

Men's Mental Health – A Trojan Horse in the Indian Familial Structure: A Sociological Review of Causes, Concealment and Remedies

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Abstract

In Indian society the family is the first and most trusted source of identity, obligation and care. For men's mental health, it can also work like a Trojan horse, welcomed in as a shield, it brings inside it the messages of stoicism, provider duty and family honour that have an unstated effect on their wellbeing and keep the erosion under the lid. Based on a conceptual narrative review of nine scholarly papers and reviews, one conference poster and three web sources, we discuss mental-health problems in Indian men, why it is unidentified and unnoticed, why mental-health care seems “feminine”, and how this cycle can be broken. The reviewed literature indicates that men have 72.5% mental-health morbidity, while treatment gaps among men for disorders studied range from 58.3% to 72.4%, and that men account for 72.5% of suicide deaths in India (NCRB 2021). However, no ongoing program of mental health services for men was found. The paper ends with a call to a new understanding of strength, in which emotional openness is not a departure from strength, but rather a part of it, and that this understanding must be shared among families, schools, workplaces, health services, and the media and among both teachers and students, and by both parents and children.

Victimization in the Indian context includes men's mental health, masculinity, Indian family, patriarchy, stigma, help seeking, suicide and India.

Keywords: Men's mental health; Masculinity; Indian family; Patriarchy; Stigma; Help-seeking; Suicide; India

Introduction

In the popular imagination the Indian family is a refuge. Despite all this, it is the same family that is taught to be the home for the person with mental illness, the place where he or she is fed, sheltered, married and buried there, and the place from where the concepts of manhood are transmitted.¹ Boys are told from a young age that men do not cry, that they must be “a man”, and that they must “handle it themselves”.^{7,12} By adulthood, the man is expected to be the breadwinner, protector and decision maker, and his value is assessed on his ability to perform these tasks well.^{3,5}

That's why the paper employs metaphorical language: a Trojan horse. The family is accepted without question, but the trouble it has on the inside – the silence, the self-reliance, provider anxiety and embarrassment – is working against the one person it was designed to protect: the man. When harm comes in the guise of duty and love, neither the man nor his relatives readily acknowledge it as a health issue.

The size of the concern is reflected in national information. However, a scoping review of the Indian literature also revealed that there was only one paper focusing specifically on the mental health of men and there was no long term programme addressing men's mental health.³ Additionally, there is a growing trend of national press coverage, calling

for rethinking of masculinity and for destigmatising men's mental health.¹³

In this context, the question posed by the paper is simple: How does the protective structure that is supposed to protect Indian men also conceal their distresses and what can be done about it?

2. REVIEW OF LITERATURE

Global and clinical perspectives. Affleck, Carmichael and Whitley suggest there is a “silent crisis” in mental health among men, citing high rates of suicide and drug and alcohol abuse among males compared with recorded depression rates, and they say that men tend to “act out” instead of “act in,” with irritability, alcohol consumption, and risky behaviors all being “depressive equivalents. There is a “silent crisis” in mental health among men, with high rates of suicide and drug and alcohol abuse among males but low recorded rates of depression, Affleck, Carmichael and Whitley say, noting that men are more likely to “act out” than “act in.” Unemployment, divorce, and adverse childhood experiences and life transitions like fatherhood are all recurring risk factors, and both blame the “stubbornness” of men for low use of service while failing to acknowledge social factors or gaps in services, pointing to a form of victim blaming.^{6,9} Camacho-Ruiz and colleagues conclude in a 2026 narrative

review that hegemonic masculinity, a social construct that is learned through gender-differentiated socialisation, creates attitudinal barriers (e.g., self-stigma, shame, symptom minimisation), as well as structural barriers (e.g., lack of tailored services, navigation challenges) and that men typically seek help as a “last resort”.⁹

The Indian evidence.

Nasir et al.’s scoping review of 35 records (2010–2024) found high levels of mental-health problems in Indian men, linked to socio-economic disadvantage, financial instability, job loss, restrictive gender roles, stigma and poor social support, alongside large treatment gaps.³ Chakrapani and Bharat place these findings in the wider Indian context of an 80.4% treatment gap for common mental disorders, very few mental-health professionals, and a strong tendency to hide symptoms or turn to faith healers, partly because stigma extends to the whole family, for example by affecting the marriage prospects of siblings.¹ Patwardhan and Jaishik add that workplace pressure, loneliness, gaming, substance use and social-media culture intensify the strain on young men.^{5,7}

Masculinity, patriarchy and the family.

