

Cross-Cultural Complexities in Psychological Diagnosis and Treatment: A Qualitative Exploration among Psychologists

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Received: 26-10-2025

Revised: 10-11-2025

Accepted: 25-11-2025

Published: 09-12-2025

ABSTRACT

The psychological diagnosis and treatment process is influenced by social norms, belief systems, and the contextual meanings of distress and is not treated as a culturally neutral process. The purpose of this qualitative study was to gain an understanding of the ways psychologists working within Pakistan have perceived and dealt with the cross-cultural complexities associated with psychological diagnosis and treatment. The research utilized an interpretative qualitative methodology, where semi-structured interviews were carried out with (n=12) psychologists currently practicing in different types of clinical settings including hospitals, private practice clinics, universities, NGOs, and rehabilitation centers. The collected data were analyzed based on thematic analysis to identify common themes. The results of the study indicate there are three main themes: cultural difference in diagnostic criteria, socio-cultural factors in the therapeutic relationship, adaptive and negotiated ways in which clinical psychologists practice. Psychologists reported that there were many difficulties within the ability to diagnose clients because of the conflict between Western diagnostic criteria and the clients' somatic, spiritual, and culturally based signs of distress. Family control over decisions for treatment, use of faith as a means of coping and the stigma surrounding mental illness, honor-related issues etc, all had a significant effect on the disclosure, diagnosis, and treatment engagement process of their clients. Psychologists used adaptive strategies such as disclosing diagnoses to their clients over time, using clients' cultural and religious values, and using an ongoing ethical negotiation process between cultural sensitivity and professional responsibility to help resolve these issues.

Keywords: Cross-cultural psychology, psychological diagnosis, cultural competence, mental health

INTRODUCTION

Mental health diagnoses and treatments are not universally applicable but instead are influenced by social expectations, belief systems, and the meaning given to mental health issues within each culture (Gopalkrishnan, 2018). Much of what is viewed as "best practices" for psychology today comes from diagnostic systems and practice methods based on Western cultures; these systems tend to emphasize the individual, openly express feelings, and use medicine as the main way to explain mental disorders (Huang & Zane, 2020). However, there is growing evidence showing that applying these ways of

thinking about mental health issues in different cultural settings can create confusion over diagnosis, misinterpretation of the symptoms, and decreased effectiveness of treatment (Patel & Hall, 2021).

Diagnostic systems in the West, such as the DSM-5 and ICD-11, have significant Western bias according to Pakistani culture since they were created in individualistic societies (mainly the USA) using a symptom checklist approach and categorical diagnoses, without consideration of cultural context for diagnosis (Stein et al., 2013). The evidence provided by Tahir et al. (2022) suggests that distinct cultural norms play a significant role in how psychological distress is expressed. By way of examples: somatic symptoms, relational problems, and spiritual explanations. Consequently, in collectivist cultures and contexts, emotional pain is often experienced in ways that don't conform to standardized diagnoses (Vandecasteele et al., 2024). As such, psychologists working in those contexts must create a bridge between their professional diagnostic tools and the realities of their clients' cultures. This is particularly true for developing nations, where mental health systems have fewer resources and need to respond to many different socio-cultural beliefs and expectations (American Psychological Association, 2017).

Psychological diagnosis and treatment in Pakistan occur in a very complex sociocultural environment with strong focus on family interdependency, religious or spiritual worldviews, sex-roles, and stigma associated with mental illness (Ahmad & Koncsol, 2022). While research shows that most mental health issues are defined and understood in moral, spiritual and physical terms (Ahmad & Khawar, 2025), this causes most people and their families to visit religious healers and doctor rather than psychologists (Malik et al., 2025). Because of this, psychologists generally deal with clients who have a very different explanation for their distress than the clinical explanations, making it extremely difficult for psychologists to conduct assessments, engage with clients and develop treatment plans.

In Pakistan, family involvement is critical in mental health and heavily influences decisions about how to diagnose and initiate treatment as well as whether to continue treating a person with mental health issues (Dayani et al., 2024). Family support can improve treatment adherence; however, it may also limit a person's autonomy and/or restrict that person from being able to disclose the full scope of their mental health problems to their clinician and/or perpetuate stigma toward individuals with mental health problems, particularly for women and younger adults (Iman, 2025). Furthermore, a person's gender and the cultural elements of honor and social reputation can influence how they seek help for themselves and how they interact with their therapist, making the psychologist's role an ethically and culturally sensitive position in working with individuals suffering from psychological distress (Tahir, 2025).

