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RESEARCH ARTICLE

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A qualitative study on lived experience of self-harm in South Asians in the UK: From reasons to recovery

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Abstract

Objectives: Self-harm rates and clinical presentations differ by ethnicity. South Asian women are at risk of self-harm. Previous research suggested investigating individuals' experiences with self-harm with qualitative studies in developing self-harm prevention strategies. This research aims to explore self-harm experiences among South Asians in the United Kingdom.

Design: Qualitative study.

Methods: Participants were recruited via third-sector organizations and online platforms. Semi-structured interviews were conducted with 11 South Asian individuals with a history of self-harm living in the United Kingdom. The data were analysed based on a reflective thematic analysis approach.

Results: Results revealed four main themes: (1) reasons for self-harm; (2) recovery journey; (3) culture and mental health; and (4) the transition to suicidal thoughts and behaviours. Reasons for self-harm included negative life circumstances, social life difficulties, challenges faced during COVID-19 and mental health problems. Participants described their recovery journey by acknowledging the role of professional help, self-care, psychoeducation and personal growth, improving social relationships, and faith and spirituality. Cultural factors included generational differences and stigma. Culturally adapted psychological interventions were perceived as promising. The reported transition from self-harm to suicidal behaviours was linked to experiencing major stressful life events and the use of severe methods of self-harm.

Conclusions: The findings suggest that socio-cultural factors impact mental health and recovery processes among South Asians. Mental health services should consider improving culturally sensitive clinical practices in responding to self-harm among South Asian communities.

KEYWORDS
ethnic minority, recovery, self-harm, South Asian, suicide, United Kingdom

1 | INTRODUCTION

Self-harm is a critical mental health problem in the United Kingdom (UK) and worldwide. Self-harm is broadly defined to include various self-harm behaviours with or without suicidal intent (Skegg, 2005). In this study, we used the self-harm definition to refer to 'any act of self-poisoning or self-injury, irrespective of the motivation' (National Institute for Health and Care Excellence, 2022).

The prevalence of self-harm increased in all ages in England, according to a general population survey, which was carried out between 2010 and 2014 (McManus et al., 2019). Similarly, self-harm rates increased among young people in Ireland between 2007 and 2016, according to National Self-Harm Registry data (Griffin et al., 2018). Moreover, self-harm is likely to be underreported due to stigma (Long et al., 2013). As self-harm and suicidal thoughts were found to be risk factors for suicide (Andover et al., 2012; Large et al., 2021), understanding self-harm and suicidal ideations is crucial in order to support clinical efforts aimed to decrease the risk of self-harm and prevent future suicide.

South Asian people are the largest ethnic minority group in the UK, with up to four million in the UK population (Office for National Statistics, 2013). Previous research found that South Asian women have a higher risk of self-harm in the UK (Cooper et al., 2006; Husain et al., 2006). Moreover, a systematic review suggested that Pakistani women were less likely to access inpatient services in comparison with White women (Kapadia et al., 2017).

Qualitative research on self-harm among South Asians in the UK investigated socio-economic and cultural risk factors such as being subject to racism, higher gender-based or academic expectations, isolation and domestic violence (Chantler, 2003; Chew-Graham et al., 2002). Stigma from inside and outside of the community and confidentiality concerns for help-seeking behaviours were reported (Chew-Graham et al., 2002; Kapadia et al., 2017). South Asian service users reported a lack of cultural understanding among service providers, which authors suggested improving culturally sensitive clinical practices (Prajapati & Liebling, 2021). Culturally adapted interventions can be promising to improve mental health prevention for culturally diverse groups, including South Asians (Rathod et al., 2020).

Most qualitative studies on South Asians were conducted more than 10 years ago, and these studies examined mostly the reasons for self-harm, lacking in exploring the recovery process of self-harm. Also, to our knowledge, only one self-harm study included British South Asian men adolescents (Klineberg et al., 2013). A recent systematic review has also illustrated a dearth of research on emotional distress and help-seeking behaviour in South Asian men (Awan et al., 2022). In addition, despite the requirement for culturally sensitive treatments, there have been no studies on culturally adapted self-harm interventions for South Asians in the UK. A contemporary understanding of the reasons for and recovery from self-harm based on the lived experiences of South Asians living in the UK is needed.

