A Case Study of Female Clients' Experiences of Psychotherapy in Islamabad

Nadia Bukhtawer[1]

https://doi.org/10.62345/jads.2024.13.3.68

Abstract

The current study is based on a qualitative analysis of experiences of five female patients who are under treatment for mental health disorders. The main aim was to highlight the contribution of psychosocial factors in the development of their symptoms and analyze the challenges they face in seeking treatment. Selection of the cases was done using purposive sampling technique and five clients within age range of 25-43 years were selected who had been in psychotherapy for at least ten sessions. Sessions of the clients were recorded by notes taking by the researcher with consent while they took session with their counselor. Thematic analysis of the notes reveals that women suffering from different mental health disorders lack social support from family and friends. Their family issues and social support emerged as significant factors triggering symptoms of anxiety, depression, post- partum depression, obsessive compulsive disorder and schizophrenia. The major challenges in utilizing mental healthcare services includes lack of awareness about mental disorders, stigma and perceived side effects of medications. The study highlights need for gender specific therapeutic interventions taking social and cultural factors into consideration to provide holistic treatment.

Keywords: Experiences of Mental Health Patients, Psychotherapy, Treatment Seeking, Psychosocial Factors.

Introduction

Mental health is vital part of health that shapes a person's thinking, feelings and behaviors. According to World Health Organization (WHO) it is defined as the capacity to identity and cope with stressors presented in everyday lives (WHO, 2005). Despite this definition, there has been ongoing discussions among practitioners as well as researchers about what constitutes mental wellbeing and mental illness. Researchers have found that the understanding of mental health is different in multiple cultures. Stigma is found to be a common cultural construct associated with mental health. In many cultures, it compels mental health patients to hide their illness due to shame, to protect family from embarrassment, or fear of becoming a burden for their families. Another major factor is lack of comprehension about mental health disorders which may lead to adverse coping, delay in treatment seeking and experience of negative emotions. They emphasize the need to understand the perception of individuals about their own mental health as it will influence how they cope with it or seek treatment for it (Madhani et al., 2023; Misra et al., 2021; Choudhry et al., 2016; Van der Ham, 2011). Gender is a cultural construct and the way men and women develop their gender identities is through socialization which begins in childhood.

[1]*Lecturer, Department of Gender Studies, Fatima Jinnah Women University, Rawalpindi, Punjab, Pakistan.*
Email: nadia_azhar@fjwu.edu.pk

Compliance with ethical standards: There are no conflicts of interest (financial or non-financial). This study did not receive any funding.

Gender and mental health have an established link where is it is discussed that social norms for gender greatly influence mental health. For example Baird et al. (2019) found that men and women who conform to traditional gender roles show less psychological distress. However, for these men and women other researchers has identified higher risk for specific mental health which has been observed worldwide (Otten et al., 2021; Tannenbaum et al., 2016). Women's mental health issues gained popularity in research in the previous decade and researchers began to highlight the critical need for gender specific health needs and the guidance required for health care practitioners to cater to them in a culturally sensitive manner. This not only included physical health but also mental health issues (Popay et al., 2003; Patel, 2007). Recent studies report women are at higher risk of developmental a psychopathology (Serpytis et al., 2018) particularly mood disorders and anxiety (Albert, 2015) as compared to men. In Pakistan, similar trends are observed with women having higher rates of prevalence for mood disorders. As reported by Jaffree (2020) that in a sample across Pakistan, 30% women reported suffering from depression and severity was associated with number of psychosocial factors including lack of access to resources, less decision making power and experience of more difficulties in everyday life. WHO (2017) reports in their press release that approximately 4% population suffers from mental health disorders and majority of them are women. Domestic violence and gender discrimination in rights of women is also common. According to the report of Pakistan Demographic and Health Survey 2017-2018, 90% of employed women in any sector experience from harassment at their place of work and 23% of married women report experience of physical or psychological violence at the hands of partner or family. More than half (56%) of these victims did not report or speak out about their abuse (NIPS, 2018). This kind of abuse exposes them to mental health disorders including depression, anxiety, post-traumatic stress disorder and suicidal ideation (Niaz, 2004). Staying silent and not seeking any help for such type of abuse is very common and complicated to understand. A recent study on 227 Belgian victims revealed that 90% of victims never go for any therapy or help nor do they report it. They discussed that this is contributed by many factors including stigma, self-blame and existing taboos in the society about sex related issues (Nobels et al., 2024). Stigma and shame are associated with mental illnesses and particularly in developing countries it is reported that below 35% patients seek psychiatric treatment. Negative attitude towards mental health services is common and patients who do seek treatment suffer from stress and prejudice (Byrne, 2000; Corrigan et al., 1999). In Pakistan, a survey by Waqas et al. (2014) reported that out of sample of 650 university students, 41% considered black magic to be a reason for mental illness and a lot of stigma was associated with mental health patients. The cultural belief about why an illness occurs and how it may be treated are closely associated. According to Devkota et al. (2021) the role of cultural beliefs about mental illnesses determines whether they seek medical or psychological intervention or go for spiritual healing. If they belief mental ailment is a result of magic or supernatural forces, they prefer to go to spiritual healers. Financial constraint is another factor discussed as a barrier to treatment particularly for women. A recent study highlights that in their survey of diagnosed patients with severe mental disorders, they did not take any treatment as they could not afford the cost (Kohn et al., 2022). These studies highlight that treatment seeking for mental health issues is a multidimensional process which is impacted by social, cultural and economic factors. All of these factors are true for both men and women. But they become more pronounced for women as there is rampant gender inequality across the globe. In Pakistan, majority of women lack access to basic needs including education, healthcare and access to services (UN Women, 2021; Ali et al., 2022). This highlights the need to identify what challenges