Many researchers recognize how important it is to be aware of other cultures when providing therapeutic or counseling services; however, there are only a few studies that explore what it is like for the psychologist when helping someone from another culture (Dayani et al., 2024). Most research has concentrated mostly on altering traditional therapeutic techniques, measuring how effective those techniques were for different cultures rather than gathering information about what it was like for the psychologist as they worked through cultural conflicts while diagnosing their patients and providing therapeutic or counseling services to them (Hwang, 2011). The empirical literature available regarding the experiences of Pakistani psychologists with respect to cross-cultural issues is minimal. Therefore, this leaves an opportunity for researchers to investigate how psychologists working in Pakistan address these conflicting professional and ethical cultural issues throughout their daily practices (Andrade, 2017).

The contextual, relational, and meaning-based characteristics of the challenges are such that qualitative research is an appropriate methodological approach. The qualitative methodology allows for a deeper exploration of psychologists' perceptions of how cultural beliefs, social structures, and professional frameworks interact with one another within a clinical context. The intent of this study is to develop contextually based insights into the lived experiences of psychologists to enhance the culturally sensitive approach to diagnostic practices, treatment strategies, and mental health training programs in the Pakistani context.

Purpose of Study

The aim of this qualitative research was to understand how psychologists working in Pakistan experience and manage the complexity of navigating cultural differences when diagnosing and treating patients. It specifically looks to identify the many elements (religion/family/social) which affect the way psychologists make clinical decisions regarding treatment, as well as how they practice therapy. The study explored the lived professional experiences of psychologists to better understand how psychologists interpret and apply standardized psychological models in a mental health environment that is both culturally diverse and restricted by contextual factors. This study also explored what strategies psychologists use to resolve the cultural clash between their patients' culturally defined explanations of mental distress (i.e., their "explanation framework") and the formal diagnoses and treatment protocols they use for their patients. This qualitative inquiry sought to shed light on the ethical, practical, and professional challenges that arise in culturally complex clinical situations and to illustrate how psychologists maintain clinical effectiveness while providing culturally sensitive care.

Research Questions

1. How does psychologist practicing in Pakistan experience and interpret cultural complexities in psychological diagnosis and treatment?
2. What cultural, religious and familial factors do psychologists perceive as most influential in shaping diagnostic decisions and therapeutic process?
3. How do psychologists adapt or negotiate diagnostic treatment practices to address cultural challenges while maintaining clinical effectiveness?

RESEARCH METHODOLOGY

In conducting this research, a qualitative methodology was chosen to examine the experiences of psychologists regarding the challenges associated with cross-cultural differences in their diagnostic and treatment practices within Pakistan as a cultural community. Additionally, the interpretivist paradigm, which supports the view that clinical realities are socially and culturally constructed, was employed to inform the research and guide the interpretation of findings based on the lived experiences of participants.

Psychologists who had directly worked as psychologists, diagnosing and treating people from culturally varied backgrounds within Lahore (Pakistan) were chosen using a purposive sampling technique. A total of (n=12) psychologists were included in this research study. Psychologists had qualifications in

Psychology Science (i.e., master of science in psychology degree or equivalent) and had worked as a practicing psychologist with patients of several different cultures, religions, and/or societies. Psychologists in this sample were recruited from within clinical counselling and mental health settings. To be eligible to participate, psychologists needed to be (a) professionally trained psychologists; (b) have completed assessments and therapeutic interventions; and (c) have practiced in Pakistan's socio-cultural context.

For data collection, participants were interviewed using semi-structured methods, enabling them to describe their individualized experiences while allowing for all areas of critical importance regarding the research questions to be covered. An interview guide based on the literature based on cross-cultural psychology and clinical practice, the interview guide was developed to meet the research objectives of the study. Through the interviews conducted, psychologists were able to provide insight into their experience of culture's effect on their diagnosis and treatment of psychological symptoms, as well as the challenges associated with diagnosing and treating patients from a culturally diverse background; how family and/or religious beliefs have influenced the psychologist's ability to diagnose and treat; and strategies used to accommodate culturally complex cases when diagnosed. All interviews were recorded with the participant's understanding and consent, using the participant's preferred language. Each interview lasted about 45 - 60 minutes, with enough time to reflect and discuss in depth.