Key Practitioner Message

- Socio-cultural risk factors for self-harm, such as loneliness and experiencing discrimination, should be addressed sensitively by mental health professionals when working with South Asians.
- Social and cultural protective factors of mental health could enhance the recovery process among South Asians who self-harm. South Asian values such as the importance of family, cultural teaching and knowledge, supportive social networks, religious practices and spiritual growth would be essential components of the recovery process.
- Culturally adapted interventions were positively valued by South Asian individuals. Mental health policies would aid the implementation of the growing literature on South Asian mental health in practice. Evidence-based culturally-adapted psychological interventions should be designed for self-harm.
- Culturally sensitive practices would flourish by providing cultural awareness training and supervision to mental health professionals who work with diverse communities. Professionals should be aware of the cultural aspect of mental health and reflect on any possible bias or the tendency to stereotype individuals based on their cultural background.

Therefore, this study aims to:

1. Understand the perceptions and experiences of self-harm among South Asians in the UK
2. Identify the risk and protective factors of self-harm
3. Explore the recovery stories, including the role of informal and professional help
4. Shed light on participants' opinions and suggestions with regard to the use of culturally adapted psychological interventions for self-harm prevention

2 | METHOD

The study was carried out using semi-structured interviews to explore the self-harm experiences of South Asians in the UK. The Standards for Reporting Qualitative Research (SRQR) was followed (O'Brien et al., 2014).

2.1 | Participants

We recruited participants who identify themselves as South Asian, regardless of whether they were born in the UK or are immigrants. South Asian countries are Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Other eligibility criteria included having a history of self-harm, residing in the UK, being 18 years of age or older, and being fluent in English. Individuals were excluded if they reported self-harm episodes in the last 12 months.

2.2 | Procedure and data collection

Purposeful sampling was used for participant recruitment. To increase the representativeness of the target population in the research sample, the study was promoted on various academic platforms, third-sector mental health organizations and a study-specific Twitter account. Potential participants interested in the research emailed the researcher. Participants were then provided with the study forms, which consisted of the screening form, the participant information sheet, the consent form and the demographic information form. If they were eligible and agreed to consent, the interview was scheduled. The interview topic guide included open-ended questions exploring the participants' perspectives on reasons for self-harm, the recovery process, received health services, and the participants' opinions about the culturally adapted psychological interventions.

Eleven in-depth semi-structured interviews were conducted by the first author over the 7 months between November 2021 and May 2022. The interviews lasted about an hour. All interviews were conducted remotely. Nine interviews were carried out using a video call via Zoom, whilst two were carried out via a phone call. All interviews were audio-recorded. The researcher made sure that the interviews were conducted in a private and comfortable environment for both the researcher and the participants. At the end of the interview, the researcher asked about the participants' current feelings and provided emotional support if needed. Debrief sheet was provided to the participants, including mental health services contact details after the interview. In addition, the lead researcher engaged in regular supervision meetings to discuss the emotional effects of the interviews, revise the topic guide questions and address the participants' comments on the interview method and questions.

2.3 | Data analysis

The data was analysed using reflective thematic analysis (Braun & Clarke, 2006, 2019). The first author transcribed the data verbatim and conducted the analysis. The analysis steps were getting familiar with the data by reading the transcripts multiple times, creating codes using line-by-line coding and identifying initial patterns and concepts throughout the data.

2.4 | Quality, rigour and reflexivity

The quality of the analysis was assessed by using the 15-point checklist for thematic analysis (Braun & Clarke, 2006). To enhance the credibility of the themes, the coding process was further checked by the other research members who are experienced in qualitative research. The research team included professionals with diverse professional and cultural backgrounds. The lead researcher kept a reflective research journal. The interview process, transcription, analysis, the researchers' positions and relation to the research topic were discussed in regular supervision meetings.

