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COGNITIVE BEHAVIORAL THERAPY INTERVENTION FOR DEPRESSED WORKING FATHERS: A RANDOMIZED CONTROL STUDY

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Abstract

Depression among working fathers is an increasingly recognized yet underexplored mental health concern, especially in low-resource settings like Karachi, Pakistan. This study aimed to assess the effectiveness of a Cognitive Behavioral Therapy (CBT)-based intervention in reducing symptoms of depression among working fathers. A randomized controlled trial (RCT) was conducted with 32 participants, aged 25–55 years, who were randomly assigned to either a control group (n = 16) or an intervention group (n = 16). The intervention group received 10 weekly and 2 fortnightly group CBT sessions, while the control group received no psychological intervention. Depression severity was measured using the Patient Health Questionnaire-9 (PHQ-9) at baseline and post-intervention. Paired samples t-tests showed a statistically significant reduction in depressive symptoms in the intervention group ($M = 7.44$, $p < .001$), whereas no significant change was found in the control group ($p = .759$). These results indicate that CBT was effective in significantly reducing depression among working fathers. The findings underscore the importance of gender-sensitive, culturally tailored mental health interventions for men balancing professional and familial roles. This study contributes to the limited body of research on paternal mental health and provides empirical support for integrating CBT into workplace and community-based mental health programs for men in South Asia.

INTRODUCTION

Depression in working fathers is a growing concern, as many faces unique stressors that significantly impact their mental health and overall well-being. These stressors include the challenge of maintaining a healthy work-life balance (Macdonald & Fletcher, 2025), societal expectations related to gender roles, financial pressures, and the struggle to fulfill both professional and familial responsibilities (Baxter et al., 2018,). Despite the increasing involvement of fathers in childcare and household duties, many still experience societal pressure to be the primary breadwinner, adding to the stress (Fox, 2016).This combination of factors can lead to an increased risk of depression, anxiety, burnout, and other mental health issues among working fathers, negatively affecting their personal well-being, relationships, and job performance. Studies show that between 5-12% of fathers experience depression in the first year of their child's life, similar to rates seen in postpartum mothers. One study by Ramchandani et al. (2008) found that about 10% of new fathers suffer from postnatal depression, often unnoticed or untreated due to societal stigmas and fewer screening opportunities compared to mothers. Other research suggests that work-related stressors, such as long working hours and lack of work-life balance, contribute significantly to fathers. many fathers struggle to balance demanding work schedules with family responsibilities. The pressure to excel in both domains often lead to emotional exhaustion and feelings of inadequacy. Fathers may experience guilt for not spending enough time with their children or for not being fully present at work, contributing to heightened stress. Traditional gender norms often dictate that men should be the primary providers, placing undue pressure on working fathers. Even as gender roles evolve and more fathers take on caregiving roles, societal expectations about masculinity and breadwinning persist, leading to conflicts about their identity and self-worth.

Fathers, particularly those in single-income households or lower-income jobs, often feel immense pressure to provide financial security for their families. Economic instability, job insecurity, or concerns about meeting the rising costs of living can heighten stress, leading to feelings of anxiety and helplessness.

Many fathers feel they cannot express vulnerability or seek help due to societal beliefs about masculinity, resulting in emotional

isolation. This lack of emotional support worsens depressive symptoms, as they may internalize their struggles rather than seek guidance or assistance.

Effects on relationships: Depression can affect the quality of relationships with partners and children, creating a cycle of guilt, frustration, and emotional withdrawal. Fathers may become less emotionally available to their families, leading to further isolation.

There is a pervasive stigma around men seeking help for mental health issues, particularly related to depression. This is compounded by traditional gender norms that expect men to be stoic, self-reliant, and emotionally reserved. As a result, working fathers may be less likely to seek support, and mental health services often fail to account for their reluctance. This gap in service provision means that mental health resources for men, particularly fathers, are limited and often not tailored to their needs.

Many workplaces mental health programs are not designed with the specific challenges of working fathers in mind. Fathers may face stress from balancing long work hours, financial pressures, and family obligations, yet workplace policies often do not provide adequate support for paternal leave, flexible work schedules, or mental health services tailored to this demographic. The lack of father-focused mental health initiatives in the workplace leaves them feeling unsupported in managing stress and emotional well-being.