Thematic analysis was applied to the collected data using an iterative, systematic approach (figure 1). Interviews were transcribed verbatim prior to data analysis: first stage of the analysis was data familiarization performed through a series of multiple readings of the transcripts until the themes were understood. The next stage involved initial coding to identify units of meaning related to different 'cross-cultural challenges', 'diagnostics', 'treatment adaptation' and the professional experiences that were recorded during the interview process. After coding all transcripts, the researcher compared the codes identified from all transcripts and grouped them into broader categories. The categories were then compared, and a determination was made about which themes would be designated as the major themes based on the ongoing comparisons of categories. The researcher was also continually aware of their own reflexivity throughout the analysis process, to reduce any potential bias and maintain the rigor of the interpretation.

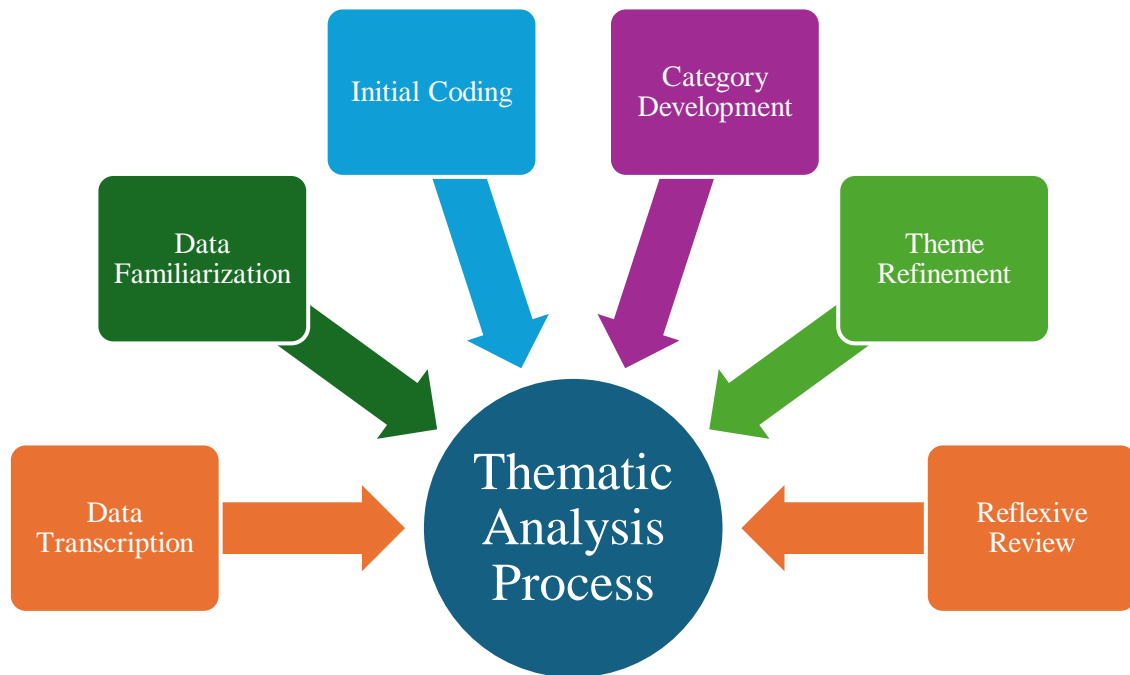


Figure 1 Data Analysis

Trustworthiness and Rigor

To uphold high quality and rigor of this research, the researcher has used a standard set of criteria for qualitative trustworthiness. The researcher utilized the verbatim accounts of the study's participants to enhance credibility by closely reviewing the data, as well as using their verbatim accounts. The dependability of the study has been established by creating a clear audit trail of the coding decisions and development of themes. The confirmability of this research is established by writing reflexive memos to establish the researcher's assumptions and analytical decisions. The transferability of these research conclusions is enhanced by the researcher providing rich and contextual descriptions of both the participants and the research site.