2.5 | Safety and ethics

Ethics approval was received from the University Research Ethics Committee. Ethical and safety issues were assessed, and the distress protocol and debrief form were developed prior to the interview. Participants were reimbursed with a £15 voucher for their time.

3 | RESULTS

3.1 | Participants

Eleven participants were interviewed, aged between 19 and 40 (M = 26). Five participants identified themselves as female; six participants identified themselves as male. The demographic information of the participants is presented in Table 1. As the data was anonymised, the participant's numbers in Table 1 do not match the participant's numbers shown in Section 3.

3.2 | Main themes

Table 2 outlines the main and sub-themes that were generated from the analysis. The main themes are reasons for self-harm, recovery journey, culture and mental health, and the transition to suicidal thoughts and behaviours.

1. Reasons for self-harm

The researcher asked what had made participants self-harm at the beginning of the interview. The participants mentioned various difficulties related to self-harm. Four subthemes were generated: negative life circumstances, social life difficulties, challenges faced during COVID-19 and mental health problems.

a. Negative life circumstances refer to the events or situations potentially leading to individuals experiencing poor mental health and an increase in the risk of self-harm. Childhood emotional abuse, academic stress, and difficult times in school because of racial and weight-related bullying were mentioned.

TABLE 1 Participant demographic information.

Number	Gender	Age	Nationality	Ethnicity	Marital status	Religion	Occupation
1	Female	40	British	Asian or Asian British–Pakistani	Married	Islam	Preferred not to answer
2	Female	23	Indian	Asian or Asian British–Indian	Single	Hindu	Psychologist
3	Female	19	British	Asian or Asian British–Indian	Single	Hindu	Student
4	Female	21	British	Mixed-White and Asian–Indian	Single	Preferred not to answer	Student
5	Female	23	Indian	Asian or Asian British–Indian	Single	Preferred not to answer	Student
6	Male	29	British	Asian or Asian British–Indian	Single	Sikh	Clinical manager
7	Male	26	Indian	Asian or Asian British–Indian	Single	Hindu	Student
8	Male	32	British	Asian or Asian British–Pakistani	Single	Islam	Finance assistant
9	Male	20	Korean and Sri Lankan	Mixed-Korean and Sri Lankan	Single	Christian	Student
10	Male	25	British	Asian or Asian British–Pakistani	Single	Islam	NHS worker
11	Male	27	British	Asian or Asian British–Pakistani	Single	Islam	Student

TABLE 2 Themes

1. **REASONS FOR SELF-HARM**
   a. Negative life circumstances
   b. Social life difficulties
   c. Challenges faced during COVID-19
   d. Mental health problems
2. **RECOVERY JOURNEY**
   a. Professional help
   b. Self-care
   c. Psychoeducation and personal growth
   d. Improving social relationships
   e. Faith and spirituality
3. **CULTURE AND MENTAL HEALTH**
   a. Generational differences
   b. Views on mental health professionals' understanding of South Asian culture
   c. Stigma and misconceptions
   d. Views on the culturally adapted interventions
4. **THE TRANSITION TO SUICIDAL THOUGHTS AND BEHAVIOURS**
   a. Major stressful events
   b. Self-harm becomes close to suicide

> I did not really have a great time in school, I went to school in quite a posh white area, I guess. So, I stuck out like, I just was different to everyone, really…I got picked on quite a lot. I guess I was like racial stuff. And then also, I kind of developed quite quickly. So, my body was different to everyone else's, and I sort of had more weight in certain places and I got picks on for that as well. (P4)

b. Social life difficulties included loneliness, a lack of financial and emotional support from the parents, having bad arguments with the parents, high expectations set for them, comparison with others, a lack of privacy as a result of being observed by the community, and gender inequality. These social factors put further pressure on young people to be perfect in the eyes of others. A quote exemplifies how social pressure was experienced.

