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I am submitting herewith a dissertation written by Elizabeth Ann Campbell entitled "Perspectives on Self-Immolation Experiences among Uzbek Women." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Human Ecology.

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PERSPECTIVES ON
SELF-IMMOLATION EXPERIENCES AMONG UZBEK WOMEN

Dissertation
Presented for
the Doctor of Philosophy Degree
The University of Tennessee Knoxville

Elizabeth A. Campbell
December 2005

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DEDICATION

This dissertation is lovingly dedicated to my mother, Anne E. (Nancy) Campbell, and my aunt, Mary Lou MacMullan. For without their support and encouragement, I never would have accomplished this.

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Many people helped me through the process of earning my Doctor of Philosophy degree in Human Ecology and deserve to be recognized. I would like to thank my dissertation committee, led by my Chair, June Gorski, Dr.PH. I am grateful for her encouragement and guidance and our mutual love of the world. I am also grateful to Sandra Thomas, Ph.D., who helped me to focus my interest and encouraged and supported me (along with the students in Dr. Thomas's Nursing 606 class). I also wish to thank Susan Smith, Ed.D. and Paula Carney, Ph.D., for their valuable input, knowledge and experience. And I thank Bob Muenchen of the Statistical Consulting Center and Brenda Lawson of the Research Compliance, both of whom helped me tremendously.

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ABSTRACT

The purpose of this study was to examine the motivation of Uzbek women who committed acts of self-immolation and survived. The study examined the role of the religion and culture of Islam, whether the act of self-immolation was a suicide attempt or an act of protest, and whether the use of fire had some symbolic significance. Self-immolation, or deliberate self-burning, is increasingly becoming a cause of death and disability among young Muslim women in the Middle East and Central Asia. However, little is known about this phenomenon.

This was a qualitative, bounded case study, which used a blended model of case study that combined elements of Yin and Stake. The setting was the Umid Center, a rehabilitation center and shelter for victims of self-immolation and domestic abuse located in Samarkand, Uzbekistan. The sample for this study included nine residents and former residents of the Umid Center who had survived acts of self-immolation. Semi-structured interviews were conducted with the assistance of a translator. These interviews were audiotaped and the English responses were transcribed. The data were analyzed both manually and using the qualitative data analysis software program QDAMiner, for thematic categories and code words.

The results of the study suggest that all women interviewed were attempting suicide when they set themselves on fire and that the use of fire had no symbolic significance, but was a method of convenience. The findings also suggest that the religion and culture of Islam cannot be assumed to be contributing factors to female self-

immolation. Domestic abuse and harsh lifestyles of the rural village (kishlocks) culture were the main motivating factors in self-immolation among the women interviewed.

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CHAPTER ONE

INTRODUCTION

A tragic phenomenon has come to the attention of the world. Some women, in mostly Muslim countries, choose to set themselves on fire. Self-immolation by fire has become relatively commonplace in the region of the Middle East and Central Asia, particularly Uzbekistan. It has been suggested that this is done not as a suicide attempt but as an act of protest. Women are protesting forced participation in the commercial sex trade, early arranged marriage, and/or domestic abuse, for which there is no legal recourse for abuse because it is not considered a crime in Uzbekistan. The researcher chose to address the issue of women who set themselves on fire after visiting the Umid Center in Samarkand, Uzbekistan in June 2003. Dr. Bibisora Oripova is a plastic surgeon who has established and operates the center for women who have suffered self-inflicted burns. Through the acquisition of funds from non-governmental organizations, she is building an operating room on the center site. In addition, the center acts as a rehabilitation center where the burned women are able to recuperate. Women, who no longer can return to their homes, live at the center. After meeting several of these young women, the researcher chose to further investigate the phenomenon of female self-immolation.

There is documented evidence that annually hundreds of women set themselves on fire in the Middle East and Central Asia (Gall, 2004; Health Reference Center, 2002; InfoTrac OneFile, 2005; InfoTrac OneFile, 2004). It is unknown exactly how many women attempt self-immolation yearly in Uzbekistan. However, Dr. Oripova, a plastic

surgeon who works closely with the women, gives a rough estimate for 2003 as 250 to 275 women who had set themselves on fire (B. Oripova, personal communication, June 11, 2003). Statistics are difficult to determine for many reasons. When a woman dies as a result of self-inflicted burns, her family may claim that the death was accidental in order to maintain family honor. Even if a woman survives, she may decide to claim that the injury was accidental so her family will not disown her. Women tend to use open fire for cooking, so accidental burns are not uncommon.

Although information on self-immolation in Uzbekistan is sparse, there have been reports of self-immolation from other parts of Central Asia and the Middle East (Gall, 2004; Health Reference Center, 2002; InfoTrac OneFile, 2005; InfoTrac OneFile, 2004). Although increasingly becoming a cause of death and disability among young Muslim women, very little is known in the professional Western literature about self-immolation. Most information regarding female self-immolation is generally reported in the local news media, which is often limited to locally published and circulated newspapers. Some online news services (Esfandiari, 2004; Off Our Backs, Inc., 2003; Shekarloo, 2003) have begun reporting about the increasing incidence of self-immolation among young Muslim women in Afghanistan, Iran and Tajikistan. Right to Decide, an online initiative for sexual rights, reported that during the last ten months of 2004, 180 Afghani women committed self-immolation and 100 of them died from self-inflicted burns (Right to Decide, 2004). News of self-immolation continues to be reported in Afghanistan, Uzbekistan, Pakistan, Tajikistan, Iran, Egypt and other parts of the Muslim world (Nawa, 2002; Zarghami & Khalilian, 2002).

In addition, fire has historical and customary significance in Uzbekistan. Prior to the assimilation of Islam in the seventh century, Zoroastrianism was the main religion of the area. A central element of Zoroastrianism is the worship of a fire god. To this day in the villages of Uzbekistan, a bride and groom hold hands as they walk around three bonfires during their wedding celebration. What is not found in the literature is what, if any, significance the use of fire actually has in the act of self-immolation.

There is a dearth of literature in both the Western medical and lay literature about self-immolation. Consequently, there are many more questions than answers about the phenomenon. More information is needed in order to address the issue.

In order to understand the phenomenon of self-immolation, questions were asked of the women who have suffered burns and of their health care providers. The content of these questions was designed to obtain demographic information, reasons for self-immolation, why fire is used, what they thought would occur if they survived and how this has affected their health. Specifically, the researcher was interested in any aspects of the Muslim culture related to the health practices and beliefs of this group of women.

Research Questions

The major research questions guiding this study were:

1. How do Uzbek women, who survive acts of self-immolation, describe their experiences with self-immolation?
2. Is the culture of Central Asia, which is predominantly Islam, as self-reported, related to the phenomenon of self-immolation?

3. Is the act of self-immolation self-described as a suicide attempt or an act of protest?
4. Is there significance to the use of fire in the suicide attempt or is it a convenient method?

Assumptions

Based on the literature, the nature of the study and the researcher's experiences, there were several assumptions made prior to embarking upon this study. These were:

1. The status of women is less than the status of men in Uzbekistan, restricting their life choices.
2. There is significance to the use of fire in the attempt to inflict self-harm.
3. The researcher will gain insight into the phenomenon of self-immolation through the interview process

The Stance of the Researcher

The researcher, having visited these women in the Umid Center once before, has preconceived beliefs that being Muslim significantly increases the risk of committing self-immolation. The researcher also suspected that the use of fire might hold some greater significance than merely as a means to inflict self-harm.

The researcher's educational background includes a Master's of Science Degree in Burn, Emergency and Trauma Nursing. In addition, she has professional experience in providing emergency burn care and has taught seminars on the subject of the field treatment of burns.

Significance of the Study

This study has significance not only in regards to the health aspects of self-immolation, but upon the role of women's rights in some parts of the world. What data are available suggests that the incidence of self-immolation by women is increasing. In light of the world's population, the number of burn victims is relatively insignificant. However, those generally affected by this phenomenon are young, seemingly otherwise healthy women. With the incidence increasing, it is incumbent for health professionals around the world to investigate this phenomenon and look for ways to prevent it or more appropriately deal with it. In addition, when it does occur, are the appropriately trained people in place to provide the necessary emergency interventions? The researcher believed it would be beneficial to identify women at risk and determine what interventions may be initiated that will offer choices for the susceptible women.

Delimitations

The delimitations of this study are:

1. Interviews will be conducted only in Samarkand, Uzbekistan.
2. Subjects will be obtained through their contact with the Umid Center in the city of Samarkand and Dr. Bibisora Oripova.
3. Interviews will be used to elicit information from the subjects.

Limitations

The following factors were recognized as limitations in this study:

1. The researcher lacks Uzbek language skills.
2. A translator was used in the interviewing process.

3. Prior to arriving in Uzbekistan, it was impossible to predict what type of data would be obtainable or what number of subjects would be available for interviews.

Definition of Terms

1. Self-immolation: The act of intentionally setting oneself on fire (Geller, 1997).
2. Islam: The religion that worships Allah, by following the teachings of the Prophet Muhammad that originated in the seventh century.
3. Koran or Qur'an: the holy book of Islam.
4. Muslim or Moslem: the term that refers to the followers of Islam.
5. Muhammad: a man from Mecca, Saudi Arabia who claimed to have received revelations from the angel Gabriel.
6. Uzbekistan: a country that was part of the former Soviet Union until September 1, 1991 when it gained independence and now, with four other countries, comprise the area known as Central Asia.

The Study Setting

Uzbekistan is 447,400 square kilometers, slightly larger than the state of California (CIA, 2004). Along with Liechtenstein, Uzbekistan is one of only two doubly landlocked countries in the world, being bordered by Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Afghanistan. After almost seventy years as the Uzbek Soviet Socialist Republic within the Soviet Union, the Republic of Uzbekistan declared independence on September 1, 1991. President Islam Karimov, a member of the Communist party when Uzbekistan was part of the Soviet Union, has been the authoritarian ruler of the republic

since that time. With a population of almost 26 million, Uzbekistan is the most heavily populated country in Central Asia. Because of the Soviet Union's emphasis on free education for all, education in Uzbekistan is compulsory until age fifteen and the literacy rate is 99.3% (CIA). Despite its size, only 10.8% of Uzbekistan's land is arable. The evaporation of the Aral Sea, one of the worst ecological disasters in the world, has severely impacted Uzbekistan. The desertification has been blamed on heavy concentrations of chemical pesticide use and natural salts. This, in addition to soil contamination from buried nuclear processing, has been blamed for many health disorders.

Uzbekistan, as are the other four Newly Independent States of Central Asia (Kazakhstan, Tajikistan, Turkmenistan, and Kyrgyzstan), is predominantly Muslim. Under the Soviet Union, all religions were suppressed. Upon gaining independence in 1991, the Russian Orthodox Church, Islam, and other religions found new life. However, the government of President Islam Karimov has become more repressive in recent years (Hill, 2004). There have been mass arrests of observant Muslims. Social activists have been detained and sentenced to prison. Muslim extremism is being blamed for several bombings that have occurred over the past year and a half. Poverty is a fact of life in Uzbekistan. Hill (2004) suggests that poverty could easily be confused with government policy to be used as a tool for social control.

Uzbekistan, which shares a small border with Afghanistan, has allowed the United States of America (U.S.A.) to station military installations in that area of

Uzbekistan. Honabad Air Base is located in the southern Uzbek city of Qarshi, easy flying distance to Afghanistan. The Uzbek government allowed the U.S.A. access because it believed that the U.S. military presence provided a source of legitimacy. However, the U.S. did not exert any influence over Uzbekistan's human rights issues, which are described in Chapter Two. In early 2005, for unclear reasons, Uzbekistan requested that the U.S.A. vacate the country within a limited time frame.

The Umid Center, the main setting for the study, is located in the city of Samarkand. Samarkand, the second largest city in Uzbekistan, is more than twenty-five centuries old. Lying on the Silk Road between China and the Middle East, ancient Arab manuscripts have referred to Samarkand as the Gem of the East (Wikipedia, n.d.). Uzbek, along with Russian, are the national languages.

The Umid Center, Umid meaning hope, is a rehabilitation center and shelter for burn victims, including those victims of self-immolation and/or domestic abuse. Dr. Bibisora Oripova, a plastic surgeon who has worked with burn patients for 35 years, runs the center. Umid center operates on a yearly budget of $15,000. According to Dr. Oripova, the director, the majority of those funds are obtained from internationally funded non-governmental organizations such as Counterpart International and USAID (B. Oripova, personal communication, June 11, 2003). At any one time, the Center houses a varying number of young women, from five to twenty, who need rehabilitation (multiple surgeries over a period of time, psychological counseling or regular non-acute care) or shelter.

Data Collection

Data collection was accomplished through semi-structured interviews. That is, interview questions were designed and used to facilitate and encourage conversation and to elicit information necessary for answering the research questions. However, the interviews were loosely conducted in order to allow for each subject to talk and respond, as she desired. A translator was used in the interviewing process. The original translator to be used was a recent medical school graduate that had significant translation experience from Uzbek and Russian into English. Because of a request by Dr. Bibisora Oripova, a Peace Corps volunteer assigned to the Umid Center was substituted initially and translated several interviews. A list of questions was used to elicit information and initiate dialogue. The interviews were audiotaped. The researcher transcribed the English responses. The Office of the Public Prosecutor was said to have statistical data related to self-immolation. Efforts to obtain this information by mail and e-mail from March through May of 2004 were unsuccessful. Because of fear of political and legal repercussions on the part of Dr. Oripova, the researcher did not further attempt to contact the Office of the Public Prosecutor in person while visiting Uzbekistan.

