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THERAPEUTIC CONFIDENTIALITY AND THE LIMITS OF DISCLOSURE IN SAUDI ARABIA AN INTEGRATED SHARIA–SAUDI LEGAL–CLINICAL FRAMEWORK

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ABSTRACT

Effective psychological treatment requires therapeutic confidentiality as it promotes the transfer of vulnerable information by patients and enhances the therapeutic relationship. Nevertheless, there is no complete confidentiality because clinicians need to find the balance between the ethical and legal boundaries that would include significant danger of injury, child maltreatment, domestic violence, judicial decree, clinical partnership, and electronic data laws. These issues present themselves in a peculiar context, in Saudi Arabia, influenced by Sharia concepts of *amānah* (trust), *satr* (concealment of mistakes), and harm prevention, and practiced by state regulations on medical secrecy, reporting obligations, and rights to patients, and research on the relationship between confidentiality and trust, disclosure, and patient outcomes. In this paper, a comprehensive Saudi clinical psychology model is formulated using analytical frameworks grounded in legal and Sharia maxims, and in empirical research as a secondary source. It suggests a proportional disclosure model based on necessity, minimal disclosure, and documentation. It covers the risks to data protection in electronic records and tele-mental health, and concludes with policy recommendations aligned with Vision 2030.

KEYWORDS: Sharia; Saudia Arabia; confidentiality; disclosure; therapeutic alliance

1. INTRODUCTION

The issue of confidentiality is not a professional courtesy in psychotherapy, but a functional tool without which therapy would be impossible. Trauma, suicidal ideation, sexual issues, addictions, interpersonal violence, illegal behavior or conflict in the family, are all areas of stigmatization that patients reveal specifically due to the nature of the therapeutic relationship as a secure zone. Confidentiality in clinical psychology assists in three fundamental therapeutic conditions: (a) the sense of safety, (b) trust in the role of the therapist, and (c) readiness to participate in the emotionally expensive self-disclosure. These circumstances are strongly correlated with treatment engagement and the working alliance, which are among the most consistent predictors of the outcomes process across all types of therapy (Flückiger et al., 2018; Martin et al., 2000).

Simultaneously, there is no mature ethical or legal system where confidentiality actually exists. Such cases are sometimes called limit cases: a significant danger to others and self, plausible threats, child abuse and neglect, exploitation, profound incapability, communicable danger, domestic violence, court orders, and multi-disciplinary care settings. In such cases, the clinician's responsibilities might conflict: the responsibilities to the patient's privacy and autonomy might be in opposition to the responsibilities to save life, avoid harm, follow binding legal regulations, or collaborate with protective authorities. The dilemma is compounded by the clinician's expectation that disclosure is likely to harm therapy, leading to broken trust, discouraged repeat disclosure, or discouraged help-seeking among patients and communities.

Such tensions are especially timely in Saudi Arabia for four reasons. To begin with, the Saudi clinical practice is engaged in a normative culture that is informed by Sharia, emphasizing concealment of the intimate sphere (satr), fidelity (amānah), and protection of honor, integrity of families and dignity, and prevention of harm (*dar' al-mafasid*) and safeguarding of life (*hifz al-nafs*) as more important goals. Second, Saudi health regulation encompasses direct confidentiality obligations and patient rights (even in a mental health case), as well as creating reporting obligations towards cases involving abuse. Third, the process of help-seeking for mental health issues in Saudi Arabia is affected by stigma and perceived privacy risks; the issues of confidentiality are included in the Saudi literature as a barrier to seeking help (Alhumaidan et al., 2024). Fourth, the rapid digitalization of health services in Saudi Arabia, driven by Vision 2030, poses new confidentiality risks (including electronic records, access to practice on the platform, cross-border cloud services, and breaches), as well as official requirements for personal data protection.

1.1 Aim and contribution

The objective of this paper is to generate a publishable scholarly work on a secondary data contribution that will combine:

1. Clinical evidence of confidentiality, disclosure, and outcomes concerning alliances;
2. Saudi legal and regulatory requirements of secrecy, right to mental health, and reporting requirements;
3. Sharia-oriented normative acceptance through well-known maxims and modern studies applicable to medical/therapeutic privacy; and
4. An effective model of decision-making and recording that may be implemented in Saudi clinical practice.

1.2 Research questions

1. What does the clinical evidence imply about the connection between the expectations of confidentiality and therapeutic outcomes (in particular, alliance, disclosure, and help-seeking)?
2. What are the fundamental Saudi legal responsibilities and exceptions on the issue of confidentiality and disclosure in clinical psychology?
3. What is the role of Sharia maxims and objectives (maqasid) in resolving the conflicting role of confidentiality and disclosure requirements in risk and reporting cases?
4. Which operational model can guide Saudi clinicians in making ethically and legally defensible, clinically sensitive disclosure decisions?

2. METHOD (SECONDARY-DATA DESIGN)

The paper belongs to the category of secondary datasecondary data, integrative, doctrinal-normative evidence synthesis. It does not require any new subjects to recruit, does not involve any vignettes, and does not involve any original surveys. Rather, it combines three sources of existing materials: (i) Saudi legal and policy material, (ii) normative reasoning in Sharia, which is founded on existing juristic tools, and (iii) empirical material on confidentiality and

therapeutic process, peer-reviewed. The paper is more of an integrative review (which integrates both empirical and non-empirical sources) than a strict, intervention-oriented systematic review (Whittemore & Knafl, 2005).

2.1 Doctrinal and policy analysis (Saudi legal texts and institutional standards)

2.1.1 Corpus definition and source hierarchy

The doctrinal component aims to work with Saudi legal and policy texts as the primary data. In accordance with classical doctrinal (black-letter) logic of legal research, the goal is to identify, interpret, and systematise the rules that regulate professional secrecy, as well as the conditions that justify or require disclosure (Chynoweth, 2008/2011).

The corpus of the documentary is defined to encompass:

1. Primary and quasi-primary law tools about confidentiality and disclosure in the medical and mental health settings (e.g., professional secrecy obligations; mental health laws and privacy protections; reporting obligations and procedures within the regimes of the abuse-related legislation; the regulations of lawful authority requests).
2. Authority executing documents and institutional policies (e.g., guidance provided by the ministry, national expectations related to patient rights, and facility-wide confidentiality policies that are publicly accessible).
3. Information management tools for data governance and privacy compliance in the context of managing mental health records in Saudi Arabia (including the personal data protection rules and official guidelines on controllers/processors).

