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The Silent Struggle: A Scoping Review of Men's Mental Health and Help-Seeking Barriers in Urban Pakistan

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Abstract
Mental health in low and middle-income countries is a severe public health problem wherein men reveal severe unmet need and a significant treatment gap. This scoping review is a systematized review and synthesis of a bedrock of literature on what stops adult men in urban Pakistan (a population facing the interplay of strict masculine ideals and urban-stressful environments) to seek mental health. As part of the Joanna Briggs Institute (JBI) approach, a search of key academic databases, grey literature was conducted. Twenty-one researches were included and subjected to critical review. The results indicate a multi-layered ecosystem of barriers, which is synthesized into five overarching themes, including: (1) the hegemony of cultural masculinity ideals (ghairat,

stoicism) that view help-seeking as sign of weak character; (2) overwhelming stigma and shame that endangers familial honour (izzat); (3) severe systemic and structural inadequacies in the mental healthcare infrastructure; (4) a critical lack of mental health literacy leading to somatic presentation and spiritual explanations of distress; and (5) economic precourty that der These obstacles are not discrete but are held together in the finest details which constitutes a perfect storm to normalize silent suffering. It is the conclusion of the review that the low help-seeking behavior is the rational reaction to the socio-cultural and economical environments that formally disables and discourages it. A multi-sectoral policy response with a sense of urgency is needed to take these barriers down, such as the integration of mental health into primary care and destigmatization campaigns, as well as economic incentives to be created to receive care. The review is a starting point evidence that researchers, clinicians and policymakers can use in developing culturally competent approaches to deal with this silent crisis.
Keywords: *Men's Mental Health, Help-Seeking Barriers, Urban Pakistan, Masculinity, Stigma, Mental Health Services, Scoping Review.*

Introduction

Mental health in men is an under-recognized and deeply rooted public health issue around the world, one typified by a disturbing mismatch: high levels of psychological distress on the one hand and deeply low help-seeking tendencies on the other. Men have three to four times higher death rates due to suicide than women in high-income countries, a trend that is also being replicated in large numbers of low- and middle-income countries (World Health Organization, 2021). This difference does not suggest that there are lower rates of prevalence but of a disastrous failure of identification, expression and management of mental illness. Men have lower rates of disclosure of common mental disorders, such as depression and anxiety, but are over-represented in substance use disorders and externalizing behaviors, which can be used as a maladaptive coping style (Seidler et al., 2021). This is what some people have called the silent crisis since suffering is instigated to be internalized, even normal or hidden as a result of the prevalent expectations in the society, which depict masculinity as a phenomenon of stoicism, lack of emotions, and invulnerability. Help-seeking behavior when a man is experiencing psychological upset is, in this strict scheme, often confused with the pitifulness of character or disloyalty to manhood, which constitutes a rather difficult obstacle on the way of early prevention and treatment (Robertson et al., 2022). Effectively, unmanaged mental illnesses among men are leading to a high burden of disease, not just at individual levels but also in the stability of families, economic prosperity and the overall health of the society.

The extreme severity of this global crisis has taken particular form in the context of the unique socio-economic crucible of urban Pakistan, a country faced with the complicated interaction between the pervasive demographic transition and deep resource scarcity. Pakistan has a population of 227.8 million, which makes it the fifth most populous nation in the world, with more than 40 percent living in urban areas, notably densely populated areas that include Karachi, Lahore, and Faisalabad, which are set to increase tremendously in the next few decades (United Nations Population Fund, 2022). This rampant urbanization has surpassed infrastructure creation such that there is a high competition of the limited resources, as well as high levels of unemployment, and informal settlements with extreme poverty and overcrowding levels. The ensuing

environment creates a sequence of chronic stressors, e.g., economic insecurity, job insecurity, environmental pollution, and a general threat of violence, which have a net psychological resilience-eroding effect (Khalid & Qadir, 2020). The formal mental healthcare system is woefully underprepared to respond to this exploding demand, and there are only 0.5 psychiatrists per 100,000 people with most concentrated in major cities and, nonetheless, inaccessible to most because of financial and systemic obstacles (WHO, 2020). This presents an ideal storm because the need of mental health support is increasing exponentially, and yet the system is in critically limited capacity to provide such support, so people have to turn to their own, largely ineffective informal coping strategies.

It is in this context that the interplay of highly embedded cultural norms and the ready-made gender identities turns out to be the point of convergence against the backdrop of which the mental health epidemic in the Pakistani men has to be deciphered. The ideals of ghairat (honor, dignity and vigilance), himmat (courage), and the breadwinner (kamaane wala) and protector liabilities are strong in Pakistan and form the ideal concept of masculinity in the country (Chaudhary, 2021). This male status quo glorifies suppression of emotions, self-sufficiency, and show of strength in the society, and at the same time, it demonizes displays of weakness, i.e., psychological pain and help-seeking as weakness and a risk to familial izzat (honor) (Saeed et al., 2023). As a result, the mental distress is often somatized, reflecting in such physical symptoms as headaches or fatigue, or covered in the form of aggression and substance use, which are more acceptable options due to the culture of male gender roles (Husain et al., 2020). Conflict between inner suffering and outer expectation, leads to a debilitating inner contradiction that keeps men quiet in their own shell. Although a small, but growing literature on the qualitative studies and small-scale research has started to shed some light on these processes, this area is still characterized by the lack of comprehensive synthesis that would provide a map of the extent and character of these barriers. Thus, the current scoping review is highly necessary to promote existing knowledge and establish thematic areas of help-seeking barriers in addition to identifying critical gaps, which are likely to inform the enactment of culturally meaningful and gender-sensitive mental health interventions and policies in targeting such a vulnerable yet underserved population.