female patients seeking mental health services face and those who do seek these treatments, what are their experiences.

The insights from these studies highlight the need to explore lived experiences of clients seeking mental health services and address the difficulties they face during this process. Majority of the studies on services emphasize the macro level factors such as challenges in accessing healthcare systems or policy barriers. There is a need to focus on micro or individual level factors such as gender, mental health and social norms. Keeping in view the above mentioned statistics and literature, the current study aims to explore in depth the experiences of women who suffer from mental health conditions and seek psychotherapy in a healthcare facility. A considerable amount of literature is available on prevalence, causes and stigma but most of it is quantitative in nature. This study aims to fill this gap by focusing on the experiences of female patients and investigate their perceptions about illness, contributing factors or causes and experience of therapy to gain a nuanced insight into the factors affecting their wellbeing.

Methodology

The study employed a qualitative research design based on five case studies of female clients utilizing therapy as a treatment with one counselor for at least ten sessions. Using purposive sampling technique, four clients were selected by the researcher who gave consent to share their therapeutic experiences and allowed the researcher to attend their sessions. The researcher took permission from a renowned practicing psychotherapist in a reputed private hospital in Islamabad. The researcher was granted access to their clinical case files after both counselor and client consented to their participation in research. Written informed consent was taken from them to use their clinical information for research purposes without giving any personal identifying information. Their therapy sessions were recorded by notes taking and the details of the history was accessed in client history taking form. Observations about nonverbal gestures and body language made by the researcher were also noted during the sessions and used as reflections. The five clients selected for the sample are women aged between 25-43 years of age from Islamabad who came to seek treatment for mental illness in the hospital. Each client took minimum ten sessions for psychotherapy and each session lasted for minimum 45 minutes. The sessions were held once or twice a week and the data was collected in three months. The data was analyzed using thematic analysis and findings are discussed below. For confidentiality purpose, pseudo names have been used to refer to participants.

Results & Discussion

Table 1: Profiles of the selected clients N=5

Sr. No	Name	Age	Birth Order	Education	Occupation	Marital Status	No of Children	Source of Referral
1	Rihanna	43	First born	B.A	Home maker	Married	None	Referred by Psychiatrist
2	Nigaar	30	First born	MS	Home maker	Married	One	Referred by Psychiatrist
3	Sonia	25	First born	M.Sc. (in progress)	Student	Single	None	Referred by Psychiatrist
4	Filza	26	Middle child	MS (in progress)	Student	Single	None	Referred by Psychiatrist
5	Aleeza	39	Youngest child	M.A	Teacher	Divorced	One	Referred by Physician

*The names used here are fictitious for maintaining confidentiality.

The tables illustrated above provides a brief picture of the demographic profiles of each client. It shows that all of the clients are educated and consulted a psychiatrist first. All are first born except for one middle child and none of them is working. Out of two married, one has a child.

Table 2: Initial Presenting complaints of the clients to Out Patient Department (OPD) N=4

Client	Presenting Complaints
Rihanna	Fear of contamination or dirt, Needing things orderly and symmetrical Unwanted thoughts, including aggression Intense stress when objects aren't orderly arranged Sleep disturbances, Tiredness and lack of energy, Anxiety, agitation and restlessness
Nigaar	Depressed mood and severe mood swings, Excessive crying Difficulty bonding with baby, Withdrawing from family and my friends Loss of appetite , Inability to sleep, Overwhelming fatigue and loss of energy Reduced interest and pleasure in activities, Intense irritability and anger Fear of not being a good mother
Sonia	People in her neighborhood are plotting to harass her (Delusions) Hearing voices that make fun of her and insult her (Hallucinations) Impaired family relations and academics, Suicidal thoughts ,Panic attacks, Low self esteem
Filza	Feelings of sadness, tearfulness, emptiness and hopelessness Angry outbursts, irritability and frustration, over small matters Loss of interest and pleasure in all normal activities Sleep disturbances, Tiredness and lack of energy, Reduced appetite, Weight loss Anxiety, agitation and restlessness, Slowed thinking and speaking
Aleeza	Consistent sadness, hopelessness, difficulty concentrating at work, anxiety about parenting, sleep disturbance including nightmares, hyper vigilance, two panic attacks in past month.