To mitigate interpretive drift, the hierarchical approach is adopted: binding legal texts and official implementing regulations are considered as sources of higher-order, institutional policies, which are considered as operational translations that should not conflict with higher-order rules, and professional guidance is viewed as interpretive support instead of binding law, where it has no formal legal force.

2.1.2 Extraction and doctrinal coding procedure

Reading through the legal-policy texts is performed with the help of a structured extraction template, which captures:

1. the area of confidentiality (what is covered, to whom it is covered, and what the covered circumstances are);
2. legal position of disclosure (illegal, legal, obligatory);
3. the triggering conditions (e.g., serious risk; signs of abuse/neglect);
4. the recipients who have been entitled to it (e.g., designated protective authorities vs. third parties who are not entitled);
5. procedural security (documentation, chain-of-command, reporter identity confidentiality); and
6. any explicit or implicit limitation that is the minimum necessary.

Coding of the doctrines is carried out by clustering the extracted provisions into thematic groups: default secrecy, consent-based sharing, mandatory reporting, risk-based protective disclosure, court/authority compulsion, and intra-system information flows (e.g., team-based care). The given step resembles methods of qualitative document analysis: documents are treated as analyzable artifacts; a relevant portion is defined, classified, and integrated into a coherent description (Bowen, 2009).

2.1.3 Doctrinal synthesis outputs

The doctrinal stage produces two outputs that are later used in integration:

1. a rule map (a simplified version of an if-then expression of when confidentiality applies and when it is allowed/necessary to disclose it), and
2. a scenario-rule chart associating habitual clinical scenarios (e.g., suicidality disclosure; threat of violence; child maltreatment indicators; family requests; insurer requests; court subpoenas; inter-professional coordination) with the applicable legal triggers, legal channels, and legal documentation.

2.2 Normative Sharia analysis

2.2.1 Analytical stance: normative integration, not fatwa issuance

The Sharia study is presented as normative scholarly integration rather than as the issue of independent fatwa issuance. It seeks to explain the extent to which Sharia principles are widely accepted for organizing ethical argument by clinicians and policymakers, in the sense that it does not purport to possess the final jurisdiction to resolve disputable juristic issues. This position is the same as approaches to methodological distinction in jurisprudential reasoning as applied

to policy/ethics and formal fatwa processes.

2.2.2 Juristic tools and reasoning steps

The analysis utilizes known instruments of usul al-fiqh and modern Sharia literature to address the confidentiality and disclosure issues by following the following steps (Kamali, 2003):

1. The theory underpinning confidentiality is discussed in terms of amānah (trust) and involves the responsibility to safeguard dignity and prevent the exposure of personal matters.
2. Maxim selection: the framework defines the most applicable qawa'id fiqhiyyah to apply to cases involving the limits of disclosure, particularly maxims of harm prevention, necessity, and balancing (such as the principle that harm avoidance should take precedence in cases of severe harm).
3. Maintenance of maqasid: it verifies the rationality of the decision with higher values (e.g., life and dignity are preserved), and it should be considered that confidentiality is the default because it is conducive to treatment and dignity, whereas disclosure is an exception that should be exercised due to the prevention of grave harm.
4. Operational limitations: Sharia reasoning is summarized into practice-facing restrictions, necessity, proportionality, and minimal disclosure such that even where disclosure is warranted, it is constrained (e.g., disclose what is necessary, to those who require to know, with a limited purpose attached). This logic of harm-elimination is well-known in the Sharia-maxim book.

2.2.3 Normative outputs used for integration

The Sharia stage produces:

1. a cluster of normative assessments (necessity, minimality, intention, accountability), and
2. a justification vocabulary which can be implemented in institutional policies and used in clinician documentation (e.g., why disclosure was necessary to avoid severe harm, showing what the steps were to help save dignity and exposure to the minimal).

2.3 Evidence synthesis (clinical and public health literature)

2.3.1 Review type and selection logic

The evidence component is a discriminating integrative evidence synthesis, focusing on high-level peer-reviewed evidence (systematic reviews and meta-analyses) where possible, and on influential primary evidence (where needed) to elucidate mechanisms. Such a decision is methodologically appropriate for a paper that seeks to generalize empirical data to law and normative categories rather than to estimate a single pooled effect size across homogeneous trials (Whittemore & Knafl, 2005).

2.3.2 Evidence domains and inclusion priorities

The synthesis is structured in a way that there are four domains of evidence:

1. Confidentiality as a disclosure and help-seeking determinant (e.g., nondisclosure behavior in healthcare environments; privacy-related avoidance of care).
2. Alliance processes that are applicable to trust, perceived safety, and engagement.
3. Rupture/ Repair dynamics in the presence of trust-compromising (and the therapeutic implication of perceived betrayal).
4. Local evidence (where possible), e.g., systematic reviews of barriers to help-seeking in Saudi Arabia and stigma-related determinants.

It is limited to peer-reviewed sources or other authoritative professional standards. The paper will state the heterogeneity of narrative form where there is mixed or context-dependent evidence, instead of implying the unjustified certainty.

2.3.3 Transparency and reporting discipline

Although the article is not portrayed as a whole PRISMA systematic review, the article adheres to transparency standards, including the clear description of the sources types, domains searched/targeted, and the rationale, which underlies the prioritization used. The paper allows readers to determine completeness and replicability (Page et al., 2021).

2.4 Integration strategy

Integration is performed using a defined triangulation and constraint-based synthesis. Instead of considering law, Sharia ethics, and empirical evidence as alternative authorities, the paper harmonizes them with three limitations:

1. Legality limitation: any disclosure must comply with binding Saudi laws (such as reporting and lawful authority requirements).
2. Necessity condition: disclosure should be necessary (e.g., aimed at preventing serious harm; fulfillment of a legally obligatory duty to disclose).
3. Clinical proportionality constraint: although disclosure is legal/necessary, it must be

formulated in a way that avoids therapeutic harm through (a) transparent limits-of-confidentiality communication, (b) minimum-necessary disclosure, and (c) structured documentation.

Continuously, operationally, the process of integration follows four steps:

1. Step A: Classification of scenarios. A clinical scenario falls under (high-risk, abuse, legal request, coordination by consent, etc.).
2. Step B: Rule identification. Legal provisions and procedural requirements are mapped out in the doctrinal rule map.
3. Step C: Normative bounding. The balancing of the maxims of necessity and harm in the Sharia contains proportional limits (who, what, why, how much).
4. Step D: Reduction of clinical impact. The strategies of disclosure communication (e.g., timing, transparency, alliance repair practices) that promise to reduce the possible risk of rupture and keep the engagement alive are chosen on the premise of empirical data.

