Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

Cultural Norms and Socioeconomic Factors Influencing Ethical Decision-Making among Clinical Psychologists in Pakistan

Noreena Kausar
Assistant Professor, Department of Psychology, University of Gujrat
Email: noreena. kausar@uog.edu.pk

Ume Habiba
Ph.D. Scholar, Department of Psychology, University of Gujrat
Email: umehabiba4050@gmail.com

ABSTRACT
A qualitative exploratory study was conducted on the influence of cultural values, the role of families, religion, and socio-economics on the decision-making of clinical psychologists regarding ethical issues in Pakistan. A total of 14 clinical psychologists participated in semi-structured interviews about their experiences within the public and private mental health systems in Pakistan. The results indicated that clinical psychologists in Pakistan are confronted with multiple ethical dilemmas on a daily basis, including pressure from family members to take a certain course of action, breaches of confidentiality, a low level of awareness of mental health issues within their communities, financial difficulties, stigma attached to those seeking mental health care, reliance on religious healers, gender bias, and a lack of regulation of the mental health system. Additionally, clinical psychologists expressed heightened levels of stress, burnout, and emotional distress, based on the heavy caseloads for which they are responsible, combined with few resources. The study concludes that ethical decision-making of clinical psychologists in Pakistan is heavily impacted by their socio-cultural context, rather than solely by the professional ethical code prescribed by their respective licensing boards. Additionally, it has been determined that there is a tremendous need for more comprehensive training and robust regulatory frameworks, along with systems of support and culturally relevant guidelines, to support ethical clinical practice in Pakistan.

Keywords: Ethical Decision-Making, Clinical Psychology, Cultural Norms, Stigma, Ethical Issues

Introduction

Clinical psychology practice can introduce a variety of ethical issues, and the issue is even more complicated when it is conducted in societies that are developed on the basis of powerful cultural traditions and unequal socioeconomic conditions. In Pakistan, where the traditionally deep-rooted communal values are intertwined with the relatively recent psychological frameworks, ethical decisions are made not in vacuums but they are constantly subject to outside environmental influences (Arumi et al., 2024; Oppong, 2023). The social context of the country is heavily impacted by the religious principles and extended family that contribute to the way the ethical dilemma can be comprehended and addressed in everyday clinical activities (Ghafran & Yasmin, 2024). Despite the fact that professional ethics are the basis of protecting clients and the benefits of practitioner actions (Roberts, 2021), in non-Western countries, their implementation tends to assume a different form that undergoes cultural interpretation of the principles (Oppong, 2023).

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

Stigma against mental illness is still acute in Pakistan and both factors affect access to services as well as mean that clinicians need to shape ethical issues differently. Decisions concerning confidentiality, consent, and disclosure are greatly complicated in the circumstances where mental illness has the risk of a client experiencing social alienation (Nafees & Anjum, 2020). Trainees and new professionals in the field of psychology have frequently complained about conflicting expectations with their training with the requirements of their collectivist cultural background, especially where the rights of the family, or society, take precedence over those of individuals (Lárez & Sharkey, 2021). Such conflicts do not solely pertain to the situation in Pakistan, but are particularly evident in those countries where the psychological activities which have been cultivated in the realms of the West have been exported to the society that has very different social priorities (Oppong, 2023; Lárez and Sharkey, 2021). It is in this context that the present paper examines the issue of ethical decision-making by clinical psychologists in Pakistan, operating in a cultural context whereby family approval, societal status and collective welfare take precedence over that of an individual (Memon et al., 2024). How these cultural forces (with gender role, family and social expectations) influence the dilemmas that psychologists face in their daily practice is also the subject of research.

Clinical psychology Ethical Decision-Making

Making ethical decisions in psychology is not that of making use of general rules. Rather, it is a situational, dynamic process structured by local realities and in most cases, the local realities drag clinicians into circumstances where principles do not match practice (Oppong, 2023). This gap is particularly clear in the culturally diverse societies where the Western ethical lessons, despite being taught so often, may not be in the perfect agreement with the local cultures. As an example, the importance of individual autonomy in the Western models usually contradicts the collective-oriented approach typical of South Asian families, medical and psychological decisions are made regularly with, or sometimes without, the family member (Memon et al., 2024). This situation makes the issues of informed consent and confidentiality more complicated because it obliges psychologists to compromise by balancing between personal interests and fulfilling family expectations.

These moral issues are further tackled by social economic inequalities. The lack of education, the availability of the resources, and access to quality mental-health care determine the degree to which clients can lead an autonomy-friendly quality life (Thakkar et al., 2024). In most of the rural and semi-urban areas, physicians or senior relatives often play the role of the primary decision-maker in reducing the participation of the individual in the consent process (Memon et al., 2024). Consequently, the ethical standards just need to be accommodated, but not violated, to meet the cultural norms while not sacrificing the quality of psychological care (Oppong, 2023). Theorists have thus presented the possibility of a more cultural approach to ethics, one that honors local cultures, but maintains professional accountability (Lárez and Sharkey, 2021). This balance is very important to understand so as to create culturally and professionally acceptable ethical practices in countries such as Pakistan.

The Role of Cultural Norms

The cultural norms in Pakistan do have a significant force on influencing clinical psychologists to make ethical decisions especially in matters of consent, privacy and sharing of information. In a community where the common good more often than the personal one, families can often be decisive in mental-health care (Memon et al., 2024;

ISSN Online: 3007-3154
ISSN Print: 3007-3146

Lárez and Sharkey, 2021). This participation may be positive and more so when the family support enhances compliance with therapy. It may, however, make it difficult as well involving client confidentiality and family expectations. Informed consent, such as that, might also require an agreement of the client and/or the family, which would be consistent with the current cultural focus on joint responsibility (Memon et al., 2024). Although this is unlike the models in the West, in many cases therapy may only be conducted successfully in a Pakistani context.

The demands of privacy and confidentiality also acquire new genres within the culture that views intimate relationships as a characteristic element and inflicts a significant stigma upon a state of mental illness. The psychologists have to decide on the extent to which their information may be shared without abusing the trust, especially when the families demand to know the details of the condition of the client (Maqsood et al., 2024). The resulting ethical conflict is aggravated by the stigma of psychological diagnoses, as the family occasionally does not want to disclose information to preserve the social image, which also causes an additional conflict (Azad et al., 2022). The role of gender conventions cannot be underestimated either; females can lack independence in health-related choices, and any decisions made by females can be affected or disapproved by their family members (Memon et al., 2021). Psychologists in such situations have a fine line to walk where they need to consider the cultural practices and profession-related obligations to the rights of individuals (Memon et al., 2024).

