https://doi.org/10.35845/2025.kmuj.23787

CASE REPORT

# 'Just Being Dramatic?' Sociocultural invalidation and suicide attempts in women: A report of two cases

Fatima Saeed Khan [1], Shezah Khalid [1], Abdul Wahab Yousafzai [2]

1: Department of Clinical Psychology, Shifa Tameer e Millat University, Shifa International Hospital, Islamabad, Pakistan

2: Department of Psychiatry, Shifa Tameer e Millat University, Shifa International Hospital, Islamabad, Pakistan

Email: wahab.yousafzai@gmail.com

Contact #: +92-330-9999845

**Date Submitted:** October 09, 2024

**Date Revised:** May 05, 2025

**Date Accepted:** May 15, 2025

## ABSTRACT

**Background:** In recent years, mental health awareness has advanced, reducing stigmas and encouraging open discussions about conditions like major depressive disorder. However, a persistent issue is the frequent invalidation of women's psychological distress, often dismissed as oversensitivity or drama. This invalidation exacerbates their suffering and can worsen symptoms, potentially leading to severe outcomes like suicidal behavior. We present two cases exemplifying this pattern.

**Case Presentation: Case 1:** Mrs. S, a 28-year-old female, attempted suicide by ingesting hydrochloric acid after an argument with her husband. She suffered severe burns to her oral cavity, Esophagus, and stomach, requiring emergency surgery. During psychiatric evaluation, her husband reported agitation and crying spells. Six weeks later, Mrs. S expressed emotional distress, feeling unsupported by her husband and in-laws, who dismissed her actions as dramatic. She had engaged in self-destructive behaviors during episodes of intense distress. She was diagnosed with major depressive disorder.

**Case 2:** Mrs. R, a 41-year-old female with a 15-year history of depression, showed signs of major depressive disorder, including anhedonia, insomnia, and suicidal ideation. She had also been diagnosed with hypothyroidism, which was being managed with thyroxine. Her daughter dismissed her symptoms as melodramatic. Mrs. R had attempted suicide by overdosing on thyroxine, requiring emergency intervention. The family's delayed response, initially dismissing her condition as theatrics, highlighted their lack of understanding of her serious mental health struggles.

**Conclusion:** Both cases highlight the detrimental impact of dismissing women's psychological distress, emphasizing the need for timely recognition and empathetic support to prevent severe outcomes.

**Keywords:** Mental Health (MeSH); Depressive Disorder, Major (MeSH); Psychological Distress (MeSH); Suicidal Behaviour (Non-MeSH); Suicidal Ideation (MeSH); Behaviour (MeSH); Suicide (MeSH).

**THIS ARTICLE MAY BE CITED AS:** Khan SF, Khalid S, Yousafzai AW. 'Just being dramatic?' Sociocultural invalidation and suicide attempts in women: a report of two cases. Khyber Med Univ J 2025;17(2): 229-32. https://doi.org/10.35845/kmuj.2025.23787

## INTRODUCTION

Major depressive disorder (MDD) is a serious mental health condition characterized by persistent low mood, loss of pleasure or interest in activities, changes in sleep patterns, loss of appetite, a sense of worthlessness or guilt/regret and suicidal behaviour.[1] MDD stands as a prevalent mental health condition impacting around 300 million individuals across diverse age groups worldwide, significantly adding to the Global Burden of Disease (GBD). The estimated global suicide rate stands at 14 per 100,000 individuals, demonstrating a gender disparity with 18 per 100,000 for males and 11 per 100,000 for females.[2] While the symptoms may manifest differently in individuals, women with MDD often find their experiences to be invalidated by society at large.[1]

Invalidation of depression can trigger feelings of shame, regret, guilt, and self-doubt, which may amplify their emotional distress. Moreover, the suggestion that their symptoms are "all in their head" further perpetuates the stigma around mental health and discourages them from seeking the support they desperately require.[3] Historically, there has been a tendency to see suicidal behavior in women as manipulative, even in cases where there is clear evidence of intent, lethality, and the necessity for hospitalization.[4]

