World Journal of Medical Case Reports
2026, Vol. 7, No. 1, pp. 5–8
https://doi.org/10.11648/j.wjmcr.20260701.12

Case Report

A Case Report Highlighting the Impact of Socio-cultural Misunderstandings on Psychiatric Diagnosis

Puja Neupane*, Shailendra Raj Adhikari

Department of Psychiatry, Beautiful Mind Institute of Psychiatry and Rehabilitation Centre, Chitwan, Nepal

Abstract

Psychiatric diagnoses are often shaped not only by patient-reported symptoms but also by the clinician's interpretation, and both processes are highly influenced by sociocultural context. This case report describes a 52-year-old woman who was initially diagnosed with Bipolar Affective Disorder (BPAD) despite the absence of clear evidence for manic or hypomanic episodes. Her presenting symptoms primarily included persistent insomnia, restlessness, and multiple somatic complaints, which on the surface appeared complex and difficult to categorize. However, upon hospital admission and through careful, repeated evaluation, it was revealed that her difficulties were more closely linked to chronic stress arising from long-standing familial obligations, social responsibilities, and culturally ingrained expectations rather than from an underlying bipolar condition. Over time, her diagnosis was revised to a depressive episode, and with appropriate treatment she demonstrated marked improvement in sleep, mood, energy, and overall functioning. This case vividly illustrates how cultural norms, coping mechanisms, and socially reinforced patterns of expressiveness can sometimes be misinterpreted as psychopathology, thereby complicating clinical judgment. In her situation, emotional expressiveness, resilience in dealing with family burdens, and heightened involvement in social roles were mistakenly viewed as indicators of bipolar illness. Such misinterpretations underscore the danger of overlooking cultural context, which may result in diagnostic errors, unnecessary stigma, ineffective treatment plans, and prolonged patient suffering. The case therefore emphasizes the critical importance of adopting a culturally informed approach in psychiatric assessments, one that seeks to carefully distinguish between genuine psychopathological symptoms and behaviors that are normative, adaptive, or culturally shaped. By systematically integrating cultural and social understanding into diagnostic evaluations, clinicians can enhance diagnostic accuracy, avoid mislabeling, and ensure that treatment strategies are both individualized and therapeutically effective. Ultimately, culturally sensitive assessments contribute to improved mental health outcomes, strengthen the therapeutic alliance, and foster a more compassionate model of psychiatric care.

Keywords

BPAD, Depression, Psychiatric Diagnosis, Socio-cultural Phenomena

1. Introduction

Mental health and illness are not only dependent on biological and psychological variables but are also correlated with socio-cultural factors [1]. A greater understanding of patients' psychopathologies must be obtained from the cultural perspective of patients. Considering the diverse cultural backgrounds of people makes it difficult to comprehend the complexity of

*Correspondence: Puja Neupane (pujaneupane39@gmail.com)

Received: 30 August 2025; **Accepted:** 18 September 2025; **Published:** 30 January 2026

psychotic symptoms [2]. People's perceptions and interpretations of their experiences with mental health are greatly influenced by culture, which encompasses a society's collective ideas, values, and expectations [3].

Few cultural factors must be correlated to mental health and illness.

1) Social inter-relationship
2) Psychological sophistication
3) Linguistic competence
4) Social support
5) Expressed emotions
6) Material culture

This cultural variation can either help or hinder the effective diagnosis and treatment of psychotic disorders [4].

Misdiagnosis can occur in a variety of ways, including failing to recognize a mental health issue (underdiagnosis), incorrectly diagnosing a disease that does not exist (overdiagnosis), or misunderstanding one ailment for another (misidentification). Overdiagnosis frequently occurs when culturally typical actions are incorrectly interpreted as evidence of psychopathology, whereas underdiagnosis can occur when true symptoms are rejected as normal cultural expressions [5, 6].

In cases like bipolar illness, where symptoms resemble those of other mental health conditions, the likelihood of misinterpretation increases, especially if diagnostic criteria are used too loosely [7]. This case study investigates how misconceptions of social and cultural aspects lead to an inaccurate diagnosis of Bipolar Affective Disorder (BPAD) in a patient, highlighting the necessity of taking cultural context into account in psychiatric examinations.

2. Case Presentation

A 52-year-old woman reported with four years of psychiatric symptoms that started during the first COVID-19 outbreak. Initially, she had several health issues, acute insomnia, a sad mood, anhedonia, helplessness, and somatic symptoms. The patient was treated at several medical facilities with antidepressants, benzodiazepines, and other psychiatric drugs, which resulted in a considerable improvement for over a year. However, she progressively stopped taking her prescription on her own, and after three months, she experienced insomnia, restlessness, depression, and irritability.

Despite further assessment and treatment at various facilities, the patient continued to experience symptoms. Informants (the patient's husband and daughters) described symptoms such as over-talkativeness, increased expenditure, and grandiosity. The patient had been married for 30 years and had dealt with her husband's long-term substance abuse issues, including cannabis and alcohol. She managed household responsibilities and cared for her three children and in-laws due to her husband's dysfunction. Despite these significant stresses, she reported no psychiatric issues, and even during her pregnancies, she was functioning well.

