

Stigma, Mental Health and the Culture of Help-Seeking Behavior Among Married Male Teachers in Pakistan



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Abstract: *Men's mental well-being continues to be a neglected issue in Pakistan due to the culturally imposed norms of behavior and expectations of masculinity that do not encourage emotional expression and help-seeking. Married male teachers face unique challenges dealing with professional issues while maintaining traditional gender norms. Thus, the present qualitative study is designed to investigate how married male teachers in Pakistan perceive masculinity and emotional suppression and its impact on mental well-being. Twenty married male teachers aged between 25 and 35 years from different educational institutions in Pakistan have been interviewed using the semi-structured interview technique. Thematic analysis in accordance with the methodology suggested by Braun & Clarke (2006) has been employed for data analysis. The analysis has revealed two main themes: "(1) 'Strength' as a Performance" where participants discussed the way in which masculinity was viewed as performing control over emotions despite experiencing deep emotional pain inside; and (2) "Consequences of Silence" where participants theorized about psychological and physical consequences of emotional suppression.*

Keywords: Masculinity, Emotional Suppression, Men's Mental Health, Married Male Teachers

Introduction

Background of the Study

Millions of people worldwide suffer from mental health disorders, and men are less likely to see professionals for their issues despite being more suicidal than women (Sweeney et al., 2024). As defined by the World Health Organization (2022), mental health is a state that "enables [a] person to realize his or her own abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to his or her community" (cited in Camacho-Ruiz et al., 2026, p. 2). Although the definition is universal, there are notable discrepancies in accessing mental health services between different groups of individuals, including males (Camacho-Ruiz et al., 2026; Gough & Novikova, 2020).

There is a paradox when it comes to male mental health, which can be quite alarming. Despite the fact that the possibility for men to suffer from psychological disorders is much greater than that of women, there are fewer diagnosed cases of psychological illnesses, such as depression or anxiety disorders, among men (Camacho-Ruiz et al., 2026). However, in contrast to what many people think, this paradox is not explained by the fact that men suffer from fewer psychological disorders than women. In fact, this paradox is due to the differences in how the psychological distress is manifested in men and women (Camacho-Ruiz et al., 2026). Namely, the external manifestation of psychological distress in the form of aggression, alcohol and drugs, and risky behaviors are more prevalent among men.

The impact of mental illnesses left untreated in men is extremely grave. Men are three to four times more prone to committing suicide than women worldwide (Gough & Novikova, 2020). This is referred to as a "silent epidemic" (Sweeney et al., 2024). Although the probability of suicide among men is higher, they are significantly less willing to seek professional help in comparison with women. This is explained by various

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masculine gender roles, societal norms of emotional repression and stigma associated with the revelation of one's mental well-being (Sweeney et al., 2024). Such a condition is known as "the gender paradox in suicide." This concept is rooted in the reluctance of males to disclose emotional pain and receive psychological treatment (Gough & Novikova, 2020). In addition to it, men employ maladaptive coping mechanisms that consist of substance abuse, which results in an increased vulnerability to alcohol abuse disorders (Bilsker et al., 2018). Therefore, male mental health has become a highly overlooked field in modern public health discussions.

Inadequate treatment of mental health is even more pronounced in developing countries. The nation of focus in the research, Pakistan, is facing an acute issue in terms of mental health, with approximately 90 percent of those suffering from common mental disorders not receiving any form of treatment (Latif et al., 2025). Essentially, there is only one person out of ten who suffers from anxiety, depression, and other common mental disorders who receives basic mental health care in Pakistan. The case is worse for men due to cultural reasons (Latif et al., 2025).