Even where the legal stance is not clear or operationally defined, the default mode of the framework is a conservative, minimal-disclosure one: only have to disclose what is necessary; go via formal institutional procedures; write up the reasons; and consult/oversee where necessary.

3. CLINICAL AND EMPIRICAL FOUNDATIONS: WHY CONFIDENTIALITY MATTERS (AND HOW DISCLOSURE CAN HARM)

3.1 Confidentiality as a mechanism of therapeutic change

Clinical psychology has differentiated the concepts of confidentiality and privacy yet the two are closely related. Privacy is the right of the patient to control the access to his life; confidentiality is the task of the therapist not to disclose information which he/she has provided in the course of the professional relationship. Psychotherapy Confidentiality is functional but not ethical. A patient will withhold information, lie and/or check out when they believe that the information will leave the therapy. These actions compromise the quality risk assessment, case formulation and the establishment of the alliance.

Regardless of modality or diagnosis, the meta-analytic literature consistently shows that therapeutic alliance is associated with outcome (Flückiger et al., 2018; Martin et al., 2000). The conceptualization of alliance is commonly based on goal agreement, task agreement, and bond (Bordin, 1979). Confidentiality helps the bond component (trust, safety) and the task component (willingness to undergo exposures, trauma processing, risk discussions, or relapse prevention planning) indirectly.

3.2 Disclosure fears, withholding behavior, and help-seeking

A general behavioral principle is also supported by empirical evidence beyond psychotherapy: privacy concerns may lead people to hide information from professionals. Extensive survey data on the issue in healthcare settings indicate that patients who become anxious about privacy/security tend to withhold information, avoid care, or refuse testing (Levy et al., 2018). Although this evidence does not pertain to psychotherapy per se, it is very relevant as mental health information is more stigmatized and socially sensitive.

Confidentiality is also an issue that may hinder the ability to seek the services of the clinicians and share sensitive matters in youth mental health. The study of medical ethics was conducted qualitatively and reported that teenagers might avoid visiting doctors because they believe doctors' confidentiality will not be honored (Carlisle et al., 2006). In general, systematic reviews of youth help-seeking reveal that confidentiality and trust are facilitators (and a lack of them, barriers) (Gulliver et al., 2010). Even though these studies involve adolescents, the underlying mechanism is arguably generalizable: perceived risk of disclosure reduces treatment engagement.

3.3 Alliance rupture and the cost of "unexpected disclosure."

Of importance, a clinical difference lies between:

1. anticipated, agreed disclosures (e.g., patient signs a release to coordinate with insurance and knows the extent), and
2. unintentional revelations (patient thinks that information is to be kept confidential, and it is revealed to others).

Unforeseen revelation is like an alliance break: it conveys to the patient that the therapist is not a noncustodial agent of confidential content. Rupture is fixable; however, the fix is only possible through intentional relational work, openness, and responsibility. The meta-analysis suggests that outcomes are related to rupture-repair processes and that rupture-resolution strategies are relevant (Eubanks et al., 2018). Repair following disclosure under confidentiality might be more difficult, as it

involves extrinsic implications (family conflict, legal consequences, social implications) that persist even after the therapist capitulates.

3.4 Confidentiality communication as an evidence-informed intervention

There is empirical evidence that confidentiality cannot be reduced to a single checkbox; it is a recurring communication process. A systematic review of the practice of confidentiality and informed consent in psychotherapy shows that there are variations in what is disclosed and how clients perceive the concept and its boundaries (Lamont-Mills et al., 2018). This inconsistency increases the probability of being misinterpreted and complaining. This might mean a therapist needs to explain confidentiality just like any other treatment: what will remain confidential, what can be disclosed to the care team, and what exceptions apply (risk, abuse reporting, legal orders), and to renegotiate these boundaries when situations evolve (e.g., emergent suicidality).

3.5 Saudi-specific context: confidentiality and stigma-related barriers

The evidence offered by the Saudis on the barriers to help-seeking in mental health reveals that the factors influencing care usage are stigma, cultural problems, and system problems (Alhumaidan et al., 2024). In that case, the perceived disclosure risk may increase the deterrent effect: a patient may not even receive treatment assuming that relatives may do harm or ruin his or her reputation. This highlights the clinical and population health importance of the maintenance of confidentiality: good confidentiality policies can be used as a stigma-reducing infrastructure.

4. SHARIA FOUNDATIONS: CONFIDENTIALITY (KITMĀN AL-SIRR) AND THE ETHICS OF NECESSARY DISCLOSURE

Professional ethics usually define confidentiality in clinical psychology as one of the foundations of trust, therapeutic alliance, and safe disclosure. Within Sharia-informed ethical reasoning, the same pillar may be understood in terms of well-developed moral and juristic notions such as kitmaman al-sirr (keeping confidences/entrusted secrets), amānah (trust), satr (hiding personal faults and defending dignity), and the overall taboo on unwarranted intrusion into privacy. Notably, Sharia does not, in principle, regard confidentiality as a matter of more or less private regulation or a more or less professional norm; it views confidentiality as one of the components of a larger moral ecology that helps protect human dignity, societal unity, and the greater purpose of the Law (maqāṣid al-sharīʿah). However, Sharia also acknowledges that secrecy cannot be absolute, as it becomes a tool for facilitating serious evil. It is the peculiar contribution of Sharia analysis not only to justify confidentiality but also to explain principled limits to disclosure: necessity-based, proportional, harm-prevention-focused, and minimum reputational and relational harm.

- A Sharia-clinical synthesis can add analytical value from a publication perspective in at least three ways. To begin with, it explains that confidentiality is an ethical responsibility grounded in professional norms and religious-juristic obligations (amah, satr). Second, it provides a systematic vocabulary for exception cases (darūrah/necessity, ḍarar/harm, maṣlaḥah/public interest) without reducing Sharia to catchphrases ((Boateng et al., 2025). Third, it provides operational advice that could be translated into policy: where the disclosure is warranted, it is limited by (a) a strict need-to-know constraint, (b) a minimum-necessary constraint, and (c) cautious documentation and control to repair-focused communication to safeguard the therapeutic relationship.