This table gives information about the exact symptoms of issues reported by each client on their first visit to the out-patient department of the hospital. All of them took appointments with psychiatrist on call in OPD and expressed the complaints given in the table above. After assessment and examination, the psychiatrist referred them to the psychologist and the researcher of this study for further evaluation. Except for one (Sonia) all of their presenting complaints include physiological symptoms such as sleep disturbances, fatigue, lack of energy and reduced appetite. Psychological symptoms of all except one (Sonia) include inability to regulate anger, agitation, low mood, sadness and loss of interest in activities. Sonia experienced delusions of persecution, auditory hallucinations, suicidal ideation, panic attacks and low self-esteem. Rihanna additionally reported obsessive thoughts about organization and cleanliness and stress associated with it. Aleeza reported nightmares and panic attacks. Social dysfunctions are reported by all five clients in their own personal aspects such as Nigaar and Aleeza have fear of not being a good mother and Filza getting frustrated over small issues.

Table 3: Information about assessment, diagnosis and treatment of clients N=5

Name	Assessments administered	Diagnosis	Therapy sessions	Prescribed medication
Rihanna	Beck Depression Inventory (BDI) Beck Anxiety Inventory (BAI) Rotter's Incomplete Sentence Blank (RISB) Bender Gestalt Test (BGT) Thematic Apperception Test (TAT)	300.3 (F42.0) Obsessive-compulsive disorder	12	Paxil Clonazepam 5 mg
Nigaar	House Tree Person (HTP) Beck Depression Inventory (BDI) Beck Anxiety Inventory (BAI) Rotter's Incomplete Sentence Blank (RISB)	(O90.6) Postpartum Depression	10	Citalopram 20mg
Sonia	House Tree Person (HTP) Beck Anxiety Inventory (BAI) Rotter's Incomplete Sentence Blank (RISB) Bender Gestalt Test (BGT) Thematic Apperception Test (TAT) Mental Status Examination (MSE)	295.3 (F20.0) Paranoid schizophrenia	15	Olanzapine 5mg Alprazolam 0.5mg Neuxam 250 mg
Filza	House Tree Person (HTP) Beck Depression Inventory (BDI) Beck Anxiety Inventory (BAI)	296.33 (F33.2) Major depressive disorder, recurrent severe without psychotic features	14	Velax 75 mg Rize plus Inderol 10 mg

	Rotter's Incomplete Sentence Blank (RISB) Bender Gestalt Test (BGT) Thematic Apperception Test (TAT)			
Aleeza	House Tree Person (HTP) Beck Depression Inventory (BDI) Beck Anxiety Inventory (BAI) Rotter's Incomplete Sentence Blank (RISB)	296.33(F33.2) Major depressive disorder Comorbidity with 309.81 (F431.10) Generalized Anxiety Disorder and symptoms of PTSD from domestic violence 309.81 (F43.10)	11	Alp 0.5 mg

The table above describes the diagnostic tools used for diagnosis of each client and their diagnosis given by counselor as per Diagnostic and Statistical Manual (DSM) V-TR which informed the therapeutic intervention. All of the clients were administered structured screening instruments which are validated and common in clinical practice including BDI and BAI. These are screening tools which are objectively scored and showed that all of them were in the clinical range for mental health symptoms including anxiety and depression. Projective techniques are based on the principles of psychodynamics and prove very effective in identifying the underlying psychological processes and malfunctioning areas of the personality which are associated with specific disorders. These include TAT, RISB and HTP. BGT was used to assess any cognitive impairment or perceptual inability. These are commonly used in clinical assessment (Saklofske et al., 2012, Selbom & Suhr, 2020; Leak, 2021). All of the clients are taking medication in adjunction to psychotherapy. The total sessions reported for each client included three stages of progression in therapeutic journey. First stage was rapport building, history taking and assessment which took 2-4 sessions for reaching the diagnosis. The second stage was goal setting for therapy and working on the mutually agreed outcomes for therapy which took 4-8 sessions and last stage was termination or continuation depending on the client needs. For termination the client took 2-3 for closure and adapting skills to use independently in their life. For continuation the client becomes more adept at working on their goals and continues providing feedback. In these cases, three clients continued therapy while Nigaar moved towards termination of therapy and planned her follow up session to be held every month for 6 months.