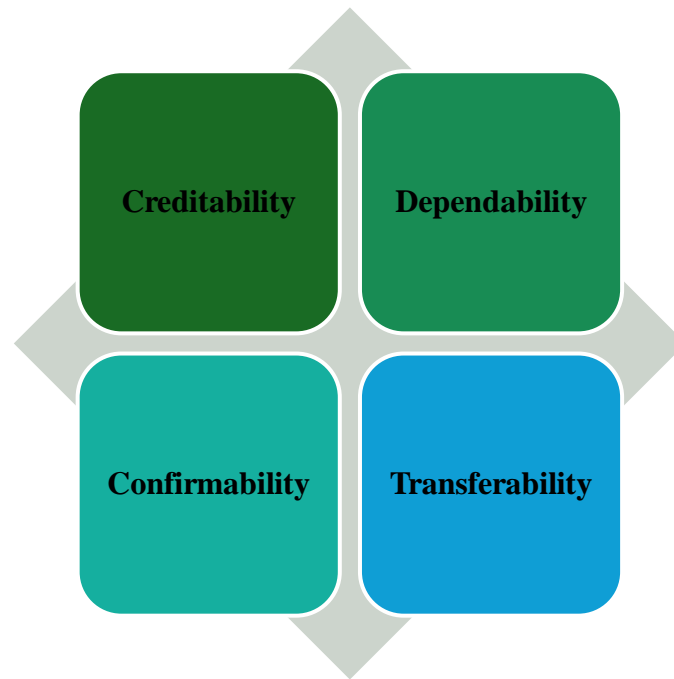


Figure 2 Strategies to ensure Trustworthiness of qualitative study

Data collection for this research project was only initiated after receiving ethical approval from the Institutional Ethical Review Board. Participants received detailed information about this investigation (including methods used for protection of privacy), and all gave informed written consent to participate. In addition, participation was completely voluntary, and any participant had the option to withdraw themselves from this research at any time without fear of negative consequences. The confidentiality and anonymity of all participants were upheld by assigning each participant a pseudonym, as well as removing any identifying information from the transcripts and reports. Data from this research project will be stored in a secure environment and will only be used for the purpose of conducting research.

RESULTS

Table 1 Demographic Information of Participants (N=12)

Participant Code	Gender	Age Range (Years)	Highest Qualification	Years of Clinical Experience	Practice Setting
P1	Female	25-30	MS Clinical Psychology	2-4	Private Clinic
P2	Male	31-35	MS Clinical Psychology	5-7	Hospital

P3	Female	36-40	PhD Psychology	10-12	University Clinic
P4	Female	31-35	MS Clinical Psychology	5-7	NGO
P5	Male	41-45	PhD Psychology	15-18	Hospital
P6	Female	25-30	MS Psychology	1-3	Private Clinic
P7	Male	36-40	MS Clinical Psychology	8-10	Rehabilitation Center
P8	Female	31-35	MS Clinical Psychology	6-8	Private Clinic
P9	Male	41-45	PhD Psychology	18-20	Hospital
P10	Female	26-30	MS Psychology	2-4	NGO
P11	Male	36-40	MS Clinical Psychology	9-11	University Clinic
P12	Female	31-35	MS Clinical Psychology	6-8	Private Clinic

The sample consisted of 12 practicing psychologists from a variety of professional and demographic backgrounds, including males and females (table 1). All the subjects had either a master's or a doctorate in psychology (including Clinical Psychology, MS Psychology, and Ph.D. in Psychology) demonstrating different types of advanced training. The clients that psychologists worked with had a diverse range of clinical experience from one year to twenty years of working as professionals, thus providing an ability to provide insight into the differences between newer and more experienced psychologists working in Pakistan. Additionally, subjects were sampled from many different types of settings including private practice, hospitals, university settings, not for profits, and rehabilitation centers. This level of diversity in practice settings provided a more comprehensive view of the environment that psychologists provide services in and provided deeper thought into how psychologists deliver their services considering cultural differences across societies.

Table 2 Main Theme and Subtheme of Research Question 1

Theme	Subtheme
Cultural Mismatch in Diagnosis	<ul style="list-style-type: none"> • Western diagnostic frameworks vs. local expressions of distress • Spiritual and somatic interpretations • Fear of diagnosis and concealment

Main Theme 1: Cultural Mismatch in Diagnosis

Participants commonly expressed a perceived gap between the Western diagnostic criteria and culturally mediated displays of distress. Psychologists noted that clients often struggled to describe emotional or cognitive symptoms in a clinical sense.