4.1 Confidentiality as amānah (trust) and protection of dignity

Amānah (trustworthiness) in relation to entrusted information is a moral and religious obligation closely related to Sharia. Clinical psychotherapy can be regarded as a modern institution whose basis is amaniah: patients disclose personal information precisely because they expect the relationship with the professional to be characterized by trust, secrecy, and limited access. This conceptualization is not ideological. The definition of secrecy in the context of Islamic juristic discourses of the topic of secrets (sirr) is that information is relevant and secret not only when the patient explicitly requests the absence of disclosure, but also when custom (urf) and the content of the information make it reasonably apparent that the information was confidential (Muhsin, 2021). This is specifically so in mental health care, where the disclosure can be associated with the vulnerability of trauma, family conflict, addiction, suicidality, or socially stigmatized symptoms.

The second Sharia anchor is the safeguarding of dignity (ird) and the moral disapprobation of revealing personal vices (satr). In the clinical

context, reputational harms may result from breaches of privacy, which may spill over to the family and social network in addition to the individual, and are magnified in contexts of high stigma and strong communal contact. The ethical nature of Sharia, which emphasizes the avoidance of unjustified exposure, encourages the therapeutic agent of restricting the dissemination of sensitive information, even within institutions, except when such dissemination is clearly necessary on a case-by-case basis. This is not to say that the principle of secrecy as entails merely protecting the patient against being embarrassed, but instead, avoidable social evil (mafsadah) that the thoughtless dispensation of information can cause. The defense of dignity has been directly associated with medical secrecy in modern Islamic bioethics literature, and counseled that unreasonable disclosure could lead to real harm of individuals and society (Muhsin, 2021).

The Sharia reasoning behind this case is not in conflict with clinical evidence the perception of confidentiality is part of help seeking and disclosure, especially in young people and within societies where the aspect of reputational issues and stigma apply (Agostino & Toulany, 2023). Among the problems in the Saudi mental healthcare context, the ones related to confidentiality are stated several times in the context of the barrier landscape, along with stigma and low awareness (Alhumaidan et al., 2024). The Sharia framing supports the policy argument that confidentiality is not a kind of soft preference but rather a condition without which care delivery cannot be effective and that the provision of clinical truth is difficult to achieve. The experience of the absence of confidence in the confidentiality as something not so stable or easy to break, the patients can under report or disengage or fail to attend therapy altogether, putting the interests of the individual and social health at risk.

At the same time, by introducing confidentiality as Amānah, the responsibility is implied. Amānah when evil deed is made an instrument Amānah does not allow permitting the wrongdoing when it becomes a weapon of serious evil. It is a duty that should be implemented in the moral framework of Sharia: protection of privacy and at the same time not to engage the professional in any serious, non-essential damage. This is an extremely significant duality: confidentiality is a default of morality, and not an absolute.

4.2 Sharia maxims that shape the limits of confidentiality

The feature that distinguishes Islamic juristic reasoning is the use of qawāʿid fiqhiyyah (legal maxims) to control similar dilemmas in various contexts. These maxims never exclude secrecy, but merely bring the conditions under which disclosure is permitted or even required. The practical consequence is the proportionality model: only in the cases where the disclosure would remove a serious harm which, otherwise, would not reasonably be removed, do also reveal but to a small extent.

4.2.1 "No harm and no reciprocating harm" (lā ḍarar wa lā ḍirār)

The maxim: no harm and no harm to reciprocate is one of the most widespread moral- juridical principles of Islam. It also informs the clinician in situations of confidentiality dilemma by convincing him or her to suspect that supporting secrecy would have the predictable result of inflicting tremendous harm on a patient or those around the patient. It is not that a person ought to always disclose the existence of risk; it is merely a harm sensitive magnifying glass: the possibility and degree of harm is material (e.g. imminent lethal danger), and thereafter the ability to remain quiet about things can be morally objectionable. The Islamic ethics of bioethics underline the fact that the harm should be actual or highly probable to happen, and Sharia gives less significance to improbable, speculative possibilities that should prevail over significant duties (Muhsin, 2023). This nuance can be put into clinical practice that will be correspond to the level of disclosure and professional judgment and ordered risk assessment.

4.2.2 "Necessities permit the prohibited" (al-ḍarūrāt tubīḥ al-maḥẓūrāt), constrained by proportionality

The maxim of necessity has been mistaken with a blanket license to violate the rules in large scale. Other limitations of necessity in juristic method are: (a) necessity must be real and substantial, and (b) necessity is measured by its degree (al-ḍarūrah tuqaddar bi qadarihā). This gives a clear idea of how operations should be carried out in terms of confidentiality. Even though disclosure can be justified, the clinician only has to give out the minimum information needed to kill the harm, and only to the party capable of doing it. This is in tandem with a small required strategy according to

the contemporary ethical and data protection standards.

This, in practice, means that disclosure is not a binary switch (secret vs. fully shared). Instead, gradations preferred by the Sharia-based proportionality are closed internal consultation, advised escalation, commanding reporting to competent powers and avoiding informal community exposure, all of which augment stigma, not safety. The proportionality standard is also applicable to clinical best practice: preserve the therapeutic relationship where possible by being transparent, using cautious procedures of consent, and repair-oriented communication in response to disclosures that are inevitably made.

4.2.3 "Harm is removed" (al-ḍarar yuzāl) and prioritizing prevention of major harms

Two other maxims reinforce the reasoning of prudently limited disclosure: (a) avoidance of harms (al-darar yuzali), and (b) aversion to harms is observed (dar jalb al-mafrazi) over gaining benefits (dar al-mafrazi muqaddam ʿalajalb al-maṣaliuh). Combined, they warrant disclosure when nondisclosure will tend to result in a serious harm that disclosure can feasibly prevent - imminent suicide, credible threats of deadly violence, or severe abuse of a minor (Alotaibi, H. A. (2020). Significantly, these maxims further imply that, on the part of the clinician, they should ask themselves whether disclosure will indeed eliminate harm, or whether it will simply reallocate harm (e.g., reputational destruction) while leaving the safety status quo intact. Even the disclosure, which may take place due to anxiety or institutional pressure, may turn out to be ethically problematic as long as it does not plausibly decrease the risk.