The Pakistani Cultural Context

Pakistan, a South Asian nation where the population exceeds 240 million, faces some difficulties when it comes to mental awareness and access to mental health services. According to WHO, one of the nations with a large number of patients with mental disorders is Pakistan, but at the same time, there is only a small number of psychiatrists (less than 500), which means that there is only one psychiatrist for 500,000 people (equal to 0.2 psychiatrists per 100,000 population). Nevertheless, although the availability of such services is crucial, few Pakistanis with depression and anxiety disorders visit any specialists due to some reasons. Researchers state that there are numerous obstacles to mental health services in collectivist Islamic societies (e.g., Pakistan) (Elshamy et al., 2023).

As the fifth largest population of the world with more than 240 million people, Pakistan represents characteristics of extremely patriarchal, collectivist, and Muslim majority society (WHO, 2022). The gender hierarchy of Pakistani society includes male superiority and dominance in terms of power and authority as opposed to subordinate women (De Visser et al., 2022). Although the modernization and greater participation of women in work progressively modify these roles, particularly in large urban centers like Karachi, Lahore, and Islamabad, the impact of traditions remains significant (Latif et al., 2025).

The values of hegemonic masculinity in Pakistan include such values as *ghairat* (respect, honor, and diligence in defending the honor), *himmat* (courage and bravery), *izzat* (reputation and honor of the family), and *sabar* (courage and endurance) (Khan, 2019). The concept of "a real man" (*mard*) implies that a man should be the breadwinner of the family, the protector of his female relatives, emotional but non-expressive, tough, physically strong, and independent. Weakness, vulnerability, and dependence are undesirable traits of men even in seeking help from mental health professionals (Latif et al., 2025; Khan et al., 2023).

In fact, asking for help with psychological issues is directly against the core values of masculinity. Being diagnosed with depression, anxiety or any other kind of mental disorder is perceived as a failure and weakness of personality, which means that men cannot provide for themselves and cannot take care of themselves (De Visser et al., 2022). Mental health stigma in Pakistan involves not only a patient but his/her entire family, because the diagnosis affects the *izzat* of the family, making marriage of siblings or offspring impossible due to the social stigma (Latif et al., 2025; Khan et al., 2023). In other words, in order to save one's family from shame and stigma, it ignores the mental disorder of one of its members and encourages alternative ineffective methods of treatment.

However, the rate of mental health literacy in Pakistan is very low. In fact, many people, even educated and professionals in urban areas, hold a misconception about the source and nature of the problem (Latif et al., 2025; Youssef et al., 2014). The most frequent mental illnesses such as anxiety and depression are attributed to spiritual reasons like being possessed by jinns, suffering from evil eye, black magic, or having a

bad relationship with God (Mubbashar, 2003). As a result, when facing mental problems, people prefer to turn to a religious person like a pir, imam, or someone else rather than visiting a psychiatrist or psychologist (Mushtaq et al., 2024; Mubbashar, 2003). Even though the spiritual treatment might bring satisfaction to individuals, it does not solve the actual problem.

The Unique Position of Married Male Teachers in Pakistan

The teaching job in Pakistan has become very stressful. Teachers have to deal with overcrowded classes (usually with 50-60 pupils in one class), lack of appropriate teaching aids and facilities, poor salaries that are paid irregularly, long working hours, and pressure from parents, school authorities, and government officials (Mushtaq et al., 2024). There are high levels of teacher burnout associated with emotional exhaustion, depersonalization, and lowered personal achievement in Pakistan, but it does not get proper attention (Carroll et al., 2022). Unattended mental issues of teachers have serious implications not only for teachers but also for their pupils who get poor quality education.

Teachers in Pakistan are under a lot of pressure regarding gender roles. Teaching is considered a “feminine” profession, where one has to care for people emotionally (Jugovic, 2022). On the other hand, male teachers might find themselves feeling like they should prove their masculinity by focusing on such qualities as being authoritative and self-controlled to ensure that they do not seem too feminine or are questioned about their intentions when working with children. It can be hard for male teachers to fulfill two contradictory roles at the same time and have specific risks to their psychological health.