While depression has historically been associated more with women, particularly postnatal depression in mothers, there is increasing recognition of mental health issues, including depression, among working fathers. Studies suggest that working fathers face unique stressors related to their dual responsibilities at work and home, which increase vulnerability to depression. However, their struggles are underrepresented in research and healthcare.

While few studies focus specifically on working fathers, evidence from broader male populations suggests that CBT is highly effective in addressing depressive symptoms. Rochlen et al. (2005) showed that CBT is particularly useful for men hesitant to engage with traditional talk therapy due to stigmas surrounding emotional expression. CBT's structured, goal-oriented approach appeals to many men, including working fathers, as it focuses on practical solutions to reduce stress and improve mental health.

Group-based CBT interventions have shown promise in treating depression in fathers. A

study by Vollmer et al. (2017) evaluated group CBT sessions for fathers experiencing paternal postnatal depression. Results indicated these sessions helped participants feel less isolated and provided coping strategies for work and family-related stressors. Group-based approaches may also foster a supportive environment for men to discuss challenges around fatherhood without fear of judgment.

With the increasing demand for flexible mental health services, several studies have examined the efficacy of online or telehealth CBT interventions. Andersson et al. (2014) found that internet-based CBT is an effective option for fathers facing barriers to accessing traditional in-person therapy, such as time constraints or stigma. These remote interventions are particularly valuable for working fathers, allowing them to access mental health support without sacrificing work or family time.

In addition to CBT, other mental health interventions have been studied in populations of fathers and working men, including mindfulness-based stress reduction (MBSR), peer support groups, and workplace mental health programs.

Statement of the Problem

While interventions like CBT and MBSR are well-established for treating depression in the general population, fathers are less frequently studied as a distinct group. Studies on mothers, for example, have led to targeted postpartum depression interventions, but similar approaches for fathers are lacking. A meta-analysis by Goodman (2004) found that mental health services for new fathers are significantly underdeveloped compared to those for mothers, leading to a disparity in support. Moreover, fathers are less likely to seek help due to stigma, further complicating the delivery of effective interventions.

Workplace interventions designed to improve mental health have been shown to reduce stress and depression in working fathers. Hammer et al. (2015) conducted a study on workplace flexibility and mental health, showing that fathers given more control over work schedules experienced lower stress levels and improved mental health outcomes. Interventions such as mental health days, flexible work hours, and on-site counseling services can significantly impact the well-being of working fathers by reducing the pressure to juggle multiple responsibilities.

Depression in working fathers was linked to challenges in maintaining a healthy work-life balance, societal expectations related to gender roles, financial pressures, and the struggle to fulfill both professional and familial responsibilities. Despite the increasing involvement of fathers in childcare and household duties, many still experienced societal pressures to be the primary breadwinner, which added to their stress. This combination of factors often led to an increased risk of depression, anxiety, burnout, and other mental health issues among working fathers, with negative implications for their personal well-being, relationships, and job performance.

Objective of the study

To assess the effectiveness of Cognitive Behavioral Therapy (CBT) in reducing symptoms of depression among working fathers.

Rationale of the study

Previous studies had predominantly focused on postpartum depression in mothers, leaving a significant research gap in understanding paternal depression. While some studies had investigated male depression in general, few had examined targeted interventions specifically for working fathers. This study contributed to the literature by assessing the effectiveness of CBT in reducing depressive symptoms, improving overall well-being, and enhancing family dynamics in this understudied population.

Significance of the Study

Depression among working fathers was a significant yet often overlooked mental health concern that impacted both individual well-being and family dynamics. This study aimed to evaluate the effectiveness of Cognitive Behavioral Therapy (CBT) in reducing depressive symptoms among employed fathers, offering a structured psychological intervention tailored to their unique stressors. The findings contributed to mental health research and clinical practice by providing evidence-based support for CBT as a viable treatment for working fathers struggling with depression. By improving emotional well-being, the intervention potentially enhanced work productivity, parenting effectiveness, and overall family relationships. Additionally, the study helped bridge the gap in mental health services for men in low-resource settings like Karachi, Pakistan, where psychological support for working fathers remained limited. The results of this randomized controlled trial (RCT) provided policymakers, mental health professionals, and organizations with valuable

insights into integrating CBT into workplace and community-based mental health programs, ultimately fostering healthier families and societies.

