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Exploring self-harm: A narrative review of socio-cultural factors

Venkatesan S *

Formerly Dean-Research, Professor & Head, Department of Clinical Psychology, All India Institute of Speech and Hearing, Mysore: 570006, Karnataka, India.

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Abstract

This narrative review explores the socio-cultural factors influencing self-harm behaviors by synthesizing insights from 75 publications across diverse themes, including media, culture, religion, nations, and ethnicity. By examining secondary data, this review highlights how cultural perceptions and societal norms shape individuals' experiences with self-harm. It reveals that in some cultures, self-harm may be interpreted as a form of expression or resistance, while in others, it is stigmatized and misunderstood. The role of media is critically analyzed, showcasing its dual capacity to both normalize self-harming behaviors and provide platforms for support and awareness. Additionally, the review investigates how religious beliefs and practices can influence self-harm, either by offering frameworks for understanding distress or exacerbating feelings of guilt and shame. Ethnic variations in the experience and reporting of self-harm are also discussed by emphasizing the need for culturally sensitive approaches in mental health care. This comprehensive review underscores the importance of considering socio-cultural contexts when addressing self-harm, advocating for tailored interventions that resonate with individuals' backgrounds. Ultimately, it aims to enhance understanding and inform more effective, compassionate responses to self-harm as a significant public health concern.

Keywords: Self-mutilation; Religion; Superstition; Media; Ethnic; Mythology

1. Introduction

Self-harm (SH) is referred to by various terms, including non-fatal suicidal behavior, self-attack, self-infliction, self-injurious behavior, self-mutilation, anti-suicide, partial suicide, parasuicide, non-suicidal self-injury, self-injuring, wrist cutting, self-burning, skin-picking, self-scratching, self-hitting, hair pulling, bone breaking, tattooing, and self-wounding. A recurring theme that defines these behaviors, regardless of the terminology used, is that they are fundamentally individual, private, and personal actions carried out in isolation. This phenomenon has evolved into a significant public health concern, with reports indicating an increase in lifetime prevalence from 2.4 percent of the population in 2000 to 6.4 percent in 2014, and projected to be between 19-21 percent in 2024 (Haregu et al. 2023; Gandhi et al. 2021). The figures on the prevalence of SH as 31 percent in India appear to be higher than the global estimates (Patra et al. 2023; Singh, 2018; Kharsati & Bhola, 2015).

1.1. Prevalence by race & ethnicity

Most research on SH primarily focuses on Caucasian samples from Western populations. Studies indicate that referral rates for Black adolescents align with community demographics. While the socio-demographic characteristics, psychiatric symptoms, and circumstances surrounding SH attempts are similar for both Black and White adolescents, the Black group reports higher levels of social stress (Goddard, Subotsky, & Fombonne, 1996). Factors such as gender and socio-economic status influence the higher rates of SH among different racial and ethnic groups (Gholamrezaei, De Stefano, & Heath, 2017). Additionally, social support, cultural attitudes, and role expectations contribute to the over-

* Corresponding author: Venkatesan S

representation of females in SH studies, with gender being a more significant factor than ethnicity in increasing SH prevalence (Zaineb, 2009; Bhugra et al., 2003; 1999).

In the Indian scenario, SH is seen as part of many psychiatric conditions, such as depression, adjustment disorder, schizophrenia, Borderline, Histrionic, Antisocial Personality Disorders, Phobias, Dissociative Disorders, Conduct Disorders, and substance abuse (Krishnaram, Aravind, & Vimala, 2016). The odds of SH were 50 percent more likely among adolescents who had internet access, experienced parental physical abuse, had moderate to severe depressive symptoms, or showed involvement in fights (Sinha et al., 2021).

Parkar, Dawani, and Weiss (2008) explored the socio-cultural aspects of SH within urban general hospital settings in Mumbai, India, and found that men typically explained their behavior about problems at work, money, and alcohol use. On the other hand, women normally discussed domestic problems, in-law relations, victimization, and problem drinking by the men that affected them. Brossard (2018) posited that SH is a specific form of dialectical self-relationship–very often associated with forms and functions of social learning, self-image, self-punishment, social signaling, and social support.