Summary

The study of women who self-immolate by fire could have far reaching implications for the health care and health practices of Muslim women in Central Asia and the Middle East, particularly those who are or may be driven to acts of self-immolation. It may be possible to determine who is most at risk, what are the risks factors and what interventions may be used to prevent these acts. In addition, it may be

possible to recommend training opportunities or interventions for those people who provide emergency care for these burn victims. The purpose of the study was to investigate women and self-immolation and to assess the women's reasons for self-infliction of burns. In addition, this study examined the health consequences, including the health care of these women as well as psychosocial factors related to the practice of self-immolation.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

Tradition in Uzbekistan has women marrying by the time they are 20 years old. Their primary role is to bear many children and devote themselves to their homes and families. Spousal abuse is common, but is considered a personal matter rather than a criminal act. The bride usually moves in with her husband's family where she occupies the lowest status (Uzbekistan, 1999). The husband or the wife's mother-in-law has full control over the young brides. According to Dr. Bibisora Oripova, because of the reduced status and poor treatment in marriage, a troubling practice is occurring in Uzbekistan. Young women, desperate to flee abusive, arranged marriages, pour gasoline or kerosene on themselves and set themselves on fire (B. Oripova, personal communication, June 11,2003). While female self-immolation has been reported by the media and been observed and reported by medical professionals in Central Asian Countries like Uzbekistan, no research studies have been found in the literature addressing this important issue. Self-immolation, or voluntary death by fire, may be more common than previous expected. It has been reported that when a young woman is found to be unacceptable to her husband or his family after she is married, or if she is unable to have children, she may be encouraged to end her life by setting herself on fire (Samarkand, n.d). Although exact numbers are difficult to ascertain, in one Uzbek city, Samarkand, approximately forty women attempted self-immolation during the first six months of 2004. Eighty percent of these women could not be saved (IWPR, 2003).

Most of the women who attempt self-immolation live in villages, or kishlocks, outside of larger cities (Oripova, 2003). Life there is very difficult with little employment available and consequently, the people are poor. Electricity is only available for short periods of time during each day. There are very few, if any, community provided resources. With few jobs opportunities and the financial pressures of raising families, some men spend their time avoiding the realities of their lives. Although alcohol is forbidden in Islam, it is not illegal to buy in Uzbekistan, and many men drink. In some villages, illegal drugs are plentiful and used by men (Oripova, 2003). The kishlocks, or small, rural villages, are governed by a board of elders called the mahalla (Tabyshalieve, 2005). The mahalla is comprised of the oldest, most respected men in the village. When issues arise within a community, including marital problems, it is the mahalla that makes decisions and enforces the laws (Tabyshalieve, 2005). Women have no representation on the mahalla and subsequently find little justice through that route (Oripova, 2003; Tabyshalieve, 2005).

The Umid Center

Dr. Bibisora Oripova has made it her mission to provide care for women who self-immolate (B. Oripova, personal communication, 2003). A plastic surgeon specializing in burns, she developed the Umid Center in Samarkand through the support of several small grants from various organizations and non-governmental organizations such as Counterpart and USAID. The Center acts as shelter for women who attempt self-immolation and those who suffer domestic abuse. Many of the women at the Umid Center are between the ages of 18 and 36 years of age (Oripova, 2003). Those who

survive their attempts at self-immolation usually cannot return home. Death, which often results from the act of self-immolation, is not always the goal of these self-inflicted burns. Sometimes self-immolation is done as an act of protest (IWPR, 2003).

It appears that some of these women set themselves afire out of desperation, more as an act of protest than a suicide attempt. Often, the act is done in the presence of others in an attempt to force the people abusing them to suffer feelings of guilt (IWPR, 2003). In the event that death does not occur, these women often experience severe scarring over much of their bodies. These physically scarred women are usually no longer welcome in their former homes. They may often suffer short- and long-term complications of burn injuries such as infection, contractures, disfiguring scars and psychological consequences (Hadjiiski & Todorov, 1996; Hammond, Ward, & Pereira, 1988). Many women remain at the Umid Center, which acts as a shelter for those women who become displaced. They live in a community sharing similar life experiences, while cooking and caring for each other. In an attempt to acclimate to a new way of life, they learn weaving and other crafts in hopes of selling their products (Mitchell, 2004). This cottage industry encourages women to become productive members of the Uzbek society.

Research Related to Content

Self-Immolation

Self-immolation is not unique among Uzbek women, or to women in particular. There is documentation in the literature about self-immolation as a socio-economic or political protest, particularly among groups such as the Kurds (Açikel, Peker, EbrinÇ, Ülkür,& Celiköz, 2001). Husni, Koye, Cernovsky and Haggarty (2002) also suggest that

self-immolation is used as a political tool and method of protesting by oppressed groups like the Kurds. Suicide by self-immolation has also been related to religious behavior (Grossoehme & Springer, 1999). For example, Buddhists have used self-immolation as a form of protest. The best-known example is the self-immolation by Thich Quang Duc, a Buddhist monk in Vietnam (Holy Suicide, 1999). The monk sat cross-legged in a busy Saigon street and set himself ablaze in protest of the Dinh Diem Government's repressive policies. The practice of suttee or sati, in which widowed Hindu women ritually place themselves upon their husbands' funeral pyres still occurs in India, although it has been outlawed by the Indian government (Parrilla, 1999). Muslim women throughout the world, like those in Uzbekistan, use self-immolation to escape hopeless family situations (Gall, 2004; Health Reference Center, 2002; Kadyr,1992; Zarghami & Khalilian, 2002). Reports of self-immolation have been reported in Afghanistan, Pakistan, Egypt and other parts of the Arab world (Nawa, 2002; Zarghami & Khalilian, 2002).

Burns are an enormous public health issue in terms of morbidity and long-term disability, particularly in developing countries, such as Uzbekistan (Panjeshahin, Lari, Talei, Shamsnia & Alaghehbandan, 2001). A study done in eastern Sri Lanka found that eighty-seven patients were admitted to a tertiary burn center with self-inflicted burns over a two year period (Laloë & Ganesan, 2002). Another study from Zimbabwe found 9% of burn victims over a three-year period were self-inflicted (Mzezewa, Jonsson, Aberg & Salemark, 1999). A study from Bulgaria found that suicide attempts by burning were common in Eastern European countries and Africa, while in Western Europe and North America this is uncommon (Hadjiiski & Todorov, 1996).

In a study done by Mabrouk, Omar, Massoud, Sherif and El Sayed (1999), suicide by self-immolation in Egypt was examined. During a period of 20 months from May 1995 to December 1996, 759 male and female patients presented to the burn unit of Ain Shams University in Cairo. Twenty-three were known to have attempted suicide, although male burn patients outnumber female burn patients, the number of female burn patients who have attempted suicide is increasing (Mabrouk, Omar, Massoud, Sherif and El Sayed). However, because of social and religious reasons, the researchers believed that figure for suicide attempts was underestimated.

In a retrospective study of burn patients admitted to two burn units in Karachi, Pakistan, Marsh, Sheikh, Khalil, Kamil, Jaffer-uz-Zaman, Qureshi, et al. (1996), found it likely that the estimate for self-inflicted burns was low. Reviewing clinical logs between November 1992 and October 1993 of burn patient admissions, and interviewing 47 patients from 28 November and 12 December 1993, the researchers found that the typical profile of a burn victim was a young, uneducated woman, who experienced prolonged contact with fire, received no first aid, was transported to the hospital in a common carrier, and died two days after admission.

In a study of 1089 burn patients in the Kurdistan Province of Iran, the majority of self-inflicted burns were by women and resulted in 76.5% mortality (Groohi, Alaghehbandan, & Lari, 2002). Flame was the most common type of burn and kerosene the most frequently used accelerant. From March 1991 to March 1992 Zarghami and Khalilian (2002) conducted a prospective descriptive study where they examined 318 cases of self-burning in Mazandaran, Iran. The average age was 27 years and 83% of the

victims were women. Of the 318 victims, 39% had a known marital conflict. Açikel, et al. (2001) found that over a four year period, about four percent of the 956 burn patients treated at a burn unit in Turkey were self-inflicted.

According to Zarghami and Khalilian (2002), the method of choice for suicide attempts varies in different countries. The choices are usually based on what mechanisms are easily accessible and they may, occasionally, have some symbolic significance. Deliberate self-burning is more common in Asian countries, and until recently was unheard of in the West. The majority of patients who set themselves on fire in western countries usually have some preexisting psychiatric disorder (Hammond, Ward & Pereira, 1988).

In May 2003, five women were treated for burns suffered after attempting suicide in the city of Samarkand, Uzbekistan. All five women were the victims of domestic abuse (IWPR, 2003). According to the IWPR report, these women used self-immolation as a means of escaping their abuse. Women in Uzbekistan, who do not die from the self-immolation attempt, face ongoing problems. These include lingering medical problems, such as infections, contractures and scarring. In addition, to these physical problems, there may be psychological consequences due to disfiguring scars and possible rejection. A woman's husband, and even the woman's own parents, may reject the woman who survives self-immolation. Women who survive the first attempt are have been reported to be more likely to attempt self-immolation a second time (Kueppers, 2003).

Women and Suicide

Although self-immolation is an uncommon method for suicide in the western part of the world, suicide in women is not unique to Uzbekistan. In fact, it is has been reported by Formanek and Gurian (1987) that in general, three times as many women attempt suicide, as do men. The rate of female deaths by suicide is increasing faster than that of men. Formanek and Gurian (1987) have also reported that it is possible to identify specific characteristics of suicidal women. The most commonly reported characteristics of suicidal women include social isolation and marital problems.

Studies have been done that looked at women and suicide (Daniels, 2005; Ahmed, van Ginneken, Razzaque & Alam, 2004; Dubnova & Joss, 1997). In a study done by Martins, Holzapfel and Baker (1992), the researchers reported that in female patients who suffered spousal abuse, there was a significantly higher risk for rape, homicide and suicide than in those not suffering spousal abuse. In a study looking at domestic violence all over the world, researchers (Dubnova & Joss, 1987) reported that domestic violence against women is a significant health and social problem that affects virtually all societies.

In a five-year follow-up study of 117 abused women in the United States, researchers examined emergency department visits by abused women. Researchers reported that it was usually some problem not directly related to the abuse that brought the abused women to an emergency department. Suicide attempts were among the reasons for the hospital visits (Bergman & Brismar, 1991). Suicides and homicides often were preceded by oppression, physical and mental abuse. Researchers reported this to be

the case in a study that looked at violent deaths among women of reproductive age in Bangladesh (Ahmed, van Ginneken, Razzaque & Alam, 2004). Another study by Daniels (2005), also reported that intimate partner violence placed women at increased risk for depression and suicide. A study in Germany reportedly found that common psychological sequelae of domestic violence were anxiety, depression and suicide attempts (Brzank, Hellbernd, Maschewsky-Schneider, & Kallischnigg, 2005).

Research into female suicide is relatively new and sparse (Formanek & Gurian, 1987). However, in cases of female suicide, two concepts have been identified as being protective factors against suicide (Canetto & Lester, 1995). According to Blumenthal & Kupfer (1990), social support is the single most important protective factor in suicide prevention. A social support system may include friends, family, community and/or religious affiliations. The second protective factor is the concept of self-efficacy. Individuals who have, or perceive that they have control over a situation, or experience confidence, are less likely to consider suicide. One study concluded that health care providers could be instrumental in preventing suicide in women by helping women to develop the necessary skills, resources and support systems (Coker, Smith, Thompson, McKeown, Bethea & Davis, 2002). Another study on intimate partner violence also suggested that the frequent, consistent support of their friends and family, including unconditional and nonjudgmental acceptance, is of great importance in preventing suicide ideation (Daniels, 2005).

Religion and Culture of Islam

There are over one billion Muslims in the world. Although often associated with the Middle East, only about 25% of Muslims are Arab with the majority of Muslims being Asian or African (Ott, Al-Khadhuri, & Al-Junaibi, 2003). In the early seventh century, the Prophet Muhammad, at the age of 25 years, founded Islam when he claimed the angel Gabriel appeared to him (Beyer, 1990). Following Muhammad's death, a follower was believed to have collected Muhammad's revelations from Gabriel and put them together as Muhammad's teachings into a book now known as the Qur'an. Additional teachings of Muhammad that are not in the Qur'an can be found in the Hadith and the Summa, which are known to compliment the Qur'an.

The Shari'a, a legal interpretation and commentary on the Qur'an and the Hadith, guides the Islamic religious life (Willems, 2002). Originally, the Islamic religion did not discriminate against women to the extent that it does today. In fact, Muhammad is believed to have been liberal and progressive for his time. It is reported that he did household chores and believed in the right of women to sexual satisfaction (Beyer, 1990).

According to Brooks (1995), Muhammad's first wife, Khadija, was a wealthy businesswoman who proposed marriage to him. Ten years his senior, she ran a successful trading business, in which Muhammad was employed. At that time, Muhammad was a poor, illiterate orphan. It was during this marriage that Muhammad claimed to have first heard the voice of the angel, Gabriel. Although disturbed by these visions, he was encouraged to trust himself by his wife Khadija. She became his first convert to Islam. During their twenty-four year marriage, they had four daughters.

It was after Khadija's death that Muhammad began to receive revelations from God concerning the status of women (Brooks, 1995). It was during this time that he began to acquire multiple wives. Muhammad eventually had twelve other wives and concubines, most of who had a variety of occupations outside of the home. One wife was a judge, warrior, and political activist (Beyer, 1990). If alive today, it is unlikely that these very women would be unable to do what they did then and enjoy their independence under Islam.