Literature Review

In order to understand this scoping review in a very clear manner, it will be necessary to conceptualize its principal tenets first. The phenomenon of mental health, which is much more than the absence of illness, can be described as a state of well-being in which an individual has achieved their full potential and is able to simultaneously manage usual stressors in life, engage in work, and provide positive contributions to community or others (World Health Organization, 2022). In the context of the present research, we should concentrate on the obstacles to reaching this state. The process of seeking external assistance to treat mental health issues includes many steps in which individuals engage in an effort to receive external support and is an experience full of complex decision making (Rickwood & Thomas, 2023). The behavior can be classified as formal (it involves trained professionals such as psychiatrists, psychologists or clinical social workers in institution settings) and informal that involves seeking help to family and friends, religious leaders or traditional healers. The route to aid-seeking is rarely straight-forward and it is often hindered by obstacles which are anything that makes an

individual less willing to contact or continue contact with suitable support systems. Such barriers do not exist as a monolith; instead, they exist as a social-ecological continuum, spanning intrapersonal (e.g., knowledge, attitudes), interpersonal (e.g., stigma, social norms), and structural (e.g., cost, availability of services), and are heavily affected in their nature and strength by cultural background (Gulliver et al., 2023).

In the South Asian region, the mental health of men is becoming a rather serious topic, but it still exists under a delicate web of universality and uniqueness in cultural pressure. There is also an emerging literature pointing to the fact that the patriarchal systems in other countries such as India, Bangladesh, Nepal, etc., establishes a rather strict hegemony of masculinity that is assumed to be stoic, unemotional, and one that must constantly provide economically as it is an undisputed male determinant (Dutta & Sircar, 2023). The cultural script goes against the softness of being vulnerable in experiencing and admitting psychological distress. Indian studies indicate that men often somatize mental health disorders because they complain about their physical well-being to physicians instead of reporting emotional distress, a culturally-acceptable loophole against the stigma of a psychiatric diagnosis (Kohrt et al., 2020). In Bangladesh, researchers have attributed economic recession and unemployment to increased levels of depression and anxiety among men, with cases of depression and anxiety seriously underreported because of the amount of shame that accompanies their failure to meet the ideal of a breadwinner (Hossain & Ahmed, 2022). Although such regional trends may point towards a shared background in patriarchal values, it is imperative to avoid homogenization; the particular phenomena of these patriarchal values and the particular political and religious history of each country, Pakistan included, form a differentized landscape of male psychological trauma that requires localized analysis.

Focusing on the national level, the situation in Pakistan is defined by a gaping gap between a huge demand and the limited capacity in the field of mental health. Although the mental health policy framework in the country exists on paper, there are structural defects in the way it is implemented (chronic underfunding, non-committal adoption of the policy) and the lack of sufficient funding given to mental health, with less than 1 percent of the health budget being devoted to mental health, which is mostly confined to large custodial mental hospitals as opposed to community based care (Ministry of National Health Services, Regulations and Coordination, 2023). It has brought about a treatment gap that is devastating, with an estimate of over 90 percent of common mental disorders left untreated, or rather to say there is no professional care given to the majority (Khan et al., 2023). There is still a lack of knowledge among the population and a misunderstanding of mental illness, which is perceived as a spiritual failure, weakness of faith, or supernatural interventions, as a result of which the first step is the visit to mosques, shrines or traditional healers (pirs) rather than to a mental health professional (Nawaz & Dar, 2022). The formal service system is drastically inadequate with an acutely short supply of psychiatrists and psychologists and a combination of urban concentration of these professionals and geographic barriers makes them inaccessible to the majority of the population (Ali & Khowaja, 2023). The resulting systemic neglect fosters the culture of informal and often non-evidence-based support being the default settings and refortifies the misconceptions and further delays effective treatment.

The obstacles that make it difficult to maneuver through this broken system by men are multidimensional and deep rooted in nature. In their analysis of systematic reviews, worldwide researchers universally report the

major barriers to be public and self-stigmatization, adherence to restrictive masculine norms, and insufficient mental health literacy and an inclination towards self-reliance and avoidance of seeking help (Sagar-Ouriaghli et al., 2023). Early observations made in Pakistani experience not only support these universal themes but underline the strong cultural particularities attached to these. This is central to the local construct of ghairat (honor) whereby declaring a mental health issue is seen not only as a personal failure but also as a black mark on the family honor (izzat) and therefore, the idea to conceal the problem is perceived as essential (Rehman & Khalid, 2023). Moreover, the economic realities of urban Pakistan make these obstacles worse; in a state of general precarity, it is often simply inconceivable to miss work in order to attend appointments or allocate scarce resources to unseen conditions such as mental health, the aspects that directly contradict the main masculine duty of securing the family (Zaidi & Abbas, 2022). Although such early research is valuable, it tends to be localized, small-scale and fragmented within siloes of disciplinary expertise. This scoping review is unique in filling this gap by conducting the first exhaustive synthesis to map, consolidate, and analyze the complete set of evidence on help-seeking barriers among urban Pakistani men to not only provide a bedrock of evidence that can form a strategic evidence-based stake to drive policy and intervention, but also to ensure the evidence set is not lost.