Thematic Analysis and Discussion

The thematic analysis carried out on the notes taken during sessions, observations made and the history collected through their files helped the researcher develop a comprehensive formulation of experiences of female clients seeking psychotherapy. The analysis is divided into two main overarching themes:

i. Contributing factors to mental illnesses
ii. Experience of psychotherapy

Contributing Factors to Mental Illnesses

Under the first main theme it is elaborated what are the reported factors by the female clients in their lives which contributed to the development, maintenance or precipitation of their mental health problems. The in depth insights provided by the participants were analyzed and few sub themes are extracted from it and discussed below.

Family Dynamics

Thematic analysis of the client's history of illness revealed that family is a significant contributing factor to the development of symptoms and mental disorder. All of these women reported that in one way or another their family life influenced their thinking, feelings and behaviors in an adverse manner and impacted their mental health.

In case of first client, Rihanna (43) expressed that her symptoms triggered when she got married and was not able to conceive successfully for five years after marriage. She took a lot of treatments but it result in two miscarriages. Third time she succeeded to give birth but the infant did not survive. This was when she started having symptoms of obsessive compulsive disorder (OCD). In her own words

> *I was broken. I did not care about anything after my baby died. I just cried all day. After a while, I would spend all day trying to clean the house or end up crying for no reason. I was afraid I left the stove on checked ten times. I could not sit long before I got up again to it all over again. It is exhausting.*

In case of Nigaar (27) she also had a miscarriage after one year of her marriage. After that she got depressed but did not seek any treatment. When she conceived successfully again and gave birth, her depression was triggered. She withdrew from her husband and other family members. She developed a delusion that her baby did not love her as he did not smile at her. She obsessed with his health and got angry at others. She started feeling she couldn't take care of the baby and got more depressed. She expressed

> *Since the birth of my baby I have become so careless. I cannot function. This pregnancy was hard on me but it is not his fault. That innocent angel does not deserve a dumb mother like me. I can hard sleep or do anything right. I get so nervous so panic that I end up messing everything up. Then I cry what else can I do?*

Sonia (25) discussed that her father separated from her mother. She never developed a bond with him. She began feeling inferior to her sister who was taller and a fair complexion. She started feeling her mother didn't love her the same because she was ugly. She began hearing and seeing people taunting her and harassing her because she is ugly. She started fighting with all other family members as well and did not trust them anymore as no one believed what she was saying. She voiced "I know they want to kill me. No one loves me. They think I am ugly. See I have ugly hair and ugly nose. I am alone. All alone."

Filza (26) has a very controlling mother. She has always tried to meet her expectations but failed to do so and fell into depression since 6th grade. Her father is submissive. On her mother's demand, she got married *(Nikkah)* to a relative who was abusive towards her. When she got slapped by him in front of her father, her father called off the wedding and filed for divorce. After this her mother became more abusive towards her and blames her for everything. This has led to more depression. Filza told

> *My mother is doing a government job. She treats us like her subordinates too. Always commanding us what to do. She never cared about me. She is my worst enemy. She destroyed my life and I can never be happy again.*

Aleeza (39) discussed that she was married at the age of 27 by her parents who arranged it. From day one of her marriage she entered a house where she was not welcome and treated as an outsider. She is shy and flexible so she tried hard to fit in and be accepted. Her husband who was five years older than her was very authoritative and did not develop any communication with her. The in laws were also distant and only ordered her around. She was not allowed to have friends or family over or go out. She became isolated. Her husband used to slap her on minor issues and verbal abuse was used by all family members. As she said

> *I forgot I was a human any more. I was afraid all the time that I may not irritate him or make a mistake. When my daughter was born, I cried. I was used to it but how will I save this helpless thing from them?*

Family dynamics are considered as vital contributing factor in various mental health issues. Family conflicts such as parental conflicts are associated with development of psychopathology in children (Hudson, 2005; Buehler et al., 1997). Similarly Fergusson and Horwood (2008) found that quality of marital relationship is negatively related to anxiety and depression. Family violence and lack of communication further increases risk of mental illnesses (Luvira et al., 2023). The literature supports the qualitative findings of the study highlight the key role family plays in women's mental health. Particularly considering the family context of these five cases, the role of parents and the type of relationship they share with them directly influences their mental wellbeing. It also highlights the social position of women in the society is secondary and in subordination to men. The psychological and social pressure on women to conform to the societal expectations including in laws, family and community values in general puts them at a greater risk for mental disorders.

