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# Living with burn scars caused by self-immolation among women in Iraqi Kurdistan: A qualitative study

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ABSTRACT

Patients with burns have to live with a variety of long-term physical and psychosocial consequences. Burns lead to prolonged hospital stay, disfiguring scars, disability, and even death. Since self-immolation is common in women of Iraqi Kurdistan, the present study sought to explore the experiences of women living with scars caused by self-immolation. This paper was part of a qualitative research study. A purposive sample of 18 female self-immolation survivors from Iraqi Kurdistan was selected, and 21 individual interviews were conducted and analyzed using conventional content analysis. Four categories emerged during the data analysis: (1) feelings of disbelief, regret, and anger caused by post-burn scars; (2) desperately seeking solutions; (3) grief due to disappointment and surrender to despair; and (4) rejection and isolation. In conclusion, individuals with scars and disfigurements sometimes adopted inappropriate measures to deal with the psychological problems caused by others' behaviors and wrong perceptions. Educational and support programs are hence indicated to promote awareness levels of self-immolation survivors, their families, and the whole society.



## 1. Introduction

Suicide is a common psychosocial challenge in most countries of the world. It is the third leading cause of death among the 15- to 44-year-old population and the sixth leading cause of death in adolescents and young people in the US. While there are a variety of approaches to suicide, an individual's choice of a particular method is affected by the cultural and ethnic characteristics of his/her society [1]. Self-inflicted burn or self-immolation is a common, method of attempted suicide, whose survivors receive not only long-term physical treatment but also continued psychosocial rehabilitation [2]. If not leading to death, self-immolation attempts are accompanied by prolonged hospital stay, disfigurement, and disability [3].

While self-immolation is rare in Western societies and developed countries, it is a common method of suicide and a major cause of severe burns and thus burn deaths in the Eastern world. It is the method of choice in 27% of suicide attempts in developing countries such as Iran, India, and Sri Lanka [4]. The annual incidence rate of self-immolation has been reported to be 2.9–21.0 per 100,000 people in the Eastern

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Mediterranean Region [5]. Self-immolation has also been found to be responsible for 2–37% of admissions to burn units in Iraqi Kurdistan [6].

Self-immolation has become more popular among young people, particularly females, of Iraqi Kurdistan during recent years [7]. Young women are at a higher risk of suicide than other groups of population in the Kurdistan region. They usually self-immolate in their suicide attempts [8]. According to the Ministry of Interior-Kurdistan Region, Iraq, 73% of women who choose self-immolation for committing suicide are aged between 14 and 30 years. This underscores a major social problem among the young females of Iraqi Kurdistan [7].

Advances in burn treatment, fluid resuscitation, wound care, and reconstructive burn surgery have enhanced the survival of burn victims and thus increased the number of people who have to deal with severe complications of burns [9]. Medical care such as medicines, surgery, and rehabilitation received for the reduction of such complications is costly and time-consuming [10]. The fear caused by the horrible experiences of burn victims is further intensified by painful medical procedures. Patients and their families thus develop feelings of anger, guilt, or frustration. Burn victims are haunted by nightmares and memories of self-immolation and go through different distressing experiences that affect both their mental health and their willingness to undergo treatment [11].

Several quantitative studies on the physical and psychological problems of patients admitted to burn units have shown complications after burns such as joint contractures, which exert significant effects on the physical function and vitality of burn victims. Moreover, the physical, emotional, social, and occupational challenges experienced by these patients reduce their quality of life [12].

Because of their cultural beliefs, families in Iraqi Kurdistan set strict gender-related rules that can lead to domestic violence, honor crimes, and forced marriages and prevent women from leaving abusive situations. Family demands and pressure on women were identified as major causes of suicide attempts among women in Iraqi Kurdistan and Turkey. Although the occurrence of domestic violence in Iraqi Kurdistan, and all other parts of the world, is undeniable, its exact prevalence is not known [8].

Many Kurdish women and girls choose various methods of suicide, mostly self-immolation, to escape from the existing gender, social, or tribal discriminations. Some others burn themselves because their families do not approve of their marriage. The majority of Kurdish women's right activists believe that self-immolation and suicide attempts are forms of protest against the existing conditions in the patriarchal society, i.e., the discriminations and restrictions imposed by their fathers, brothers, and sometimes even mothers. While various factors, including traditional beliefs and sociopolitical problems, contribute to the increased incidence of suicide attempts among Kurdish women, gender discriminations and patriarchal rules seem to be the main causes of such an increasing trend [8].

Few studies (in fact, none in Iraqi Kurdistan) have used qualitative methods to examine the problems faced by burn survivors. Qualitative research can be used to explore first-hand detailed information about the psychological and social complications experienced by self-immolation survivors who have scars and disfigurements after hospital discharge. On the basis of the findings of such studies, relevant authorities and decision-makers will be able to develop clinical interventions and practical strategies and provide self-immolation survivors with effective and comprehensive evidence-based psychosocial support programs.

## 2. Material and methods

The present research used qualitative conventional content analysis as an approach to explore the experiences of self-immolation survivors. In conventional content analysis, the researcher seeks to gain a new insight about the phenomenon under study by immersing in data. Inductive reasoning is, in fact, used to extract categories directly from text [13].

Since self-immolation and adaptation to its consequences are complicated phenomena rooted in an individual's psychological, family, and sociocultural background, quantitative methods may fail to deeply explore all aspects of such phenomena [14]. Qualitative approaches can help researchers collect first-hand in-depth information by listening to the participants' lived experiences [15].

The research population included women with disfigurements (on any parts of their body) caused by self-immolation. The participants aged over 18 years were not hospitalized at the time of the study (had been already discharged) and had lived with their burn scars for at least 6 months. Eight participants were living in urban areas and 10 in rural areas.

After receiving the approval of the Ethics Committee of Tehran University of Medical Sciences (Tehran, Iran), medical records of the discharged burn patients were collected from the burn units of all hospitals. A purposive sample of these patients was selected and the women were contacted, and the interview time was set. A number of participants were also purposefully selected from a plastic surgery clinic in Erbil. Some of the participants were selected through snowball sampling. The eligible women were ensured about the voluntary nature of the participation, their right to withdraw at any time, and the confidentiality of the collected data. They were also asked to provide a written consent prior to the initiation of the research. Finally, 21 interviews were conducted with 18 women 1–21 years after their experiences of self-immolation. The selected participants represented maximum variation in age, job, marital status, time of self-immolation, and site and severity of disfigurements. Sampling was continued until data saturation was reached.

Data were collected through face-to-face semi-structured interviews, lasting for 42–85 min, with all participants. The interviews were conducted at locations that were more suitable for the participants (e.g., their homes). For conventional content analysis, all interviews were recorded with the participants' permission and transcribed verbatim immediately afterward. Following several times of careful reading of the transcripts, a deeper understanding of the material was obtained and the key concepts were identified. Categorization was performed according to relevance to the context, the observed reactions, and the outcome.

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