Religion and traditional forms of treatment are also very ingrained in the cultural interpretation of mental illness. The power of spiritual constructs and religious authorities often creates an impact on the perceptions of clients of the measures of psychological misery and the admissibility of any treatment (Ethical Considerations in Conducting Clinical Research among Patients with Mental Health Problems in Arab Countries, 2023). Ethical work to many practitioners entails the recognition of such beliefs without involving the boundaries of the profession. The appropriate partnership with religious leaders would assist in bridging the divide in beliefs that are culturally familiar and the evidence-based interventions (Cucchi, 2022). Culturally sensitive strategies may increase treatment methods and contribute to compliance, particularly in societies where conventional and biomedical views co-exist (Musa, 2024).

Ethical Practice and Socioeconomic Facts

The socioeconomic factors are central in determining such ethical realities that clinical psychologists have to work with in Pakistan. The scarcity of financial resources, together with the unequal distribution of trained professionals and mental-health facilities, particularly in the non-large cities, leads to the situation when achieving the ethical principles of justice, beneficence, and fairness, becomes more and more challenging (Bhasin et al., 2021; Nafees and Anjum, 2020). Most psychologists are forced to work in systems in which the lack of resources affects the choices made during treatment process. This can result in ethically awkward conditions where the capacity to pay care has a secondary role in the first-served basis of care or the capability to pursue long-term treatment, which find reflection in low-income settings worldwide (Sattar and Jawaid, 2024). These differences make it challenging to engage in informed consent and continuity of care especially when the clients drop the therapy sessions in a financial crunch. Since these social-economic restrictions intertwine with the culture, a psychologist often has to juggle a complicated landscape in which the principles of ethics should be observed in the light of the realities of social class differences and institutional downsizing (Lárez & Sharkey, 2021). This intersection is thus important to understand

ISSN Online: 3007-3154
ISSN Print: 3007-3146

since economic hardship does not only influence the access to services but it also influences how clinicians understand their ethical duties.

Clinical Psychology in Pakistan: Of Special Circumstantial Considerations

When combined with the cultural and socioeconomic dynamics it can be observed that the practice of clinical psychology in Pakistan is drastically different in practice compared to that of Western settings. Psychologists regularly have to work through the contradictions between universal ethics and the realities of the lives of their clients, which, in many cases, require the combination of professional standards and cultural respect (Tharani et al., 2024). This balancing act involves flexibility because clinicians will make adjustments to internationally acknowledged ethical principles so that they may be applicable to local standards that attach importance to collective decision-making, religious beliefs, and family participation (Wei and Zheng, 2025). The current research study is part of this current debate because it looks at how the Pakistani clinicians deal with these multifaceted forces in their practice. In such a way, it underscores the necessity of framing ethical models and proposals built on some local ground and not necessarily on foreign tropes, which do not correspond easily to the sociocultural setting.

Nature of Research Gap and Significance

Despite the current acknowledgment of mental health worldwide, this does not exclude an observable insufficiency of empirical research undertaken to evaluate ethical decision-making among clinical psychologists operating in the non-Western environment due to low income (Fazal, 2021). Specifically, this specific blend of cultural demands, inequalities in classes and major mental-health infrastructures gaps, characteristic of Pakistan, has yet to be researched (Grace et al., 2020). This disconnect is alarming, particularly in the light of chronic problems, like a lack of mental-health specialists and the lack of national policies that comprehend such problems, which increase the ethical issues of clinicians (Alvi et al., 2023; Fatima and Ilyas, 2024). The proposed research would fill this gap to join the conversation about how culture as well as socioeconomic pressures influence ethical decision-making in Pakistani clinical psychologists. By so doing, it is trying to educate the establishment of ethical principles and training courses that appeal to local requirements (Amin and Akram, 2024; Wei and Zheng, 2025).

This study does not just identify challenges but has its contribution. It emphasizes the need to develop ethnically sensitive ethical frameworks that will be specific to the sociocultural context of Pakistan and will eventually enhance the quality and availability of ethical mental-health services (Humayun et al., 2025; Qayyum et al., 2025). Majority of the literature available is focused on the Western societies, which neglects differences present in a South Asian cultural context (Global Sociological Review, 2020). Previous studies have repeatedly noted that various ethical models that are centered on the Eurocentric approach are incapable of capturing the complexity that is experienced in the diverse population (Renteria et al., 2020). Thus, it is necessary to understand the intersection of cultural expectations, socioeconomic, and professional ethics in Pakistan, and how psychologists address these entangled issues in their daily practice (Juntunen et al., 2023).

It is always revealed in the literature that cultural norms and socioeconomic realities have a decisive effect on the understanding and implementation of ethical guidelines by clinical psychologists in Pakistan. The cultural beliefs have a potent effect on the general interpretation and interpretation of psychological distress and what is deemed as normal

ISSN Online: 3007-3154
ISSN Print: 3007-3146

behavior of a professional, alongside the socioeconomic differences that impact the degree to which people access psychological services in the first instance. All these overlapping forces underscore the necessity of ethical theories not expected to mimic the examples of the West but rather based on the social values of Pakistan, as well as the challenges which Pakistan needs to face in practice. The academic community believes that in the absence of contextualization, ethics standards may become impractical regarding a real-life of both practitioners and their clients (Amin &Akram, 2024).

Sahar et al., 2021 provided a valuable contribution through a qualitative study. Their reports include rampant issues like improper referral channels, rude communication and the absence of formal training. According to the interviewed psychologists, there is an urgent need to have standardized processes, adequate supervision, and control mechanisms to guarantee the adequate and ethical delivery of the services.

Additional evidence regarding the difficulties involves the research of Ethical Dilemma Distress Scale that was created to be used by mental-health practitioners in Pakistan. This book illuminates the existence of four large groups of dilemmas that are often described by clinicians to include value-based conflicts, boundary issues, disclosure pressures, and systemic limitations (Fatima & Ilyas, 2024).

Sajid, et al., (2022) stated that mental-health practitioners in the rural areas of Pakistan face a distinct set of ethical challenges that are caused by geographic seclusion, insufficient institutional backing, and the intimately close communities of rural-areas. These pressures are well described by a qualitative study carried out in the Malir district of Karachi among fifteen practitioners. Sajid et al., 2022 found that the rural practitioners are also exposed to the pressures of ethical stress and impaired clinical judgment unless exposed to training that takes into consideration the local cultural expectations and the available resources. Similarly, Siddiqui and Khan (2021) highlight the overall crisis in the mental-health situation in Pakistan and demonstrate how structural void, cultural attitudes, and socioeconomic stress all interact, leading to massive obstacles in delivering ethical and equitable services to the population.

