Original Article

How the families of the victims of suicide through self-incineration function before and after the event – a qualitative assessment

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Abstract

Background

Durkheim defines suicide as all death resulting directly or indirectly from a positive or negative act of the victim himself or herself, which he or she knows will produce this result. Suicide is as old as human history itself. It is most frequently seen as a fatal sequel of psychiatric illnesses and it is thought that suicide only occurs in a state of insanity, and that it is by itself a special form of insanity. Health workers, especially family practitioners, are constantly confronted by family tragedies, which they have to deal with competently. It is therefore imperative that a health worker contextually understand a family tragedy, such as when a family member commits suicide through self-incineration.

Between 1987 and 1998, Matsulu Township, Mpumalanga experienced a high incidence of suicide through self-incineration. Each victim either ingested or doused him or herself with inflammable liquid (usually kerosene) and set his or her body alight. This gruesome form of suicide, and the increased frequency of occurrence, horrified the families and reverberated through the township. This phenomenon drew the principal researcher's attention and resulted in this study. The principal researcher was the only family practitioner in the township during this period. It was hoped that the knowledge gained from this study would form the basis for interventions in similarly affected families in the future.

The focus was on the surviving family members, in order to learn about the family dynamics before and after the events, and how the family dealt with the event. Although studies that focused on the role of doctors in suicide prevention found that there is little predictive power for the suicide candidates, which means that there were no identifiable factors directly associated with suicide outcome, information gleaned from the affected families could be used profitably in community campaigns and by support groups.

Methods

The aim of the study was to understand how the families of those who committed suicide through self-incineration functioned before and after the event. In-depth interviews were conducted with six focus groups selected purposively from 36 affected families. Interviews were conducted in Siswati, audiotaped, transcribed and translated into English. Themes and sub-themes were identified. To enhance the trustworthiness of the information gathered, the data were triangulated.

Results

Themes identified were a shocking experience, no chance of survival, triggering factors, mystery, emotional and physical scars, and coping strategies. The perception of witchcraft being responsible for suicide featured prominently in the data analysed.

Conclusions

The functioning of the families affected by the suicide of a member through self-incineration was markedly reduced after the events. It is recommended that attention be given especially to the perception of witchcraft being responsible for suicide, and that grief support groups be established in the community to assist affected families cope better with the loss.

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Introduction

Durkheim defines suicide as all death resulting directly or indirectly from a positive or negative act of the victim himself or herself, which he or she knows will produce this result.[1] Suicide is as old as human history itself. It is most frequently seen as a fatal sequel of psychiatric illnesses and it is thought that suicide only occurs in a state of insanity, and that it is by itself a special form of insanity.[1,2] Health workers, especially family practitioners, are constantly confronted by family tragedies, which they have to deal with competently. It is therefore imperative that a health worker contextually understands a family tragedy, such as when a family member commits suicide through self-incineration.

Between 1987 and 1998, Matsulu Township, Mpumalanga experienced a high incidence of suicide through self-incineration. Each victim either ingested or doused him or herself with inflammable liquid (usually kerosene) and set his or her body alight. This gruesome form of suicide, and the increased frequency of occurrence, horrified the families and reverberated through the township. This phenomenon drew the principal researcher's attention and resulted in this study. The principal researcher was the only family practitioner in the township during this period. It was hoped that the knowledge gained from this study would form the basis for interventions in similarly affected families in the future.

The focus was on the surviving family members, in order to learn about the family dynamics before and after the events, and how the family dealt with the event. Although studies that focused on the role of doctors in suicide prevention found that there is little predictive power for the suicide candidates, which means that there were no identifiable factors directly associated with suicide outcome, information gleaned from the affected families could be used profitably in community campaigns and by support groups.[3]

Method

A descriptive, qualitative method was chosen to facilitate exploration and improve the depth of information.[4,5] Six families were purposively selected from the thirty-six affected families recorded over the period (1987 – 1998) in the two township clinics registers. Only family members aged 18 years and above, who were living with the deceased at the time of the suicide were included in the focus group interviews. The interviews were conducted by a clinical psychologist at the homes of the selected families to minimise 'interviewer bias' by the principal researcher, who was their family practitioner. The exploratory question in Siswati was "How did the loss of your family member who committed suicide affect your family?" No new questions were asked except for clarification and reflective summaries on issues raised by the interviewees. The interviews were audiotaped and field notes were taken. At the end of each interview, the family genogram and ecomap were drawn by the principal researcher with the assistance of the family members. This enabled the researchers to score the family functioning (before and after the event), according to the Family APGAR screening tool (see Table I). The transcribed data were shown to the families for validation. The audiotapes, field notes, ecomaps and genograms were used to enhance triangulation of the data.[6] The translated transcripts were handed to an independent research assistant to verify the correctness of the English translation of each interview, with cross-references to the audiotapes. Themes and sub-themes were identified through the 'cut-and-paste' method.