Research Question:

How effective will a Cognitive Behavioral Therapy (CBT)-based intervention be in reducing symptoms of depression among working fathers?

Will there be a significant difference in depressive symptoms between the experimental group (receiving CBT) and the control group (not receiving CBT)?

Hypothesis:

H1: The Cognitive Behavioral Therapy (CBT) intervention will significantly reduce symptoms of depression in working fathers compared to the control group receiving no treatment or standard care.

H2: There will be a significant difference in depressive symptoms between the experimental group (receiving CBT) and the control group (not receiving CBT).

Methodology

Study Design:

A Randomized Controlled Trial (RCT) was conducted to evaluate the effectiveness of the intervention by randomly assigning participants to one of two groups: an intervention group that received Cognitive Behavioral Therapy (CBT), and a control group that did not receive CBT.

Study Duration:

The total duration of the study was 10 months, which encompassed the following phases:

Data Collection (2 months): This phase included participant recruitment and the administration of PHQ-9 Scale.

Intervention Phase (5 months): Participants in the intervention group received Cognitive Behavioral Therapy (CBT) sessions, along with routine follow-ups with those participants not received CBT.

Data Analysis (1 month): This period was dedicated to data entry, cleaning, and the conduct of statistical analyses.

Manuscript Preparation (2 months): The final phase involved writing, reviewing, and finalizing the study manuscript.

Sample Size:

As per the selection criteria, the sample of the present study comprised a total of N = 32 working males from different organizations and residing in Karachi, Sindh, Pakistan. The age range of the entire sample was from 25 to 55 years.

Sampling Technique:

The study employed a non-probability purposive sampling technique, where participants were selected based on specific criteria relevant to the research objectives. This method ensured the inclusion of individuals who met predefined characteristics, allowing for a more focused and meaningful analysis.

Inclusion Criteria:

Working fathers, aged 25–55, who were diagnosed with mild to moderate depression.
Scored 10 or above on the PHQ-9 scale.
Were living in Karachi.
Were willing to participate voluntarily.

Exclusion Criteria:

Individuals with severe psychiatric conditions or substance abuse.
Participants with severe medical illnesses were excluded (unable to talk).
Those temporarily living in Karachi.
Those who were currently receiving any medication or psychotherapy for depression.

Operational Definition:

This study was conducted in Karachi, Pakistan, and targeted male individuals who were biological or legal fathers, employed in either full-time or part-time occupations. Eligible participants met the diagnostic criteria for depression, demonstrated by a Patient Health Questionnaire-9 (PHQ-9) score of 10 or above, and had been experiencing depressive symptoms for a minimum of two weeks. The intervention consisted of a structured, evidence-based group Cognitive Behavioral Therapy (CBT) program, delivered by a qualified PhD scholar. The program comprised 10 weekly sessions and 2 additional fortnightly sessions, with each group including 8 participants. CBT sessions were designed to enhance accessibility and feasibility for participants and focused on core therapeutic components such as cognitive restructuring, behavioral activation, and the development of effective coping strategies for managing depressive symptoms.

Measures:

Demographic

A self-developed questionnaire was utilized in the study to collect demographic information. A demographic form was designed to gather essential details about the participants, including their age, gender, family structure, education level, and socioeconomic status, with a focus on working fathers.

The PHQ-9 (Patient Health Questionnaire-9)

The PHQ-9 is a widely used, validated, and self-administered tool designed to assess the severity of depression. It consists of nine items derived from the diagnostic criteria outlined in the Diagnostic and Statistical Manual of

Mental Disorders, Fourth Edition (DSM-IV), measuring the frequency of depressive symptoms experienced over the past two weeks. Each item corresponds to a core symptom of depression—such as anhedonia, sleep disturbance, fatigue, and feelings of worthlessness—and is rated on a 4-point Likert scale: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day. The total score serves as a quantitative measure of depression severity, facilitating both clinical diagnosis and monitoring of treatment outcomes. The PHQ-9 has demonstrated strong psychometric properties, including high internal consistency (Cronbach's alpha ranging from 0.86 to 0.89) and excellent test-retest reliability (correlation coefficients between 0.84 and 0.96), confirming its reliability and suitability for use in both clinical and research settings.