Thompson and Saleem (2025) further this debate by saying that the mental-health system of Pakistan is worst of the under-resourced in the region. The number of Pakistanis who have no mental-health services is in the millions; with 0.4 percent of the national health budget allocated to mental-health care and the estimated number of psychiatrists (0.19) per 100,000 people, millions of Pakistanis are not receiving the fundamental psychological care that they need. Mashhood (2025) opined that the mental-health system in Pakistan is still straining because of a long-term structural, cultural, and socioeconomic nature, and a significant segment of the population is deprived of the adequate care. The country is under chronic shortage of specialized facilities and trained professionals because there are less than one psychiatrist to every 100,000 individuals (by far less than what is recommended in the whole world).

These issues are added to by Naz et al. (2024) who write about how these obstacles remain nationwide to limit access to mental-healthcare. Based on focus groups and in-depth interviews conducted in various parts of Pakistan, the authors discovered that due to the lack of psychiatrists, psychologists, and well-trained general practitioners, many people are poorly diagnosed and never treated of psychological diseases, in particular in rural districts where coverage of mental illness is insignificant. Stigma was identified as the most widespread obstacle and many respondents indicated that the fear to be labeled as mad or immoral was the reason why people do not want to seek help.

Ahmad and Koncsol (2022) also prove that the cultural and religious systems of beliefs impact the level of mental-health stigma in Pakistan to a significant degree. Their study

ISSN Online: 3007-3154
ISSN Print: 3007-3146

of emerging adults showed that spiritual and supernatural factors are commonly used to explain psychological distress by a number of respondents who attribute the issue to jinn possession or sorcery and supernatural retaliation. As demonstrated by Daraz et al. (2025), cultural discourses and social norms remain the determinant to develop mental-health stigma and help-seeking trends throughout Pakistan.

Polley (2019) provides a complementary insight into that the ethical issues clinicians face when dealing with Muslim clients are complex. The author elaborates that mental-health practitioners have to strike a balance between the demands of the profession and the teachings of Islam that uphold a spirit of compassion, mercy and the sanctity of life. Such ethical conflicts are especially evident when it comes to suicidal ideation, as religious forbids on suicide can influence the client to be more or less open about their ideation, or to undergo risk-assessment processes. Tanhan and Young (2022) continue discussing the application of mental-health services by Muslim communities and emphasize cultural beliefs, religious perceptions, stigma, and structural barriers. In their work, it is available that in most Muslims psychological distress is conceptualized through spiritual models, such as jinn, nazar, or divine testing, which frequently leads to it being pursued through spiritual healers, bypassing both formal mental-health providers. According to Tanhan and Young (2022), to enhance access and engagement, it is necessary to present culturally-based interventions sensitively combining religious and cultural values and ensuring a high quality of care.

Methodology

Research Design

The research was a qualitative exploratory type of study to test how cultural norms and socioeconomic status influence the ethical choices of Pakistani clinical psychologists. The study will be guided by a constructivist -interpretivist epistemology and assume that ethical judgments are socially enacted within the dynamics between clinicians and their clients, families, institutions, and the culture in general systems. Qualitative method was critical in order to gain access to lived experience and meaning-making that lies beneath ethical dilemma in clinical practice.

Study Setting

The data were gathered in a semi-urban District, Jhelum and Gujrat in Punjab where mental-health services are provided in a combination of public and government health-centers, private practice as well as counseling clinics. It was carefully chosen to these districts due to the fact that they represent various cultural setting and different degrees of access to resources, thus, being suitable in terms of studying contextual impact on ethical practice.

Participants and Sampling Strategy

The purposive sampling was used to recruit the participants, with clinical psychologists who are actively involved in psychotherapy, assessment, and clinical decision-making being the target group of study participants. The study involved 14 clinical psychologists. Both practitioners in public sector (e.g. district hospitals, government mental-health units), and private-sector practitioners (e.g. personal clinics, independent practice, counseling centers) were brought in, so that there would be heterogeneity in institutional experiences. Recruitment was done until data saturation ensued which was whereby the successive interviews did not bring in any new idea.

Eligibility criteria required participants to

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

Hold at least a Master's or M.Phil degree in Clinical Psychology
Have a minimum of one year of clinical experience
Be actively practicing in Jhelum or Dist. Gujrat
Provide informed consent to participate in an in-person interview

Table 1: Participants Demographics (N=14)

Variable	Category	n
Gender	Male	4
	Female	10
Years of Clinical Experience	2 years	3
	4–7 years	5
	15+ years	2
Sector of Employment	Public Sector	4
	Private Sector	10
Location / District	Jhelum	4
	Lalamusa	3
	Gujrat	5
	Sarai Alamgir	2
Clinical Specialization	Child Cases	6
	Mixed Caseload (Adults + Children)	3
	Adult Cases Only	5
Highest Qualification	MS Clinical Psychology	Majority
	MSc Psychology + ADCP	Some participants
	ADCP Only	Few participants

Data Collection Procedures

Data were gathered through in-person, semi-structured interviews conducted over several weeks. Interviews took place at locations chosen by participants, including clinical offices, hospital meeting rooms, and private workspaces, ensuring comfort and privacy. Each interview lasted between 45 and 70 minutes.

The interview guide explored:

Ethical challenges encountered in daily practice
The influence of family norms, cultural expectations, and religious beliefs
Socioeconomic pressures affecting clinical decisions
Conflicts between professional ethical codes and contextual realities
Perceived gaps in supervision, training, and regulatory systems

All interviews were audio-recorded with permission and supplemented by field notes capturing contextual observations, nonverbal cues, and preliminary analytic reflections.

Data Analysis

The analysis of the data was performed on the basis of reflexive thematic analysis, as proposed by Braun and Clarke (2006) with the six-phase framework. A number of times the transcripts were read to produce familiarity with them, and at the same time, first codes were produced inductively. The categorization of codes was done into broad categories and codes were refined and further developed as higher order themes. There was an analytic depth and both inductive (emerging out of the data) and deductive (directed by the focus of the study) approaches were utilized.

There was an iterative, cyclical approach to analysis that was assisted through analytic

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

memos, codebooks and an active reflexive participation. The last themes manipulated patterned connotations of the subjects among the participants in the instructiveness of cultural norm, the socioeconomic and ethical decision making.

Researcher Reflexivity

As it is stated in QHR standards, reflexivity was the priority in the process of research. To ensure that the researcher minimized personal assumptions, positionality and emotional response during the data collection process and during data analysis, the researcher kept a reflexive journal. Reflexive memos were incorporated wherein interpretations could have been clouded with the background, training and cultural position of the researcher. Analytic transparency was strengthened and bias that could not be checked was reduced.

Ethical Considerations

Ethical approval was obtained from the appropriate institutional review board. All participants were briefed about the study's purpose, risks, and confidentiality measures and provided written informed consent. Participation was voluntary, and individuals were free to withdraw at any stage. Identity of the participants was protected and all audio recordings and transcripts were securely stored and accessible only to the researcher.