Some practitioners of Islam believe that the Koran teaches that women are genetically inferior to men. According to the Koran, Surah 2:228 states that men have a "degree" over women (Caner & Caner, 2002). In the Hadith, Muhammad said that women are genetically and legally inferior and that it was because of the deficiency of the woman's mind. Muhammad also said that he had been shown Hell-fire, and the majority of its inhabitants were women. Because of this, women are regarded as a bad omen and harmful to men (Caner & Caner, 2002).

A practice of the Islamic faith has been identified as contributing factor to the unhappy family lives these women experience. That practice is polygamy (Brooks, 1995; Issues & Controversies, 2001). Although rare in most parts of the Middle East, Islamic shari'a law allows men to marry up to four wives. The caveat is that the man must be able to treat each wife equally, satisfying each woman's physical, sexual, emotional and financial needs. However, it does not always happen this way. According to Sama Aweidah, the director of the Women's Studies Center in East Jerusalem, "Polygamy goes against the dignity of all women" (Issues & Controversies, 2001).

The foundation of Islamic society is the family (Ott, et al., 2003; Hodge, 2000). Extended family structures are common. Children are valued and caring for one's elders is expected. Marriages are often seen as the joining of two extended families instead of just the union of two people (Hodge, 2000). In Uzbekistan, and many other Islamic societies, the bride often moves into the groom's home with him and his parents. The mother-in-law becomes the woman of the house, and when domestic abuse occurs against the daughter-in-law, the mother-in-law may play a role in the abuse (Kueppers, 2003. In addition, other members of the husband's family may abuse the bride, including sisters-in-law.

Domestic Abuse and Islamic Culture

When domestic abuse occurs in Arab and Islamic societies, it is often seen as private by everyone, including health care workers and the police (Douki, Nacef, Belhadj, Bouasker & Ghachem, 2003). In certain situations, individual members of Islamic societies were reported to view domestic abuse as necessary and legitimate. Douki ,et al. reported that Islamic societies accept violence correlated with three ideas: that wife abuse is a religious practice and duty of the man; that women are economically dependent on men; and, that they often tolerate and justify the domestic abuse of women. In many cultures, abuse is justified based on a wife's misbehavior, the religious commandments, and the factor's influencing a man's daily life (Caner & Caner, 2002). The Koran teaches that the husband is to train his wife, and the writings give a great deal of latitude as far as punishment is concerned. However, according to the Hadith, the man must avoid beating her excessively or disfiguring her (Caner & Caner). The Koran teaches "light striking"

which does not leave marks on the woman's body (Douki, et al.). However, domestic abuse does not necessarily stop with beatings.

In 2002, at least 461 Pakistani women were reportedly killed by family members in "honor killings", an increase over the previous year (Ahmad, 2002). Women in Pakistan were reportedly murdered to protect the family honor for behavior as benign as talking to men or cooking poorly. Women who are victims of rape are reported to have dishonored their families. It has been reported that many male perpetrators of these crimes go unpunished. According to Ahmad (2002), these situations are examples of the lack of status women have in some Muslim countries.

Women are reluctant to report episodes of abuse because they are at risk for being socially isolated and ostracized (Ahmad, 2002). The study conducted by Ahmad reported that women, who survive acts of self-immolation, often state that the burns were caused by an accident so that they will be accepted back by the spouse's family.

Domestic abuse was reported by Douki, et al. to be the result of both the practice of Islam and a patriarchal society (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003). This study found that often husbands use religion as a rationale or justification for abusing a spouse (Douki, et al.). The study found that many of the practices that promote abuse have become so far removed from the actual teachings of Islam, that domestic abuse practices are now based more on customs than religion (Douki, et al.).

Islam and Health

The relationships between men and women are regulated by the Islamic faith. Because of this, it is usually preferred that the health care provider be of the same gender

as the patient. In some Muslim countries, it is absolutely required, except in life and death situations (Ott, et al., 2003).

When death occurs, the body must remain covered at all times. Only same gender health care providers can touch the body. The responsibility of the death rituals falls to members of the extended family (Gatrad & Sheikh, 2002). Prayers may be said over the body and verses from the Koran read. Ritual washing is a vital death ritual, so the health care provider should only remove any blood, exudate or excrement from the body (Ott, et al., 2003). Family members wash the body with water at least three times. Camphor is used in the last washing for its aromatic effect. It is also believed to prevent decay. Autopsies are not routinely done, although organ donation is permitted. The body is wrapped in white sheets after the washing and buried in a deep grave facing Mecca. The death rituals take only a few hours and should occur within 24 hours of death (Ott, et al., 2003).

The Koran gives specific dietary guidelines. Pork and pork products, any kind of blood, meat of animals that have not been slaughtered according to Islamic law, and alcoholic beverages are strictly prohibited for human consumption (Rassool, 2000). In addition to these dietary restrictions, there are several other Islamic health behavior and practices. Cleanliness and personal hygiene have a high importance in Islam and has both physical and spiritual importance (Rassool, 2000). Male circumcision is practiced.

Caring is an important concept in Islam (Rassool, 2000). Health care providers must approach the provision of health care to Muslims holistically. That is, care must be provided to the patient while taking into account three factors of healing, holiness, and

wholeness (Rassool, 2000). Furthermore, Rassool (2000) indicated that health care providers must have the capacity to appreciate the importance of the truths of Islam to the healing of a patient.

Symbolism of Fire

Throughout history, fire has been a symbol of significance for humankind. There were gods in both Greek and Roman mythology that represented fire in some form (Topp, 1973). Fire has also played a significant role in the Judeo-Christian religion, such as the story of the burning bush. Prior to Islam permeating Central Asia, Zoroastrianism was the main religion. There was a fire god and people were encouraged to meditate on fire. In fact, there is still a holiday celebrated in Uzbekistan that dates back to this time. The celebration of Navruz is a spring holiday where the end of winter season is observed. The Sun is celebrated as burning away the winter and calling in the spring (Uzdessert, 2004).

In recent history, fire has been used as a form of protest (Geller, 1997). As mentioned earlier, the most memorable and significant event occurred in 1963 when Quang Duc, a 73-year old Buddhist monk, set himself on fire to protest against the religious policies of the then Catholic President Diem's regime. Since that incidence, there have been many more self-immolations used to protest various causes and governments (Geller, 1997).

The use of fire in suicide attempts and other self-injurious behaviors is often believed to have underlying religious meaning (Grossoehme & Springer, 1999). The use of fire and its symbolism for religious purposes has been described in the literature

(Geller, 1997; Topp, 1973). Previous studies have described religiosity as a common theme among survivors of self-inflicted burns (Grossoehme & Springer, 1999; Husni, Koye, Cernovsky, & Haggarty, 2002; Maghsoudi, Garadagi, Jafary, Azarmir, Aali, Karimian & Tabrizi, 2004; Mzezewa, Jonsson, Aberg, & Salemark, 1999). However, it is not known if religiosity is related to self-immolation of the Uzbek women selected for investigation in the present study.

Qualitative Research

According to Creswell (1998, p13), qualitative research is defined as:

> An inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting.

There are particular characteristics of qualitative research. Primarily, qualitative research is done in a natural setting, as opposed to a laboratory. That is, a setting in which is familiar and comfortable to the subjects. Secondly, the researcher is the key instrument of data collection. Next, data collection is done through words or pictures. Another characteristic is that the outcome is the process rather than the product. The data is analyzed inductively, with special attention to the details. The focus of qualitative research is on the meaning of the participants' perspectives and their use of expressive language and non-verbal messages (Creswell, 1998).

Qualitative data is very good at answering the questions "why", "how", and "what" (Lacey & Luff, 2001). There are three different kinds of qualitative data, but the primary data comes from interviews (Patton, 2001). Interviews can be conducted in a

variety of ways, such as structured or semi-structured. Open-ended questions allow for in-depth responses, but closed-ended questions can closely guide the interview. A second form of data is observations. Observations by the researcher may be done either directly, or while functioning as a participant, or both. The third source of data is documents. These may take the form of, but are not limited to, reports, publications, records, or letters.

There are advantages of qualitative research over quantitative research (Ratcliff, n.d.). Qualitative research allows for a level of depth and detail that cannot be acquired through the use of standardized questionnaires. Qualitative research can also help to generate new theories. Qualitative research is particularly advantageous and even necessary, when dealing with phenomena that have not been addressed previously by researchers and the literature. In addition, qualitative research often eliminates the pre-judgment of researchers as well as stimulating them to observing their subjects within the context of the subjects' own worldviews. Thus, the process helps to avoid imposing the researcher's own categories upon the subjects (Ratcliff, n.d.).

The Case Study

Case study research is a type of qualitative research that helps to bring understanding to a complex issue. Case study research also generally answers "how" and "why" questions (Soy, 1997). Yin (1994) describes the case study and the approach used in case study research. Stake (1995) has suggested the necessary steps for completing case study research, including this study. Those steps include posing research questions, gathering data, data analysis and interpretation (Zucher, 2001).

The major information of case study research for this study comes from two sources, Yin and Stake. According to Yin (1994, p13), the case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." Case study research may involve the research of one case or multiple cases, or it can involve a bounded system. A bounded system describes a particular case, bounded by time, place, individuals, or phenomenon (Creswell, 1998). Stake (1995) contends that case studies must always have boundaries. Creswell contends that the bounded system is the case being studied, whether an individual, event or activity. Some, like Stake (1995), consider the case as an object of study, while others consider it a methodology. This particular study focuses on the bounded case study of the phenomenon of female self-immolation in Samarkand, Uzbekistan, in which the case is both the object of the study and the methodology.

Yin states that there are five components in a case study design (Yin, 1994). The five components are the research questions, the propositions, the unit of analysis, a determination of how the data are linked to the propositions, and criteria to interpret the findings (Zucker, 2001). The unit of analysis in this study was the women who had survived acts of self-immolation. However, the context of this case study included other sources of information, such as interviews with individuals, including the director of the center and the Peace Corps volunteer assigned to the center.

According to Stake (1995), there are several types of case studies. They are intrinsic, instrumental, and collective case studies. This study was a collective case

study, as defined by Stake. An intrinsic study is done because the researcher wants a better understanding of the case. In this study, the researcher wants to understand everything there is to know about Uzbek women in Samarkand who self-immolate. An intrinsic case study is not conducted to contribute to theory building, but because of a researcher's intrinsic interest in the topic (Stake, 1995). According to Stake's definitions of case studies, this study may also be considered a collective case study in that nine cases of self-immolation were studied.

Yin (1994) describes case studies somewhat differently. Three types of case studies, according to Yin, are: descriptive, exploratory, and explanatory. This study, based on Yin's categories, is an exploratory case study. In an exploratory case study, a great deal of data collection, such as a review of the literature, is done prior to composing research questions.

Stake (1995) and Yin (1994) agree that data collection in case study research comes from several sources. These include: documentation, records, interviews, direct observations, participant observation and physical artifacts. In this study, interviews with the women survivors of self-immolation were the primary source of information. Field notes taken during direct observation were also used in this study. Documentation, records and artifacts were not available.

Case researchers look for what is both common and unique about a case, but they often find something uncommon in the results. Researchers draw from a variety of things, including: the nature of the case, historical background, the setting, economic context, cultural context, religious context, and informants who know about the case. Case

studies are usually organized around a small number of research questions (Stake, 1995). The questions for this study are listed in both Chapter I and Chapter III.

For the purposes of this study, a blended methodology with elements of both the Yin model and the Stake model of case study research was used. This study, based on Stake, is a collective, intrinsic case study. There were nine cases of female self-immolation in which the survivors were interviewed. Based on Yin, the design of this case study was exploratory and had five components he had identified as being an integral part of a case study. The first component was the research questions. For this study, there were: four research questions, the propositions, the units of analysis, a determination of how the data were linked to the propositions, and criteria to interpret the findings. The cases were bounded by time, in that the case was the period of time between the act of self-immolation and the time of the interview.

Particularly in qualitative research, it is important to collect meaningful data. Thirteen tactics for generating meaningful data have been described by Miles and Huberman (1994). Of those thirteen, several were used in this study. First, patterns were noted within cases as well as in comparison of cases. Counting was used in data analysis when looking for code words. Again, comparisons were made between the nine cases. By comparing the cases, it was possible to identify themes. Another strategy used was noting relations between variables and finding intervening variables.

Summary

The literature review describes the various factors being analyzed as contributing to the problem of female self-immolation. This includes the practice of self-immolation,

the culture and religion of Islam and health. Also reviewed was the symbolism of fire usage. A review of the literature on qualitative research and case studies was included as well.

In the following chapter, Chapter III, methodology, sample, data collection, procedures and instrumentation will be discussed. Also included will be a description of the model used for data analysis and an overview of quality control for qualitative research.

CHAPTER THREE

PROCEDURE OF THE STUDY

This collective, exploratory, bounded, case study, as described by Yin (1994) and Stake (1995) was designed to explore the phenomenon of female acts of self-immolation in a population in Uzbekistan, Central Asia. The structure and methodology of this study were based on the combined methodology of Yin and Stake, as described in the previous chapter. This chapter will: define the sample, outline data collection procedure, present the instruments, present the interview questions, and describe the method of analyses.

Research Questions

The research questions guiding this study are:

1. How do Uzbek women, who survive acts of self-immolation, describe their experiences with self-immolation?
2. Is the culture of Central Asia, which is predominantly Islam, as self-reported, related to the phenomenon of self-immolation?
3. Is the act of self-immolation self-described as a suicide attempt or an act of protest?
4. Is there some significance to the use of fire in the suicide attempt or is it a convenient method?