4.2.4 Additional maxims relevant to clinical uncertainty and decision thresholds

Clinical psychology is habitually based on uncertainty. The decision thresholds can be structured with the help of Sharia maxims:

1. "Doubt does not eliminate certainty (al-yaqīn lā yazūl bi al-shakk): this is discouraging that confidentiality should be overruled due to mere weak suspicion, rumor, or vague indications.
2. In various juristic traditions, however, consideration is commonly given to so-called predominant probability (ghalabat al-ẓann), such that action can be taken when there is a high probability of substantial harm and indicators support that probability (Muhsin, 2023). This can be projected onto clinical risk formulations, where fleeting ideation is differentiated from imminent intent, with means and a plan.
3. The principle of blocking the means (sadd al-dharā'iʿ) is used to prevent situations in which the path to harm is effective and close; however, it must not be transformed into an instrument of undue observation or premature loss of confidentiality (Muhsin, 2023). Mental health in mental health, sadd al-dharā'iʿ, can be used to justify earlier intervention when the risk trajectory is becoming increasingly steep, but proportionality is required.

In effecting such maxims into conflict, they result in a consistent Sharia-grounded norm of actions: confidentiality is the default, disclosure is required when (a) serious harm is involved or will result, (b) it is required to prevent such harm, and (c) it must be disclosed only to the least amount of information, to the least recipient, and with the least end.

4.3 Maqāṣid al-Sharīʿah and mental health: preserving life, intellect, and dignity

Maqāṣid al-sharīʿah (the best interests of Islamic law) offers the concept of macro-ethics, especially in the context of mental health ethics, as it combines the welfare of individuals and the stability of society. In classic formulations of maqāṣid, the focus is on the preservation of life (ḥifẓ al-nafs), intellect (ḥifẓ al-ʿaql), lineage/family (ḥifẓ al-nasl), property (ḥifẓ al-māl), and religion (ḥifẓ al-dīn). Mental health cuts across many of these goals all at the same time, which means it is paradigmatic of a balanced, non-reductionist ethical thought.

Preservation of life (ḥifẓ al-nafs) is also directly involved in suicide prevention, self-harm crisis, and threats of extreme violence. The life-protecting orientation of Sharia in such situations underpins the interventions that can and should prevent death or grievous bodily injury, such as restricted disclosure when disclosure is obligatory to avert imminent injury. Intellectual preservation (ḥifẓ al-ʿaql) is important since hard psychiatric decompensation, untreated psychosis, severe depression, and substance-related impairment may be a threat to cognitive agency, judgment, and social functioning. Confidentiality helps ḥifź al-ʿaql by facilitating engagement in treatment: patients are more likely to disclose early symptoms, continue treatment, and accept follow-up, thereby reducing long-term impairment.

Dignity and honor (commonly addressed in maqasid literature as ḥifẓ al-irdr) preservation is paramount in mental health since stigma may be a

long-lasting source of social and marital damage. That is why confidentiality is not only a clinical method but also a maqasid-consistent preventive measure against avoidable social harm. Notably, this objective is not lost in high-risk circumstances; it shapes how disclosure is to be done. The clinician should continue to honor the concept of dignity by disclosing as little as possible, avoiding humiliating language, seeking the patient's involvement when it is safe, and providing a supportive explanation to avoid abandonment and shame, even when disclosure is required.

The result of this maqazi logic is a moderate opinion that is particularly publishable: axiomatic secrecy is the practice, as it safeguards dignity and facilitates treatment (which, in turn, indirectly safeguards life and intellect). One exception is disclosure, which may be obligatory when necessary to save a life or avoid serious harm. Still, it must be limited and mediated by the professional in a way that maintains dignity as much as possible. This equilibrium is also consistent with help-seeking evidence: the fear of stigma and a confidentiality breach impedes access to services, as is true in Saudi Arabia (Alhumaidan et al., 2024). Therefore, the application of maqāishid can be used in both clinical ethics and policy justification: robust confidentiality rights will help achieve Sharia goals and support the work of the country's mental health system.

4.4 Contemporary Islamic medical ethics on confidentiality and necessary disclosure

According to the current literature on Islamic medical ethics, confidentiality is typically regarded as a professional and ethical responsibility, but may be disclosed under necessity-based and law-based exceptions. One of the focal points is the International Islamic Fiqh Academy (OIC), which has stated that medical confidentiality covers what is explicit and what the practice believes to be confidential, and also what the individual does not want to see in print, and should be restricted by necessity and intent (International Islamic Fiqh Academy, 1993/Resolution 79 [10/8]). Scholarly debates also point out that unreasonable disclosure breaches dignity and trust, whereas justified disclosure is geared towards harm prevention, especially when harm is real or very likely to materialize (Muhsin, 2023).

In the case of clinical psychologists, such modern literature validates the existence of four operational norms:

1. The default ethical posture and a fundamental professional identity is confidentiality.
2. The exceptions should be principled (necessary, will not cause severe harm, legitimate power, or voluntary consent) and not convenient.
3. The disclosure must be minimal and role-limited (mitigation must be limited to those who can harm).
4. The decisions to be made must be written and reported in a manner that maintains therapeutic integrity.

The sources on clinical literature on ruptures and repair in alliance indicate the significance of communication style. Sudden, vaguely, or without adequate explanation disclosures that are ethically justified can destroy alliances. Rupture-repair interventions are linked to better outcomes, and they could be used to diminish the damage to relationships in cases when clinicians have to take hard decisions (Eubanks et al., 2018). Therefore, a Sharia-knowledgeable approach would suggest not only the issue of the disclosed information, but also the manner of disclosed information because it is related to the dignity, trust, and the harm reduction.

5. SAUDI REGULATORY LANDSCAPE: CONFIDENTIALITY DUTIES AND DISCLOSURE EXCEPTIONS

In this section, the Saudi obligations that apply to clinical psychologists in the healthcare field are mapped, in an operational perspective and not an abstract legal commentary. The overlapping levels have impacts on the confidentiality decision-making processes since most psychologists normally operate in multidisciplinary teams and integrated health systems and thus affected by the mental-health rights laws, health-profession general laws, mandatory reporting laws, data-protection laws and institutional accreditation laws. Integrative is the most reasonable practice model in Saudi settings: default to strict secrecy; the structured exceptions founded on definite legal basis; minimal disclosure; and care in the documentation and alliance sensitive communications.

This is an intellectual discussion presented as analysis to assist in policy and ethics development; this is not one-on-one legal counsel. Clinicians ought to use their legal avenues in the institutions and refer to qualified authorities where necessary.

