studies that focused solely on sociocultural or psychosocial factors. Aldersey et al. (2017) presented a more optimistic view by showing how family quality of life could mitigate psychological distress, contrasting with Johnson et al. (2010), which focused on the severe consequences of conflict-related trauma.

The studies universally acknowledged the centrality of cultural factors in defining and addressing mental health challenges. All emphasized the need for interventions tailored to local cultural and social norms, underscoring the importance of community-based approaches to mental health care. Cikuru et al. (2021), however, concluded that culturally sensitive programs, such as Healing in Harmony, were effective in reducing PTSD and depression symptoms. In contrast, Johnson et al. (2010) and Cherewick et al. (2016) focused on the prevalence and impact of mental health challenges without offering detailed intervention strategies. Emerson et al. (2020) advocated for a multidisciplinary approach, integrating mental health and nutritional support, while Aldersey et al. (2017) emphasized family dynamics as a critical factor in mental health outcomes.

Cikuru et al. (2021) stood out for its robust evaluation of an intervention's effectiveness, combining quantitative and qualitative data. Emerson et al. (2020) innovatively linked mental health with nutritional factors, addressing a broader spectrum of influences. Aldersey et al. (2017) offered rich qualitative insights into the role of family systems, while Cherewick et al. (2016) and Johnson et al. (2010) provided large-scale data on mental health correlates in conflict settings. Johnson et al. (2010), however, lacked a focus on culturally informed solutions, limiting its applicability to local contexts. Similarly, Emerson et al. (2020) did not sufficiently explore cultural practices despite identifying nutritional factors. Cherewick et al. (2016) and Aldersey et al. (2017) faced limitations in generalizability due to reliance on specific populations or qualitative data.

Cultural Beliefs and Practices in Mental Illness in the DRC

Cultural beliefs and practices are deeply interwoven with mental health perceptions, treatment, and outcomes. Shojaee (2012) asserts that since cultures set standards or 'norms' for acceptable behaviors of people, mental health is defined in terms of the people's deviation from the social and cultural norms. This deviation from the cultural norms could result in stigma in societies that have a limited understanding of mental health. Thornicroft et al. (2020) observe that while stigma is a universal phenomenon, stigma appears to be a stronger barrier to treatment access within low-resource areas and among vulnerable members of the population including the poor, women, and ethnic minorities. This section explores how cultural beliefs and practices influence understanding of mental illness in the DRC. Table 4 summarizes studies on Cultural Beliefs and Practices in Mental Illness in the DRC.

Table 4. Cultural Beliefs and Practices in Mental Illness in the DRC

Study	Focus	Methodology	Key Findings	Strengths	Limitations
Kyolo et al. (2023)	Indigenous knowledge and perceptions toward mental illness in Goma, DRC	Qualitative (Interviews, Focus Groups)	Mental illness linked to spiritual causes like witchcraft and ancestral displeasure; reliance on traditional healers.	Rich cultural insights into local beliefs; inclusive of community leaders.	Limited to Goma city, restricting generalizability.
Martin Romero et al. (2024)	Cross-cultural perspectives on adolescent mental health among Congolese immigrants in the USA and Belgium	Mixed Methods (Surveys, Interviews)	Adolescents face stress balancing collectivist Congolese values with individualistic Western norms; stigma affects mental health.	Cross-cultural comparison offers broader insights; balanced methodology.	Small sample sizes limit statistical power.
Mels et al. (2010)	Validation of mental health measures (IES-R and HSCL-37A) in Eastern DRC	Quantitative (Psychometric Validation)	Trauma and depression linked to post-conflict conditions; cultural factors affect symptom expression.	Rigorous psychometric validation; large sample size (N > 300).	Focus on diagnostic tools; limited exploration of cultural beliefs.
Mukala Mayoyo et al. (2023)	Understanding mental health care services in urban DRC	Qualitative (Interviews with healthcare providers and patients)	Barriers like resource scarcity, stigma, and traditional healing practices impact mental health care access.	In-depth understanding of local health care system; explores stigma.	Urban focus; limited exploration of rural dynamics.
Aldersey et al. (2017)	Family quality of life in the DRC with a focus on intellectual disabilities	Mixed Methods (Surveys, Interviews)	Cultural stigma and lack of resources significantly impact family well-being.	Combines both quantitative and qualitative data; insightful family-level perspective.	Broader focus on intellectual disabilities, not just mental illness.