Furthermore, getting married gives additional responsibilities to the male teacher. In Pakistani society, marriage means taking on a role of provider, protector, and patriarch that includes, but is not limited to, being psychologically balanced and financially stable. Not taking up that role and having psychological issues in general can be considered shameful both on personal and on familial levels. As a result, the married male teacher will have less incentive to turn to psychologists since his inability to take care of the family could be interpreted in this manner (Naz et al., 2020; Qureshi et al., 2016). Nevertheless, being married and having family members, especially wives, could be helpful in identifying psychological issues and getting professional help (Gough & Novikova, 2020).

Teachers hold a special position because they are part of the community and at the same time models for others. Teachers are respected members of society in Pakistan, and their behaviors and attitudes could have an impact on students, parents, and other members of the community (Jugovic, 2022). Married male teachers who are afraid to seek professional help because of the stigma and their masculinity may inadvertently encourage adherence to cultural norms that make it difficult for males to seek help. However, if it is possible to involve married male teachers into mental health treatment and empower them to speak about their experience, they could become great masculinity capital role models for the whole community (Gough & Novikova, 2020; Wilson et al., 2022).

The issue of married male teachers has not received sufficient attention in the mental health literature. The majority of research done on male mental health issues in Pakistan was carried out among university students (De Visser et al., 2022; Mufti & Mirza, 2025) or the general community (Latif et al., 2025). The problem of teachers and, especially of married male teachers has not been discussed at all. It is very important since teachers comprise a big occupational group that can use workplace interventions in mental health.

Theoretical Framework

Hegemonic Masculinity Theory

The current paper is based on the hegemonic masculinity theory developed by Connell (1995), which defines the culturally idealized image of masculinity that validates the patriarchal system of domination over women and non-hegemonic men. The traits of hegemonic masculinity include the following: emotional control (repression of “feminine” emotions such as fear, sadness, and vulnerability), independence (problem-solving

without any help from other people), toughness (mental and physical strength), competition, heterosexuality, and rejection of everything considered feminine (Camacho-Ruiz et al., 2026).

According to Connell (1995), hegemonic masculinity does not have to be the most widespread type of masculinity in any particular society, but it is always the one that is considered the most culturally ideal and desirable model of being a man that all other types of masculinity should live up to. Individual males are incentivized by society—its families, friends, media, education system, workplace, among others—to adhere to hegemonic masculinity. Behaviors associated with health are the key areas of expression and formation of masculinity by men (Camacho-Ruiz et al., 2026). The norms of hegemonic masculinity clearly prohibit such health behaviors as balanced dieting, having enough sleep, doing medical check-ups, and most importantly, asking for help with health problems, as all of those actions are seen as feminine or weak (Camacho-Ruiz et al., 2026; De Visser et al., 2022). Asking for help in case of experiencing psychological problems is particularly troublesome within the context of hegemonic masculinity, as it means admitting vulnerability, feeling emotional pain, losing control over oneself—that is contradictory to the traditional perception of a strong and self-reliant protector and provider (Camacho-Ruiz et al., 2026; Gough & Novikova, 2020).

In Pakistan, hegemonic masculinity is practiced by means of culture-specific constructs like *ghairat* (dignity and vigilance to safeguard it), *himmat* (courage and endurance), *izzat* (reputation and family honor), and the breadwinner/protector role played by *kamaane wala* and *muhafiz* (Latif et al., 2025). Seeking help for mental health concerns is in direct violation of these constructs since it indicates vulnerability, lack of strength, dependence, and inability to take care of oneself.

The use of the hegemonic masculinity theory has been well documented in the literature on men's mental health. According to Camacho-Ruiz et al. (2026), hegemonic masculinity norms create stigma related to help-seeking, restrict mental health literacy of men, and cause self-stigmatization. In their study conducted among several countries in Europe, Gough and Novikova (2020) identified traditional masculinity norms, emotional repression, self-reliance, and being strong as the most prevalent barriers to help-seeking.