5.1 Core confidentiality duty in Saudi health practice

According to Saudi health regulations, confidentiality is a professional obligation and a patient's right. The law has been categorical on the

right to confidentiality of a patient in the Mental Health Care Law and the law outlines a few circumstances where the confidentiality is not protected (e.g., patient consent; situations necessitated by judicial/investigative authorities, and protection of public safety and the safety of the patient or the safety of other persons) (Ministry of Health [MOH], 2014). This language of rights is significant: not just because it defines confidentiality not as clinicians' discretion, but as a right and an ethical right that patients introduce into the therapeutic space.

In addition to the mental health-related literature, the general Law of Practising Healthcare Professions includes an explicit confidentiality clause stating that the practitioner shall not reveal information acquired during their practice and may not disclose it to any other party (MOH, 2005/ updated portal PDF). The exceptions listed can be used to depict the logic in regulation:

1. disclosure to report deaths occasioned by criminal acts or to prevent a crime (to competent authorities),
2. reporting epidemic/communicable diseases,
3. Disclosure was required to refute charges of incompetence/practice.
4. through the express written consent of the patient, or disclosure can be convenient to treat the family,
5. disclosure as per judicial order (MOH, 2005/ updated portal PDF).

In the case of clinical psychologists, the informal interpretation is that confidentiality applies only to clinical content (symptoms, diagnoses, session narratives, closure of risk) but also to advance/identity metadata (being treated at all). Even confirmation of attendance can be quite delicate in the mental health. Consequently, the conservative operational policy, which follows the Sharia ethics and modern governance principles, is to consider all the identifiable information about patients confidential and with strict access to such data given to the people who have a direct clinical necessity.

Moreover, the confidentiality is not related to the professional secrets nowadays but to the data management. The Saudi data protection systems (PDPL and implementing regulations) offer an oblique layer of compliance with the processing of personal and sensitive data which highlights the significance of access controls, purpose limitation, secure storage, and breach response procedures (Saudi Data & AI Authority [SDAIA], 2022; 2023). Even though the institutional data controller may not be the clinicians, another important place of health data creation and sharing is through clinical practice. It is due to this fact that one can view the notion of confidentiality as (a) an ethical issue, (b) a compliance aspect that can be implemented into record-keeping and intra-organizational communication.

Finally, the duty is justified by the professional advice: The Code of Ethics of Healthcare Practitioners of the Saudi Commission of Health Specialties has introduced confidentiality as one of its core professional values, and the explanation is that clinicians are required to keep secrets and are prohibited to disclose them without a reason (SCFHS, n.d.). All in all, the subsequent strata offer a sound basis: secrecy is presumed; it is extraordinary and must be infrequent and justified.

5.2 Mental health–specific protections and the logic of limited exceptions

Mental health confidentiality is one of the phenomena that are to be given special attention due to two reasons. First, the effects on therapeutic effectiveness and confidentiality have a cause and effect relationship: the relationship is based on the premise that patients are free to discuss with the practitioners without excessive exposure. Second, mental health stigma can convert minor coming out into major life consequences (job, marriage, family strife); that is, the harm of coming out may be even more excessive than in other medical specialties. The Saudi mental-health rights frameworks are sensitive to it and locate confidentiality as one of the rights yet with few exceptions (MOH, 2014).

The exceptions will be interpreted operationally, on a limited-disclosure basis, as opposed to a broad interpretation. As an illustration, the mental health law permits disclosure in the cases where the knowledge is required to promote the safety of the patient or other people or in the cases of safety to the population (MOH, 2014). It is a necessity-based high-threshold safety exception, which is aligned to Sharia maxims and international clinical ethics. It is not a blanket authorization to disclose information to relatives, employers, or other individuals who are not family members, so that family members can be at ease. Rather, it demands institutional risk evaluation and a focused response, preferably through institutional channels: risk management, social services, and legitimate authorities, where required (Alotaibi et al., 2025).

Team-based operations (psychiatry, nursing, social work, psychology) are also required in mental health systems. Sometimes the continuity of treatment requires internal information sharing;

however, team-based refers not to institution-wide. The justifiable solution is to use role-based access: disseminate information only to everyone participating in patient treatment, and only the details needed to play the role. This aligns with the minimum-necessary ethos of data governance and the proportionality-based disclosure logic of Sharia.

One culturally salient issue is family involvement. Saudi clinical practice is usually conducted in a social setting involving families, and families may require information. The legal documents offer few points of entry: disclosure of the patient's consent, or disclosure to the family when it helps treat the patient (MOH, 2005/updated portal PDF). Clinicians must, in the ethical sense, (a) obtain express informed consent to family involvement whenever the patient is in a position to decide, (b) explain what is to be and what will not be disclosed, and (c) have the scope of the consent written. In instances of impaired capacity or when the patient is under legal guardianship, institutional legal advice should be sought. Still, the clinician is encouraged to maintain the patient's dignity by disclosing only what is necessary for the patient's care and safety.

5.3 Reporting obligations: abuse and child protection

Saudi law includes direct obligations to disclose abuse and safeguard children, and this has a direct impact on the scope of confidentiality in clinical psychology. These responsibilities are not ethical choices; they may be legal requirements and prevail over the default of secrecy.

First, the Protection from Abuse Law and its implementing regulations impose extensive reporting obligations. According to this law, legally any individual who knows about abuse is obligated to report the abuse to the competent authority and to place a certain responsibility on employees who have knowledge about the existence of abuse and report it to the competent authority through their work-related functions (Ministry of Human Resources and Social Development [HRSD], 2013; HRSD, 2014). In the case of psychologists, it implies that revelations of domestic abuse, extreme neglect, or violence can raise compulsory reporting pathways. Notably, the executive regulations focus on the confidentiality of the reporter's identity and the management of reports, promoting a managed process rather than an informal transfer of allegations (HRSD, 2014).

Secondly, the Child Protection Law and the executive rules set comparable duties towards child abuse and neglect. According to the executive regulations, it is the duty of any person to report in case of child abuse or neglect. If the information arises during their employment, it is the employee's responsibility to report it to the competent authority. The employer subsequently reports to the competent authority (HRSD, 2015). Such laws incorporate psychological harm in the conceptual framework of child protection which is especially applicable in the case of clinical psychologists who could detect emotional abuse, extreme family dynamics, or neglect in the mental well-being of a child.