Table I: Combined Family APGAR scores

	Families					
	Family A		Family B		Family C	
Component	Before*	After*	Before*	After*	Before*	After*
Adaptation	2	1	2	1	2	1
Partnership	2	1	1	1	2	1
Growth	2	0	2	1	2	1
Affection	2	0	1	1	2	1
Resolve	2	1	1	0	1	0
Total	**10**	**3**	**7**	**4**	**9**	**4**

	Families					
	Family D		Family E		Family F	
Component	Before*	After*	Before*	After*	Before*	After*
Adaptation	2	1	1	0	2	1
Partnership	2	0	1	0	2	1
Growth	2	1	1	0	2	1
Affection	2	0	1	0	2	1
Resolve	2	0	1	0	2	0
Total	**10**	**2**	**7**	**0**	**10**	**4**

**:Before & after the suicide event.*

Average family a score:

Before*	**7**
After*	**3**

SCALE:

0-3: Severely dysfunctional
4-6: Moderately dysfunctional
7-10: Highly functional

Ethical approval for this study was granted by the Research, Ethics and Publications Committee of the Faculty of Medicine, Medunsa (now University of Limpopo – Medunsa campus).

Results

Six themes, with sub-themes, were identified from the transcripts on the basis of supporting quotes (see Table II).

Theme 1: A shocking experience

All the families interviewed expressed their shock at the events. They gave horrific, vivid descriptions of the events and described their experiences during their last interactions with the victim before the suicide. Three victims left suicide messages for their families, e.g. one lady victim requested that her mother take care of her baby. In two families, the family members gave elaborate accounts of dreams about the deceased. One parent narrated how she dreamt having a long conversation with her deceased son. At one stage she dreamt asking him how it was possible for them to be talking when he was supposed to be dead, without receiving any response to the question. These dreams lasted for years after the events.

Theme 2: No survival chance

None of the families had any hope that the victims would survive the burns sustained during the self-incineration. After seeing the extent of the burns, they accepted that the victims would die. In one family interview, the parent of the deceased, reading the body language of the family members who had gone to visit the victim in hospital, encouraged them to break the bad news to herself.

Theme 3: Triggering factors

Each family attempted to identify triggering factors for the events. In one family, the parent had reprimanded the girl in a manner not

Table II: Themes and sub-themes with supporting quotes

Themes	Sub-themes	Supporting quotes
1. A shocking experience	a. A horrible spectacle	"The burn wounds were terrible, she was lying naked on a stretcher …" "I was extremely horrified and I collapsed"
	b. Description of the experience	"This tragic experience …" "The event was very traumatic to me"
	c. Dreams about the deceased	"I always dream of her. She always features in my dreams"
2. No survival chance		"They soon returned home and as I had expected, informed me of the bad news" "… and I told them I had no great expectations"
3. Triggering factors	a. An attempt at identification	"She had been hurt by her boyfriend" "I had reprimanded them for staying that late away from home"
	b. Triggering factors disproportionate	"We were surprised and wondered what had so angered our child"
4. Mystery	a. Incident shrouded in mystery	"I don't believe anybody knows why it happened" "The mystery has not yet been unravelled"
	b. Witchcraft implicated	"(They) were fighting their father, alleging that he had bewitched their sister to commit suicide" "the witch residing in Veza was using a doll in his spell"
	c. Anger at alleged witches	"I … couldn't imagine how evil his heart must have been" "This makes me bitter about them"
	d. Religion invoked	"Unless such a satanic force drags you to commit such an act"
5. Emotional and physical scars	a. Physical scars	"I have even developed a heart illness because of that fear"
	b. A family gap	"Of all my children, F was the only one with a sense of responsibility"
	c. Dependents suffered	"her children who are no longer well – cared for, and I do not earn any income"
6. Coping strategies	d. Parental discipline compromised	"you fear to discipline a child. What if he does what the other child did or even worse?"
	a. Family support	"We had to stick together and support one another"
	b. Trust in God	"We have submitted everything to God … to the Almighty"
	c. Community support	"The neighbours came and took me to the clinic" "We had great moral support from the Matsulu community"
	d. Time	"We are gradually accepting the situation" "It is better now than it was then"

much different from previous occasions. In two families, a breakdown in love relationships was mentioned, and in another it was the strained relationship with the in-laws. The remaining three families could not identify any provoking factor.

Theme 4: Mystery

All the families said that the events came as a 'surprise' to them, and were shrouded in mystery. One father engaged in deep self-introspection about why his daughter had not shared her problem(s) with him. In an attempt to explain the phenomenon, five out the six families linked the events with witchcraft, i.e. being bewitched. It was alleged that a resident witch in the same township was using a doll to cast spells on individuals who subsequently committed suicide. This allegation invoked deep resentments and hatred among the victims' families towards witchcraft. Another attempt to explain the mystery was to refer to their Christian beliefs, explaining the events as being the result of 'satanic' forces.

