Cracked Mirrors: Deconstructing Bipolar Disorder Through a Cultural Lens

Chengze Li

Department of Psychology, University of Toronto Mississauga, Mississauga, Canada
chengzeli.li@mail.utoronto.ca

Abstract. Bipolar disorder (BD), long conceptualized through a predominantly biomedical and Eurocentric lens, is increasingly understood to be substantially shaped by social-cultural factors. This paper critically examines the impact of culture on the phenomenology, diagnosis, treatment, and lived experience of BD. Inspired by the social-cultural determinants of mental health perspective, this analysis argues that culture molds bipolar symptom expression, informs or interference clinical interpretation, generates unique illness narratives, and affect social and familial responses. Through a synthesis of current research on racial disparities in diagnosis, clinician bias, culturally specific practices, and local explanatory models, this paper deconstructs the universalist assumptions often implicit in psychiatric diagnosis. It highlights systemic inequities in care and reveals the limitations of a purely biological paradigm. By analyzing how factors from religious practices (e.g. Ramadan fasting) to cultural concepts (e.g. Indigenous Taqe Onqoy) interact with BD, the paper highlights the urgent of integrating social-cultural context into both bipolar clinical practice and research. Finally, it proposes a new research direction focused on developing culturally-validated assessment tools, employing community-based participatory methods, and exploring gene-environment-culture interactions to cultivate a more equitable, comprehensive, and globally relevant understanding of BD.

Keywords: Bipolar Disorder, Cultural Psychiatry, Health Disparities, Cross-Cultural Psychology

1. Introduction

Bipolar disorder (BD) is one of the most widely studied mental illnesses. However, most of people's understanding of it is limited to a narrow biomedical and Western reference framework. For decades, psychiatry has described BD as a widespread brain disorder characterized by recurrent episodes of mania and depression, which are usually controlled with medication such as lithium salts or mood stabilizers [1]. This approach has played a crucial role in legalizing BD as a disease and improving its treatment accessibility. However, it may also create the impression that BD has the same manifestations and functions in all communities, cultures and environments.

The previously dominant assumption of BD as a universal, culture-independent condition is increasingly being challenged. Contemporary scholarship and clinical practice recognize that culture plays a central role in shaping the onset, symptom expression, diagnosis, and treatment trajectory of

BD, rather than functioning as a peripheral factor. Broadly defined, culture encompasses shared values, beliefs, social norms, and systems of practice that provide a framework through which individuals interpret and navigate the world. Culture profoundly influences the way people express their pain, the way families deal with diseases, and the types of care individuals choose to accept or avoid. Therefore, BD is not only a physical illness but also a phenomenon endowed with meaning through culture. Ignoring its cultural dimension may lead to serious consequences. Studies show that minority patients are more likely to be misdiagnosed or have delayed detection. Compared with white patients, they often receive insufficient treatment and rehabilitation support [2].

Studies have shown that cultural factors can affect the diagnosis of BD. At the same time, under the influence of religious beliefs, family expectations and social norms, the medication compliance, sleep habits and coping strategies of BD will all change. Furthermore, interpretive models in different cultural contexts offer various ways to understand bipolar disorder. Therefore, the focus of this study is on four interwoven areas: 1) Differences in diagnosis and symptom expression among different races and ethnic groups; 2) How does the cultural perspective of clinicians influence assessment and interpretation? 3) The role of cultural customs in daily disease management; 4) Partially explain the impact of the model on patients' life experiences. By integrating these four areas, this analysis aims to provide a foundation for achieving more precise and personalized care.