Subtheme 1.1: Western Diagnostic framework vs. local expression of distress

The findings from psychologists indicated that many clients presented their distress in terms of their physical symptoms or other non-specifically defined issues rather than using the traditional psychological definitions used in the DSM. For example, one participant indicated, "Most clients don't talk about their issues in psychological terminology. They usually show up with some type of pain or fatigue, which is not an easily identifiable diagnosis within the DSM" (P3). Another psychologist added, "We have been trained in Western diagnostic models, but we are confronted with patients who describe their distress in terms that do not fit those Western models" (P7). Because of this discrepancy, many clinicians have had to expand their education to allow them to better understand the way patients present and interpret their symptoms within the framework of the cultural context that clients reside.

Subtheme 1.2: Spiritual and Somatic Interpretation

Many people involved in the study stated that clients would often attribute their psychological distress to either some spiritual or mystical experience. A psychologist shared an example of this type of thinking by saying that "Many clients think they are having psychological problems due to black magic or spiritual possession" (P1). Another participant made mention of this phenomenon when he pointed out that, "Often, a person will seek spiritual care prior to seeing us, and if that did not alleviate their issues, only then will they come to us" (P9). It was noted that these types of beliefs impact both supportive diagnostic clarity as well as the level of engagement from clients.

Subtheme 1.3: Stigma of Fear and Labeling

Stigma is also said to be a major reason for a person not being correctly diagnosed. According to many of the psychologists interviewed for this article, clients and their families frequently do not want to accept a diagnosis because they are afraid of being judged by society. For example, one of the participants stated, "Clients are scared of being diagnosed as mentally ill because of what society might think about them" (P4). Another participant, who also talked about this issue, said, "Even families that are highly educated are reluctant to accept a mental health diagnosis" (P11). Therefore, stigma is pervasive and crosses all social strata.

Table 3 Main Theme and Subtheme of Research Question 2

Theme	Subtheme
Socio-Cultural Influence	<ul style="list-style-type: none"> • Family-controlled decision-making • Faith-based coping and resistance • Restricted disclosure and honor concerns

Main Theme: Social Cultural Influence

Cultural, religious and family were viewed as strong influences on the clinical interaction with participant ratings of the degree to which cultural, religious and family influenced clinical interactions having a direct impact on assessment and treatment outcomes.

Subtheme 2.1: Family-controlled decision-making

According to the psychologists, family members often exercise influence over the treatment decisions and choices made by the individual receiving treatment. One participant shared that, “The client may not have the ability to speak for themselves in the process and thus the family member(s) speak for them and control the decisions related to treatment.” (P 2). Another participant noted, “There have been instances in which a client desires therapy, but the family does not support the continuation of those sessions.” (P6). In many instances, family involvement proved to be beneficial, while in other situations, it restricted the individual receiving treatment from having a voice in the decision-making process.

Subtheme 2.2: Faith-based coping and Resistance

Religious beliefs were cited as having a substantial impact on clients’ views towards therapy. “Many clients believe that they can ‘pray the problems away’” (P8) was one participant statement. A psychologist explained that “Engaging in therapy tends to be complicated if there is any tension between therapy and religious beliefs” (P12) due to the need for psychologists to delicately navigate therapeutic comments due to these beliefs.

Subtheme 2.3: Restricted Disclosure and honor concerns

The social constructs of gender have been described as barriers to the ability of people disclose information about their situation, especially among female clientele. As one psychologist stated, "The family is usually the source of the insecurities that affect female clients (P5)." Another stated that, "The issue of one's marital status and honor has a significant impact on treatment." (P10), indicating that social constructs play an important role in the establishment of boundaries within the therapeutic relationship.

Table 4 Main Theme and Subtheme of Research Question 3

Theme	Subtheme
Adaptive and Negotiated Clinical Practices	<ul style="list-style-type: none"><li data-bbox="807 298 1225 339">• Gradual disclosure of diagnosis<li data-bbox="807 359 1321 400">• Integrating cultural and religious values<li data-bbox="807 421 1321 461">• Balancing sensitivity and responsibility

Main theme: Adaptive and Negotiated Clinical Practices

By adjusting their clinical practices to accommodate the cultural complexities of their patients and to maintain the ethical and professional standards expected of health care providers, all participants stated that they were able to achieve more effective outcomes in terms of overall quality of care, patient safety, and patient satisfaction.