Results and Discussion

The analysis generated six interconnected themes that illustrate how cultural norms, socioeconomic constraints, religious beliefs, systemic failures, gendered structures, and case-specific complexities shape ethical decision-making among clinical psychologists in Pakistan. These themes reveal a practice environment where therapists must constantly negotiate between professional ethical codes and deeply embedded sociocultural expectations. The findings reflect a context in which ethical dilemmas are not isolated incidents but ongoing negotiated processes mediated by families, institutions, belief systems, and resource limitations.

Table 02: Themes, Sub themes and Initial Codes

Main Theme	Sub-Theme	Initial Codes
Cultural Norms, Family Control & Stigma as Barriers to Ethical Decision-Making	Family Dominance & Boundary Intrusions	Privacy breach; family over-involvement; family as decision-makers; confidentiality compromised; pressure to disclose session content; incomplete client disclosure; family dominating sessions; therapist counseling family first
	Stigma, Shame & Concealment	Stigma toward psychological issues; shame in help-seeking; fear of judgment; hidden therapy; stigma-driven therapy dropout; clients hiding symptoms
	Derogatory Cultural Language & Labeling	Use of stigmatizing terms ("pagal," "majnu," "sai"); cultural ridicule; shame-reinforcing

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

		vocabulary
	Autonomy & Confidentiality Violations	Autonomy minimized; family overriding client decisions; confidentiality tensions; expectations to disclose; blurred therapeutic boundaries
Socioeconomic Inequalities Influencing Access, Engagement & Ethical Choices	Awareness Gaps Across Classes	Elite vs. low-SES differences; lack of mental-health literacy; psychoeducation needs in low-SES clients
	Financial Limitations & Therapy Discontinuation	Inability to afford sessions; premature dropout; financial pressure shaping ethical decisions; inability to sustain long-term therapy
	Misrepresentation of Financial Need	Families lying for concessions; manipulating SES status; ethical tension in fee adjustments
	Need for Affordable Services & Government Support	Need for low-cost therapy centers; lack of government support; demand for awareness programs; accessibility challenges
Religious–Spiritual Beliefs Shaping Treatment Pathways	Reliance on Pirs/Amils Before Therapy	Preference for spiritual healers; delayed clinical help
	Concurrent Spiritual & Clinical Treatment	Rituals during therapy; conflicting healer vs. therapist instructions
	Harmful or Exploitative Spiritual Practices	Harassment; worsening symptoms; spiritual abuse; exploitative healers
	Therapeutic Modification to Align with Religious Beliefs	Adjusting techniques to fit beliefs; culturally responsive modifications
Gendered Constraints on Autonomy & Therapy-Seeking	Limited Privacy & Autonomy for Women	Need for family permission; restricted movement; inability to seek therapy secretly
	Men's Independence in Help-Seeking	Men accessing therapy privately; less stigma for men; greater autonomy
	Patriarchal Control Over Women's Mental-Health Decisions	Husband/family control; cultural policing; restricted decision-making
Structural Failures, Professional Strain & Ethical Burden on Psychologists	Lack of Regulation & Professional Standards	No licensing; malpractice; unqualified practitioners; lack of accountability
	Resource Constraints	No standardized tools; improvised

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

	& Poor Infrastructure	assessment material; noisy environments; interruptions
	Weak Interprofessional Collaboration	Doctors unaware of psychological roles; minimal psychiatrist–psychologist communication
	High Caseloads & Burnout	Excessive workload; burnout; irritability; reduced care quality
	Ethical Distress, Moral Conflict & Emotional Labor	Conflicts between personal values and client issues; therapist moral dilemmas; self-counseling as coping; feeling undervalued
	Training & Professional Development Gaps	Lack of standardized supervision; insufficient training; inadequate professional development
Ethical Complexities in Child & Neurodevelopmental Cases	Extended Family Overshadowing Parents	Relatives bringing child; missing maternal input; incomplete developmental history
	Concealment & Denial of Child's Condition	Parents hiding therapy; denial of diagnosis; stigma-related avoidance
	Untrained Practitioners Handling Sensitive Cases	Therapists acting like teachers; lack of specialization; improper management
	Family or Organization Dictating Therapy	Families controlling therapy process; organization-driven decisions; compromised autonomy
	Marital Conflict Affecting Treatment Decisions	Non-cooperative husbands; family disputes influencing therapy pathways

THEME 1: Cultural Norms, Family Control, and Stigma as Barriers to Ethical Decision-Making

In the interviews, almost all of the clinical psychologists described cultural and familial norms to be the most dominating in shaping their ethical decisions. In the Pakistani culture, clients usually do not have the autonomy and families exercise considerable authority over clients' personal choices. Such pattern results in creating problems in following and assuring ethical principles such as autonomy, confidentiality and non-maleficence. Therapists often found themselves balancing between their professional responsibilities and the cultural expectations of clients' families.

Family Dominance and Boundary Intrusions

Many psychologists reported that families involve themselves a lot in the therapeutic spaces. It directly influences the direction of therapy. Participants reported that family members want to know everything reported by the client. Such behavior highly compromises confidentiality leading to privacy breach. And clients then feel hesitant to speak openly.

"They want to know everything that is going on inside during the session. Some even

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

want to be part of the session and stay inside."(Extract Participant no: 2)

"Before even starting the session, we have to counsel the family first. It takes extra energy and time. They want updates, explanations. It becomes difficult to provide our client with a safe space."

Stigma, Shame, and Concealment of Psychological Difficulties

Throughout the interview process, stigma emerged as s powerful social factor. It shapes help-seeking behavior among the clients and it was reported as another factor that made the client uncomfortable to share information. Participants shared their experiences about the clients who usually withdrew or minimized their symptoms while reporting due to the fear of judgement and "log kya kahenge?"

"Clients coming to us try to hide their psychological issues like it is a crime. Even during the session, they feel hesitant to share although they are alone but due to the fear that someone in their family may find out." (Extract Participant no: 4)

It was also reported by the participants that many clients delayed their sessions or tried to approach for online sessions so that they can keep their issues hidden and private. Such patterns directly affect with ethical decision making among clinical psychologists.

Derogatory Cultural Language and Labeling

Participants reported that in Pakistani culture, psychological issues are not taken seriously. People with psychological issues are labelled as "pagal" and "majnu" by their own family members. Such disrespectful labels are quite commonly used in Pakistani culture. It also results in creating shame among clients and impedes therapeutic rapport.

"A mother casually said her child behaves like a 'majnu.' She didn't see how damaging that word was. The child sat there absorbing it." (Extract Participant no: 1)

This normalized labeling in the culture contributed to creating an uncomfortable environment not only for the client but the therapist as well.

Autonomy and Confidentiality Violations

Ethical principles that focus on autonomy of the client often face clashes with the cultural norms that focus on the opposite. Psychologists participating in the study reported cases where families demanded insights into the sessions.