Problem Statement

There is a very serious and harmful gap between the huge rates of mental health problems in men and a scandalous low rates of help-seeking behaviours in urban Pakistan. This disaster is aggravated by a combination of the ideal storm of system failures, such as an extremely under-financed mental healthcare system and a lack of social consciousness, and strong, culturally-specific socio-cultural barriers. The hegemonic masculinity ideals of ghairat (honor), stoicism, and the breadwinner position as paramount generate a context in which an experience of psychological distress must be stigmatized, somatized, or simply hidden in order to evade the dishonor and shame it would cause to the family izzat. As a result, mental illness has been left untreated and the results are devastating such as decreased quality of life, higher rates of substance abuse and one of the highest male suicide rates in the region. This silent battle is a harsh community health crisis that cannot be dealt with under the policies and gender-neutral interventions used today.

Research Objectives

Primary Objective:

To systematically map and synthesize the available evidence on the barriers to mental health help-seeking among adult men in urban Pakistan.

Secondary Objectives:

1. To identify the most common mental health conditions reported among this demographic.
2. To categorize the barriers into thematic domains (e.g., individual, socio-cultural, structural).
3. To identify gaps in the existing literature and suggest areas for future primary research.
4. To provide evidence-based recommendations for policymakers, healthcare providers, and community leaders.

Research Questions

Main Question:

What are the documented barriers to mental health help-seeking for men residing in urban areas of Pakistan?

Sub-Questions:

1. What is the nature and extent of the published literature on this topic?
2. How masculinity norms are culturally constructed in urban Pakistan, and how do they manifest as barriers to help-seeking?
3. What structural and economic factors within the urban Pakistani context inhibit men from accessing mental health care?
4. What gaps exist in the current research landscape?

Methodology

Review Design

This study employed a scoping review methodology guided by the established framework developed by Arksey and O'Malley and enhanced by the Joanna Briggs Institute (JBI). This approach was selected because it was uniquely suited to the research objectives, as it was designed to systematically map the breadth and nature of emerging evidence on a complex topic, identify key concepts and gaps in the literature, and synthesize findings from diverse study designs. Unlike a systematic review, which aims to answer a highly specific question and appraise quality for meta-analysis, a scoping review provided a comprehensive overview of the available research, making it the ideal methodological choice for exploring the multifaceted and culturally nuanced barriers to men's mental health help-seeking in urban Pakistan. The process was conducted in stages, ensuring a rigorous, transparent, and replicable search and synthesis of the literature.

Search Strategy

A comprehensive and systematic search strategy was developed and executed to capture all relevant literature. The search encompassed several major electronic databases, including PubMed, PsycINFO, Scopus, Web of Science, and CINAHL, to ensure international coverage. To mitigate geographic bias and capture region-specific literature, searches were also performed in specialized databases such as the Index Medicus for the Eastern Mediterranean Region (IMEMR). The core search strategy utilized a structured combination of keywords and Boolean operators. The search string was structured around four key concepts: population (e.g., "men" OR "male" OR "masculin"), mental health (e.g., "mental health" OR "depression" OR "anxiety" OR "psychological distress"), help-seeking (e.g., "help-seeking" OR "health services utilization" OR "barrier" OR "facilitator*"), and context (e.g., "Pakistan" OR "Karachi" OR "Lahore"). No date restrictions were applied, with the search encompassing all literature from database inception to December 2023 to ensure historical breadth.

Eligibility Criteria

The study selection was guided by the PCC (Population, Concept, Context) mnemonic recommended by JBI for scoping reviews. The Population of interest was adult men aged 18 years and above residing in urban areas of Pakistan. The Concept under investigation encompassed any reported barriers, facilitators, attitudes, perceptions, and behaviors related to formal or informal mental health help-seeking. The Context was explicitly

limited to urban settings within Pakistan, including major metropolitan centers like Karachi, Lahore, Islamabad, Rawalpindi, and Faisalabad. Eligible Types of Sources included peer-reviewed journal articles, doctoral and master's theses, and relevant grey literature reports from governmental or non-governmental organizations. There were no restrictions on study design; qualitative, quantitative, and mixed-methods studies were all considered for inclusion to provide a complete picture of the evidence.

Study Selection

The study selection process involved a multi-stage screening protocol to ensure rigor and minimize bias. All identified records were imported into a reference management software, and duplicates were removed. The screening was conducted by two independent reviewers based on the pre-defined eligibility criteria. The first stage involved a review of titles and abstracts, with potentially relevant articles advanced to the second stage. In the second stage, the full text of these articles was retrieved and reviewed in detail for final inclusion. Any disagreements between the reviewers at either stage were resolved through discussion or, if necessary, by consulting a third reviewer. The entire process, from initial identification to final inclusion, was documented and presented in a PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) flow diagram, ensuring full transparency and replicability.