Stigma Theory

The study is also guided by the stigma theory by Goffman (1963) whose theory describes stigma as an attribute that is "deeply discrediting, such that it reduces the bearer from a whole and usual person to a tainted, discounted one" (p. 3). Three types of stigmas exist according to Goffman namely: abominations of the body, blemishes of individual character (mental illness), and tribal stigma (p. 4).

In order to fully grasp the wide-ranging impacts of stigma, there have been several stigmas defined. The various forms of stigmas as per Corrigan and Bink (2016) are public stigma, self-stigma, label avoidance, and structural stigma (p. 231). Label avoidance occurs when a person experiences stigma due to his/her associations with programs regarding mental health treatment services. In such a case, the person tries to avoid the labeling by avoiding any assistance. Structural stigma is stigma due to organizational practices against individuals suffering from mental illnesses.

The evidence shows that the higher the levels of both public stigma and self-stigma, the less likely it is for men to seek professional assistance, especially those men who adhere strongly to male stereotypes (Maeshima & Parent, 2022). The extensive literature from different academic disciplines proves that conventional masculine roles play an extremely important role in determining men's behavior concerning their health issues, especially seeking help with mental health disorders (Camacho-Ruiz et al., 2026; Gough & Novikova, 2020).

Research Questions

This study was guided by the following research questions:

1. How do married male teachers in Pakistan see the connection between masculinity and emotion?
2. What techniques do married male teachers use to cope with their emotions?

3. What are the psychological and physical effects of the long-term repression of emotions by married male teachers in Pakistan?

Methodology

Research Design

This study utilized a qualitative design that involved exploring the lived experience of married male teachers in Pakistan in relation to masculinity, emotional suppression, and mental health issues. The choice of a phenomenological design is justified by the fact that this approach involves studying the "lived experience" of a particular phenomenon through which the researcher can develop detailed descriptions of how the participants make sense of the world around them (Neubauer et al., 2019; Smith et al., 2021). This type of design is best suited for examining complex and little-explored phenomena of social nature as it emphasizes the role of subjective meanings and interpretation of the phenomena in question.

This research used a cross-sectional approach in a qualitative design, which means that the data was collected from the participants at one particular point in time as opposed to conducting long-term studies. Such an approach was appropriate in this study as it helped collect the current perspectives of the participants in relation to masculinity, emotional suppression, and mental health issues.

Participants

For this study, 20 male teachers who were married and within the age bracket of 25 to 35 years were selected from different educational institutions of Pakistan using purposeful sampling techniques. The selection of the participants was done using the following inclusion criteria:

1. Married male teachers within the age of 25 to 35 years.
2. Permanent citizen of Pakistan.
3. Ability to participate in discussion on perception towards mental well-being, stigma and help seeking behavior.

Participants not currently undergoing any form of formal counseling or therapy related to family conflicts, and those who lacked the capacity to give informed consent because of cognitive or intellectual incapability were excluded from the study.

Sample size for the study was decided upon qualitative considerations and was driven by the need for attaining data saturation. Data collection for this study was continued until further individual interviews did not yield any new information, codes, or themes about the experiences of the participants. At this level of data saturation, the main themes of this research study emerged after conducting a total of 20 interviews.

Data Collection

The use of an interview guide that was developed internally was done as the major means of ensuring all essential core meanings were captured in a flexible manner. An interview guide helped capture all the necessary information in a flexible but consistent manner. The key areas included the following: cultural perceptions of masculinity and mental well-being, social-professional implications of stigma, and facilitators and barriers to professional help.

