

Quality of Life of Clinical Psychologists: Lived Experiences from Pakistan



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Abstract: *Clinical psychologists are in a pressurizing role in the mental health field where they are charged with the long-term responsibility of the psychological well-being of the clients and at the same time they have to deal with the emotional labor, the secondary traumatic stress and organizational demands. Although there is an increasing body of research showing that practitioner well-being is a key determinant of mental health service delivery quality and safety, little empirical research has been done into the lived quality of life (QoL) experiences of clinical psychologists, especially in lower-middle-income country environments. The purpose of the study was to examine the multidimensional determinants of QoL of practicing clinical psychologists with a view considering the interactive role of personal coping resources, professional structures, and socio-cultural environmental and economic determinants. The phenomenological qualitative design was used. Convenient sampling with a purpose identified 20 clinical psychologists, working in hospitals, private clinical practices, and rehabilitation centers and NGOs with experience of at least three years. The information was collected through semi-structured, in-depth interviews, and later analyzed using thematic analysis. Seven analytically discrete themes emerged, namely (1) Physical Health and Occupational Well-Being, (2) Emotional Regulation and Psychological Well-Being, (3) Autonomy and Functional Independence, (4) Perceived Support and Social Relationships, (5) Environmental and Financial Conditions, (6) Professional Development, Leisure and overall Quality of Life and (7) Spirituality, Religious Beliefs, and Meaning in Life. The results of this study can contribute in the provision of evidence-based self-care initiatives, supervisory systems, fair workload policies, and culturally sensitive well-being systems for the clinical psychologists.*

Keywords: Clinical Psychologists, Emotional Labor, Professional Well-Being, Quality of Life, Qualitative Research

Introduction

The concept of quality of life (QoL) changed over the last 30 years, shifting its marginal role in clinical discourse to a primary evaluative variable in health psychology and psychiatric rehabilitation, and even in the overall policy of health promotion. This trend indicated a more primary redefinition of health itself - not the lack of pathology but a positive, multidimensional condition of physical, mental and social well-being. In this paradigm shift, QoL was used to refer not only to an objective index of functioning but also to a subjective measurement of personal satisfaction, meaning, and the extent to which the life situation fits the personal values and aspirations (World Health Organization, 2018).

The role of clinical psychologists was paradoxical in the context of these issues. Having been trained to help others get a better quality of life by using evidence-based psychological intervention, they get exposed to an occupational environment that puts them in chronic emotional stress, exposes them to traumatic content, ethical challenges, and in many, cases precarious institutional circumstances. Empirical literature has also been rising to record the incidence of burnout, compassion fatigue, and secondary traumatic stress among mental health practitioners, all of which have proven implications for individual well-being and quality of therapeutic work output (Cocker & Joss, 2016; Maslach & Leiter, 2016). However, the Quality of Life of clinical psychologists (QoLCP) as a group of research subjects, unlike overall healthcare worker well-being, remained a relatively understudied phenomenon.

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This disregard was especially sharp in the Pakistani context. Pakistan had an estimated mental health burden of about 50 million individuals, and the ratio of mental health professionals to population was critically wanting. (WHO, 2020). The clinical psychologists working in such a setting had to work within resource-limited, infrastructure-limited, and socially stigmatized mental illness, and frequently lacked formal supervision or peer consultation systems. These structural facts cannot help but overlap with the personal well-being of practitioners, but the qualitative inquiry of this overlap had not been present in the Pakistani research literature.

Qualitative research methodology would be considered especially suitable to fill this gap. Well-being as lived experience, including subjective meaning-making, the felt texture of the stress of professional work, and individual bargaining of professional identity, could not be well-represented solely with psychometric measures. With semi-structured interviewing, the participants narrate subtle descriptions of their daily realities in a context-sensitive fashion, which is also culturally embedded and individual variant (Smith & Nizza, 2022). The current research endeavor sought to (a) explore lived experiences of QoL of clinical psychologists; (b) discover the personal, professional, environmental, organizational, socio-cultural, and economic influences of QoLCP; and (c) produce theoretically based and empirically oriented information that has the potential to inform institutional policy and professional development systems within the mental health system of Pakistan, specifically.

