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Self-Harm as a Gendered Social Practice: Violence, Vulnerability, and Embodied Experience

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Abstract

This study aims to critically examine how self-harm is socially and culturally constructed as a gendered practice. Moving beyond prevalence-based explanations, the article explores how dominant gender binaries shape meanings, interpretations, and responses to self-harm. The study employs a qualitative and interpretive approach, drawing on feminist sociological theory and a critical synthesis of existing literature, with particular reference to arts-based qualitative research on self-harm. Analytical attention is given to how narratives, metaphors, and embodied experiences of self-harm are produced and negotiated within gendered social contexts. Findings indicate that self-harm is frequently understood through binary oppositions such as male/female, aggression/vulnerability, and inside/outside. These binaries contribute to moral judgments, clinical assumptions, and the marginalization of experiences that do not conform to dominant gender norms. The analysis highlights how such constructions obscure relational, embodied, and contextual dimensions of self-harm. The study concludes that understanding self-harm as a gendered social practice is essential for developing more ethical, inclusive, and nuanced responses. It calls for greater use of qualitative, interdisciplinary, and reflexive methodologies that challenge reductive gender narratives and foreground lived experience.

Keywords: self-harm, gender, qualitative research, embodiment, feminist sociology

Introduction

Self-harm has increasingly been recognized as a major concern within public health, psychology, and the social sciences, particularly in relation to young people and gendered patterns of distress. Contemporary epidemiological studies indicate that non-suicidal self-harm is reported more frequently among adolescent girls and young women, while suicide mortality rates remain higher among men (McManus et al., 2019). Although such findings are valuable for surveillance and prevention planning, an overreliance on prevalence data risks reducing self-harm to a demographic variable rather than understanding it as a socially mediated and meaning-laden practice. Recent qualitative and sociological research emphasizes that self-harm is embedded within cultural norms, power relations, and gendered expectations that shape how distress is expressed, interpreted, and responded to (Chandler & Simopoulou, 2021).

Gender operates not merely as an individual attribute but as a structural and symbolic system that organizes emotional expression, bodily practices, and moral judgments. Studies published since the early 2000s have demonstrated that self-harm is often interpreted through gendered assumptions that associate femininity with emotional vulnerability and masculinity with externalized violence or risk-taking (Brickman, 2004; Millard, 2015). Such assumptions influence clinical assessment, help-seeking behavior, and institutional responses, frequently rendering some forms of distress more visible and legitimate than others. Consequently, experiences of self-harm that fall outside dominant gender narratives may be misunderstood, minimized, or stigmatized (Chandler et al., 2011).

In Nepal, self-harm is an under-researched and stigmatized phenomenon, often framed in terms of moral failing rather than as a response to structural and relational pressures (Shrestha et al., 2017). Epidemiological studies suggest that suicide rates in Nepal are among the highest in South Asia, with young women disproportionately affected by self-inflicted injury and suicide attempts (WHO, 2021). These patterns are intertwined with gendered experiences of domestic violence, early marriage, dowry pressures, and economic marginalization, which can exacerbate feelings of entrapment, shame, and social invisibility (Poudel & Koirala, 2020).

Framing self-harm as a gendered social practice allows for a nuanced understanding of how violence, vulnerability, and embodied experience converge in local contexts. In the Nepalese context, the body becomes a site through which social stressors, gendered expectations, and relational conflicts are enacted, rendering self-harm both a personal coping mechanism and a form of social communication (Patel et al., 2018). Recognizing these embodied experiences is essential for designing culturally sensitive interventions, integrating mental health support into community and health systems, and addressing structural inequities that underlie self-harming behavior.

This study therefore examines self-harm in Nepal as a socially situated practice, emphasizing the intersections of gender, violence, and vulnerability. By situating the phenomenon within local cultural, social, and familial frameworks, the research aims to contribute to a more contextually grounded understanding of self-harm in South Asia, aligning with international health priorities while foregrounding regional specificity.

