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SUICIDE BOMBER OR MURDER VICTIM?: A CAPTIVE PHYSICIAN'S OBSERVATION OF A FUTURE SUICIDE BOMBER

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Abstract

The number of suicide bombings substantially increased in recent years in Afghanistan resulting in devastating consequences for Afghans and the coalition forces. In Afghanistan, a significant number of suicide bombings are carried out by individuals with who are coerced or have mental illness. Here we present the case of a would-be suicide bomber observed by a captured physician. The physician's testimony and observations showcase that not all suicide bombings in Afghanistan are voluntary acts. We conclude that, with appropriate intervention, it is theoretically possible to reduce the number of suicide bombings. We recommend that the scientific community explore measures to improve psychiatric care in Afghanistan, a measure that will not only improve the quality of life in the country but also reduce causalities related to suicide bombing.

Introduction

The number of deaths due to suicide bombings in Afghanistan has substantially and dramatically increased since 2004(CPOST, 2011). While there are large numbers of videos interviewing failed or would-be suicide bombers, not surprisingly there is little information on the psychiatric condition of suicide bombers immediately prior to attempting suicide bombings. It would be, however, naïve to assume--as commonly believed(Hakim, 2011; Kenber, 2013)-- that all suicide bombings are ideologically motivated voluntary acts. In fact, some of these "suicide bombings" are plain murders by any standard (Guerin, 4 February 2010; Miller, 2006). We present a unique perspective on behavior of a would-be suicide bomber as observed by a United Nation (UN) employee physician taken hostage by the Taliban in Afghanistan, followed by a discussion of suicide bombing in the country and recommendation to help vulnerable youth. Because of security risks and lack of personel, the Taliban housed the suicide bomber (Fedayee, which literally means "self-sacrificing person", is a generic term used by the Taliban to glorify suicide bombers) and the hostages together: they were moved from house to house in the village. The physician, thus, had the opportunity to observe the suicide bomber for three days and two nights. The captive doctor, who had previously been beaten up by the Taliban for his belief in educating women, was explicitly instructed not to talk to the Fedayee. For this reason, the following assessment is understandably limited.

Case Report

The suicide bomber (Fedayee) appeared to be a 16-18 year old adolescent who was brought from some other part of the country to one of the Northern provinces to "volunteer" for a suicide mission. The adolescent was constantly under psychological pressure to carry out his mission. The Taliban used different methods to encourage the Fedayee. For example, the Taliban showed him videos of other Fedayees, with background songs called *Tarana* honoring the deceased (the only type of songs allowed by the Taliban). It must be noted that this method is so effective that, in parts of Afghanistan, if children are asked what they want to do when they grow up, they respond "be a Fedayee and have *Tarana* in my name." The Taliban also frequently talked to him about the "brutality and barbarity that the NATO and coalition forces exercised in Afghanistan and against Muslims around the world." Moreover, the men of the village were perhaps forced to come daily to honor the Fedayee by kissing his hands and expressing statements such as "please invite us to go with you when you go to Paradise".

To the physician's surprise, the Fedayee appeared uninterested in any of the above activities and discussions. For instance, rather than walking outside, he preferred to stay in the dark dungeon with the hostages almost the entire time. He communicated very little, but his dialect was indicative of him being from Afghanistan. His appetite was poor, and the villagers were forced to bring food, but he only ate one banana each day during the time that the captive physician observed him. The Fedayee took numerous ablutions even when he did not have to (although not prohibited, excess in any form is discouraged in Islam). He slept poorly, waking up numerous times during the night and early morning and frequently napped during the day.

