THE PSYCHOLOGY OF SELF-IMMOLATION IN INDIA

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Four cases of attempted self immolation were investigated. The psychiatric evaluation was done according to DSM-III-R criteria. The findings are discussed with reference to the psychological and socio-cultural perspectives.

Durkheim (1858-1917) described three types of suicide viz egoistic, altruistic and anomie. He concluded that suicide is an individual phenomenon but its causes are essentially social. If certain individuals commit suicide, in all probabilities they were predisposed to it by their psychological make up (Aron, 1967). The Durkheimian concept not only includes the cases of suicide usually recognised so, but also the cases of fast-unti-death, ‘Suttee’ in India and ‘Harakiri’ in Japan (Aron, 1967). The social, historical and religious factors and their relationship to the attitude towards and feelings about suicide have been reported by many authors (Farberow, 1983; Headley, 1983; Tatai, 1963). The Indian society had been permissive to suicide in certain circumstances e.g. by ascetics, ‘Suttee’ in which a woman immolated herself on the funeral pyre of her husband; and Jauhar, in which Rajput women killed themselves to avoid humiliation and molestation in the face of defeat in war (Venkoba Rao, 1983). Suicide is an unlawful act in most of the countries including India. Suicide among students is of great concern. Rao and Chinnian (1972) reported a high degree of personality disorders in the student suicide. The ‘copy-cat’ suicides among adolescents who know each other have been reported (Gould and Shaffer, 1986). The acceptance and decision to implement the Mandal Commission report in mid 1990, was followed by widespread student unrest and incidents of attempted self immolation; resulting some times in death.

Because of the recent spate of self immolations the present study was undertaken with the following objectives:

1. To assess the psychiatric status of attempted self immolators.

2. To understand the motivational factors that underlie such self harming behavior in relation to the historical, socio-cultural and economic context.

MATERIAL AND METHOD

Four subjects who were reported to have had attempted self immolation in the wake of Mandal Commission report constituted the sample of our study. All were admitted to the Accident and Emergency Department and/or the Burn Unit of Medical College and Hospital, Rohtak during August to October, 1990. Rohtak is about 70 kms. from Delhi which was the hub of activities during anti-Mandal agitation. As the sample was small, case study method was employed to undertake the present study. A detailed psychiatric evaluation was done in each case by two psychiatrists. The psychiatric evaluation was undertaken only when the subjects had recovered sufficiently for a comprehensive psychiatric interview. The diagnosis were made according to DSM-III-R.

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* The Commission appointed by Government of India to identify various socially and educationally backward classes.
Case Reports

Case one: RM, a 24 years old unmarried Hindu male educated up to higher secondary and an accredited life guard was admitted to the A & E department with 30% burns. The patient had been unemployed for the last two years. He had held a gainful job prior to this. He resigned that job in anticipation to an assignment abroad which did not materialise. A few days before the act of self-immolation, he was reported to be irritable and despondent, ruminating about his unemployment. He used to blame the government for this. One day before the act he participated in an anti-Mandal agitation.

Premorbidly, the patient was described to be unpredictable and fickle. For instance, at time, in an impulsive fit he would be abusive and garrulous even towards his closest friends and family members. Otherwise he would be nice and polite. He was interested in outdoor activities like swimming and games and was fond of dancing, singing and reading books. He often complained of having difficulty in controlling his emotions. RM craved for companionship and brought strangers to his house but his relationship tended to be of short term. His mother, in one instance, was surprised to hear expletives about a friend whom he had adored so much a few month earlier. He lacked long term career choice and was indecisive about marriage and types of friends he preferred. He had episodes of unexplained moodiness during which he was poorly communicative. He was reported to be abusing alcohol and tobacco in a non dependent manner.

On examination, he exhibited a grandiose sense of self importance, considering himself a special person expecting special treatment. When criticised for his act he expressed feelings of shame and anger and retorted that his actions could be appreciated only by a person with a special mind. He constantly sought approval for his acts which if not forthcoming made him talk philosophically. He exhibited mood swings during the interview, arguing at one moment and depressed at next. He didn't exhibit any disturbance of thinking, perception and cognition.

According to DSM-III-R the patient was diagnosed as follows:

Axis I No manifest clinical syndrome.

Axis II Borderline personality/Narcissistic personality disorder.