Sample

The Yin and Stake Definition of a Case

The intended population of this study was adult women who committed self-immolation and survived. The researcher interviewed nine women who committed self-

immolation. Each woman constituted a case and all nine women constituted a collective case. The cases were bounded between the time of self-immolation and the time of the interview. The convenient sample was drawn from current and former residents of the Umid Center in Samarkand, Uzbekistan, who voluntarily chose to participate in this qualitative research study focused on self-immolation.

Data Collection Procedure

The Yin and Stake Model of Data Collection

According to Yin (1994), data collection for exploratory case studies begins prior to the study using literature reviews and others forms of data collection. In this case, the researcher spoke with Dr. Bibisora Oripova at length in the summer of 2003 about the problems and ramifications of female in self-immolation. An extensive literature search was done on the subject of self-immolation, including where it was found geographically, who the victims tended to be, and factors that seem to be related to the practice of self-immolation.

After accumulating and reviewing the literature, the methodology of the study (case study) and research questions were developed to explore the topic of female self-immolation. These steps are important in the development of case study research (Yin, 1994; Stake, 1995). Dr. Oripova was contacted about the possibility of conducting the research on female self-immolation at the Umid Center. She enthusiastically agreed.

The researcher developed a set of questions that would guide the interview. The questions were composed in such a way as to elicit information about each woman's experience with self-immolation, and factors leading to the decision to self-immolate.

The questions were designed to help determine the "how" and "why" of self-immolation. The questions were designed in a way that answer, or provide meaning to the research questions. The researcher was careful when forming the questions, not to suggest other methods of suicide, such as, "Why did you use fire instead of slitting your wrists?" (See appendix A). After the study methodology and setting were determined, the process of receiving Internal Review Board approval began.

Because the researcher intended to audiotape the interviews with the subjects and take still photography, it was necessary to apply to the Internal Review Board using Form B. A consent form was written in English and translated into Uzbek by the translator, Kamila Lyapina. It allowed the subjects to consent to the interview and the photography, or allowed the subject to choose not to have her photo taken.

After obtaining approval from the University of Tennessee Internal Review Board, the research was conducted in July 2004. The researcher flew to Toshkent, Uzbekistan, and then took a train to the city of Samarkand. The researcher spent two weeks living in the Umid Center with several survivors of self-immolation attempts, as well as some children who had been burned and their mothers and siblings. The residents of the Umid Center were told who the researcher was and that the researcher wanted to talk to the women who had self-immolated. The women were asked by Dr. Oripova to voluntarily participate in interviews. Over the course of one and one half weeks, women would come to the researcher individually at certain times of the day. The translator came to the center between two and four o'clock in the afternoon. The women were told when the translator would be at the center.

During July 2004 nine Uzbek women living in Samarkand, Uzbekistan, who had committed acts of self-immolation but survived, were interviewed. The interviews were held in a small office within the Umid Center in order to ensure confidentiality and to promote the subject's comfort level. The only people present were the researcher, the subject, and the translator. Before interviewing each of the subjects, the researcher and the translator prepared for the interview by discussing the questions, where each would sit and where to place the tape recorder. The researcher and the translator discussed what would be done in case a subject objected to a question or refused to answer. It was decided that if a subject objected to a certain question, the researcher and translator would go on to the next question.

The roles of the researcher and the translator were carefully and thoroughly explained to each woman. After the translator read the consents to each woman in Uzbek, the women were given a copy of the consent form in the Uzbek language and were given an opportunity to read the consent form. The women were asked to sign the English language consent form for the researcher's records, after the translator explained to each woman that the consent form written in English had the identical content as the form that was given to them. For any who were unable to read, a verbal consent to participate was given after the tape recorder was turned on. Each interview was designed to elicit information related to demographic information, marital status, domestic situations, religion and education as well as questions related to the individual's experience related to the act of self-immolation, and personal feelings before and after the self-immolation attempt. One translator was Kamila Lyapina, a recent graduate from

medical school in Samarkand, Uzbekistan, who was experienced in translating Uzbek into English. Assistance with translation was also obtained from Joellen Mitchell, a United States Peace Corp Volunteer trained in the Uzbek language, recently assigned to the Umid Center.

The interviews were semi-structured and focused. Because the interviews were semi-structure, the list of questions (Appendix A) was used as a guide (Tellis, 1997). Sometimes it was necessary to use a question to elicit information; sometimes it was necessary to use a question to prompt conversation. Some of the women talked freely and easily, requiring the researcher to ask relatively few questions. In other interviews, it was necessary to ask every question in order to gather the necessary information. A focused interview is used when the subject is interviewed for a short period of time, usually answering a set of questions. Data collected from another source can be confirmed using this technique (Tellis, 1997).

The interviews were done during the first week and a half at the Umid Center. In order to ensure rigor by avoiding bias in the researcher, it was decided to interview the women prior to meeting with health care providers to prevent preconceived ideas related to self-immolation. Also, data were collected through interviews with health care personnel who care for these women, including Dr. Bibisora Oripova, a plastic surgeon. Dr. Oripova has worked for thirty-five years with women who have committed acts of self-immolation. The researcher met with approximately ten health care providers as a group after the individual interviews with the women who had self-immolated. Because of Dr. Oripova's fears of incurring the wrath of the director of surgery at the hospital, she

invited her co-workers to the Umid Center for a discussion with the researcher. This meeting was set up as a social gathering with food and beverages, including vodka, for an exchange of information between the Samarkand health care staff and the researcher. Although the researcher had intended to interview health care providers individually as part of this study, the political environment of Dr. Oripova's position at the hospital made this impossible. Dr. Oripova was afraid of attracting negative attention from government officials on issues pertaining to female self-immolation.

The Yin and Stake Model of Case Study Evidence

At least six different sources of evidence in case studies have been identified by Yin (1994) and Stake (1995). In addition to interviews, this study used direct observations. The direct observations were done as the researcher lived among the survivors of self-immolation at the Umid Center. Data were collected in written field notes based on the researcher's observations, thoughts and private conversations, as well as audio recordings of every interview. Interviews of the female subjects were recorded and later transcribed by the researcher into hard copies. Every woman interviewed agreed to have her photo taken. Those photos were stored with the audiotapes of the interviews.

In summary, data collection occurred in a variety of ways. Field notes were used to document observations, private conversations and thoughts. Interviews were the primary form of data collection and the audiotaped interview comments were transcribed.

Instrumentation

The research techniques included note taking with the use of a blank notebook. Field notes consisted of a variety of materials including a running description of observed events and people, conversations with people, interpretations and thoughts from the investigator. As recommended by Roper and Shapira (1999), each page of the notebook was divided in half vertically, with the left side for observations and the right side for interpretations and thoughts. Other techniques employed included audio recordings and still photography. The audiotaping was done after the consent forms were signed. The researcher transcribed the audiotapes. The researcher used a small, micro-cassette recorder during each interview. Each tape contains the question as it was asked in English and Uzbek, and the answer in Uzbek and English. The researcher transcribed the answer translated into English into a different MSWord document for each interview. A transcript of each interview can be found in Appendix E.

The researcher addressed coercion by making it clear to each subject that she could choose to participate or not. It was reiterated that the subject could withdraw from the interview or refuse to answer a question at any time. The researcher strongly emphasized this point because of the researcher's status within the center. Dr. Oripova and the staff of the Umid Center treated the researcher as a mexmom, or honored guest. Therefore, the researcher was concerned that the subject would feel compelled to talk. However, the subjects were free to come voluntarily to the office where the researcher conducted the interviews. The researcher shared with each individual prior to the

interview, that the researcher wanted to learn more about self-immolation in order to help women around the world.

The researcher gained trust and acceptance in three ways. Primarily, the women trusted the researcher because of the researcher's affiliation with Dr. Oripova. The women who had self-immolated, were cared for by Dr. Oripova. The women all revered Dr. Oripova for what she had done for them. There was some transference of respect to the researcher. Secondly, the compassionate nature and accepting nature of the researcher put the women at ease. Lastly, Americans are viewed as being resourceful and knowledgeable in underdeveloped countries such as Uzbekistan. Being an American gave the researcher an advantage that perhaps someone else may not have had in gaining trust and acceptance.

Semi-structured interviews were used to collect data, using the questions listed in Appendix A. The subjects' personal stories were elicited using an informal or conversational style. Stimulation recall was used when necessary, to prompt the subjects in informal discussion concerning specific events.

At the conclusion of the study, the hard copies of each transcript, the cassette tapes and the consent forms, were in a locked file box in the researcher's home. The transcribed interviews in MSWord files, as well as the QDAMiner program was stored on a flash drive and the "C" drive of the researcher's laptop computer.

The data was analyzed for convergent data and themes that run through the data. The transcripts of the interviews were limited in depth due to the majority of close-ended questions and the use of a translator. Therefore, it was relatively easy for the researcher

to identify themes and code words without the use of a software program. However, as planned, the researcher did utilize the QDAMiner program, the qualitative data analysis software. Because the data was not robust, the QDAMiner program was not entirely useful.

The data were analyzed for particular observable characteristics. These included recurring themes or linguistic units. With QDAMiner, variables were identified, including age, marital status, and education. It is possible to run frequency statistics with QDAMiner, although the researcher used SPSS for the frequencies in this study. Recurring themes were considered from comments made by the interviewees of a similar nature. The themes were then identified using code words. Code words are the linguistic units that are used repeatedly among the interviewees and identify themes. In this study, code words used in identifying the domestic abuse theme included: domestic abuse, abuse, verbal abuse, physical abuse, beatings, and fight. Code words used to identify the issue of suicide included: suicide, die, protest and attract attention. Themes were then identified manually, without the benefit of the QDAMiner program.

Interview Questions

Questions were asked of the women who have experienced burns. An experienced translator, Kamila Lyapina, translated the questionnaire into Uzbek. The questionnaire was used as a guide while conducting the semi-structured interview with the researcher and either translator Kamila Lyapina or Joellen Mitchell. All interviews were audiotaped with the English translation of the answers subsequently transcribed by the researcher. The list of questions can be found in Appendix A.

Analyzing the Data

The Yin and Stake Model of Data Analysis

Findings from both Stake (1995) and Yin (1994) have contributed to the analytic techniques of this study. Analysis of the data consisted of making a detailed description of the collective case. The data were analyzed looking for issue-relevant meanings to emerge. The researcher also established patterns and looked for a correspondence between two or more categories. Finally, the researcher developed naturalistic generalizations. The data were initially analyzed using the software program QDAMiner, from Provalis Research. QDAMiner is used for coding textual data, annotating, retrieving and reviewing coded data and documents (Provalis Research, 2005). However, because the narrative data generated from the interviews were not robust, it was not necessary to use more than the word coding and analysis functions. The researcher had transcribed all the interviews into MSWord and imported them into the QDAMiner program in order to be analyzed. The data from the transcripts were not robust enough to use QDAMiner to identify themes. However, QDAMiner was used for coding analysis. The interviews were analyzed using a cross-case comparison, which involved analyzing each interview for certain keywords and phrases, and then comparing the responses to the other interviews. The cross comparison of the case data used pattern matching, another major mode of analysis (Yin, 1994). The researcher did theme identification by hand prior to performing the coding analysis. The codes were designed to look for evidence of domestic abuse, which was an identified theme. It was apparent throughout the interview process that similar themes were emerging. The code words for domestic violence

included: abuse, hit, beat, fight, and quarrel. One of the research questions asked whether the self-immolation attempt was a suicide attempt or act of protest. The code words used were: suicide, die, kill myself, attract attention, and protest. An explanation of the findings is described in Chapter Four.

Generalization and Quality Control

Rigor according to the Yin and Stake Model of Case Studies

Unlike quantitative research which is judged by reliability (internal and external) and validity (construct, content and face) and sampling (random and deliberate), qualitative research uses other methods (Zucker, 2001). In qualitative research, validity relates to whether the study findings are true (Gurion, 2002). Triangulation is a method qualitative researchers use to establish validity. There are five types of triangulation: data triangulation, investigator triangulation, theory triangulation, methodological triangulation and environmental triangulation (Gurion, 2002). Validity of this study can be determined through the use of data triangulation.

Data triangulation uses different sources of information (Gurion, 2002). In this study, data was obtained from a variety of sources. The nine subjects of the study were nine different sources of data. Data from Dr. Bibisora Oripova was also obtained. Her comments and experiences in caring for women who had self-immolated during a 35-year career confirmed the account of what the women had said. Data were also gathered from the health care providers, which confirmed the data obtained from the women who had survived acts of self-immolation.

In case study findings, generalization is limited to the case itself or the types of cases (Zucker, 2001). That is, the findings of this study could not be generalized to other self-immolation cases unless they were the same type. However, Yin (1994) believed that theoretical generalization is to the case study what statistical generalization is to a true experiment. Yin (1994) also commented that generalization of results, whether from a single or multiple designs, is made to theory and not to populations. However, multiple cases increase confidence in the robustness of the theory by strengthening the results by replicating pattern matching (Yin, 1994).

The blended model of case study design based on Yin and Stake has been used in this study to ensure that the researcher assigned meaning using qualitative rigor rather than personal opinion. The preparation, study design (with its five components), data collection methods and data analysis techniques have been structured to support this study. Yin (1994) described four principles that guide quality research. These included: showing that the analysis relied on all the relevant evidence; including major rival interpretations in the analysis; addressing the most significant aspect of the case study; and, using the researcher's prior knowledge and experiences to further the analysis.