> My experiences of my parents setting very high expectations for myself and being compared to a lot of people and just giving me that sense of feeling that I'm not good enough… (P2)

Further, the impact of loneliness and isolation on self-harm was reported. Making friends is crucial and can be a distressing process, especially for those who have moved to a new country to study or work. A sense of isolation and a lack of meaningful interactions were linked to self-hate and punishment:

> Not having social life, not having a good social network, made it very difficult for me to adjust … Like, nobody likes me. I'm just going to be alone, I'm gonna die alone. And all of those thoughts … I thought, what is the point anymore? Or, you know, what, like, I deserve this punishment, whatever it is. (P2)

> It (self-harm) was probably like the first two or three weeks of moving into university. I was just really scared that I wasn't going to fit in again and that I wouldn't meet anyone, and I was just quite low and quite lonely, and I was in my room. (P4)

c. Challenges faced during COVID-19 described isolation during the lockdown, restricted social life, the impact of the pandemic on occupational health and losing someone to COVID-19. A participant who works at the National Health Service (NHS) felt that his special needs were overlooked whilst working from home and found adjusting to the new situations difficult.

> Due to their lack of communication, as well as empathy, which they were showing to my needs, and situation working from home, which were very though as I did not have the proper set up. That caused me to start self-harming as a result. The level of stress and pressure and overall workload. Exactly, I was going to future unpredictable … time was very unbearable. (P9)

One participant shared a self-harm history as a teenager. Years later, he engaged in self-harm again following the unexpected loss of his father to COVID-19.

> I received a call (about his dad). I kind of, I think I threw my phone across the room. And then yeah, probably, I think I had hit my head the wall a couple times…It was the kind of shock of it. Because he was quite healthy… I probably had suicidal thoughts without intent or plan. (P11)

Students who lived away from their families reported increased isolation:

> It was the peak of COVID-19. I got an individual room (at the student accommodation). I was staying there alone, going out only for food. I had no family or friends around me. (P9)

d. Mental health problems are described as both reasons for and consequences of self-harm. Depression and anxiety were associated with self-harm. Sadness, guilt, anger, feeling disheartened and confusion were mentioned. Some participants felt that they had low self-worth, self-hate, negative body image and self-image around the period of self-harm. Feelings of remorse and guilt were reported after the self-harm episode.

> I was quite confused. Yes, combination of feelings, confusion, sadness, depression. (P6)

> I used to hate myself quite a lot. (P3)

In some accounts, self-harm was seen as a way of releasing anger, expressing emotional pain, punishing oneself, and relieving stress.

> That was like the way tips, the way that I ended up expressing the internal anger. (P1)

2. Recovery journey

The researcher asked participants what helped them to reduce self-harm and improve their well-being. Recovery stories involve professional help, self-care, psychoeducation, enhancing social relationships, faith and spirituality, and personal growth.

a. Professional help was described by some participants as an effective way for self-harm cessation and improving mental health. Professional help included one-to-one counselling, university counselling, life coaching and online support groups for self-harm. It helped participants to gain insights into the self-harm experiences by increasing their awareness of their feelings and managing their psychological symptoms with professional help.

> The counselling helped me to really unpick my past. The life coaching was more about how I moved forward … I think that those two thinks, really were the foundations. (P7)

> I just found them (support group) online and yeah, even if I do not, like, interact with people that much just like reading about other people's stories, just that makes me feel better because I know, okay, other people have gone through it, and they've become better. So, like, I can also do the same. (P8)

One participant was hesitant to seek mental health services due to their awareness of the long waiting lists in the NHS. They believed that individuals in more challenging situations should be given priority instead. Another participant was unable to secure an appointment despite making at least four phone calls from the university counselling.