In practice, these laws mandate that informed consent procedures in treatment involve transparent boundaries of secretiveness. Clinicians need to inform patients that therapy is confidential by default, but these cases may need to be reported in case of child abuse/neglect or severe abuse. This transparency can defend the alliance clinically by preventing the subsequent sense of betrayal when a report is needed. Research on adolescent and youth health care has consistently shown that the promise of confidentiality affects willingness to disclose; however, with clear, understandable boundaries, trust can be maintained despite exceptions (Agostino & Toulany, 2023).

Best practice, in a non-operational sense, is the absence of impulsive or informal reporting. Rather, clinicians are expected to adhere to the institution's safeguarding procedures: immediate safety assessment, consultation with the assigned safeguarding leads, and reporting through official channels, as outlined by the institution and qualified authorities. It makes disclosures limited, legally based, and documented- lessening patient harm and clinician liability.

5.4 Court orders and lawful authority requests

The other method of disclosure is by way of court orders or requests by competent authorities. General health-profession regulations and mental health-specific regulations acknowledge that judicial orders may require disclosure (MOH, 2005/updated portal PDF; MOH, 2014). The ethical risk in this case is not the presence of legal authority, but the propensity to informal disclosure to take place outside of the process- e.g., picking up the phone, giving biased information to persons not entitled to it, or simply being helpful with someone without first ascertaining authority.

A defensible protocol comprises: (a) checking on the authority and identity of the requesting party, (b) making a formal request or order through institutional legal protocol, (c) the disclosure should be of only the required and requested scope

of information, (d) disclosure should be made to the correct recipient only (not to broad network), and (e) documentation of specific disclosure, to whom, when, and why. It is a methodology acceptable under Sharia proportionality and contemporary compliance standards: despite the obligatory disclosures, it must be regulated and limited.

As much as time and safety allow, clinicians need to ask themselves whether disclosing such information to the patient is clinically appropriate. Transparency, in most instances, mitigates ruptures in alliances. However, exceptions may exist (e.g., when telling the patient that one is in immediate danger). The choice must be recorded and, preferably, made under the supervisory input.

5.5 Institutional standards and patient-rights culture

Institutional standards transform legal and ethical principles into operational expectations in day-to-day activities. The rights to respectful treatment, privacy, and confidentiality are contained in the MOH Patient Bill of Rights and Responsibilities in Saudi Arabia (MOH, 2021). In addition, CBAHI fulfills the role of various national accreditation of healthcare facilities, and patient rights, management of medical records, and privacy controls are also part of the quality and safety systems (CBAHI, n.d.; MOH, 2016 national standards listing). Even though a disclosure might be legal, an institution might not comply with the requirements as long as it does not have access controls, staff training, and breach response procedures. Therefore, the confidentiality habits of the clinicians should comply with the law, the institution policies and the accreditation requirements.

This proves useful in practice, as violations of confidentiality in mental health are frequently violations of the process, rather than deliberate violations of the ethics: conversations in the hallway, unsecured messages, unauthorized access to documentation, or too many discussions in a meeting. A policy document should focus on stating that, confidentiality has to be designed into the system, as the role-based access controls, auditing trail, secure and electronic documentation and employee training. This is in line with the wider national digital health governance and complies with the PDPL requirements of protection of data (SDAIA, 2022; 2023).

5.6 Practical legal–ethical synthesis for clinicians (Sharia + Saudi law + clinical alliance)

The most defensible model of confidentiality used by Saudi clinical psychologists, is a frame of a structured default + exception:

5.6.1. Fall back to strict confidentiality and restricted internal disclosure.

The patient's right and the practitioner's duty are to maintain confidentiality. Role-based and minimal sharing within the company should be done (MOH, 2014; MOH, 2005/updated portal PDF). Even appointment attendance should be viewed as sensitive by clinical providers.

5.6.2. Determine the basis of disclosure clearly (do not disclose on a just-in-case basis).

All permissible or mandatory bases are typically divided into: (a) patient written consent, (b) treatment-relevant disclosure to family with consent or clear treatment utility, (c) mandatory reporting (abuse/child protection), (d) communicable disease reporting, (e) imminent serious harm to self/others/public safety or (f) judicial order (MOH, 2014; MOH, 2005/updated portal PDF; HRSD, 2013; 2014; 2015). When the foundation is questionable, seek advice from supervisors and the legal institutions.

5.6.3. Use proportionality: minimum content, recipient, and purpose.

Sharia maxims support necessity-based and proportionate disclosure. This can be operationalized as a minimum necessary: only what the receiver needs to act, not the entire story of therapy.

5.6.4 Secure the therapeutic relationship by transparent and repair-focused consent procedures.

Patients may feel that disclosures are explained as betrayal when limits are explicated at intake and reviewed when risk becomes apparent. Clinicians in areas where disclosures are made can apply alliance repair mechanisms, such as clear explanation, empathic framing, and follow-up engagement, to minimize dropout risk. Rupture repair also correlates with better outcomes and can be used to manage clinical risks in situations of unavoidable disclosure (Eubanks et al., 2018).

5.6.5. Write down the decision-making process very well.

The justification of the risk, legal justification, the procedure of consultation, what was revealed, and to which person and how the patient was informed (or not) should be documented. Documentation

protects patients, clinicians, and institutions, and addresses quality and data governance criteria (MOH, 2016; SDAIA, 2022; 2023).

On the whole, the Saudi regulation environment, Sharia, and clinical evidence overlap in a congruent model: confidentiality is the norm; disclosure is an exception, that are controlled by law, necessity, and clinical proportionality. A special worth of an interrelated Sharia-law-clinical framework is that it provides not only moral legitimacy but also operational transparency so that psychologists can maintain dignity and relationship, as well as play legal roles in protection.

6. AN INTEGRATED DECISION FRAMEWORK: "PROPORTIONAL DISCLOSURE" IN SAUDI CLINICAL PSYCHOLOGY

This section will propose a working framework for clinicians to apply in practice. The goal is to reconcile:

1. clinical evidence (alliance and disclosure dynamics),
2. Saudi legal compliance (requirement of duties), and
3. Sharia morality (confidence, honor, injury avoidance).

6.1 The proportional disclosure principle

Proportional disclosure implies: only justified; only necessary; only to people who need to know; the least damaging method possible; and documentation and transparency.

There are three normative roots of this principle:

1. clinical proportionality (prevent needless disengagement and discouragement),
2. legal minimalism (scope-restricted compliance), and
3. Sharia requires and prevents harm (do not subject to unnecessary exposure).

6.2 The 9-step pathway (practical workflow)

Step 1: Clarify the trigger.