2. The cultural shaping of symptoms and diagnosis

After a long period of development, the diagnosis of BD has become a standardized process, and healthcare personnel take it as an objective clinical practice in accordance with established norms. However, this diagnostic process neglects the influence of cultural and racial biases within it. In the Western medical system, when showing similar emotional symptoms, people of African descent are more likely to be diagnosed with schizophrenia rather than BD. Even if their symptoms are similar, they have more difficulty obtaining an accurate diagnosis of BD than white people, and thus have serious consequences for social controversy and health equity [2]. Due to diagnostic differences, black BD patients will receive biased prescriptions in subsequent treatment processes, and they are more likely to receive overprescriptions of antipsychotic drugs. This makes it possible for black BD patients to fail to achieve good therapeutic effects due to insufficient doses of mood stabilizers such as lithium, and also increases the risk of drug side effects [3]. This is because the initial diagnostic error triggered a series of adverse chain reactions, further exacerbating the treatment differences.

From a clinical perspective, these differences are not accidental; they reflect the influence of culture on symptom manifestations and clinical interpretations. Through an analysis combining two races, Li et al. [3] found that, unlike white patients, black BD patients were more prone to psychotic characteristics such as emotionally inconsistent delusions and persecutory hallucinations. These symptoms are different from the typical manic characteristics emphasized by the European training system (such as euphoria or exaggerated behavior), and they are more inclined to show irritability and restlessness. However, due to doctors' use of traditional diagnostic frameworks, they often misdiagnose these symptoms of black patients as schizophrenia. This is because the shaping effect of cultural and social background on these symptoms is often overlooked. For instance, if the life experiences of systemic racism, everyday discrimination, surveillance and social marginalization are ignored, the vigilance and defensive behaviors of patients may be wrongly interpreted as paranoia [4].

The differences in the course of the disease among different groups also affect the diagnostic results. Kennedy et al. [5] found in their epidemiological study in London that African American and Afro-Caribbean patients were less likely to experience depression before their first manic episode

than white patients. When these patients first experience mania accompanied by obvious psychotic characteristics, clinicians tend to misdiagnose them as schizophrenia, while ignoring the possibility of BD. This misdiagnosis is not only an individual judgment issue, but also reflects the potential structural bias in the mainstream diagnostic framework.

Similar phenomena also exist among other minority groups. Hwang et al. [6] conducted a study at a university clinic in the United States and found that Asian and Latino patients were more likely to develop severe bipolar I disorder than white patients. Researchers believe that this pattern is related to cultural stigma and care disorders, which often cause patients to delay seeking medical treatment until their symptoms significantly worsen. Because clinical samples are mostly from patients with severe symptoms or acute attacks, misleading conclusions are prone to arise, that is, a minority group seems to inherently experience "more severe" diseases. This indicates that cultural factors not only influence diagnostic interpretation but also shape the way patients participate in medical care. In communities where mental illness is highly stigmatized, patients with mild or early symptoms may not receive attention, and only those in severe crisis will seek or receive treatment.

These studies draw attention to a crucial problem: the DSM and associated diagnostic instruments were primarily created for individuals with European ancestry and fall short in addressing the wide range of BD manifestations in a cross-cultural setting. The risk of misdiagnosis rises sharply when these Europe-centered models are used without critical thought. Treatment choices, hospitalization trends, and long-term recovery paths may all be impacted by this diagnostic bias. This demonstrates that clinical practice is not culturally neutral; rather, it is laden with deeply ingrained presumptions that disproportionately damage minority patient groups through incorrect diagnoses and inequitable treatment.

3. The clinician's gaze: culture and the subjectivity of assessment

The patient is frequently the center of discussion when discussing diagnostic differences in BD, whether it be the manner symptoms are communicated, the idioms of distress used, or how help-seeking is influenced by cultural stigma. However, the clinician is a source of prejudice that is just as significant. Mental health professionals are not neutral observers. They bring cultural backgrounds, personal assumptions, and implicit biases to the diagnostic encounter, which shape how patient behavior is interpreted. The same expression—assertiveness, spiritual experience, or irritability—may be coded as pathological in one cultural context but considered normative in another. Standardized instruments such as the Young Mania Rating Scale (YMRS), often assumed to eliminate subjectivity, are themselves cultural artifacts, reflecting the norms of the societies in which they were created.