Intervention

Cognitive Behavior Therapy This section includes basic principle of Cognitive Behavior Therapy (CBT) that are adapted from Thinking Healthy Program and Group CBT manual by Jeanne Miranda (Ngo, V. K., & Miranda, J. 2018).The CBT aims at helping fathers about CBT and depression, connection between thoughts and mood, helping men that noticing and managing their thoughts can help them feel better

and enable them to notice healthy and unhealthy thoughts. Mode of Delivery: 10 sessions weekly and 2 sessions forthrightly.

Session 1: Understanding Depression & CBT Basics

Goal: Educated participants about depression and introduced the principles of Cognitive Behavioral Therapy (CBT).

Explained the definition, symptoms, and causes of depression.

Described how CBT works by highlighting the connection between thoughts, feelings, and behaviors.

Activity: Participants identified their personal depression triggers.

Homework: Tracked their moods, thoughts, and behaviors throughout the week.

Observed Impact:

Participants expressed appreciation for understanding depression as a medical condition rather than a personal weakness.

Early rapport and trust were established, setting a positive tone for future sessions.

Session 2: Identifying Negative Thought Patterns

Goal: Helped participants recognize unhelpful thought patterns.

Discussed common cognitive distortions such as all-or-nothing thinking and catastrophizing.

Explained how negative thoughts influence emotions.

Activity: Participants identified their own negative thoughts.

Homework: Recorded automatic thoughts and associated emotional responses.

Observed Impact:

- Participants expressed surprise and insight upon realizing how frequently negative thinking patterns occurred in daily life.
- The session fostered a non-judgmental atmosphere that encouraged honest self-reflection and group support.

Session 3: Challenging & Reframing Negative Thoughts

Goal: Taught participants how to challenge and reframe negative thoughts.

Introduced strategies to dispute distorted thinking.

Practiced generating more balanced and realistic thoughts.

Activity: Participants engaged in paired exercises to practice cognitive restructuring.

Homework: Applied techniques to challenge negative thoughts during the week.

Observed Impact:

- Participants expressed a sense of empowerment, noting that they felt "more in control" of their thoughts and emotions.

The interactive format helped normalize cognitive distortions and allowed participants to support one another in developing healthier perspectives.

Session 4: Behavioral Activation – Increasing Pleasant Activities

Goal: Encouraged participants to increase engagement in enjoyable and meaningful activities.

Explained how depression often leads to decreased activity levels.

Emphasized the positive impact of pleasurable activities on mood.

Activity: Participants developed a personalized activity plan.

Homework: Engaged in at least one pleasant activity each day.

Observed Impact:

Participants expressed optimism and increased motivation after identifying simple, realistic ways to reintroduce pleasure into their daily routines.

Many acknowledged that even small activities helped reduce feelings of isolation and sadness, reinforcing the link between action and improved mood.

Session 5: Overcoming Avoidance & Procrastination

Goal: Addressed avoidance and procrastination behaviors.

Discussed how avoidance maintains depressive symptoms.

Introduced strategies to reduce procrastination.

Activity: Created action plans to tackle postponed tasks.

Homework: Completed one previously avoided activity.

Observed Impact:

- Participants expressed a greater sense of control and motivation after planning realistic steps to manage delayed responsibilities.
- Several reported initial anxiety when approaching avoided tasks but described improved mood and reduced guilt after taking action.

Session 6: Managing Stress & Problem-Solving Skills

Goal: Introduced effective stress management and problem-solving techniques.

Explained the impact of stress on mental health.

Outlined the steps of structured problem-solving.

Activity: Participants applied the steps to a personal issue.

Homework: Practiced using problem-solving skills throughout the week.

Observed Impact:

Participants

reported feeling more capable of addressing challenges systematically rather than avoiding or feeling overwhelmed by them.

Session 7: Improving Sleep & Self-Care Habits

Goal: Focused on improving sleep and self-care routines.

Discussed sleep hygiene and its relation to depression.

Highlighted the role of physical health in emotional well-being.

Activity: Developed individualized self-care plans.

Homework: Implemented at least one positive self-care behavior.