> I am mostly just frustrated, I guess, because I was trying to get help, and I could not access it, even though I really wanted to. And, yeah, I was just mostly frustrated that it was so hard to get an appointment. (P8)

Those who have not accessed health services mentioned that they were unaware of the available professional support. One participant did not consider getting professional help because self-harm was one-off, and he perceived it as a mistake that should not be repeated. One participant said self-harm occurred during her adolescence, and she did not feel comfortable using the school counselling service due to concerns that the school might share the information with the parents. Another reason for not accessing support was that the participant did not feel emotionally ready to discuss their experience and preferred to take time to process what had happened before seeking help.

b. Self-care covers healthy coping strategies such as good distractions and trying to keep themselves occupied. Participants also talked about the positive effects of having a routine, good diet, regular exercise and sports during recovery. Spending some time on writing, mindfulness and breathing was found helpful.

> Writing was very powerful, just kind of writing letting go on a piece of paper. I started write from the beginning. So, it was just about releasing, letting go and it is changed my life. (P7)

c. Psychoeducation and personal growth involved reading about depression and anxiety, working on negative feelings and low self-worth, and reflecting on feelings and thoughts. Participants said that they reframed the experience and realized the functions of self-harm. Positive coping skills were gained after learning from the experience through psychoeducation and personal growth.

> I think there is probably lots of things I did, you know, in the months after that to help cope with that loss. Like, I started, like exercising and running a bit more. I think just taking some time in my day to like, sit and like, think about things like some reflection time. (P11)

d. Improving social relationships was described as healing. Better connections with parents, support from family and friends, and attending social clubs were reported.

> I knew that I'd made friends. I didn't feel that lonely anymore. (P4)

> Talking about my mental health to people, being more open about it. So, feeling less like I was carrying this thing with me. (P8)

e. Faith and spirituality were described as positive resources. Muslim participants reported that practicing Islam and believing in Allah increased their resilience. A participant explained that having a strong faith and knowing God is present to help gave him strength and confidence. Another expressed that teaching Sufism and self-coaching were helpful.

> All I can say is my spirituality, because I'm a Muslim, helped me overwise… I think what else helped was at that time I was seeking someone to help I have learned the fact you know my relationship with my God, Allah is the current. So, I prayed I prayed on days. (P5)

3. Culture and mental health

The researcher asked about South Asian culture and mental health. This theme covers generational differences, participants' views on professionals' understanding of South Asian culture, stigma and misconceptions, and culturally adapted interventions. Cultural aspects of mental health are not limited to this theme. Under the main theme of reasons for self-harm, social life difficulties were presented as a sub-theme. The main theme of recovery journey included improving social relationships, faith and spirituality, which are considered cultural aspects.

a. Generational differences were highlighted as young participants reported that although they are more open to talking about mental health, it is uncommon in some South Asian families and among older generations. Also, it was reported that the first generation has more experiences of crime and racism in the UK, which affected their level of trust in health organizations.

> I wanted to pretend like everything was okay … But I guess, it's also part of South Asian culture. And like my parent's generation or my grandparents' generation, none of them would talk about mental health or things like therapies now it's a lot better, but still, it's very secret. (P8)

> I think in the South Asian community, a lack of education in the first generation of South Asians who had migrated to the UK, the education levels were very poor illiteracy, and integration, you know, community awareness was very limited. They experienced a lot, coming to the UK, for example, racism and trying to find their place. They're victims of crime, like the first generation of South Asians had it very difficult. Whereas the second generation, they've integrated to some extent, but there's still a lot of barriers and challenge. (P5)

b. Views on mental health professionals' understanding of South Asian cultural aspects in relation to mental health were shared by some participants based on their therapy experiences. They had space to talk about cultural aspects of their problems in the therapy. It is because they perceived that the service providers were there to listen professionally, even if it could be difficult to explain some cultural concepts. Counselling with a White British counsellor was effective and valuable for one participant because she felt understood even though the therapist's limited perspective on her lived experience. Thus, a participant emphasized that professionalism is beyond cultural knowledge. Showing empathy and trust and using a non-judgmental approach were mentioned as some qualities of a good therapist.