The ideals of dominance and emotional control also push men to the margins, as Dochania and Dochania argue (2010) in the context of hegemonic masculinity, and women as mothers, wives and sisters often pass on these norms within the household.² Patwardhan distinguishes between hegemonic and subordinate masculinities: men who cry or show fear risk being labelled feminine and devalued.⁵ Kulandai Raj and Vijayalakshmi add an intersectional lens, arguing that there are additional burdens for Dalit, gay and disabled men, and that national suicide data do not record caste, sexual orientation or disability.⁸ A student poster by Retana, using symbolic interactionism, similarly stresses that societal and self-internalised stigma keep men from seeking help.¹⁰

Law and popular commentary. Tagore argues that gender-specific laws leave male victims and falsely accused men with little recourse, and that being accused can cause lasting psychological harm.⁴ This claim is contested and rests on selected case reports and police closure data, so it is treated in this paper as one perceived stressor within family and marital conflict rather than as an established finding. Popular sources point to externalised coping such as substance use, lower mental-health literacy among men,¹¹ and to the value of family, school and workplace change and of women as allies.¹²

3. AIM AND OBJECTIVES

The goal of this study is to explore the impact of the Indian family structure on the manifestation, concealment and alleviation of men's mental-health issues. The specific objectives are:

To determine the social and family of poor mental status among males in India.

To provide reasons why these problems are not detected and not noticed.

To understand how a patriarchal mentality shapes mental-health services as a ‘feminine’ space.

To recommend feasible solutions to remove such barriers.

4. METHODOLOGY

Research design. This study has a qualitative and an interpretive design based on conceptual narrative synthesis. It is inspired by sociological theories of gender, family and health, especially Connell's theory on hegemonic masculinity, and looks at the influence the Indian familial system has on, obscures and can answer questions about men's mental health problems.

Data sources. The analysis is based on a purposive secondary data that has been selected. It consists of peer-reviewed research works from the fields of sociology, psychiatry, public health and gender studies, an academic conference poster and contemporary commentaries from print media and civil-society organisations from India. Sources included those that discussed men's mental health, concepts of masculinity, stigma, help seeking and/or family and social determinants, and provided Indian evidence or conceptual insight that could be transferred to the context of India. International scholarship was treated as supporting evidence and not as equivalent to Indian findings. Figures are reported as presented by the original sources and second-hand figures are designated as such.

Analytical procedure. The material was read in detail and thematically coded, according to the goal of the study. Four themes emerged in the analysis; (i) what causes poor mental health in Indian men, (ii) why men are not identified or noticed as suffering with poor mental health, (iii) why men's help-seeking is characterised as “feminine”, and (iv) how change is possible. Results were later compared with each other and areas of convergence, contradiction and gaps identified. The ‘trojan horse’ metaphor was used to create an organising framework based around the family, which is a ‘safe place’ for both reinforcing positive and problematic values.

5. RESULTS AND DISCUSSION

Table 1 summarises the principal figures reported in the reviewed sources. Table 2 maps the mechanisms through which the family transmits and hides distress.

Table 1. Key data on men's mental health in India (as reported in the sources)

Indicator	Reported value	Source	Ref.
Men's share of suicide deaths, 2021	72.5%; 73,900+ more men than women	NCRB 2021, as reported in	[7, 11, 12]
Male suicide deaths, 2014 → 2021	89,129 → 1,18,979 (female 2021: 45,026)	Lancet Reg Health/NDTV, as reported in	[5]
Suicide among daily wage earners, 2014–21	Increase of 170.7%	NCRB, as reported in	[11]
Mental-health morbidity, men vs women	13.9% vs 7.5% (lifetime 16.7% vs 10.8%)	Gautham et al. (2020) via	[3]
Prevalence of all mental disorders	14.2% men vs 14.4% women	Sagar et al. (2020) via	[3]
Treatment gap in men	Bipolar 58.3%; anxiety (GAD) 72.4%; common mental disorders overall 80.4%	NMHS-based studies via	[3, 1]
Kiran helpline callers	70.5% of 13,550 calls from men	Ministry data, as reported in	[3]
Men who discuss mental health with no one	About 4 in 10	Manipal research, as reported in	[12]
Mental-health workforce and funding	0.75 psychiatrists per 1,00,000; 898 clinical psychologists; ~1% of health budget	Chakrapani & Bharat; Nasir et al.	[1, 3]
Job loss and men's symptoms	aIRR 1.16 for symptoms after job loss	Chatterji et al. (2021) via	[3]
Dalit suicides in media reports, 2015–21	51 of 80 (63.75%) were men	Bhai Patel & Kumar (2021) via	[8]

Note: figures are reproduced from the cited papers; definitions and samples differ, so rows are not directly comparable. The psychiatrist density is reported as 0.3 per 1,00,000 in [12].