The participants were initially informed about the interview through a face-to-face meeting. Before conducting the interview, an agenda for the interview was initially shared with the participants so that they can get mentally prepared to organize their thoughts. After receiving the informed consent of the participants, the interview was recorded. Interviews were either conducted face-to-face or through zoom meetings based on the ease of the participants. The time period for each interview ranged between 30-40 minutes. After reaching a well-informed agreement, the participants were encouraged to speak their minds freely for the protocol of the interview. The participants were given the permission to voice their own thoughts and the researcher just played the role of an initiator. Good interview technique teaches an interviewer to refrain

from voicing his/her opinion at the beginning of the interview to avoid any kind of bias. The major responsibility of an interviewer is just to keep the discussion on track (Bhaila et al., 2025). As Urdu is the native language in Pakistan, the interviews were either held in Urdu or English according to the preference of the participant. The researcher initially asked about the language preference of the participant before conducting the interview. However, all the interviews (20) were conducted in the Urdu and English language. The interviews were translated into English.

Data Analysis

Thematic analysis using the six phases outlined by Braun & Clarke (2006) was conducted on the data set. Thematic analysis was done through the following steps:

- **Phase 1:** Familiarization with the Data: All the interviews were transcribed verbatim. The researcher read and re-read the transcripts a number of times alongside the audio recording to capture the voice and tone of the participants.
- **Phase 2:** Generating Initial Codes: The open coding technique was used to analyze the transcripts. Important phrases, emotions and ideas in the data were coded and labeled.
- **Phase 3:** Searching for Themes: These initial codes were then sorted out into categories and further classified into major themes.
- **Phase 4:** Reviewing Themes: Candidate themes were then verified by checking whether they fit with the individual extracts and with the whole data set.
- **Phase 5:** Defining and Naming Themes: A thematic table was created where each theme is documented alongside the participant quotes that support it.
- **Phase 6:** Producing the Report: The final report was produced using rich descriptions and participant quotes.

In order to make sure that the analysis is based on the real experience of the participants, the use of member checking was employed. Here, the results obtained were fed back to the participants for validation purposes.

Methodological Integrity

In order to make sure that the research is trustworthy, the study took into consideration the criteria of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). A number of strategies have been used throughout the research. In order to make sure that the findings are true and represent the real views of the participants, member checking has been done. The participants checked the summary of their interviews to see whether the interpretations made by the researcher are accurate. An audit trail of all the data and the research process has been created in order to keep the findings transparent. This includes all the raw data and all the field notes and the coding process of the data.

Ethical Considerations

Consent of all the participants was obtained as part of this study. In order to ensure the confidentiality of participants and their anonymity, any identifying details have been stripped from the transcripts. Considering the sensitivity involved in the topic of mental health, ethical concerns remained at the forefront of the entire research process. This entailed obtaining ethical clearance, complete anonymity by using pseudonyms and safekeeping of the data collected. In addition, a referral policy has been put in place in case the interviews provoke any emotional distress amongst the participants (American Psychological Association, 2002).

Results

The analysis revealed two major themes which were (1) "Strength" as Performance and (2) Consequences of Silence. Each of these themes was made up of two sub-themes.

Theme 1: "Strength" as Performance

This theme reflected how the participants perceived masculinity as needing the exhibition of control of emotions despite the presence of deep distress inside them. It was clear from the responses of the participants how they would distinguish between feeling the pain and displaying the pain by expressing deep emotional distress inside themselves without having to express them.

Sub-theme 1a: Solitary Emotional Processing

Silence, retreat, and inner dialogue were among the ways in which participants managed emotional distress. Some participants revealed that this way of handling things has been there in their lives for as long as they can remember and that they never discussed their psychological problems with anyone.

Participant 19 expressed this clearly:

If I talk about myself, I have never expressed my mental stress to anyone. I manage my stress on my own level. Like I express it through silence.

Participant 2 described his attempts to conceal visible signs of distress:

I have tried to hide my emotions from my family; I use glasses to hide my eyes and try to divert my attention to my phone to stop the tears.

Participant 7 explained his preference for handling difficulties alone:

When I am in distress, I do not share it with people, I turn to God or, in the past, I would share it with my father. I prefer to deal with my pain in solitude.

Participant 16 described the internal process that accompanies solitary coping:

He might go to a quiet place to sit in silence and have an internal dialogue, convincing himself to persevere because he believes he alone is responsible for his actions.