The mental status examination (MSE) as such was limited to observation by a physician who was under constant threat of execution (fortunately the physician was rescued by the coalition forces). The boy appeared well groomed, was pale and cachectic, and did not seem mentally present when the Taliban or the villagers were around. He appeared to be experiencing depersonalization and/or derealization and was quite and withdrawn, with overt psychomotor retardation. The boy conversed very little with the Taliban or the villagers, but when he did, he spoke in a low voice and gave monosyllabic answers. His affect was flat, and he showed little change in facial expressions while conversing with the Taliban or the villagers. He was indifferent to the frequent praise he received from them. When he was watching the videos shown to him by the Taliban, he seemed dazed. His face was pale with conjunctival reddish discoloration possibly secondary to insomnia or cannabis usage. Albeit based on scant conversations with the doctor and others, his thought process appeared linear and coherent. His vocabulary and unsophisticated language abilities were suggestive of lower level of educational attainment (if any).Although his thought contents could not be assessed, the adolescent did not appear to respond to internal stimuli; frequent ablutions may have been indicative of obsessive rumination. It is not clear whether he had suicidal ideations or was simply coerced into eventual "self-sacrifice.". Insight and judgment could not be assessed. During those few days, the Fedayee did not act impulsively.

Discussion

Suicide-murder for ideological reason is not a modern phenomenon: all major religions have sanctioned suicide-murder in some form (e.g. Samson in the Bible or accounts attributed to Sahabah Islam). Suicide bombing, however, has only been possible since gun powder and dynamite became available. In recent centuries, episodic suicide bombings have been reported throughout the world from China, Russia (the assassination of Alexander II is probably the first clear instance of a suicide bombing), and India to Western European countries. Large scale, systematic suicide bombings were glorified in the Second World War by both Soviet Union (USSR) and Japanese military forces.

Traditionally, suicide-murders were not associated with Afghanistan. Suicide is interpreted as a sin in Islamic faith and is punishable by the refusal of proper burial rituals and eternal condemnation. Considering that Afghan society is highly religious, it is not surprising that suicide bombings/suicide-murders were historically rare in the country. Even during USSR occupation and in the immediate aftermath of the fall of the Taliban, the rate of suicide bombing did not increase: only a dozen suicide bombings were reported in Afghanistan between 2001 and 2004 (CPOST, 2011; Goodenough, 2011).

In contrast to Afghanistan, suicide bombing had been common in the Middle East for several decades (Afghanistan is geographically part of South Asia). After seeing that suicide bombing were effective military strategy and psychological warfare in Iraq, Afghan extremists adopted it. These extremists also found ways to justify such acts in religious terms (Hakim, 2011; Kenber, 2013; Naqvi, Kazim, & Huma, 2011; Shay, 2004). According to this new interpretation, the Fedayee (suicide bomber) is not only innocent, but would also become both a Ghazi (hero who kills infidels) and a Shaheed (martyr) with guaranteed entrance to heaven. This new interpretation is highly appealing to hopeless, unemployed, repressed, depressed, and isolated youth. Therefore, suicide bombings increased in number quite sharply in Afghanistan from 2004 onward, and the trend still continues (Albawaba, 2013; CPOST, 2011; Goodenough, 2011). Although accurate statistics are lacking, in five years (2006 to 2010) over 500 attacks were carried out, resulting in close to 3,400 deaths and three times as many casualties (CPOST, 2011; Goodenough, 2011). Among the coalition forces in Afghanistan, at least 60 US military personnel lost their lives to suicide bombings (iCasualties.org, 2014).

It would be inaccurate to assume that all of these suicide bombing cases in Afghanistan are purely ideologically motivated (Miller, 2006). In the above case report, even though this assessment is limited to observation by a physician who narrowly escaped death, it still illustrates that motivations for suicide bombings are diverse. Once could argue that the adolescent in this case met the criteria for depressive disorders, appeared to be experiencing depersonalization and derealization, and had obsessive rumination. Even though this assessment is inherently limited, his lack of interest and behavior suggest that he was likely an unwilling "volunteer"; he appeared to be under immense stress, as if he was an inmate awaiting an execution (AtalPakhtun, Dec 2009; Guerin, 4 February 2010) rather than a motivated jihadi (Hakim, 2011; Kenber, 2013).