> I continued with the therapist because I found that space where I could talk. And that's kind of what I needed. You know, she wasn't unsympathetic… She didn't understand my culture… I guess it's beyond culture, really, isn't it? You know, like, how can

> anyone understand something that they haven't gone through? (P7)

On the other hand, some participants said that they hesitated to talk about their culture because service providers could not understand them and it could be time-consuming to explain the social and cultural factors. The professionals from the same ethnicity could have a better insight into the cultural aspects, and the information given by them could better relate to the patients. In one account, the therapist blamed the culture, and for this reason, the person decided to withdraw from the therapy.

> He (therapist) was predominately blaming my community, my culture, for you turning up with where you're, what life has put forward for you. That that's not what you want, you don't want to hear the negative, you want to dig deep into what has led you to this situation, and how can you move forward. (P5)

> Whereas a white therapist, he has no understanding, I have been seen two white therapists. I'm not saying like their body language, their way of observation, the way of questioning, I felt like I was a victim, I felt very uncomfortable. Not saying like, they made me feel that way. But the questions that were asked, so I'm not saying I'm against that. Just need to have more understanding of culture that communities, so they can relate that to people. (P5)

One participant said she specifically chose a South Asian professional in private service.

> I was very specific that I wanted a South Asian therapist. Because I knew the problems that I was having had so much to do with the way I was raised, and I didn't want to spend most of my therapy session explaining like, something to them that they don't even understand. (P2)

c. Stigma and misconceptions around mental health were reported. The awareness about mental health issues should be increased to tackle the stigma and reduce misconceptions of mental health. It is difficult to confide mental health problems to family and friends in some cases. If there was a problem, it was an 'elephant in the room'. Community programmes, having experts with experience from the society were suggested for increasing awareness.

> This (mental health) is not something that's talked about in our culture. Because some people think that you have mental illness because you're just not good practising religion. And some people see that due to possession perhaps. There are misinformation and misconceptions. (P6)

> Culture can impact mental health, I think. I mean, I've probably, yeah, a bit luckier in a sense, because my family have been very, very understanding, and open to things, whereas some of the wider family or culture, you know, mental health is still hugely stigmatised in that sort of South Asian communities. (P11)

d. Views on culturally adapted interventions were explored with some questions. The researcher asked participants about their opinions on culturally adapted psychological interventions and whether they would like to consider getting this kind of service if offered, and how it could be better for them. Participants were optimistic about the idea and mentioned that if the service is offered, they would consider taking it.

> Cultural adaptation is absolutely a great idea. Because I think if I did want to, you know, if someone from a South Asian community did want to seek help, I think, yeah, having someone who can be culturally sensitive to that. Culture is important. (P10)

> I will look into to attending with a therapy session with such a therapy, yes. (P6)

One participant described the effectiveness of a private therapy she received. The therapist incorporated cultural understanding into Dialectical Behavioural Therapy. Having examples from South Asian culture, a good balance of cultural focus, and therapists from the same ethnicity were especially beneficial.

> I think the approach she (the therapist) took was a good balance. It was really about the examples that she used and the way that she used them, and trying to make sure that the examples were culturally appropriate, but at the same time, universal enough that if somebody from North India was trying to understand something, it's not like someone from South India couldn't understand it like everybody could. (P2)

Using a culturally adapted intervention should be a choice for the patients. A participant described that he would not prefer to get a culturally adapted intervention as his problems were not about the culture. He suggested that the selection of intervention types depends on the reasons for accessing the service:

> I would say I would not prefer that service just because I'm South Asian because I feel that's not my trouble to be honest…My problem is related to self-worth and

> self-esteem. And that can be solved by either of them. Probably I won't choose South Asian sort of specific counselling. Because it's not something that I think I require. My problems are different. (P9)

4. The transition to suicidal thoughts and behaviours

Some participants shared their stories about suicidal thoughts and behaviours, and what helped them to recover. Although having suicidal thoughts or behaviours is not an inclusion criterion for this study, it is also not an exclusion criterion.

a. Major stressful events: Participants described devastating situations that led to suicidal thoughts and attempts, including bereavement, hopelessness, loneliness during the COVID-19 pandemic, stressful academic pressure and forced marriage without escape.