Theoretical Framework of Quality of Life

The World Health Organization Quality of Life (WHOQOL) Framework, created by the World Health Organization (WHO, 1995), serves as the foundation for this study. Quality of Life (QoL) is defined by the WHO as:

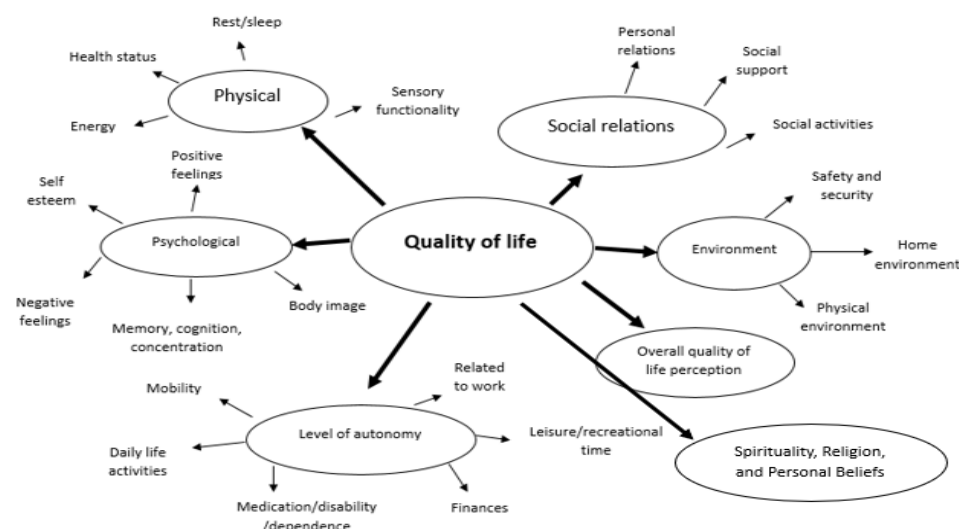
"An individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns." (WHO, 1995)

This definition emphasizes that a person's quality of life is subjective, multifaceted, and impacted by their physical and mental well-being, degree of independence, social connections, surroundings, and personal values.

The WHOQOL includes an evaluation of general health and overall quality of life organized into six domains. i.e. Physical Capacity, Psychological domain, Level of Independence, Social Relationships. Environment and Spirituality, Religion, and Personal Beliefs. Overall quality of life and its concept in general is also discovered. The domains are further sub divided as shown in the figure image below.

Figure 1

Diagram of WHOQOL model



Literature review

Significant Ideas of Quality of Life

Quality of life was generally perceived as a multidimensional concept that involves subjective judgments in terms of physical health, psychological functioning, social relationships, and environmental conditions (WHO, 2023). The operational definition used by WHO placed QoL as an individual conception of an individual's position in life with reference to the cultural values, personal goals, and normative expectations of the social context. This definition was an intentional prediction of subjectivity, as it acknowledged that two people with objectively comparable life circumstances can give vastly different judgments about their well-being.

A major difference in concepts was related to QoL and health-related quality of life (HRQoL). Although the concept of HRQoL was directly related to how health status or medical conditions affect the functional capacity and everyday living (Karimi & Brazier, 2016; Haraldstad et al., 2019), the broader concept of QoL incorporated areas that do not necessarily pertain to health, such as vocational fulfillment, spiritual well-being, environmental safety and relational connectedness. In the case of professional groups like clinical psychologists, whose well-being is closely interwoven with occupational role-demands as well as individual resources, a general framework of QoL is more analytically suitable than a health-based, narrowly focused framework.

Research studies have already repeatedly established that subjective experience elements: resilience, perceived social support, personal agency, and ability to control emotions, often perform better than objective health or socioeconomic measures as predictors of QoL (Diener et al., 2018). This highlights the significance of inquiry procedures that can reach the interpretive systems of the participants and not use only standardized scoring measures for the construct.

Well-Being at Work in Mental Health Professions

Various constructs have been interrelated to study the occupational well-being of mental health practitioners. Burnout, as developed by (Maslach & Leiter, 2016; Schaufeli, 2021; World Health Organization, 2019), is a state of constant exhaustion at work in the form of a state of emotional emptiness, depersonalizing of clients and a loss of a feeling of professional achievement. Similarly, the term compassion fatigue refers to a secondary traumatic reaction due to chronic empathic interaction with traumatized or adversely affected individuals (Laverdière et al., 2019; Molnar et al., 2020). Both of the phenomena are over-represented in the context of psychotherapy and clinical psychology as compared to other professional groups.

