New Perspectives in Behavioral & Health Sciences

S. M. Yasir Arafat · Murad M. Khan
Editors

Suicide in Bangladesh

Epidemiology, Risk Factors, and Prevention

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Editors
S. M. Yasir Arafat
Department of Psychiatry
Enam Medical College and Hospital
Dhaka, Bangladesh

Murad M. Khan
Brain & Mind Institute
Aga Khan University
Karachi, Pakistan

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Asma Khatun, wife of S. M. Yasir Arafat

Preface

Suicide is a major, however, an under-researched public health problem in Bangladesh. The country still lacks a national suicide surveillance system, and a national suicide prevention strategy. Therefore, access to quality suicide data for policymaking is a fundamental challenge. There are wide variations in the suicide rate as per different studies and international reports. Additionally, there are strong possibilities of under-reporting of suicide in the country. Suicide is a criminal offense in the legal system of the country that certainly hinders the disclosure of suicide. A high level of stigma, lower level of suicide literacy, enduring culture, Muslim majority religious background, criminality badge, and patriarchal social norms affect suicide prevention in Bangladesh. Fortunately, an increased number of studies are coming out in the current decade exploring multiple aspects of suicidal behavior indicating that social factors have a prominent role than mental disorder which is a noticeable difference in the country. Nevertheless, there is no book on suicide in Bangladesh neither in English nor in Bangla. Therefore, this book aimed to present a comprehensive outlook on suicide in Bangladesh based on existing evidence and expertise covering epidemiology, sources of quality data, local culture, forensic and legal aspects, health and mental health care, media and suicide, crisis management system, suicide prevention, and status of evidence in the country. This book is the first of its kind to address multiple aspects of suicide in Bangladesh. It would be a useful resource material for academics, researchers, policymakers as well as non-governmental and voluntary organizations interested in suicide prevention in Bangladesh. It highlights the research gaps and recommendations for the national suicide prevention strategy in Bangladesh.

Dhaka, Bangladesh — S. M. Yasir Arafat
Karachi, Pakistan — Murad M. Khan

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About the Editors

Dr. S. M. Yasir Arafat is currently working as an Assistant Professor of Psychiatry at Enam Medical College and Hospital, Dhaka, Bangladesh. His research focused on suicidal behavior, social aspects of human behaviors, and psychometrics. He completed his M.D. in Psychiatry from Bangabandhu Sheikh Mujib Medical University, Dhaka, and his MBBS from the Dhaka Medical College, Dhaka, Bangladesh. He also did an MPH in Health Economics and M.B.A. in Marketing. Dr. Arafat has (co)authored more than 300 peer-reviewed articles and book chapters. He has been included in the global 2% researcher list in 2021 and 2022 due to his authorship contribution. Earlier, he (co)edited two books with Springer on Panic Buying; those are the first published books on Panic Buying in academia.

Professor Murad M. Khan MRCPsych, Ph.D., is Professor Emeritus, Department of Psychiatry and Brain & Mind Institute, Aga Khan University. He is also Associate Faculty at the Centre for Bioethics and Culture (CBEC), Karachi. Professor Khan is the past President of the International Association for Suicide Prevention (IASP) 2017–2020, and continues to serve on the Board of IASP, where he contributes to the organization's global suicide prevention strategy. He also serves in several other mental health non-governmental organizations and bioethics forums in Pakistan. Professor Khan's research interests include focusing on epidemiology and socio-cultural and religious factors in suicide and self-harm in South Asia and developing economies, mental health of women and the elderly, narrative medicine, and organizational ethics. His extensive research work, findings, and contributions to social and ethical issues have been published in several medical journals and the Lay Press, where he is a frequent contributor.

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CHAPTER 1

Epidemiology of Suicide and Data Quality in Bangladesh

Russell Kabir, Md. Rakibul Hasan, and S. M. Yasir Arafat

Abstract As a public health problem, suicide gets less attention than it deserves in Bangladesh. The exact rate of suicide is still arguable based on different sources as the country does not have any national suicide surveillance system and it varies in different reports and empirical studies. We know very little about the epidemiology of suicidal ideation, plan, and non-fatal attempts. The available evidence suggests that the majority of suicides happen among young populations especially those under 30 years of age, females are dying more than males, and students and housewives are vulnerable groups. Life events, psychiatric disorders, unemployment, social isolation, sexual abuse, marital discord, and familial disharmony are the prominent risk factors for suicide. Social events show more harmful associations than psychiatric illnesses. The family has an untapped role in suicide prevention as a significant proportion of suicides could be attributed to events closely related to family conflicts. Forensic medicine and police are identified as the prominent sources of data for suicide research in Bangladesh. This chapter aims to discuss rates, gender distribution, and risk factors for suicide in Bangladesh. It also discusses the sources of suicide data in the country along with concerns about its quality.

R. Kabir (✉) · R. Kabir (✉) · Md. R. Hasan
School of Allied Health, Anglia Ruskin University, Essex, UK
e-mail: russell.kabir@aru.ac.uk

S. M. Y. Arafat
Department of Psychiatry, Enam Medical College and Hospital, Dhaka, Bangladesh

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Keywords Suicide in Bangladesh · Epidemiology · Data quality · Suicide rate · Protest suicide

1 Introduction

According to the World Bank, Bangladesh has been one of the fastest growing economies in the world over the past decade (The World Bank, 2022). Like many other developing nations, Bangladesh is also experiencing enormous political, environmental, and social challenges within itself. Her most significant challenge is the country's large population. Dhaka, the capital, is the sixth most densely populated city in the world, with around 29,069 per square kilometer (World Atlas, 2020).

Although the public health scenario has improved remarkably in Bangladesh over the last 30 years, the country still faces significant health challenges, and there are still numerous health issues that its healthcare system is yet to handle successfully (Muhammad et al., 2017). Suicide is one of them (Shah et al., 2017). Suicide is a complex phenomenon and is considered as a major public health problem. Not only demographic factors but also an amalgam of psychological, social, biological, cultural, and environmental factors pushes an individual to die by suicide (Zalsman et al., 2016). Effective suicide prevention warrants good empirical studies, and epidemiological data helps us to identify the population at risk, emergency preparedness, and population-level disease progression, and this, in turn, can be used to reinforce decision-making (Fairchild et al., 2018). Against this backdrop, this chapter is aimed to explore the epidemiological aspects of suicide in Bangladesh and evaluate the quality of suicide data in Bangladesh.

2 Epidemiology of Suicide in Bangladesh

2.1 Suicide Rate

Bangladesh has no central suicide database or national suicide surveillance system. To the best of our knowledge, no nationwide study has been conducted to assess the burden of suicide in the country in different age groups. There are wide variations among the rates published in World Health Organization (WHO) reports, non-government organization data, and empirical studies. Above all, there are concerns about under-reporting and misclassification of suicides that hide the real gravity of the problem. The WHO publishes suicide rates periodically using a modeling approach. We mention the WHO-published suicide rates in Bangladesh in 2012, 2016, and 2019 in Table 1.

Table 1 Suicide rate in Bangladesh according to WHO reports

Year	*Sex*	*Number of suicides*	*Crude suicide rate (per 100,000)*	*Age-standardized suicide rate (per 100,000)*
2012	Total	10,167	6.6	7.8
	Female	5,773	7.6	8.7
	Male	4,394	5.6	6.8
2016	Total	9,544	5.9	6.1
	Female	5,666	7.0	6.7
	Male	3,878	4.7	5.5
2019	Total	5,998	3.7	3.9
	female	1,331	1.7	1.7
	Male	4,667	5.7	6.0

Adapted from WHO (2014, 2017, 2021)

Surprisingly, the data revealed that Bangladesh is relatively prosperous in suicide reduction without any visible efforts and research from the government. In 2012, the suicide rate for both sexes was 7.8/100,000, while it was 6.1/100,000 in 2016, and 3.9/100,000 in 2019. Another surprising finding is that the rate was more in females until 2016, but the recently published 2019 data showed that males died more than females, as shown in Table 1. WHO (2014) reported that the age-standardized suicide rate for both sexes was 7.8/100,000: for males it was 7.3/100,000 and for females 8.2/100,000. A community-based survey conducted by Feroz and his colleagues identified the rate of suicide attempts was 281.8 per 100,000 and the rate of suicide was 128.8 per 100,000 which seems to be significantly higher in comparison to the WHO reports (Feroz et al., 2012). Another community-based study with 20 years duration conducted in South-East part of the country from 1983 to 2002 identified a suicide rate of 39.6 per 100,000 population (ICDDR,B, 2003). Mashreky and his colleagues interviewed 819, 429 community populations from 12 different districts of Bangladesh in 2003 and found the rate of suicide was 7.3 per 100,000 population (Mashreky et al., 2013). Another rate was revealed from police data from 1996 to 2014 that revealed the rate of unnatural death was 10.4 per 100,000 population; among them, hanging and pesticide poisoning covered 6.5 per 100,000 population (Chowdhury et al., 2018). The unnatural deaths include hanging, pesticide/medication poisoning, road traffic, railway, and waterway accidents, fall from height, construction injury, snake bite, drowning, electrocution, thunderbolt injury, and burn-related deaths (Chowdhury et al., 2018). Another report published in 1998 found that the suicide rate among young populations was 30 per 100,000 populations living in the rural part of Bangladesh (Ruzicka, 1998 cited in Begum, Rahman et al., 2017). A recent study in *Jhenaidah* district of Bangladesh assessed 3,152 suicide data of an NGO (*Societies for Voluntary Activities (SOVA*) during 2010–2018 (Khan et al., 2020). The study found

the suicide rate was 20.6/100,000 in *Jhenaidah* (Khan et al., 2020). Available evidence suggests that suicide happens more in the peripheral districts and rural parts mentioning *Chuadanga*, *Jenaidah*, *Kustia*, *Meherpur*, *Jashore*, and *Chandpur* (Arafat, 2019a). However, caution is warranted to consider the areas with high rates as we do not have any countrywide data and the rate varies widely.

2.2 Gender Distribution

In Bangladesh, it has been shown that females are dying more by suicide in the available literature which is opposite to the Western country distribution (Arafat, 2019a, b; Tandon and Nathani, 2018; Bachmann, 2018; Jordans et al., 2014; Shahnaz et al., 2017). Several empirical studies revealed this female predominance in Bangladesh (see Ahmad and Hossain, 2010; Reza et al., 2014; Feroz et al., 2012; Talukder et al., 2014; Ali et al., 2014; Shah et al., 2017, 2018; Arafat et al., 2018; Qusar et al., 2010; Khan et al., 2020; Mashreky et al., 2013). We speculate that patriarchal societal norms, perceived passive gender roles, early marriage, low empowerment, comparatively lower educational attainment, forceful marriage, and lack of economic freedom could be the potential reasons for this high rate of suicide in females (Reza et al., 2014; Feroz et al., 2012; Arafat, 2017, 2019b). However, further studies are warranted to identify the precise explanations for this female dominance in suicide in Bangladesh.

2.3 Age Distribution

Arafat (2017) cited in his review that the younger generation of Bangladesh is dying more by suicide than other age groups. Suicides are noted from 8 to 78 years old (Arafat, 2017). We identified only one study revealing the highest rate of suicide among the older age group (Mashreky et al., 2013). Several other studies identified that the third decade (20–29 years) of life is the most risky period for suicide in Bangladesh (see Arafat, 2017, 2019a; Feroz et al., 2012; Ali et al., 2014; Choudhury et al., 2013; Hossain et al., 2012; Sarkar et al., 2013; Talukder et al., 2014; Begum, Khan et al., 2017; Ahmad and Hossain, 2010). Loss of life during this decade creates an immense social burden. This is the time of life when people start to contribute to society and family. Many of the deceased have little kids and spouses. Therefore, it causes a huge burden on society. The recent trend of increased suicides among adolescent students in Bangladesh is a major matter of concern. It is important to note that all the studies assessed a group of populations in a specific period of time. To get a clearer picture, there is a need for nationwide long-term follow-up studies.

2.4 Risk Factors for Suicide

Assessment of risk factors for suicide is a neglected area of Bangladesh. The first case–control study was published in 2013 by Reza and his colleagues. It found several risk factors mentioning as love affair problems, discord with relatives, economic hardship, academic failure, long-term disability, chronic diseases, past suicidal attempts, familial conflict, sleep disturbance, and substance abuse (Reza et al., 2014). The study included samples of both fatal and non-fatal attempts. Nevertheless, it did not clearly indicate the number of suicides and the number of self-harm cases. The only case–control psychological autopsy study revealed existing mental illness, past suicidal attempts, immediate life events, physical disability, physical abuse, social isolation, unemployment, substance abuse, and encounter with sexual abuse as notable risk factors for suicides (Arafat, Mohit et al., 2021b). It also revealed that individuals with psychiatric disorders are 15 times more likely to, and individuals who experienced sexual abuse are 12 times more likely to die by suicide. A separate analysis revealed different characteristics of suicide with and without mental illness. It noted that psychiatric disorders were more common in suicides among males, adults, and deceased living alone (Arafat, Mohit et al., 2021a). In 2021, Arafat and colleagues, in their psychological autopsy study reported that social risk factors such as life events, physical and sexual abuse, employment, and social isolation are playing a more influential role than clinical risk factors like psychiatric disorders (Arafat, Khan et al., 2021). Arafat and Khan (2021) shared that there is a close relationship between psychosexual issues with suicides in Bangladesh due to sociocultural effects. About 47% of the suicides are taking place concerning sexual and marital matters such as extramarital relationships (12%), premarital love relationships (12%), sexual abuse (6%), and forceful marriage (2%) (Arafat and Khan, 2021). Li et al. (2021) analyzed that younger women within one year of pregnancy are more vulnerable to committing suicide. Age, education, employment, living with parents, and ownership are also reported as risk factors by Begum et al. (2017), and they found that adolescents who live with other people than their parents and are unemployed have a higher risk of committing suicide (Begum, Rahman et al., 2017). Shah et al. (2017) found that conflict within the family (34.32%) and sexual harassment and problems in the relationship (10.34%) were the prominent risk factors for suicide. Also, Arafat (2017) highlighted in his review that a quarrel between husband and wife is a common risk factor for suicide in Bangladesh. Another research by Arafat et al. (2018) found affair-related issue (14.25%) is a major contributor to committing suicide. Research by Khan et al. (2020) concluded that married women between the ages of 15 and 29 who have experienced physical and sexual abuse and who live in rural regions are the group most at risk for engaging in suicidal behavior. Sharmin Salam et al. (2017) identified that married adolescents are 22 times more likely to attempt suicide than never-married people in Bangladesh.

Suicide is extremely multifactorial. A higher prevalence of psychiatric disorders is noted in Western countries while in Bangladesh, along with mental illness, life events closely related to family members (family discord, disapproval of affair marriage) and psycho-sexual events (extra-marital affair, sexual harassment) play a significant role in suicides (see Feroz et al., 2012; Reza et al., 2014; Arafat, 2017, 2019a; Ali et al., 2014; Hossain et al., 2012; Talukder et al., 2014; Ahmed and Hossain, 2010; Arafat and Khan 2021; Shahnaz et al., 2017; Shah et al., 2017; Arafat et al., 2018). According to the empirical studies from the aforementioned review, married women and adolescents between the ages of 12 and 29 who live in rural areas and who are subjected to physical and sexual abuse by their husbands and their families are significantly more likely to die by suicide, attempt suicide, or have suicidal thoughts.