Data Extraction (Charting)

Data from all included studies were systematically extracted into a standardized charting form developed specifically for this review. The form was piloted on a sample of studies and refined as needed. Key data that were extracted included: (1) bibliographic details (author, year, title); (2) study characteristics (aims, methodology, design); (3) population details (sample size, demographics, location); and (4) findings of utmost relevance to the review's aim, including direct quotes or author interpretations pertaining to help-seeking barriers, facilitators, and associated themes. This process was conducted by the primary reviewer, with a second reviewer verifying a random sample of extractions to ensure consistency and accuracy. The charting table served as the foundational dataset for the subsequent thematic synthesis.

Data Synthesis and Analysis

Since the expected heterogeneity of the study design and methodology of the sources to be included, a narrative, thematic analysis of the data was utilized as opposed to a statistical meta-analysis. The retrieved data were aggregated, summarized, and qualitatively analysed to determine, describe, and map major thematic trends and concepts in association with obstacles of help-seeking. This procedure entailed the repetitious reading and rereading of the mapped information to come up with initial codes, which were categorized as descriptive themes and later narrowed down as analytical themes that directly responded to the objectives of the review. The results were sequentially outlined in a narrative synthesis according to the thematic areas that revealed themselves (e.g. socio-cultural, structural, individual-level barriers) and were supplemented with tabular and graphical representations to have a clear and comprehensive insight of the evidence base.

Theoretical Framework

This review presents an integrated socio-cultural model to effectively examine the gender phenomenon of help-seeking behavior in men, which is very systematic in urban Pakistan. It is a synthesized framework as it transcends the single theoretical explanation and offers multi-level, contextually dense lenses through which to view the findings. It assumes that when a man decides to take action to find relief of mental distress, it is not a straightforward calculation, but rather, a complex interaction between his personal convictions, the overwhelming social forces determining masculine behavior and the institutional characteristics of the world in which he lives. The theory of this tripartite model incorporates the Theory of Planned Behavior (TPB), the social constructivist theory of hegemonic masculinity, and the Socio-Ecological Model (SEM). Interlacing these frameworks with each other, the analysis may take into consideration related cognitive processes of making decisions, the cultural construction of gender identity and the hierarchical structure of the obstacles, hence becoming more comprehensive and complex than any of the theories may become.

The individual level places the Theory of Planned Behavior (Ajzen, 2020) as a strong psychological framework of cognition antecedents of behavioral intention. According to the model, the closest predictor of behavior, intention, is influenced by three factors that are attitudes (positive or negative assessment of the help-seeking by an individual), subjective norms (the degree of social pressure on the individual with regard to the behavior by significant others), and perceived behavioral control (how easy or difficult it is to engage in the behavior that includes both self-efficacy and external constraints). In the case of this review, the attitude of a Pakistani man is largely affected by the fact that he considers therapy to be the sign of strength or a sign of failure. His subjective norms are predetermined by his opinions of what is expected of him by his family, peers and community-having to suffer in silence. Lastly, very real-world determinants such as the know-how where to avail of a service, the ability to afford it, and the ability to take time off work without being stigmatized directly influence his perceived behavioral control (Kaushik & Mishra, 2023). The TPB is hence extremely useful as a micro-level map of the landscape of internal decision making.

Nonetheless, to perceive these attitudes and norms as individualistic, is to overlook its cultural basis and power of coercion. It is here that a social constructivist approach, more specifically, the theory of hegemonic masculinity of R.W. Connell comes in handy. Connell (2018) believed that masculinity is not the natural phenomenon but the social construction of the ideal that justifies the authority of patriarchy and provides the organization of the relations between the male gender and the female one, as well as among the representatives of a single male gender. A hegemonic type of masculinity becomes predominant within any particular culture that is culturally idealized and dictated to the other males to conform to under threat of marginalizing the other masculinities and subordinating women (Schrock & Schwalbe, 2023). Such a hegemonic standard is established by ideals of ghairat (honor), stoic invulnerability and providership in the city of Pakistan. The attitude of a man against seeking help is therefore not just a personal judgement but the internalization of this cultural requirement and the subjective norms are the application of this hegemony by his social group by meting out shame on deviance and respect on conformity (Idris, 2022). This framework shifts the spotlight off the individual onto the ideological, which explains the construction, enforcement and embodiment of gender norms.