The systematic reviews of the well-being of psychotherapists and clinical psychologists have pointed out several common risk factors: heavy clinical caseloads and lack of appropriate supervision, organizational cultures that pathologize help-seeking, lack of provision of time to allow reflective practice, and insufficient clarity of boundaries between professional and personal roles (Simionato & Simpson, 2018; Taylor et al., 2020). On the other hand, variables that are linked to well-being and professional longevity comprise availability of significant collegial connections, perceived professional autonomy, continuous skill enhancement, and deliberate self-care strategies. (Posluns & Gall, 2020; Rupert et al., 2021).

The difference between emotional labor and the controlled expression of professional emotionality under the banner of therapeutic interests, and the emotional cost this imposes on an intrapsychic level, is especially relevant to clinical psychologists. The original theorization of emotional labor by Hochschild (1983), utilized widely in the context of health care and therapeutic practice, was shown to induce higher levels of exhaustion and lower levels of personal well-being in the long run in practitioners who have developed a habit of suppressing or managing genuine emotional reactions within the professional setting. (Chen et al., 2022; Zhang et al., 2021).

Contextual and Organizational Determinants

The organizational structures were found to have a great impact on the welfare of clinical psychologists. Psychological practitioners were less likely to experience burnout and more likely to have high job satisfaction in the institutions that were marked by open governance, equitable allocation of workload, and availability of clinical supervision (West et al., 2018; De Hert, 2020). On the other hand, those environments where there is role ambiguity, lack of administrative support, financial precarity, and structural isolation have a significant impact on undermining QoL and clinical effectiveness. (Mwakyusa & Mcharo, 2024; The Lancet Regional Health, 2024).

In the context of lower-middle-income countries (LMIC) in particular, clinical psychologists often faced systemic under-resourcing factors limiting their ability to practice in evidence-based ways. The lack of access to continuing professional education, a poor remuneration system, and the lack of licensing or regulatory accountability frameworks, as well as the social stigma surrounding the use of mental health services, all contributed to an occupational environment which had unique challenges that were not fully reflected in studies that were undertaken in high-income environments (Bhui et al., 2018; Kohrt et al., 2016)

Spirituality, Meaning, and Protective Resources

In addition to other structural determinants, increasing literature on the protection of occupational adversity in clinical psychologists by psychological and existential resources was found. Sense of coherence, i.e., the sense of life in a harmonious, manageable, and meaningful living, was revealed to be an important moderator of stress outcomes in helping professions (Mittelmark et al., 2017). On the same note, reflective self-inquiry, involvement in personally meaningful activities, and spiritual or religious practice were discovered to be associated with improved QoL among healthcare professionals who deal with the underlying moral burden of clinical practice (Kuchinka, 2021; Captari et al., 2022).

Religious and spiritual commitments were learned to form a major aspect of the daily life of a significant majority of the Pakistani population, in their cultural context. Coping based on faith, prayer, and interpretive frameworks that were based on Islamic philosophy had been reported to be relevant resilience mechanisms in a sample of Pakistani communities (Khan et al., 2022). But to what degree these culturally specific resources could be considered protective factors of clinical psychologists' QoL was a question that needed to be investigated.

Research Gap and Rationale

An overview of the literature available showed that there were two salient gaps. To begin with, clinical psychologists' QoL (QoLCP) had seldom been singled out as an area of research by the wider group of healthcare worker well-being, which traditionally focused on nursing and medical groups. Second, the empirical literature on lived QoL experience of clinical psychologists working in LMICs, and Pakistan specifically, had little to no qualitative research on it. (Iqbal et al., 2023; Riaz et al., 2021). The current research aimed to fill these two research gaps by using a comprehensive qualitative research approach and analyzing the subjective QoL narratives of Pakistani clinical psychologists working in various practice settings.

Research objectives

The current study had an aim to:

1. Explore the definition and perception of quality of life among Pakistani clinical psychologists.
2. Investigate the physical factors that affect the quality of life of clinical psychologists.
3. Examine the emotional and psychological factors that influence their quality of life.
4. Comprehend the influence of degree of independence and professional obligations on clinical psychologists' quality of life.
5. Determine how social connections and support networks affect clinical psychologists' quality of life.