During the mental state examination, she exhibited no current psychopathological signs except for insomnia and somatic complaints. During the patient assessment, the patient claimed her personality to be like "habits of talking more than other people" which had been there since her very young age. Her expenditure was confined to financial and social limits, but she was boastful of her children's academic achievement and worried about their marriage. Her premorbid personality was described as cheerful, easily socialized, and extroverted. Under stress, she became more vocal and highly impulsive. Initially diagnosed with severe depression without psychotic symptoms, including somatic symptoms of insomnia, and later misdiagnosed with BPAD-mania/hypomania/depression. During admission to our setting, she showed no signs of hypomania or mania. The patient was diagnosed with a depressive episode and received appropriate treatment at the hospital. The patient was significantly improved upon discharge. The patient's social skills and coping mechanisms which were unique compared to others, her over-familiarity and over-talkativeness, as well as her suggestibility, were attributed to prolonged stress and emotional repression. The patient was able to express her symptoms, emotional pain, and frustration openly and cheerfully with the therapist.

This case teaches mental health professionals a very valuable lesson: the critical role of cultural and social contexts in psychiatric assessments. Her actions were misunderstood as signs of BPAD rather than reactions to ongoing stress and family obligations.

3. Discussion

Patients' misdiagnosis of Bipolar Affective Disorder (BPAD) highlights how important it is to incorporate social and cultural elements into mental health evaluations.

The term "psychological sophistication" describes conflicts that occur within the psyche rather than in the outside world. This is related to insight, understanding of illness and problems, and what must be done to ameliorate them. People with so-called "low psychological sophistication" have an increased tendency to "somatize". Another cultural factor that can arise due to errors in diagnosis is "linguistic competence". It is "intrinsic language ability." Language promotes greater precision in the expression of things that matter most in society. It will also have a greater correlation with the explanation of phenomenology and outcomes in certain psychiatric morbidities [1].

Errors in diagnosis can arise when clinicians overlook significant diagnostic details or fail to consider the social, cultural, and environmental contexts that shape a patient's symptoms and behaviors [6].

Bipolar disorder is a costly and disabling disease. Patients with bipolar disorder may be misdiagnosed with another illness during their initial presentation. An incorrect diagnosis of bipolar illness can have serious therapeutic implications for patients receiving mood stabilizers by exposing them to the

side effects of these drugs when an unnecessary accurate diagnosis of bipolar disorder is always complicated by depressive disorders, anxiety disorders, substance abuse, and personality factors [8]. These factors lead to misdiagnosis or overdiagnosis of bipolar disorders, which is complicated by sociocultural factors such as language competence, psychological sophistication, and family support.

Recent research has highlighted concerns about the overdiagnosis of bipolar disorder; [9] for instance, in a study of 172 patients with disability due to bipolar disorder, only 47.6% met the diagnostic criteria [10].

Her symptoms were misinterpreted as indicative of BPAD, indicating the difficulty in differentiating mood disorders from certain personality traits that the patient developed from early puberty. Her prolonged exposure to trauma from the beginning of her adolescence also shaped her personality, and when under stress were misinterpreted and had symptoms of serious mental illness. This case further illustrates the limitations of psychiatry, as they have to depend on information given by patients, relatives, certain rating scales, and diagnostic criteria that lack neurobiological evidence [11].

Overdiagnosis of BPAD can have significant negative consequences, including unnecessary labeling of patients, potential harm from inappropriate treatments, and inefficient use of medical resources, which carry substantial financial and human costs [12, 13]. The standard timeline for the accurate diagnosis of bipolar disorder often spans several years [14]. and requires careful observation of cyclical mood patterns and neurobiological indicators. The patient's quick misdiagnosis, however, indicates a disregard for the larger sociocultural influences at work, which results in inappropriate treatment and protracted suffering.

When the patient's social background was examined more closely, it became clear that her life circumstances and mental health issues were closely related. The stress from her husband's substance abuse and associated family burdens significantly influenced her psychological state. Clinicians need to understand that, without a comprehensive understanding of a patient's social environment and cultural background, there is a heightened risk of diagnostic errors.

The patient’s condition highlighted the need for cultural competence in psychiatric practice [15]. Conducting a thorough diagnostic assessment, including physical examinations and relevant laboratory tests, is crucial for ruling out non-psychiatric conditions that might be similar to bipolar illness [16, 17].

In order to assess patients in their social and cultural contexts, clinicians must be trained to understand that behaviors that are viewed as symptomatic in one cultural framework may be normal or stress-induced in another [18].

This thorough, culturally aware approach is necessary for both successful treatment and an accurate diagnosis.

4. Conclusions

This case exemplifies the potential for overdiagnosis when cultural and social contexts are overlooked during psychiatric assessments. Accurate diagnosis and appropriate treatment necessitate a comprehensive understanding of the patient's social and cultural background. Cultural competence in improving diagnostic accuracy and patient outcomes must be prioritized.

Abbreviations

BPAD Bipolar Affective Disorder

Author Contributions

Puja Neupane: Writing – original draft, Writing – review & editing, Visualization, Conceptualization

Shailendra Raj Adhikari: Supervision, Conceptualization

Funding

The work is not supported by external funding.