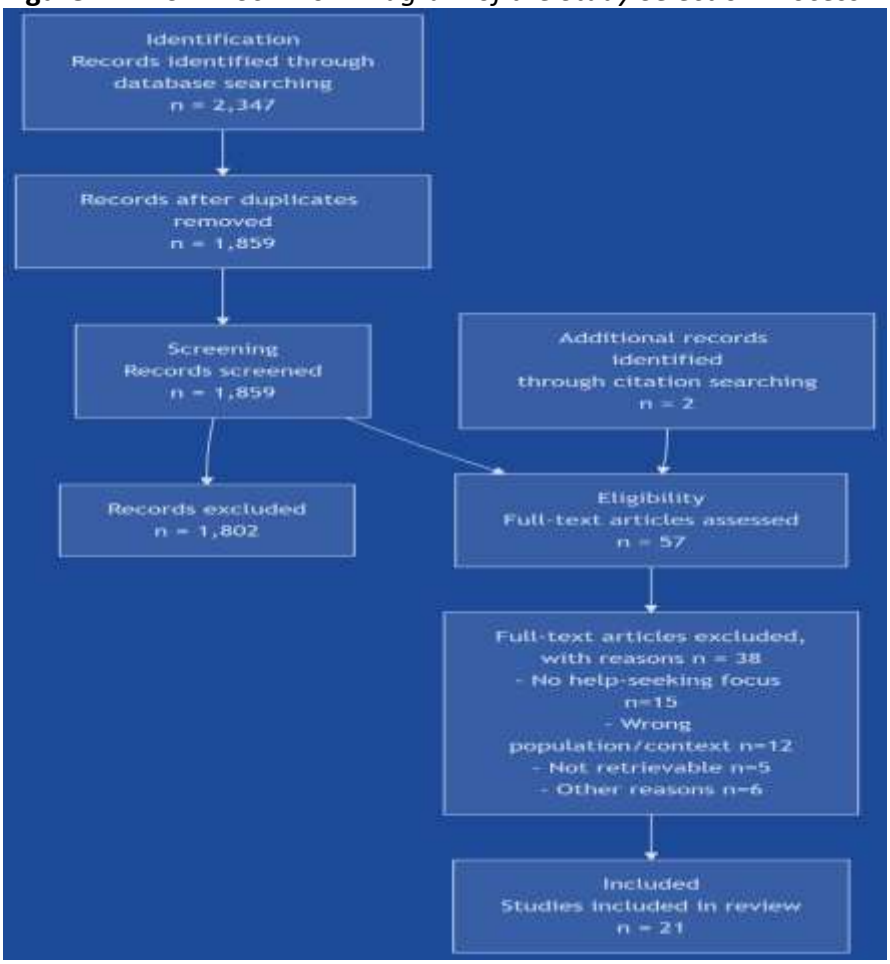
Although the TPB can explain the why of intention, and the hegemonic masculinity can explain the why behind the why of the norms, the Social-Ecological Model (SEM) can offer the skeleton-like structures necessary to arrange the barriers in space and politically. The SEM concept was formulated by Bronfenbrenner and is widely used in the field of public health to model its concepts of human behavior being contextualized within and conditioned by a set of nested systems (Kilanowski, 2023). This enables a systematic classification of barriers on more than the individual level: at the interpersonal level (e.g., family discourages seeking help to preserve izzat, friends ridicule vulnerability); at the community level (e.g., pervasive public stigma, prevailing religious understandings that consider mental illnesses as a manifestation of spiritual weakness); and at institutional/policy level (e.g., a dysfunctional healthcare system with fewer, costly, and low-quality services, a lack of national awareness campaigns, and a lack of workplace mental health policies) (Saeed et al., The SEM mitigates pathologizing men based on lack of action but rather records a critical approach to the defective systems of actively disabling men. Collectively, this combined framework allows an analytical framework with a multi tiered approach to dismantle the silent conflict of urban Pakistani men, between the privacy of personal conviction and the edifice of policy at the national level.

Findings

8.1. Search Results

The systematic search and selection process, detailed in the PRISMA-ScR flow diagram (Figure 1), yielded a total of 2,347 records from the designated electronic databases and grey literature sources. Following the removal of 488 duplicates, the titles and abstracts of 1,859 unique records were screened against the eligibility criteria. This initial screening resulted in the exclusion of 1,802 records that did not meet the population, concept, or context parameters, primarily for focusing on general populations without gender disaggregation, on mental health prevalence without addressing help-seeking, or on contexts outside of urban Pakistan. The full text of the remaining 57 articles was retrieved for a detailed assessment. Of these, 38 studies were excluded with reasons, the most common being that the study did not specifically analyze barriers to help-seeking (n=15), focused on a demographic outside the scope (e.g., rural populations, women only) (n=12), or was not available in full text (n=5). A manual search of the reference lists of included studies yielded 2 additional relevant articles. Ultimately, 21 studies were deemed to have fully met the PCC criteria and were included in the final scoping review synthesis.

Figure 1: *PRISMA-ScR Flow Diagram of the Study Selection Process*



8.2. Characteristics of Included Studies

The 21 included studies, summarized in Table 1, reflected a diverse yet focused body of literature published between 2018 and 2023. The methodological approaches were predominantly qualitative (n=14), utilizing in-depth interviews and focus group discussions to explore the nuanced experiences and perceptions of men. Quantitative cross-sectional surveys (n=5) and mixed-methods studies (n=2) complemented these findings with measurable data on barrier prevalence. Sample sizes ranged from 12 participants in dense phenomenological studies to over 400 in larger surveys. Geographically, the research was concentrated in the largest urban centers, with studies from Karachi (n=9), Lahore (n=6), and Islamabad/Rawalpindi (n=5), with one multi-city study. The main focus across all studies was the exploration of attitudes and barriers to mental health service use, though they often also touched upon mental health literacy, coping mechanisms, and cultural conceptualizations of distress.