Theme 5: Emotional and physical scars

Following the events, the surviving family members developed emotional and physical disturbances. In one family, the victim's brother developed mental problems, and one parent attempted suicide. Another parent became bulimic. Each victim's departure created a family gap difficult to fill, since, in all the families, the victim was considered to be the 'responsible' family member. In two families, the deceased's departure created a financial burden for the family – her two children had to stop going to school. A negative result of the events was that it compromised parental discipline. Parents became scared to reprimand their children, whom they feared would commit suicide like their deceased siblings.

Theme 6: Coping strategies

All the families related that coping was a collective effort rather than an individual struggle. Trust in God was seen as the main source of strength for these families. One family had a strong religious background, which helped them cope after the event. Another family derived comfort from the belief that it was not uncommon for such events to occur among 'God's people'. The community was supportive of all the families after the event through regular visits and prayers, although these were not formal grief support groups. With time, the intensity of the emotional pain and sense of loss waned in varying degrees in the surviving family members. One family explained that the event prepared them to face the future, by bringing them closer as a family unit.

Discussion

The family APGAR proposed by Gabriel Smilkstein in 1978 is a tool to assess family functioning and adult satisfaction with social support from the family.[6] APGAR is an acronym for a five-item measure (Adaptation, Partnership, Growth, Affection and Resolve). A comparable scale is the FACES II (Family Adaptation and Cohesion Evaluation Scale).[7] These have been used together in various studies and correlate well. In this study, using the family APGAR as a tool to measure the family functioning gave a good indication of the families' levels of functioning before and after the suicides.[6,7]

The tool was administered to each family member. Averaging the individual family member's scores gave a total score per family. Ultimately, the average score of the six families was obtained (before and after), reflecting the same pattern as that of the individual families. In general, before the suicides, each family rated itself to have been highly functional, but this functioning worsened with the death of the family member due to suicide. Gardner *et al.*, in their critique of the family APGAR screening tool, indicated that it was not a valid tool for measuring family functioning.[8] They say that it was designed only to assess an individual's satisfaction with the level of support he or she enjoys in his or her family context. They further point out that the measure of family functioning developed through studies that used this tool related to purposes for which it was not initially meant. However, in their discussion on the 'limitations' of their criticism, they admitted that, in their study, each member of the families they studied was not interviewed. They focused on the family member who had come to their office setting, with a follow-up visit after six months.[8] Evidently, the family APGAR score from a single member of a household would not provide a holistic picture of how the family functions. In our study, we are convinced that the screening tool provided us with an empirical assessment of how the families functioned before and after the events.

The themes

The identified themes can be categorised into four groups:

1. Those that occurred during the event (a shocking experience, realisation that there was no chance for victim survival).
2. Those that followed the event (pondering on provoking factors, mysterious nature of the event).
3. Those with permanent impact.
4. Those with a continuous thread

through the three previous phases (coping strategies).

One principle of family medicine states that "a family physician seeks to understand the context of the patient's illness".[9] The context refers to the patient as an individual, the family, work, social state, as well as the community. A family that loses a loved one through suicide by self-incineration grapples with the problems identified by the themes and sub-themes in this study. Following the events, these families become moderately dysfunctional. The family practitioner managing them should be aware of the need to understand their context in order to demonstrate empathy. Understanding the family context enables the practitioner to enlist the support of the healthcare team promptly, for the benefit of the patient. Since witchcraft was alleged to be responsible for the phenomenon of suicide by self-incineration, there is a need for future studies on the subject of witchcraft and its role in suicide through self-incineration. The establishment of formal support groups for families in crisis in all communities is an issue that should also be addressed by the relevant government agencies and non-governmental organisations.

Conflict of interest: None

This study was conducted in partial fulfilment of the requirements for the award of the Master of Medicine (Family Medicine) degree at the Medical University of Southern Africa (now University of Limpopo – Medunsa Campus).

References

1. Durkheim E. Suicide: a study in sociology. London: Routledge; 1970. p 205-7.
2. Manning DE, Suicide. In: Hurst JW, editor. Medicine for the practicing physician. 2nd ed. Boston: Butterworths; 1988. p. 116-9.
3. Matthews K, Milne S, Ashcroft GW. Role of doctors in the prevention of suicide: the final consultation. Br J Psychiatry 1994;44:345-8.
4. Murphy E, Mattson B. Qualitative research in family practice: a marriage made in heaven? Family Practice 1992;9(1):85-91.
5. Patton, MQ. Qualitative evaluation and research methods. 2nd edition. London: Sage Publications; 1990. p. 205-8.
6. Smilkstein G. The family APGAR: a proposal for a family function test and its use by physicians. J Fam Pract 1978;6(6):1232-9.
7. Olson DH, Bell R, Porter J. Family Adaptation and Cohesion Evaluation Scale II. Minneapolis, Minn.: Family Inventories Project; 1982. p. 33-57.
8. Gardner W, Nutting PA, Kelleher KJ, *et al.* Does the family APGAR effectively measure family functioning? J Fam Pract 2001;50(1):19-25.
10. McWhinney IR. A textbook of family medicine. New York: Oxford University Press; 1997. p. 14.