> There was a time when I just had a sort of weekly meeting with my supervisor in Manchester, it was online. And then soon after the meeting, I don't know what I felt. And I thought maybe I'm not doing well in work. And I started having suicidal tendencies. (P9)

b. Self-harm becomes close to suicide: The transition from self-harm to suicidal behaviours was described as the shift from less severe self-harm methods to more medically severe ones. When the overdose as a form of self-harm became a suicide attempt, one participant considered getting professional help. Another participant did share self-harm experiences with his brother because he was concerned that self-harm could lead to a suicide attempt.

> I told him (self-harm). I was quite afraid that I was going to commit suicide. (P3)

4 | DISCUSSION

This study explored the lived experience of self-harm among South Asians in the UK, capturing reasons for self-harm, recovery paths, and cultural aspects of mental health and self-harm. Along with personal and unique accounts of their experiences and perceptions, participants shared their reflections on how social and cultural factors may be associated with those processes.

Regarding the reasons for self-harm, negative life circumstances, social life difficulties, mental health difficulties and challenges faced during COVID-19 were reported. Negative life circumstances included childhood emotional abuse, academic stress, and racial and weight-related bullying in school, which are all consistent with recent research on reasons for self-harm (Cipriano et al., 2017; Fisher et al., 2012; Myklestad & Straiton, 2021; Varley et al., 2022). For example, emotional abuse was found to increase the risk of self-harm, and this association was mediated by self-hate, suggesting the importance for clinicians to be conscious and assess for self-hatred among individuals with emotional abuse in order to prevent self-harm (Nilsson et al., 2022).

Social and cultural challenges, such as pressure to be successful in academic and professional work, could be precipitating factors for self-harm. Academic and work achievements were priorities in South Asian families, and that might create stress on their children (Husain et al., 2006). Furthermore, social isolation and loneliness increase the risk of self-harm among youth and adults (Shaw et al., 2021; Yang et al., 2022). Apart from the social risk factors of self-harm, cultural aspects of mental health were discussed, including generational differences, stigma and misconceptions around mental health. Experience of racism and discrimination could lead to mistrust in governmental organizations, including health care services among South Asians in the UK (Kapadia et al., 2017; Prajapati & Liebling, 2021). Moreover, stigma around mental health difficulties prevented individuals from psychological help-seeking (Kapadia et al., 2017).

The COVID-19 pandemic has been linked to a rise in feeling lonely (John et al., 2021) and reduced psychological help-seeking behaviours for self-harm (DelPozo-Banos et al., 2022). Furthermore, COVID-19-associated bereavement has catastrophic dimensions. These included sudden and unpredictable loss, inability to visit loved ones in the hospital, lack of in-person contacts and the opportunity to say goodbye, and restrictions on funerals. (Torrens-Burton et al., 2022). Moreover, Selman et al. (2022) conducted research on the accessibility of bereavement services from the service providers' perspective using a cross-sectional survey and interviews. The study reported a concerning disparity in access to services for ethnic minority groups before and throughout the COVID-19 pandemic in the UK. The study highlights the need to improve culturally sensitive bereavement services for ethnic minorities (Selman et al., 2022).

The findings also confirmed that mental health difficulties such as depression and anxiety were associated with self-harm, which is in line with previous studies (Singhal et al., 2014). Self-harm was seen as a response to deal with negative feelings that were difficult to manage at that time, such as anger and sadness, and this aligns with the theory of emotion dysregulation (Andover & Morris, 2014). Emotion regulation strategies have been proposed in the literature as a way to overcome thoughts of self-harm (Hetrick et al., 2020).