Mashreky and his colleagues found more suicides in rural areas in comparison to urban parts of Bangladesh. Repeated countrywide studies are warranted to get the picture more precisely. The reasons for higher suicide rates in rural areas of Bangladesh are taking place due to lack of literacy and failure to overcome poverty (Mashreky et al., 2013). Several studies noted that suicide is happening more in married persons in comparison to never-married persons (Feroz et al., 2012; Ali et al., 2014; Ahmad and Hossain, 2010). Marriage is found as a protective factor against suicide in Western countries which is the opposite in Bangladesh. We speculate several possibilities like early marriage, economic dependency on parents, and less freedom in choosing partners (Arafat, 2017).

2.5 Methods of Suicide

The common methods of suicide in Bangladesh include hanging, pesticide poisoning, road traffic, and railway accidents, falling from a height, drowning, electrocution, firearms, cut injury, and burn (Arafat, 2019a, 2017; Chowdhury et al., 2018). Hanging and poisoning are the two prominent methods of suicide in Bangladesh. A recent systematic review identified that hanging was the most commonly used method in Bangladesh during 2011–2020 (Arafat, Ali et al., 2021). Earlier studies conducted in rural samples found poisoning as the most common method, while recent studies found hanging as the most common method (Chowdhury et al., 2018; Arafat, 2019a; Mashreky et al., 2013; Shahnaz et al., 2017; Arafat, Ali et al., 2021; Halim et al., 2010). Ban of class I pesticides (the year 2000) could be an important factor in Bangladesh (Chowdhury et al., 2018). Police data for the period 1996–2014 revealed that pesticide poisoning was the commonest method (37.1%) of suicide, followed by hanging (30.5%) (Chowdhury et al., 2018). Other studies found hanging as the commonest method of suicide (see Sharmin Salam et al., 2017; Shah et al., 2017; Arafat et al., 2018; Feroz et al., 2012; Arafat, Mohit et al., 2021b; Ali et al., 2014; Hossain et al., 2012).

2.6 *Rare Suicide Events in Bangladesh*

2.6.1 *Protest Suicide*

Sometimes, suicide is a tactic of persuasion (Biggs, 2013). Suicide protest is noted when someone selects suicide as a form of tactic to obtain their argument against potent challenges (Tilly, 2013). In the first week of July 2022, a 50-year-old businessman from Kushtia, Bangladesh, attempted suicide in front of National Press Club (NPC) in Dhaka by setting himself on fire (Correspondence, 2022). He got burns on 90% of his body and died the next day in a specialized burn hospital. He attempted but couldn't get hold of his 1.2 Crore taka ($1.3 million) that he lent to the owner of a company (Correspondence, 2022). He arranged a human chain in front of the NPC a few days earlier as a method of protest, but it did not assist him much to bring back his money from the borrower.

In the last week of October 2022, a 35-year-old, mother of three children, from Narayanganj attempted suicide along with her three children (3,10, and 16 years old) by setting herself and the children on fire in front of NPC, Dhaka (Representatives, 2022). The family attempted suicide because a local politically influential person was trying to evict them from their home. The lady tried to seek help from all sorts of society but failed to resolve the issue (Representative, 2022). They took sedative pills before pouring Kerosene on their bodies to set fire.

Bangladesh is facing an adverse political situation and financial problems due to price hikes and loss of jobs which is complicated by the COVID-19 pandemic and the Russia-Ukraine war. Two incidents have occurred recently where the victims were the prey of social injustice and as a method of protest, they attempted self-destruction. The cases indicate some factors of suicide prevention in Bangladesh. It indicates the role of social justice in suicide prevention. Both of the attempts happened in a nationally focused place, i.e. national press club, and both of the cases set fire for dying.

2.6.2 *Group Suicide*

In 2007, nine family members in Mymensingh died by suicide which was attributed to shared delusion (Selim, 2010). The father of that family was the primary motivating person for that event.

3 Quality Suicide Data Concern in Bangladesh

Previously, we discussed the variations in the suicide rate in Bangladesh based on WHO reports, NGO data, and empirical studies. The issue has been complicated by the lack of national suicide surveillance and nationwide epidemiological study of suicide and suicidal behavior in the country (Arafat, Hussain et al., 2021; Arafat, 2017, 2019a). Furthermore, the quality of suicide data has always been challenged in Bangladesh due to possible under-reporting and misclassification resulting from low mental health and

suicide literacy, criminalized legal status, and high stigma (Arafat, Hussain, et al., 2022; Khan, 2005). One previous study identified that Islamic countries record more "other violent deaths" than the UK indicating the misclassification (Pritchard and Amanullah, 2007). Another recent study compared the suicide data of Muslim countries with that of Western ones and identified the possibility of under-reporting of suicide (Pritchard et al., 2020). According to the WHO (2014) report, among the 183 countries, only 87 had good-quality suicide data, while suicides from the other 96 countries are being calculated by a modeling approach that covered 61% of total deaths by suicide. Good-quality suicide data is more pertinent in high-income countries than the countries with low income (WHO, 2014). The report revealed that 50 high-income countries with good-quality suicide data covered 98% of suicides in high-income group countries, whereas the rest of the 37 low- and middle-income countries (LMICs) covered only 22% of suicides that happened in LMICs in 2012 (WHO, 2014). Ritchie et al. (2015) mentioned that data on suicides is flawed due to the frequency and reliability of vital registrations of data in many countries. Generally, the estimated suicide rates from the WHO member states are based on modeling assumptions. Also, the official figures submitted to WHO by its member states are supposed to be inaccurate as they do not have a rigorous suicide registration system. Furthermore, suicidal behavior is contemplated as an illegal act in some member states, resulting in under-reporting and misclassification of suicide-related data.

Bangladesh is a country with a LMIC background where more than 90% of the population are Muslims. Suicide is prohibited in Islam, and it is a criminal offense in the country. Mental health literacy is supposed to be poor, and studies identified a low suicide literacy and high stigma toward suicide (Arafat, Hussain et al., 2022; Arafat, Mohit et al., 2021b; Sharmin Salam et al., 2017; Shahnaz et al., 2017). All these reasons contribute to the possible under-reporting and misclassification of suicides and suicidal behavior. We mention some possible areas of post-mortem examination and possible caveats of under-reporting during the forensic examination in Chap. 2 (Bose et al., 2023). We also discuss the help-seeking of and health services for suicidal behavior in Chap. 3 (Arafat, 2023). Additionally, due to low mental health and suicide literacy, family members usually make homicidal claims when death happens in the in-laws' environment without considering mental illness, personality traits, and life events. They usually consider suicide a monocausal outcome. It is important to note that, currently, we do not know the exact proportion of under-reporting and misclassification of suicides in Bangladesh.

The lack of nationally reliable sources of suicide data impedes research and policy making in Bangladesh (Arafat, 2017). Available evidence suggests that the majority of the suicide data are collected from police, records available in forensic medicine departments (which only includes data of deceased whose medico-legal autopsy is performed), some court reports, and a few epidemiological studies conducted in specific areas and/or in specific populations such

as adolescents or pregnant women (Arafat, 2017; Feroz et al., 2012). Recently, data collected from newspaper reports have been used in some publications (Shah et al., 2017; Arafat et al., 2018).

4 Current Challenges and Way Forward

4.1 Current Challenges

There is inadequate empirical large-scale nationwide research on suicide and its risk factors in Bangladesh even though an increased number of articles are coming out in recent years (Arafat, Hussain et al., 2021). Another fundamental issue that should be mentioned here is that the recent suicide-related publications are performed by collecting data from print and online media report analysis (Arafat, Hussain et al., 2021). Media reports could be a source of data, however, it is necessary to consider the epidemiological aspects of any entity. There are several reasons behind that such as not all suicides publish in the media and the data collection method for preparing a media report is not scientific. Certainly, all suicides are being reported in newspapers, especially suicides in rural areas. Crime reporters are not efficient and interested to bring out mental health-related factors. Suicide is a complex multifactorial outcome. Previous studies identified that the quality of suicide reporting in both online and print newspapers is poor compared to the WHO media guidelines (Arafat et al., 2019, Arafat, Khan et al., 2020). One study conducted in India comparing media reporting with epidemiological data identified that there are significant discrepancies between suicide metrics in the community population and the reports collected from the media (Armstrong et al., 2019). Additionally, no nationwide, longitudinal, and interventional research activities were undertaken in the last decade and lack of research funds available for the researchers to conduct empirical research on suicide (Arafat, Hussain et al., 2021).

Poor mental health and suicide literacy, high stigma, and criminalized status of suicidal behavior fundamentally affect suicide research, help-seeking, and suicide prevention in Bangladesh (Arafat, Hussain, et al., 2022). The relationship between mental illness and suicidal behaviors is documented in the country likewise the other parts of the world (Arafat, Mohit et al., 2021b; Zalsman et al., 2016). The psychological autopsy study identified that 87% of the suicides were not in contact with any mental healthcare setting which may be attributed to the before-mentioned aspects (Arafat, Mohit et al., 2021b). The same study also identified that psychiatric illnesses were more common among suicides living in upper and middle socioeconomic conditions than the deceased living in lower social class (Arafat, Mohit et al., 2021a). This also can be attributed to the fact that upper- and middle-class people may have better mental health and suicide literacy so that they can identify the illness.

Lack of quality suicide data is one of the prime challenges in Bangladesh because it affects all aspects of suicide prevention. Collecting data on a sensitive subject like suicide due to confidentiality issues in a conservative Islamic country, where it is criminalized, is challenging. Given that a substantial number of risk factors are connected to recent, very emotional occurrences, next-of kins are reluctant to talk about those (Arafat, 2021). The lack of quality data and adequate empirical studies could be attributed to some extent to this social barrier in Bangladesh.

4.2 Way Forward

There is no alternative to a national suicide surveillance system which should be an immediate priority in Bangladesh. Enduring a monitoring system would ensure the quality of suicide data at the community level. Standard quality suicide data would help suicide prevention in all aspects.

There is a paucity of suicide-related research in Bangladesh, and inadequate activities around suicide prevention are the major obstacles to implementing suicide prevention programs in Bangladesh. More empirical research activities and multilateral collaborative research in Bangladesh should be undertaken, and the emphasis should be on identifying the risk and protective factors for suicidal behavior in Bangladesh. Suicide decriminalization should be given immediate priority; this has already been accomplished in several industrialized nations, including those neighboring countries in Asia, such as India. Soron (2019) recommended decriminalizing suicide in Bangladesh; authorities need to ensure that they should not punish people for attempting suicide. Society and the state should provide adequate support systems to people experiencing mental distress.

Evidence-based initiatives that aim to raise awareness of the importance of living in the moment can be successful. With the help of financial bursaries that would cover the tuition and other expenditures of secondary schooling (academic, technical, or religious), the focus would be on a secondary school where both genders will be encouraged to enroll. Not just at the schools taking part in the planned experimental project but also in secondary schools this may be addressed through educational initiatives. Despite the dire need, very few initiatives to prevent suicide have been launched throughout the nation. The policy makers should obtain different strategies which can provide expeditious support to accomplish the sustainable development goal of suicide reduction.

Additional multidisciplinary research is required to pinpoint the risk factors and their connections to the biopsychosocial aspects of suicide that already prevail, as well as to develop the ideal, culturally specific preventive plan that makes the most use of the resources to deal with. Following WHO recommendations, a national suicide prevention program (Khan et al., 2021) should be implemented to get the attention of local, regional, and international stakeholders. Suicide is also often associated with an act of hopelessness, rage, and fleeing away from unbearable pain due to disturbances within the family

system, personal loss, and lack of social support, and the importance of family roles cannot be avoided for suicide prevention (Arafat, Saleem et al., 2022; Edwards et al., 2021; Prabhu et al., 2010).

5 Conclusion

This chapter draws attention to the epidemiological metrics of suicide and the quality and sources of data in Bangladesh. For a national suicide prevention strategy, the country needs further epidemiological studies on suicide to identify a national rate of suicide. Prevention strategies could prioritize young adults, females, students, and housewives. Increasing mental health and suicide literacy would help in all aspects including conducting epidemiological studies. Reducing stigma and decriminalization of suicide will encourage the sufferer to seek medical and/or psychiatric care. The psychiatric services spectrum should be expanded for suicidal behavior across the country. Along with other prevention strategies, gate-keeper training and involving the family members could be tested in Bangladesh as a significant proportion of suicides are closely associated with family-related events. Immediate steps should be ensured to establish a source of quality suicide data because, without quality data, there is a poor chance to have a successful suicide prevention strategy in the country.

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CHAPTER 2

Forensic and Legal Aspects of Suicide in Bangladesh

Palash Kumar Bose, Sayedul Ashraf Kushal, and S. M. Yasir Arafat

Abstract Suicide is a complex phenomenon; therefore, holistic care is needed to prevent it. Along with other areas, forensic medicine serves a vital role in ascertaining the manner of death, particularly in a country like Bangladesh where suicide attempt is a criminal offense. The police are a potential source of suicide data as the country lacks national suicide surveillance and database. In any unnatural death including suicide, the police are the first point of contact and have the authority to order a medicolegal autopsy. The legal frameworks decide the manner of death, i.e., suicidal, homicidal, or accidental with or without regard to the comments of forensic experts. Due to the criminal status, there are concerns about punishment like imprisonment after a suicide attempt that can care-seeking despite the suicidal person needing immediate support. Decriminalization would help distressed people to avail care, reduce personal suffering, and prevent further attempts and death by suicide. This chapter discusses how forensic medicine is involved in suicide declaration in

P. K. Bose
Department of Forensic Medicine and Toxicology,
Enam Medical College, Dhaka, Bangladesh

S. A. Kushal
LifeSpring Consultancy Limited, Dhaka, Bangladesh

S. M. Y. Arafat (✉)
Department of Psychiatry, Enam Medical College and Hospital, Dhaka, Bangladesh
e-mail: arafatdmc62@gmail.com

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Bangladesh. It also highlights the current legal aspects of suicide attempts in the country.

Keywords Suicide in Bangladesh · Criminal offense · Forensic psychiatry · Legal status · Decriminalization

1 Introduction

Suicide is a global public health crisis influenced by religion, culture, social class of an individual, and income of the country. According to the World Health Organization (WHO), more than 700,000 deaths happened due to suicide in 2019 in the world with an age-standardized rate of 9.0 per 100,000 population (WHO, 2021). Additionally, about 10–20 suicide attempts happen for each suicide (WHO, 2014). It is the 4th leading reason of death among individuals aged 15–29 years (WHO, 2021). More than three-fourths (77%) of global suicides happen in low- and middle-income countries (LMICs) (WHO, 2021). In case of Bangladesh, the suicide rate widely varies among published articles such as WHO reports, NGO data, and police reports as the country is yet to establish a standard suicide reporting and surveillance system (Arafat, 2019). The WHO report published in 2021 estimated the age-standardized rate of suicide in Bangladesh as 3.9 per 100 000 population (WHO, 2021). In the majority of the cases, people rely on data available from the police that seems to be an underestimation of actual rates. At the same time, we do not know the exact proportion of underestimation. The detailed epidemiology of suicide in Bangladesh is discussed in the first chapter of this book (Kabir et al., 2023).

Bangladesh is a Muslim-majority country located in *South Asia* with about 170 million populations; among them, more than 90% are Muslims (World Population Review, 2022). Suicide is prohibited in Islam and it is a criminal offense in the legal system of the country. As per the current legal structure of the country, any unnatural death should be reported to the nearby police station. Subsequently, a postmortem or medicolegal autopsy is conducted to ascertain the manner of death, i.e., suicide or other unnatural deaths like accident or homicide. At this point, a significant portion of unnatural deaths is kept away from the medicolegal autopsy to avoid the legal procedure, disfiguration of the deceased body, and the potential harassment of police due to the criminal legal identity (Rahman et al., 2010).