There is no doubt that some attacks in Afghanistan are carried out by extremists and, one could argue, that such individuals cannot be stopped (Miller, 2006; Post et al., 2009; Shay, 2004). However, the vast majority of suicide bombings in Afghanistan are attempted under conditions of immense pressure and intimidation. It is not uncommon for family members, friends, and peers to coerce others into suicide-murder (Guerin, 4 February 2010). There are also a number of reports showing that young orphans or family-estranged children are "brain-washed" (AtalPakhtun, Dec 2009; Safi, 2009). Using psychoactive substances to encourage the "volunteers" is not uncommon (AtalPakhtun, Dec 2009; Palermo, 2006). One of the commonly reported methods unique to Afghanistan is sexual blackmailing. Sexual molestation is an irreparable damage to reputation in Afghan–especially in Pashtun culture. It is widely reported that some of the youth "volunteering" for the suicide missions have been sexually molested and then given the option to either "volunteer for the mission and die honorably with guaranteed entrance to the Heaven" or "be exposed and live in humiliation." Some youth choose "martyrdom and glory" over perceived humiliation(KabulPress, 2014). These individuals can be more accurately described as victims of homicide themselves rather than as willing suicide bombers. These are among the groups of individuals whose motivation can be undermined, thus potentially lowering the disturbing trend of suicide bombings in Afghanistan.

Conclusion

There is limited literature on the consequences of suicide bombing (Amital, Amital, Shohat, Soffer, & Bar-Dayan, ; Bala, Shussman, Rivkind, Izhar, & Almogy, 2010; Pasquier, Tourtier, & Lenoir, 2012; Post, 2010; Rathore, Ayub, Farooq, & New, 2011), but, not surprisingly, there are no studies evaluating the psychiatric health of would-be suicide bombers. Such studies are challenging– if not impossible practically and ethically–especially in countries like Afghanistan. The healthcare system in Afghanistan is among the worst in the world, and psychiatric care is non-existent even in large cities and progressive provinces. Decades of war have resulted in extreme unemployment, especially among rural youth populations. Poverty, repression, sexual exploitation, lack of education, and constant propaganda depicting "eternal glory" over life in misery are among the reasons for successful recruitment and exploitation of vulnerable youth by extremists. Addressing some of these problems may take decades; however, there are "windows of opportunity" that can have dramatic public health benefits in a relatively shorter period of time.

If one assumes that all the suicide bombings are purely ideologically motivated, then it is indeed futile to attempt to stop such events (Palermo, 2006; Post, 2010). Numerous video clips are available that show that failed suicide bombers fully and rationally understand the consequences of their actions (Hakim, 2011; Kenber, 2013). Such confrontational interviews surely "proves the point" of those who are already against Islamic justification of suicide bombing. These interviews will not be effective in inciting rethinking in those who support suicide bombing. Moreover, these types of interventions would have little impact on vulnerable population and may even further alienate them. However, educating the public in a non-threaten manner is more likely to result in positive outcomes. Devising strategies to reach out to the vulnerable population is only limited by one's imagination; however, psycho-education has potential for immediate return on investment.

Most chronically depressed Afghans believe that being depressed is "their nature" and are unaware of the available effective treatments(Exeer, 2013). This problem is not limited to the uneducated public; the clinicians in rural Afghanistan (most of whom are not physicians) are less attuned to the psychiatric needs of their patients as well. Thus, inexpensive programs geared towards both the general public and clinicians could produce dramatic public health improvements. An example of such success was produced by educating midwives in Afghanistan (Zainullah et al., 2013). If similar methods to educate clinicians in screening for psychiatric disorders and available treatments are

devised in a culturally sensitive manner, it is possible to prevent some of the suicide bombings in Afghanistan, including the unwilling suicide bombers. Suicide hotlines, for instance, would not require a large operational. The Afghan medical diaspora, thus, need international support to develop methods to reach out to local leaders, religious figures, and the entire community in culturally acceptable ways in order to avert preventable suicide bombings.

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