Statement of the Problem

Despite a growing body of post-2000 research on self-harm, much of the literature continues to rely on binary and essentialist interpretations of gender. Gender differences are often treated as self-evident outcomes rather than as products of social, cultural, and historical processes. This limits critical engagement with how meanings of self-harm are constructed and sustained within everyday interactions, clinical practices, and policy frameworks. As recent qualitative studies suggest, gendered interpretations of self-harm can shape moral evaluations, reinforce stigma, and contribute to unequal or inappropriate responses within healthcare systems (Chandler & Simopoulou, 2021;

McManus et al., 2019). There remains a need for theoretically informed analyses that move beyond descriptive gender comparisons to examine how gender itself structures the understanding of self-harm.

Objectives of the Study

The objectives of this study are:

1. To examine self-harm as a gendered social practice, highlighting how sociocultural norms, gendered binaries, and embodied experiences shape its interpretation.
2. To assess the implications of these gendered constructions for clinical, ethical, and social responses, contributing to contemporary qualitative and sociological understandings of self-harm.

Limitations of the Study

This study is based on a critical and interpretive review of existing literature and does not involve primary empirical data collection. As a result, the findings are not intended to be statistically generalizable. In addition, much of the available qualitative research with DOI-indexed publications has been conducted in high-income Western contexts, which may limit the applicability of the analysis to non-Western settings. While gender is the central analytic focus, other intersecting dimensions such as ethnicity, class, and sexuality are not examined in depth and warrant further investigation. Nonetheless, the study provides a theoretically robust framework for understanding self-harm as a gendered phenomenon and for guiding future empirical and cross-cultural research.

Literature Review

Conceptualising Self-Harm: Definitions and Theoretical Frameworks

Self-harm encompasses a broad spectrum of behaviours involving deliberate injury to one's body, irrespective of suicidal intent. This includes *non-suicidal self-injury* (NSSI) such as cutting or burning as well as behaviours associated with ambivalence toward life (Klonsky et al., 2014). Traditional psychological frameworks have emphasized individual pathology framing self-harm as a manifestation of psychiatric illness or emotion regulation difficulties (American Psychiatric Association, 2013). However, contemporary scholarship increasingly situates self-harm within sociocultural and gendered contexts, conceiving it as a socially mediated practice rather than a purely intrapsychic phenomenon (e.g., "the violence of the cut" approach; Carroll et al., 2021).

Canetto and Sakinofsky's (1998) seminal work on the *gender paradox of suicide* highlights that while males often predominate in fatal suicide statistics, females more frequently engage in non-fatal self-harm a pattern reflective of sociocultural norms regarding gender, expression of distress, and acceptable forms of suffering. Such gendered interpretations foreground how deeply cultural scripts shape perceptions and practices of bodily harm rather than reduce them to psychopathology alone. Researchers argue that gendered narratives such as framing women's self-harm as "attention-seeking" reproduce oppressive norms about femininity and emotional expression (Carroll et al., 2021).

Gender and Prevalence: Empirical Patterns

Meta-analytic evidence suggests that self-harm and NSSI are more commonly reported among females in many Western contexts (Odds Ratio ~1.6; Bentivegna et al., 2015), though this pattern is less consistent in Asia. Notably, when comparing sex differences in NSSI across global regions, Asia did not demonstrate a significant female predominance, underscoring the need to contextualize gendered patterns within specific cultural landscapes (Bentivegna et al., 2023).

In South Asian populations, systematic reviews indicate a high and variable prevalence of NSSI in both clinical and community samples (3.2% to 44.8%), with correlates that include socioeconomic stress, depression, unemployment, and limited access to mental health services (Paudel et al., 2023). This suggests that gendered prevalence cannot be disentangled from broader sociopolitical determinants poverty, marginalization, and strained family relations that shape distress and self-injuring trajectories in the region.

South Asia & Nepal: Epidemiology and Sociocultural Context

Suicide and deliberate self-harm have been identified as major public health challenges in Nepal and South Asia. Early scoping work indicates that Nepal had among the highest reported suicide rates globally, with women and younger age groups disproportionately affected (Poudel et al., 2017). More recent work confirms that suicide accounting for violent deaths continues to be significant among Nepalese women, particularly those of reproductive age (Kasaju et al., 2021). Contributing psychosocial factors include abuse, interpersonal conflict, marital disputes, financial stress, and mental health issues such as mood disorders and substance use disorder (Kasaju et al., 2021).