Axis III 30% Burns.

Axis IV Extreme (Burns, unemployment)

Axis V Major impairment in several areas (no job, frequent bickerings at home, no friends).

Case two: V, a 22 years old mechanist, unmarried and belonging to a scheduled caste, was admitted with 50% burns. After being shifted to the burn unit, he had poor sleep and appetite, crying spells leading to a psychiatric referral. His history revealed that he had been repairing sewing machines for the last five years. For last one and a half months he had been away from his family without any information, and attending his work irregularly. Two to three days prior to the incident he complained to his colleagues of being depressed and disinterested about every thing; and gave indication that he would commit self-immolation as he was being neither provided a proper job nor loans by the government.

It was found out that his father had expired in his childhood and he lived with his mother and brothers. He had frequent bickerings with his family as he was very critical of them. He often lamented that he was born in such a poor and backward family. He had difficulties at his place of work, often doing slipshod job. He lacked initiative and was not assertive. He reflected that he would not go very
far in his job because he and his family lacked 'right connections'. His social life was restricted; had few friends who worked with him and with whom he had occasional drinks. His own perception about himself was negative and felt he was uninteresting to others. Family history revealed that his two elder brothers had similar problems.

On examination the patient was uncomfortable, anxious and had difficulty in concentrating. He had persistently depressed mood, pessimism and inferiority. He complained of lack of energy. His ruminations centred around those who were 'the real hard working and happy lot'. He felt inferior and intimidated of colleagues who were 'intelligent and superior'. He had felt depressed and pessimistic consistently for the last four or five years.

According to DSM-III-R he was diagnosed as follows:

**Axis I** Dysthymic disorder

**Axis II** No personality disorder

**Axis III** 50% Burns

**Axis IV** Severe (burns, poverty, job dissatisfaction)

**Axis V** Major impairment in many areas. (Constant bickering at home, absenteeism, staying away from family, suicidal ideas).

Case three: Ms. N, a 19 years old 2nd year college student was admitted to the Accident and Emergency Department with minor burns. Her mother reported that N had been, for some times, pronouncing that she would also commit self-immolation as the government was not agreeing to the agitating student's demand. She was further reported to have said that by doing so she would get name and fame.

The patient was described by her mother as a person attached to her family yet fickle emotionally. For example, she was very obstinate in her demand and would sob uncontrollably and throw temper tantrums if admonished. Her mood in general was described as unpredictable and changing. She had lot of interest in outdoor activities and was a good gymnast and dancer. She performed on stage and for T.V. and was described to be constantly seeking approval or praise. She had poor tolerance for frustration and her actions were reported to be directed towards obtaining immediate satisfaction.

In her interview, the patient was eager to give a detailed account of herself and the incident. She talked with fervor and a colourful language and made gestures and dramatic punctuations (e.g. oh! the poor students...... was said often). When asked to give her reasons for attempting self-immolation she replied with an affective display: "After hearing and watching television about self-immolation attempts even by the school children aged 12-14 years, I thought when they could do so, I could do the same." Her perception of others who attempted self-immolation was that probably their efforts would bring results. The results of cognitive examination were normal and she didn't exhibit any thought disorders or perceptual anomalies.

According to DSM-III-R, she was diagnosed as follows:

**Axis I** No manifest clinical syndrome.

**Axis II** Histrionic personality disorder.

**Axis III** Mild burns.

**Axis IV** Mild (family arguments)

**Axis V** Slight impairment in social functioning (Temper tantrums, crying spells, annoying close friends and family members).
Case four: Mr. S., a 19 years old first year college student belonging to a lower middle class Hindu family was admitted with 70% burns. He had been staying with his maternal uncle who was financing his studies and lodging for the last four years. On the day of the incident, he had left for his college in the morning but instead of going there he headed towards the local railway station. He procured kerosene oil on the way and put himself on fire behind a bush and came out shouting slogans. He was rescued by the passengers on the local railway station and was rushed to the nearby hospital.

S. was a quite and serious young man since his early childhood. As a child he rarely participated in outdoor activities or mixed with others. He rarely had any friends visiting him. He was good at studies especially in mathematics in which he scored 80% marks in his matriculation examination which was disproportionately higher than his overall 55%. He showed little interest in fashionable clothes. He kept to his books for the most part and was respectful and obedient to his seniors. He rarely quarrelled with his sibs; showed no anger even if harassed by his younger brother. He made no demands and was ‘content’ to get whatever he did from his family. It was this simple living which had prompted his father to send S to his maternal uncle for getting better education.