Social Support

A significant theme identified through these cases is lack of social support during the onset of mental illness. All women reported that they hardly had any support or empathy from their family and friends when they began experiencing symptoms. The distress of symptoms was magnified when no one around them could understand what they were going through. Social support refers to the help a person receives when faced with difficulties and challenges in life (Helgeson, 1993). Rihanna (43) did not have any social support from her husband or other family members when she went through her miscarriages or death of her baby. When she started experiencing symptoms of anxiety and OCD, she became more isolated. Her obsession with organization and orderliness became a source of conflicts with husband and family members. She expressed "all day I go through this pain that no one pays attention to. If I had my baby only they will grow up and care for me."

Similarly Nigaar (27) explained that her fears related to her infant led to her being mocked by mother in law and her husband scolded her for being fussy. She felt no one cared for her and only the baby was important in their lives. The taunts made her guiltier of being a bad mother and she said "If only once my husband would listen to me and not think I am crazy maybe I will feel better."

Sonia (25) had no social support since her childhood when her parents separated. She never got close to her mother or sister and felt being compared with her. When she began experiencing hallucinations and developed delusions, the lack of empathy from siblings and family led her to

feel threatened by them. In her words "they have never understood what I feel. They blame me for being ill. I go mad when they do this."

Filza (25) always felt alone in her home. Her dominating mother made sure no one stood up for her when she failed to meet the expected goal. When her marriage proposal was finalized, no one took a stand for her. In her words

> *Since I was in school, I felt sad and depressed. My mother never kissed or hugged me. She just scolded me for my mistakes. I really wanted to be loved but I never got it from anyone. I wish I could die.*

Aleeza (39) reported that she had no one whom she could rely in the house after she got married. Her communication with her parents was also very limited and formal and she was not allowed to have friends. Her spouse was abusive. She express "I was very alone. Only Allah knew what I went through everyday silently."

Social support is a key factor associated with the experience of mental disorders and severity of symptoms. Studies show that severity of obsessive thinking is associated with lower marital social support and mental health revealed that social support provides physiological as well as psychological advantages for mental health patients particularly women and elderly (Harandi et al., 2017). Similarly, studies in Pakistani context also focused on lack of social support available for women. According to the summary of UN Women and National Commission on Status of Women (2023) it is highlighted that women don't have access to social justice or any institutional mechanism which can provide support to them in the times of their crises. Whether it is harassment or as extreme as domestic violence, women are encouraged to stay silent and protect the honor of their families. Having no one to understand your day to day stressors can lead to deteriorating mental health.

Gender Roles and Expectations

It is analyzed by the researcher from the observations, session notes and history that gender of the clients is an important factor which influences their mental wellbeing. Furthermore, it is analyzed that gender role expectations and way women are socialized in their society is also a contributing factor to mental health. In all five cases, it is analyzed under a feminist lens that women are under duress due to the societal expectations and norms. They are encouraged to bear inequality, injustices and abuse as being "normal" part of the culture. In case of Nigaar (27), Rihanna (43) and Aleeza (39) all of them had gone through stressful times during their pregnancy. For Rihanna and Nigaar, miscarriage loss and trauma was also experienced. They did not have any social support during these times nor did anyone recognize the need for them to be cared for during these times. Adding to their stress, they were blamed or suffered guilt and shame for these losses. Aleeza says "When my daughter was born, my husband taunted that I am good for nothing couldn't even bear a son for him." Researchers have emphasized that gender, social status and ethnicity are major factors in poor mental health. Women are reported to have more mental health issues due to their gender, economic issues, lack of access and support. They also have the defined traditional role of household and care which creates pressure on them (Tryg et al., 2021; Holmes et al., 2018). Another gender related issue highlighted is the pressure of physical beauty. In case of Sonia (25) it is evident that not meeting the beauty standards set by her society is creating pressure for her. Filza (26) also mentioned in her conversation that "I know I am not that pretty that's why my mother is so hard on me. She wants me to be perfect otherwise."

This pressure is common for many women as studies have highlighted that objectification of women in society dictates them to conform to certain body image and they consume their time,

energy and money to look a certain way. Failing to achieve it causes mental health issues (Fitzsimmons-Craft, 2011; Roberts et al., 2018). Overall, gender is a significant factor in mental health and needs to be integrated into therapy.

Experience of Help Seeking for Mental Health

Now the second major theme is discussed regarding female clients' experience of seeking help and their perception of the treatment's benefits or costs. All of the women reported that seeking health care services for mental health condition was very difficult. Few sub-themes emerged which are discussed below:

What is Happening to Me?