6. Identify how their quality of life is affected by environmental elements such as access to professional resources, safety, financial resources, and working conditions.
7. Investigate how spirituality, religion, and personal convictions affect clinical psychologists' quality of life.
8. Discover the coping mechanisms clinical psychologists employ to preserve or enhance their quality of life.
9. Make known the obstacles and difficulties that have a detrimental impact on Pakistani clinical psychologists' quality of life.
10. Create recommendations for raising the quality of living and professional well-being of Pakistani clinical psychologists.

Methodology

Research Design

The phenomenological qualitative research design was adopted, which argues that subjective experiences of well-being are contextually focused, personally constructed, and poorly measured using only quantitative approaches (Creswell & Poth, 2018). The nature of the study was aimed at producing rich, contextually sensitive descriptions of the experiences and perceptions of clinical psychologists of their quality of life, as opposed to testing predetermined hypotheses or making generalizable prevalence estimates.

Participants and Sampling

Twenty clinical psychologists who are already in practice in Pakistan were recruited with the aim of achieving diversity, in terms of practice setting, experience, and geographic location in urban centers. The inclusion criteria were: (a) participants had to have a recognized postgraduate qualification in clinical psychology; (b) be actively involved in clinical practice during the period of the research and have at least three years of experience; and (c) provide informed consent. The sample of participants worked in government hospitals, private clinical practices, psychiatric rehabilitation facilities, NGOs, and psychology departments of universities. The sample included male and female practitioners. The sampling was continued until thematic saturation, in terms of successive interviews not adding substantively new categories.

Data Collection

Semi-structured, in-depth individual interviews were used to collect the data, held by the primary researcher. An interview guide was drawn up on the basis of WHO Quality of Life domains and was complemented with questions related to professional autonomy, organizational experience, spiritual well-being, and work-life integration. The guide was piloted on two individuals who were not part of the analysis; slight changes were made to sequencing and phrasing according to pilot feedback. Interviews lasted between fifty minutes and one hour and forty minutes, and were in an environment of choice on the part of the participants, and audio-recorded with their consent.

Data Analysis

Interviews were transcribed and translated where needed. Reflexive thematic analysis outlined by Braun and Clarke (2006, 2019) was used to analyze transcripts, with six stages involved, namely, "familiarization with data, initial coding, building candidate themes, theme review and refinement, theme definition and naming, and writing the analysis". The coding was done manually and through cross-referencing with each other to provide internal consistency. An audit trail was kept during the analysis process. Six participants were member-checked, and summaries of the emergent themes were reviewed; no significant differences were found.

Ethical Considerations

Before the data was collected, ethical approval was taken by the concerned institutional review board. Informed consent was given in writing to all participants and they were informed that they could withdraw

any time without any repercussions. Anonymization of all personal data ensured confidentiality; all participant quotes identified in this paper by will be by sequentially assigned numbers (e.g., P1, P2) only. The audio recording was saved safely and erased at the end of the analysis.

Results

The thematic analysis of the data of the interview of the participants revealed seven major themes. All these themes were a testament to the multidimensional and interactively determined quality of life of clinical psychologists.

Table 1

Themes Identified in the Quality of Life Experiences of Clinical Psychologists

Theme No.	Major Theme	Sub themes
1	Physical Health and Occupational Well-Being	- Physical and functional health - Physical Discomfort at Work - Occupational Fatigue and Energy Levels - Quality of Sleep and Rest
2	Emotional Control and Psychological Well-Being	- Understanding of emotions - Stress and self-regulation - Experiencing positive emotions - Emotional Regulation Strategies
3	Autonomy and Functional Independence	- Personal and professional Autonomy - Physical and functional Independence
4	Perceived Support and Social Relationships	- Family and Social Relationships - Perceived Social Support
5	Environmental and Financial Conditions	- Safety and Living Environment - Financial stability
6	Professional Development, Leisure and overall Quality of Life	- Professional Growth and Competence. - Leisure and Work-Life Balance - Overall Quality of Life
7	Spirituality, Religious Beliefs, and Meaning in Life	- Faith as a Coping Mechanism - Religious Practices and Inner Peace - Religion as Purpose and Meaning in Life - Religious Coping and Emotional Regulation

Theme 1: Physical Health and Occupational Well-Being

The respondents in all settings indicated similar physical health problems that were related to job requirements as a clinical psychologist. Chronic exhaustion, interrupted sleep habits, and postural symptoms due to inactive clinical practice, and the cumulative burden of commuting in the congestion of the urban environment were among the most common physical health issues mentioned. Some of the respondents working in the hospital environment reported that their schedule regularly went far beyond the working hours as stipulated by their contract, due to patient demand, and that recovery time is not provided.