Cross-sectional studies among Nepalese youth further establish the prevalence of self-harm behaviours and suicidal ideation in emerging adults. For instance, a study among undergraduates in Gandaki Province reported a 15.8% rate of self-harm and 30.3% rate of suicidal ideation, with significant associations between relationship difficulties, family mental health issues, and self-injuring behaviour (Magar et al., 2025). These epidemiological findings demonstrate that both interpersonal and systemic stressors are implicated in self-harm patterns, beyond individual pathology.

Gender Dynamics in South Asia and Nepal

The sociocultural construction of gender in South Asia exerts profound influence on vulnerability to self-harm. Patriarchal norms, constrained agency for women, and structural inequities in education, employment, and legal rights compound psychosocial stressors that may lead to self-injury behaviours. Extensive qualitative research in Nepal shows that ongoing gender inequality and violence whether physical, psychological, or sexual are deeply embedded in social hierarchies that subordinate women, limit their autonomy, and expose them to multiple forms of violence and stress (BMC Public Health, 2022).

Similarly, recent qualitative work reveals that nearly one in four women in Nepal experience physical, psychological, or sexual violence in their lifetime, with significant mental health consequences (Sarraf et al., 2024). These experiences of violence and inequality shape embodied subjectivity and influence how distress is both lived and communicated through the body. In contexts where articulating emotional suffering is stigmatized, bodily injury can become a visible language of distress.

Violence, Vulnerability, and Embodied Experience

The concept of *embodied experience* foregrounds how social structures, norms, and violences are inscribed on the body. Feminist and critical social theorists argue that self-harm can function as an embodied expression of social pain, relational rupture, or resistance against oppressive environments. Such perspectives shift the analytical gaze from pathology to power drawing attention to how gendered violence and norms shape the embodied enactment of distress.

In South Asian diasporic populations, systematic reviews show that socioeconomic, cultural, and political stressors intensify gendered vulnerabilities. Women within these communities often face "double jeopardy" of discrimination based on gender and ethnicity, which compounds risk for self-harm and suicidal behaviours (Stevens et al., 2024). These findings underscore the importance of examining intersecting systems of oppression including caste, class, and religion that mediate how gendered distress is embodied and expressed.

Family, Social Response, and Aftercare Dynamics

Family dynamics are central to understanding self-harm in collectivist cultures, where interdependence and relational obligations are core social structures. Research in Sri Lanka, a neighbouring South Asian context, illustrates how families respond to youth who engage in deliberate self-harm, often oscillating between caregiving and stigma, with long-term repercussions for post-incident support and recovery (Rasnayake et al., 2025). These findings are instructive for the Nepalese context, where similar patterns of familial stigma and withdrawal of support may exacerbate vulnerability.

In Nepal, family conflict, marital discord, and unmet expectations have been linked to elevated risk of self-harm among youth and adults alike. The relational terrain shaped by parental pressures, gendered role expectations, and economic insecurity constitutes a critical backdrop for understanding self-injuring behaviours. Without sensitive family and community support structures, individuals may lack socially sanctioned outlets for distress, making embodied practices such as self-harm more salient as an expression of suffering.

Implications for Clinical, Ethical, and Social Responses

Interpreting self-harm through a gendered social practice lens demands that clinical and public health responses move beyond individual-level interventions to address structural and relational determinants. Global mental health frameworks increasingly call for integrated approaches that combine psychosocial support with community-based

initiatives aimed at reducing stigma, fostering resilience, and addressing gender-based violence.

However, structural barriers limit the reach of such interventions in Nepal and South Asia more broadly. Mental health services remain underdeveloped, deeply stigmatized, and inequitably distributed. Moreover, gender disparities within the mental health research workforce indicate that women researchers which could otherwise enrich contextual understanding of gendered distress are underrepresented due to systemic barriers in leadership and resource allocation (Shrestha et al., 2025).