Participant 18 reflected on his introverted tendencies:

I have had such experiences. Basically, I am an introvert; I don't talk much. I have experienced emotional stress many times, but I manage it by myself. I don't explain it to anyone or talk about it, not even with my family or wife.

Participant 4 described his approach to stressful situations:

I remove myself from this type of situation. And when I calm down I let it go.

Participant 11 explained his belief that time would resolve his difficulties:

Instead of expressing my feelings, I chose silence because I knew that, with the passage of time, things would normalize. I believe time is the biggest mercy, after some time passes, you automatically recover.

This is evident from the above research results that show that individual emotional handling is not only a choice that people make but is rather an acquired one. It seems to have been inculcated in people since childhood and is further instilled in them throughout their lives such that when asked about it, they could still see its flaws.

Sub-theme 1b: Protecting the Family from One's Own Distress

The common thread among the interviews was that the emotional restraint was seen as an altruistic effort to ensure the emotional stability of their families. They felt that expressing vulnerability would somehow jeopardize the well-being of those that they cared for.

Participant 1 described this protective mechanism during the traumatic loss of his father:

At that moment, I could not cry; I had to remain the pillar for my mother, my sisters, and everyone else. I was controlling everything. Yet, I truly wanted to cry, because for a man, his father is everything. We often hide our emotions to protect those around us, wondering what would happen to others if we were to break down.

Participant 5 elaborated on the perceived consequences of showing weakness:

You feel that if you become weak, all the people who rely on you will also become weak. So, even when I am struggling, I feel that I cannot show it because it might affect those around me.

Participant 10 explained the burden of maintaining emotional stability for the family:

It is not that a man lacks a heart, he certainly feels pain, but he is expected to tolerate things because he is the support system for his family. If a man loses his courage, the family structure may suffer. Because of this, men often express their pain only in solitude. If a man expresses his emotions in front of his family, it may only increase their distress, so he often keeps his worries inside.

Participant 17 described the demotivating effect of showing weakness to family members:

Family-related issues should not be expressed in front of others; you should keep them to yourself. You can discuss problems outside the home with your family, and you can share workplace problems, but not home issues. If you share family issues, the family loses their courage and hope because they have their own dreams to fulfill. If the responsible person shows weakness, the family will be demotivated.

Participant 14 described the pressure of fulfilling demands regardless of emotional cost:

I once told my wife that our country's economic indicators are poor and our financial health is struggling, so we need to reduce our household expenses. Her response to me was, 'That is not an option; you should sell your kidneys instead.' That is the reality of the response in my house. In these situations, a man feels pushed to the absolute limit to fulfill demands, regardless of the emotional cost.

Participant 2 expressed regret about consistently prioritizing others over himself:

I always ignored myself and gave more time to others. Now I feel I was a fool; I favoured others beyond my limits and should have been a little more selfish. I regret that, but the time has passed, so there is no point in regretting it now.

Participant 5 reflected on the societal conditioning that enforces this pattern:

First, I was taught that I need to be strong, and I have always felt that necessity. Sometimes, the social setup you are a part of forces you to suppress your emotions.

Participant 6 summarized the prevailing societal expectation:

In our society, men operate under the theory that 'men don't cry' or 'men don't feel pain'.

Theme 2: Consequences of Silence

This theme showed participants theorizing psychological and physical effects of emotional suppression over time. Participants were aware that silence has heavy costs.

Sub-theme 2a: Somatic Consequences

Participant 12 described the physical cost most directly:

A person who stays trapped in that situation actively shortens his lifespan. Suppressing emotions can trigger major physical diseases that destroy his body structure, physical health, and mental health entirely.

Participant 5 explained the mind-body connection:

If you keep suppressing those emotions, your physical health begins to suffer. Your brain sends negative signals to your body, and you develop physical ailments. Based on my reading, the digestive system, in particular, is often disturbed by this negativity, and many diseases are linked to mental health instability.