Summary

This chapter described the methodology used in conducting the qualitative study in order to obtain data through the process of interviewing Uzbek health care providers caring for women who self-immolate and by interviewing women who self-immolate. The process for analyzing the data was also discussed. Chapter IV will describe the study respondents, the Umid Center and analysis of the data.

CHAPTER FOUR

ANALYSIS OF THE DATA

Introduction

During July 2004 nine Uzbek women living in Samarkand, Uzbekistan, who had committed acts of self-immolation but survived, were interviewed. A set of questions was used in order to elicit information about each woman's experience with self-immolation and factors leading to the decision to self-immolate (See Appendix A).

Sample Descriptions and Demographics

The subjects of this study on self-immolation were all women. For the purposes of this study, each woman's name was changed and she was given a pseudonym to ensure confidentiality. The ages of the women ranged from 21 to 56 years. The median age was 34.2 years. The ages of the women when they burned themselves ranged from 16 to 33 years. The median age was 24 years.

All subjects were ethnic Uzbeks and spoke only Uzbek. None of the women spoke Russian or English.

Geography

All the women in the study lived in kishlocks, or villages, at the time they were burned. The kishlocks were located in the areas surrounding the cities of Samarkand and Qarshi. Of the nine subjects, seven currently live in Samarkand (six at the Center) and two live in the kishlocks.

Religion

Of the nine subjects, all admitted to being of the Muslim faith. However, each subject described differently how she practiced her religion. Only one woman admitted to understanding the connection between Islam and Zoroastrianism and how that may influence one's personal view of fire.

Marital Status

Two of the subjects were single and had never been married. One woman, Mohira, was still married, but lived separately from her husband for 12 years. Four were currently married and two are divorced. Of particular interest was one woman who burned herself when she was 16 years old in order to avoid being forced to marry someone. Subject number five, Nilafar, was just sixteen when she burned herself in order to avoid an arranged marriage by her parents. She later married and subsequently divorced. Table 1 describes the marital status of the women.

Table 1. Marital status of the women interviewed.

	Frequency	Percent	Valid Percent
Single, Never Married	2	22.2	22.2
Married	4	44.4	44.4
Divorced	2	22.2	22.2
Married, but Separated	1	11.2	11.2
Total	9	100.0	100.0

Children

All of the women who were or had been married (seven), had at least one child. The number of children per woman ranged from one to six. Single women bearing children is relatively uncommon in the kishlocks.

Education

Every woman in the study graduated from secondary school (10 years of mandatory schooling), which is considered the equivalent of high school. Three women had education beyond the mandatory year. Two attended "institute" and one attended a vocational school where she learned to be a teacher of small children. One of the subjects was attending medical college to study to be a nurse. Returning to school was a part of her rehabilitation plan. Table 2 demonstrates the education levels of the women interviewed.

Table 2. Education levels of the women interviewed.

	Frequency	Percent	Valid Percent
10 years (mandatory)	6	66.7	66.7
"Institute"	2	22.2	88.9
Vocational School	1	11.1	100.0
Total	9	100.0	100.0

Employment

Some of the women were employed outside of the home, while others were not. Nadira, although single, never worked outside of the home. Dilnoza worked in a factory before she was burned and was then studying to be a nurse. Nariza is a schoolteacher. Nargiza did not work prior to her injury. While she was convalescing, she was in bed for three years; she had time to think about her life. She decided to make some changes. She went back to school. She said that her parents never wanted her to have an education. She became a member of the Communist Party, which she perceived as being very prestigious. She made friends and gained respect. She became the director of the Red Cross in Samarkand. In 2000, she organized and opened a non-governmental organization and has become, by local standards, a successful businesswoman.

Subjects

1. Aziza was a 50 year old woman who self-immolated when she was 30 years old. According to Dr. Bibisora Oripova, she did set herself on fire, but she denied it to the researcher.
2. Mahabo was a 29 year old woman who self-immolated when she was 25 years old. Her parents arranged her marriage. She quarreled often with her husband, and her mother-in-law and sister-in-law abused her physically.
3. Nadira was a 22-year-old woman who self-immolated when she was 18. Although she would not go into details, she admitted to having had disagreements with her family. These disagreements were the cause of her desire to kill herself.

4. Dilnoza was a 23-year-old woman. She self-immolated three years ago at age 20 due to a very abusive home life.
5. Nilafar was a 28 year-old woman who burned herself when she was 16 in order to avoid marrying someone her parents had chosen for her. She subsequently did marry, but divorced after her husband took a second wife.
6. Dilobar was a 24-year-old who was in an arranged marriage. Her mother-in-law abused her.
7. Nariza is a 38-year-old woman who has been married to her husband for 17 years. She self-immolated five years ago because of her husband's physical abuse and his womanizing.
8. Nargiza is a 56-year-old woman who self-immolated in 1976 at 28 years of age.
9. Mohira is a 38-year-old woman who married at age 22 years and self-immolated three years later.

The Umid Center

The Umid Center had a total of 15 residents with one third being children. Six of the women interviewed were current residents of the facility. Three of the subjects lived outside of the Center.

The Umid Center is a building were people live and work. The area closest to the street contains offices for Dr. Bibisora and the psychologist who consults, a kitchen, and a bathroom. On the second level is a large classroom where nursing classes and meetings are held. The building surrounds a courtyard that offers shade on hot, summer afternoons

and has a flowerbed in the center. Along one side of the courtyard is the wall of the adjoining property and on the other, a room that was assigned to the researcher. In the back, behind the courtyard, are a few different rooms where the women and children live dormitory style. They also have a kitchen where the women take turns cooking for the group. In the rooms that the women and children share, there are looms erected in the middle of the floor. The women wove rugs that they hoped to sell.

The women wear dresses, with slacks underneath, made of traditional, colorful patterns of silk. The women dress modestly, with rounded necklines, below-the-knee hems and sleeves that reach at least to the elbow. Some wear scarves on their heads, which are usually for covering scars rather than for religious reasons.

The women who have lived with their scars longer appear less self-conscious about them. Mohira has burn scars up the side of her neck and is missing half an ear. She is not embarrassed by it and jokes that she only has to have one earring for the other ear. Most of the women have been burned on the body surfaces usually covered by clothing. None of the women at the Umid Center have significant facial burns. Most burns affected the upper legs, torso, arms and neck. Because the women thought they would die when they burned themselves, they were not concerned with what they would look like if they survived. It is to their benefit that they lit the match to their torsos rather than their heads and avoided extremely disfiguring injuries. One woman had significant scarring that caused her head to be webbed to her shoulder. Surgery performed by Dr. Oripova released the eschar, or scar tissue, so that she could walk holding her head up. However, she was left with a significant scar on her neck, ear and shoulder.

The women are fully accepted and emotionally safe within the walls of Umid Center. There are a few men working at the center and always visitors. The women can come and go as they please, as long as it is medically possible. The women are usually quiet and reserved. For the time they are there, Umid Center is their home.

How do Uzbek Women, Who Survive Acts of Self-immolation, Describe Their Experiences with Self-immolation?

Domestic Abuse

Although intensely personal, the self-immolation experience each of these nine women shared was similar on many levels. The seven women who willingly shared the details of their experiences all stated that they had experienced some form of abuse, usually physical.

Mahabo (Subject #2) stated that her husband did not hit her, although "it is common for men to hit their wives." However, she did say that they "often quarreled". The physical abuse for Mahabo came at the hands of her mother-in-law and sister-in-law. Mahabo asked her husband for a divorce because of the abusive conditions she lived in, but he refused. After one particularly vicious fight with her sister-in-law, she doused herself with kerosene and lit a match.

For Dilnoza, her abuse came from her own family members. She lived with her parents, her older brother and his family, and five younger siblings. She stated that her parents didn't care about her, and that her mother preferred her brother's wife to her. Her oldest brother made it clear to her that he did not want her to live in the house. Her mother worked outside of the home and both her father and brother drank alcohol. She

believed strongly that her brother was highly favored in spite of the fact that he had had several unsuccessful business ventures and lost a great deal of money. He was sued by several people and spent three months in jail. According to Dilnoza, when her brother was released from jail, he wanted to live the way he did when he had money. Dilnoza said that her brother stole money from her family, and her father blamed her. Dilnoza said that she sought help from her mother, other friends and even her grandmother. All were unsympathetic. Her grandmother went so far as to tell her to "burn herself." She thought that the "only way" to escape the violence was "to kill" herself.

Subject #5, Nilafar, burned herself at sixteen years of age, to avoid an arranged marriage that her parents were forcing her into. She did not speak of physical abuse. However, she was emotionally distraught at the thought of having to marry the person her parents had chosen for her. Knowing how she felt did not change their minds. Only by Nilafar burning herself, was she saved from that forced union.

Dilobar, Subject #6, was abused by her mother-in-law and sister-in-law. Her marriage was arranged, but she had no complaints about her husband. Dilobar did make the comment that her husband was "close to his mother," so she found little support from him. She will be going back to live with her husband and daughter after her stay at Umid Center, but they will not live with his family.

Nariza had been married for seventeen years to a man her parents had chosen for her. She had worked as a schoolteacher for young children and had six children of her own. Her husband was occasionally physically abusive, which she seemed to tolerate.

What pushed her to the point of committing self-immolation five years ago was her husband "running around with other women." Although she did not go into detail, her life improved after being burned. Her husband had become the driver for Dr. Bibisora Oripova at the Umid Center and he was no longer abusive.

Nargiza (Subject #8) is a 56-year-old woman who self-immolated in 1976 when she was 28 years of age. She was married to a man that she loved. Despite the abuse, her story is somewhat romantic. She and her husband met and loved each other. They lived together without being married and had two children. Then his parents insisted he marry another woman that they had chosen for him. He did leave Nargiza and marry the woman chosen by his parents. After a period of time, he divorced his wife and told his parents that he had done what they asked, but now he intended to be with Nargiza. He and Nargiza were married. They and their two children then moved in with his parents.

It is common in Uzbekistan for families to bring food and other supplies to relatives in the hospital. When Nargiza's baby was fourteen days old, her mother-in-law was hospitalized. Nargiza was unable to get to the hospital with food because the baby was sick. Nargiza said, like Dilobar, that men are very close to their mothers. When Nargiza's mother-in-law complained to her husband about Nargiza's absence at the hospital one day, her husband went home and beat her. Nargiza said that her husband "beat her from midnight to 3 o'clock in the morning." "I was thinking that the only one I ever loved was beating me like this." She said, "he loved me but he had to do it." During the beating, she was thinking about self-immolation. Nargiza's husband left the house for about thirty minutes. When he returned, he was kissing her, saying nice things

to her and wanted sex. She said to him, "When you want, you beat me. When you want, you love me." He hugged and kissed her and led her to the bedroom. She grabbed a kerosene lamp and poured the kerosene over herself. Nargiza broke away from him and ran into the kitchen, locking the door behind her. She set herself on fire. Her husband climbed through the window and tried to put out the fire. He was burned in the process. She remained married to her husband until he was killed in a car wreck at age 34 years.

Mohira, Subject #9, was abused by her mother-in-law. She met her husband while they were students at the "institute". They loved each other, and asked their parents to arrange their marriage to each other. After they were married and moved in with Mohira's husband's family, Mohira found out that her mother-in-law had wanted Mohira's husband to marry another woman. Mohira's mother-in-law became abusive. The abuse became worse when Mohira's husband told his parents they wanted to move to another city. Mohira's husband would not allow Mohira to work outside of the home. Mohira's mother-in-law would lock Mohira in a room alone all day. She would not allow her to see friends, or to have sexual relations with her own husband. Mohira said that she "felt alone in her husband's family."

In Table 3, the type of abuse, if any, is depicted to each subject. Subject #1, Aziza, continued to say that her self-immolation was accidental and did not discuss any personal abuse experiences. Subject # 3, Nadira, refused to discuss the circumstances that led to her act of self-immolation. Therefore, that information is unavailable for those two subjects.

Table 3. Types of abuse reported by Uzbek women who survived acts of self-immolation.

Subject	Subject Name	Abuse	Type of Abuse	Abuser
#1	Aziza	Not available	Not available	Not available
#2	Mahabo	Yes	Verbal Physical	Husband; Mother-in-law; Sister-in-Law
#3	Nadira	Not available	Not available	Not available
#4	Dilnoza	Yes	Physical	Parents; brother
#5	Nilafar	Yes	Emotional	Parents
#6	Dilobar	Yes	Physical	Mother-in-law; Sister-in-law
#7	Nariza	Yes	Emotional Physical	Husband
#8	Nargiza	Yes	Physical	Husband
#9	Mohira	Yes	Emotional Physical	Mother-in-law

Domestic abuse was a major factor in the lives of the women in this study. Seven of the nine women were the victims of mental, physical, or emotional abuse. The remaining two women would not share the circumstances surrounding their self-immolation attempts. The abusers in the lives of these women varied. In two cases, it was the woman's own family (father, brother) that was the abuser. In one case, it was the mother-in-law. When in-law abuse occurred, often more than one person abused the subject, such as her sisters-in-law. In two cases, both the husband and in-laws were abusers and in three cases, only the husband was the abuser. In one case, the subject refused to give details about her act of self-immolation or what led to it. In a second case,

the subject continued to say that the burning was accidental and would give no other details.