Subtheme 3.1 Gradual disclosure of diagnosis

Several psychologists mentioned they actively manipulated the method in which they communicated diagnoses. For instance, the response from one participant was: "In the first session, I do not provide a diagnostic label" (P1). From another psychologist, this was noted as "My initial focus is on symptoms and functioning and not the diagnosis of the disorder" (P9). Psychologists that took these actions stated that they felt it created less resistance and increased trust in the relationship that develops between the psychologist-patient.

Subtheme 3.2 Integrating Cultural and Religious Values

Therapists incorporate culture and religion into their work, so their clients have higher treatment engagement. "I incorporate the belief systems of my clients as opposed to rejecting them," stated one psychologist (P4). Another psychologist stated, "The use of culture-specific examples assists with building rapport and trust within the client's relationship" (P7). Therapists view this level of care as necessary for establishing and maintaining a strong therapeutic alliance.

Subtheme 3.3 Balancing Sensitivity and Responsibility

In psychological practice, there may be circumstances whereby ethical standards conflict with cultural beliefs. One participant (P3) captured this by indicating, "Often cultural beliefs conflict with ethical practice and thus finding the correct balance is a difficult task". As P11 has illustrated, it is necessary to continue negotiating between maintaining respect for cultural beliefs and fulfilling one's professional obligations to society.

DISCUSSION

The purpose of this qualitative study was to explore how psychologists in Pakistan navigate and interpret the complexities of diagnosis and treatment in context of Pakistani culture. Findings indicate that the clinical experience of psychologists in Pakistan is marked by an ongoing struggle to align the Western-modelled diagnostic framework with the culturally, theologically and socially derived understandings of psycho-social distress in clinical practice. In summary, psychologists in Pakistan do not merely take a Western-standardized model of psychological practice. Instead, psychologists in Pakistan interpret, negotiate and balance their ethical responsibilities while practicing psychology.

Cultural Mismatch and Diagnostic Challenges

The first major theme cultural disruption in assessment demonstrates a serious conflict between Western-style diagnostics and clients' culturally based communications regarding their distress. As previously documented in the literature of cross-cultural psychology, participants indicated that they typically communicate their emotional pain through both their body and their spiritual beliefs and not through the Western psychological terms of mental illness (Yildiz et al., 2025). This supports the position that diagnostic categories developed from a Western paradigm may not be culturally relevant for people who live in a more collective, spiritually oriented context. Because of this disjunction, psychologists must often rely on their creativity and on their understanding of the client's social and cultural context when completing their assessments. The fact that many participants viewed diagnostic labels as being a major impediment in their help-seeking behavior is an example of the pervasive nature of this barrier, regardless of socioeconomic or educational background. The stigma associated with mental illness, combined with a fear of being labelled or shamed, creates limitations on the extent to which participants disclose themselves honestly during the assessment process (Campo-Arias et al., 2021). This suggests that diagnostic resistance is a feature of Pakistan that is not just due to the sparsity of mental health literacy but also derives from the broader societal norms that are associated with reputation, marriage prospects, and family honor. As a result, there is a need for development of culturally informed diagnostic communication strategies which establish Trust as a precursor to categorizing clients immediately.

Socio-Cultural and Familial Influences on Therapy

The socio-cultural influence theme identifies the key role that family, religion, and gender roles play on all aspects of the therapeutic process. Unlike individual-focused models of care, where the individual's decision-making guide, mental health decision making in Pakistan is mostly through collective means, with family members exerting a great deal of influence on whether to initiate and continue treatment and to reveal their treatment activities (Halford & De, 2020). While providing family members increases the client's ability to follow and adhere to treatment, it can also inhibit the client's autonomy, especially for women and younger adults. Religious beliefs serve as both a coping tool and a form of resistance to receiving therapy. Participants indicated that some individuals would like to explore different types of therapy but would not feel comfortable doing so due to their religious beliefs, therefore creating the opportunity for therapists to create distrust, preventing the development of a strong therapeutic alliance (Knudson-Martin et al., 2020). The dual role of religion is indicative of the difficulties involved in providing ethical and effective treatment in a culturally pluralistic environment. Additionally, gender and honor-related issues influenced client disclosure, maintaining and enforcing current power differentials between men and women, as well as determining the boundaries of the treatment discussion.