"I can't always give autonomy to the client because the family's belief system does not go accordingly. They believe it is their right to make decisions for them."

As a results, psychologists have to find a balanced path and tell some of the information to the family with client's consent. They said that we do try to assure as much confidentiality as we can however to remain fully confidential, in most cases, is not possible.

THEME 2: Socioeconomic Inequalities Influencing Access, Engagement, and Ethical Choices

Participants reported that socio-economic conditions played a significant role in determining the ability of the client to assess the professional. They highlighted that mostly the people are not aware, or cannot afford coming to therapy sessions, as they are coming from different economic backgrounds. This creates a typically complex decision making situations for clinical psychologists.

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)

Awareness Gaps across Socioeconomic Classes

It is always mentioned by psychologists that clients with less socioeconomic status demonstrated less knowledge of psychological concepts and needed lots of psycho-education in the initial stage. Conversely, clients of high backgrounds came in more mentally-health literate. One participant explained,

"You do not need tell how to do things: with educated or elite clients. However, with low-income families, it is a blank sheet. They are not even aware of the concept of anxiety." (Extract Participant no: 5)

Financial Limitations and Therapy Discontinuation

Often, financial strain did not allow clients to come out on regular sessions or follow up the treatment plans. Ethical dilemma was elaborated by therapists where clients ended the therapy too soon or clinicians were pressured to change the fees to avoid dropouts. One participant expressed,

"In some cases, I would be aware that the child requires long term therapy but the parents are unable to cover it. They disappear in two sessions and morally, it tears your heart." (Extract Participant no: 6)

Misrepresentation of Financial Need

Other participants have claimed that the families have lied about their health conditions, which has resulted in therapists finding themselves in morally dubious positions. As one clinician shared,

"Individuals lie and tell lies about how they are financially doing so as to have a discount. You do not want to deprive them of something yet you do not want to be controlled." (Extract Participant no: 3)

Need for Affordable Services and Government Support

All respondents highlighted the lack of publicly available mental-health services that are cheap. One therapist stated,

"Half of these children would receive the assistance on time; in case the government established the low-cost centers. But at this point the poor will only arrive after the problem is aggravated." (Extract Participant no: 1)

THEME 3: Religious–Spiritual Beliefs Shaping Treatment Pathways

Religious and spiritual beliefs played a significant role in shaping how clients interpreted symptoms, decided when to seek help, and engaged in therapy. Psychologists described navigating parallel belief systems, often adjusting their practice to engage clients respectfully and effectively.

Reliance on Pirs and Amils before Therapy

Most clients used to approach spiritual healers first before consulting a psychologist. Such delay usually worsened symptoms. As one of the participants said,

"People only come to us after trying every Pir and Amil in the city. By the time they reach me, the issue has doubled." (Extract Participant no: 9)

Concurrent Spiritual and Clinical Treatment

Practitioners reported that clients usually maintained spiritual practices as they were receiving treatment inducing contradictory treatment messages. One psychologist shared,

"During therapy, some of the clients continue wearing amulets or performing rituals. It

ISSN Online: 3007-3154
ISSN Print: 3007-3146

confuses them as their messages contradict and it is tricky on the side of ethics." (Extract Participant no: 14)

Harm and Exploitation by Spiritual Healers

Psychologists narrated incidents where spiritual practitioners exploited or harmed clients, particularly women. A participant recalled,

"One woman told me she was touched inappropriately by an Amil. She was so traumatized she couldn't speak for ten minutes."

Therapeutic Modification to Align with Religious Beliefs

To maintain rapport and reduce resistance, therapists often integrated clients' religious frameworks into therapy. As one clinician explained,

"If I challenge their beliefs directly, they shut down. So I use their religious language to help them understand their cognition." (Extract Participant no: 10)

THEME 4: Gendered Constraints on Autonomy and Therapy-Seeking

Gender norms strongly influenced how clients accessed psychological services. Women's autonomy was often limited, while men faced fewer social and familial restrictions.

Limited Privacy and Autonomy for Women

Those who participated talked about the tendency when women had to consult their male relatives when they needed to be in therapy and when they seldom had a chance to seek assistance alone. One therapist shared,

"A woman cannot simply enter into therapy. She must inform her husband, her father or her brother. And should they say no, then that is all." (Extract Participant no: 8)

Men's Independence in Help-Seeking

In contrast, men often sought therapy without informing family members. One participant said,

"Men can simply come alone. They don't face the same questions or control women do."

Patriarchal Control Over Women's Mental Health Decisions

Other psychologists referred to patriarchal systems where husbands or fathers would decide whether or not to undergo any therapy. A clinician recounted,

"I have also been told by husbands as to what I should work on in therapy with their wives. They also have a sense that they have the right to dictate on how to treat her." (Extract Participant no: 13)

THEME 5: Structural Failures, Professional Strain, and Ethical Burden on Psychologists

Participants described widespread systemic and institutional weaknesses that constrained ethical practice. These challenges included inadequate regulation, lack of training, limited resources, excessive caseloads, and minimal professional recognition.

Lack of Regulation and Professional Standards

Psychologists pointed out that there was no regulatory body that would control malpractice. One participant remarked,

"Any person is authorized to establish a center and identify himself with the title

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)
psychologist. Checks, no, licenses, no, nothing." (Extract Participant no: 11)

Resource Constraints and Poor Therapeutic Infrastructure
Clinicians described working without standard tools, using improvised assessments, and conducting therapy in noisy or crowded spaces. A therapist stated,
"Sometimes my office is next to a ward. You can hear everything. How are clients supposed to feel safe?" (Extract Participant no: 1)

Weak Inter-Professional Collaboration
According to the subjects, there was insignificant interaction between the psychiatrists and psychologists, which weakened the process of coordinated care. One psychologist recalled,
"Doctors are not aware of our role. They either disrupt us or are not even willing to work with us." (Extract Participant no: 12)

High Caseloads and Burnout
Clinicians in the public sector reported experiencing excessive workloads resulting into burnout and lower ethical practice. A participant admitted,
"Once a day you see 30 clients you get irritable. You are human too. It is awful morally, though." (Extract Participant no: 6)

Ethical Distress, Moral Conflict, and Emotional Labor
Therapists navigated value clashes, emotional strain, and moral dilemmas. One psychologist shared,
"Some cases go against my own values. It's emotionally heavy, so sometimes I refer them because I don't want to harm them." (Extract Participant no: 4)

Gaps in Training and Professional Development
Structured training, supervision, and certification were highlighted by the participants. As one therapist explained,
"We are thrown in the field and are not supervised. You work out by trial and error, and that is not ethical." (Extract Participant no: 9)

THEME 6: Ethical Complexities in Child and Neurodevelopmental Cases
There was also an ethical dilemma of dealing with children and particularly neurodevelopmental disorder children. Issues of unfinished information, family interference, denial and misguided practices by untrained clinicians were described by therapists.