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] S. Balaratnasingam and A. Janca, “Culture and personality disorder: a focus on Indigenous Australians,” Curr. Opin. Psychiatry, vol. 30, no. 1, p. 31, Jan. 2017, https://doi.org/10.1097/YCO.0000000000000293

[2] M. E. Rodr ́guez-Rivas et al., “Reducing Stigma Toward People with Serious Mental Illness Through a Virtual Reality Intervention: A Randomized Controlled Trial,” Games Health J., vol. 13, no. 1, pp. 57–64, Feb. 2024, https://doi.org/10.1089/g4h.2023.0118

[3] A. Stefancic et al., “Development of the First Episode Digital Monitoring mHealth Intervention for People With Early Psychosis: Qualitative Interview Study With Clinicians,” JMIR Ment. Health, vol. 9, no. 11, p. e41482, Nov. 2022, https://doi.org/10.2196/41482

[4] S. C. Faber, A. Khanna Roy, T. I. Michaels, and M. T. Williams, “The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare,” Front. Psychiatry, vol. 14, Feb. 2023, https://doi.org/10.3389/fpsyt.2023.1098292

[5] J. Westermeyer, “Cultural factors in clinical assessment,” J. Consult. Clin. Psychol., vol. 55, no. 4, pp. 471–478, 1987, https://doi.org/10.1037/0022-006X.55.4.471

[6] D. K. Novins, D. W. Bechtold, W. H. Sack, J. Thompson, D. R. Carter, and S. M. Manson, “The DSM-IV Outline for Cultural Formulation: A Critical Demonstration With American Indian Children,” J. Am. Acad. Child Adolesc. Psychiatry, vol. 36, no. 9, pp. 1244–1251, Sept. 1997, https://doi.org/10.1097/00004583-199709000-00017

[7] F. Benazzi, "Unipolar depression with racing thoughts: A bipolar spectrum disorder?," Psychiatry Clin. Neurosci., vol. 59, no. 5, pp. 570–575, 2005, https://doi.org/10.1111/j.1440-1819.2005.01416.x

[8] T. Singh and M. Rajput, "Misdiagnosis of Bipolar Disorder," Psychiatry Edgmont, vol. 3, no. 10, pp. 57–63, Oct. 2006.

[9] D. N. Iqbal, D. H. Kousar, M. Asif, M. Gulzada, and K. Lodhi, "ASSESSING THE INFLUENCE OF CULTURAL FACTORS ON THE PERCEPTION AND EXPRESSION OF PSYCHOTIC SYMPTOMS IN DIVERSE PSYCHIATRIC POPULATIONS".

[10] M. Zimmerman, J. N. Galione, C. J. Ruggero, I. Chelminski, K. Dalrymple, and D. Young, "Overdiagnosis of Bipolar Disorder and Disability Payments," J. Nerv. Ment. Dis., vol. 198, no. 6, p. 452, June 2010, https://doi.org/10.1097/NMD.0b013e3181e084e1

[11] H. K. MANJI et al., "The underlying neurobiology of bipolar disorder," World Psychiatry, vol. 2, no. 3, pp. 136–146, Oct. 2003.

[12] M. Day, "Drug industry is partly to blame for overdiagnosis of bipolar disorder, researchers claim," BMJ, vol. 336, no. 7653, pp. 1092–1093, May 2008, https://doi.org/10.1136/bmj.39577.442650.DB

[13] M. Zimmerman, C. J. Ruggero, I. Chelminski, and D. Young, "Is bipolar disorder overdiagnosed?," J. Clin. Psychiatry, vol. 69, no. 6, pp. 935–940, June 2008, https://doi.org/10.4088/jcp.v69n0608

[14] M. S. Bauer et al., "Clinical Practice Guidelines for Bipolar Disorder From the Department of Veterans Affairs," J. Clin. Psychiatry, vol. 60, no. 1, pp. 9–21, Jan. 1999, https://doi.org/10.4088/JCP.v60n0104

[15] W.-S. Tseng and J. Streltzer, Cultural Competence in Clinical Psychiatry. American Psychiatric Pub, 2008.

[16] D. M. Hilty, K. T. Brady, and R. E. Hales, "A review of bipolar disorder among adults," Psychiatr. Serv. Wash. DC, vol. 50, no. 2, pp. 201–213, Feb. 1999, https://doi.org/10.1176/ps.50.2.201

[17] J. S. Manning, R. F. Haykal, P. D. Connor, and H. S. Akiskal, "On the nature of depressive and anxious states in a family practice setting: the high prevalence of bipolar II and related disorders in a cohort followed longitudinally," Compr. Psychiatry, vol. 38, no. 2, pp. 102–108, 1997, https://doi.org/10.1016/s0010-440x(97)90089-4

[18] G. Canino and M. Alegría, "Psychiatric diagnosis - is it universal or relative to culture?," J. Child Psychol. Psychiatry, vol. 49, no. 3, pp. 237–250, Mar. 2008, https://doi.org/10.1111/j.1469-7610.2007.01854.x