In his interview, S. was ill at ease and made little eye contact. He was eager for the interview to end as quickly as possible. His affect was constricted and speech laconic. He gave short answers and made no attempt at spontaneous conversation. In fact any attempt to prompt made him anxious. He expressed the ideas that he attempted self-immolation to persuade the intransigent government to accede to the students’ demand of withdrawing Mandal Commission Report. His action would help students’ cause, he surmised. The patient’s sensorium was intact, cognitive function were normal.

According to DSM-III-R, S was diagnosed as follows:

- **Axis I**: No manifest clinical syndrome.
- **Axis II**: Schizoid personality disorder
- **Axis III**: 70% burns
- **Axis IV**: Severe (Burns, foster home).
- **Axis V**: Moderate difficulty in social functioning (few friends, restricted social interactions)

**DISCUSSION**

Suicide has been extensively investigated from various perspectives. It can be viewed both from individual’s perspective - and as a social event. Here we have presented four cases of attempted suicide i.e. cases of self-immolation in protest against the implementation of Mandal report by the Government of India. Although our sample was a small one but we believe it was generally representative of this phenomenon.

All our cases, except case 2, had no manifest clinical psychiatric syndrome on Axis I of DSM-III-R. The case 2 had dysthymia which has also been conceptualised in terms of a characterological disorder. The other cases had personality disorders on Axis II of DSM-III-R. All the cases had varying degrees of psycho-social stressors and impairment in functioning prior to the act of self-immolation. These findings are in consonance with those of Venkoba Rao and Chinnian (1972) who studied suicide in student, and Robins (1985).

Without denying the importance of individual factors, here we wish to emphasise the fact that all our cases of self-immolation were in
response to a single socio-political event which purported to have influenced the future course of lives of the student community at large. Viewed in this perspective, this particular social event acted as a catalyst in the existing socio-cultural matrix culminating in the acts of self-immolation in already predisposed individuals. It is possible to understand these acts of self-immolation within the conceptual framework of Durkheim. Cases 1, 3, and to some extent 4 had altruistic motives whereas case 2 and to some extent case 1 can be construed as anomic suicides.

For ages the social existence in India had been governed by the tenets of ‘Manu Smriti*’. However, in the contemporary times there had been lot of changes: Breaking of traditions and institutions and changes in the value system. At the time of our independence, the founding fathers of our constitution envisioned India as a welfare state. For upliftment of the socially weaker section of our society i.e. scheduled caste and scheduled tribe, they enshrined in our constitution the concept of job reservation. The implementations of Mandal Commission report further increased the quota for the caste which were not covered earlier. This triggered a state of agitation by sections of the society not covered by reservations. The Satya-grah and fast- unto-death have been the accepted means of social protest in India. Within the Hindu philosophy sacrificing one’s own life is associated with a glorifying and mystifying aura e.g. ‘Suttee’. These factors together with the atmosphere of unrest and dissatisfaction were favourable to the growth of suicidogenic impulses as Durkheim had conceived.

Another factor, which is important to understand in this sudden burst of self-immolations, is the dissemination of such information. Conscious or unconscious glorification of the deed giving a heroic halo to the protagonist might have resulted in this state of self-immolations. This is similar to the ‘Werther syndrome’ (Kaplan and Sadock, 1988), and the copy-cat suicides described by Gould and Shaffer (1986).

A curious phenomenon was, attempted self-immolation by a scheduled caste youth in our study. However, this can be explained on the basis of his poor educational background, lack of knowledge about Mandal report and also a threat of emergence of a dominant group reaping the benefit of enhanced reservation.

In the end, it’s pertinent to mention here that suicide is an unlawful act in India and all our cases were booked; but authorities usually do not pursue these cases rigorously on either humanitarian ground or because the suicide attempters have already undergone harrowing experiences.

To conclude, the findings of the study indicate that attempted self-immolations are associated with the presence of personality and other psychiatric disorders. However, the role of social factors is equally important in the genesis of this unique means of social protest. To prevent such happenings, the glorification and media blitz about cases of self-immolation should be curbed.

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