Mackin et al. had 126 psychiatrists (UK = 20; India = 24; US = 82) rate two identical US mania interviews with the Young Mania Rating Scale (YMRS). Mean total scores diverged sharply: Patient A—UK 20.6 (±0.58), US 31.6 (±0.33), India 30.5 (±0.78); Patient B—UK 27.1 (±0.97), US 38.6 (±0.32), India 40.8 (±0.68). Country effects were significant overall ($p < .001$), with US–UK and India–UK differences $p < .001$ on both vignettes; US–India differed on one ($p = .004$). Ten of eleven items varied by country—especially mood elevation, irritability, thought content, and disruptive–aggressive behavior—implying criterion variance, not simple noise. Given the YMRS's New York origins and only two American patients, what looks like "severity" partly indexes cultural norms for disinhibition/appropriateness. Therefore, Mackin et al. [7] suggest that cultural biases influence the interpretation of manic symptoms", with downstream implications for trial entry thresholds, remission definitions, and cross-site epidemiology.

The implications are far-reaching. If psychiatrists trained in English-speaking countries produce such divergent assessments, then the validity of these scales in more linguistically and culturally distant contexts is highly questionable. A patient's likelihood of meeting diagnostic thresholds, entering a clinical trial, or being declared "in remission" may depend less on their internal state than on the cultural assumptions of their assessor. Such variability undermines the reliability of multi-site trials, epidemiological comparisons, and even routine clinical care. What psychiatry often presents as objective measurement is, in reality, shaped by norms of emotional expression, disinhibition, and appropriateness embedded in the culture of the rater.

The diagnosis and treatment of BD are often influenced by the subjective judgment of clinicians. For instance, a doctor might mistake a patient's displayed confidence for arrogance and attribute it to manic symptoms, while another doctor, in the face of similar manifestations, might consider it part of cultural norms and thus overlook potential signs of illness. This difference may lead to inconsistencies in diagnosis and treatment: some patients may receive unnecessary drug intervention, while others may not receive the care they deserve. It can be seen from this that diagnostic unfairness not only stems from cultural differences among patients, but also reflects the interpretive biases and cultural assumptions of clinicians themselves.

4. Cultural practices, social rhythms, and lived experience

Cultural factors not only have an impact on the diagnosis and drug treatment of BD patients, but also influence them through specific practices in daily life. This is because the management of BD is rooted in cultural customs and social rhythms, creating complex interactions, and medical advice may directly conflict with religious and family values. Take the Islamic holy month of Ramadan as an example. Devout Muslims need to refrain from eating, drinking or taking oral medication from dawn until sunset during Ramadan. This religious custom alters the sleep-wake cycle, meal times and drug treatment regimens that are crucial for BD stability in BD patients, and has an impact on the stability of their condition [8]. Therefore, these BD patients need to make a choice among conflicting medical and religious requirements.

Mejri et al. [9] found through a study of Tunisian BD patients that some patients chose not to fast during Ramadan and persisted in taking their medication. However, these patients are more likely to experience guilt, shame and internalized stigma, which can affect the stability of their condition. Conversely, in a study in Pakistan, it was found that stable patients who fasted under clinical supervision did not have adverse reactions and even reported improved mood [10]. These studies indicate that communication and cooperation between doctors and patients are necessary during the treatment of BD. Respecting religious customs while managing the condition may be a more effective care plan.

Cultural influences also extend beyond religious rituals into the social and familial environments that shape illness trajectories. Johnson et al. [11] demonstrated that psychosocial stressors such as childhood trauma and negative life events are robust predictors of depressive episodes in BD. Among these, the concept of Expressed Emotion (EE)—a measure of criticism, hostility, and emotional overinvolvement within families—stands out as particularly powerful. Johnson et al. report that "patients with BD have a risk of relapse that is 2 to 3 times greater within 9 months if they live with a family member characterized by high EE" [11]. Yet the meaning of "criticism" or "overinvolvement" is not culturally uniform. In some societies, close monitoring and strong parental authority are experienced as protective and supportive, while in others they may be perceived as intrusive or suffocating. Similarly, communication styles that appear blunt or confrontational in one culture may be interpreted as honest engagement in another.