Sociological theories propose that the degree of social integration and regulation within an individual's social contexts (Favazza, 1987), lack of social support, isolation, feelings of disconnection, societal changes, disruptions, and a lack of clear social norms (anomie), sub-cultures, and peer influence can create strain and lead to SH as a maladaptive coping strategy (Chandler, Myers, & Platt, 2011).

1.2. Research questions

The research area on socio-cultural aspects of SH, of particular interest for this research paper, is wide open and has many unanswered questions. How do different cultures perceive and interpret SH behaviors in various age groups of people? How do family structures and dynamics influence the prevalence and expression of SH in different cultural contexts? What role does social stigma play in the willingness of individuals to seek help for SH? How do peer relationships and social networks contribute to the onset or continuation of SH behaviors? How does the media portrayal of SH impact societal attitudes and behaviors toward individuals who engage in SH? How do socio-cultural factors shape gender differences in SH behaviors and coping strategies? In what ways do socio-economic factors affect access to mental health resources for individuals who engage in SH? What culturally sensitive interventions are most effective in addressing SH in diverse populations? How do religious beliefs and practices influence the understanding and treatment of SH in various communities? How does SH serve as an expression among marginalized groups within different cultures? A focused review of existing literature may provide insights and lead to deepening our understanding of these situations.

Objectives

Based on the mentioned need, rationale, and justification for the study, the main aim of this narrative review was to compile research contributions on or about the experiences of socio-cultural aspects in SH.

2. Method

A survey method was employed to collect article titles from national and international journals focused on SH. The research covered various socio-cultural aspects, including cultural interpretations, social stigma, family dynamics, peer relationships, and the impact of friendships and social networks on the onset and maintenance of SH. Additionally, the study examined media influence, public perception, gender dynamics in SH behaviors and coping strategies, socio-economic factors, and cultural interventions for diverse populations. It also explored religious beliefs, identity expression among marginalized groups, historical contexts, and community support systems that aid in preventing and recovering from SH. The data was sourced from various online and offline databases, such as Google Scholar, PsycINFO, ResearchGate, Web of Science, and PubMed.

2.1. Procedure

After inputting the raw data into an Excel spreadsheet, themes reflected in the article titles were coded, categorized, and classified. To ensure reliability, two independent coders, who were blinded to each other's work, reviewed at least a quarter of the entries in the sample of research articles. This approach reduced bias and resulted in a strong correlation coefficient of r: 0.94. A descriptive and interpretative statistical analysis was conducted using non-parametric measures with IBM SPSS Statistics (Version 27). Effect sizes were evaluated according to Cohen's guidelines,

yielding a value of 0.92, indicating 'almost perfect agreement' (Landis & Koch, 1977). The classification of thematic categories demonstrated high face validity for the research papers included in the study.

A total of 75 original research articles published by July 2024 were examined using a harvest plot and adhering to PRISMA2020 guidelines (Table 1; Figure 1; Page et al. 2021). The analysis focused on keywords like culture, cult, custom, self-harm, and self-mutilation. Excluded materials comprised descriptive essays, newsletters, magazines, unpublished dissertations, seminar proceedings, webinars, conferences, audiovisual content, and incomplete or misleading references. Ethical considerations in researching the social aspects of self-harm included informed consent, confidentiality, awareness of potential harm, emotional distress, and cultural sensitivity (Venkatesan, 2009).

3. Results

The mandated PRISMA-narrative guidelines such as a clear introduction, outlining of objectives and rationale, formulating research questions, and developing theoretical framework, stating comprehensive search strategy, data extraction process in the methods, and summary of findings in the results was followed. The conclusion, interpretation and implications of findings for future research was also mentioned

Table 1 Harvest plot showing the frequency distribution of frequently compiled research themes/topics on SH (N: 75)

Theme/Topics	N
SH	38
Indian	18
Culture	13
Review	8
Suicide	7
Religion	6
Media	6
Suicide	6
FGM	5
Social	4
History	3
Ethnic	3
Digital harm	3