In Pakistan, women often hesitate to disclose psychological health challenges to their families due to fears of stigma, domestic repercussions, or divorce. This reluctance can lead them to place their own mental well-being secondary to maintaining family stability.[5] For many women, the challenges of dealing with MDD are aggravated by their roles as mothers. They are often reprimanded with advice to overcome these manifestations for the purpose of fulfilling their maternal responsibilities; this reinforces a sense of maternal inadequacy, subsequently amplifying their depressive symptomatology.[6] The invalidation and miscomprehension of MDD can give rise to severe repercussions. Women who perceive their suffering as disregarded may encounter heightened seclusion, an elevated inclination toward self-harm, and, ultimately, a progression toward suicidal tendencies.[7]

This paper aims to present two cases of serious suicide attempts by women who survived and came to the psychiatry outpatient department for follow-up care. These cases provide insight into the psychological distress experienced by the women, exacerbated by societal invalidation of their mental health struggles.

## CASE PRESENTATION

**Case 1:** Mrs. S, a 28-year-old female, was brought to the emergency department following a suicide attempt involving hydrochloric acid ingestion.

Extensive burns were identified in the oral cavity, esophagus, and stomach, necessitating emergency esophagogastrostomy. She was closely monitored for 48 hours' post-surgery, and a referral to the Psychiatry Department was made. During the initial psychiatric evaluation, Mrs. S, unable to speak, was accompanied by her husband, Mr. S. He reported that the patient exhibited signs of agitation and crying spells. It was revealed that the ingestion of hydrochloric acid followed a distressing argument between the couple concerning their children. Inpatient admission was recommended; however, the patient was managed on an outpatient basis with frequent scheduled follow-up.

Six weeks later, Mrs. S followed up at the psychiatry outpatient department. During the interview, the patient appeared tearful, with a constricted affect and reduced verbal fluency. She reported feelings of emotional overwhelm and perceived lack of support, particularly from her husband and in-laws. Mr. S shared that, during moments of intense distress, Mrs. S had resorted to self-destructive behaviors, such as tearing her clothes and running towards the streets. Her family's response was characterized by a lack of understanding and empathy, with an insistence that she was being dramatic and needed to fulfil her responsibilities as a mother. The mental status examination revealed low mood, eye contact was poor, and psychomotor agitation was noted. Speech was reduced in spontaneity. Thought contents reflected themes of hopelessness and helplessness with partial insight and fair judgement. Based on the presenting symptoms, clinical interview, and MSE findings, a diagnosis of MDD, severe (without psychotic symptoms) was made. Her treatment plan included management with an antidepressant, with a referral for Cognitive Behavioral Therapy (CBT) to be considered as her condition stabilizes.

**Case 2:** Mrs. R, a 41-year-old female, had presented to the psychiatry outpatient department with a history of low mood, anhedonia, insomnia, and memory lapses. These symptoms had persisted for the past 15 years, with recent worsening. She had previously been diagnosed with hypothyroidism and was being managed with 50 mcg of thyroxine daily. Despite experiencing significant emotional distress, her concerns were frequently dismissed by family members. During the interview, Mrs. R appeared withdrawn and subdued. Her daughter, who accompanied her, minimized her symptoms and described her emotional state as melodramatic. During the assessment, it was revealed that Mrs. R had attempted suicide by overdosing on thyroxine tablets. She was taken to the emergency department, where gastric lavage was performed. The family's delayed response and dismissive attitude contributed to the escalation of her depressive condition and her suicide attempt.

Mental status examination revealed psychomotor slowing and reduced verbal output. Mood was low, affect was restricted, and eye contact was minimal. Thought content centered around themes of helplessness. Memory difficulties were noted. Insight was limited, and judgement impaired. A clinical impression of MDD was made based on her symptom presentation and MSE. She was started on an antidepressant, and supportive psychotherapy was discussed. Referral for psychological intervention was to be explored depending on her engagement and clinical progression.