2 Process of Suicide Declaration in Bangladesh

According to the code of criminal procedure in Bangladesh, the declaration of suicide, whether it occurs at home or at a hospital, rests with the police. As per the legal directives, the medicolegal autopsy procedure should be preceded

by an inquest (preliminary investigation conducted by a police officer into the cause of death) report prepared by the police officer working as at least at the rank of sub-inspector of the concerned police station. In Bangladesh, post-mortem is performed under the provision of three laws: (i) *The Penal Code* (1860), (ii) *The Code of Criminal Procedure* (1898), and (iii) *The Evidence Act* (1872) (Islam and Islam, 2003). The code of criminal procedures, 1898 (act no. V of 1898, 174(1) part V chapter XIV) describes the acts of the response of police regarding suicide, accidental death, or homicide. 174(1) (a) describes the response of police in case of death by suicide; 174(1) (b); and (c) describe the duties of police in case of homicidal, accidental, and suspicious deaths (Code of Criminal Procedure, 1898). This act has empowered the police officer in the presence of two or more witnesses (usually neighbors), shall make an investigation, and prepare a report regarding the apparent cause of death, unless otherwise directed by any rule where magistrate investigation is necessary. On the other hand, Section 176(1) describes inquiry should be performed by a magistrate into the cause of death in case of death in the custody of the police and in any other case mentioned in 174(1) (a) (b) and (c) (Code of Criminal Procedure, 1898). The magistrate inquiry is performed in exchange for or accompanied by the police investigation. That means, the process of suicide declaration follows the laws enacted proceedings. The police are the authority that should carry out the declaration of suicide primarily by visiting the scene of the crime and preparing an inquest report that is to be confirmed by autopsy. In case of death by suicide in a hospital, a police case should be filed and the death certificate and the dead body should be handed over to the police. The police then make an investigation that is called an inquest (*Surathal* in Bangla) report and mention the apparent cause of death. Subsequently, the deceased body is sent for medicolegal autopsy to the nearby establishments where forensic morgues are available (Islam and Islam, 2003). But if a person dies in the custody of the police, whether it is a natural or unnatural death, the inquest report is prepared by the magistrate and then the body is sent for autopsy. A copy of the inquest (*surathal*) report and challan (Government gazetted, tabulated form no. 5371) should be sent along with the dead body. On completing the medicolegal autopsy, the physician prepares an autopsy report (form no. 5372) with a carbon copy. The hand-written copy of the postmortem is sent to the police to be produced in the concerned court. The carbon copy is kept in the forensic medicine department or the records of the district hospital. After completion of the postmortem, the dead body is handed over to the family members to perform the rituals before burial. Based on the inquest report, postmortem report, and information obtained from the police investigation, the *manner* of death whether it is natural or unnatural (suicidal, homicidal, or accidental) is decided finally by the legal bodies instead of the doctors (Islam and Islam, 2003). Sometimes the family members try to take the dead body without performing an autopsy by submitting an application to the legal authority mentioning that they don't have any complaints against anyone and will not file any case. In some other cases such as definite

road traffic accident, police may hand over the body to the family members. It is important to note that ideally, all unnatural deaths should undergo a medicolegal autopsy as per the law of the country.

Manner of death means the circumstances which make the person die. It can be better understood if the circumstantial evidence, crime scene investigation, and information from the first-hand witness, family, and friends are available and cooperative. Such information helps the autopsy surgeon a lot during the time of autopsy to collect evidence from the body for related investigations, viscera for chemical analysis, and finally prepare an opinion regarding cause, mode, and manner of death. In case of hospital death, the treatment papers help forensic pathologists to gather information related to the death. Inference from circumstantial and supportive evidence and information and autopsy findings, the opinion regarding the manner of death can be given. However, it is important to note that medicolegal autopsy along with all the necessary investigations like microscopic examination, laboratory investigation, chemical analysis of viscera, and other related investigations (if done) may fail to provide inference regarding the cause and manner of death. This is called negative autopsy which is about 2–5% of all deaths brought to the morgue. Postmortem reports don't mention the manner of death in the case of poisoning, falling from a height, jumping in front of moving objects, railway accident, electrocution, burning, and drowning. In the above cases, the manner of death is confirmed by the police investigation.

3 Current Status of Postmortem Facilities in Bangladesh

The word "postmortem" is derived from the word "post", which means "after", and "mortem" means "death". It is also called "autopsy", which is derived from the *Greek* words *autopsia*. "Autos" means "self" and "opis" means "view". So autopsy means "the act of seeing for oneself". The other name for an autopsy is a necropsy. An autopsy is a scientific dissection of a dead body in order to ascertain the cause of death. The procedure should be in a systematic and scientific manner with standard facilities for the related investigations. Inadequate facilities and poorly or untrained manpower are supposed to fail in revealing the fact.

There are eight divisions and 64 districts in Bangladesh. In the 64 districts, there are 37 public medical colleges. Among these medical colleges, 18 medical colleges are conducting autopsy under the department of *Forensic Medicine and Toxicology* as they have morgues to keep dead bodies (Table 1). Other newly established medical colleges are yet to be prepared for medicolegal autopsy though forensic medicine departments have been established without morgue facilities. Third-year students of these medical colleges have to visit the district hospital morgue for the purpose of hands-on training on medicolegal autopsy. Autopsies are conducted in public medical colleges having morgue facility by the department of *Forensic Medicine and Toxicology*.

In other settings where there are no public medical colleges or morgue facilities, autopsies are performed by the doctors who are working under the responsibility of the district hospital superintendent (previously under a civil surgeon). Especially Residential Medical Officer (RMO) in the district hospitals perform an autopsy. Unfortunately, it has been seen that the physicians working in the district hospitals who are involved in postmortem lack the necessary expertise to conduct the medicolegal autopsy (Rahman et al., 2010). Usually, they are working in other disciplines of medical science and are called on to conduct postmortem. Therefore, the whole procedure is more dependent on the morgue attendants rather than the field experts. Moreover, there are no independent forensic, pathology, and toxicology labs supporting the process of medicolegal autopsies in medical colleges and district-level hospitals in Bangladesh. There was a chemical examiner's office established in Dhaka, the capital city. Therefore, all the viscera/samples were to be sent to Dhaka (Rahman et al., 2010). Recently, two other chemical examiner labs in two other cities have been established. Autopsies are conducted during daylight hours in Bangladesh. Usually, no autopsy is carried out on that day when a dead body comes after 5 pm, and only in certain cases, if a state higher authority gives any special direction, the autopsy is done even at night. For example, an incident occurred in 2009, notoriously known as the "Bangladesh Rifles (BDR) mutiny" in which 57 army officers including the BDR director-general were brutally killed at BDR headquarter (Now known as BGB; Border Guard Bangladesh) by a group of rebellion BDR soldiers. In that case, postmortem examinations were carried out at night. But, normally when a body comes after 5 pm (scarcity of daylight), the dead body is received by the morgue attendant, papers are prepared, and the body is kept in the refrigerator/freezer for next day autopsy. Usually, the freezing facilities are available in the morgues of medical college hospitals only. In most of the district hospital morgues, this facility is currently not available, and in these facilities, postmortem examination is carried out the next day as early as possible and the body is handed over to the police for the purpose of burial.

As far as chemical labs are concerned, there are currently three labs working in Bangladesh: Dhaka (the capital city), Chattogram, and Rajshahi. Previously, there was only one chemical lab in Dhaka (Rahman et al., 2010). The second chemical analysis lab is established at Chattogram, a port and divisional city in Bangladesh. In January 2020, a third forensic laboratory including a chemical lab has been established at Rajshahi, a divisional city of Bangladesh by the *Criminal Investigation Department (CID)*. Due to this expansion of chemical labs, chemical examiner's reports are available earlier compared to the past. Along with the chemical labs, for the detection of criminals, fixation of paternity and maternity, and establishment of identity related with DNA test, two DNA labs are functioning at Dhaka also. One is the National Forensic DNA Profiling Laboratory (NFDPL), the first forensic DNA profiling lab established in 2006, which is located at the Nuclear Medicine building of *Dhaka Medical*

Table 1 List of public medical colleges in Bangladesh having medicolegal activities

SL	*Name of public medical college*	*District*	*Division*	*Medico-legal activities*[a]
1	Patuakhali Medical College	Patuakhali	Barisal	Not yet
2	Sher-e-Bangla Medical College	Barisal		Yes
3	Abdul MalekUkil Medical College	Noakhali	Chattogram	Not yet
4	Chandpur Medical College	Chandpur		Not yet
5	Chattogram Medical College (Chittagong Medical College)	Chattogram		Yes
6	Cox's Bazar Medical College	Cox's Bazar		Not yet
7	Cumilla Medical College (Comilla Medical College)	Cumilla		Yes
8	Rangamati Medical College	Rangamati		Not yet
9	Bangabandhu Sheikh Mujib Medical College (Faridpur Medical College)	Faridpur	Dhaka	Yes
10	Colonel Malek Medical College	Manikganj		Not yet
11	Dhaka Medical College	Dhaka		Yes
12	Mugda Medical College	Dhaka		Not yet
13	Shaheed Suhrawardy Medical College	Dhaka		Yes
14	Shaheed Tajuddin Ahmad Medical College	Gazipur		Yes
15	Shahid Syed Nazrul Islam Medical College	Kishoreganj		Not yet
16	Sheikh Hasina Medical College	Tangail		Not yet
17	Sheikh SayeraKhatun Medical College	Gopalganj		Not yet
18	Sir Salimullah Medical College	Dhaka		Yes
19	Jashore Medical College	Jashore	Khulna	Yes
20	Khulna Medical College	Khulna		Yes
21	Kushtia Medical College	Kushtia		Not yet
22	Magura Medical College	Magura		Not yet
23	Satkhira Medical College	Satkhira		Not yet
24	Mymensingh Medical College	Mymensing	Mymensing	Yes
25	Netrokona Medical College	Netrokona		Not yet

(continued)

Table 1 (continued)

SL	*Name of public medical college*	*District*	*Division*	*Medico-legal activities*[a]
26	Sheikh Hasina Medical College	Jamalpur		Yes
27	Naogaon Medical College	Naogaon	Rajshahi	Not yet
28	Pabna Medical College	Pabna		Yes
29	Rajshahi Medical College	Rajshahi		Yes
30	Shaheed M. Monsur Ali Medical College	Shirajganj		Not yet
31	Shaheed Ziaur Rahman Medical College	Bogura (Bogra)		Yes
32	M Abdur Rahim Medical College	Dinajpur	Rangpur	Yes
33	Nilphamari Medical College	Nilphmari		Not yet
34	Rangpur Medical College	Rangpur		Yes
35	Bangabandhu Medical College	Sunamganj	Sylhet	Not yet
36	Sheikh Hasina Medical College	Habiganj		Not yet
37	Sylhet MAG Osmani Medical College	Sylhet		Yes

[a]Till August 24, 2022

College. The second DNA testing lab is working under the Bangladesh Police-namely Forensic DNA laboratory of Bangladesh Police, under CID at Dhaka. It started its journey as a project in 2011 and finally maintaining all the validating processes, it started a case sample examination in 2014. To broaden the services all over Bangladesh, now the government had set up a separate DNA Laboratory Management Department by gazette notification on 9 August 2020. After the gazette notification, divisional DNA screening laboratories are nowadays established and are working in *Rajshahi*, *Sylhet*, *Barishal*, *Khulna*, *Rangpur,* and *Faridpur*. These six centers collect and preserve DNA samples and send them to NFDPL.

In case of autopsy and medicolegal works, where any test related to confirming the cause of death or any medicolegal works, the forensic experts have to take help from the chemical examiner's office, DNA Lab along with other departments such as radiology and imaging, microbiology, pathology, etc., which work independently. Noteworthy, due to the affiliation of various departments with poor collaboration and coordination, final reports by the forensic experts submitted to legal authority are time-consuming and delayed.

It is an unfortunate reality that there is a scarcity of forensic experts in Bangladesh due to its job nature, work environment, and benefits package. According to the Director General of Health Education Department Statistics (2 August 2022), only 22 forensic experts are now working all over

Bangladesh with a vacancy of 65 posts. There are 103 posts of lecturers. Among them, 58 are filled and 45 are vacant. Despite this shortage of manpower, very few doctors show interest to build up a career in this field due to various reasons. Sometimes they have to perform these medicolegal works under undue pressure exerted from different corners for a favor. This creates a psychological burden as well as a feeling of lack of safety for a new doctor who has just started working in this field. Nonetheless, they have to perform all sorts of medicolegal works including autopsy without additional payment. On the other hand, they have to produce evidence as an expert witness in a court of law and have to travel frequently to different districts of Bangladesh. This goes on after retirement from government service till death which may contribute as a demotivating factor. Surprisingly, after retirement from government services, they have to continue it without any remuneration even if the travel expenses are delayed. In an unfortunate condition, it may even be unpaid. During the time of cross-examination by the lawyers, forensic experts face unwanted questions with no link to the case. These sort of questions are felt humiliating by the young doctors, especially the female doctors. As a result, young doctors feel better to avoid these unexpected situations. Bearing these pressures, forensic pathologists, who are working in public medical college have to maintain academic activities like teaching and also conducting exams. Additionally, doctors are more oriented toward private clinical practice which is a source of extra income that is also an important reason for showing low interest in forensic medicine career. Moreover, there is no post of forensic pathologist at the district level. So there are unmet needs for creating positions in the district hospitals as well as to fill up the present vacancies in the *Forensic Medicine* department of public medical colleges based on the workload and responsibilities. Moreover, there are chances of creating new positions for forensic experts in medical colleges according to the rules and regulations formulated by the *Bangladesh Medical and Dental Council (BMDC)*.

It is a bitter truth we can admit simply in a way that when there is a scarcity of forensic experts, the mortuary facilities will also be far behind the standard level in the morgues of medical colleges as well as in the district hospitals in Bangladesh except a few (Islam and Islam, 2003). The poor and neglected conditions of dead bodies have been identified and criticized in previous reports (Bose, Arafat et al., 2021). We reported a complicated case of necrophilia performed by a morgue assistant at *Shaheed Suhrawardy Medical College* morgue, perhaps due to poor privacy of dead bodies, and wide access to the dead bodies by morgue assistants (Bose, Arafat et al., 2021). If we consider the standard morgue facility, we can point out the mortuary facilities ensured and recommended by the national pathology accreditation advisory council, Commonwealth of Australia. It is important for the safety of autopsy surgeons and assistants working in the mortuary (Australian Government Department of Health, 2013). The council depicts autopsy as level 1, level 2, and level 3 facility and high-risk autopsy which should be maintained

for setting up a mortuary that comprises an autopsy theater, change room, and observation area. Level 1 facility indicates a mortuary where an autopsy suite is not available. This level includes postmortems that are conducted by external examinations with or without radiological support and percutaneous needle sampling. The level 2 facility contains an autopsy suite where infrastructure or manpower for high-risk autopsies are not available. The next level (Level 3) facility contains a mortuary with an autopsy suite along with infrastructure and expertise to conduct high-risk postmortems. The autopsies with the risk of hazards from infections, chemicals, biological or radiation matters are considered high-risk postmortems. Sirohiwal et al. mentioned the minimum facilities of mortuaries indicating the arrangements for receiving the deceased bodies, conducting postmortems, transferring the bodies after the medicolegal examination, postmortem observation gallery, and other basic needs for an office (Sirohiwal et al., 2011). The mortuaries should be well equipped to ensure the smooth smooth functioning of the team. It describes also the design of a mortuary for a secondary, tertiary level mortuary complex, and miscellaneous requirements (Sirohiwal et al., 2011). If we give an example of *Dhaka Medical College* morgue, the country's most familiar and reliable hospital, the autopsy is still done with ancient equipment like hammer, chisel, knife, etc. As a result, it is time-consuming to complete an autopsy and hand over the bodies to the police and finally to the relatives of the victims.