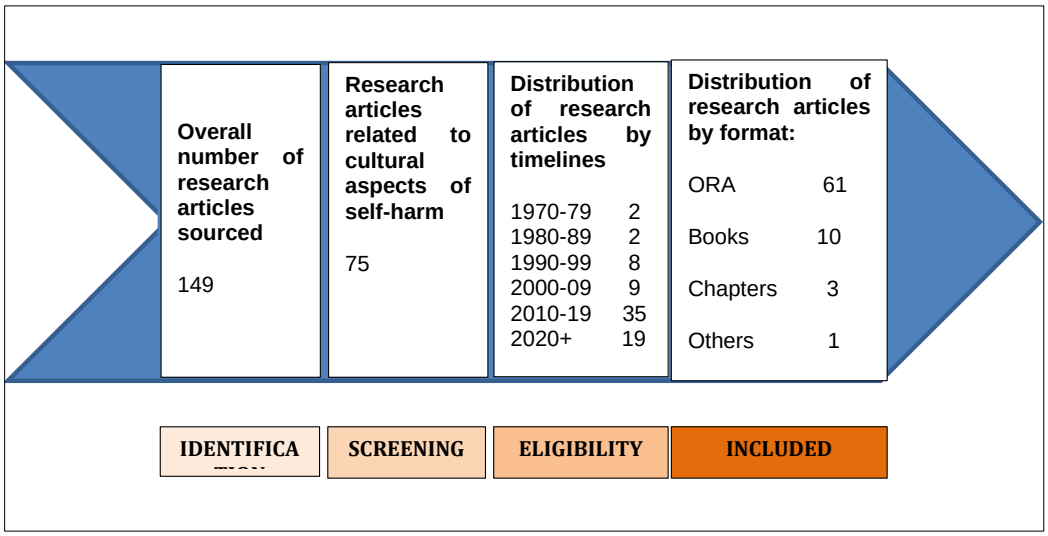

Figure 1 Prisma Flow Diagram depicting the procedure for review and frequency distribution of research articles by various parameters

This study analyzed 75 records, categorizing them by publication format, journal titles, study themes, and publication years. Most publications (61 out of 75; 81.33%) were original research articles, followed by books (10; 13.33%) and book chapters (3; 4.00%). The research encompassed over 60 different journal titles, but no single journal featured more than two or three articles on the subject of SH in one issue. There is no dedicated journal for SH. A notable increase in publications occurred from 2010 to 2019 (35 articles; 46.67%), with a decline in the subsequent period after 2020 (19 articles; 25.33%). Study themes (Table 1) varied, with 38 articles directly addressing SH or its synonyms, 18 focusing on Indian samples, and 13 on culture. More empirical research is needed on the connections between SH and media, FGM, religion, mythology, superstitions, history, ethnicity, and digital SH.

3.1. Individual act vs social phenomenon

SH can be understood from two distinct perspectives: (i) as an individual or private psychological act; and, (ii) as a common or shared social phenomenon. As an *individual psychological act,* it is viewed as a symptom of underlying mental health issues, such as depression, anxiety, borderline personality disorder, or trauma-related disorders. Individuals engage in SH as a way to cope with emotional pain, express feelings, or exert control over their bodies. It can serve as a release mechanism for overwhelming emotions. The focus is typically on psychological interventions, such as therapy (e.g., cognitive-behavioral therapy, dialectical behavior therapy) and medication, aimed at addressing the underlying mental health conditions. The emphasis is on the individual's experiences, mental state, and the personal reasons behind their SH behavior.

SH as a *social phenomenon* is a behavior that occurs in a broader social context, influenced by cultural, societal, and environmental factors. Social factors, such as peer influence, societal norms, or media exposure contribute to the prevalence of such behaviors in certain groups. Different cultures interpret SH in varied ways. Societal attitudes impact how individuals perceive their SH behaviors and the support they receive. This perspective emphasizes community-based interventions, awareness campaigns, and support systems to address the social factors contributing to SH. Understanding both perspectives is crucial for a comprehensive approach to prevention and intervention

Examples of SH as a social phenomenon are fire walking, skin piercing with hooks, carrying burdens for a deity, self-flagellation, eating food off the floor, breaking coconuts on one's head, and burning camphor in one's palm. Other group ritual practices involve self-flagellation, self-piercing/cutting/biting/punching, hair cutting, or inflicting injuries on oneself as a group. Exercising too much to the point of collapse or injury, having unsafe sex, deliberately starving themselves or binge eating, consuming an overdose of tablets or toxic substances, and picking at scabs and wounds can be both individual as well as collective behaviors.