An interesting observation about domestic abuse was that it involved violence perpetrated against women by women. Often, the abuser has been the mother-in-law or the mother-in-law and the sister-in-law. Nargiza, who was abused by a husband that loved her, said, "my daughters are married and very happy now. They have good husbands." But when asked what she would do if their husbands abused her daughters, she said, "I would advise my daughters to be patient. It is difficult to fight tradition."

In Table 4, the frequencies related to the incidence of self-immolation among the women interviewed who survived self-immolation are demonstrated.

Table 4. Perpetrators of abuse reported by Uzbek women who survived acts of self-immolation

	Frequency	Percent	Valid Percent
Parents and siblings were abusive	1	11.1	14.3
Husband was abusive	3	33.3	42.9
In-laws were abusive	3	33.3	42.9
Total	7	77.8	100.0
Missing data	2	22.2	
Total	9	100.0	

Life in the Kishlocks

Every woman interviewed described life in the kishlocks, or villages, as being very hard. Employment is difficult to find. Dilobar's husband did not work. Dilnoza's mother worked, but her father and brother did not. For those whose husbands were employed, the work was sparse and not well paid. Nazira's husband was a driver. Kishlocks were overall very poor and secluded. Most women had no transportation. Public transportation is limited both in quantity and in its routing. People living in the kishlocks cannot afford their own vehicles. Utilities are restricted in the kishlocks. Toilets are pits in the ground. Electricity is turned on for a few hours every day. Water often comes from a creek or pump. Women cook with fire and frequently must cut and haul wood. Bread, or non, is a standard at every meal. Women make it using brick or concrete ovens. They make flattened rounds of dough, then reach inside the oven, wearing heavy leather gloves, and stick the dough to the side of the oven. It is hot, dangerous work.

There is little in the way of recreation. People of the kishlocks must make their own fun. Some have televisions, but electricity is only turned on for about three hours a day. There are no movie theatres, bowling alleys, or sports stadiums. Many unemployed men use illicit drugs or drink alcohol.

Dilnoza said that people in the kishlocks have little or no access to information about social services, domestic abuse, or other issues. The Mahalla is the extent of the village government. Comprised of several old men, the Mahalla decides disputes and enforces the rules of the village. The law enforced is less about what is right and more

about what is traditional. The following table, Table 5, describes characteristics of each subjects experience with self-immolation.

Is the Culture of Central Asia, Which is Predominantly Islam as Self-reported, Related to the Phenomenon of Self-immolation?

Every woman in this study admitted to being of the Muslim faith. That in and of it itself is not sufficient to state whether being Muslim puts a woman at higher risk of attempting self-immolation. It was found that all of the women in this study have lived in the kishlocks, or villages. It was also found that almost all of the subjects had suffered some form of domestic abuse. Mohira, Subject # 9, made the statement that "self-immolation is forbidden in Islam." Nargiza, Subject #8, stated, "some people think that self-immolation is a sacred way to die." None of the women mentioned a connection with choosing self-immolation as a way to die and the fact that they were Muslim.

Is the Act of Self-immolation, Self-described as a Suicide Attempt or an Act of Protest?

One hundred percent of the subjects intended to die when they set themselves ablaze. Eight of the nine subjects admitted to intentionally setting themselves on fire. In all cases, it was a spontaneous act which seemed to result when each woman was pushed to the brink of despair and desperation. Only one woman, Mahabo, stated that she knew that she wanted to die but at the same time was "concerned about my children." Nadira "wanted to kill myself." Dilnoza did not know of any other help available to her and believed the only way to escape the abuse was "to kill myself." Dilobar "hoped to die"

Table 5. Factors surrounding the self-immolation attempts made by the women interviewed who survived acts of self-immolation

Subject	Age at Time of Burn	Where Living at Time of Burn	Living with at Time of Burn	Method Used to Burn	Others Present at Time of Burn	Significance of Fire
#1	30	Kishlock	Husband; In-laws	Kerosene & flame	Unknown	Convenient method
#2	25	Kishlock	Husband; In-Laws; Husband's siblings	Kerosene & flame	Sister-in-law & Brother-in-law	Convenient method
#3	18	Kishlock	Her family	Kerosene & flame	Unknown	Convenient method
#4	20	Kishlock	Her family; Her brother & his family	Kerosene & flame	Unknown	Convenient method
#5	16	Kishlock	Her family	Kerosene & flame	Mother, brother & sister	Convenient method
#6	23	Kishlock	Husband & his parents	Kerosene & flame	Unknown	Convenient method
#7	33	Kishlock	Husband & Six children	Kerosene & flame	All six children	Convenient method
#8	26	Kishlock	Husband & Four children	Kerosene & flame	Husband was in the room; four children	Convenient method
#9	25	Kishlock	Husband & his parents &siblings	Kerosene & flame	Mother-in-law and her two children	Convenient method

when she set herself on fire. Nargiza "just wanted to die" when she set herself on fire. Mohira thought burning herself "was an easy way to die." Every woman described the act of self-immolation as a suicide attempt done in an act of desperation.

Is there significance to the use of fire in the suicide attempt or is it a convenient method?

Based on the interviews with the subjects, the use of fire appeared to have no symbolic significance when used in suicide attempts. Only Nargiza was aware of the link that fire has to Zoroastrianism, which is the religion that predated Islam. She mentioned the Book of Avesta and discussed how many of the rituals that occur in the kishlocks are traditions passed down from Zoroastrianism, including the bride and groom walking around three bonfires during their wedding. Nargiza stated that the purpose of walking around fire is to cleanse the couple and to get rid of evil and protect against the evil eye.

Kerosene is a readily available accelerant. It is used to fuel lamps. Natural gas, kerosene and wood are used for cooking, so there is always the presence of fire and flames. Every woman in this study used kerosene to douse herself and then set herself on fire. In fact, one woman went to a neighbor to borrow kerosene.

Some of the subjects admitted to knowing someone or hearing about someone who had self-immolated. Others had never known of anyone to self-immolate. In Dilnoza's case, her grandmother told her she should set herself on fire if she was unhappy.

Fire is a convenient method for women living in the kishlocks (See Table 5). None of these women owned cars, so they did not have access to carbon monoxide

poisoning or drinking antifreeze. Medications are extremely expensive and not easily accessible so poisonings and overdoses are not typical suicide methods. These women cook and have access to knives, but arterial slicing is not commonly used as a suicide method.

What Can be Done About Self-Immolation?

The women were asked what they think could or should be done about self-immolation and what could help women considering self-immolation. Mahabo thought that there should be more job opportunities for the men in the kishlocks. She also believed that women should be allowed to work or go to school after marriage.

Dilnoza thought that the government should improve human rights and provide information via television and mass communications on divorce and domestic abuse. She said, "nobody in the kishlocks knows about these issues." Dilnoza also believes that there should be more psychologists and social organizations so that the women could see that there are other options. Women need to be told the best ways to deal with their problems.

Nariza also believed that the psychological courses and counseling, organized by the government, would help women. Nariza has helped organize a support center for women in her kishlock. Mohira has also helped to establish a center in her kishlock where women can go for support. Mohira also believed that women need to be educated about options in life and human rights.

Nargiza thinks men should be educated because nothing will change if only the women are educated. Nargiza would also like to see the non-governmental organizations

and other organizations do ads on television about domestic abuse. Nargiza does not think that the government can do anything to stop self-immolation.

Summary

Chapter Four presented the analyses and interpretation of the data. This data was generated through interviews with the nine women and analyzed manually. The use of QDAMiner was helpful in determining themes and coding.

CHAPTER FIVE

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to look at the phenomenon of self-immolation among a small group of women in Samarkand, Uzbekistan. Nine female subjects, who had survived self-immolation attempts, were interviewed using a list of questions designed to elicit information that would describe each woman's own experience. The interviews were taped. The interviews were conducted with the aid of a translator, and transcribed by the researcher. The transcripts were analyzed for specific variables including age, marital status, number of children, education, religion and employment.

All nine women interviewed were Muslim. They all lived in the kishlocks, or rural villages at the time of their self-immolation attempts. All women had at least the mandatory ten years of education, although employment outside of the home varied among the women. Suicide was the goal of the self-immolation attempt for the women interviewed, and fire and an accelerant were used because they were convenient.

Findings

Based on the analyses of the data in the study of nine Uzbek women and self-immolation, the following findings were revealed.

Research Question #1: How do Uzbek women who survive acts of self-immolation, describe their experiences with self-immolation?

In general, the Uzbek women in this study, who survived acts of self-immolation, described their experiences with self-immolation as a suicide attempt. The attempts were

not premeditated and therefore, no thought was given to what would happen in the event the woman survived.

Research Question #2: Is the culture of Central Asia, which is predominantly Islam as self-reported, related to the phenomenon of self-immolation?

Domestic abuse was the overriding factor in contributing to each subject's self-immolation attempt. Overall, it appears that, even though all the women were Muslim, self-immolation is a result of the harshness of village life, which includes poverty and unemployment. It cannot be said, based on the findings that the same living conditions exist for Uzbek city dwellers. Nor do the findings suggest that domestic abuse occurs only in the kishlocks and not in the urban areas. The culture of Islam may be apparent in the society's acceptance of domestic abuse. The interpretation of Islam has been distorted to a point that takes the role of the husband to a frightening and dangerous level. Although, the culture of Islam may protect abusers, it cannot be concluded that the religion of Islam is not responsible for the practice of self-immolation. Based on the results of this study, it can be suggested that domestic abuse and life in the kishlocks directly contribute to a woman's decision to self-immolate.

Research Question #3: Is the act of self-immolation, self-described as a suicide attempt or an act of protest?

Every woman interviewed who admitted deliberate self-immolation (eight of the nine women interviewed), admitted that she wanted to kill herself. During the interview process, each of the eight began to cry when asked if she had intended to die when she set herself on fire.

Research Question #4: Is there significance to the use of fire in the suicide attempt or is it a convenient method?

It cannot be said that the use of fire has any symbolic significance. Each subject who admitted deliberate self-immolation described the use of fire as a convenient method when choosing a method of suicide. Each subject replied in such a way that suggested she had considered no other method. Some of the subjects knew of other women who had self-immolated, some of the subjects did not. None of the women related the use of fire to the religion of Zoroastrianism and only one woman acknowledged knowing anything about the Zoroastrian practices of fire worship.

Conclusions

The conclusions of this study are based upon the analysis of the data obtained during the interviews and observations. The lack of research in the area of female self-immolation fueled the importance and urgency of this study.

How do Uzbek women, who survive acts of self-immolation, describe their experience with self-immolation?

The women in this study, who gave details of their self-immolation (seven of the nine women), all described their act of self-immolation as a suicide attempt. The women in this study did not describe the act as a protest of the abuse each was receiving. It was described as a desperate act after repeated episodes of verbal, emotional and/or physical abuse at the hands of family members. This abuse often consisted of violence perpetrated against women by women. Historically, this has been seen in female genital mutilation and can be seen today in female gangs. Each woman described it as a virtually

unplanned act. Each woman believed that setting herself on fire was the only option she had in dealing with her unpleasant living situation. This conclusion differs from that of Açikel, et al., (2001), where their study demonstrated self-immolation as a socio-economic or political protest. The conclusion that self-immolation was a suicide attempt among the Uzbek women interviewed also differed from a study by Husni, Koye, Cernovsky and Haggarty (2002), which also suggested that self-immolation is used as a political tool and a method of protest, particularly among oppressed groups such as the Kurds.

Therefore, the act of self-immolation by the subjects in this study can be described as an unplanned, suicide attempt, motivated by a history of abuse and feelings of hopelessness.

Is the culture of Central Asia, which is predominantly Islam as self-reported, related to the phenomenon of self-immolation?

It cannot be concluded from this study that the act of female self-immolation is connected in any way to the religion or culture of Islam. The women in this study all were Muslim, but this study did not address the tenets of the religion, or evaluate the piousness of the subjects or their abusers. This study also did not examine the incidence of self-immolation in all predominantly Muslim countries. The literature, although sparse, does not mention self-immolation occurring in every the country of the Middle East or Central Asia. It would appear that the phenomenon of self-immolation was the result of the harsh, difficult living conditions of the kishlocks and the presence of domestic abuse. This conclusion supports the findings of Zarghami and Khalilian (2002),

who found that Muslim women throughout the world use self-immolation to escape hopeless family situations. The incidence of women perpetrating violence against women, such as a mother-in-law abusing the daughter-in-law, was relatively unique to this culture. Again, it cannot be ascribed to the entire culture of Islam. None of the subjects in the study were city dwellers at the time of their immolation attempts. Many of the subjects actually described the life in the kishlocks as being problematic and that living conditions contributed to a decision to self-immolate. The lack of reliable electricity made for harsh living. Cooking was by open flame and kerosene lanterns had to be used when the electricity was restricted. Additionally, transportation was unreliable and sporadic. However, the overriding problem of kishlock living, according to the women interviewed, was the lack of employment for their spouses.

Is the Act of Self-immolation, Self-described as a Suicide Attempt or an Act of Protest?

It can be concluded from this study, that the subjects all were attempting suicide when they set themselves on fire. This supports the research by Zarghami and Khalilian (2002), who concluded that deliberate self-burning was a form of suicide more common in Asian countries. Every woman cried when asked if she wanted to die when she set herself on fire. None suggested they were protesting their treatment.

Is there Significance to the Use of Fire in the Suicide Attempt, or is it a Convenient Method?

It can be concluded from this study that there was no symbolic significance to the use of fire in the suicide attempt. However, the study by Grossoehme and Springer, described religiosity as a common theme among survivors of self-inflicted burns.