Extended Family Overshadowing Parental Roles
Relatives often brought children to sessions instead of mothers, resulting in incomplete histories. One clinician shared,
"Grandmothers come with the child, but they don't know the behavioral history. The mother is missing, and we can't get the full picture." (Extract Participant no: 14)

Concealment and Denial of Child's Condition
Parents frequently hid diagnoses due to stigma or refused to accept their child's condition. A psychologist recalled,
"Some parents say nothing is wrong and only come because someone forced them. They

Dialogue Social Science Review (DSSR)
www.thedssr.com

ISSN Online: 3007-3154
ISSN Print: 3007-3146

DIALOGUE SOCIAL SCIENCE REVIEW

Vol. 3 No. 12 (December) (2025)
don't want the label." (Extract Participant no: 4)

Untrained Practitioners Mishandling Cases

Respondents raised an issue that the field of treating children, more so those with developmental disorders, involves the unqualified people. One therapist said,

"I have witnessed how so-called psychologists treat the autistic children like school children. It's painful to watch." (Extract Participant no: 5)

Families and Organizations Dictating Therapy

The therapists reported loss of autonomy by having families of institutions telling them how to treat children. A participant noted,

"In other cases, the school dictates how to deal with the child. Sometimes the parents do. It seems like they are the therapist." (Extract Participant no: 2)

Marital Conflict Affecting Child Treatment

Changes in family dynamics, particularly those that entailed defiant husbands, made matters more difficult when it came to making decisions on treatment. One clinician reflected,

"In most marriages, a husband will never agree to contribute or take part. It makes it all slow and impedes the development of the child." (Extract Participant no: 3)

Discussion

Pakistan has limited mental health care practices which are limited by structural, cultural and socioeconomic influences which to a large extent inhibit access to mental treatment. The lack of awareness and stigmatization slows down the process of seeking help, compelling individuals to turn to spiritual healers instead of professionals. As less than one percent of the budgetary expenditure in the health sector is allocated to mental health and with the majority of expenses being paid out-of-pocket, services are unaffordable to a large number of people. The lack of psychiatrists, specialists, and specialized facilities adds to the weaknesses of the service delivery as unregulated private practice and unequal training are the factors that enable the breach of confidentiality, misdiagnosis, and other ethical issues (Siddiqui, 2021). The WHOAIMS report solidifies this fact by stating that funding has always been chronically underfunded, and there is a lack of human resources and standardized guidelines of practice. In spite of increasing demand, especially among young people, there are very few children mental-health services and geographic variations are so wide that access is restricted to rural communities. A centralized licensing system of psychologists is lacking and thus leads to extensive disparities in the training and ethical practice that influences the quality of clinical decision making in the entire nation (WHO & Ministry of Health, Pakistan, 2009).

Pathways of treatment seeking also depend on cultural and religious beliefs. Most people initially attend faith healers who believe that mental illness is something caused by the supernatural that deals with jinn or black magic causing them to create very much delays in seeking medical attention which also leads to clients being exposed to bad practices. Families, in turn, being the main decision-makers, tend to support such non-clinical pathways and continue parallel spiritual treatment even after having clinical contact, which makes it difficult to intervene (Khan et al., 2023). Nevertheless, in the conservative areas, like Peshawar, the stigma is related to gender ideas and religious perceptions that dishearten disclosure and demand seeking help. The sickness of the mind is usually hidden to keep the family name intact and symptoms are explained in

ISSN Online: 3007-3154
ISSN Print: 3007-3146

terms of morality or spirituality. Women also have fewer amenities in mobility and control over their health-related choices, and it is even harder to seek care in time (Khan et al., 2023).

The central means of explaining psychological distress in Pakistan is the religious and supernatural explanations. The mental illness is seen as either punitive, witchcraft, or possession by many people hence delayed treatment and over reliance on faith-based medicine. These paths are useful spiritually to some but tend to lead to an incorrect interpretation of symptoms and improper or hazardous intervention (Ahmad and Koncsol, 2022).

These are even complicated by the governance issues. Watchdogs of mental-health issues are mostly ineffective, and the lack of control body enables those who are not qualified to practice in that sphere to be free. There are terrible shortages of workforce approximately 500 psychiatrists and 100 clinical psychologists per more than 200 million people, which means that almost 90 percent of the population will be deprived of official treatment. The poor quality of services and access is also curtailed by old-fashioned policies, inadequate funding, and lack of citizen literacy (Dayani et al., 2024). The mental-health trajectories are all determined by stigma and gender norms alongside cultural expectations. There are also women who hide the symptoms because they are afraid of the reputation and being pressurized by their families, and because cultures promote modesty and honor and discourage emotional expression and seeking help. Religions support keeping quiet and postponing professional interaction, which leads to enduring mental-health inequalities (Khan et al., 2023).

The patterns are similar in the research regarding trauma and stigma. People often do not seek help because of the fear of being declared to be pagal, and parents tend to conceal mental disorder because of the stigma surrounding the social status. Lack of such awareness leads to individuals being driven towards informal networks and spiritual solutions, putting on hold proper care. These trends show that cultural norms, family-related relationships, and socioeconomic restrictions cannot be separated when it comes to mental-health issues in Pakistan (Neoh et al., 2022). Additional research into psychosis establishes that the access to treatment is influenced by stigma, misinformation, family decision making and the financial barriers that all contribute to the development of psychosis treatment. Cultural appreciations- spiritual possession to moral weakness- lead individuals into non-clinical routes and lack of service and excessive caseload hinder continuity of care. Such results represent the convergence of cultural (especially feminine) and familial, as well as structural, influences in the context of mental-health outcomes in Pakistan (Sajid and Hassan, 2022).

Limitations and Future Directions

The focus of this research involves several limitations that must be taken into account when making use of the findings produced. Like this research was only conducted within two districts in Punjab, therefore, the experiences presented in this research do not encompass the full extent of ethical dilemmas experienced by Psychologists working in other areas of Pakistan. It is not possible to generalize the conclusions drawn from this research to other populations due to the qualitative nature of the research collected. Additionally, the research results only included responses from clinical psychologists, therefore, the responses from Psychiatrists, Counselors, Social Workers and other professionals who manage Ethical Dilemmas in Mental Health Services were not included in this research study, providing direction for future investigations.

A mixed-method design that will use larger sample sizes and include a broad spectrum of

ISSN Online: 3007-3154
ISSN Print: 3007-3146

Vol. 3 No. 12 (December) (2025)

professional experiences will assist in providing a more complete understanding of the ethical dimension in this area. Finally, future studies will provide information regarding the impact from training, supervision, and institutional policies on ethical judgments in both the public and private sectors. A further area of future research that also requires attention is developing and testing culturally appropriate ethical guidelines for psychologists who are working in the unique sociocultural environment in Pakistan.