These observations underscore the need for culturally sensitive approaches to both assessment and intervention. A clinician who assumes that all forms of high EE are equally harmful may misinterpret family dynamics and overlook culturally adaptive strategies of care. Conversely, without an awareness of cultural nuance, interventions designed to reduce EE could inadvertently erode important sources of social support.

5. Cultural narratives and explanatory models

The local interpretive patterns and cultural narratives provide a coherent, non-biomedical perspective for understanding bipolar disorder. These cultural frameworks not only shape patients' daily experiences but also challenge the dominance of biomedical centered psychiatric diagnoses. The Western biomedical approach is merely one way to understand psychological distress, while many cultures have long developed rich and enduring empirical models that correspond to the symptoms and processes of bipolar disorder. These models are not merely "unscientific" beliefs, but rather a set of meaningful systems with practical functions, providing individuals and their families with ways to understand, cope with and manage emotional fluctuations. For example, Ayvar et al. [12] reported the traditional Andean concept of Taqe Onqoy (roughly translates into 'dancing sickness'). This condition, characterized by hyperactivity and euphoria, is not seen as an internal brain disease but as an external phenomenon where "the symptoms in the Andean context are seen as the expression of the vital force overtaking the person from the outside" [12], often through the influence of a sacred spirit (waka). According to this concept, this situation is not a person's illness, but simply a fleeting moment of mental disequilibrium. Instead of enforcing shame or placing blame on specific people, the goal of treatment is to restore societal peace and inner balance through rituals and community involvement.

In Taiwan, similar cultural interpretations also exist. When manic symptoms occur in specific seasons, they are particularly characterized by impulsiveness and hypersexuality, and are colloquially referred to as táohuādiān ("peach blossom insanity") [13]. This term provides a shared language for families and communities, enabling behavioral changes to be explained without referring to clinical pathology. By placing symptoms in familiar seasons and social cycles, this way of expression makes the manifestations of BD easier to understand and accept. Táohuādiān is not only a cultural interpretation model but also a mechanism for transforming psychiatric phenomena into local painful idioms to reduce stigma.

These cultural interpretation models show that cultural background is crucial in shaping disease experience and interpretation. If it is regarded as superstition, it may alienate patients and their families and weaken trust in medical providers. On the contrary, respecting these cultural narratives can enhance treatment compliance and collaboration. For instance, in the context of Taqe Onqoy, drug treatment is regarded as a means to regulate "vitality", enabling patients to incorporate biomedical intervention into their understanding of cultural significance, thereby promoting acceptance and treatment alliances.

6. Discussion and future research directions

The evidence reviewed in this paper highlights a central truth: culture is not an external factor that merely “colors” BD, but a constitutive element of how the illness is diagnosed, treated, and lived. Culture shapes the expression of symptoms, determines how clinicians interpret them, influences management strategies in everyday life, and provides explanatory frameworks that guide families and communities. The persistent diagnostic and treatment disparities experienced by racial and

ethnic minorities demonstrate that psychiatry's dominant paradigms have not adequately accounted for human diversity. Rather than representing universal standards, current diagnostic practices have historically privileged a White, Euro-American prototype as the implicit norm. This has led to structural inequities, including the pathologizing of certain psychotic symptoms in Black patients, the under-recognition of milder forms of BD in Asian and Latino groups, and the marginalization of non-biomedical explanatory models.

Psychiatric practice must be critically reevaluated in light of persistent disparities. The challenge extends beyond the observation that patients from diverse cultural backgrounds "present differently"; rather, the field has too often construed difference itself as pathological. Evidence indicates that the conventional concept of "cultural competence," which assumes that clinicians can acquire a finite set of knowledge about other cultures, is insufficient. Instead, cultural humility—defined as an ongoing, reflective process of self-examination, learning, and collaborative engagement—is necessary. Achieving such humility requires institutional reform that addresses the ways in which clinical practice, research, and training structures reproduce inequities. From this perspective, four interrelated directions for future research and implementation emerge, providing a roadmap to advance equitable, culturally attuned psychiatric care.