Observed Impact:

Participants acknowledged neglecting self-care and expressed motivation to prioritize healthier habits.

Many reported improved sleep quality and energy levels after implementing small changes.

Session 8: Strengthening Social Connections

Goal: Enhanced social skills and relationships.

Explored the role of social withdrawal in depression.

Taught assertiveness and boundary-setting techniques.

Activity: Participants role-played assertive communication scenarios.

Homework: Initiated contact with one supportive individual.

Observed Impact:

- Participants reported increased willingness to connect with others and described positive emotional effects from even brief social interactions.

Session 9: Managing Rumination & Worry

Goal: Reduced excessive worry and rumination.

Differentiated between productive and unproductive worry.

Introduced techniques to refocus attention away from negative thinking.

Activity: Practiced mindfulness and grounding techniques.

Homework: Used a grounding strategy when experiencing rumination.

Observed Impact:

- Many participants felt relief after practicing mindfulness and noted that the tools were helpful for redirecting focus during emotional distress.

Session 10: Handling Setbacks & Preventing Relapse

Goal: Prepared participants to manage setbacks and prevent relapse.

Discussed early warning signs of relapse.

Supported the creation of personalized maintenance strategies.

Activity: Identified personal warning signs and coping responses.

Homework: Developed a written relapse prevention plan.

Observed Impact:

Participants expressed confidence in their ability to recognize when they are slipping and take steps to prevent full relapse.

Session 11: Gratitude & Positive Thinking

Goal: Promoted a positive mindset through gratitude and optimism.

Shared research on the benefits of gratitude.

Taught techniques for fostering positive thinking.

Activity: Created personal gratitude journals.

Homework: Noted three positive experiences each day.

Observed Impact:

Participants shared that actively focusing on positives helped them feel more hopeful and emotionally balanced.

Session 12: Reflection & Moving Forward

Goal: Reviewed progress and facilitated future planning.

Summarized key concepts learned throughout the CBT sessions.

Guided participants in setting long-term goals.

Activity: Participants shared reflections on their growth and progress.

Homework: Created individualized plans for ongoing self-improvement.

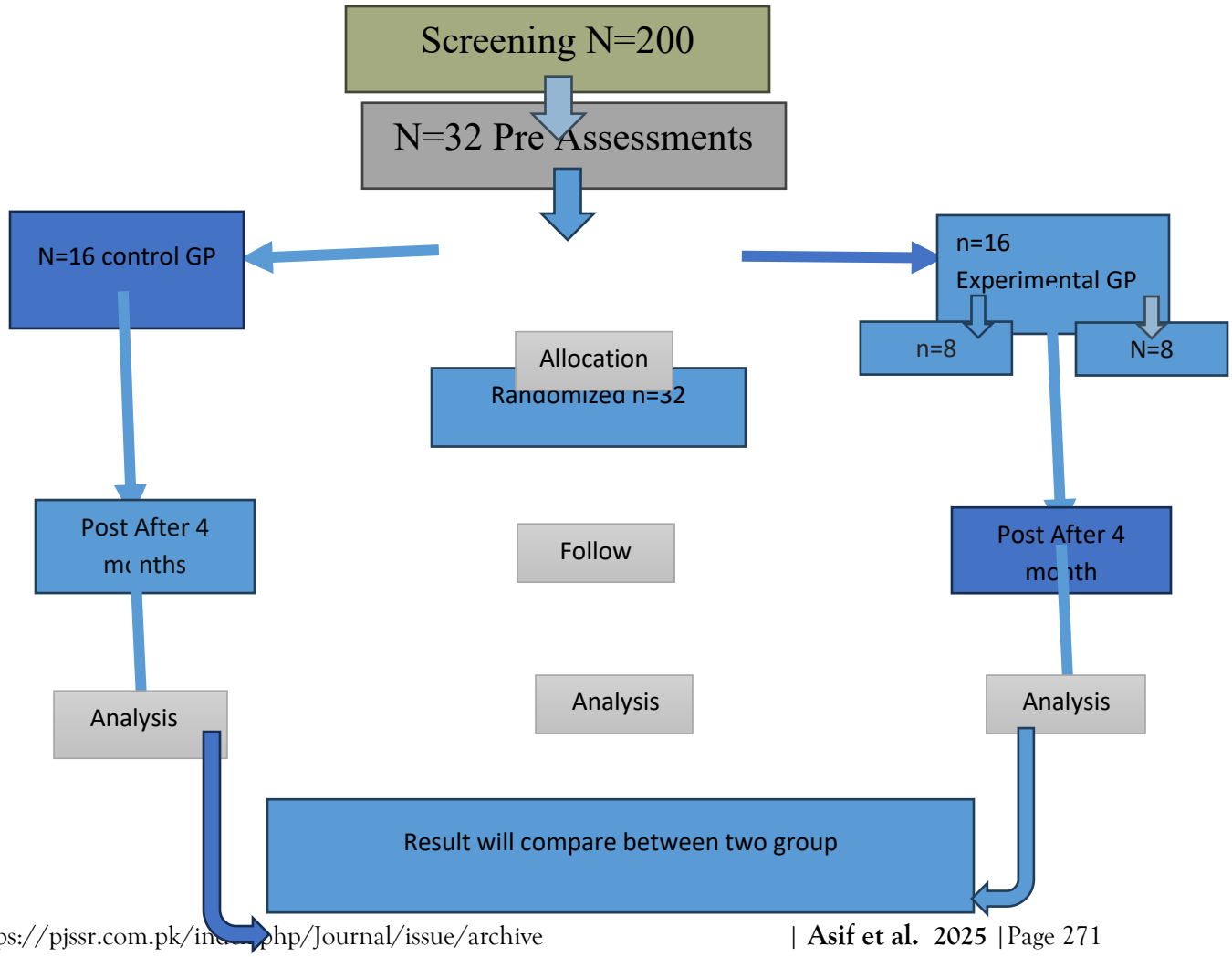
Observed Impact:

- Participants expressed pride in their progress and a sense of hope for the future.
- The session fostered closure, confidence, and a commitment to continued growth.

Procedure of the Study

Participants who met the inclusion criteria were recruited from Karachi. A total of 32 participants (N = 32) were randomly assigned to either the control group (n = 16) or the intervention group (n = 16). The intervention group was further divided into two subgroups of eight participants each. The intervention group received the designated treatment program, while the control group did not receive any intervention. Data were systematically collected and analyzed to compare outcomes between the groups and to assess the effectiveness of the intervention.

Flow Chart



Results

Table 1 Demographics

		Frequency	Percent	Valid Percent	Cumulative Percent
Age	Age 20 to 25	2	6.3	6.3	6.3
	Age 26 to 30	8	25.0	25.0	31.3
	Age 31 to 35	6	18.8	18.8	50.0
	Age 36 to 40	14	43.8	43.8	93.8

Ethical Consideration

Informed consent was taken from the participants. It was assured that the information was kept confidential and used only for research purposes, and they were free to withdraw at any time. Research participants were notified about the nature of the research. Participants were assured that all information would remain anonymous and confidential. No form of deception was used to obtain information. All participants were treated equally.

Proposed Data Analysis:

Data were analyzed using IBM SPSS Statistics version 22. Descriptive statistics, including frequencies and percentages, were calculated to summarize the demographic characteristics of the participants. To assess the effectiveness of the intervention, independent samples t-tests were conducted to compare mean scores between the control and intervention groups. Additionally, paired samples t-tests were employed to evaluate pre- and post-intervention differences within each group.

Age 41 to 45	2	6.3	6.3	100.0
Total	32	100.0	100.0	
Education				
Middle	1	3.1	3.1	3.1
Matric	2	6.3	6.3	9.4
Intermediate	1	3.1	3.1	12.5
B.A/BSc	11	34.4	34.4	46.9
Master	17	53.1	53.1	100.0
Working Status				
Private job	20	62.5	62.5	62.5
Govt job	8	25.0	25.0	87.5
Own work	4	12.5	12.5	100.0
Family System				
Single	16	50.0	50.0	50.0
Joint	16	50.0	50.0	100.0
Family Status				
Low	11	34.4	34.4	34.4
Middle	21	65.6	65.6	100.0