The recovery process was described from the decisive moment of getting help to managing everyday life stress and triggers and improving well-being. The participants' perspectives in terms of coping with self-harm were in line with the conceptual reframing of recovery from self-injury proposed by Lewis and Hasking (2019). They suggest that recovery is not limited to self-harm cessation and that a personalized and holistic approach should be taken to understand individuals' journeys (Lewis & Hasking, 2019).

The recovery process includes professional help, social support and personal growth, and awareness, which aligns with a recent meta-synthesis (Brennan et al., 2022). Their meta-synthesis highlighted the

importance of self-care, improving interpersonal relationships and having awareness of the association between the psychological state and self-harm, and managing this channel to reduce self-harm (Brennan et al., 2022). Our analysis also revealed that religious values and practices contributed to the recovery process for some Muslim participants. Therefore, culturally sensitive psychological therapies that involve religious teaching and reflections may be particularly beneficial for Muslim patients (Naeem et al., 2015).

Our study showed that some suicidal thoughts and behaviours were linked to self-harm, which is a well-studied association in the literature (Grandclerc et al., 2016). Further investigation is needed to understand the specific pathways through which self-harm may lead to suicidal behaviours.

4.1 | Strengths and limitations

This study is one of the few current research projects that explores self-harm experiences among male and female South Asians. The study explored not only the reasons and risk factors of self-harm but also the recovery process and cultural perspectives on mental health among South Asians.

Our study is limited by including only participants who are fluent in English and a relatively small sample size. Even though we targeted a representative sample, none of the participants were over 45 years old. A study on the research participation of South Asians in the UK suggested that younger age is a facilitator for the recruitment of South Asian people to the research (Quay et al., 2017). Also, the identified countries in South Asia were eight, but the sample recruited are originally from three countries only (India, Pakistan and Sri Lanka).

Our study included individuals who self-identified as South Asians, regardless of immigration or citizenship status. It is essential to acknowledge that mental health experiences might vary between sub-groups, such as first-generation South Asian immigrants or third-generation UK-born British South Asians. Further research might explore the differences in self-harm experiences and psychological help-seeking behaviours in South Asian sub-groups.

The aspect of mental health services was explored only from the service users' perspective, and service providers' views on supporting South Asian patients should be investigated in future research. Another limitation is the narrow conversation about culturally adapted interventions. It could be more informative if further studies used interviews or focus groups that explored specifically the cultural adaptation of the psychological interventions for South Asian communities.

4.2 | Clinical implications

This study would provide beneficial clinical implications. We suggest that sociocultural aspects of self-harm should be acknowledged and addressed by mental health professionals when working with individuals with South Asian backgrounds. Mental health services should provide training and supervision on culturally sensitive clinical practice to support health professionals who work with diverse service users (Moller et al., 2016). Moreover, the participants perceived the cultural adaptation of psychological interventions as helpful and much-needed innovations. Meta-analysis on the effectiveness of culturally adapted interventions was found promising (Rathod et al., 2018). Further, the culturally adapted psychological intervention was found acceptable and feasible for improving maternal depression among South Asian mothers (Khan et al., 2019) and for psychosis among ethnic minorities, including South Asians in the UK (Rathod et al., 2013). Another trial of culturally adapted intervention from Pakistan was found to be effective in improving suicidal ideations (N. Husain et al., 2014). We suggest culturally adapted psychosocial interventions for self-harm among South Asians would be beneficial and contribute to self-harm and suicide prevention.

5 | CONCLUSIONS

This study suggests that social and cultural factors could impact the experience of and recovery from self-harm among South Asians. Understanding the individuals' perspectives on the causes and treatments of self-harm is important in the development and implementation of self-harm prevention strategies. Culturally adapted psychological interventions could be effective ways of improving mental health and self-harm behaviours in South Asians.

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CONFLICT OF INTEREST STATEMENT

We declare that none of the authors has conflict of interest that has arisen from this study.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS APPROVAL STATEMENT

Ethics approval was received from the University Research Ethics Committee, The University of Manchester. Participant's consents were received prior to the interviews.

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