## DISCUSSION

Major depressive disorder is a pervasive and debilitating mental health condition that affects millions of individuals globally. Unlike transient feelings of sadness, it is a chronic condition characterized by a persistent disruption to an individual's ability to function in daily life.[8] MDD is not merely a temporary emotional state but a serious health issue that can lead to significant impairments if left untreated.[3] Despite its severity, MDD is often misunderstood and stigmatized, leading to its dismissal as a mere lack of motivation or willpower, rather than being recognized for the life-threatening condition it truly is.[9] Gender differences play a critical role in the experience and expression of depression. It has been found that women are nearly twice as likely as men to experience depression, often due to a combination of biological, hormonal, and psychosocial factors. Societal expectations and gender roles can exacerbate depressive symptoms in women, leading to feelings of inadequacy and overwhelming stress.[4]

The link between depression and suicide is well-established, with depression being a major risk factor for suicidal thoughts and behaviors. The stigmatization of mental illness not only exacerbates depressive symptoms but also increases the risk of suicide by discouraging individuals from seeking help.[10] The trivialization and stigmatization of psychiatric illnesses are pervasive problems that contribute to the underreporting and under treatment of these conditions. The stigma attached to mental health issues often deters individuals from seeking help, as they fear being judged or misunderstood.[11] This societal stigma is particularly damaging for women, whose emotional experiences are frequently invalidated or dismissed as 'overreactions.' Trivialization, where symptoms are seen as mere exaggerations or weaknesses, further marginalizes those suffering from psychiatric conditions, preventing them from receiving the care and empathy they need.[6,11]

The consequences of invalidation can be severe, as it may lead to heightened isolation, an increased propensity for self-harm, and ultimately, a dangerous progression toward suicidal tendencies. Family education on psychiatric illnesses is also necessary, and its significance equals that of educating the patients themselves. The lack of insight into psychiatric problems can lead to severe outcomes, with suicide being a particularly grave consequence.[12] Inadequate focus on informational care and a major issue related to the insufficient understanding of treatment options, including the use of psychotropic medication and therapeutic intervention, contribute to this problem. Collaboration between psychiatrists and psychologists is essential in the field of mental health.[13] Addressing these challenges requires an approach involving informational care, family education, and a scientific

perspective.

Empathy towards patients and an understanding of their struggles are pivotal aspects. Neglecting these elements can lead to devastating consequences, including suicide.[14] Patients' complaints are sometimes dismissed with statements like "God has given you everything; why do you feel this way?" Such dismissive attitudes may leave patients feeling unheard and misunderstood. Following such interactions, patients may struggle with profound existential questions, intensifying their struggles with thoughts like "What is the point in living anymore?" (Personal Communication).

Avoiding dismissal is essential, as it is extremely detrimental to a patient's health. The unjust characterization of this narrative vividly portrays the distress affecting women dealing with mental illness, especially how they frequently go unnoticed and unheard. Their suffering is often overlooked in a society that should provide compassion and support.[15] Interventions like enhancing public consciousness through campaigns, integrating mental health education within educational institutions, formulating supportive workplace frameworks, establishing support circles, initiating community-based health programs, offering comprehensive training for medical professionals, and promoting resilience and coping techniques are crucial for elevating understanding regarding MDD and its significant effects on women.[16,17]

## CONCLUSION

In depression remains a debilitating mental health condition that disproportionately affects women, a population frequently exposed to societal stigma and invalidation. Such psychosocial stressors can exacerbate depressive symptoms, heightening the risk of self-harm and suicide. As demonstrated in the case studies, family support and understanding are essential in preventing these outcomes. Comprehensive psychiatric care, combined with community-based efforts to reduce stigma, is essential to empower affected women in managing their condition and preventing progression to severe mental health crises.