4 Current Legal Structure and Decriminalization

Suicide ends one's life by own choice. Likewise, in many other countries, attempted suicide or non-fatal suicide attempt is considered a punishable criminal offense in Bangladesh (United for Global Mental Health, 2021; Mishara and Weisstub, 2016). According to the review of Mishara and Weisstub (2016) among 192 countries and states, suicide is still illegal in twenty-five countries and it is punishable with jail sentences in additional twenty countries that implement Islamic or Sharia law. Individuals who attempt to take their own lives risk severe penalties for themselves and even their families. Punishments vary, with penalties ranging from 1 to 3 years of imprisonment and fines (United for Global Mental Health, 2021). In Bangladesh, already previously mentioned in chapter XVI, Section 309, penal code 1860 criminalizes attempted suicide. The law is as such, "whoever attempts to commit suicide and does any act toward the act of commission of such offense, shall be punished with simple imprisonment for a term which may extend to one year, or with fine, or with both" (The Penal Code, 1860). On the legal aspect, attempted suicide in our country is considered as a criminal offense and punishment is simple imprisonment extending up to one year with or without a fine. Nevertheless, there is no record of giving punishment for any non-fatal attempts. Basically, Bangladesh is bearing the legacy of criminal laws of the British Raj formulated more than160 years ago (Islam and Islam, 2003).

One should bear in mind that criminalization along with social stigma makes suicidal attempts underreported and even the deaths are driven away to show it as other causes. Therefore, the data on suicidal rates and non-fatal attempts available in Bangladesh do not depict the actual picture. Logically, the question comes, if you don't know the real picture of a problem, then how is it possible to formulate a solution to the event?

Nowadays keeping and addressing these problems in mind, academicians have started to raise their concerns and demand decriminalization of suicidal behavior which in turn will encourage the help-seeking by the victim for mental support without any legal harassment (Soron, 2019; Arafat and Khan, 2019; Arafat et al., 2019). As we know mental support, psychiatric evaluation, and counseling are the ultimate steps in order to prevent further attempts to die by suicide. Readily available and easily accessible mental health support to distressed and indicated persons has proven the preventive role in suicide prevention (Zalsman et al., 2016). However, no initiative has been identified to make policy-level changes to date.

Now we may have to face the question of whether decriminalization of suicide is equivalent to the legalization of suicide? Really it's a matter of unwanted debate. Bhatti et al. describes it in a fantastic manner by differentiating decriminalization and legalization (Bhatti et al., 2021). Something that is being decriminalized doesn't indicate it as a legal entity. Referring to the perspective of mental health professionals, the article upholds it in a way that decriminalization would not legalize suicidal behavior, instead, it will inhibit the legal steps for persons with suicidal behavior.

Another question may arise, whether decriminalization should create a positive impact on lowering suicide or not. This sort of question is just a model of argument rather than a solution. Because a person attempting suicide is already suffering mental pain and agony and punishment sanctioned on him/her would change nothing but prevent the said accused to seek help from others. Hence, it is a hard time to take the necessary steps to adjust or change the laws in a timely manner, to make it decriminalized which would create a space to seek consultation from others without the fear of jail.

In the South-East Asia region, suicide has been already decriminalized in Bhutan, Indonesia, the Maldives, Nepal, Sri Lanka, and Thailand (Arafat et al., 2020). Now we could get a look at the legal framework related to suicide that existed in the Indian subcontinent where Bangladesh, India, and Pakistan reside. In India, Section 309 Penal Code, 1860 criminalizes attempted suicide. This is as same as in Pakistan and Bangladesh described in Section 325 and 309, respectively. Ranjan et al. mentioned a judgment of 1985 by the Delhi High court as a landmark judgment (Ranjan et al., 2014). The court commented, "*the continuance of Section 309 I.P.C. (criminalizing suicide) is an anachronism unworthy of a human society like ours*." This *Indian Penal Code* was commenced during the British empire in 1860 and it persisted in India, albeit, suicide has been decriminalized in the United Kingdom in 1961 (Ranjan et al., 2014). Suicide is criminalized in Pakistan as per Section 325 in

the Pakistan Penal Code, 1860. It criminalizes attempted suicide with punishment (Mehtab et al., 2022; Pakistan Penal Code Act, 1860). After a long battle, India has stopped the effects of the law that criminalized attempted suicide in 2017 by formulating the Mental Healthcare Act. Yet, further steps are warranted to remove the Penal Code act in India. Like India, strong notions have been raised in Pakistan in favor of decriminalization that are yet to be accepted in the parliament of Pakistan (Mehtab et al., 2022; Behere et al., 2015).

5 Current Challenges and Way Forward

5.1 Criminal Status of Suicide

The law in our country acknowledges the suicidal attempt as criminal offense which is prevailing 50 years counting from 1971, the birth year of Bangladesh that started over 160 years ago in British regimen. It is clear that criminalizing suicidal attempt is not a way to mitigate the problems. Rather the law is deterring people to seek consultation and even to escape from the hospital without fulfilling the course of treatment just to avoid legal problems. So we will have to think again and again in order to stop suicide or suicidal attempts. Current criminal legal status hinders people to disclose suicidal behavior and help-seeking, which in turn increases the risk of further attempts and death by suicide. Therefore, attempting suicide should be decriminalized, which will help the victim for seeking necessary help for the management of further suicidal attempts without any fear of imprisonment and social stigma.

5.2 Modernization of Medicolegal Autopsy Facilities

There is a lack of modern mortuary and forensic experts in Bangladesh. Without modern facilities and experts, it is difficult to give an opinion on any unnatural deaths, especially in case of advanced decomposed, mutilated, and burnt bodies, where there is effacement of identities. Recently, we noticed that it took about a week to identify a body with cut-throat wound due to LSD intoxication (Bose, Ray et al., 2021). The traditional ways of performing an autopsy in case of unnatural deaths should be upgraded. Forensic expert should continuously be trained. For an instance, the traditional procedure of dissecting the dead body for confirmation of death in case of suicide can also be performed by psychological autopsy, that is, to ask the relatives, friends or roommates who were in close contact with the deceased about the habits, history of taking anti-depressant or anti-psychotic medications, suicidal thoughts, failure or frustration, etc., regarding any issue without dissecting the body. These will help us to follow the trend and pattern of suicide which in turn will facilitate the formulation of suicide prevention. But in any doubtful cases, we can dissect the body as well. Furthermore, related laboratory investigations such as toxicological, histopathological, and radiological facilities

should be set up under the forensic departments in order to avoid undue delay in giving an opinion. In district hospitals, forensic consultants must be appointed for performing an autopsy. Rahman and his colleagues recommended setting up of medical examiner's system through international support which could be tested in the country to assess its suitability in current decades (Rahman et al., 2010).

5.3 Human Resource in Forensic Medicine

The number of forensic medicine experts needs to be increased, and decentralizing the services may help the health and judicial systems manage autopsy cases with limited resources. Without adequately trained experts and supporting staff, further expansion and up gradation of forensic services cannot be expected. Adequate facilities should be ensured in such a pattern that young doctors spontaneously choose their careers in forensic medicine. Secondly, in addition to forensic medicine, adequate opportunities for forensic psychiatrists would expand the services. Adequate training (both national and international) should be arranged to ensure the continuous progression of expertise.

5.4 Proper Training and Benefits of Morgue Staff

Morgue staff (well known as Dom in Bangla) play a vital role in medicolegal autopsy. They are engaged in receiving the dead body, dissection, preservation of viscera, reconstruction, and finally handing over the body to legal authority. Surprisingly they are inheritably engaged in this profession; the legacy started from their families. But still, nowadays, they are not well trained as professional ones. They learn to handle autopsy cases only by seeing the procedure from their family members though they need to be scientifically well trained. That is why there is a lack of well trained mortuary staff. Moreover, their salary and remuneration are so undervalued that is really unacceptable. If we want to take initiatives for upgrading forensic medicine, we will have to have a holistic approach like morgue attendants should be properly trained up with ensuring full monetary benefit packages.

5.5 Well-Documented Liaison

Suicide prevention is everyone's business (World Health Organization, 2014). Currently, the scattered and scantly prevention strategies are not harmonized in Bangladesh (Arafat and Khan, 2019; Arafat, 2018). Enduring liaisons between mental health professionals, forensic experts, journalists, and legal bodies are warranted to change the legal status, raise awareness, and improve medicolegal decisions.

6 Conclusion

There are undeniable roles of forensic medicine, forensic psychiatry, and legal bodies in suicide prevention that should not have any exception in Bangladesh. Death declaration, identification of suicides, and crafting laws and regulations affect help-seeking behavior and suicide prevention. Immediate initiatives are warranted to change the criminal status of suicidal behavior in Bangladesh. Additionally, both qualitative and quantitative improvement of forensic services should be prioritized. Adequate measures should be made to reduce postmortem dropouts so that the underestimation of suicide could be resolved. There is no alternative to an enduring collaboration among forensic medicine, psychiatry, police, media, and other stakeholders.

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CHAPTER 3

Mental Health and Suicide in Bangladesh

S. M. Yasir Arafat

Abstract The notion of having a psychiatric disorder in at least 90% of suicides cannot be supported by available evidence in Bangladesh. Although the rate is lower, the health system is not adequate and even not prepared to deal with suicide and self-harm behavior in the country. Due to being categorized as a criminal offense, persons with suicidal behavior are being avoided by private hospitals while public hospitals literally neglect the psychological care demand in the country. There is inadequacy and inequitable distribution of psychiatrists, psychologists, and psychiatric social workers. Additionally, there is no notable formal training on suicide prevention for any category of service providers. There are only two suicide prevention clinics in Bangladesh that are yet to get momentum due to poor awareness, high stigma, and low suicide literacy. There is no alternative to extending psychiatric services, raising awareness about suicide prevention, urgent attention of policymakers, and responsible authorities to address the service care of patients and their family members with suicide and self-harm behavior. This chapter discusses the psychiatric morbidity among suicides and the current status of psychiatric services provided to the incumbents in Bangladesh.

Keywords Mental health · Suicide in Bangladesh · Health services · Depression · Suicide attempt · Psychiatric disorder

S. M. Y. Arafat (✉)
Department of Psychiatry, Enam Medical College and Hospital, Dhaka, Bangladesh
e-mail: arafatdmc62@gmail.com

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1 Introduction

Suicide is a global public health issue that is not an exception for Bangladesh (World Health Organization, 2021). In 2019, about 703,000 people died by suicide in the world; 77% of the suicides happened in low- and middle-income countries (LMICs) (World Health Organization, 2021). It is still mysterious to know the suicide pathway in a definitive fashion. Suicide is an outcome of a complex interaction between several factors like gene-environment interaction, proximal–distal factor interaction, and biopsychosocial interaction (Zalsman et al., 2016; World Health Organization, 2014). Among several factors, the psychiatric disorder has been considered as an important risk factor for suicide across the world with some variations in rate (Zalsman et al., 2016; Cho et al., 2016). Current evidence supports that about 90% of suicides have at least one psychiatric illness in Western countries (Zalsman et al., 2016). However, recent repeated autopsy studies from eastern countries like China, India, and Bangladesh revealed a lower rate of mental illness among suicides (Zalsman et al., 2016; Cho et al., 2016; Milner et al., 2013; Arafat, Menon, et al., 2022). One systematic review concluded that the prevalence of mental illness is possibly lower in LMICs (Knipe et al., 2019). Another recent meta-analysis replicates the lower prevalence of the depressive disorder in suicides and suicidal behavior in South Asian regional countries (Arafat, Saleem, et al., 2022). It revealed the pooled prevalence of depression was 37.3% in suicide and 32.7% in non-fatal attempts (Arafat, Saleem, et al., 2022).

Bangladesh is an LMIC located in South Asia with potential economic growth in recent decades. It has an area of 147,570 square kilometers and about 171 million populations substantiating it as one of the highest densely populated states in the world (World Population Review, 2022). Among the population, more than 90% are Muslims. Suicide is prohibited in Islam and it is considered as a criminal offense in the country (Arafat, Martheonis et al., 2022). Bangladesh is enjoying a demographic dividend from its huge young population that makes its prolific economic growth despite huge corruption and money laundering to Western countries. The country is lifted from low-income to lower-middle-income groups in recent years. At the same time, it is facing a double burden of diseases with a gradual inclination to non-communicable diseases. Currently, more than 60% of the disease burden is incurred by non-communicable diseases (Ahmed, 2018). Mental disorders are one of the major burdens after cardiovascular diseases, diabetes mellitus, chronic respiratory diseases, and malignancy (Ahmed, 2018). The latest nation-wide mental health survey of Bangladesh conducted by the national institute of mental health (NIMH), the Ministry of Health, and World Health Organization (WHO) in 2018–2019 revealed that the prevalence of psychiatric disorders was 16.8% (95% CI 15.5–18.2) which was 16.1% in 2003–2005 (World Health Organization, 2019b). Among the disorders, the highest prevalence was noted for depression (6.7%), followed by anxiety disorders (4.5%), somatic symptoms and related disorders (2.1%), and psychotic disorders (1%)

(World Health Organization, 2019b). The study identified a treatment gap of 92.3% among the adult populations of Bangladesh (World Health Organization, 2019b). A significant portion of the patients visits traditional healers (Samans, Kabiraz, etc.) and non-medical health professionals before reaching the mental health professionals (Giasuddin et al., 2012; Nuri et al., 2018). Studies identified that less than 30% of the patients visit mental health professionals at their first contact (Giasuddin et al., 2012; Nuri et al., 2018). Another important aspect of health services should be mentioned regarding the high out-of-pocket expense for the treatment of mental illness in Bangladesh. I couldn't find any specific study on the out-of-pocket expense of psychiatric disorders in the country. However, available studies identified the out-of-pocket expense on overall health revealed more than 70% of the expenses are incurred as out-of-pocket expenses in Bangladesh (The World Bank, 2022). Being a densely populated country with a low health budget, double disease burden, low mental health literacy, high stigma, and attribution of mental illness to super-natural power like jinn, overall mental health care is grossly under-prioritized especially for the community people of Bangladesh. As a result, the association between suicide and psychiatric disorders is yet to be discovered adequately.

2 Epidemiology of Suicide in Bangladesh

We discuss the details of the epidemiology of suicide in Chap. 1 of this book (Kabir et al., 2023). We mention here some details to maintain the context. At the same time, I was careful to reduce the repetitions. Suicidal behavior is an under-researched problem in Bangladesh. The country still lacks a suicide surveillance system and any national suicide prevention initiative (Arafat, 2017). The rate of suicide rate varies among the empirical studies and WHO reports (Arafat, 2019a). The latest WHO report revealed the suicide rate was 3.9 per 100,000 population in 2019 which was 6.1 in 2016, 7.8 in 2012, and 7.8 per 100,000 in 2000. The total number of suicides was 5998, 9544, and 10,167 in 2019, 2016, and 2012, respectively (WHO, 2014, 2019c, 2021). The statistics indicate a decline in suicide rates and numbers in the last decade. However, the empirical studies revealed different rates in regard to the WHO estimates and even vary among the studies (Arafat, 2019a). Nation-wide studies are warranted to determine the prevalence rates. Additionally, there is an extreme dearth of research estimating the prevalence rate of self-harm in the country.