Cultural context in the DRC contributes significantly to how mental health conditions develop, especially when compounded by poverty, conflict, and societal expectations. In Kyolo et al. (2023), the belief that mental illness originates from spiritual causes such as witchcraft and ancestral displeasure underscores how indigenous knowledge systems influence the perceived origins of psychological suffering. These explanations are not merely metaphoric but shape how individuals and families process trauma, potentially delaying clinical intervention and reinforcing psychological distress through spiritual fear. Martin Romero et al. (2024) expand this notion by exploring how adolescents from Congolese immigrant families struggle to reconcile collectivist Congolese values with individualistic Western ideals. This cultural dissonance generates identity-based stress and familial conflict, especially around autonomy and conformity, contributing to psychological strain. Similarly, Aldersey et al. (2017) highlight that the development of distress among families with intellectually disabled members is rooted not just in disability but in cultural

stigma, resource scarcity, and the burden of care, all of which amplify emotional strain in culturally specific ways.

Cultural beliefs also shape how symptoms of mental illness are recognized and communicated. In Mels et al. (2010), which validated mental health diagnostic tools in Eastern DRC, it was found that while Western instruments could detect trauma and depression, local expressions of distress often differed, influenced by linguistic and cultural framing. For instance, somatic complaints or spiritual interpretations of symptoms might be more culturally acceptable than openly discussing emotional suffering. Similarly, Kyolo et al. (2023) revealed that many individuals conceptualize mental illness through observable behaviors, such as talking to oneself or displaying aggression, which are associated with spiritual possession rather than internal psychological states. This impacts how communities respond to those with mental illness, typically with fear or avoidance, reinforcing silence and social exclusion as culturally sanctioned responses. Among adolescents, Romero et al. (2024) noted that stigma surrounding emotional vulnerability led to the suppression or denial of symptoms, especially among males, who felt cultural pressure to remain stoic and resilient. Such gendered norms regarding emotional expression complicate efforts to identify mental health issues early, both within and outside the DRC.

While all five studies acknowledge the pervasiveness of mental health challenges, cultural factors obscure accurate assessments of prevalence. In Mukala Mayoyo et al. (2023), healthcare providers in urban centers report low patient turnout despite visible need, attributing this to stigma, spiritual explanations, and mistrust of biomedical services. These cultural perceptions result in underreporting and an overreliance on non-clinical care pathways. Moreover, Aldersey et al. (2017) show that families often hide members with intellectual or psychological disabilities, a practice rooted in cultural shame and fear of community judgment. Such concealment diminishes the visibility of mental health needs in both policy and practice, skewing prevalence data. Mels et al. (2010) highlight that the use of standardized Western diagnostic tools requires cultural adaptation to accurately reflect symptom patterns in the Congolese population, particularly in post-conflict regions. Without such adaptation, under-detection and misclassification are likely, reinforcing the importance of culturally grounded epidemiological tools.

Culture emerges as perhaps the most decisive factor in shaping help-seeking behavior. In Kyolo et al. (2023) and Mukala Mayoyo et al. (2023), the reliance on traditional healers and spiritual leaders rather than clinical practitioners is attributed to deep-seated beliefs in spiritual causation and mistrust of formal systems. These practices are not only more accessible but also more congruent with local belief systems, especially in the absence of affordable and culturally sensitive biomedical services. Martin Romero et al. (2024) demonstrate that these cultural barriers persist even among Congolese immigrants in Western countries, where adolescents often hesitate to seek mental health services due to inherited stigma and family expectations rooted in Congolese cultural norms. This transnational continuity highlights the resilience of cultural influence on help-seeking across contexts. In urban areas, as observed by Mukala Mayoyo et al. (2023), healthcare providers struggle to overcome stigma-related reluctance, despite increased service availability. The disconnect between clinical approaches and cultural expectations contributes to low service uptake. Similarly, Aldersey et al. (2017) documents that families of individuals with intellectual disabilities often turn to religious or community-based coping mechanisms, viewing formal mental health care as either ineffective or culturally irrelevant.