Therefore, this research did not confirm the conclusions of Grossoehme and Springer (1999). Of the eight who described the burning, all admitted to kerosene and fire being used. These findings support the research of Groohi, Alaghehbandan, and Lari, who found that flame was the most common type of burn and kerosene the most frequently used accelerant (2002). Only one woman suggested premeditation when she went to a neighbor to borrow kerosene. None of the subjects admitted to any significance to the use of fire.

Recommendations

The following recommendations are:

1. Further studies need to be conducted that include a greater number of women in Uzbekistan who have committed acts of self-immolation.
2. Psychological counseling services provided by trained, medical personnel need to be made available to the women of the Umid Center. Personal psychological counseling and family therapy services would be beneficial to the women considering self-immolation as well as to those who have survived acts of self-immolation. Also, families may be helped by psychological counseling services.
3. Increased funding is needed for non-governmental organizations including the Umid Center so protection is available to adults and children.
4. The Umid Center could enter into partnerships for educational and training programs with organizations such as the Red Cross and local hospitals.

Program topics to be considered include burn care, basic first aid and unintentional injury prevention.

5. Support groups could be formed among the current and past residents of the Umid Center that act as an advisory committee to the Center. These groups could look at ways of preventing self-immolation attempts among other women in their kishlocks.
6. The Umid Center should be a catalyst for social and community support of issues effecting women's health and domestic abuse.
7. The Umid Center needs to consider conducting consortiums for the village Mahallahs (board of elders) and religious leaders to enlist their assistance in addressing problems related to kishlock living and domestic abuse.
8. The Umid Center may benefit from educational and social forums that include both the mothers-in-law and daughters-in-law.

Summary

This study examined the phenomenon of self-immolation among a small group of women only in Samarkand, Uzbekistan. It is known that women in other countries, including Iran, Pakistan, Tajikistan and Afghanistan have attempted self-immolation. Therefore, research into the phenomenon of self-immolation should be done in those countries as well.

The findings of this study suggest that there are several factors that lead to a woman's decision to set herself on fire, with life in the kishlocks that includes domestic abuse, being a leading factor. The findings of this study correspond to reports of similar

events emanating from other countries in the Middle East and Central Asia, such as Afghanistan. The findings also correspond to other studies that suggest that domestic abuse may be a motivating factor in suicide among women in various parts of the world.

This study, to the best of the researcher's knowledge, presented the first account of female self-immolation as a health problem in Uzbekistan. Therefore, it would be beneficial to further investigate the phenomenon as it occurs among different populations in different parts of the world, particularly other countries of the Middle East and Central Asia.

CHAPTER SIX

THE STUDY IN RETROSPECT

The journey of this research project began on a visit to Uzbekistan. An Uzbek friend, Dr. Shukhrat Aripov, invited me to attend a public health conference being held in Tashkent, Uzbekistan in June of 2003. Following the conference, he acted as my tour guide around the country, including trips to the cities of Samarkand and Bukhara. While in Samarkand, I was introduced to Dr. Bibisora Oripova. Dr. Oripova is a surgeon specializing in burn care. She also runs the Umid Center, a shelter and rehabilitation center for Uzbek women who survive acts of self-immolation. After a tour of her facility, we enjoyed a cup of green tea, and she described the phenomena of female self-immolation in Uzbekistan. Having a background in burn nursing, I was stunned to learn that women, not suffering from clinical mental illness, would choose to set themselves on fire. I was also horrified that, although exact numbers were unknown, hundreds of women each year were setting themselves on fire. I became fascinated by this phenomenon and wanted to learn more about it. Our experiences with burn patients gave Dr. Oripova and me common ground. We quickly developed a rapport, despite the fact neither of us spoke the other's language. An interesting fact about Dr. Oripova is that she did not have any interest in burn care when she started her training. It was during the Cold War when she began medical school. Because of the threat of nuclear warfare and the atom bomb, she, like many other surgeons, was encouraged to learn burn care in the event of a mass casualty resulting from war and bombings.

It did not occur to me while I was at the center in Samarkand, that I would make female self-immolation the focus of my dissertation research. But long after I left Uzbekistan, I was consumed by nagging questions about the scarred women I had met at the center. I cannot imagine what would compel a young healthy woman to douse herself with a liquid accelerant and light a match. What would make her that desperate or unhappy to not only attempt suicide, but in such a painful manner, that even if she survives, she will be left with devastating consequences? Why is little being done to prevent this from occurring? Why is there not adequate emergency care and transportation to tertiary care facilities? How did the Western world know so little about this horrible practice when so many women were affected by it? The questions went on and on. I decided to look for answers to these questions.

In reviewing the literature, I found almost nothing in medical journals and books related to female self-immolation that was not connected to mental health problems. I found more information in the news literature, but most of it pertained to Afghanistan. So it was happening in other countries! I found evidence of female self-immolation occurring also in Tajikistan, Iran, Pakistan, Kyrgystan, Iraq, and India. Female self-immolation was occurring in a specific part of the world, the Middle East and Central Asia, but I still didn't understand why. That is when I decided to make the issue of self-immolation among Uzbek women my dissertation research topic.

When asked if I could go back to Uzbekistan and interview the women at the Center about their experiences with self-immolation, Dr. Oripova reacted enthusiastically. As it turned out, I was welcomed back with open arms and great

acceptance by Dr. Oripova and her staff. A room was made up for me and I was treated as an honored guest. I had hoped to live with the women, who live dormitory style, but at least I was living in the Center with them. Shy at first, many of the women would walk by me and only nod a greeting. At the end of my two weeks living at the Center, many of them sobbed when I said, "good-bye".

I interviewed nine women at the Center. I had hoped to interview more, but my guidelines were only to interview those who had set themselves on fire. Some of the women had been torched by their spouses, an entirely different situation, although equally horrifying, and a few of the residents of the Center were children, having surgery to correct deformities resulting from burns.

Dr. Oripova works under the radar of the government of Uzbekistan. President Karimov has spoken publicly that there is no domestic abuse in Uzbekistan. If that were true, then there would be little reason for attempted suicide in the form of self-immolation to occur. Consequently, Dr. Oripova does not want to draw attention to her efforts. To honor her wishes, only women residing in the Center or closely associated with it, and not those living in and around Samarkand, were interviewed for this study. I also met with several health care providers, nurses and physicians, at the Center where I had the opportunity to discuss at length their experiences with female self-immolation. Staff was present that Dr. Oripova has worked with for year. The only person she did not invite was her boss, who is not as sympathetic to the issue of self-immolation because of the political fallout that may result. Also at Dr. Oripova's request, I used a Peace Corps volunteer, who was new to Uzbekistan as well as to the language of Uzbek, to help

translate. Because of issues she didn't make clear to me, she asked me not to use a newly graduated medical doctor with translating experience. Dr. Oripova said that Kamila, the translator, was working for another non-government organization in Samarkand and felt that that would compromise her Center in some way. Of course, this was not an optimal situation for me, but I did not want to jeopardize Dr. Oripova's welfare or organization.

Through my interviews, I found the answers to many of the questions I had when I initially meet Dr. Oripova and the residents of her center. I have also found that there is so much that needs to be done to address the issue of female self-immolation, not only in Uzbekistan but in the other areas of the world experiencing this tragic phenomenon. The worldwide community needs to be aware that there are women living in atrocious conditions that drive them to acts of self-immolation. The education begins with the awareness that this problem exists. That was one of my goals -- to bring awareness to the issue of female self-immolation. Perhaps by drawing people's attention to the problem, human, financial and political resources can be directed toward eradicating female self-immolation.

So much can and must be done to come to the aid of these women who live in deplorable conditions that lead to self-immolation attempts. Work must be done on the local, regional, national and international levels in order to effectively address the issue of self-immolation. My goal is to return to Uzbekistan as well as to visit Afghanistan and other affected countries, to support the cause of these women. My hope is that the issue of self-immolation will gain worldwide attention and be brought particularly to the

attention of global health care providers, human rights activists and others. Self-immolation is both a public and personal health issue and needs to be addressed by the leadership in countries where the problem exists.

Research should be done to include additional qualitative studies in an effort to gather information and then conduct quantitative research. Areas of research should include, but not be limited to: female self-immolation, particularly in the Middle East and Central Asia, domestic violence as to causes and interventions, the standard of care of burn victims, and interventions in the prevention and treatment of women who self-immolate.

Education programs should be developed, implemented and targeted at students in secondary schools. Content should include: information on human rights and equality, preparation for marriage, the issue of domestic violence, and personal communication skills. Education programs also should be designed and developed for the village populations. These should include first aid classes that provide field treatment for burns. The mahalla (the board of elders of the village) should also be educated about the problems of domestic violence and should develop guidelines for interventions. I would like to see shelter and/or support groups or counseling services made available at the local level for women of the kishlocks (villages). In that many of the husbands who abused their wives were unemployed, government programs should be developed that provide monetary assistance, employment services and occupational training.

So much could be done on a government level to address the domestic abuse and harsh living conditions. First of all, the government must publicly recognize that self-

immolation exists. Secondly, governments must publicly recognize that domestic abuse is a very real problem. The government must support an infrastructure that supports public welfare programs. It is important for the governments where self-immolation is a problem to make a strong commitment to improving the lives of its citizens through better health care, education, and the support of human rights. Government agencies must do a better job at keeping good records of incidents of self-immolation.

The international community must recognize that the act of self-immolation is affecting woman in many parts of the world. Resources must be made available to non-governmental organizations and countries in order to address the issue of self-immolation and provide the necessary programs. One program, the Women's Integrated Legal Literacy sponsored by Winrock International, provides training and awareness in gender issues. This program has trained over 3,000 government officials in women's rights and gender analysis (Winrock International, n.d.). The attention of the world must be brought to the issue of self-immolation. If the world community doesn't know about the problem, nothing can be done.

Finally, Muslim religious leaders could take a lead in educating Muslim men on what the Qu'ran really teaches as opposed to what culture has influenced, about family life and husband/wife relationships. The religious leaders should also give guidance and education in regards to marriage, particularly forced and arranged marriages. As stated in the findings, the religion of Islam is not responsible for self-immolation. Self-immolation does not occur in every Muslim country, but in a few of the poorest Muslim countries. Tradition has been altered when men have taken the "discipline" of their spouses to a

violent extreme. Muslim religious leaders should take a stand against the abuse practices that have evolved. These religious leaders could encourage a more literal adherence to the Koran in order to protect women.

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APPENDICES

APPENDIX A

QUESTIONNAIRE FOR WOMEN WHO HAVE BURNED THEMSELVES

Questions for Women Who Have Been Burned

Demographic Information

1. What is your age?
2. Have you ever been married?
3. Was your marriage arranged?
4. What is the date you were married?
5. Are you still married?
6. Who lives with you now? Who lived with you in your home?
7. What does your husband do?
8. Do you have any children?
9. Where do your children live?
10. Have you ever been employed outside of the home?
11. What is your religion?
12. What is your native language?
13. How much education do you have?

Questions Related to Being Burned

1. When were you burned?
2. How were you burned?
3. Was anyone else with you at the time you were burned?
4. What medical attention did you receive?
5. How did you burn yourself?

6. Why did you burn yourself?
7. What did you use to burn yourself?
8. Did you know anyone else who had been burned?
9. What did you think would happen when you burned yourself?
10. What does your husband feel about you being burned?
11. How has being burned changed your life?
12. Did you expect to die?
13. What are your plans for the future?
14. What do you think the government should do about self-immolation practices?
15. What do you think health agencies should do about self-immolation practices?
16. Who is responsible for the practice of self-immolation?

APPENDIX B
CONSENT FORM IN ENGLISH

INFORMED CONSENT STATEMENT

Self-Immolation Experiences among Uzbek Women and Their Health Care Providers

You are invited to participate in a research study that will look at the practice of women setting themselves on fire. Especially of interest are the reasons women feel like they have to set themselves on fire. You will be asked about your experiences, thoughts and feelings associated with women burning themselves. The interview will be taped so that your exact words can be used.

Information
If you agree to help with this study, you will be asked to answer several questions. The questions will be about your own personal experiences with women who set themselves on fire. Participation is voluntary. You may drop out at any time during the interviewing process and any information all ready obtained will be destroyed. If you choose to not participate after the interview has taken place, it will be impossible to discard your information because it won't have your name on it. The interview will last approximately one hour, although you may stop at any time, or talk as long as you would like. The interviews of women who have been burned will take place in a private room at the Umid Center, with only you, a translator and Elizabeth Campbell present. The interviews with health care providers will take place in a conference room at the Umid Center, at their convenience, ensuring confidentiality.

Risks
There are few risks to you. No one will be able to connect your name and your responses. However, a few people may find that talking about being burned is upsetting. If you do become upset, you can discuss your concerns with the Elizabeth Campbell, a nurse practitioner with experience in counseling, or talk to Dr. Bibisora Oripova who can provide either counseling or medical interventions. There are no foreseeable risks to health care provider participants.

Benefits
Although you will not receive any payment for your participation, the results of this study may help those women considering setting themselves on fire in the future. You may also find it helpful to discuss your own situation and expe3rience some relief and comfort in sharing your story with someone who is interested in your situation. For health care providers, a better understanding of the impact of self-immolation and the issues surrounding this phenomenon may result, resulting in better education for health care providers and improved health care delivery.

Confidentiality
All information in the study will be kept confidential. All the information will be kept in a safe place, and only Elizabeth Campbell will have access to the information. The tapes

will be destroyed after transcription is finished. The transcripts and field notes, as well as any photographs, will be stored for up to 5 years, for use in professional writings for educational purposes or academic presentations on the subject of self-immolation. Your name will not be used with your answers and comments. Your name will not be attached to your photograph. The translator will abide by the same confidentiality agreement described here. Confidentiality of transcripts will be maintained because Elizabeth Campbell will do the transcriptions.