The first nation-wide epidemiological study among adolescents and youths on suicidal behavior was completed in 2021 by NIMH (Dhaka), WHO (Bangladesh), and Non-communicable diseases control, Ministry of Health, Bangladesh (NIMH, 2021). The study utilized the adapted Bangla WHO multisite intervention study on suicidal behaviors *SUPRE-MISS* among 1744 participants aged between 10 and 24 years. It found the rate of suicidal ideation, planning, and attempt was 4.7%, 1.5%, and 1.5%, respectively. The

rate was significantly higher among females and urban populations. Several aspects should be considered while considering the rates such as sources of data, concerns of under-reporting and misclassification, and methods of data recording in the context of countries like Bangladesh.

Hanging is the commonest method of suicide followed by poisoning (Arafat, Ali et al., 2021). Females die more than males and the majority of the suicides occur among persons under the age of 30 years (Arafat, 2019b). Familial discord, marital disharmony, psychiatric disorders, immediate life events, past suicide attempts, sexual violence, unemployment, and social isolation were identified as the major risk factors for suicide in Bangladesh (Arafat, 2017, 2019a; Arafat, Mohit, Mullick, Khan et al., 2021; Feroz et al., 2012, Reza et al., 2013; Salam et al., 2017; Shahnaz et al., 2017). However, social factors have a dominant role over clinical factors in Bangladesh (Arafat, Khan, et al., 2021). One analysis identified that if the life events could be prevented about 86% of suicides would be prevented which was about 50% for psychiatric disorders (Arafat, Khan, et al., 2021).

3 Psychiatric Disorders in Suicide and Self-Harm in Bangladesh

3.1 Psychiatric Disorder in Suicide in Bangladesh

The assessment of the prevalence and role of psychiatric disorders in suicide and suicidal behavior is grossly under-studied in Bangladesh. Only one case–control psychological autopsy study was conducted in an urban setting, i.e. Dhaka city, the capital of the country which was published in 2020 (Arafat, Mohit, Mullick, Kabir, et al., 2021). The study identified that 61% of the suicides had at least one mental illness. Among them, the major depressive disorder was the most prevalent diagnosis (44%), followed by personality disorder (14%), amphetamine (yaba) use disorder (9%), acute stress disorder (4%), adjustment disorder (3%), and schizophrenia (1%) (Arafat, Mohit, Mullick, Kabir, et al., 2021). The study also identified co-morbidities of psychiatric disorders, personality disorders, and substance use disorders among suicide deceased. Among the suicides, only 13% were previously diagnosed and being treated and only one suicide with depression was regular and compliant with the psychiatrist. Among the 13 previously identified cases, five had depressive disorder, seven had substance use disorder, and the rest one was psychotic (Arafat, Mohit, Mullick, Kabir, et al., 2021). The study identified the service gap was 87%. It also revealed that only 14% had past suicidal attempts (Arafat, Mohit, Mullick, Kabir, et al., 2021). This is perhaps the only systematized attempt assessing the psychiatric disorders among suicides where the psychiatric diagnoses were assessed by *Structured Clinical Interview for DSM-IV Axis I Disorders* (SCID-I) (First et al., 1996) and *Structured Clinical Interview for DSM-IV Personality Disorders* (SCID-II) (First et al., 1994). A different analysis of the same data by comparing suicides with and without

mental disorders revealed some additional interesting findings (Arafat, Mohit, Mullick, Khan, et al., 2021). Mental illness was significantly higher among the suicides that happened in adulthoods than adolescents, males than females, and socially isolated persons than whom were living with family (Arafat, Mohit, Mullick, Khan, et al., 2021). The analysis indicates that 70% of the depressive disorder cases were males, 70% of the adults had psychiatric disorders while it was 36% among suicides by adolescents. Significantly higher age was noted among the suicides with mental disorders than suicides without mental illness. All the suicides with acute stress disorder were developed among females in response to sexual harassment (Arafat, Mohit, Mullick, Khan, et al., 2021). Interestingly, psychiatric disorders were significantly higher in the middle and upper socio-economic class and persons living in a parental house or had house ownership (Arafat, Mohit, Mullick, Khan, et al., 2021). In a summary, psychiatric disorders were more common among suicides of adult age, males, living alone, and having a middle- and upper-class environment. The findings clearly indicate a lower rate of mental illness among the suicides in Bangladesh in comparison to the Western countries. Additionally, it drags our attention toward the social factors and life events like marital discord, familial disharmony, sexual harassment, and premarital and extramarital relationships in attributing and preventing suicides. However, poor mental health and suicide literacy could be important reasons for this low attribution.

3.2 Psychiatric Disorder in Self-Harm/Non-Fatal Attempt in Bangladesh

Assessment of psychiatric morbidity in suicidal behaviors has been poorly prioritized in Bangladesh. Available studies indicate the rate is 45–65% (Uddin et al., 2019; Islam et al., 2019; Roy et al., 2016; Reza et al., 2013; Qusar et al., 2009). A study of 51 patients with NSSI in Chattagram (Chittagong) revealed that 45% of the patients had psychiatric disorder which was assigned by clinical interviews conducted by a psychiatrist (Uddin et al., 2019). Among the disorders, the depressive disorder was found in 23.5%, followed by borderline personality disorder (BPD) (11.8%) and schizophrenia (5.9%) (Uddin et al., 2019). Another study at Comilla (Cumilla) medical college determined the prevalence of psychiatric disorders was 65% (Islam et al., 2019). Islam and his colleagues interviewed 120 patients with suicidal behavior through the *Composite International Diagnostic Interview* (CIDI) and diagnoses were assessed as per the DSM-5 classification (Islam et al., 2019). They identified BPD as the top most psychiatric morbidity which was found in 16.7% and depression was found in 7.5% of patients (Islam et al., 2019). In one study conducted at *Rangpur Medical College* in 2017 among 101 clinical patients who presented with non-fatal attempts were assessed for psychiatric morbidity where the diagnosis was assigned clinically by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association, 2000; Roy et al., 2016). The study revealed that 65% of the

patients with non-fatal attempts had psychiatric disorders where depressive disorder was highest (18%), followed by conversion disorder (12%), psychotic disorder (12%), bipolar disorder (6%), and substance abuse disorder (4%) (Roy et al., 2016). Another case–control study published in 2013 assessed psychiatric morbidity by SCID-I in the rural part of Bangladesh (Chuadanga) among 113 respondents with suicidal behavior (Reza et al., 2013). The study revealed that psychiatric morbidity was 58.5% (Reza et al., 2013). However, it didn't categorize the respondents based on suicidal behavior, i.e. how many were suicides and how many had only non-fatal attempts. Additionally, it was not demarcated whether the interview was conducted by a psychiatrist or any other well-trained clinician (Reza et al., 2013). A study was conducted in 2008 on 44 admitted patients in the intensive care unit (ICU) after a non-fatal attempt assessed psychiatric morbidity by clinical interview and diagnoses were confirmed as per DSM-IV criteria (Qusar et al., 2009). It identified that about 59% ($n = 26$) of the participants had psychiatric disorders; among them, the depressive disorder was the highest morbidity and was identified in 25% of the cases followed by personality disorder (9.1%), psychosis (9.1%), obsessive–compulsive disorder (4.5%), substance-related disorder (4.5%), and acute stress disorder (4.5%) (Qusar et al., 2009). It is important to note that these 44 cases are supposed to have severe intent and clinical outcomes as they were collected after a life-threatening attempt and admitted in ICU. Therefore, the rate of morbidity among less severe attempters may not be the same. It is important to note that prevalence has been calculated irrespective of the assessment of intent whether suicidal or non-suicidal self-harm. Interestingly, the studies revealed nearly a low prevalence (45%, 58.5% vs. 59%, and 65%) both in community (Reza et al., 2013) and clinical sample (Uddin et al., 2019; Islam et al., 2019; Roy et al., 2016; Qusar et al., 2009).

4 Psychiatric Services for Suicide and Self-Harm

Whatever the service burden, there is an extreme insufficiency and inadequate readiness for the provision of evidence-based services for suicide and self-harm in Bangladesh. The autopsy study identified the unidentified mental health need was 87% (Arafat, Mohit, Mullick, Kabir, et al., 2021). The latest mental health survey conducted in 2018–2019 identified the treatment gap of psychiatric disorder as 92.3% (World Health Organization, 2019a). After the service gaps, let us check the service delivery pattern of the health system in Bangladesh. The criminal legal status creates an additional burden for services provision as well as services receiving for non-fatal attempts. As the patients with self-harm and suicidal behavior have been considered as police case and a seal is stamped on the hospital file of the patients mentioning "police case". This stamping is supposed to create a further psychological burden in addition to the primary distress. Private hospitals are reluctant to provide services and usually they refer such patients to the public hospitals to avoid unwanted legal hazards. Usually such patients are treated in the public hospitals starting

from Upazila Health Complex to District (Sadar hospital in Bangla) and then medical college hospitals. These hospitals have a separate corner for stomach wash for patients with poisoning and medication overdose. After that, they are being grossly neglected as most of the cases are kept on the floor of the hospital veranda. In the general hospital settings, the patients with suicidal behavior have been treated by medicine specialists in the majority of the situations. There is almost no privacy and psychological support and even such patients are not being referred to the psychiatrist for evaluation of suicidal intent, mental health status, and tailored need of psychological supports. Due to these reasons, patients with NSSI do not take medical advice unless any emergency arises. If we look into available human resources for services provision, we can see that there are about 270 psychiatrists in Bangladesh, and every year about 10–20 psychiatrists are coming out including the MCPS, FCPS, MD Psychiatry, and MD child and adolescent psychiatry (Hasan et al., 2021; WHO, 2020). The country pertains 0.17 psychiatrists per 100,000 population, 0.43 mental health nurses, and 0.35 psychologist per 100,000 population (WHO, 2020). If we calculate the proportion with the prevalence of the latest national mental health survey, I find that only one psychiatrist is available for 16,800 patients. The situation is further complicated by the inequitable distribution of mental health professionals. Most of the psychiatrists are located in the city and the majority of the psychiatrists are living in Dhaka (capital city). Only about 0.5% of the total country budget has been allocated for mental health and the total mental health expenditure is about 9 Taka (0.1 USD) for an individual (WHO, 2022). Only two specialized services centers have been identified in the country; both of them are located in Dhaka city. The first *Suicide Prevention Clinic* (SPC) was started at the psychiatry department of *Bangabandhu Sheikh Mujib Medical University* (BSMMU). It was started in September 2016 aiming at providing a specialized service to the patients with active suicidal ideation or previous suicide/self-harm attempts. The clinic works at weekly two hourly basis outpatient department (OPD) services, only on Saturday from 11.00 a.m. to 1.00 p.m. (Arafat, 2018). Prof. *Mohsin Ali Shah*, Professor of psychiatry, started the services of milestone in the country. The clinic maintains follow-up by making phone calls to the service receivers to ascertain whether attempts are made. Reports from the clinic revealed that about two-thirds of the patients were aged under 25 years, 70% were females, and depressive disorder was the most common psychiatric morbidity (Shah et al., 2018).

The second SPC was started at the department of psychiatry of *Enam Medical College and Hospital (EMCH)*, a private medical college in Dhaka by Dr. *S. M. Yasir Arafat*, a disciple of Prof. *Mohsin Ali Shah*. The service hour is extended from 9 a.m. to 5 p.m. on working days. It is started in October 2021. Any other specialized clinical services for suicide prevention have not been identified in Bangladesh. The visited patients at the SPC of BSMMU are mostly referred by the psychiatry OPD while the SPC of EMCH gets by self-report due to some awareness materials like banners containing

basic information on suicide and self-harm. A mental health OPD is available at 72 hospitals country-wide (WHO, 2022). However, it is questionable whether any mental health specialist is available in all the centers except the medical colleges. Even, general physicians having training in mental health would be difficult to find out in every center at the primary care level of Bangladesh. Therefore, it is unexpected that these centers would be able to handle suicide and suicidal behavior efficiently. It is important to note that none of the persons in the SPCs has any formal training on suicide and suicide prevention except for their academic background.

5 Current Challenges and Way Forward for Suicide Prevention

Detailed suicide prevention activities have been discussed in Chap. 9 of this book by Hoque (2023). Here, I tried to mention the prevention activities closely associated with mental health. Criminal legal status, low-quality data, inadequate services, high out-of-pocket expense, low mental health and suicide literacy, low research, lack of national databases and suicide surveillance system, non-existence of inter-sectoral collaboration, inadequate funds, unavailability of professional training, and lack of national suicide prevention strategies are the potential challenges of suicide and self-harm prevention in Bangladesh. Self-harm behavior is a covert problem in Bangladesh. Usually, the young child(ren) hide(s) it from their parents. Parents are not aware in such a stage to consider it as a mental health issue due to high-level stigma and low mental health literacy. There is an extreme dearth of health services having adequate training and expertise to deal with the problems. The problem is yet to get the political attention to have any health policy and visible prevention activities. The mental health act of Bangladesh was passed in 2018 and contains nothing about the suicide prevention (Mental Health Act, 2018; Khan et al., 2020).

There is no alternative to raising awareness among the services providers first and then among the general population indicating that suicide is preventable and past attempt is the strongest risk factor for suicide (WHO, 2014). Adequate mental health services should be ensured throughout the country with proper psychological supports in a readily available manner. Periodic training for human resources working in suicide prevention should be ensured. General physicians should be adequately trained to identify the warning signs of suicide, depression, and substance abuse (Arafat and Kabir, 2017). Enduring collaboration is necessary between the mental health professionals, media personnel, crisis service centers, and forensic experts. Decriminalization of suicide would help people to disclose the suicidal behavior and hospitals to provide necessary services to the needy people (Soron, 2019). Initiating the school mental health programs and ensuring the gate-keeper training of teachers to identify the signs of depression, substance misuse, and

suicidal behavior could be a potential area in the country (Zalsman et al., 2016). There is a dire need for research in suicide and suicide prevention to identify the role of psychiatric disorders in suicide as well as to test any culture-sensitive suicide prevention strategies.

6 Conclusions

Mental health and mental illness are closely associated with suicide and suicidal behavior in Bangladesh likewise the other parts of the world even though the available rate is lower when compared to Western countries. However, both the mental health care providers and the service receivers are not ready in either way to deal with suicidal behavior with psychiatric care. Low mental health and suicide literacy, high stigma toward suicide and mental health services, lack of service outlets, and awareness could be the potential factors. There is no alternative to raising awareness about suicide prevention among all the stakeholders in the country. Urgent attention of policymakers and responsible authorities is warranted to address the service care of patients and their family members with suicide and self-harm behavior as well as to train the service providers. Academic institutions should prioritize suicide prevention research to find out the risk factors for suicide in the country. And finally, the implication of the research findings into the policy should be started in Bangladesh.

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CHAPTER 4

Cultural Perspectives of Suicide in Bangladesh

Anisur Rahman Khan

Abstract The French classical sociologist, Émile Durkheim, in his groundbreaking research *Le Suicide* (1897/2002) drew our attention to the role of socio-cultural perspectives to meaningfully understand the study of suicide. Since then, there has been a growing scholarly interest to tap the diverse association between suicide and culture. The case for Bangladesh, however, proves otherwise. This chapter tries to extricate the cultural perspective of suicide in Bangladesh. Drawing predominantly on the existing literature, it attempts to synthesise the prevailing manifestations of the cultural elements affecting suicide and captures the deep relationships between the cultural indexes (e.g., religion, gender, legal status, methods, demographic characteristics, intervention, and research) and suicide. Unfortunately, as a country, Bangladesh has not been able to develop a positive culture of help-seeking in the event of suicidality due to the strong sense of collective stigma and shame. Considering the grievous situation of suicide, Bangladesh must approach to adopt culturally sensitive interventions to appropriately address the problem.