Is it a danger of injury, abuse reporting, computer court request, insurance liaison, family request, or inter-professional correspondence?

Step 2: Determine the governing basis.

1. Patient consent?
2. Mandatory reporting rule?
3. Serious risk is imminent, of a nature that demands protection?
4. Order of court/competent authority?

Step 3: Evaluate harm (clinical risk) immediacy and severity.

Normal risk assessment instruments and clinical judgment. Where there are imminent risks, then safety takes precedence.

Step 4: Consider the Sharia-compliant harm balance.

Question: What are the disadvantages of disclosure and nondisclosure? What is the greater and more probable? Does necessity apply?

Step 5: Try the least invasive protection.

Examples: safety planning, more sessions, involving the emergency services with the patient when able, voluntary referral, supervised disclosure.

Step 6: Learn what is required to meet the minimum.

In cases where disclosure is needed, limit content: do not include any full-session stories if a short statement of risk is adequate.

Step 7: Select the right recipient and channel.

Protective authorities, emergency services, specific protective unit, or institutional legal office--neither informal sharing with friends nor with off-duty personnel.

Step 8: Have open communication with the patient (when appropriate).

In every instance that is possible, inform the patient of what will be disclosed, the reason, to whom, and what will be done to safeguard them. This is supportive of repairing alliances.

Step 9: Write it all down in writing.

Record: risk facts, legal basis, alternatives considered, proportionality decisions, recipient of information and communication with the patient.

6.3 Alliance-sensitive communication: preventing rupture before it happens

Since the term unexpected disclosure is particularly harmful, alliance-sensitive practice entails:

1. discussion of constraints of confidentiality early,
2. Revisiting these limits once there is a risk increase, and
3. The disclosure is not a form of betrayal but role-consistent care when, by law/ethics, it is professionally necessary.

6.4 Supervision and institutional governance

The high-risk disclosure should be supported by:

1. case consultation pathways,

2. on-call supervisory assistance, and
3. fit-off-the-shelf documentation templates.

This is a quality issue, but also a clinician protection issue. Formal consultation will minimize errors and ensure that disclosure decisions are not hasty, biased, or extravagant.

7. DATA GOVERNANCE, DIGITAL THERAPY, AND SAUDI PERSONAL DATA PROTECTION

Nowadays, the concept of confidentiality cannot be discussed out of the context of data governance. Confidentiality may still be breached by weak access controls, insecure messaging, shared accounts, or the exposure of vendor data, even when clinicians act ethically.

7.1 Mental health data as "high sensitivity" information

Mental health records are associated with high amounts of stigma and possible social implications. Thus, administrative and technical measures must be implemented to ensure confidentiality as the default setting: least-privilege access, audit trails, secure storage, and hard policies against copying, forwarding, and informal messages.

7.2 The Saudi personal data protection environment

Saudi Arabia has a clear personal data protection system, managed by the Saudi Data & AI Authority, comprising legislative regulations and enforcement tools. As a clinician, the significant implications of compliance are:

1. providing a legally identifiable legal basis to process (in most cases, consent and healthcare necessity),
2. regulating access and distribution,
3. using purpose limitation and data minimization,
4. keeping data as little as needed, and
5. installing the process of breach response.

7.3 Tele-mental health and platform risk

Tele-therapy may lead to a risk to confidentiality by:

1. security vulnerabilities of the platforms,
2. recording by participants,
3. third-party cloud storage,
4. sharing of devices at home, and
5. unintentional exposure by notification.

The clinical safety measures must encompass:

1. selection of a platform based on security provisions,
2. home privacy education to patients,
3. no-session-recording (except where specifically justified and agreed), and
4. protected means of delivery of worksheets or notes.

7.4 Ethical continuity: data protection as an extension of amānah

From a Sharia-ethical perspective, amānah is a continuation of modern data governance: the entrusted information must not be revealed through negligence. Therefore, the disclosure of confidentiality through weak systems cannot be called technical accidents; these are ethically significant failures that must carry institutional responsibility and a remedial response.

8. RECOMMENDATIONS FOR SAUDI PRACTICE, TRAINING, AND POLICY

8.1 Clinical practice recommendations

1. Turn the confidentiality explanation intervention into a structured one (short, clear, repeated, and culturally sensitive).
2. Language: apply the tiered confidentiality language: what will remain confidential, what can be shared with the care team, and what may raise the potential for mandatory disclosure.
3. Embrace proportional disclosure documentation forms: decision rationale, legal underpinning, minimum content, recipient, and communication with the patient.
4. Prepare an alliance repair in the event of disclosure: spelling out the effects, confirming the validity of the patient's feelings, and redefining protective intent and limits.

8.2 Training and supervision

1. Develop Saudi legal trigger training (abuse reporting, child protection, lawful requests) and skills in clinical rupture/repair training.
2. Develop supervision measures on high-risk disclosures (fast-track consultation procedures, second opinion on dubious matters).

8.3 Institutional policy recommendations

1. Mental health record role-based access controls, audit reviews.
2. Ethical guidelines regarding WhatsApp/informal communication of patient information.
3. Response paths for a suspected privacy breach.
4. Coordination procedures with protective authorities that reduce over-disclosure.

8.4 Research agenda using existing data

Future research may build on without gathering

new data:

1. aggregated institutional incident and complaint reports (de-identified),
2. national help-seeking surveys and datasets of stigma,
3. access logs and breach incident data of the hospital audit, and
4. systematic review update with Middle East/Saudi context.

9. CONCLUSION

Clinical necessity and moral trust. Therapeutic confidentiality is a moral trust and a clinical necessity. The Sharia values of dignity and secrecy reinforce confidentiality in Saudi Arabia, but within strict limits: not to cause serious harm and to obey protective laws. The clinical fact that perceived disclosure risk decreases help seeking, disclosure, and the strength of an alliance is supported by empirical evidence; hence, controlling the communication of confidentiality and proportionality is the key to successful therapy.

This paper proposes a secondary-data, integrative framework: confidentiality as the default; disclosure as the exception; and proportional disclosure as a means of operational differentiation among Sharia ethics, Saudi law, and clinical effectiveness. By having well-organized consent communication, having well-defined reporting channels, having the minimum disclosure requirements, and a solid documentation process, Saudi clinical psychology will be able to preserve patient dignity, as well as the safety of the population, while enhancing the confidence of mental health users in the face of the rapid national digitalization.

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