Conclusion

The research shows that factors like culture, family control, religious beliefs, and financial situation affect the ethics of clinical psychologists in Pakistan when making ethical decisions. Psychologists are often unable to remain autonomous, maintain confidential relationships with their clients, or have clear boundaries with their clients; this is due to a cultural expectation that families will share in the therapeutic process with the client. The stigma and shame that accompany mental health issues cause clients to delay treatment and/or to hide their true issues. Many clients also seek help from spiritual healers, which can further delay treatment and contribute to client's confusion. Additionally, female clients often experience more restrictions than male clients when seeking treatment. Furthermore, the difficult working conditions faced by psychologists today—namely weak regulation, oversight, insufficient resources, and high caseloads—place an additional organizational burden on psychologists. Therefore, it is impossible to ensure the ethical practice of psychologists solely by using written codes; the cultural and socioeconomic context of Pakistan must also be taken into account when providing training, educating, and providing mental health systems to psychologists in order to help them make the most ethical decisions possible.

References

Ahmad, S. S., & Koncsol, S. W. (2022). Cultural factors influencing mental health stigma: Perceptions of mental illness (POMI) in Pakistani emerging adults. Religions, 13(5), 401. https://doi.org/10.3390/rel13050401

Alvi, M., Ashraf, T., Kiran, T., Iqbal, N., Gumber, A., Patel, A., & Husain, N. (2023). Economic burden of mental illness in Pakistan: an estimation for the year 2020 from existing evidence [Review of Economic burden of mental illness in Pakistan: an estimation for the year 2020 from existing evidence]. BJPsych International, 20(3), 54. Cambridge University Press. https://doi.org/10.1192/bji.2023.4

Amin, R., & Akram, B. (2024). Importance of Ethical Code of Conduct for Psychological Practice in Pakistan. Journal of Professional & Applied Psychology, 5(1), 1. https://doi.org/10.52053/jpap.v5i1.275

Arumi, M. S., Sulastiana, M., Kadiyono, A. L., & Ninin, R. H. (2024). Assessing Ethical Climate: Adaptation and Psychometric Properties in the Indonesian Context. Psychology Research and Behavior Management, 2297. https://doi.org/10.2147/prbm.s462945

Azad, A. H., Khan, S. A., Ali, I., Shafi, H., Khan, N. A., & Umar, S. A. (2022). Experience of psychologists in the delivery of cognitive behaviour therapy in a non-western culture for treatment of substance abuse: a qualitative study. International Journal of Mental Health Systems, 16(1). https://doi.org/10.1186/s13033-022-00566-3

Bhasin, S. K., Bharadwaj, I. U., Beniwal, R. P., Gupta, V., Bhatia, T., & Deshpande, S. N. (2021). Ethical dilemmas encountered in suicide research and management:

ISSN Online: 3007-3154
ISSN Print: 3007-3146

Vol. 3 No. 12 (December) (2025)

Experiences of young mental health professionals. Indian Journal of Medical Ethics, 1. https://doi.org/10.20529/ijme.2021.096

Cucchi, A. (2022). Integrating Cognitive Behavioural and Islamic Principles in Psychology and Psychotherapy: A Narrative Review [Review of Integrating Cognitive Behavioural and Islamic Principles in Psychology and Psychotherapy: A Narrative Review]. Journal of Religion and Health, 61(6), 4849. Springer Science+Business Media. https://doi.org/10.1007/s10943-022-01576-8

Daraz, U., Hussain, S., Abbas, F., Khatri, S. A., & Ali, A. (2025). Cultural narratives, social norms, and psychological stigma: Implications for mental health help-seeking in Pakistan. Frontiers in Psychiatry, 16, 1560460. https://doi.org/10.3389/fpsyt.2025.1560460

Dayani, K., Zia, M., Qureshi, O., Baig, M., & Sabri, T. (2024). Evaluating Pakistan's mental healthcare system using World Health Organization's assessment instrument for mental health system (WHO-AIMS). International Journal of Mental Health Systems, 18, Article 32. https://doi.org/10.1186/s13033-024-00646-6

Ethical Considerations in Conducting Clinical Research among Patients with Mental Health Problems in Arab Countries. (2023). Jordan Journal of Nursing Research, 2(4), 1. https://doi.org/10.14525/jjnr.v2i4.01

Fatima, M., & Ilyas, U. (2024). Development of Ethical Dilemma Distress Scale for Mental Health Practitioners (EDDS-MHP). Pakistan Journal of Psychological Research, 39(3), 613. https://doi.org/10.33824/pjpr.2024.39.3.34

Fazal, A. (2021). Ethical Issues in Conducting Cross-Cultural Research in Low-Income Countries: A Pakistani Perspective. Asian Bioethics Review, 14(2), 151. https://doi.org/10.1007/s41649-021-00196-w

Ghafran, C., & Yasmin, S. (2024). Participation Strategies and Ethical Considerations in NGO Led Community-Based Conservation Initiatives. Journal of Business Ethics. https://doi.org/10.1007/s10551-024-05665-4

Global Sociological Review. (2020). Global Sociological Review. https://doi.org/10.31703/gsr

Grace, B., Wainwright, T., Solomons, W., Camden, J., & Ellis-Caird, H. (2020). How do clinical psychologists make ethical decisions? A systematic review of empirical research [Review of How do clinical psychologists make ethical decisions? A systematic review of empirical research]. Clinical Ethics, 15(4), 213. SAGE Publishing. https://doi.org/10.1177/1477750920927165

Humayun, A., Muneeb, N. ul A., Najmussaqib, A., Haq, I. U., & Asif, M. (2025). Bridging the gaps: Contextualizing the mhGAP Humanitarian Intervention Guide to implement in Pakistan. bioRxiv (Cold Spring Harbor Laboratory). https://doi.org/10.1101/2025.05.21.25327990

Juntunen, C. L., Crepeau-Hobson, F., Riva, M. T., Baker, J., Wan, S., Davis, C., & Caballero, A. M. (2023). Centering equity, diversity, and inclusion in ethical decision-making. Professional Psychology Research and Practice, 54(1), 17. https://doi.org/10.1037/pro0000488

Khan, Z., Qureshi, O., Pasha, A., Majid, O., Saleem, S., Fearon, P., & Shaikh, M. (2023). Exploring biomedical and traditional care pathways for people with psychosis in Karachi, Pakistan. Frontiers in Psychiatry, 14, Article 1086910. https://doi.org/10.3389/fpsyt.2023.1086910