Ethically, research and practice must center the voices and lived experiences of those who self-harm, particularly members of marginalized gender groups. This includes not only women and girls but also gender-diverse populations who may face distinct forms of stigma and violence. Understanding varied gender identities within South Asian contexts remains a substantial gap, reinforcing the need for inclusive frameworks that transcend binary gender categories.

Gaps in Knowledge and Directions for Future Research

Despite growing empirical evidence, significant gaps persist in the literature. First, there is a dearth of qualitative research on the lived experience of self-harm in Nepal and broader South Asia, limiting nuanced understanding of meanings and motivations behind embodied practices. Integration of qualitative methodologies that foreground subjectivity, narrative complexity, and cultural idioms of distress is essential for contextually grounded scholarship.

Second, intersecting axes of inequality such as caste, ethnicity, sexuality, and rural-urban divides require systematic exploration to elucidate how multiple forms of marginalization shape self-harm practices. Third, longitudinal research is needed to trace causal pathways and observe changes in self-harm behaviours over time, particularly within rapidly changing sociocultural landscapes.

Finally, intervention research remains limited; robust evidence on culturally appropriate prevention and support strategies including community education, gender-based violence mitigation, and family-focused interventions is urgently needed to inform policy and practice.

Reviewing the literature on self-harm as a gendered social practice reveals that sociocultural norms, gender inequalities, and embodied experiences are central to understanding patterns of self-injury and suicidal behaviours especially within Nepal and South Asia. Prevalence data point to substantial burdens among women and youth, shaped by interpersonal conflict, economic precarity, and structural violence. Gendered frameworks emphasize how cultural expectations and inequalities inform both the expression of distress and societal responses.

To advance scholarship and practice, research must integrate sociological, feminist, and public health perspectives that situate self-harm within broader matrices of power and inequality. Clinically, this translates into multi-layered interventions that address mental health needs alongside gender-based violence, family relationships, and societal stigma. Ethically, it necessitates inclusive research that amplifies voices of those most affected. Advancing such integrated, context-sensitive work will enhance both theoretical understanding and practical responses to self-harm in Nepal and the wider South Asian region.

Methods and Procedures

Study Design

This study employed a qualitative, interpretive research design to explore self-harm as a gendered social practice. An interpretive approach was selected to understand the meanings, lived experiences, and sociocultural contexts in which self-harm occurs, emphasizing embodiment, vulnerability, and gendered power relations (Creswell & Poth, 2018). This design aligns with the study's objective to foreground subjective experience while situating findings within broader social and cultural structures.

Study Setting

The study was conducted in Nepal, focusing on urban and semi-urban communities in and around Butwal. These locations were selected to capture diverse social, economic, and cultural contexts while maintaining access to participants with varied experiences of self-harm. The study setting also allowed engagement with local NGOs, mental health clinics, and community organizations that provide support to individuals experiencing self-harm, thereby ensuring ethical recruitment and referral pathways.

Participants

The study employed purposive sampling to select participants who could provide rich, in-depth insights into gendered experiences of self-harm. Participants included:

- Individuals (aged 18–35) who had engaged in self-harm within the last five years.
- Family members or close acquaintances of individuals who had self-harmed, to capture relational perspectives.
- Mental health professionals and social workers familiar with gendered patterns of self-harm in Nepal.

Inclusion criteria required participants to have direct experience with self-harm or professional engagement, while exclusion criteria included individuals with severe cognitive impairments that would preclude informed consent or articulate participation. The final sample comprised 30 participants (18 female, 10 male, 2 gender-diverse), achieving saturation for thematic analysis.

Data Collection Procedures

Data were collected using semi-structured, in-depth interviews, supplemented by focus group discussions (FGDs) with mental health professionals and community workers. Interview guides were designed to explore:

1. Participants' experiences and interpretations of self-harm.
2. Gendered meanings and social expectations shaping self-harm.
3. The role of family, community, and social institutions in supporting or stigmatizing self-harming behaviours.
4. Reflections on embodiment, vulnerability, and relational dynamics.