One significant struggle reported by all of them was the lack of awareness about mental disorders. Initially all of them did not understand what was happening to them and consulted a general physician for their symptoms. No one in the family had adequate knowledge about mental disorders. So they had to go to several doctors before being referred to psychiatrist. As Nigaar (27) expressed

> *I thought all of this was due to fatigue of going through pregnancy and childbirth. I kept telling my gynecologist about my symptoms but she prescribed some relaxants and advised rest. I consulted a medical specialist later who referred me to a psychiatrist.*

These findings are supported by literature. WHO (2017) reports that in Pakistan there is general lack of knowledge and awareness about mental health conditions in Pakistan due to low education. It is highlighted in above literature as well that lack of awareness about mental illness and cultural understanding of why these illnesses develop can greatly influence the response to such problems. In Pakistan, overall health literacy is low and very low understanding of mental health disorders exists in the society and general masses. It is still considered a taboo topic and many don't prefer to seek treatment or hide it due to stigma and shame (Munawar et al., 2020). Societal norms regarding mental health need to be demystified and mass awareness and acceptance of mental healthcare is required.

Everyone Calls Me Crazy

Another sub theme which emerged from the all clients was the experience of stigma for being diagnosed. All of them were hesitant to visit psychologist for frequent counseling because their family and friends labelled them as crazy. They were afraid of the prejudiced comments and attitude of people towards their seeking treatment for mental health. As Filza (26) said,

> *Now my mother taunts me every time I come for therapy to hospital. She says she always knew I was crazy and would bring her shame. Now she has to suffer the shame of having a crazy daughter. I really hate her when she says that.*

Stigma is a commonly associated with mental health conditions. As discussed earlier, studies show that cultural understanding of mental health is very traditional and often associated with black magic. Patients are labelled and suffer a lot of shame for seeking treatment (Byrne, 2000; Corrigan et al., 1999; Waqas et al., 2014). As discussed in the theme above, these societal attitudes need to be reformed by providing mass awareness about mental health disorders and its treatment.

Medicines Make Me Slow

Finally, a challenge for all clients is managing the side effects of psychiatric medication they are prescribed. All of them report having some distressing side effects of the medicines such as drowsiness, weight gain, irregular menstrual cycle etc. These side effects generally are not explained by the psychiatrist so when they first appeared it caused them greater anxiety and fear. Sonia (25) told

> *When I first started taking these pills they make me sleepy. I couldn't do anything. I was like a drowsy patient. I felt so afraid that they might end up killing me. I told the doctor to stop giving me so many pills. He listened and reduced the dose. They still are very disturbing but they make me take it.*

Literature suggests that negative attitude towards side effects of medication is common among psychiatric patients and almost 50% patients stop taking medication at some point or think of it as a burden of their illness (Milan & Vasiliadis, 2020). The treatment non adherence is a common phenomenon worldwide and in Pakistan as well. It is tied to social attitudes toward illness and health. Overall, community doesn't trust allopathic treatment due to cultural beliefs so they stop taking medications or don't follow doctor's instructions. Another factor maybe financial costs and lack of information.

I feel Unburdened

All of the clients reported that therapy was helpful and provided them with a safe space to talk freely about their problems. It also helped them make sense of their symptoms and educated them about their own illness. However, they expressed doubts about how long it would remain helpful or if they have to take sessions for all their life. In Nigaar's words "initially I was very nervous talking to a stranger about my personal life. But as sessions continued, I realize it is a source of relief. I feel lighter after taking session."

Studies have reported that therapeutic settings particularly in one on one sessions, patients report having a positive experience related to counseling. They associate therapy sessions with a safe space for them to openly express their emotions and talk about their problems with a professional. They acknowledged that counselors help them understand their symptoms better (Bendelin et al., 2011; Heilemann et al., 2016). In Pakistani context, a recent study which surveyed patients from multiple cities found reports that women report more positive attitudes towards psychotherapy. Furthermore, they reported that 31% of their sample showed their preference to consult a psychologist regarding mental health issues (Hussain & Riasat, 2022). This shows that although still majority of society is not in favor of mental healthcare services but those who are aware know its advantages and more women prefer to seek treatment than men.

Therapy is Expensive

This subtheme emerged as all of the clients showed their financial concern. Each therapy session is charged fees. Average fee ranges from Rs. 2000-5000. They explored many options but majority on the upper range were not affordable by all and they selected the current counselor they were seeing. All of them were of opinion that mental health services should be cheaper and affordable. Aleeza for instance who supports herself remarked,

> *I am doing well but it takes a lot to provide a good life to myself and my daughter. I know my therapy is important but I do feel the burden of taking out this money*

and spending on myself. I hope some affordable options can become available in Pakistan for mental health as this is a luxury.

The financial cost of therapy is a major factor in treatment seeking behavior and lack of finances may pose a barrier to mental health (Kohn et al., 2022). According to Khalily (2011) there is a lack of adequate mental health professionals and mental healthcare facilities to meet the needs of people of Pakistan and He emphasizes the need to reform health and mental health policies.