Adaptive and Negotiated Clinical Practice

The third recurring theme within the data regarding participants' efforts to achieve an acceptable balance between the psychologist's duty as a professional and the need to be culturally sensitive to the client was the psychologist's ability to be flexible and adapt to the needs of the client and negotiate clinical issues within the context of local cultural norms (Kausar & Ume Habiba, 2025). Some of the strategies used for adapting include the gradual introduction of a mental illness diagnosis starting with identifying the symptom's function, incorporating the client's cultural and/or religious values into the clinical process of diagnosis or treatment, and prioritizing the needs of the client. These strategies reflect that a client-centered approach to treatment supports culturally responsive care models, which value flexible practices over the use of diagnostic labels. The participants also recognized that a tension exists regarding the negotiation of professional ethics and cultural considerations. There are many times when a psychologist must respect a client's religious beliefs but also maintain compliance with the ethics of the profession particularly in instances concerning gender-based restrictions, risk-taking behaviors, and client autonomy. The findings further suggest that when providing psychological services in Pakistan, psychologists work within a "negotiation space" that provides a framework for determining what is considered ethical practice within the context of their culture rather than attempting to apply universal standards of ethical practice (Sohail et al., 2025). The findings of this research study support that psychologists should be trained to use ethical reasoning, be culturally humble, and be able to apply adaptive communication skills.

Limitations of Study

There are limitations associated with the research which need to be taken into consideration when interpreting the results. The limitations are described as follows. The first limitation is due to the small sample size ($n = 12$) and the use of purposive sampling which restricts the degree of generalization of the findings beyond or outside the professional environments represented in this study. Secondly, as the study is based on self-reported data collected through interviews, there is the potential for recall bias or social desirability to distort the results. Thirdly, the study only captures the perspectives of the psychologist(s) who participated in the research; therefore, it does not reflect the views of the client or family members (the people who are critical in the decision-making process about mental health care in Pakistan). Finally, the findings of this research reflect a specific context and are strongly influenced by the socio-cultural context of Pakistan; thus, care should be taken when attempting to generalize the findings to other contexts.

IMPLICATION FOR PRACTICE AND TRAINING

Overall, these findings suggest that culturally informed diagnostic reasoning, culturally flexible therapeutic strategies, and an understanding of socio-religious dynamics are necessary for effective psychological practice in Pakistan. Therefore, training programs for mental health practitioners should provide structured education on cultural formulations, family-based intervention strategies, and ethical dilemmas in non-Western contexts in addition to providing technical training in the technical competencies required for mental health practice. Furthermore, mental health policy should recognize the appropriateness of culturally adapted methods of treatment as opposed to viewing them as inferior forms of evidence-based treatment.

CONCLUSION

This qualitative research examined how psychologists within Pakistan navigate the intersection of culture and the complexities involved within the diagnostic/treatment process. The results of this study acknowledge that culture significantly impacts what constitutes psychological distress for individuals; additional cultural variables of family involvement, religious beliefs and stigma surrounding the perception of mental illness, all play an important role in the differing culturally based diagnostic views of psychological suffering that exist between the West and Pakistan. As such, it is imperative for psychologists to alter their assessments/treatments to fit the individual cultural context of the client and be flexible with those processes and not stay rigid to a pre-established framework (like the Diagnostic Statistical Manual DSM). Psychologists within Pakistan will also utilize and incorporate cultural/religious values in their practice through gradual disclosure processes; creative negotiation processes between culturally based ethics and professional ethics, and building relationships of trust with clients will all facilitate the use of adaptive strategies; the culturally adaptive nature of these strategies emphasizes the importance of cultural competence, reflexivity and ethical competence in providing psychologists with the ability to provide clinical effectiveness within a complex sociocultural environment. Additionally, this study emphasizes the need for psychologists to train, practice and develop policies to be more culturally competent within Pakistan, as cultural competence is to be understood relative to Pakistan and other similar non-western cultures.

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