Participant 6 described specific physical outcomes:

If he keeps ignoring his emotions, his physical health begins to suffer. In many ways. For example, he might get a heart attack or some other diseases.

Participant 11 explained the physical manifestation:

One is that a man absorbs his circumstances, and he might break inside, which could manifest as a physical condition like a heart attack.

Participant 14 described the statistical reality:

The statistics show a very high ratio of male suicides. Similarly, men experience a significantly higher rate of heart attacks. These outcomes happen because when you suppress emotions, they inevitably show up in your behavior. It aligns with the law of cause and effect, every action has an equal and opposite reaction. If you suppress your feelings, they are bound to force their way out through negative behavioral reactions.

Participant 15 described the deterioration:

Either their physical health deteriorates and they suffer from internal medical problems.

Participant 17 explained the progression:

When mental health is disturbed, physical health is definitely affected.

Participant 20 described the overall impact:

He becomes sick and can not do any properly like he will behave in certain ways in which he does not have to be.

Sub-theme 2b: Psychological and Relational Consequences

Participant 1 described the behavioral outcomes:

Ultimately, it leads to severe stress and anxiety. He may become completely withdrawn, or, conversely, he might begin to act out, which leads others to label him as 'mad' or 'crazy.'

Participant 3 described the eventual outburst:

He will not be okay. Until you share something, there will eventually be an outburst at a place that is very important to you whether in your family life, job, or social sector. It can result in an outburst toward anyone, which serves as a clear indication that your relationships will be disrupted, leading to even more pressure on you in the long run.

Participant 14 described the relationship consequences:

A man who is continuously ignored and suppresses his emotional pain often drifts toward extra-marital affairs or heads toward divorce. There are many divorce cases that stem directly from this pattern. Alternatively, many men remain trapped in an unhappy life cycle because they feel forced to carry out their family responsibilities indefinitely.

Participant 15 described the volatility:

They become highly volatile, start shouting at others over minor mistakes where there was no real issue, and verbally hurt the people around them.

Participant 19 described the loneliness:

His personality becomes a victim of loneliness. He begins to like being alone.

Participant 16 described the loss of self:

He lost himself. No other factor affects a person as much as emotional attachment. Men have very few options to share these feelings they cannot share with parents, family, or relatives.

Participant 9 described the progression to stress:

If a man refuses to express himself, that suppressed emotion will eventually lead to stress.

Participant 18 described the impact on work and relationships:

I think it affects their work, their profession, and their relationships.

Participant 2 described the severity:

Generally, personality stability is lost, which leads to shocking events that we see in the media. We only realize someone is mentally ill when these extreme events occur, at which point they should have been in rehabilitation instead of roaming free.

Discussion

Interpretation of Findings

It can be seen from the findings of this study that married male teachers in Pakistan are faced with a contradictory reality of living emotional experiences on one hand and cultural expectations of emotional repression on the other.

The first theme, "Strength" as Performance, shows that masculinity is performed through self-control and not lack of emotionality. This finding is supported by the work of Mubashir and Salahuddin (2025) where it was found that cultural norms of masculinity in Pakistan do not allow men to go for any professional help. Likewise, hegemonic masculinity and cultural scripts like *ghairat* (honor), *himmat* (courage), *sabar* (patience/ endurance) have been cited as help-seeking barriers by Latif et al. (2025).

The suppression of emotions described by the participants was portrayed as an altruistic deed in that they were protecting their family's morale. This observation concurs with the findings of Shah et al. (2026), who found out that switching off emotions is perceived as a form of masculinized emotion work connected to the local values of *sabar* (endurance) and *izzat* (honour). The common use of the metaphor of the pillar or support system in the interviews implies that the emotional suppression is not portrayed as a deficiency but as a necessity for a masculine man.