Conclusion

The current study provided a comprehensive qualitative analysis of five case studies seeking treatment for mental health. The study has highlighted the experiences of women who suffer from different mental health disorders and the challenges they face. The main contributing factors to mental disorders are family issues and lack of social support. Women clients face a lot of challenges in seeking treatment including lack of awareness about mental health issues and treatment, stigma and management of medication side effects. All women report that psychotherapy is helpful. Thematic interpretation discussed under the light of previous literature has highlighted the significance of these findings in the context of Pakistani society. Gender is a cross cutting variable which interacts with the social and cultural norms of the traditional Pakistani society. The experiences of these five women who come from different backgrounds highlight how some experiences for women who are suffering from mental health conditions can be similar due to their gender role and societal expectations. The family dynamics, role of parents, interaction with in laws and position of women in the society all contribute their life stressors, experiences and precipitation of mental health symptoms. Cultural beliefs, stigma, taboos and myths associated with mental health shape their attitudes towards mental ailments, responses to symptoms and actions they take to overcome their illnesses. Seeking psychotherapy by these five selected cases has highlighted their experiences, facilitating and challenging factors to treatment seeking. The study has practical implications and informs practitioners about gender specific needs for mental health treatment. It is concluded that gender inclusive approach is needed to be incorporated in the practice of psychotherapy. Mental health promotion strategies can be designed keeping in view the insights of this study with a client centered approach.

Future Directions

This study is limited to urban, middle class and upper middle class women living in the capital city of Islamabad, Pakistan who came to a renowned clinic for treatment. The scope of the study doesn't include women from other socio-economic strata. Further studies may focus on exploring the role of social demographics including class, education, geographic location and work status to infer a wider information about contributing factors to experience of therapy. Comparative studies on public and private mental healthcare facilities can also be carried out to analyze differences in quality of treatment.

References

- Adra, A., & Duchonova, K. (2024). Suicidal behaviour in the Syrian Arab Republic. In *Suicidal Behavior in Muslim Majority Countries: Epidemiology, Risk Factors, and Prevention* (pp. 287-301). Singapore: Springer Nature Singapore.
- Albert, P.R.(2015). Why is depression more prevalent in women? *Journal of Psychiatry Neuroscience, 40*(4), 219-221.

- Ali, T. S., Ali, S. S., Nadeem, S., Memon, Z., Soofi, S., Madhani, F., & Bhutta, Z. A. (2022). Perpetuation of gender discrimination in Pakistani society: results from a scoping review and qualitative study conducted in three provinces of Pakistan. *BMC Women's Health*, *22*(1), 540.
- Bendelin N, Hesser H, Dahl J, Carlbring P, Nelson KZ, Andersson G. (2011).Experiences of guided internet-based cognitive-behavioural treatment for depression: a qualitative study. *BMC Psychiatry, 11*, 1-10
- Buehler, C., Anthony, C., Krishnakumar, A., & Stone, G. (1997). Interparental conflict and youth problem behaviors: A meta-analysis. *Journal of Child and Family Studies*, 6(2), 223-247
- Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric treatment*, *6*(1), 65-72.
- Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta-synthesis. *Neuropsychiatric Disease and Treatment*, 12, 2807-2818.
- Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American psychologist*, *54*(9), 765.
- Devkota, H. R., Baral, Y. R., Khanal, B., & Adhikary, P. (2023). How effectively are social accountability mechanisms being applied in mental health services within the newly federalized health system of Nepal? A multi-stakeholder qualitative study. *BMC Health Services Research*, *23*(1), 762.
- Dow, H. D. (2011). Migrants' mental health perceptions and barriers to receiving mental health services. *Home Health Care Management & Practice*, *23*(3), 176-185.
- Fergusson, D. M., Boden, J. M., & Horwood, L. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect*, 32(6), pp.
- Fitzsimmons-Craft EE (2011) Social psychological theories of disordered eating in college women: Review and integration. *Clinical Psychology Review, 31*, 1224–1237.
- Helgeson V. S. (1993). Two important distinctions in social support: Kind of support and perceived versus received. *Journal of Applied Social Psychology*, *23*(10), 825–845.
- Heilemann, M. V., Pieters, H. C., & Dornig, K. (2016). Reflections of low-income, second-generation Latinas about experiences in depression therapy. *Qualitative health research*, *26*(10), 1351-1365.
- Husain, W., & Riasat, A. (2022). Attitudes Toward Mental Health And Psychotherapy In A Collectivistic Muslim Culture: Variations By Gender, Age, Education, Marriage, Profession, And Income. *Journal of Internal Medicine: Science & Art*, *3*(1), 28 - 35.
- Jafree, S. R. (2020). Determinants of depression in women with chronic disease: Evidence from a sample of poor loan takers from Pakistan. *Journal of Community Psychology, 48*(7), 2238–2251.
- Khalily, M. T. (2011). Mental health problems in Pakistani society as a consequence of violence and trauma: a case for better integration of care. *International journal of integrated care*, *11*.
- Kohn, L., Christiaens, W., Detraux, J., De Lepeleire, J., De Hert, M., Gillain, B., & Jespers, V. (2022). Barriers to somatic health care for persons with severe mental illness in Belgium: a qualitative study of patients' and healthcare professionals' perspectives. *Frontiers in Psychiatry*, *12*, 798530.