## REFERENCES


1. Otte C, Gold SM, Penninx BW, Pariante CM, Etkin A, Fava M, et al. Major depressive disorder. Nat Rev Dis Primers 2016;2:16065. https://doi.org/10.1038/nrdp.2016.65
2. GBD 2019 Diseases and Injuries Collaborators. Global burden of 369 diseases and injuries in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet 2020;396(10258):1204-22. Erratum in: Lancet 2020 Nov 14;396(10262):1562.https://doi.org/10.1016/S0140-6736(20)30925-9
3. Covan EK. Chronic illness: misunderstood, misdiagnosed, and mistreated among women. Health Care Women Int 2022;43(1-3):1-4. https://doi.org/10.1080/07399332.2022.2028470
4. Vijayakumar L. Suicide in women. Indian J Psychiatry 2015;57(Suppl 2):S233-8. https://doi.org/10.4103/0019-5545.161484
5. Yousafzai AW, Khan SA, Bano S, Khan MM. Exploring the phenomenon of suicidal behaviour (SB): an explanatory, mixed-method study in rural Pakistan. Int J Soc Psychiatr 2022;68(8):1629-1635. https://doi.org/10.1177/00207640211045414
6. Burt VK, Quezada V. Moo-d disorders in women: focus on reproductive psychiatry in the 21st century--Motherisk update 2008. Can J Clin Pharmacol 2009;16(1):e6-e14.
7. Brandão T, Brites R, Hipóli-to J, Nunes O. Perceived emotional invalidation, emotion regulation, depression, and attachment in adults: a moderated-mediation analysis. Curr Psychol 2022;42(18):15773-81. https://doi.org/10.1007/s12144-022-02809-5
8. Culpepper L. Understanding the burden of depression. J Clin Psychiatry 2011;72(6):e19. https://doi.org/10.4088/JCP.10126tx1c
9. Kuehner C. Why is depression more common among women than among men? Lancet Psychiatry 2017;4(2):146-58. https://doi.org/10.1016/S2215-0366(16)30263-2
10. Franklin JC, Ribeiro JD, Fox KR, Bentley KH, Kleiman EM, Huang X, et al. Risk factors for suicidal thoughts and behaviors: a meta-analysis of 50 years of research. Psychol Bull 2017;143(2):187-232. https://doi.org/10.1037/bul0000084
11. Yen S, Kuehn K, Tezanos K, Weinstock LM, Solomon J, Spirito A. Perceived family and peer invalidation as predictors of adolescent suicidal behaviors and self-mutilation. J Child Adolesc Psychopharmacol 2015;25(2):124-30.https://doi.org/10.1089/cap.2013.0132
12. Gantt AB, Goldstein G, Pinsky S. Family understanding of psychiatric illness. Community Ment Health J 1989;25(2):101-8. https://doi.org/10.1007/BF00755382
13. Schindler FE, Berren MR, Beigel A. A study of the causes of conflict between psychiatrists and psychologists. Hosp Community Psychiatry 1981;32(4):263-6. https://doi.org/10.1176/ps.32.4.263
14. Witko KD, Bernes KB, Nixon G. Care for psychological problems. Collaborative approach in primary care. Can Fam Physician 2005;51(6):799-801, 805-7.
15. Sherbourne CD, Dwight-Johnson M, Klap R. Psychological distress, unmet need, and barriers to mental health care for women. Women's Health Issues 2001;11(3):231-43. https://doi.org/10.1016/s1049-3867(01)00086-x
16. Caroline HA, Bernhard LA. Health care dilemmas for women with serious mental illness. ANS Adv Nurs Sci 1994;16(3):78-88.

https://doi.org/10.1097/00012272-199403000-00009

17. Thornicroft G, Brohan E, Kassam A, Lewis-Holmes E. Reducing stigma and discrimination: candidate interventions. Int J Ment Health Syst 2008;2:3.https://doi.org/10.1186/1752-4458-2-3

## AUTHORS' CONTRIBUTION

The following authors have made substantial contributions to the manuscript as under:

**FSK & SK:** Identification and management of the case, drafting the manuscript, approval of the final version to be published

**AWY:** Identification, diagnosis and management of the case, drafting the manuscript, critical review, approval of the final version to be published

*Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.*

## CONFLICT OF INTEREST

Authors declared no conflict of interest, whether financial or otherwise, that could influence the integrity, objectivity, or validity of their research work.

## GRANT SUPPORT AND FINANCIAL DISCLOSURE

Authors declared no specific grant for this research from any funding agency in the public, commercial or non-profit sectors

## DATA SHARING STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request

## ETHICAL CONSIDERATION

This case report was conducted in accordance with institutional ethical standards. Consent was obtained from both patients for the publication of anonymised clinical details. All identifying information has been removed to maintain patient confidentiality



KMUJ web address: www.kmuj.kmu.edu.pk
Email address: kmuj@kmu.edu.pk