Firewalking, the act of walking on hot coals, is often seen as a cult-based rite of passage, a test of faith, or a method of spiritual cleansing performed publicly. While it can cause self-harm, it is not merely an individual coping mechanism. It often occurs as a communal experience. Many participants describe it as transformative, fostering personal growth

through challenges. In some rare cases, poltergeist phenomena may coincide with SH behaviors in those dealing with repressed emotions like anxiety or anger (Diesel, 1994; Obeyesekere, 1978).

Another cult-based SH behavior is *Kavadi Attam* seen in South Indian Hindus when devotees pierce their skin with hooks and carry burdens to their deity Murugan. Extreme tattooing is adopted, not for decoration, but to signify lineage, symbolize strength or bravery, showcase social status, and reflect personal stories or achievements. Self-injury may be inflicted through burning camphor on their palm (Ramesh, 2018; Chittoria et al. 2014), breaking coconuts on their heads (Devi & Ghatani, 2022), consuming cow excreta or urine (Wadley, 2000). Other rituals may include eating food from the floor (Pattanaik, 2013), self-flagellation, or branding different parts of their bodies (Singh, 2015).

Another custom that romanticizes SH through body modifications is *urulu seva*, where individuals roll on the ground, often in front of a temple, as a self-offering to a deity despite experiencing pain, bruising, or injuries. This act symbolizes detachment from materialism and expresses humility, devotion, and surrender, aiming to seek blessings, atone for sins, and fulfill vows. For many devotees, participating in this ritual fosters community acceptance, strengthens their identity, and offers spiritual purification to help them navigate personal challenges (Mohapatra, 2013; Glucklich, 2001; Favazza, 1996).

Female genital self-mutilation is a culturally accepted and encouraged practice in some rural Nigerian communities, framed as a "development" and "rights issue" in other regions (Nnamani & Mathias, 2023; Lupu et al., 2021; Boyer & Tucker, 2020; Evans, 2020) as well as among Dawoodi Bohra Muslims in Pakistan (Syyed, 2019; Marshall & Yazdani, 1999)even though such practices cannot be justified under the euphemism of cultural relativism (Kelly, 2011; Parke, 1999).

Witchcraft, Wicca, Satanism, and Druidry associated with SH are seen as culture-bound syndromes, like amok in Southeast Asia, tabanca in Trinidad, and Hi-Wa-itck among American Indian communities. Littlewood (1985) described tabanca, a lovesick behavior, as a local interpretation of depression in rural Trinidad that can lead to suicide, particularly affecting working-class Afro-Caribbean males aspiring to white, middle-class values (Cowan & Bromley, 2015; Maharajh & Abdool, 2005).

These practices are often performed during festivals and ceremonies, symbolizing prayer, purification, and offerings to a deity, while also representing the surrender of one's ego. They express themes of sacrifice, devotion, respect, humility, and submission to a higher power. Such acts are viewed as religious offerings or means of connecting with ancestors, warding off evil spirits, promoting well-being, and seeking forgiveness for sins or wrongdoings. They serve to achieve spiritual cleansing and connect with the divine, marking significant life transitions like coming of age or joining a community. Some practices may involve intentional bodily modifications such as scarification or branding. In certain cultures, SH can be a sanctioned expression of grief or a ritual honouring the deceased, with acts like self-cutting or hair-cutting occurring during mourning. Additionally, SH may be used as a form of socio-political protest, with self-immolation serving as a method of political dissent in various regions worldwide (Staples, 2012; Staples & Widger, 2012).

3.2. Self-harm in media

Media encompasses different channels and platforms for conveying information, ideas, and entertainment to a broad audience. It includes various formats such as print (newspapers, magazines, brochures, and books), broadcast (television and radio), digital (websites, social media, podcasts, and streaming services), outdoor (billboards, posters, and transit ads), and multimedia (a mix of text, audio, images, animations, and video). Media is essential in influencing public opinion, spreading news, and offering entertainment. Both popular fiction and grey literature on SH have recently gained traction among general readers. Notable titles include Why Do We Hurt Ourselves? (2018), Psyche on the Skin (2017), Flesh Wounds: Safe with Self-Injury (2017), Self-Injury, Society, and Medicine (2016), Queer Youth, Suicide, and Self-Harm (2016), A History of Self-Harm in Britain (2015), Making Sense of Self-Harm (2015), Blades, Blood, and Damage (2012), The Tender Cut: Inside the Hidden World of Self-Injury (2011), and Writing on the Body (1992). These works are widely available in the market.