6.1. Cross-cultural validation and development of assessment tools

The above-mentioned research indicates that insisting on using a uniform assessment scale across different cultural backgrounds may lead to misdiagnosis. Because this uniform standard has certain limitations, it stipulates the uniform behavior of patients from different cultural backgrounds. To mitigate this limitation, future research should adopt a hybrid approach that combines cultural factors with psychometric measurement and develops and validates assessment tools based on local realities. This specific assessment tool will identify the unique manifestations of mania in different specific cultures. For instance, the improvement of social skills or changes in mental experiences, as well as somatization symptoms in a depressive state. This scale can improve the accuracy of diagnosis by capturing the different manifestations of BD patients in different regions.

6.2. Community-Based Participatory Research (CBPR) to address disparities

Cultural factors have led to unfair treatment of BD patients in different regions and communities. To reduce misdiagnosis and eliminate this inequality, clinical medicine needs to conduct research in collaboration with the community rather than merely targeting the community [2]. Collaborating with the community can provide a deeper understanding of the diverse manifestations, social customs and religious practices of BD patients in the local cultural context. Therefore, by establishing cooperative relationships with community leaders, religious organizations and local therapists [14], researchers can jointly design research protocols that are both culturally acceptable and relevant. This kind of cooperation not only helps identify local care barriers but also enables the formulation of culturally distinctive and inclusive intervention measures, thereby enhancing the participation of historically marginalized groups in various studies.

6.3. Integrating cultural and biological models through gene–environment–culture interactions

Psychiatry has long been regarded as being related to biological variables, while the role of cultural variables has been overlooked. However, in reality, genes, environment and culture constantly interact to influence an individual's mental state. Future research should jointly focus on the impact

of these factors on BD. For instance, certain cultural experiences, such as immigrant background, discriminatory experiences or traditional gender standards, may lead to different genetic pathways of stress responses. Falgas-Bague et al. [15] emphasized that multidisciplinary collaboration among geneticists, neuroscientists, anthropologists, and sociologists is a necessary condition for understanding these complex relationships. Researchers need to integrate social structure and cultural background to establish a more comprehensive and globally applicable cognitive model. This model will focus on the culture of specific regions on the basis of universal mechanisms, thereby leading to fairer and more successful diagnosis and intervention.

6.4. Development and testing of culturally adapted interventions

For BD patients, their psychosocial intervention methods are also influenced by Western assumptions about family structure, communication styles and individualism. These commonly used intervention measures are directly applied to different cultural backgrounds rather than taking into account the cultural differences among patients in different regions. Therefore, it is crucial to conduct research to integrate these intervention measures with the local culture. For instance, local family structures should be taken into account, such as multi-generational families. Communication habits, such as more indirect or implicit ways of communication; Religious activities, such as adjusting the treatment arrangements during Ramadan; And disease-explaining models of specific cultures, such as cultural metaphors like Taqe Onqoy of the Andes Mountains. By integrating the intervention content with the actual life and cultural values of the community, the relevance, acceptability and participation of the treatment can be enhanced, thereby more effectively improving the mental health status of patients.

7. Conclusion

The diagnosis and treatment of BD have long been dominated by Western culture, ignoring the influence of other cultures on patients. However, it should be noted that the performance and management of BD are deeply influenced by the social environment, historical background and cultural framework. Under different cultural backgrounds, patients will have different manifestations and interact with different social customs and religious habits. However, the traditional Western diagnostic and therapeutic paradigms have abandoned these differences and are unable to stabilize the mental health status of some patients. After recognizing the significance of cultural factors in the diagnosis and treatment of BD, researchers should move towards cultural humility, respect patients' experiences, and keep learning. This approach encourages clinicians to critically examine their own hypotheses, view patients as partners, and recognize the diversity of mental health concepts. Researchers need to develop culturally sensitive assessment tools, adopt community participation research methods, and integrate social and biological factors to achieve fair and inclusive psychiatric practices. Through these strategies, mental health services can not only enhance the effectiveness of diagnosis and treatment, but also strengthen patients' trust and treatment compliance.