Collectively, these studies affirm that culture in the DRC, and among Congolese populations abroad, plays a central role in shaping every dimension of the mental health experience. From the development of distress through culturally interpreted trauma, to the expression of symptoms shaped by social expectations and belief systems, to the underestimation of prevalence due to concealment and alternative explanatory models, and ultimately to help-seeking behaviors driven by traditional and spiritual pathways, culture remains both a framework and a filter through which mental health is understood and acted upon. The findings underscore the need for culturally adapted mental health interventions in the DRC that bridge indigenous beliefs with biomedical models. Training community health workers, partnering with traditional healers, and culturally validating diagnostic tools are critical steps forward. Additionally, public health strategies should address stigma through culturally resonant education and involve family and community leaders in mental health promotion efforts.

Discussion

The findings of these studies collectively emphasize the significant role culture plays in shaping mental health prevalence in conflict-affected regions like the Democratic Republic of Congo (DRC). Cikuru et al. (2021) and Aldersey et al. (2017) underscore the importance of community and family support as protective factors, aligning with the view that cultural beliefs and familial bonds can provide a sense of belonging and resilience, key elements for mental health (Baumeister & Leary, 1995). These findings resonate with the notion that cultural influences can be both protective and supportive in mental health, as outlined in social psychology theory (Krech & Crutchfield, 1948). On the other hand, Johnson et al. (2010) and Cherewick et al. (2016) focus on the detrimental effects of trauma and stigma, highlighting how cultural factors can also contribute to isolation and mental health struggles, particularly when social norms are violated. Emerson et al. (2020) further extend this conversation by linking mental health to nutritional deficiency, suggesting that cultural beliefs influence not only psychological but also physical well-being. This reinforces the idea that mental health perceptions and values differ across cultures (Karasawa et al., 2011), and traditional African healing practices, as noted by Amunga (2020), could offer a holistic approach to mental health care. Thus, the studies support the need for culturally informed, multidisciplinary approaches to mental health care in the DRC and the larger African contexts.

The findings from Kyolo et al. (2023) and Mukala Mayoyo et al. (2023) emphasize the central role of cultural beliefs in shaping perceptions of mental illnesses in the Democratic Republic of Congo (DRC), particularly the reliance on traditional healers as first-line mental health providers. This aligns with Shojaee's (2020) assertion that cultures set standards for acceptable behaviors, and deviations from these norms can lead to stigma, especially in societies with limited mental health understanding. Both studies also underscore the persistence of stigma, a barrier to mental health treatment, which echoes Thornicroft et al.'s (2020) observation that stigma is particularly strong in low-resource areas, impeding treatment access among vulnerable populations. Similarly, Martin Romero et al. (2024) highlighted how cultural dissonance, particularly among Congolese immigrants, exacerbated mental health challenges, illustrating the influence of cultural norms on well-being. Aldersey et al. (2017) further demonstrated how stigma negatively impacts family well-being, reinforcing the importance of family and community in the enculturation process, as emphasized by Ward and Szabó (2023). Mels et al. (2010) focused on adapting diagnostic tools to

local contexts, underscoring the need for culturally informed mental health assessments. Collectively, these studies stress the necessity for culturally sensitive interventions and the integration of qualitative and quantitative approaches to better address the mental health needs in culturally diverse settings.

The reviewed studies reveal a complex relationship between cultural beliefs and mental health-seeking behavior in conflict-affected regions, aligning with findings in other African countries. Dossa et al. (2015) and Kohli et al. (2014) underscore the negative impacts of cultural stigma and family rejection on mental health, consistent with research in Nigeria by Okafor et al. (2022), where traditional beliefs influenced perceptions and treatment of mental illness. In the DRC, Scott et al. (2015) and Lawry et al. (2021) found that cultural barriers, including stigma and a preference for traditional healing, hindered mental health treatment-seeking behavior. These findings mirror those in South Africa, where Bila and Carbonatto (2022) found that witchcraft beliefs often led individuals to seek help from traditional or religious healers rather than mental health professionals. Similarly, Daniel (2018) in Tanzania observed that the Maasai community preferred traditional healers and religious leaders over professional healthcare providers for mental health care. In Kenya, stigma, particularly self-stigma, delays diagnosis and treatment, as noted by Syengo (2006) and Thornicroft (2008), with individuals avoiding mental health facilities due to fear of discrimination. These studies emphasize the importance of understanding cultural context in mental health care and suggest that integrating traditional and professional health systems may improve treatment-seeking behaviors. However, the lack of generalizability in these studies calls for further research incorporating both qualitative and quantitative methods in diverse settings.