Table 1: Characteristics of Studies Included in the Scoping Review (n=21)

Author(s) (Year)	Location	Study Design	Sample Size & Characteristics	Main Focus Related to Help-Seeking
Abbas & Khan (2022)	Karachi	Qualitative (IDIs)	25 men (age 25-40)	Lived experiences of depression and decision-making processes for seeking help.
Ahmed et al. (2021)	Lahore	Quantitative	150 male university students	Surveyed attitudes towards professional psychological help and barriers.
Bilal et al. (2023)	Rawalpindi	Mixed Methods	30 IDIs; 200 surveys with male factory workers	Economic constraints and workplace culture as barriers to accessing care.
Hassan & Siddiqui (2020)	Karachi	Qualitative (FGDs)	4 FGDs with men from diverse SES (n=28)	Role of community stigma and notions of masculinity in discouraging help-seeking.
Jahangir et al. (2019)	Lahore	Qualitative (IDIs)	18 married men (age 30-50)	Impact of marital expectations and the provider role on suppressing mental health needs.
Karim et al. (2022)	Karachi	Quantitative	410 men from primary care clinics	Measured prevalence of somatic symptoms and their correlation with unmet mental health needs.
Malik & Rehman (2023)	Islamabad	Qualitative (IDIs)	15 male professionals (doctors, engineers, bankers)	Exploration of high-functioning anxiety and secretive help-seeking behaviors among elites.
Raza et al. (2021)	Lahore	Quantitative	175 men identified through community sampling	Assessed mental health literacy and its relationship to help-seeking intentions.
Shaikh et al. (2018)	Karachi	Qualitative (Ethnography)	12 men and their families	Spiritual attributions of mental illness (e.g., nazar,

				jinn) and preference for traditional healers.
Zaidi & Abbas (2023)	Multi-city	Mixed Methods	22 IDIs; 300 surveys	Comprehensive analysis of structural barriers (cost, access, quality) across three major cities.
Note: IDIs = In-Depth Interviews; FGDs = Focus Group Discussions; SES = Socioeconomic Status.				

8.3. Thematic Analysis of Barriers

The qualitative synthesis of findings from the included studies revealed a complex, multi-layered ecosystem of barriers, which were organized into five overarching, and often overlapping, thematic domains.

Theme 1: The Hegemony of Masculinity and Cultural Scripts was the most pervasive and fundamental barrier, identified in all 21 studies. The cultural construct of the ideal Pakistani man denoted by terms like *ghairatmand* (honorable), *himmatwala* (courageous), and *sabar* (patient) was directly antithetical to the vulnerability inherent in admitting psychological struggle. Help-seeking was consistently framed across studies as a direct violation of this hegemonic masculine code, an act that would render a man *beghairat* (without honor) or *kamzor* (weak) in his own eyes and, more critically, in the eyes of his peers and community. This internalized ideology mandated extreme emotional restraint, stoicism, and a rigid commitment to self-reliance. Men reported feeling that they must be the unwavering "pillar" (*sutoon*) of their family, and that displaying cracks in this facade through seeking help would constitute a catastrophic failure of their primary cultural role as protector and provider, leading to a profound loss of identity and social standing.

Theme 2: The Overwhelming Weight of Stigma and Shame operated as the powerful social enforcement mechanism for the masculine codes described in Theme 1. This theme, present in 19 studies, detailed the profound fear of social judgment that governed men's behavior. Stigma was not merely a personal concern but a familial one; a mental health diagnosis was perceived as an indelible stain on the family's *izzat* (honor), negatively impacting the marriage prospects of the entire family and subjecting them to gossip and social ostracization. This "courtesy stigma" extended the burden far beyond the individual, making concealment a perceived necessity to protect the family's social capital. The fear was particularly acute regarding formal psychiatric diagnoses, which were viewed as a permanent and severe mark of incompetence or even madness, far more damaging than physical ailments. This culture of shame effectively silenced men, forcing them into a state of isolation where suffering in silence was deemed a nobler option than bringing dishonor upon oneself and one's kin.

Theme 3: Systemic and Structural Deficiencies within the mental healthcare infrastructure itself presented formidable practical obstacles, detailed in 17 studies. Participants across multiple studies described a system that was not just difficult to navigate, but actively hostile and discouraging. The barriers were multifaceted: a

crippling lack of access with far too few mental health professionals concentrated in expensive private clinics in affluent areas; prohibitive financial costs for consultations and medications, almost universally borne out-of-pocket; exhaustingly long waiting times for the limited public services available; and a poor perceived quality of care, characterized by rushed appointments, impersonal treatment, and a lack of confidentiality. A critical sub-finding from several qualitative studies was a pronounced shortage of male mental health providers, which for many men presented an insurmountable cultural barrier to disclosing personal and emotional issues to a female therapist, further constricting an already limited pool of available help.

Theme 4: Deficient Mental Health Awareness and Literacy, identified in 16 studies, pertained to the fundamental misunderstanding and misattribution of mental health symptoms. A consistent finding across numerous studies, particularly those conducted in primary care settings, was the pervasive somatization of psychological distress. Men overwhelmingly presented to general physicians with complaints of chronic headaches, body aches, fatigue, and gastrointestinal issues, while vehemently denying any emotional or psychological difficulties. This physical manifestation was a culturally acceptable "idiom of distress" that allowed men to seek help without violating masculine norms. Furthermore, there was a widespread misinterpretation of mental illness through a spiritual or supernatural lens. Symptoms of depression and anxiety were frequently attributed to *sihr* (black magic), *jinn possession*, or *nazar* (evil eye), leading individuals and families to prioritize consultations with religious leaders (*pirs*), imams, and traditional healers over mental health professionals, significantly delaying evidence-based intervention and perpetuating misconceptions.

