

Psychosocial and cultural motivations for self-inflicted burns among Iranian women

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When the world of public health considers the health of women, one tendency is first and foremost to link the well-being of women to that of children and the family, and, legitimately, to the health of society overall. Epidemiological data point to sex differences in the patterns and clusters of psychiatric disorders and psychological distress. The origins of much of the pain and suffering particular to women can be traced to their social circumstances. Depression, hopelessness, exhaustion, anger and fear grow out of hunger, overwork, domestic and civil violence, entrapment and economic dependence. Understanding the sources of women's ill health demands awareness of how cultural and economic forces interact to undermine their social status. This article highlights aspects of social suffering among women in Iran. Self-inflicted burns, a significant indicator of mental health among Iranian women, are discussed in order to increase awareness of the phenomenon among the international community, as a first step towards initiating an improvement in the health of women in Iran.

Cultural context

Self-inflicted burns are known to occur mostly in countries in the Middle East, such as Iran. Self-inflicted burns represent a mental health challenge that many men but mostly women are facing in Iran (Rastegar Lari & Alaghebandan, 2003). Although self-immolation is becoming an increasingly common cause of death and disability among young women in Iran, little has been written about it in the Western professional literature, although there have been reports of its increasing incidence (Panjeshahin *et al*, 2001; Groohi *et al*, 2002; Rastegar Lari & Alaghebandan, 2003; Maghsoudi *et al*, 2004; Saadat *et al*, 2004). Groohi *et al* (2002) reported that the female:male ratio of patients with self-inflicted burns was 8.8 during 1994–2000 in Kurdistan. Panjeshahin *et al* (2001) showed that, in the Province of Fars (south-east Iran), the majority of self-inflicted burns occurred among young women of low socio-economic status. Also, 99% of self-inflicted burns patients in Tabriz (northern Iran) were women (Maghsoudi *et al*, 2004).

Reasons and consequences

Almost all studies of self-inflicted burns in Iran have found that young married women are at greater risk of suicide than others (Groohi *et al*, 2002; Maghsoudi *et al*, 2004). This is contrary to the notion of marriage acting as a protective factor against suicide as reported in Western literature. Alaghebandan (2002) and Maghsoudi *et al* (2004) reported that quarrels between married couples were the most common precipitating factor for self-inflicted burns in Iran. Most patients attempted suicide in the hope of resolving a chronic interpersonal problem or to make the partner feel guilty (Alaghebandan, 2002). It was not a planned action and therefore the consequences had not been considered. According to Alaghebandan (2002), more than 95% of women who attempt suicide by burning later regret doing so. Most victims did not realise that they were at risk of a slow, painful death or horrific disfigurement (further details available from R. A. on request). Most of the patients initially insisted that the burn was an accident and went to great lengths to explain how the kerosene lamp had fallen over them, for example (further details available from R. A. on request). In fact, the initial reaction in coping with any major stress is denial. In addition, there is widespread religious and social disapproval of suicide attempts. With time, however, denial recedes.

Some women set themselves on fire as a form of protest against social discrimination. Often the act is done in the presence of others, in an attempt to force the people abusing them to suffer feelings of guilt. In such a scenario, death, which often results, is not the goal. On the other hand, some women who feel they have no other choice find death preferable to a life of domestic violence and suffering.

In a large survey conducted by Noorbala *et al* (2004) in Iran, women (mainly married) were found to be more at risk of mental disorders (26% v. 15% of the men surveyed). We believe that family problems (such as drug addiction of the spouse, difference of age, bigamy, lack of love, premature marriage and the taboo of divorce) are the most common reasons for suicide and acts of self-harm among women in Iran. Unemployment, illiteracy, the sexual inequality of opportunity,

Maryam (a fictitious name), a 20-year-old woman in Iran, is sitting in a dark room working on a small carpet. Her face is partially covered by a scarf. When the scarf is removed, the reddish purple leathery scars of a burn are revealed on her face and scalp. Sadly, this burn was self-inflicted. This act is known as self-immolation.

With more attention being given to women's rights, some non-governmental organisations, such as Amnesty International, have started to keep accounts of incidents of self-immolation by women. It is necessary to transfer our limited knowledge of this issue (and similar ones) to healthcare professionals around the globe.

traditional male domination and less respect for their work place women in an unequal and unfair situation in Iran.

Conclusions

Human rights are founded on the principles that all members of the human family are equal, and should accordingly be granted equal dignity and equal rights. However, where social discrimination against women exists, they are often excluded from effective participation in identifying and securing their rights. In recent years, some have argued that health – defined in the World Health Organization's 1948 constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' – requires the protection and promotion of human rights. With more attention being given to women's rights, some non-governmental organisations, such as Amnesty International, have started to keep accounts of incidents of self-immolation by women. It is necessary to transfer our limited knowledge of this issue (and similar ones) to healthcare professionals around the globe. It is also necessary to inform people in developed countries

about female self-immolation, to stimulate attention and discussion of the issues, and generate health research, interventions and policies for the prevention and reduction of self-immolation among women in Iran.

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THEMATIC PAPER – WOMEN'S MENTAL HEALTH AND OPPRESSION

Attitudes to women and their mental health in Mexico

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Despite globalisation and the influence of the feminist movement, traditional roles still prevail in Mexico. The dominant male role is known as 'machismo', which amounts to a cult of virility, where the main attributions are an exaggerated aggressiveness and intransigence among males and an arrogant and aggressively sexual attitude towards women.

In Mexico, there are two females with depression for each male (Medina-Mora *et al*, 2003) and the rate among poor females is three times higher than that among those with the highest income (Berenzon *et al*, 1998). Most research findings suggest that depression cannot solely be explained by a simple biological theory but that sociocultural variables also play a major role. These include the different degree of control and power that women and men have over socio-economic determinants and the differences in social position, status and gender role expectations. Traditional gender roles are expressed in prescriptions such as 'women should be passive and submissive in relation to men', while the lower value attributed to them, their higher rates of exposure to violence and other stressful risk factors and their scarce opportunities for development affect women's susceptibility to

specific mental health problems. The present paper describes Mexican attitudes towards women and women's exposure to stressful life experiences that may contribute to their increased psychiatric morbidity, and shows what it means to be female in different Mexican contexts.

Attitudes towards women

Despite globalisation and the influence of the feminist movement, traditional roles still prevail in Mexico. The dominant male role is known as 'machismo', which amounts to a cult of virility, where the main attributions are an exaggerated aggressiveness and intransigence among males and an arrogant and aggressively sexual attitude towards women; the complementary female role is one of submissiveness or the 'syndrome of the suffering woman', which amounts to a cult of superior