- Leak, S. (2021). Through a psychoanalytic lens: A sharpened view of neuropsychological assessment. In J. A. Yalof & A. D. Bram (Eds.), *Psychoanalytic assessment applications for different settings* (pp. 28–57). Routledge/Taylor & Francis Group.
- Luvira, V., Nonjui, P., Butsathon, N., Deenok, P., & Aunruean, W. (2023, January). Family Background Issues as Predictors of Mental Health Problems for University Students. In *Healthcare,11*(3), 316.
- Mehboob, R. (2023). Impact of Psychological and Social Determinants on Health. *Pakistan Journal of Health Sciences*, *4*(07), 01.
- Madhani, F. I., Tompkins, C., Jack, S., & Byrne, C. (2023). Perceptions of Mental Health among Pakistani Women with Micro-Finance Loans: An Interpretive Descriptive Study. *The Qualitative Report*, *28*(8), 2401-2420.
- Milan, R.; Vasiliadis, H.-M.(2020).The Association between Side Effects and Adherence to Antidepressants among Primary Care Community-Dwelling Older Adults. *Aging Mental Health, 24*, 1229–1236.
- Misra, S., Jackson, V. W., Chong, J., Choe, K., Tay, C., Wong, J., & Yang, L. H. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: Implications for interventions. *American journal of community psychology*, *68*(3-4), 486-512.
- Niaz U. (2004). Women's mental health in Pakistan. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *3*(1), 60–62.
- Nobels, A., De Schrijver, L., Van Landuyt, M., Vandeviver, C., Lemmens, G. M. D., Beaulieu, M., & Keygnaert, I. (2024). "In the End You Keep Silent": Help-Seeking Behavior Upon Sexual Victimization in Older Adults. *Journal of Interpersonal Violence*, *39*(9-10), 2318-2343.
- Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, *81*, 609-615.Patel, V. (2007). Mental health in low-and middle-income countries. *British Medical Bulletin, 81-82*(1), 81-96.
- Roberts, T. A., Calogero, R. M., & Gervais, S. J. (2018). *Objectification theory: Continuing contributions to feminist psychology.*
- Saklofske, D. H., Austin, E. J., Mastoras, S. M., Beaton, L., & Osborne, S. E. (2012). Relationships of personality, affect, emotional intelligence and coping with student stress and academic success: Different patterns of association for stress and success. *Learning and Individual Differences*, *22*(2), 251-257.
- Sellbom, M., & Suhr, J. A. (2020). *The Cambridge handbook of clinical assessment and diagnosis.* Cambridge University Press.
- Serpytis, P., Navickas, P., Lukaviciute, L., Navickas, A., Aranauskas, R., Serpytis, R., & Samalavicius, R. (2018). Gender-based differences in anxiety and depression following acute myocardial infarction. *Arquivos brasileiros de cardiologia*, *111*, 676-683.
- Trygg, N. F., Månsdotter, A., & Gustafsson, P. E. (2021). Intersectional inequalities in mental health across multiple dimensions of inequality in the Swedish adult population. *Social Science & Medicine*, *283*, 114184.UN Women Data Hub. (2021). Pakistan - Country Fact Sheet. Retrieved from UN Women.
- Van der Ham, L., Wright, P., Van, T. V., Doan, V. D., & Broerse, J. E. (2011). Perceptions of mental health and help-seeking behavior in an urban community in Vietnam: An explorative study. *Community Mental Health Journal*, *47*(5), 574-582.

- Waqas, A., Zubair, M., Ghulam, H., Wajih Ullah, M., & Zubair Tariq, M. (2014). Public stigma associated with mental illnesses in Pakistani university students: a cross sectional survey. *PeerJ*, *2*, e698.
- World Health Organization. (2005). *Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization.* Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne.
- World Health Organization. (2021). WHO Pakistan celebrates World Mental Health Day. *URL: http://www.emro.who.int/pak/pakistan-news/who-pakistan-celebrates-world-mentalhealthday.html*.https://www.emro.who.int/pak/pakistan-news/who-pakistan-celebrates-world-mental-health-day.html