Interviews were conducted in Nepali or Tharu, depending on participant preference, and lasted approximately 60–90 minutes. FGDs included 6–8 participants per group and lasted 90–120 minutes. All sessions were audio-recorded with participant consent and transcribed verbatim. Translations into English were conducted for analysis and reporting, ensuring semantic fidelity and cultural nuances were preserved.

Data Analysis

Data were analyzed using thematic analysis, following Braun and Clarke's (2006) six-step framework:

1. Familiarization: Reading transcripts multiple times to gain an overview of content.
2. Coding: Generating initial codes for meaningful units related to self-harm, gender, violence, and embodiment.
3. Theme Development: Grouping codes into overarching themes and subthemes, reflecting social, relational, and bodily dimensions of self-harm.
4. Reviewing Themes: Cross-checking themes against raw data to ensure consistency and completeness.
5. Defining and Naming Themes: Refining thematic categories to capture nuanced insights into gendered practices of self-harm.
6. Reporting: Integrating illustrative quotes and linking findings to theoretical frameworks on gender, vulnerability, and embodiment.

NVivo 12 software was used to manage and organize data systematically. A peer-debriefing process was implemented with co-researchers to enhance credibility and reduce interpretive bias.

Trustworthiness and Rigor

To ensure trustworthiness, the study employed:

- Triangulation: Comparing data across participants, FGDs, and secondary literature to validate findings.
- Member Checking: Sharing preliminary findings with a subset of participants to confirm interpretations.
- Audit Trail: Documenting methodological decisions, coding strategies, and theme development processes.
- Reflexivity: Researchers maintained reflective journals to acknowledge personal assumptions and positionality.

These measures strengthen credibility, dependability, and transferability of findings, aligning with qualitative research best practices in public health and sociology.

Results and Discussion

Overview of Findings

Analysis of interviews and focus group discussions revealed that self-harm in Nepal is deeply gendered, relational, and socially mediated. Three overarching themes emerged:

1. Gendered Vulnerability and Socio-Cultural Pressures
2. Embodiment of Distress and Self-Harm as Social Communication
3. Responses and Negotiation within Family and Community Structures

These themes demonstrate how individual experiences of self-harm are embedded in broader cultural, structural, and relational contexts, emphasizing the interaction of violence, vulnerability, and gendered expectations.

Gendered Vulnerability and Socio-Cultural Pressures

Participants consistently highlighted how gendered expectations and social norms shape the experience of self-harm. Women frequently described pressures related to marital expectations, domestic responsibilities, early marriage, and dowry-related conflicts, which were sources of chronic stress and emotional distress. One participant reflected:

> "When my husband's family constantly criticized me and blamed me for not fulfilling their expectations, I felt trapped. Hurting myself was the only way I could express how suffocated I felt." (Female, 24)

Men, in contrast, often cited economic pressures, unemployment, and failure to meet societal standards of masculinity as triggers for self-harm, though their injuries were less visible due to stigma around male emotional expression:

> "In our community, a man showing weakness is looked down upon. I felt hopeless, but I couldn't tell anyone. I ended up hurting myself in secret." (Male, 27)

These narratives echo findings from South Asian research, where patriarchal norms, gendered division of labor, and societal expectations create distinct vulnerabilities for men and women, shaping both the incidence and expression of self-harm (Vijayakumar, 2015; Shrestha et al., 2017). Gendered stressors intersect with class, caste, and rural-urban location, producing multiple axes of vulnerability, consistent with intersectional frameworks (Stevens et al., 2024).

Embodiment of Distress and Self-Harm as Social Communication

A central theme was the embodied nature of distress. Participants described self-harm not merely as an individual coping mechanism but as a visible expression of social suffering, a language of the body where words or social action were constrained. In Nepalese contexts, where emotional disclosure is often stigmatized, the body becomes a medium to signal distress:

> "No one understood how I felt. Cutting myself was a way to show my pain without saying anything." (Female, 21)

This aligns with theoretical frameworks of embodied experience, where the body mediates social and relational pressures (Patel et al., 2018). Self-harm was simultaneously a response to interpersonal violence and a form of communication within families and peer networks. Participants emphasized that self-harm was often interpreted as a cry for help, reflecting relational and societal dynamics rather than purely intrapsychic pathology.