Keywords Suicide in Bangladesh · Suicide · Culture · Society · Durkheim

A. R. Khan (✉)
Department of Sociology, East West University, Dhaka, Bangladesh
e-mail: arkhan@ewubd.edu

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1 Introduction

Émile Durkheim's classic research *Le Suicide* (1897/2002) laid the foundation of empirical sociology by producing a methodical, extensive, coherent, and testable theory of suicide (Joiner, 2007), which positioned him as the founder of the scientific study in suicide (Jaworski, 2016). Durkheim (1897/2002) viewed suicide as a much more complex social fact embedded in a varied range of socio-cultural (external) contexts and perspectives. For Durkheim, suicide is a manifestation of socio-cultural norms, values, role expectations, interactions, needs, and circumstances specific to a given socio-cultural milieu (Staples, 2012). In this sense, academic interests in extricating the influence of cultural/social (structural) factors on suicide evidently derive from the Durkheimian tradition of the sociology of suicide (Goldston et al., 2008).

Considering the implications of cultural factors in the event of growing rural suicide rates, Gessert (2003: 698) strongly asserted, "ultimately, suicide reflects a determination that death is preferable to life. Such a determination cannot be understood without a thorough understanding of the culture in which it occurs." To reiterate, suicide everywhere is culturally patterned and each society has developed its own cultural narratives of suicide (Canetto, 2015). Cultural factors such as norms, values, and role expectations shape the suicidal acts in diverse ways including the classifications/forms, methods, motivations/causes, and demographic distributions based on gender, age, social class, ethnicity, or other socioeconomic variables. The perceptions, understandings/meanings, and reactions to suicide may differ across cultures. Cultural contexts may also shape the risk and protective factors as well as the frameworks of prevention and intervention (Goldston et al., 2008; Lester, 2013; Stack, 2021; Staples, 2012).

Notwithstanding the difficulties associated with understanding the cultural meanings of suicide due to its diverse contestation across culture and society, scholarly efforts unremittingly highlight the obvious ramifications of culture on suicide (Cloucci, 2013; Maharajh and Abdool, 2005). Against this backdrop, this chapter examines the interface between culture and suicide (excluding suicide attempt or suicide intent) in the context of Bangladesh. Despite suicide being a grievous public health crisis in Bangladesh, the risk factors of suicide have not yet been studied so meticulously (Arafat, Saleem et al., 2022). Considering the critical imprint of culture on suicide, any systematic assessment of this relationship may improve the efficacy of reducing suicide (Maharajh and Abdool, 2005).

2 The Meaning of Culture

Culture as a concept has been used extensively to comprehend the ways of life of people. The core social science disciplines dealing with cultures, such as sociology and anthropology, have not only expressed the concept in varied

ways but also ignited a high degree of controversies, disagreements, and paradoxes concerning its meaning and shaping (Cheal, 2003; Cloucci, 2013). Culture is dynamic and changeable. Its meaning-making, practices, and relationships are subject to continuous (re-)building. As such, the culture of any society does not have a stable measurable structure (Patel, 2017). For example, the extensive classical review by A.L. Kroeber and C. Kluckhohn in *Culture: A Critical Review of Concepts and History (1952)* noted very little agreement between scholars regarding the meaning of culture. Since space will not allow highlighting the vast array of conceptual developments and incongruities of culture, it seems to be more appropriate to focus on some of the key sociological/anthropological meanings of culture.

In *Primitive Culture*, E.B. Tylor (1871/1920: 1), the great cultural anthropologist, provided the most formal, explicit, and wide prevailing definition of culture as, "that complex whole which includes knowledge, belief, art, law, morals, customs and any other capabilities and habits acquired by man as a member of society. The condition of culture among the various societies of mankind, in so far as it is capable of being investigated on general principles, is a subject apt for the study of laws of human thought and action." Briefly, for Tylor, culture comprises names of things and events required for human beings (White, 1959).

In *Social Change*, sociologist W.B. Ogburn (1922) viewed that culture makes a significant contribution towards shaping societies and behaviour of people. He categorically distinguished culture into two forms: material and non-material. For him, material culture includes the tangible/physical/technological aspects of social life while non-material culture includes the intangible aspects like values, norms, customs, philosophies, religions, and so on. Non-material culture is seemingly slow to cope with material culture, leading to a period of maladjustment called *cultural lag*.

Kroeber and Kluckhohn (1952: 157), on the other hand, expressed their own definition as, "culture is a product; is historical; includes ideas, patterns, and values; is selective; is learned; is based upon symbols; and is an abstraction from behaviour and the products of behaviour."

In *the Interpretation of Cultures*, Clifford Geertz (1973: 145) defined, "culture is the fabric of meaning in terms of which human beings interpret their experience and guide their action; the social structure is the form that action takes, the actually existing network of social relations. Culture and social structure are then but different abstractions from the same phenomena." Geertz (1973: 50) furthered, "our ideas, our values, our acts, even our emotions, are, like our nervous system itself, cultural products—products manufactured, indeed, out of tendencies, capacities, and dispositions with which we were born, but manufactured nonetheless." Considering the importance of culture on human behaviour, he (1973: 49) stated, "without men, no culture, certainly; but equally, and more significantly, without culture, no

men….We are, in sum, incomplete or unfinished animals who complete or finish ourselves through culture."

The elements comprising the behaviour of individuals and the elements comprising culture are indistinguishable (White, 1959). Once an eminent sociologist R.M. MacIver (1932: 322) said, "culture is expression of ourselves, of our nature." Statement as such necessarily means that nothing in human nature or behaviour can be separated from or independent of culture. Thereby, suicide as an act cannot be separated from the cultural context. Culture influences the gamut of suicide in diverse ways (Lester, 2008). Since all people clearly follow a culture, no matter whether recognisable consciously or unconsciously, it may have a direct impact on any despairing behaviour including suicide (Shiang, 1998), and without understanding the cultural context, it is not possible to appropriately understand suicide and suicidal people (Hjelmeland, 2011).

3 The Cultural Elements in Suicide: An Overview

Since the concept of culture is so encompassing, caution is required in interpreting the cultural indexes associated with suicide. Herein, a brief overview is placed on the nexus between some salient cultural variables and suicide by citing examples from different cultural contexts.

Culture shapes the demographic features of various groups for motivation towards suicide. Although most suicide deaths (around 77%) are committed in low-and-middle-income countries, high-income countries record the highest age-standardised suicide rate (10.9 per 100,000). More than half (58%) of global suicide occurs before the age of 50 years, and it is one of the leading causes of death for young people aged 15–29 years (World Health Organisation [WHO], 2021). Rates of suicide for the elderly vary disproportionately across cultures or regions. In some regions, suicide rates increase considerably with age while rates are higher for young adults in other regions (WHO, 2014; Stanley et al., 2016). The act of suicide is, however, a rare phenomenon for children (Amini et al., 2021).

Cultural contexts influence the categorisations of suicide as well. For example, Durkheim (1897/2002) articulated a four-fold categorisation of suicide based on two social/cultural forces: integration and regulation—the degree to which people are attached to and controlled by society and culture. Egoistic and altruistic suicides are the result of too little and too much social integration, respectively. Conversely, too little and too much social regulation produce anomic and fatalistic suicide, respectively. Suicide can also be categorised as pact suicide committed by an agreement between two individuals (Rastogi and Nagesh, 2008), often instigated by romantic, dramatic, or heroic events (Risal, 2017). Cluster suicide is committed by individuals linked by time, spatial, or social relationships. Cluster suicides may also occur through means of contagion (Rezaeian, 2012). Mass suicide or simultaneous suicide is undertaken by the members of a particular social group who blatantly

follow various evocative social and cultural models (i.e., religious cult: People's Temple mass ritual suicide, Heaven's Gate mass ritual suicide) as a means of their salvation (Misra et al., 2019).

Suicide is culturally disapproved of if undertaken due to selfish reasons but considered positively when undertaken for heroic or altruistic/self-sacrificial reasons (Misra et al., 2019). The acts of Muslim suicide bombers may generally be considered as suicide, but for themselves or many other Muslims, such deaths are essentially linked to martyrdom, caused for the sake of holy war (*Jihad*) (Lester, 2013; Joiner, 2007). Martyrdom, based on a firm faith connected with holy war (*Jihad*) and the purpose of defending one's homeland, is an essential duty in Islam, but many Westerners consider it as martyrdom suicide or altruistic suicide (Abdel-Khalek, 2004). In the same vein, *Sati*, an old Indian custom where the widowers self-immolate on their deceased husbands' funeral pyres is often defined as ritual or altruistic suicide, and often as culpable homicide (Vijayakumar, 2004). *Sati*, was specifically categorised by Durkheim (1897/2002) as an altruistic suicide because this Hindu customary practice defines it as the duty of women.

Gender plays an important role in different cultures for suicidality. Durkheim (1897/2002) regarded suicide essentially to be a "male phenomenon" particularly because it occurs at a substantially higher rate in males than females. Even today, suicide rates are higher (2.3 times) in males than in females across regions and socioeconomic groups. The rates are slightly over 3 times higher in higher-income countries, 2.9 times higher in low-income countries, 1.8 times higher in lower-middle-income countries, and 2.6 times higher in upper-middle-income countries (WHO, 2021). Among others, social and cultural expectations on men to perform traditional masculine responsibilities are linked to a higher prevalence of male suicide. If men fail to conform to culturally ideal masculine standards (i.e., employment or ability to provide), they might recourse to suicide as a means to escape (Platt, 2017). Women's lower suicide rates are due to their intense cultural attachment to various protective factors and reduced exposure to risk factors (Stack, 2021). While Durkheimian proposition entails that conjugal society has a harmful function for a woman as it aggravates their inclination to suicide (Durkheim, 1897/2002). In support of this argument, an example may be drawn from a non-Western country like India where the demand for dowry is established as the leading cause of female suicides. In the event that dowry expectations are not met, the young brides are often abused/tortured by their husbands and in-laws, causing many female suicidal deaths by self-immolation (Chen et al., 2012).

Methods used for suicide vary across cultures and subsequently carry cultural implications. There is strong interconnectedness between suicide and the availability of lethal means including their social acceptability (Gross et al., 2007; Lester, 2008). For example, hanging and poisoning are the most widely used methods in South Asia (Arafat, Mohit et al., 2021), but firearms are commonly used in many Western countries (Lester, 2008). The ritual suicide

through *hara-kiri/seppuku (cutting the belly) is an hara-kiri/seppuku/*seppuku (cutting the belly) is an honourable method practiced by the *samurai* (military men) in Japan (van den Bergh et al., 2013). Well-known sites can also be culturally symbolised as suicide hotspots or sources of attractions for intended individuals (Gross et al., 2007). Examples might include the Golden Gate Bridge in San Francisco (the world's leading suicide location), the Cliffs of Moher in the Republic of Ireland, Niagara Falls on the Canadian–US border, London Underground Metro, and *Aokigahara*, known as the "Suicide Forest" in Japan (Zhi et al., 2019). The use of suicide methods may also be linked with the notion of "gender paradox of suicide" which expresses the fact that men die more than women from suicide although women make more attempts (Canetto and Sakinofsky, 1998). Such difference is largely due to the fact women choose less lethal means than men (Elnour and Harrison, 2008).

Religion as an integral element of culture may be effective to minimise the risk of suicide. Faiths and practices in certain religions and practices categorically reduce suicidal risks (Stack, 2021). For example, Islam, the second largest religion with approximately 1.9 billion adherents, has a strong prescription against killing oneself (Arafat, Ali et al., 2021). According to the cultural scripts of the Quran, the key essence of the cultural scripts of the *Quran* marks suicide as an unforgivable sin, and thereby, those who commit suicide would serve in hell forever (Khan, Ratele, Helman, Dlamini et al., 2022). Since suicide is a sinful behaviour in Islam, suicide rates are generally lower in the Muslim/Muslim majority countries. The strong faiths/integration and adherence to the practice of Islam provide important protective belts against suicide for the inhabitants of Muslim countries (Arafat, Ali et al., 2021; Arafat, Marthoenis et al., 2022). An ecological study covering 46 Muslim/Muslim majority countries calculated that average suicide rates (5.45/100,000) in 2019 for the total population of these countries tend to be significantly lower than the global rates with few exceptions such as Burkina Faso, Chad, Guinea, Kazakhstan, and Somalia (Arafat, Marthoenis et al., 2022). Another extensive ecological study spreading from 2000 to 2019 also noted that the age-standardised suicide rates in most of the Muslim/Muslim majority countries are consistently lower when compared with the global average (Lew et al., 2022). In *Le Suicide* (1897/2002), Durkheim explicated that suicide rates are higher among Protestants than Catholics or Jews. He argued that Catholics and Jews have stronger cohesion and collectivism as a religious community that offers them better immunity to suicide. The Protestants are more exposed to (egoistic) suicide because of their less integration within the community and the Church. For Durkheim, without a strong collective belief, no religious society be formed or unified. Understandably, the strong cultural formation of the Muslims, Catholics, and Jews as religious societies provides them with better protection in terms of suicidality.

The legal status of suicide also varies across cultures. Countries following Islamic or *Sharia* laws have specific legal provisions for suicide/attempted suicide. The vast majority of other countries as well have made it a criminal

offense to provoke, encourage, or assist a person to commit suicide (Mishara and Weisstub, 2016). Notably, only a few developed countries and particular states of the United States have legally allowed euthanasia or assisted suicide on medical grounds (De Leo, 2022). Despite the importance of self-sufficiency, self-determination, and the right to a "good death" over the long-lasting tolerance of excruciating physical suffering or incurable medical diseases, many religions such as Islam, Judaism, and Catholicism expressly forbid euthanasia and suicide (Pierre, 2015). The issue of stronger social integration, according to Durkheimian (1897/2002) argument, influences the debate between criminalisation and decriminalisation.

Studies have an inconclusive understanding regarding suicide rates for both urban and rural areas (Casant and Helbich, 2022). Given the predominance of rurality, higher rural suicide rates are found in several Asian cultures (Chen et al., 2012). Several socio-cultural factors such as poverty/relative deprivation, social isolation and disconnection, insufficient knowledge/stigma about mental illness, self-reliance in the face of illness, lack of help-seeking services, and easy access to lethal means or pesticides stand as critical factors in terms of rural suicidality (Chen et al., 2012; Gessert, 2003; Casant and Helbich, 2022). Rural farmer suicide is deeply ingrained in the cultural contexts. Many countries have identified farming as a dangerous practice for suicide. In particular, countries like India, Sri Lanka, USA, Canada, England, and Australia have recorded higher suicide rates among farmers (Behere and Bhise, 2009). In India, severe socioeconomic hardships of small and marginal farmers such as indebtedness and monetary concerns, crop failure, and other farming-related issues constitute 60% of the suicide deaths (Rao et al., 2017). Drought, on the other hand, is a highly precipitating factor for farmer suicide in Australia (Behere and Bhise, 2009).

There are etiological variations in suicide between high-income countries (HICs) and low- and middle-income countries (LMICs). A systematic meta-analysis noted that psychiatric disorders tend to be strongly associated with high-income countries, responsible for 80–90% of suicide deaths in these countries. But such an association is less pronounced or known for low-and middle-income countries. Conversely, socio-cultural factors such as poverty, unemployment, domestic violence, and easy access to lethal means (e.g., pesticides) are more highlighted in these countries (Knipe et al., 2019). Unlike HICs, with a very low-level mental health service structure to identify individuals as suicidal in LMICs, it is still more demanding to consider borderer social/cultural determinants to contextualise suicide in these countries (Bantjes et al., 2016). One specific example concerning social/cultural determinants can be drawn from female suicide trends in LMICs. Cai et al. (2021) noted that LMICs maintain proportionately lower smaller male–female suicide ratios compared to high-income countries. The study concludes that relatively higher female suicides in these countries are due to deliberate social and structural discrimination directed towards this population.