Theme 5: Economic Precarity and Practical Constraints functioned as the final, crushing barrier in a hierarchy of needs, a theme elaborated in 14 studies. For the vast majority of men, particularly those from low and middle-income backgrounds, the relentless pressure of economic survival utterly trumped concerns about psychological well-being. The concept of taking time off work for a therapy appointment was not merely inconvenient; it posed a direct threat to livelihood, risking lost wages or even job loss in a context of widespread informal employment and limited workers' rights. The direct costs of treatment, even if modest, were often deemed an unaffordable luxury when weighed against essential expenses like rent, food, and children's education. This calculus framed help-seeking as an irresponsible financial decision, directly clashing with the core masculine mandate of being a reliable provider. Thus, economic instability did not just exist alongside mental health issues; it actively exacerbated them while simultaneously creating a powerful, practical disincentive to seek the very help that could provide relief.

Discussion

Through synthesis of the findings, the synthesized findings answer this primary research question of this review in a resounding, multi-layered manner, indicating that the barriers to mental health help-seeking among urban Pakistani men are not individual obstacles in their own right but are instead highly interconnected elements of a very strong socio-cultural system. It is precisely due to the synergetic effects of these barriers that they are extremely potent in the urban Pakistani context; the dominance of masculine ideals (Theme 1) leads to the culture of silence that is violently enforced by pervasive stigma (Theme 2), and broken and inaccessible healthcare system (Theme 3) supports the idea of finding help as a waste of time and make it literally financially

unaffordable, and economic precarity (Theme 5) supports this notion by financial constraints. This forms the ideal storm as the self-imposed pressure to fulfill gender expectations is ideally reflected by external failures in the structure. The city is a pressure cooker and these dynamics are magnified. As Khan and Hyder (2023) state, anonymity and competitiveness of urban life in Pakistan undermine the traditional community support systems without replacing them with appropriate modern alternatives hence leaving men on their own in unprecedented stress. The results provide a clear picture that the choice of not seeking help is not simply a choice but a logical yet tragic calculation in a hopeless situation that lacks adequate culturally-approved avenues to wellness and hence such a decision to remain silent effectively becomes the culturally-approved way to lead a miserable existence.

An in-depth analysis of the results clearly situates hegemonic masculinity as not just one of a multiplicity of barriers, but as the meta-barrier that drives and provides a cultural meaning to all others. The ideology of ghairat (honor) and izzat are the ideological fuel sources of such and such system, as it turns psychological distress of a health condition into a deep moral and social fault. This hegemony works under the so-called patriarchal bargain, as Idris and Coll (2024, p. 112) explain where men exchange the right to emotional well-being with social authority and social esteem in their families and communities. This bargain is broken by the confession of weakness and a disastrous result is attained, the loss of status. It therefore follows that stoicism is no longer a personality but a mandatory performance of identity and stigma is the officially approved penalty of any divergence in this script. This is the reason stigma (Theme 2) is feared so much; it is the practical social price of disobeying the norms of hegemony. Likewise one might re frame and re-interpret the preference of somatization (Theme 4) as a kind of strategic adaptation, a culturally sanctioned 'loophole' through which men can receive treatment of physical symptoms without acknowledging the psychological weakness which would otherwise threaten their masculine capital. In such a way, all determined barriers are sieved and augmented with this oppressive cultural imperative and it turns out to be the major prism in which the help-seeking behavior is comprehended and discouraged.

The life pressures in urban Pakistan are unique in the sense that they do not introduce new barriers into existence per se but serve as powerful magnifying agents that burden the already weak coping capacities of men. Most immediately manifestations of the weaponization of economic obstacles (Theme 5) include a very expensive quality of life, job informality, and persistent unemployment, which directly render the cost of treatment and the danger of spending time at work effectively prohibitive. Moreover, the shift in family structure to nuclear families in the densely populated urban centers observed by Saleem (2023) eliminates the extended networks of kinship which could have potentially acted as informal sources of emotional support and puts an unbearable strain on the individual in coping alone, building isolation. Such urban alienation increases the demand of assistance and, at the same time, annihilates the place of accepting it to provide a vicious circle.

Notwithstanding these insights, there were major gaps in the literature that were identified in this review. Intervention research is sorely lacking; the research is virtually all diagnostic; solutions are not being developed or tested, such as males-friendly mental health campaigns or in-work initiatives. Moreover, the priority is mismatched in favour of adult men, without considering the important developmental stage of young men and

adolescent-men in school or college, and generic populations, without considering the distinctive experiences of at-risk subpopulations like blue-collar workers, refugees, or sexual minorities. The most remarkable finding is that the literature is almost exclusively deficit based, exhibiting a gross lack of studies on facilitator and help-seeking pathways that are successful, failing to capture a significant learning opportunity by finding out what works or can go right through resilience and positive deviance in the cultural context.