P7 said: "On Thursday of each working week I am literally exhausted, not tired in the manageable sense, but that kind of tiredness that takes me into the weekend. I do not sleep well and I know that I am not physically healthy in the way I should be to do this work well."

Interestingly, a great number of respondents indicated their understanding of the linkage between physical depletion and clinical efficacy, recounting situations where physical exhaustion had impaired their ability to focus on the counseling or to be emotionally accessible during the session. Physical self-care was professionally recognized as a significant concern but was practically unfeasible to implement into busy work schedules. Lack of availability and free access of such facility was an issue.

Theme 2: Emotional Regulation and Psychological Well-Being

The area of most subjective salience among the participants appeared to be the emotional aspect of the clinical practice. Repeated exposure to clients who reported having high levels of psychological distress, traumatic experiences, and suicidal ideation was reported to have a cumulative emotional impact that respondents reported as not being associated with any critical event. The participants described emotional compartmentalization, the conscious cognitive disconnection between clinical and personal life, as a requirement of professional functioning, and as a kind of cost to the individual when practiced over a long period of time.

P3 explained the experience as follows: *“There is a version of me that comes into the consulting room and that version is controlled, demarcated, current but the end result of keeping that version up over eight hours is real and so at the end of the day, that version is exhausted and the individual who returns home is carrying something that is hard to put down.”*

The respondents also stated that personal psychotherapy availability or formal supervision were a qualitatively different source of emotional processing from informal peer discussion, and that these resources were unevenly distributed among the sample. The ones with access to frequent supervision referred to it as an important modulator of emotional well-being.

Theme 3: Professional Autonomy and Functional Independence

Perceived professional autonomy was a strong positive predictor of QoL in the sample. Participants who indicated a significant level of control over their clinical decision-making, the composition of their sessions, and their caseload reported much more work-related satisfaction and professional identity than those who worked within highly prescribed institutional settings. Respondents working in the environment of individual practice tended to have more freedom, but they were also facing specific financial insecurities and a lack of institutional support.

P12 commented: *“When I am allowed to practice based on my clinical judgment--when I am trusted to decide what a patient needs and how to organize our work together--then I feel like a psychologist. When I find myself filling out forms and with administrative procedures that dictate my clinical judgment, I feel like a bureaucrat who also happens to have a clinical degree.”*

Different participants reported higher perceived agency and lower perceived constraint on professional experience, respectively, and the tension between professional autonomy and institutional accountability was negotiated differently, with the more senior or academically affiliated participants reporting greater perceived agency and the subordinate hospital position participants reporting more constrained experience.

Theme 4: Perceived Support and Social Relationships

Social support became a frequently reported well-being protective factor, but there were significant differences between the relational sources of social support among the participants. Collegial support, which is the possibility to informally consult colleagues, exchange clinical issues, and feel as a part of a professional community, was reported as especially important in moderating the emotional load of clinical practice. Respondents in remote environments, or who worked in an environment that did not comprehend psychological work well with other professionals who were not psychologists, stated that they felt more professionally lonely.

Most of the participants indicated that family support formed the basis of their capability to maintain professional commitment, but a few of them mentioned the natural challenge of sharing the nature of their work experience with their partners and family without breaching client confidentiality and overwhelming intimate relationships.

P5 remarked: “My spouse is very supportive and yet he does not and cannot, fully imagine what it is to sit with someone who is in real psychological crisis an hour, and then do it again. There is something in my professional life that is necessarily alone--not my choice, but my position in what this work is.”

Theme 5: Environmental and Financial Conditions

The material conditions of their work and family conditions significantly influenced the assessments of the participants on their QoL. Monetary compensation was a major issue, especially among those who work within the government setups, where a compensation system often does not adequately compensate the level of specialization that psychological training demands or the individual investment that is needed to make an individual clinically effective. A number of respondents said that they have had to augment the earnings provided in the public sector with some private practice to attain simple financial security.