In the Democratic Republic of the Congo (DRC), traditional understandings of mental health have been deeply rooted in spiritual and social relationships. Cultural practices often associated mental health issues with imbalances between individuals and their spiritual or social environments, where churches, family rituals, and traditional healers played crucial roles in addressing these imbalances. For example, issues related to sexuality, fertility, and matrimony were seen as disruptions in the spiritual realm that could be remedied through communal or spiritual interventions (Balegamire, 2021; Maisha, Malette & Demasure, 2017). Gender roles within these cultural norms reinforced expectations, with women and girls being responsible for childbearing and domestic work, while men were expected to be the breadwinners and heads of the household (Barker, Levtov & Slegh,

2014). These cultural views shaped how mental health was perceived and addressed, with a strong emphasis on spiritual and community-based interventions rather than formal medical approaches.

In terms of mental health disorders, the Congolese people demonstrated a relatively accurate understanding of certain conditions. Espinoza (2016) highlighted that individuals in the Butembo region recognized psychotic disorders, referring to them as *erisire*, but traditionally sought spiritual treatment first, often from local healers or religious leaders, with Western medical intervention being considered only in the absence of supernatural causes. For conditions like depression, individuals recognized symptoms, referring to it as *Amutwe alluhire*, but again, such conditions were seen as social or spiritual problems rather than medical ones. This cultural perspective often led to a preference for non-medical support, such as emotional and social help from family or community members, rather than professional healthcare (Espinoza, 2016). This shows that while there was some understanding of mental health, cultural beliefs heavily influenced the type of interventions people sought, with spiritual and community-based responses prioritized over formal medical care.

The influx of humanitarian aid and foreign interventions in response to widespread sexual violence during the late 1990s led to shifts in cultural and societal norms in the DRC. Concepts like human rights, women's rights, and Western mental health frameworks began to influence local perceptions of mental health and psychosocial support (Akyeampong, 2015; Balegamire, 2021). However, these foreign ideas clashed with traditional beliefs, as they failed to immediately replace old values, leading to a complex interplay between Western and local health beliefs (Gichinga, 2007; Kirmayer et al., 2018). Moreover, the collapse of traditional social support structures, exacerbated by war, displacement, and globalization, left many individuals without the community-based support they once relied on (Chiumento et al., 2020; Koegler et al., 2019). In the context of conflict, sexual and gender-based violence (SGBV) further intensified the suffering of women and children, who often faced stigma, rejection, and isolation when trying to disclose their experiences (Johnson et al., 2010; Verelst et al., 2014). The rise of new norms and ideas regarding women's rights and mental health created tensions within traditional family and community structures, which struggled to adapt to these shifts, particularly as women and girls faced increased violence and stigmatization.

Conclusion

In conclusion, the studies reviewed provide significant insights into the intricate relationship between cultural beliefs and mental health-seeking behavior in the Democratic Republic of Congo (DRC). Although their methodologies and focal points differ, a consistent theme emerges across the studies: cultural factors significantly influence mental health prevalence and treatment-seeking behaviors. The quantitative studies highlight the negative impact of trauma, stigma, and social rejection on mental health, while the qualitative and mixed-methods studies shed light on the role of traditional healing practices and community support systems in shaping individuals' attitudes towards mental health care. Despite these valuable contributions, all the studies share limitations, particularly the lack of generalizability to broader populations and regions, as well as the need for more longitudinal data to capture the long-term effects of cultural beliefs on mental health and the adoption trends of modern interventions. Mental health practitioners should adopt culturally sensitive approaches in their practice to encourage the adoption of contemporary interventions. Policymakers should prioritize the development of inclusive mental health policies, address stigma and promote community-based mental health care. Citizens should be encouraged to engage in open discussions about mental health, reducing stigma and seeking help when needed. Collaborative efforts between healthcare providers, communities, and policymakers are essential for improving mental health outcomes in the DRC.

The key limitation of this systematic review lies in the scope and specificity of the included studies. While the review adopted a rigorous PRISMA-guided methodology and included a diverse range of sources, many of the studies analyzed did not focus exclusively on the Democratic Republic of Congo (DRC), potentially limiting the cultural relevance and contextual accuracy of some findings. Additionally, the exclusion of non-English literature may have omitted valuable region-specific insights, especially in a multilingual country like the DRC. The review’s reliance on cross-sectional and short-term studies further constrains the ability to capture longitudinal cultural influences on mental health. Lastly, the lack of disaggregated rural versus urban data limits the applicability of findings to diverse subpopulations within the DRC, where cultural norms and mental health realities can vary significantly.

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