Two observations follow. First, prevalence evidence is mixed: one national survey reports higher morbidity in men, while other estimates show near parity or higher common-disorder rates in women.^{1,3} Second, the suicide and treatment-gap figures are consistently high for men. This combination is exactly what would be expected if distress is present but poorly detected.^{6,9,11}

5.1 Causes

Emotional socialisation. Boys are taught to suppress fear and sadness, and the habit continues into adulthood as emotional repression that shows up as stress, anxiety, anger and substance use.^{5,7,12} Men in India are expected to be dominant, self-sufficient “pillars” of the family, and talking about mental health is experienced as a loss of control and power.³ A qualitative study reviewed by Nasir et al. found that men's depression was linked to “socialised masculinity in early family experiences” and was itself constructed as a threat to masculinity.³

Provider burden and economic precarity. In one study, the earlier onset of depression among men than women was

attributed, by its authors, to the breadwinner stress.³ There is evidence to suggest that the intersection of economic insecurity and the provider role affects men more than women, as seen in a 170.7% increase in suicides among daily wage earners.¹¹

Family relationship loss, conflict and loneliness. The loss of a partner and of a nuclear family has been shown to increase isolation among men, with lower social capital being associated with an increased risk of major depression (although migration was not a statistically significant predictor), and functional limitations and multimorbidity also associated with depressive symptoms.³ Some men may see legal disputes within marriage as an additional stressor, though the evidence for this is not definitive.⁴

Intersecting, structural factors. Everyone's access to care is hindered by very few professionals and minimal funding, and even less by masculine norms. Social media comparison, online teasing of male vulnerability and long working day add to the burden,^{5,7} whilst men who are also Dalit, gay or disabled suffer compound stigma with even less data and support.⁸

5.2 What helps to prevent men from having their mental health problems recognized

The instruments lack sensitivity to men's signs of distress. Boys and men were more likely to experience “acting out” symptoms, which were more likely to be interpreted as a character problem or social issue than a health problem, resulting in a punitive, not health-based response.⁶ A large difference was observed between recorded depression and self-reported depression in men aged 50–54 (0.4% vs. 7.4%) in India, which also indicated significant underdiagnosis.³

Self-stigma and ‘last resort’ help-seeking. Men are typically the only ones suffering psychologically, and they wait until a crisis occurs before seeking help, with 70.5% of those who have called the national helpline being male (national helpline data).³ This is thought to be due to stigma and men's belief that they do not have a mental-health problem.

The family's own silence. It is a stigma “by association” in India – the family hide the symptoms of mental illness, ascribe them to weakness, lack of willpower, curse/possession, and may seek assistance from faith healers before educated professionals.¹ When an educated family seeks professional help, it is only when symptoms are very severe. A man's honor and a family's honor are knotted, and the family hides its image at the man's expense.

No probing professionals or systems. Counselling has been suggested to be more gender-sensitive, due to norms of patriarchy, in India because health-care providers are less likely to ask men about emotional suffering, to diagnose it or act on it, and men are given shorter explanations.³

Table 2. The family as “Trojan horse”: mechanisms, effects and concealment

What the family provides	Hidden payload	Why it goes unnoticed	Ref.
Upbringing and discipline	“Men don’t cry”; emotional suppression	Seen as building resilience or character	[7, 12, 9]
Provider status	Constant earning pressure; shame at job loss or debt	Framed as duty; stress is “normal”	[3, 5, 6]
Family honour	Need to hide symptoms and avoid stigma by association	Silence protects family reputation	[1]
Women as custodians of norms	Reproduction of stoic ideals in sons, husbands	Care and affection carry the message	[2]
Marital and kin support	Support tied to one partner or nuclear family	Loss (divorce, migration, bereavement) exposes isolation	[6, 3]
Caregiver role	Man cares for all but is not cared for	“Last resort” help-seeking	[9]

Source: authors’ synthesis of references [1–3, 5–7, 9, 12].

5.3 Patriarchal mind and why mental health “is seen feminine.”

Hegemonic masculinity, as theorized by Connell, has been characterized by the strength of domination, aggression, emotional control and resistance.² Patriarchy shapes, therefore, the definition of a “real man”: anything that indicates weakness is pushed to the other extreme of the spectrum. Men who manifest traits beyond this ideal are considered feminine, of lower status and less respected; the risk of such a label makes them limit their emotional expression, even if they would like to express it, and makes vulnerability appear as weakness or femininity.