Compensation
The decision to participate in this study is totally voluntary. You will not be paid for participating.

Contact Information
If you have questions at any time about the study or the procedures involved, please contact Elizabeth Campbell at ecampbe3@utk.edu; at 001-423-239-7156; or at 161 Walton Court, Kingsport, TN, 37663, USA. Questions about your rights regarding participation can be asked by contacting the Compliance Office at 011-865-974-3466. From 2 July to 17 July, Elizabeth Campbell may be contacted at the Umid Center, in Samarkand, Uzbekistan. Her email address at the center is also ecampbe3@utk.edu.

Participation
Your participation in the study is voluntary. You may withdraw from the study at anytime. If you choose to withdraw from the study before data collection is completed, your data will be returned to you or destroyed. Elizabeth Campbell.

Consent
I have read the information provided n this form. I have received a copy of this form. I agree to participate in this study.

Participant's Signature _____Date _____

Investigator's Signature_____Date _____

Translator's Signature_____Date _____

Photography Consent
I agree to have my photograph taken and give Elizabeth Campbell permission to use it for professional writings related to this study and for academic presentation on the topic of self-immolation.

Participant's signature _____Date_____

Investigator's signature _____Date_____

Translator's signature_____Date_____

I agree to have my photograph taken only if my facial identity is hidden and give Elizabeth Campbell permission to use it for published manuscripts related to this study and for academic presentations on the topic of self-immolation.

Participant's signature_____Date_____

Investigator's signature_____Date_____

Translator's signature_____Date_____

I do not wish to have my photograph taken and refuse to give permission to have my photograph taken.

Participant's signature_____Date_____

Investigator's signature_____Date_____

Translator's signature_____Date_____

APPENDIX C
CONSENT FORM IN UZBEK

Тадкикотда катнашиш хакида тасдик

Узбекистон аёлларнаро «узини ёкиш» муаммолари ва тиббий ёрдам бериш тажрибалари

Сиз аёллар уртасида «узини ёкиш» муаммолари тадкикотларига таклиф килиндингиз. Бу тадкикотда ургу аёлларнинг «узини ёкиш» муаммоси сабабларига каратилган. Сизга «узини ёкиш» муаммоларига учраган аёллар билан муомала тажрибангиз, шахсий муносабат ва хиссий фикрларингиз куламидаги саволлар тақдим килинади. Учрашув натижаларининг самарали, яъни сизнинг фикр ва хиссиётларингиз соф маъноли булиши учун аудиокассетага ёзиб борилади.

Маълумот

Агар сиз ушбу тадкикотда катнашишга тайёр булсангиз, сиздан бир канча саволларга жавоб беришингиз талаб килинади. Саволлар «узини ёкиш» феноменига учраган аёллар билан булган шахсий муомала тажрибангиз доирасида булади. Сиз учрашувни хохлаган вактингизда тухтатишингиз мумкин ва шу вактгача килинган барча кайдлар йук килинади. Шуни хам айтиб утиш керакки, учрашувдан кейинги барча маълумотлар ва кайдлар, агар сиз истикболда тадкикотда катнашишни истамай, бекор килмокчи булсангиз хам, маълумотлар йук килинмайди. Чунки, жами йигилган маълумотлар базасидаги такризлар, кайдлар, вокеаларнинг барчаси, ушбу муаммоларга учраган кишиларнинг исми-шарифисиз киритилади (учиришнинг иложи булмайди). Учрашув бир соат атрофида булади. Лекин сиз истаган вактингизда тухтатиб, бекор килишингиз ёки сизга керак булган вакт доирасида сузлашишингиз мумкин. Барча учрашувлар «Умид» марказида ажратилган алохида хонада булади ва интервьюда сиз, Элизабет Кэмпбелл ва таржимон катнашадилар.

Кутилмаган хавф-хатарлар

Умуман олганда, тадкикотда иштирок этиб, таваккалчиликка учрамайсиз. Хеч ким сиз билан ушбу тадкикотга боглик мавзуларда алока урнатмайди. Баъзи иштирокчилар хавотирланишлари мумкин. Аммо, сиз бу холда психологик консультация тажрибасига эга булган тиббий хамшира Элизабет Кэмпбеллга ёки маслахат ва тиббий ёрдам сураб врач Орипова Бибисорага мурожат килишингиз мумкин. Тадкикотда иштирок этувчи тиббий хизматкорлар учун хеч кандай хавф-хатар йук.

Тадкикотда катнашишнинг ижобий томони

Катнашишингиз молиявий томондан рагбатлантирилмаса хам, сизнинг ишингиз натижаси бошка куплаб аёлларга «узини ёкиш» муаммоларини хал килишга ва олдини олиш чораларини яратишда катта ёрдам беради. Бундан ташкари, сиз кечган ички туйгуларингизни ёрдам бермокчи булган одамларга етказишингиз ва узингизни эркин ва хотиржам хис этишингиз мумкин. Шунингдек, ушбу фаолият натижалари тиббий кумакка хам эгадир, чунки тиббиёт ходимлари «узини ёкиш» муаммолари ва шунга боглик феноменларга асосланган саволларга жавоб топишга ва ходимларни укитишни тараккий этишга йирик кумак булади.

Конфиденциаллик

Тадкикот мобайнида йигилган барча маълумотлар конфиденциалдир ва хавфсиз, ишонарли манбада сакланади. Маълумотлар базасидан фойдаланиш хукукига, факатгина, Элизабет Кэмпбелл эгадир. Аудиокассетага ёзилган барча маълумотлар ёзма кайдларда уз аксини топганидан сунг йук килинади. Тадкикот давомида килинган барча кайдлар ва расмлар архивда 5 йил мобайнида сакланади ва малакали олимлар томонидан илмий максадларда ва «узини куйдириш» муаммоли саволларига доир укитиш материалларида кулланилади. Барча материалларда, факатгина, сизнинг жавобларингиз ва фикрларингиз ишлатилади (исмингиз ва фамилиянгиз курсатиб утилмайди). Шунингдек, расмингизда хам исми-шарифингиз берилмайди. Таржимон тиббиёт сохаси студенти ва у маълумотлар конфиденциаллиги

хакидаги келишувга имзо чекади. Ёзма кайдлар конфиденциаллиги хам кафолатланади, чунки кайдлар килиш билан Элизабет Кэмпбеллнинг узи шахсан шугулланади.

Тадкикотда катнашганлик учун рагбатлантириш

Тадкикотда катнашиш каторини кабул килиш ихтиёрийдир. Катнашиш молиявий томондан рагбатлантирилмайди.

Алока урнатиш учун маълумотлар

Агар сизда тадкикот юзасидан саволлар тугилаётган булса, илтимос, Элизабет Кэмпбеллнинг электрон почтаси: ecampbe3@utk.edu ; телефони: 001-432-129-7156 ёки 161 Walton Cort, Kingsport, TN, USA манзилига ёзиб юборишингиз, алока урнатишингиз мумкин. Сизнинг, тадкикот давомидаги хукук нормаларингиз билан боглик булган саволлар билан куйидаги телефонга мурожат килинг: 011-865-971-3466. Элизабет Кэмпбелл билан 2004 йилнинг 2-17 июль кунлари «Умид» марказида алока урнатишингиз мумкин. Элизабет Кэмпбелл хизмат сафари давомида, юкоридаги электрон почтасида хатларни кабул килади.

Тадкикотда катнашиш

Сизнинг тадкикотда катнашишингиз ихтиёрийдир! Сиз интервьюни ихтиёрий вактда тухтатишингиз мумкин. Агар бу хол маълумотлар туласинча тупланганидан олдин юз берса, у холда сиз хакингиздаги барча маълумотлар сизга кайтарилади ёки йук килинади.

Элизабет Кэмпбелл

Тадкикотда катнашиш хакида розилик

Мен ушбу хужжат маълумотлари билан танишиб чикдим ва хужжат нусхасини олдим. Мен тадкикотда катнашишга розиман.

Катнашувчи имзоси_____Сана_____

Тадкикотчи имзоси _____Сана_____

Таржимон имзоси _____Сана_____

Иштирокчи[redacted]

Мен Элизабет Кэмпбеллга менинг расмимни, узининг, «узини ёкиш» муаммоларига боглик малакавий кайдларида ва академик чикишларида ишлатишига рухсат бераман ва розилигимни билдираман.

Катнашувчи имзоси_____Сана_____

Тадкикотчи имзоси _____Сана_____

Таржимон имзоси _____Сана_____

Менинг расмим кайси максадларда ишлатилишидан катъий назар, расмга тушишга рози эмасман.

Катнашувчи имзоси_____Сана_____

Тадкикотчи имзоси _____Сана_____

Таржимон имзоси _____Сана_____

APPENDIX D

UNIVERSITY OF TENNESSEE HUMAN SUBJECTS

(FORM B)

THE UNIVERSITY OF TENNESSEE

Institutional Review Board
Office of Research
404 Andy Holt Tower
Knoxville, Tennessee 37996-0140
865-974-3466
Fax: 865-974-2805

06/24/2004

IRB#: 6648B

TITLE: Self-Immolation Experiences Among Uzbek Women and Their Health Care Providers

Campbell, Elizabeth
Health & Human Sciences
161 Walton Court
Kingsport, TN 37663

Gorski, June
Health & Human Sciences
HPER Bldg.
Campus

The points of clarification you submitted to this office regarding the above-captioned project, satisfied the concerns of the reviewers and the IRB, thus your project is approved.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. To retain signed consent forms from subjects for at least three years following completion of the project.
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice on the anniversary of your approval date.

Sincerely,

Brenda Lawson
Compliances

THE UNIVERSITY of TENNESSEE
Institutional Review Board
Office of Research
1534 White Avenue
Knoxville, Tennessee 37996-1529
Phone: (865) 974-3466
Fax: (865) 974-7400

Date: 07/22/2005

To: Campbell, Elizabeth
Health & Human Sciences
161 Walton Court
Kingsport, TN 37663

From: Brenda Lawson
Compliances

Subject: Annual Review and Progress Report:
Project Involving Research with Human Subjects

IRB #: 6648B

IRB-APPROVED RENEWAL

Project: Self-Immolation Experiences Among Uzbek Women and Their Health Care Providers

Initial Approval Date: 06/24/2004 Last IRB Approval Date: 07/21/2005

Approval Expires: 06/24/2006

In response to our request regarding annual review and a progress report of the above protocol, you indicated that the study is still active and that there have been no changes with regard to the use of human subjects in this project since the last date of review. Therefore, the Institutional Review Board has approved the protocol until **June, 2006**, which coincides with the anniversary month of your initial approval date.

If there should be any modifications in the project before the date of next annual review, please submit them, utilizing a Form D, to the Compliances Office immediately for review. Requests for your next annual review will be sent to you approximately one month prior to the expiration date.

VITA

Elizabeth A. Campbell was born in Norristown, Pennsylvania on March 30, 1956. She graduated from North Penn High School in Lansdale, Pennsylvania in May 1974. In 1978, she received a Bachelors of Science Degree in Individual and Family Studies from the Pennsylvania State University in University Park, Pennsylvania. She worked in a nursing home, first as Activities Director, and then as Director of Admissions before returning to school. She graduated from Montgomery County Community College in Blue Bell, Pennsylvania with an Associate's Degree in Nursing in December 1985. She immediately began working at the Hospital of the University of Pennsylvania (HUP) in Philadelphia, where she was a staff nurse in gynecology, urology and general surgery. After two years, she transferred to the emergency department and worked as a trauma nurse in the Level I trauma facility. While at HUP, she completed her Bachelors in Nursing from Pennsylvania State University in 1988 and her Master's in Burn, Emergency and Trauma Nursing from Widener University in Chester, Pennsylvania. She also participated in several research projects with emergency department attending physicians, for which she received the Excellence in Nursing Award from the Hospital of the University of Pennsylvania.

After completion of her Master's Degree in 1992, Elizabeth took a position in Spokane, Washington as Emergency/Trauma Clinical Nurse Specialist for Empire Health Services. While there, she completed her post-Master's certification as a Family Nurse Practitioner at the Intercollegiate Center for Nursing Education through Washington State University. She also was an adjunct nursing instructor for Washington State University.

After resigning from Empire Health Services, she worked in several nurse practitioner positions before moving to northeast Tennessee.

Upon locating to Kingsport, Tennessee, Elizabeth worked at Holston Valley Hospital and Medical Center as an acute care clinical nurse specialist. She then accepted a position as Assistant Professor of Nursing at King College in Bristol, Tennessee. She worked there for four and one half years before resigning in August 2003 to attend The University of Tennessee full-time in order to complete her doctoral education. A Doctor of Philosophy in Human Ecology with a concentration in Community Health, emphasis in Public Health and cognate in Nursing, was awarded in December 2005.

Elizabeth, a nationally certified family nurse practitioner through the American Academy of Nurse Practitioners, is a member of Sigma Theta Tau, Inc., the International Nursing Honor Society and Eta Sigma Gamma, the National Professional Health Education Honorary. She also belongs to numerous professional organizations including the American Public Health Association, the American Academy of Nurse Practitioners, the Global Health Council, the Society for Public Health Education, the Transcultural Nursing Society and the International Society of Travel Medicine. Elizabeth is also a veteran of nine international medical mission trips to Central and South America, Eastern Europe, Asia and the Indian sub-continent.