Table 1 presents the demographic characteristics of the study participants (N = 32). The majority of participants (43.8%) were aged between 36 and 40 years, followed by 25% in the 26–30 age group, and 18.8% in the 31–35 age group. A small proportion of participants were aged 20–25 (6.3%) and 41–45 (6.3%).In terms of educational background, over half of the participants (53.1%) held a Master's degree, while 34.4% had completed a Bachelor's degree (B.A/BSc). A small number had Intermediate (3.1%), Matric (6.3%), or Middle (3.1%) level education. Regarding employment status, the majority of participants (62.5%) were employed in private jobs, 25% were working in government sectors, and 12.5% were self-employed. Family system data showed an equal distribution, with 50% living in nuclear families and 50% in joint families. Socioeconomic status indicated that 65.6% of participants identified as belonging to the middle class, while 34.4% reported being from a lower socioeconomic background.

Table 2

Paired Samples Statistics indicate Difference of Depression within Groups

Group		Mean	N	Std. Deviation	Std. Error Mean
Control	Pre_ Depression	13.94	16	3.021	.755
	Post_ Depression	13.63	16	2.825	.706
Intervention	Pre_ Depression	12.75	16	2.436	.609
	Post_ Depression	5.31	16	1.662	.416

Table 2 displays the paired samples statistics for pre- and post-intervention depression scores in both the control and intervention groups. In the control group, the mean depression score slightly decreased from 13.94 (SD = 3.02) at pre-test to 13.63 (SD = 2.83) at post-test, indicating minimal change. In contrast, the intervention group, which received the CBT-based intervention, showed a notable reduction in mean depression scores, dropping from 12.75 (SD = 2.44) at pre-test to 5.31 (SD = 1.66) at post-test. This substantial decline suggests the potential effectiveness of the intervention in reducing depression symptoms.

Table 3
Paired Samples Test

Group			Paired Differences					T	Df	Sig. (2-tailed)
			Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Control	Pair 1	Pre_ Assessment - Post_Assessmnet	31.3	3.995	.999	-1.816	2.441	.313	15	.759
Intervention	Pair 1	Pre_Asessments - Post_Assessmnet	7.438	2.581	.645	6.062	8.813	11.526	15	.000

Table 3 presents the results of the paired samples t-test used to evaluate pre- and post-intervention changes in depression scores within the control and intervention groups. In the control group, the difference in depression scores from pre-test (M = 13.94) to post-test (M = 13.63) was not statistically significant (M = 0.313, *SD* = 3.995), $t(15) = 0.313$, $p = .759$, indicating no meaningful change in depression levels over time without intervention. Conversely, in the intervention group, a statistically significant reduction in depression scores was observed from pre-test (M = 12.75) to post-test (M = 5.31). The mean difference was 7.44 (*SD* = 2.581), with a $t(15) = 11.53$, $p < .001$. The 95% confidence interval for the difference ranged from 6.06 to 8.81, confirming the effectiveness of the CBT-based intervention in reducing depressive symptoms among participants. **Discussion**

The current study aimed to evaluate the effectiveness of Cognitive Behavioral Therapy (CBT) in reducing symptoms of depression among working fathers in Karachi, Pakistan. This study is among the few in the South Asian context to address paternal mental health an often overlooked yet critical area of psychological research and intervention. The findings demonstrated that group-based CBT significantly reduced depressive symptoms in working fathers, supporting the study's primary hypothesis and aligning with existing literature on the utility of CBT in treating depression in male populations. The paired samples t-test revealed a statistically significant reduction in depressive symptoms in the intervention group ($p < .001$), while the control group, which did not receive CBT, showed no significant change ($p = .759$). This substantial decrease in depression scores in the intervention group underscores the efficacy of CBT as a therapeutic approach for this population. These results are consistent with previous studies that highlight CBT's effectiveness in addressing depression among men who are often reluctant to engage in traditional therapy due to gendered stigma and emotional reservation (Rochlen et al., 2005; Addis & Mahalik, 2003).

CBT's structured and solution-focused model likely contributed to its success in this context. Working fathers often experience high levels of stress due to conflicting demands between work and family responsibilities, societal expectations of masculinity, and financial pressures (Macdonald & Fletcher, 2025;

Baxter et al., 2018). The CBT sessions focused on core therapeutic elements such as cognitive restructuring and behavioral activation, which helped participants recognize negative thought patterns and develop more adaptive coping strategies. These strategies have been shown to be particularly effective in collectivist societies, where interpersonal and role-based stressors are prominent (Rahman et al., 2008).