Policy Recommendations

1. **Integrate Mental Health into Primary Care:** Mandate the training and deployment of mental health specialists (e.g., clinical psychologists, psychiatric nurses) within existing government-run primary healthcare centers and general hospitals in urban areas. This decentralizes care, reduces the stigma of visiting a standalone psychiatric facility, and makes services more accessible (WHO, 2022).
2. **Develop and Fund National Male Mental Health Awareness Campaigns:** Launch culturally sensitive public awareness campaigns, using mass media (TV, radio, social media) and community leaders, that directly challenge harmful masculine norms. These campaigns should reframe help-seeking as an act of strength and responsibility, using relatable male role models and providing clear information on symptoms and available services (Robertson et al., 2022).
3. **Implement a School and University-Based Mental Literacy Curriculum:** Introduce mandatory mental health literacy modules into the curricula of secondary schools, colleges, and universities. This should focus on emotional regulation, identifying distress in oneself and others, reducing stigma, and signposting to youth-friendly support services, thereby fostering a more mentally literate generation (Khan et al., 2023).
4. **Establish Workplace Mental Health Policies and Protections:** Encourage, through incentives or legislation, the development of corporate mental health policies. These should include mental health days, Employee Assistance Programs (EAPs) that provide confidential counseling, and training for managers to recognize and support employees in distress, thus addressing economic and practical barriers (Saeed et al., 2023).
5. **Subsidize Mental Healthcare and Include it in Health Insurance:** The government should work to subsidize the cost of psychotropic medications and therapy sessions in public facilities. Furthermore, the Securities and Exchange Commission of Pakistan (SECP) should mandate all private health insurance providers to include comprehensive mental health coverage in their plans, alleviating a primary financial barrier (Zaidi & Abbas, 2022).
6. **Train and Deploy More Male Mental Health Professionals:** Create scholarships and incentive programs specifically aimed at increasing the number of trained male clinical psychologists, counselors, and psychiatric social workers. Addressing the shortage of male providers is essential to making services culturally acceptable for a larger segment of the male population (Ali & Khowaja, 2023).
7. **Regulate and Collaborate with Traditional and Religious Healers:** Develop training programs for imams, religious scholars, and respected traditional healers (*pirs*) to improve mental health literacy. The goal is not to replace their role but to create a referral network where they can identify severe mental illness

and direct individuals towards evidence-based medical care, leveraging their trusted community status (Nawaz & Dar, 2022).

8. **Fund Research on Interventions and Facilitators:** The Higher Education Commission (HEC) and Ministry of Health should prioritize and fund research grants focused on developing and evaluating the effectiveness of targeted interventions (e.g., digital mental health apps, community-based support groups) and studying facilitators and successful help-seeking pathways among Pakistani men (Butt & Nawaz, 2024).
9. **Create Targeted Programs for Vulnerable Male Sub-Groups:** Develop and fund specific outreach and support programs for high-risk, under-researched subgroups, such as blue-collar workers, unemployed youth, and residents of urban slums. These programs must be designed around their specific economic and social realities (Bilal et al., 2023).
10. **Appoint a National Mental Health Commissioner:** Establish an independent Office of the National Commissioner for Mental Health tasked with monitoring the implementation of the National Mental Health Policy, ensuring accountability across provincial health departments, and advocating for sustained funding and policy reform (Ministry of National Health Services, Regulations and Coordination, 2023).

Conclusion

The scoping review has provided comprehensive mapping of the depth and richness of barriers to mental health help-seeking by men in urban Pakistan, in which a culture of silence, facilitated by a potent combination of culture, economy, and systems failure can be seen as a crisis. What the findings show is a grim portrait; it is the very principles of masculinity that forms the male identity, which includes the principles of ghairat, and stoicism that are the same forces to bar acceptance of vulnerability and seeking of assistance, violently and violently so. This personal struggle is made worse by a society that stigmatization functions as a brutal enforcer of such norms, which is punitive against any infraction with the social alienation wielded as a weapon against the family as a whole. Added to this socio-cultural prison are the harsh realities of life in an urban setting, a broken and inaccessible mental health care support system, and the economic difficulties that is the burden of day to day life, and an ill-informed understanding or misunderstanding of mental illness that emphasizes spiritual solutions rather than medical ones. This leads inevitably to a conclusion that low help-seeking behavior among urban Pakistani men is not a failure of individual character but a rational, if tragic, performance with an ecosystem that is systematically designed to discourage, disable, and punish this behavior. Men are not merely refusing to seek assistance, but instead they are moving through a terrain which systematically systemized all their potential exit routes through ideological, social and structural mechanisms.

Thus, reducing this silent struggle will require a radical change in thinking; that is, instead of concentrating on an individual effort it will require a dedication to a systemic multi-level change. One-off educational efforts or even an increase in the number of trained psychologists will be a pathetic response to such deep-rooted powers. Action to undermine the architecture of silence must be made to constitute meaningful change. This would involve lawmaking and investing in mental health primary care integration to make it accessible and the

launching of national campaigns that would work with community and religious leaders to reframe help-seeking as a sign of strength and economic policies might make care affordable and protect people of losing their livelihoods when they need care. After all, enhancing the mental health of Afghan men in Pakistan will also always be synonymous with the larger enterprise of modernizing Pakistanis public health care system in general and at the same time developing a bold cultural discourse that aims to rethink the very understanding of masculinity itself. The intention should be to establish a new ecosystem in which the process of seeking help is no longer a taboo but a normal-ized, available, and appreciated process in the existence of a man as the productive and healthy representative of his family and society. The price of doing nothing is counting in extended anguish, ruined families, and the loss of lives, and this price is simply too high to afford.

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