Gendered dimensions were evident in the types and visibility of self-harm. Women reported more superficial cuts, burns, or self-poisoning, often performed privately yet intended to signal distress to family members. Men reported more covert self-injury, such as hitting objects or substance-related harm, reflecting masculine norms discouraging vulnerability. Gendered embodiment thus mediates both method choice and social meaning, supporting Canetto and Sakinofsky's (1998) gendered suicide paradox and extending it to the Nepalese context.

Family and Community Responses

The study revealed a complex interplay between self-harm and family/community reactions. Participants reported a mix of supportive, punitive, and stigmatizing responses, which influenced subsequent behaviours. In many cases, familial criticism or blame exacerbated distress, reinforcing self-harm as a coping strategy:

> "When my parents scolded me after seeing my injuries, I felt even worse.
> (Female, 19)

Conversely, supportive engagement such as counseling by local NGOs, peer support groups, or empathetic family members was associated with reduced recurrence and improved emotional regulation. Focus group discussions with mental health professionals emphasized the need for gender-sensitive interventions that recognize social, relational, and cultural factors rather than focusing exclusively on clinical symptoms.

These findings align with regional studies indicating that stigma, secrecy, and relational dynamics play critical roles in both the prevalence and persistence of self-harming behaviour (Paudel et al., 2023; Rasnayake et al., 2025). They underscore the importance of community-based, culturally sensitive approaches in intervention planning.

Discussion

The findings reinforce the conceptualization of self-harm as a gendered social practice, rather than merely an individual psychological phenomenon. In Nepal, as in broader South Asia, gendered power relations, social expectations, and cultural norms critically shape the vulnerability, experience, and social interpretation of self-harm. Women's experiences were closely tied to domestic and relational stressors, while men's self-harm reflected societal pressures around masculinity and economic responsibility.

The study extends the literature by integrating embodiment theory, demonstrating that the body serves both as a site of suffering and a medium of communication. This aligns with prior qualitative studies in Asia, which highlight the expressive and relational functions of self-injury (Carroll et al., 2021; Patel et al., 2018). Such perspectives challenge purely biomedical frameworks, advocating for holistic, socially informed approaches in mental health practice.

Importantly, the study highlights intersections of violence and gender in shaping self-harm. Exposure to domestic violence, coercion, and relational inequities exacerbates vulnerability, consistent with global evidence linking abuse to self-injury (Mars et al., 2014). In Nepal, the intersection of gender, familial expectations, and structural inequities creates unique patterns of risk, which cannot be adequately addressed by interventions developed in Western contexts.

Finally, the study underscores implications for public health policy and clinical practice. First, mental health interventions must be gender-sensitive and culturally responsive, integrating family engagement, social support mechanisms, and community-based services. Second, public health strategies should address structural determinants such as gender inequality, domestic violence, and social stigma. Third, further research should adopt qualitative and mixed-methods approaches, foregrounding the lived experience, meaning-making, and social context of self-harm, particularly for marginalized gender populations.

Conclusion

This study highlights that self-harm in Nepal is not solely an individual psychological phenomenon but a gendered social practice shaped by cultural norms, relational dynamics, and structural inequalities. Women's self-harming behaviours were closely linked to domestic pressures, gendered expectations, and experiences of violence, while men's self-harm was influenced by societal norms around masculinity, economic responsibilities, and social stigma. Across gender identities, self-harm emerged as an embodied expression of distress, serving both as a coping mechanism and a form of social communication in contexts where emotional expression is constrained.

The findings underscore the importance of situating self-harm within its sociocultural and relational context, emphasizing the intersections of gender, vulnerability, and violence. Effective public health and clinical interventions in Nepal and South Asia must be gender-sensitive, culturally responsive, and relationally informed, integrating family engagement, community support, and strategies to mitigate stigma.

Finally, this study contributes to the broader scholarship on self-harm by demonstrating the utility of qualitative, embodiment-focused approaches for understanding lived experience. Future research should expand on intersectional perspectives, include gender-diverse populations, and evaluate contextually tailored interventions to support individuals who self-harm, thereby advancing both theory and practice in the region.

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