In terms of help-seeking behaviour, it is noted that some cultural groups might not be interested in seeking formal services because of stigma and anxieties/attitudes associated with health services (Goldston et al., 2008). Stigma and attitudes are deeply rooted in a cultural context and can explain the differences in help-seeking across cultures and regions (Reynders et al., 2015). For example, men are generally reactive towards seeking help during suicidality. The rigid masculine ideals such as impassiveness, stoicism, and self-reliance, deter men to seek professional support or disclose their feelings which eventually increases their risks of suicide (Oliffe et al., 2020). Conversely, women, including the elderly, tend to demonstrate more positive help-seeking attitudes and higher help-seeking intentions (Calear et al., 2014).

4 The Cultural Elements in Suicide: Bangladesh Context

This ensuing analysis will highlight the cultural scripts of suicide in Bangladesh. The paucity of field-based empirical studies grossly deters the extraction of actual context-driven cultural practices of suicide in Bangladesh. No substantial interpretation can be captured from the available studies, except in a few instances, which are predominantly conceptual and/or secondary document-based, concealed evidence from police, media, and hospital sources (Khan, Ratele and Helman, 2020).

The major religious faith, Islam, predominates, with Muslims comprising 90.4% population of the country (Bangladesh Bureau of Statistics, 2015). The rate (3.9/100,000) of suicide for both sexes in Bangladesh, as per WHO's (2021) global suicide mortality estimates, is lower than neighbouring South Asian countries such as Bhutan (5.1/100,000), India (12.9/100,000), Sri Lanka (9.8/100,000), and Nepal (9.8/100,000) where Islam is not the major religious faith. As Islam plays a pivotal role in shaping and prescribing the personal and community lives of the followers in Bangladesh, the warnings of the *Quarn* against self-killing are likely to make explicit imprints on their suicidal thoughts and actions. Being a Muslim majority society, suicide is culturally stigmatised in Bangladesh. Therefore, family members occasionally tend to hide information regarding suicide which may affect the extent of under-reporting and under-estimation of suicide information (Mashreky et al., 2013). Within the purview of religious stigmatisation of suicide in the context of Bangladesh, Khan, Ratele, Helman, Dlamini et al. (2020) expressed that the fact of suicide by Muslim men is to be treated as an unmanly cowardly act before God. On a positive note, Islam plays a pivotal role to shape and dictate the personal and community lives of the followers in Bangladesh—a cultural context that might help people to protect themselves from suicide.

Suicide (attempt also) is a criminal offense in Bangladesh. Specifically, Section 306 of the Penal Code 1860 overtly mentions that, "if any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend

to ten years and shall also be liable to fine (Section 306)" (The Penal Code, 1860). Section 309 states that, "if a person who survives an attempt to suicide will also be liable for his intended action and has to face legal consequences. Attempt to commit suicide is punishable with imprisonment for a term which may extend to one year or with fine or both (Section 309)" (The Penal Code, 1860). Such legal provisions attest to the fact of strong cultural reservation against suicide associated with the ideology of the major religious faith of the country. While Bangladeshi scholars are debating on matters of decriminalisation or criminalisation of suicide (see, Soron, 2019; Arafat and Khan, 2019), policy intervention on this issue should be undertaken only by prudently considering the socioeconomic, cultural, ethical, moral, and religious contexts of Bangladesh (Khan, Arendse et al., 2020).

Demographic analyses consistently suggest that the younger groups, aged under 30, are more exposed to suicide in Bangladesh (Arafat, 2019a; Arafat et al., 2018; Arafat, Mohit et al., 2021; Shah et al., 2017; Khan, Shimul et al., 2021). Given the escalating trend of students' suicide, as documented by a growing number of studies, specific considerations are warranted to contextualise the cultural aspect of this type of suicide. Some critical socio-cultural factors, among others, connected with suicide committed by the tertiary level students include academic persecution/stress, perfectionism, family problems, relationship break-up, lack of social support, financial crisis, and academic stress (Urme et al., 2022; Arafat and Al Mamun, 2019; Mamun, Misti et al., 2020). In Bangladesh, the culture of exam-centric education puts a huge burden on students, as it is connected with the future (higher education and career pathways) prospects of the students, social status of the parents, the reputation of the teachers and academic institutions, and the overall general image of the government. Students, thereby, should not only uphold their own hopes but the expectations of their parents, teachers, and schools (Al Amin and Greenwood, 2018). It is not even to disregard the case of public university admission test failure (Khan, Shimul et al., 2021). Students expecting university admission also feel serious social pressure. Failure to secure placements in so-called reputed educational institutions or the subject of choice damages the social status of the students and their families. The parental investment in their children's education and the accompanying high expectations affect not only the families, but it increases the mental stress and workloads of the students. Factors as such may deprive them from participating in social, recreational, and sports activities (Mahmud, 2021), a context that seems to be dangerous for suicide to occur.

Hanging and pesticide ingestion are the two common methods of suicide in Bangladesh (Arafat, 2017). However, while some researchers found the use of poisoning as widely used in rural areas (Arafat, Mohit et al., 2021; Mashreky et al., 2013), other contexts found hanging as the most common method for suicide (Khan, Ratele, Arendse et al., 2020; Shah, Ahmed and Arafat, 2017). One study captured the variations of ligature materials used for hanging and found *dupatta/orna* (38.55%), jute rope (30.12%), and *sari* (16.86%) are the

most common materials followed by nylon rope, towel, *kamiz*, and electric ware (Ahmad and Hossain, 2010). Another study also noted *dupatta/orna* (38.55%) as the most common ligature material followed by nylon rope (28.21%) and *sari* (10.26%) (Begum et al., 2017). On the other hand, Ali et al. (2014) categorically distinguished gender dimensions concerning ligature materials used for hanging. Men tend to use both soft and hard materials for hanging, but females use soft materials only. Clothing is a form of material culture that shapes human values and behaviour. Women/girls of Bangladesh tend to wear *saree* and *salwar kamiz* (Mahamud, 2016), the latter being the most preferred. *Dopatta (orna)* which comes with *salwar kamiz* often stands as a readily available ligature material for hanging to women/girls (Ahmad and Hossain, 2010).On the other hand, the wider ingestion of pesticides for suicide in Bangladesh is due to the availability of various pesticides and other poisonous substances in rural areas. Being predominantly an agrarian country, Bangladesh makes extensive use of pesticides and relevant substances (Khan, Ratele, Arendse et al., 2020). Although Bangladesh has policy frameworks to ban highly hazardous pesticides (HHPs) from agricultural use (Chowdhury et al., 2018), the implementation of those policies is yet to be meticulously monitored (Khan, Ratele, Arendse et al., 2020). Thereby, the free availability of pesticides in rural areas used for high yielding and the higher rates of rural suicide seem to be strongly correlated. Notably, according to a wider survey, rural suicide rates are 17-fold higher in comparison to urban Bangladesh (Mashreky et al., 2013).

Since the country does not maintain any national suicide surveillance system, the exact male–female ratio cannot be adequately recorded (Arafat, 2019b), yet Bangladesh was always noted as one of those few countries where suicide rates among females occur at a higher rate than males. For example, WHO's (2021) global suicide mortality estimates confirmed that rates of female suicide (6.7/100,000) were higher than male suicide rates (5.5/100,000). Several in-country analyses also consistently recorded a higher frequency of female suicides than males (see, Mashreky et al., 2013; Arafat, 2019b; Khan, Ratele, Arendse et al., 2020). But WHO's (2021) most recent estimates for the first time recorded a much higher male suicide rate (6.0/100,000) than the female rate (1.7/100,000). A remarkable reduction in the female suicide rate (so on the national rate as well) has been recorded by this global document. Nonetheless, married from lower socioeconomic strata (Arafat, Mohit et al., 2021), adolescents (10–19 years) and early adults (20–30 years) are always the most vulnerable groups to suicide (Shahnaz et al., 2017; Arafat, 2019a). Critical provocative socio-cultural contexts for female suicides include rigid patriarchal culture, early/forced marriage, dowry demands, marital conflict or disharmony, rape/sexual abuse, poverty, infidelity/extramarital affair, lack of opportunity for economic advancement, failure to meet husband's expectation, divorce/expulsion from the family, and domestic violence, among others (Bagley, Shahnaz and Simkhada, 2017;

Shahnaz et al., 2017; Mashreky et al., 2013; Arafat, Mohit et al., 2021).On a specific note, Arafat, Mohit et al. (2021) determined that for females, sexual harassment could stand as a critical risk factor for suicide before marriage and marital disharmony or relationship troubles after marriage. Within the purview of Bangladeshi family culture, women are advised/expected not to expose their private problems to others. Due to a strong sense of stigma and shame, women silently bear their sufferings and pains which stands as a risk factor for suicide (Mamun, Siddique et al., 2020). Most of the above perspectives are generated at the family level. A recent insight by Arafat, Saleem et al. (2022) confirms that complicated family events are critical risk factors for both female and male suicides in Bangladesh. The following discussions will extend the cultural embodiments of male suicide in Bangladesh. Given the escalating trend of male suicide on the female rate, it is imperative to delve into more attention on the male suicidality in Bangladesh.

It is noteworthy that the ideal version of hegemonic masculinity/real manhood in the context of Bangladesh includes, among others, the ability of men to earn an income, provide and protect the family, being dominant, fearless, and powerful, having control over family matters and members, being physically and sexually competent, and possessing an honest and strong character (Khan et al., 2022). In line with the attributes of manhood, an in-depth empirical study conducted by Khan, Ratele, Helman, Dlamini et al. (2022) found that cases of rural male suicide were disturbingly caused due to intricacies/challenges associated with hegemonic/traditional masculine ideals. The challenges men faced before suicide include economic troubles/poverty, debt trap, sexual impotency, failure to control spouses or meet the expectations of the spouses, loss of self-esteem and respect in the family, and long-term illness, among others. Another publication by Khan, Arendse et al. (2021) suggests that various disturbing marital/intimate relationships such as troubles with family provider/breadwinner responsibilities, issues related to men's polygamous practices, difficulties to control over wives, and betrayal of loyalties by the partners/wives through engaging in extramarital relations, among others, prompted men to take their own lives. On the other hand, a content analysis by Khan, Shimul et al. (2021) applying Durkheimian four-fold social typology based on the extent of social integration and regulation found that most male suicide cases fall under the egoistic category, followed by anomic, fatalistic, and altruistic suicides.

4.1 Case: Male Suicide and the Cultural Context

The next section provides some brief impressions of a recently completed research to further delve into the interconnection between suicide and culture in Bangladesh. The said study was conducted in 2020 by the author with a purpose to explore the complex interplay between social/cultural aspects and suicidal acts of rural men in the selected rural settings of the *Jhenaidah* district. *Jhenaidah* is assumed to be one of the suicide-prone areas of the

country with an estimated standardised rate of 20.6/100,000 (Khan, Ratele, Helman, Dlamini et al., 2022; Khan, Ratele, Arendse et al., 2020). It included fifteen cases of male suicide using purposive and snowball sampling, aged eighteen and above, and applied post-hoc retrospective in-depth qualitative interviews with forty-five individuals who are close to the deceased (family members, friends, and relatives). For one case of suicide, three persons close to the deceased were interviewed. Being a qualitative study, specific to location, caution is warranted not to generalise the findings in the whole context of Bangladesh. Data were analysed following the steps of thematic analysis suggested by Braun and Clarke (2006). The incidents of suicide occurred between 2017 and 2020. The Centre for Research and Training (CRT), East West University, Dhaka, Bangladesh, approved the ethical protocols of this research.

4.2 Culture of Taboo

Several participants went through dreadful relationship troubles that were socially and culturally unacceptable in Bangladesh. These culturally non-granted relationship issues stood as critical suicidal risk factors for men involved in the process. One example is as follows:

Niranjan, aged 19, a Hindu young man fell apart by two identical/cultural realities: religion and family. Once Niranjan approached his parents to marry his fiancé who is a Muslim. His family did not accept the relationship because of the inter-religious taboo issues. Moreover, there was pressure on the girl from her own family to cut off this relationship on the same ground. Even though, the girl advised Niranjan that she could only marry him if he converts to Islam. In all the ways, Niranjan failed to make a balance between the two strong cultural impediments which he compromised by killing himself in the end. His friend Hossain informed a crucial context;

> *Niranjan told the family that he wanted to marry the girl. But his family didn't agree and put him under a lot of pressure for not doing that. His family members also told him that if he did it, all his family members would commit suicide. Then he might have thought that as he was causing problems in the family, so he had better kill himself. That is how that incident took place.*

Babu, aged around 25, committed suicide by hanging from the same rope as his sister-in-law Rinki. Babu used to maintain a romantic relationship with his sister-in-law. This case of pact suicide drew huge public attention because of a socially taboo issue—"brother-in-law and sister-in-law (*Shalika-Dulabhai*) romance episode." Babu married Rinki's elder sister Ruma in 2014. The couple were living happily until their baby was born in 2016. Then after, Babu lost interest in Ruma and gradually became romantically involved with his unmarried sister-in-law Rinki. At one stage, both of them eloped from home, but the community leaders managed to bring them back home after a

few days. A local arbitration was arranged on this issue. Babu was physically punished and charged with a penalty. After the event, Babu felt humiliated and managed a time to hang to death along with his fiancé. Babu's mother Salma said;

> *They arranged a big arbitration on the issue. My son was beaten severely and insulted in a disgraceful manner. As if, my son did all the wrongdoings. That girl did not do anything. The arbitration charged us a penalty for Taka 10,000.*

4.3 Culture of Poverty

Some men went through life-long intricacies with their poor financial conditions. They could not perform the socially prescribed role of the family provider in an expected manner. They confronted huge pressure to maintain their family with their limited income. Eventually, they comprised their failure with suicide.