3.2.1. Media Portrayals

Movies and TV shows often depict cult leaders as charismatic individuals who manipulate followers into blind obedience, including SH behaviors in their strange rituals. Characters are typically isolated from their families and society, sometimes meekly submitting or resisting the cult's oppression. These narratives include horror elements, creating a sense of dread, thrill, and suspense. Many television series aimed at middle-class audiences portray

characters resorting to SH as a coping mechanism for emotional pain, extreme stress, or depression (Karupiah, 2023; Shekhar, 2016).

3.2.2. Social Media Usage

It has been found that youth who participate in SH are, on average, more active on online social networking platforms, which they use to communicate or seek social support from others. At times, negative self-images and advertisements act as triggers for SH behaviors (Biernesser et al. 2021; Memon et al. 2018; Dyson et al. 2016). Excessive use of social media can lead to or worsen mental health issues, prompting individuals to engage with peers or social forums for over three hours daily (Tørmoen et al. 2023). The depiction and normalization of SH in social media and television can create a "social contagion" effect, increasing the likelihood of such behaviors in vulnerable individuals (Silva & Botti, 2018; Emma Hilton, 2017; Zdanow & Wright, 2012; Peek et al. 2010).

3.2.3. Digital Self Harm

Digital self-harm refers to the act of teenagers anonymously posting cruel and hurtful comments about themselves on social media. This form of self-cyberbullying involves creating a false sense of on-line victimization, which negatively impacts one's psychological health. The main characteristics of this behavior include its on-line aspect, the element of deceit, and the presence of harmful content (Soengkoeng & Moustafa, 2022; Twenge et al. 2020; Patchin & Hinduja, 2017).

3.3. History

Exploring the history, ancient customs, religious contexts, medical viewpoints, mythological figures, symbolism, and cultural stories related to SH reveals a distinct cultural lens. In the sixth century AD, Maya priests engaged in auto-sacrifice by cutting their bodies to shed blood. The Hebrew Bible mentions Baal's priests who inflicted wounds on themselves. In Catholicism, this is termed self-mortification, while some Islamic traditions observe Ashura with self-flagellation rituals using chains and swords to honour Imam Hussain's martyrdom (Rodriguez, 2019; Dogra, 2017).

Excavated self-sacrifice stones from Nalgonda, Telangana, dating back to the 13th and 14th centuries, reveal that voluntary death was accepted in medieval Deccan culture, particularly among Hindu Veera-Saiva worshippers of Lord Shiva (Storm, 2018). Sati, a form of non-psychiatric suicide, has been documented among Hindus in the Indian subcontinent for centuries, influenced by cultural factors and gender dynamics (Kitts, 2018; Bhugra, 2005).

Several 17th-century sources (European travel literature and Mughal historiography) record the practice of SH, and possibly ritual suicide, at the Hindu temple of Vajreśvarī (Kāngṛā, HP), an important place of pilgrimage related to the *Śakti* cult (Cid, 2018). Blood spilling, symbolizing fertility, played a central role in these sacrifices, which were discontinued in the 18th century as they entered into conflict with the non-violent view of Hinduism supported by urban elites. In Indian culture, superstitions related to SH are deeply ingrained and differ by region, arising from cultural beliefs, religious practices, and societal norms. They contribute to stigma, anxiety, and self-blame in those struggling with mental health issues, making it difficult for them to seek help. SH in India is a complex matter linked to religious beliefs, coping strategies, and family obligations. Recognizing these cultural nuances is essential for effective support and intervention (Mandal, 2018).

In Buddhism, suicide is acceptable in certain exceptional circumstances as a pathway to attain nirvana. In Hinduism, suicide is entirely unacceptable, a violation of the code of non-violence, and therefore sinful. Jainism allows *Sallekhana* or fasting until death which is not an act of suicide, but an observance undertaken devoid of all earthly attachments. In Islam, suicide is considered a major sin and those who kill themselves will be punished in the Fire on the Day of Judgement (Lindsay, 2005).