Physical environment at workplace was also found to be a determinant of well-being. The participants who practiced in well-resourced, privately-equipped, professionally-equipped settings articulated the conditions as being conducive to clinical focus and personal dignity, whereas participants in overcrowded, shared or under-maintained settings articulated the conditions as an enduring background stressor that added to other work demands.

Theme 6: Professional Development, Leisure and Overall Quality of Life

The respondents mentioned professional development, leisure experiences, and life satisfaction in general as mutually dependent aspects of the quality of life. The balance between personal development, working requirements, and leisure became an important key to well-being maintenance.

Participants also identified opportunities to further professional development as having a crucial impact on clinical competence as well as personal QoL. Involvement in the current research, involvement in the continuing professional education, and access to advanced training were not only instrumentally experienced as a contributor to clinical effectiveness, but intrinsically experienced as a source of intellectual stimulation and renewal of professional identity. Those who indicated less access to professional development said there was a qualitative sense of stagnation with which they related less vocational motivation.

Work-life integration, not as simply management of conflicting time demands, but as the sustenance of personally meaningful life outside of professional role, was found to be a key factor in QoL. Participants who had developed non-clinical and well-organized interests, safeguarded their own time, and had significant personal relationships beyond the profession reported higher resilience and continued involvement compared to those whose identities were largely absorbed by their professional identity.

P17 wrote: *“I have kept, by design, interests and relationships unrelated to psychology, and that time is not always easy to guard, but I have come to feel that it is non-negotiable with me, not in the sense of self-indulgence, but of the precondition of my doing this work at all.”*

Theme 7: Spirituality, Religion and Meaning in Life

Spiritual faith and religious activity were a major source of existential stability and work stability to a substantial percentage of respondents. Among the Pakistani population, Islamic religion not only offered a system of applying the meaning of suffering, but also an active process, prayer, community, and dependence on the divine supply, which members of the population referred to as specifically sustaining in times of career-based or individual trouble. The ability to place their work in a framework of moral and spiritual meaning, the participants said, lowered the psychological load of being exposed to human suffering.

P9 explained that it was as follows: *“When I am with a patient who is in a lot of distress and I feel the boundaries of what I can give them, my faith provides me with a feeling that I am part of something larger, this life of the patient, which is not limited to what I can see or what psychology can help. That does not diminish what I do; it contextualizes it in a way that I find sustaining.”*

Those who did not identify with religious structures, however, described secular counterparts, such as commitments to social justice or the intrinsic worth of human flourishing or the accrual of their work to a wider societal good, as sources of meaning which also countered against work-related demoralization.

Discussion

The present study offered a qualitatively rich and contextually grounded account of QoL of clinical psychologists, illuminating the multidimensional and interactive nature of practitioner well-being across personal, professional, socio-cultural, economic and environmental domains. Several findings warranted substantive discussion in relation to the extant literature and their implications for practice and policy.

The identification of physical health and emotional regulation as prominent QoL domains corroborated the broader literature on occupational health in helping professions. The embodied cost of sustained emotional labor—the progressive depletion associated with containing clients' distress while maintaining a regulated professional presence—had been theorized by Hochschild in 1983 and operationalized in clinical contexts by researchers like Lampert (2019) and Tragantzopoulou (2024) recently. Our findings extended this analysis by illustrating that participants experienced this depletion not as episodic but as cumulative and structurally embedded—a consequence not of individual clinical encounters but of the systemic absence of adequate recovery conditions within their professional environments.

The centrality of professional autonomy to QoL mirrored findings reported in clinical psychology research (Hasanfard et al., 2024; Akbaş Uysal & Ekiz, 2025) and reinforced the theoretical proposition that self-determination is a fundamental psychological need whose satisfaction within occupational contexts has direct well-being consequences (McAnally & Hagger, 2024). Crucially, however, our data suggest that autonomy in the Pakistani context is mediated by institutional power dynamics and resource availability in ways that render it more precarious and contested than accounts drawn from high-income settings might imply. (Khan et al., 2026, Farooq et al., 2018)

Social support findings aligned with established protective factor frameworks in occupational health psychology (Hammer et al., 2024) while adding contextual nuance regarding the particular isolation experienced by psychologists whose professional role is poorly understood by institutional colleagues and whose ethical obligations constrain the relational sharing that might otherwise mitigate occupational stress. These findings pointed towards the value of formal professional support structures—peer consultation groups, supervisory frameworks, and professional association communities—as institutionally designed responses to an isolation that is structurally produced rather than personally chosen.