References

[1] Fullerton, J. M., & Tesfaye, M. (2025) Global diversity in bipolar disorder: The role of cultural and social differences with a view to genomics. Biological Psychiatry, 98(4): 354–364.

[2] Akinhanmi, M. O., Biernacka, J. M., Strakowski, S. M., McIntosh, A. M., Schulze, T. G., Rietschel, M., … McMahon, F. J. (2018) Racial disparities in bipolar disorder treatment and research: A call to action. Bipolar Disorders, 20(6): 506–514.

[3] Li, K., Richards, E., & Goes, F. S. (2023). Racial differences in the major clinical symptom domains of bipolar disorder. International Journal of Bipolar Disorders, 11(1), 17.
[4] Ghanem, M., Evangeli-Dawson, C., & Georgiades, A. (2023) The role of culture on the phenomenology of hallucinations and delusions, explanatory models, and help-seeking attitudes: A narrative review. Early Intervention in Psychiatry, 17(9): 843–863.
[5] Kennedy, N., Boydell, J., Van Os, J., & Murray, R. M. (2004). Ethnic differences in first clinical presentation of bipolar disorder: results from an epidemiological study. Journal of affective disorders, 83(2-3): 161-168.
[6] Hwang, S. H., Childers, M. E., Wang, P. W., Nam, J. Y., Keller, K. L., Hill, S. J., & Ketter, T. A. (2010). Higher prevalence of bipolar I disorder among Asian and Latino compared to Caucasian patients receiving treatment. Asia-Pacific Psychiatry, 2(3): 156-165.
[7] Mackin, P., Targum, S. D., Kalali, A., Rom, D., & Young, A. H. (2006). Culture and assessment of manic symptoms. The British Journal of Psychiatry, 189(4): 379-380.
[8] Eddahby, S., Kadri, N., & Moussaoui, D. (2014) Fasting during Ramadan is associated with a higher recurrence rate in patients with bipolar disorder. World Psychiatry, 13(1): 97.
[9] Mejri, S., & Ghannouchi, S. A. (2023). A proposed guidance approach for BP performance improvement. Procedia Computer Science, 225: 1425-1437.
[10] Farooq, S., Nazar, Z., Akhtar, J., Irfan, M., Subhan, F., Ahmed, Z., Khan, E. H., & Naeem, F. (2010) Effect of fasting during Ramadan on serum lithium level and mental state in bipolar affective disorder. International Clinical Psychopharmacology, 25(6): 323–327.
[11] Johnson, S. L., Cuellar, A. K., & Gershon, A. (2016). The Influence of Trauma, Life Events, and Social Relationships on Bipolar Depression. The Psychiatric clinics of North America, 39(1): 87–94.
[12] Uscamayta Ayvar, M. J., Sanchez Garrafa, R., Escobar, J. I., & de Erausquin, G. A. (2019). The Concept of Mania in Traditional Andean Culture. The American journal of psychiatry, 176(5): 338–340.
[13] Wei, L. C., & Huang, W. C. (2024). Cultural narratives and modern psychiatry: Bridging perspectives on bipolar disorder's impact on sexual and familial dynamics. Bipolar disorders, 26(6): 624–625.
[14] Qureshi, N. A., Khalil, A. A., & Alsanad, S. M. (2020). Spiritual and Religious Healing Practices: Some Reflections from Saudi National Center for Complementary and Alternative Medicine, Riyadh. Journal of religion and health, 59(2): 845–869.
[15] Falgas-Bague, I., Cruz-Gonzalez, M., Zhen-Duan, J., Nagendra, A., Alvarez, K., Canino, G., ... & Alegría, M. (2023) Association of sociocultural stressors with bipolar disorder onset in Puerto Rican youth growing up as members of a minoritized ethnic group: results from the Boricua youth longitudinal study. The Lancet Regional Health–Americas, 24. 100549.