Lárez, N. A., & Sharkey, J. D. (2021). Decision-Making Model for Addressing Role Conflict for Psychology Trainees When Supporting Family and Community

ISSN Online: 3007-3154
ISSN Print: 3007-3146

Vol. 3 No. 12 (December) (2025)

[Review of Decision-Making Model for Addressing Role Conflict for Psychology Trainees When Supporting Family and Community]. Frontiers in Psychology, 12. Frontiers Media. https://doi.org/10.3389/fpsyg.2021.745368

Main Thompson, A., & Saleem, S. M. (2025). Closing the mental health gap: Transforming Pakistan's mental health landscape. Frontiers in Health Services, 4, 1471528. https://doi.org/10.3389/frhs.2024.1471528

Mashhood, A. (2025). Contemporary mental health issues in Pakistan: Focus on forensic psychiatry. Journal of Pakistan Psychiatric Society, 22(1), 7–9. https://doi.org/10.63050/jpps.22.1.943

Maqsood, A., Gul, S., Zahra, T., Noureen, N., & Khattak, A. (2024). From face-to-face to screen-to-screen: exploring the multifaceted dimensions of digital mental health care. Frontiers in Psychiatry, 15. https://doi.org/10.3389/fpsyt.2024.1413127

Memon, R., Asif, M., Khoso, A. B., Tofique, S., Kiran, T., Chaudhry, N., Husain, N., & Edwards, S. (2021). Recognising values and engaging communities across cultures: towards developing a cultural protocol for researchers. BMC Medical Ethics, 22(1). https://doi.org/10.1186/s12910-021-00608-4

Memon, R., Asif, M., Shah, B. A., Kiran, T., Khoso, A. B., Tofique, S., Miah, J., Ahmad, A., Chaudhry, I. B., Chaudhry, N., Husain, N., & Edwards, S. (2024). Ethics of Informed Consent in Medical settings: A qualitative study of clinicians managing patients presenting with self-harm in Pakistan. Research Square (Research Square). https://doi.org/10.21203/rs.3.rs-3876214/v1

Musa, M. (2024). Mental Health in the Middle East: Historical Perspectives, Current Challenges, and Future Implications. Saudi Journal of Humanities and Social Sciences, 9(5), 138. https://doi.org/10.36348/sjhss.2024.v09i05.001

Nafees, S., & Anjum, G. (2020). Phenomenology of Counseling Psychologists. Clinical and Counselling Psychology Review, 2(1). https://doi.org/10.32350/ccpr.21.04

Naz, S., Aslam, M., Amin, H., Khan, S., & Sayed, A. (2024). Mental healthcare access in Pakistan: A contemporary study. Journal of Population Therapeutics and Clinical Pharmacology, 31(8), 2005–2012. https://doi.org/10.53555/a95vbb41

Neoh, M. J. Y., Airoldi, L., Arshad, Z., Bin Eid, W., Esposito, G., & Dimitriou, D. (2022). Mental health of mothers of children with neurodevelopmental and genetic disorders in Pakistan. Behavioral Sciences, 12(6), 161. https://doi.org/10.3390/bs12060161

Oppong, S. (2023). When the ethical is unethical and the unethical is ethical: Cultural Relativism in Ethical Decision-Making. Polish Psychological Bulletin. https://doi.org/10.24425/ppb.2019.126014

Polley, D. A. (2019). Navigating ethical dilemmas in mental health practice: Integrating Islamic ethics and professional codes. Journal of Social Work Values and Ethics, 16(1), 40–55.

Qayyum, H., Laghari, M., Batool, R., Akhtar, M., & Munir, S. (2025). Cultural Blueprints of Emotion: How Societal Norms Shape Expression, Regulation, and Well-Being. Journal of Social Sciences Review, 5(1), 241. https://doi.org/10.62843/jssr.v5i1.486

Rentería, R., Schaefer, A., & Rosario, C. C. (2020). Ethical Guidelines for Working with Culturally Diverse Clients. In Springer eBooks (p. 25). Springer Nature. https://doi.org/10.1007/978-3-030-32229-8_3

Roberts, M. (2021). Embodied Ethical Decision-Making: A Clinical Case Study of Respect for Culturally Based Meaning Making in Mental Healthcare. American

ISSN Online: 3007-3154
ISSN Print: 3007-3146

Vol. 3 No. 12 (December) (2025)

Journal of Dance Therapy, 43(1), 36. https://doi.org/10.1007/s10465-020-09338-3

Sahar, N., Hussain, S., & Anwaar, M. (2021). Ethical concerns in clinical psychology: A brief account of challenges in Pakistan.

Sajid, U., Sajid, N. A., & Ghazi, W. (2022). Ethics issues and training needs of mental health workers in rural areas. Pakistan Journal of Ethics, 2(2), 54–58. https://doi.org/10.5281/zenodo.7514661

Sattar, K., & Jawaid, S. A. (2024). From Challenges to Solutions: Mapping the Landscape of Medical Professionalism and Ethics in Pakistan. Pakistan Journal of Medical Sciences, 40(4). https://doi.org/10.12669/pjms.40.4.9346

Siddiqui, F., & Khan, Q. U. A. (2021). Barriers and challenges to mental health care in Pakistan. Pakistan Journal of Neurological Sciences, 16(3), 1–5. https://ecommons.aku.edu/pjns/vol16/iss3/1

Tanhan, A., & Young, J. S. (2022). Muslims and mental health services: A concept map and a theoretical framework. Journal of Religion and Health, 61, 23–63. https://doi.org/10.1007/s10943-021-01324-4

Thakkar, A., Gupta, A., & Sousa, A. D. (2024). Artificial intelligence in positive mental health: a narrative review [Review of Artificial intelligence in positive mental health: a narrative review]. Frontiers in Digital Health, 6. Frontiers Media. https://doi.org/10.3389/fdgth.2024.1280235

Tharani, A., Tharani, Z., Lalani, S., Momin, R. B., & Bhamani, S. S. (2024). The Intersection of Gender and Mental Well-Being among Adolescents in Pakistan: Challenges, Strategies, and Future Recommendations. In IntechOpen eBooks. IntechOpen. https://doi.org/10.5772/intechopen.1003953

Wei, X., & Zheng, Y. (2025). Ethical dilemmas in the development of college psychological counseling under the background of cultural integration [Review of Ethical dilemmas in the development of college psychological counseling under the background of cultural integration]. Frontiers in Psychology, 16. Frontiers Media. https://doi.org/10.3389/fpsyg.2025.1636563

World Health Organization, & Ministry of Health, Pakistan. (2009). WHO-AIMS report on mental health system in Pakistan. WHO. https://cdn.who.int/media/docs/default-source/mental-health/who-aims-country-reports/pakistan_who_aims_report.pdf?sfvrsn=1d95d2dd_3