The prominence of spiritual and religious meaning in the QoL narratives of Pakistani clinical psychologists represented a finding that both reflected and extended the cross-cultural literature on faith-based coping. While the integration of spirituality into occupational well-being frameworks had gained increasing recognition worldwide (Syahir et al. 2025, Captari et al., 2022), its salience in the present sample underscored the importance of culturally attuned well-being interventions that take the existential dimensions of clinical work seriously as experienced within specific cultural and religious frames. Interventions imported from secular, high-income contexts without such cultural calibration risk failing to engage the primary resilience mechanisms that Pakistani practitioners actually rely upon.

Taken together, the seven themes described a QoL landscape that is neither uniformly precarious nor uniformly resilient but rather dynamically constituted through the intersection of personal resources, relational conditions, institutional structures, and broader socio-cultural context. This complexity resisted reductive single-factor explanations and argued instead for multi-level policy and practice responses.

Implications for Practice and Policy

At the institutional level, the findings supported the case for the development and implementation of formal psychological well-being policies within healthcare and academic institutions employing clinical psychologists. Such policies should include provision for structured clinical supervision, equitable workload

standards with defined caseload ceilings, protected time for continuing professional development, and accessible and confidential mechanisms for practitioners experiencing occupational distress.

At the professional training level, the integration of self-care competencies and practitioner well-being content within clinical psychology training curricula is indicated. Training in emotional regulation, reflective practice, and occupational boundary management should be treated as core clinical competencies rather than supplementary concerns, consistent with the ethical obligation to maintain fitness to practice throughout a clinical career.

At the broader policy level, the persistent financial precarity of clinical psychologists within the Pakistani public sector—and its consequences for workforce retention and well-being—demands attention from health policy authorities. Salary and conditions reviews, recognition of clinical psychology as a distinct registered profession, and investment in workforce development infrastructure represent systemic prerequisites for a sustainable mental health service.

Finally, the findings underscored the value of peer-led and community-based support structures within the professional psychology community itself. Professional associations have an important role to play in facilitating collegial networks, regional peer consultation groups, and accessible continuing education opportunities that address the structural isolation many practitioners experience.

Limitations and Future Directions

Several limitations of the present study warranted acknowledgment. The qualitative design and sampling strategy precluded claims of statistical generalizability; findings should be understood as analytically generalizable to theory and contextually transferable to comparable settings rather than representatively applicable to all clinical psychologists in Pakistan. The sample, while heterogeneous across practice settings, was confined to urban centers, and the experiences of practitioners working in rural or semi-rural environments—where resource scarcity and professional isolation may be more pronounced—remained unexamined. Gender distribution in the sample is not equal, and the religion explored and accessed was only the Islamic faith.

Retrospective self-report introduced the possibility of recall bias and socially desirable responding; despite efforts to establish a reflective and non-evaluative interview environment, participants may have presented more professionally coherent narratives of their well-being than their lived experience in full would warrant. Additionally, the absence of longitudinal data limited conclusions regarding the directionality of observed relationships between organizational conditions and QoL outcomes.

Future research should address these limitations through the incorporation of longitudinal designs capable of tracking QoL trajectories across professional career stages, mixed-method approaches that integrate psychometrically validated QoL instruments with qualitative inquiry, and explicitly comparative studies examining QoL across different cultural, regional, and national contexts. Investigation into the specific efficacy of targeted well-being interventions for clinical psychologists in LMIC settings—including supervision models, peer support programs, and structured self-care curricula—represents a particularly high-priority area for applied research.

Conclusion

This study contributed qualitative evidence to a relatively underexplored domain: the lived quality of life of clinical psychologists. The findings demonstrated that QoL among this professional population is neither incidental nor separable from the broader architecture of mental health service delivery and practitioners who are physically depleted, emotionally unsupported, financially precarious, and organizationally disempowered cannot sustain the quality of clinical presence that effective psychological practice requires.

The well-being of clinical psychologists is therefore not merely a matter of personal welfare but a structural and ethical imperative for mental health systems. The Pakistani context, characterized by a

substantial and growing mental health burden against a backdrop of serious workforce under-investment, makes this imperative particularly urgent. Meeting it will require coordinated responses at institutional, professional, and policy levels—responses informed by the culturally situated realities that this study has sought to illuminate.

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