There are several misconceptions about SH: that individuals can stop if they truly wish to, that SH itself is the main issue, and that halting it will resolve everything. Some equate SH to attempted suicide or that all who SH are suicidal. Others view it as a cry for help, attention-seeking, or manipulation. Additionally, there is a belief that more severe injuries indicate greater problems and that all who SH enjoy the pain or have Borderline Personality Disorder, often linking it to past abuse. Boredom has been shown to induce the use of electricity as a tool for SH by some individuals (Yusoufzai et al. 2022; Orbach et al. 1996). Widespread negative attitudes toward SH persist, with many countries treating attempted suicide as a punishable offence, leading to significant under-reporting. These unfavourable views are deeply rooted in religious beliefs, healthcare systems, and social policies. Stigma arises from limited understanding and biased attitudes, resulting in discrimination against those who SH. Public stigma differs from self-stigma, where individuals

internalize these negative perceptions. Overcoming the stigma surrounding SH is complex and challenging, as many who SH often accept these harmful stereotypes (Aggarwal, Borschmann & Patton, 2021).

3.4. Mythology

Indian mythology, particularly in the great epics of the Ramayana and Mahabharata, features numerous instances of SH and suicide. Characters such as Aja, the grandfather of Lord Rama, and Madri, Pandu's wife, exemplify this theme. In these narratives, suicide serves as a means of relief from suffering, martyrdom, evading apostasy, or protecting one's virginity. The practice of Sati, while not prevalent during the Vedic Age (3000-1500 BC), is mentioned in passing in the Atharvaveda. The Rigveda describes a mimetic ceremony where a widow lies beside her deceased husband before being led away by a relative, after which the funeral pyre is ignited. In the Ramayana, Rama, Lakshmana, Bharata, and Shatrugna perform Jalasamadhi in the Sarayu River. The Mahabharata depicts Yudhishtra, his four brothers, and their queen Draupadi committing suicide after the end of the battle. It notes that those who take their own lives cannot attain heavenly realms. Hinduism acknowledges the right to end one's life through Prayopavesa, with self-purification rituals prescribed in the Bhagavad Gita for those who attempt suicide (Radhakrishnan & Andrade, 2012; Balodhi, 1992).

4. Discussion

SH can be examined through several models, theories, paradigms, and approaches to biological, psychological, phenomenological, and sociocultural aspects. Among these, socio-cultural dimensions require a separate expansion. Admittedly, there are many individual and group risks as well as protective factors in SH, such as age, gender, condition of mental health, disability, the severity of disease, internet use, financial stress, employment status, self-knowledge, identity confusion or integration, previous suicidal ideation, or attempts, access to counseling, education or training, peer group availability and influences. The influence of social relationships, toxic, or abusive, with family, friends, and peers, cultural norms or values, social isolation vs connectedness, social stigma versus disclosure, media representations, life events, and transitions are identified as additional variables in the social context to influence SH (Steggals, Graham, & Lawler, 2020).

Culture is the distinct way of life of a group, encompassing customs, arts, science, and behaviors that differentiate societies. Understanding an individual requires knowledge of their cultural background, as highlighted in anthropology, which studies how culture influences behavior. Key elements include cultural context, social structures, symbolism, historical perspectives, cultural relativism, and ethnographic narratives. These factors are essential for a comprehensive analysis in fields like clinical psychology and counseling, particularly within the Indian context (Venkatesan, 2016; 2016). Culturally relevant factors like gender discrimination, unrealistic achievement expectations, and poor parenting significantly impact SH. Additionally, modern pressures from academics, internet use, and romantic relationships are crucial in treatment (Chen et al. 2021). Cultural conflicts regarding arranged marriages are associated with increased SH rates among South Asian unmarried females in the UK, who often use substances like bleach and medications following family disputes (Bhui, McKenzie, & Rasul, 2007).

5. Conclusion

Culture can be viewed as a protective and destructive force in an individual's functioning ever-changing environment. The transgenerational loss of an old culture will result in conflicts between the mores of the tradition and the expectations of the modernizing society. The transition period is often characterized by increased rates of behavior disturbances like SH or suicide. Understanding the cultural context and the meaning behind individual practices involving SH is crucial for providing appropriate support and interventions. Although group practices do not strictly fall under the purview of SH, practitioners must respect the cultural diversity and autonomy of the individuals and communities involved. Sociological, socio-cultural, or social learning theories highlight how experiences of marginalization, discrimination, and oppression based on race, caste, gender, sexual orientation, or socioeconomic status can increase the risk of SH as a coping mechanism. It examined how cultural norms, values, and social pressures can contribute to the development and perpetuation of SH.

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