Mental-health care facilitates this coding in a number of ways. Men perceive talking about mental health as a sign of weakness, loss of power and vulnerability – a fact reported by Nasir et al.,¹² and stereotypically held by men, most of the psychological, social workers and psychiatric aides are women, which can feel uncomfortable for men to disclose to women.

There's a unique flavor to the Indian family. Women often act as custodians of patriarchal values, encouraging strength and dominance in boys and reproducing the ideal of manhood among close male kin.² Two cautions are needed. First, this is not to blame women: Affleck et al. warn that explaining men’s silence by their “stubbornness” is itself victim blaming,⁶ and Dochania and Dochania locate the mechanism in institutions such as family, school, media and politics as a whole.² Second, the same patriarchy that gives men authority also traps them, since a man who cannot perform strength is marginalised inside the very hierarchy he is expected to uphold.^{2,5} The “feminine” label on mental health is thus a social construction, not a fact about emotion, and it can be changed.

5.4 How to overcome

The reviewed sources agree on the following directions of remedy: multi-level, social and structural.^{6,7}

Within the family. Families are the first line of intervention: parents can name the emotions aloud, respond to the boy's distress instead of dismissing it, avoid gender-specific emotional rules and build regular low-stakes conversation - partners, mothers and sisters can be allies who acknowledge warning signs, including irritability, withdrawal, change in sleep or appetite, and increased drinking, and start with observed behaviour rather than the label “mental health”.

Schools and workplaces. Schools should include emotional education and social-emotional learning; make counselling services readily available; consider setting up peer circles for adolescent boys; and use sports or arts to teach boys how to regulate their emotions; Workplaces should normalise help-seeking from management; train management to recognise distress; encourage mental-health leave and counselling; and create programmes that recognise barriers to men seeking help, including in the workplace, which can be funded under Schedule VII of the Companies Act 2013.^{7,12}

Health services. Awareness content should be presented in a way that resonates with men, with descriptions of symptoms and symptoms of externalising, rather than psychiatric labels, and task shifting to lay counsellors, along with culturally appropriate explanatory models, can help to expand access; digital and AI-based support may increase access to men who are reluctant to attend clinics, but bias in the content and issues of data security need addressing.

Law, policy and media. There is a need for greater gender sensitivity in the implementation of the Mental Healthcare Act, 2017 and increase funding (currently 1% of the health budget) and role models like actors and cricketers, and films that portray emotional strength as a virtue.

6. SUGGESTIONS AND RECOMMENDATIONS

Expand the definition of strength at home: develop a vocabulary of emotions and give emotional permission to boys and girls equally; acknowledge that there can be signs of distress in a man's irritability, withdrawal, or heavy drinking.

Include women – and men – as partners: host workshops with couples, parents and families together and ensure that women are allies in change, not the ones accountable for it.

Emotional literacy from a young age: integrate SEL into school and college programs, have trained counsellors, boy-friendly peer spaces.

Protect workplaces that are safe for disclosure- manager training, confidential counselling, mental health leave, leaders who talk openly about stress; safeguard daily-wage and informal workers by providing social security.

Train professionals and fix measurement: gender sensitive training for doctors and counsellors, screening tools measuring anger, risky behaviours and drug and alcohol use, design that appeals to males.

Community and digital access: neighbourhood dialogue groups, helplines, lay-counsellor task-shifting and ethical use of AI.

Record caste, orientation and disability in suicide data; Invest in research and increase funding for mental health; Invest in mental health workforce and funding.

Use media and public figures: Campaigns using well-known men who are speaking about getting help, rather than being mocked for being vulnerable.

Maintain a healthy balance: have transitioning men's mental health as a human problem, not a problem that competes with women's mental health.

7. CONCLUSION

The literature reviewed indicates that the Indian family is a birthplace of men's identity as well as an unspoken source of pressures tarnishing men's mental health. Norms of stoicism, provider duty and honour are passed on with affection, which is why they are seldom questioned. The same norms make distress invisible: men express it in a way that instruments don't measure, they hide it to protect themselves and their families, and they don't seek services that are considered "feminine". The end result is a silent crisis, which only extreme statistics of suicide reveals.

The family is the first point of contact to the problem – therefore it is also the first point of contact to solutions. The horse can be emptied of its hidden payload when emotional openness is a part of being a good son, husband, father and provider. This will need family, school, work, health systems, media and laws to act in harmony, and Indian men to provide better evidence. There is a need for more empirical research, such as qualitative research on men and families, as well as intervention trials, to evaluate and adapt the model described here.

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