Notably, the group format of CBT may have played a crucial role in facilitating engagement and reducing feelings of isolation. Group-based interventions have been shown to foster peer support, normalize emotional struggles, and promote openness among male participants (Vollmer et al., 2017; Beel et al., 2019). For many fathers, participating in group sessions with peers who share similar challenges can break the silence around paternal depression and help deconstruct harmful norms surrounding masculinity. The shared experience of fatherhood and work-related stress within a structured therapeutic setting may have enhanced the therapeutic alliance and overall treatment adherence.

These findings support prior research by Andersson et al. (2014), which suggests that when psychological interventions like CBT are made accessible—particularly in flexible, group-based, or non-specialist formats—they can yield significant improvements in men's mental health. Similarly, a culturally adapted CBT intervention known as LTP + Dads, implemented in urban Pakistan, demonstrated feasibility and significant reductions in depressive symptoms among working-class fathers, emphasizing the value of culturally appropriate models (Atif et al., 2021; Zafar et al., 2024). These studies reinforce the present findings and highlight how targeted interventions for men, especially fathers, can be both acceptable and effective in low- and middle-income countries (LMICs).

Despite the promising results, this study also highlights the need for culturally sensitive and gender-responsive mental health services. Many mental health programs, particularly in South Asia, are designed primarily for women or children and often overlook the unique stressors men face. Traditional therapy models may not account for the stigma associated with male vulnerability, nor do they offer the practical flexibility that working fathers require (Goodman, 2004; Vogel et al., 2011). By delivering therapy in a group format during non-working hours and focusing on real-life stressors, this study addressed several key barriers men face in accessing mental health care.

Another key implication of this study is its relevance to workplace mental health initiatives. As Hammer et al. (2015) noted, organizational policies that support paternal mental health such as flexible scheduling, mental health days, and onsite supportcan significantly reduce stress and depressive symptoms among working fathers. Although this study was not conducted in a workplace setting, its findings suggest that integrating structured psychological support into community or workplace wellness programs could improve the well-being of working men and, by extension, their families.

Furthermore, this study adds to the growing recognition of paternal mental health as a determinant of family health and child development. Evidence from high-income countries indicates that paternal depression can negatively impact child socio-emotional development, partner relationships, and parenting quality (Ramchandani et al., 2008; Sweeney & MacBeth, 2016). These effects are likely compounded in LMIC contexts where socioeconomic pressures are intense and support systems are limited. Addressing paternal mental health can therefore have cascading benefits across the family unit.

While the findings are encouraging, there are several limitations to acknowledge. First, the sample size was relatively small (N = 32), which may affect the generalizability of the results. Second, the study used a non-probability purposive sampling method, which may introduce selection bias. Third, the follow-up period was limited, and thus the long-term sustainability of treatment effects remains unknown. Future studies should consider longitudinal follow-up to assess whether the improvements in depressive symptoms are maintained over time. Additionally, incorporating qualitative feedback from participants could provide deeper insights into the acceptability, perceived usefulness, and cultural relevance of CBT for this population.

Lastly, this study addresses a significant gap in literature by focusing on male mental health specifically working fathers in the South Asian context. While much of the previous research has focused on maternal mental health, especially postnatal depression in mothers, this study provides valuable evidence that paternal mental health is equally important and deserving of targeted interventions. Given the documented impact of paternal depression on child development, spousal relationships, and workplace productivity, mental health policies and interventions must begin to include fathers as a critical population of interest

(Ramchandani et al., 2008; Panter-Brick et al., 2014).

Conclusion

In conclusion, this study provides robust evidence that Cognitive Behavioral Therapy is an effective intervention for reducing depressive symptoms in working fathers. The findings underscore the importance of developing tailored mental health services for men, particularly those balancing the dual demands of work and family. Group-based CBT not only reduced symptoms of depression but also helped create a safe and supportive space for fathers to explore emotional challenges often silenced by societal expectations. Future mental health strategies whether clinical, community-based, or workplace-oriented should consider including structured CBT programs as a vital component of comprehensive mental health care for men.

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