The second theme of this study is Consequences of Silence, which revealed that the participants theorize the physical and psychological consequences of silence. This finding corroborates the findings of Segerstrom and Miller (2004), who found out that there exists a link between emotional suppression and chronic stress and a number of physical illnesses through the neuroendocrine and immune pathways. The emotional suppression in Pakistani men, according to Latif et al. (2025), leads to physical illness associated with stress.

The psychological effects mentioned by participants, such as withdrawing, depression, and broken relationships, are consistent with the findings made by Mubashir and Salahuddin (2025) that masculinity reduces social connectedness and the necessity to create emotionally supportive relationships among men, having negative implications for their psychological well-being. Participants' view on breaking up of relationships due to emotional suppression is consistent with the study conducted by Khan et al. (2023) on mental health stigma in Pakistan at the individual, family, community, and structural levels where *izzat* is more significant than individual psychological well-being.

Theoretical Implications

This study empirically validates the theory of hegemonic masculinity within the Pakistani culture. The results obtained illustrate how cultural ideals of masculinity, based on strength, emotional control, stoicism, and self-reliance influence men's psychological distress and their responses to it. Internal contradiction felt by the participants between suffering from emotional pain and suppression of it in order to preserve their masculine identity is an indication of how hegemonic masculinity functions as a regulative framework in gender relations and personal behavior (Connell, 1995).

The research conducted by Latif et al. (2025) has demonstrated that hegemonic masculinity and cultural scripts (*ghairat* - honor; *himmat* – courage; *sabar* - patience and endurance; and the role of the man as a provider and protector) view help seeking behavior as weakness and shame. The current study broadens the framework provided by Latif et al. and illustrates how hegemonic masculinity works among the group of married male teachers.

Practical Implications

There are important implications of these results on mental health policy, service delivery, and intervention in Pakistan.

For Mental Health Policy

1. National campaigns to raise awareness about mental health amongst men, changing the stigma attached to seeking help from mental health professionals.
2. Integrating mental health services within primary health care.
3. Subsidized mental health services using national health insurance schemes.

For Mental Health Service Provision

1. Gender sensitive services that meet the unique requirements of men.
2. Religion and family-based interventions that use culturally accepted methods of treatment.
3. Training more mental health practitioners who are male.

For Workplace Interventions

1. Teacher welfare initiatives that include access to counseling.
2. Promoting discussion of mental health at schools.
3. Peer support for teachers.

Limitations and Future Research

Limitations

1. Since the study included only married male teachers in Pakistan, it could be argued that the findings would have been applicable only to other such groups of Pakistanis or people from other cultures as well. It is also important to note that all subjects who were part of this study had at least completed their master's education, which may have had some impact on their understanding of the issue of mental health.
2. Interviews used in this study to collect the data could be subjected to social desirability bias, as the questions in interviews were not structured in advance. In addition, the analysis included only the data collected by interviews, i.e., it included no objective data about mental health status of the participants or their behaviors.
3. It should be noted that the findings are specific to Pakistani culture.

Future Research

Given the results and shortcomings of this study, the following directions for future research are recommended:

1. Investigate the mental health experiences of selected subgroups of Pakistani men, such as less-educated men, rural Pakistani men, men in different occupations, and men from diverse ethnic backgrounds.
2. Evaluate the efficacy of culturally-sensitive interventions for the mental health of Pakistani men.
3. Use a combination of quantitative and qualitative methods that include the use of psychometric and behavioral tests.

Conclusion

The present study finds that married male teachers in Pakistan suffer from severe psychological distress and encounter strong cultural barriers to accessing services. Participants find themselves caught up in the tension between the realities of their own emotions and the cultural norm of masculine emotion suppression, leading to behaviors that have major psychological, physical, and social repercussions. The results suggest an imperative need for multiple interventions at various levels in order to address this issue effectively. The key to enhancing mental health outcomes for married male teachers in Pakistan lies in the realization that emotional health is not a privilege but a basic human need.

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