Alam, a 70-year-old agricultural sharecropper hanged himself to death. Throughout his life, Alam did not have good financial means and had to fight poverty so intensely. While approaching old age, his physical condition gradually became worse. He lost the ability to work on the field. Finding no other means, Alam borrowed money to maintain the family. Unfortunately, this loan became a bone of contention as he could not repay it on time. The COVID-19 lockdown further deteriorated his financial condition. He had no way to recover. Finally, he took his own life to release his burdens. His nephew Zalal mentioned;

> *He borrowed a good amount of money from the association. Once the association finally pressured him for paying back the money within Tuesday of a week. The day he heard this, he committed suicide because he did not have any money at all.*

Abinash, aged 50, also killed himself due to his long-standing financial worries. Despite being a graduate, he did not find a suitable means of livelihood to his standard. Thereby, he had to do tuitions in the local areas. By no means, he could ensure financial comforts for his family. Money was also desperately needed for the medication/treatment of his throat tumour, treatment of his wife, and to bear the educational expenses of his children. He borrowed money and got very frustrated. With all the troubles in mind, he finally decided to commit suicide. His neighbour Hironmoy commented;

> *He escaped from the society. Men should fight, not end their lives. He was a coward. All have sufferings in their own lives. We must be more courageous and fight. Suicide can never be a solution.*

4.4 Culture of Materialism

Few men committed suicide for failing to acquire material gains. Acquiring material success was symbolically important to demonstrate their manhood. For example, Faruk, aged approximately 19, died by hanging. He had unnecessary demands for money and often forced his father to provide him with money. He was demanding a bike for more than a year. He was very crazy about riding a motorbike with his friends. Meanwhile, his father purchased a piece of land for the family which he disapproved of as he desired his motorbike. Afterwards, his father attempted to borrow money for the motorbike, but failed. Finally, Faruk killed himself as he could not purchase a motorbike. In fact, having a motorbike was a prestige issue for Faruk in the circle of friends and peers. Faruk's father Jalal commented;

> *I think boys these days are more disorganised. They want to show people that they have motorcycles. Every young man in our neighbourhood has a motorcycle. This is a social problem.*

Amir, an 18-year-old unmarried family-oriented young man, took his life by hanging. Taking good care of the family was always considered a solemn duty by him. From a very young age, he used to do different kinds of work to bring comfort to his family. Despite the financial condition of the family was not bad, he had a strong commitment to improve the condition. During the marriage of Amir's sister, his father sold the only piece of land that the family owns. Amir became so disturbed by this loss. Although he had no financial ability to buy the land again, he was keen to get it back. Often he used to persuade his father to take some loan to buy this land. One day, during supper he had some hot talks with his father on matters of land and property. Afterwards, he went out of his home and hanged himself to death from a nearby tree. His aunt Srea said;

> *You don't need 100 reasons to commit suicide, isn't one enough? Yes, he committed suicide due to the land issue. At least he understood that land is the most precious asset for a man. He thought it is worthless to live without having any asset as a man.*

4.5 Culture of Social Dignity

Each culture has a strong sense of social dignity. Losing dignity or being involved in the process of breaking the boundary of dignity can cause a deleterious effect on any person. Hasan, aged 65, killed himself by hanging as he lost his dignity when caught red-handed for sexually abusing his elder brother's minor granddaughter. Most of the villagers were disturbingly shocked by this incident caused by an aged person. Hasan was known to be a very gentle and pious person and had no previous record of misbehaving with anyone in the village. The whole episode made the society exceedingly embarrassed, and

so on Hasan. Soon after the incident, Hasan somehow managed to leave the spot secretly. On the following morning, he was found hanging to death from a mango tree far from the village.

His brother Rafiq said;

> *He felt ashamed that he is an old man caused such an incident. Then everything became known everywhere. Then a realisation worked in his mind that he would never show his face to anyone again. With this in mind, he committed suicide.--- He might have thought that he made a great mistake. Then he thought of taking his own life.*

4.6 Culture of Male Control

Being a patriarchal society, husbands usually tend to control their wives in Bangladesh. However, a few incidents went against this norm. For example, Palash, aged 19, quickly developed bad terms with his wife after the marriage. The relationship turmoil made him depressed and annoyed. Gradually, he lost control over his wife. Failure to control his wife eventually developed suicidality in him. His friend Gias depicted the preceding event of suicide in the following;

> *That day he quarreled with his wife over the phone over the issue she had been talking for long. He repeatedly asked her about whom she was talking to for long, but she was too stubborn to answer that. ----- After ending the conversation over the phone, he sat beside me in a depressed mood and asked me to take some marijuana together. I could realise that he was acting like a madman. I should have informed others about his mental condition that day. If I did that, then he could have been saved from committing suicide. I still regret that I did not do it that day.*

5 Cultural Considerations in Suicide Prevention and Research in Bangladesh

Sadly, Bangladesh grossly lacks in formulating a national suicide prevention strategy. There is no central suicide surveillance and monitoring system. The existing interventions are seemingly so sporadic and only exist at some levels of the country—often unknown to the mass population. The culture of help-seeking is extremely underdeveloped in Bangladesh (Arafat, 2019a; Arafat, Saleem et al., 2022). In fact, the help-seeking culture is grossly impacted by the low-level literacy or knowledge about suicidality of the general population. The country has not been able to develop a culture of suicide literary (Arafat, Hussain et al., 2022). The strong prevalence of social stigma and less attention to inform people regarding the risks and protective factors about suicide has failed to highlight the urgency to formulate national intervention strategy in Bangladesh (Arafat, Mohit et al., 2021). It is equally dismal to note that scholarly efforts to appropriately study the risk factors of suicide in Bangladesh have not been exposed to that level given the fact suicidal acts in

Bangladesh can be exacerbated not only by individual/biological factors, but by social/cultural factors as well (Arafat, Saleem et al., 2022). Any intervention that is not informed by scholarly efforts will not be able to make the expected imprints. Then again, scholars in Bangladesh take it as a prevailing norm to examine suicide through individualised or medicalised lenses (psychological/psychiatric). The structural (social/cultural) perspectives of suicide are vehemently marginalised as a research focus (Khan, Ratele and Dery, 2020). Given the importance of the cultural dimensions of suicide, future research and interventions in Bangladesh must include these structural issues as a priority so that a better linkage between knowledge and practice be developed. Scholars have pressed the importance of studying the cultural aspect of suicide and viewed that a meaningful understanding of the cultural context of suicide will appropriately guide the professionals to frame services that are culturally more differentiated (Cloucci, 2013; Goldston et al., 2008).

6 Conclusion

Bangladesh lacks exclusive knowledge on the cultural perspectives of suicide. This chapter travels in diverse ways to situate the connection between culture and suicide in the context of Bangladesh. Although the key focus is Bangladesh, it also discusses pertinent cross-cultural evidence to express the relationship between suicide and culture. This write-up expresses the relevant information from the existing scholarship including some findings from a recently conducted study on male suicide. Culture is an important sociological/anthropological concept that perpetuates every aspect of human behaviour including suicide. It is suggested that suicidal acts in Bangladesh are vividly embedded in various cultural ingredients such as religious faith, legal context, demographic profiles, methods, gender dimensions, interventions, and research, to mention a few. In terms of limitations, it must be noted that this analysis cannot inclusively contextualise the interface between suicide and culture in Bangladesh due to the dearth of relevant/specific literature. Both macro and micro/community level studies are needed to examine cultural factors affecting suicide. Although being a Muslim majority country, different groups of the population with diverse socio-cultural identities are also living in this country. While developing an effective national suicide intervention strategy, Bangladesh must prioritise and accommodate the cultural scripts of suicide situated for various cultural groups. Culture as a social fact might have different meanings to different groups, and so on it might affect suicidal acts of different groups in different manners. Furthermore, it is imperative to develop regional and group-specific small-scale culturally sensitive and appropriate interventions so that vulnerable people find help-seeking platforms available at their doorsteps. From the perspective of intervention, this could be one of the ways through which the culture of shame and culture of low literacy about suicidality be redressed.

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CHAPTER 5

Media Reporting of Suicide in Bangladesh

Asibul Islam Anik

Abstract Depending on the quality of suicide reporting, media can have both positive and negative impacts on suicidal behavior, especially among the vulnerable population. Suicide reporting quality in Bangladesh differs across print media, online news platforms, and motion pictures. Media professionals hardly follow World Health Organization (WHO) recommended guidelines while reporting suicides. In addition to the lack of a national suicide prevention strategy, there are also some other challenges of responsible media coverage in Bangladesh. This chapter will explore the quality of suicide reporting in Bangladeshi media, WHO-recommended suicide reporting guidelines for media professionals, and the challenges of responsible media coverage of suicidal events. Furthermore, several noteworthy recommendations that will be supportive while developing the national suicide prevention policy have been discussed.

Keywords Media reporting · Suicide in Bangladesh · Newspaper reporting · WHO · Movie · Drama

A. I. Anik (✉)
Department of Research and Evaluation, SAJIDA Foundation, Dhaka, Bangladesh
e-mail: anikra93@gmail.com

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1 Introduction

Suicide is a preventable public health issue with wide-ranging social, emotional, and economic consequences. Every year, over 700,000 people die by suicide throughout the world, and in 2019, World Health Organization (WHO) reported that more than one in every 100 deaths (1.3%) happened due to suicide (World Health Organization, 2021). South-East Asia had a higher suicide rate (10.2 per 100,000) than the global average (9.0 per 100,000 (World Health Organization, 2021). In 2019, nearly 6000 persons died by suicide in Bangladesh (World Health Organization, 2021).

Risk factors for suicide include mental health issues, financial strain, poverty, trauma, abuse, unemployment, prejudice, emotional anguish, life crises, chronic physical ailments, a lack of support, a lack of access to treatment, and so on. On the other hand, access to mental healthcare, family and community support, socioeconomic possibilities, ethical and responsible media coverage, awareness-raising, and stigma reduction could be considered as the protective factors (Suicide Prevention and Implementation Research Initiative [SPIRIT], 2021). Hence, the contributing and preventing factors of suicide are complicated and not completely understood, but scientific evidence from numerous global experiments demonstrates that media coverage of suicide can occasionally result in contagion, with higher suicide rates across a population (Niederkrotenthaler et al., 2010; Stack, 2020). After analyzing 31 studies around the world, Niederkrotenthaler and his team (2020) found that media coverage of celebrity suicide tends to accelerate the overall suicide rate in the general population by 8 to 18% within the next 30 to 60 days, and if the coverage explicitly mentions suicide method, used by the celebrity, the likelihood of applying the same suicide method increases by 18–44%. But such types of incidences or associations with suicide were not observed in general suicide reporting (Niederkrotenthaler et al., 2020). On the other hand, the likelihood of imitative (copycat) suicide may be reduced by offering beneficial educational material and coping mechanisms.

In Bangladesh, suicide has been widely publicized in online news portals and vividly dramatized in Bangla films, resulting in an unprecedented impact of media on suicide among mass population. Given the foregoing, the WHO and the *International Association for Suicide Prevention* (IASP) have recommended several guidelines for media reporting on suicide, particularly for use in countries where national standards do not already exist (World Health Organization and International Association for Suicide Prevention, 2017). This chapter aims to discuss how suicide is portrayed in Bangladeshi media, what are the media guidelines reporting suicides in Bangladesh, and what are the challenges of implementing these guidelines, along with further recommendations.

2 Role of Media on Suicidality

For never was a story of more woe than this of Juliet and her Romeo.

—William Shakespeare, Romeo and Juliet

The impact of mass media reporting on suicide has always been a controversial issue for a long time (Niederkrotenthaler et al., 2010). Goethe's novel *Die Leiden des jungen Werthers* (The Sorrows of Young Werther), published in 1774, was one of the earliest acknowledged documents which gave rise to the connections between the media and suicide. In the novel, Werther shoots himself with a revolver after he has been rejected by the woman he loves, and soon after the publication of this novel, several suicidal events of young men were reported using a similar technique to kill themselves in acts of hopelessness. Hence, the concept "Werther effect" was developed and later it was used in the technical literature to designate 'copy-cat' suicides (Myers, 2012). On the contrary, it has also been observed that media discourse sometimes supports suicide preventive efforts by educating society about the management of mental illness and suicidality. Such protective approaches had been termed as 'Papageno effect' (Niederkrotenthaler et al., 2010), which refers to Mozart's opera *The Magic Flute* (1791), where a boy in love became suicidal, but survived owing to the intervention of his friends.

The suicidal tendency influenced by the media descriptions is potentially more far-reaching than direct person-to-person propagation. Social scientists and psychologists have developed several theories which can explain both direct and indirect roles of media behind these suicidal tendencies and/or ideation. According to *Behavioral Contagion* theory, behavioral contagion in a society refers to the spread of a particular behavior through a group of people or a medium, and the propensity of an individual to copy that behavior is motivated by those (group of) people who are either nearby or to what (medium) they have been exposed (Wheeler, 1966). Though this theory was originally employed to explain unpleasant features of crowd behavior, behavioral contagion is now also concerned with the spread of media circulation and online information. *Social learning theory*, another platform for understanding parts of suicide contagion, is shaped by imitating or modeling others' behavior (Bandura, 1969). Imitative learning is influenced by several factors, including the behaviors and norms of the model (e.g., any celebrity) and rewarding outcomes or consequences associated with the observed behaviors observe the positive outcomes (e.g., public attention) others receive from such behaviors. Additionally, suicide contagion can also be conceptualized using a public health or infectious illness model of contagion. In this model, the role of agent (i.e., the model), host (i.e., vulnerable individual), and environmental characteristics (e.g., mental health disorder or social anxiety from parental and/or peer pressure) play in the overall transmission process (i.e., suicidal ideation or suicide) (Gould, 2001). However, based on the interactions of these three

theories, the following discussions will depict the impact of media on suicide contagion.

Both print media and broadcast media frequently report suicide by glorifying the death—describing in stories and/or in graphic details. Such irresponsible reporting to augment the newsworthiness and sensationalization of the event could be a grave risk for people who have already attempted suicide in the past. These editorial tactics might be ok for most people, but the few people who are struggling with depression or being mentally vulnerable, and contemplating suicide might be encouraged by these descriptions and then take the action (i.e., suicide), since someone else has already done it. Additionally, if there is a celebrity suicide published with the means of suicides, and sensationalized in a reporting style, then there might be an increase in the suicide rate. From the analyses of 42 research articles, it was found that studies that measured the influence of a celebrity suicide narrative were nearly 14 times more likely to identify a copycat effect than those that did not (Stack, 2002). This finding might explain the dramatic increase in suicide hotline calls in the month of Chester Bennington's suicide (in 2017), a world-renowned singer. For this situation, several mental health experts have blamed media reporting, since journalists prominently highlighted the method of his suicide, even in the headlines of the newspapers (Schonfeld, 2017).

When newspapers, films, and television portray the report of a suicidal event, and a child or a mentally vulnerable person is reading the details of that event, that particular child or person is indirectly learning another method of suicide. In this way, copycat suicide is mostly accountable to the media, and people learn suicide manuals from the newspaper and television reports of actual suicides. Consequently, after hearing or reading about suicide from the media, people who are vulnerable consider the incident as a glorified example, one of the simplest methods to find relief from all the existing issues, and self-assume that they also have the permission to do it.

The *Werther effect* not only forecasts an increase in suicide, but it also predicts that the majority of suicides would occur in the same or similar manner as the one reported. The effect gets amplified if people find that the publicized suicide was committed by someone in a position similar to their own. Most of the people who have already attempted to kill themselves are ambivalent, and they just want relief from their surrounding pressure. For example, in the US state of New Jersey, a 12-year old student who has been continuously bullied at school died by suicide. And immediately after this incident, the higher authority of that school took strict and adaptive measures to stop bullying at any level (BBC News, 2018). However, seeing this publicized incident with detailed background on television and/or in newspapers, other teenagers or students who are also experiencing bullying at their schools could relate to the story and be more likely to see themselves going down the same path. They see that suicide is bringing a glamorous end with an appropriate solution, along with the deceased getting sympathy and attention that they did not receive at school.

Surprisingly, a specific age group and timing were found to be influenced significantly by such suicide contagion. Younger and older people, but not middle-aged adults, appeared to be the most vulnerable group to this effect. It was found that in western countries, there's a 1–2% variance in suicide rates, 5% for adolescents, which occurred due to media reporting (Sanger-Katz, 2014). The numbers may be small but some quick calculations might clarify them better. For example, in 2016, globally, an estimated 817,000 people died by suicide (Naghavi, 2019). Here, even a change to 2 or 5% would have been associated with a reduction of 16,340–40,850 deaths, respectively. Again, in terms of timing, most suicidal actions tend to happen in the days and sometimes weeks following the suicide of a celebrity, and in exceptional cases, an extended degree of suicidal thinking may remain for up to one year (Sisask and Värnik, 2012). For example, after Marilyn Monroe died from a suspected suicide in 1962, the national suicide rate increased by more than 10% in the year following her death.

Nevertheless, news stories focusing on the adverse effect of suicidal ideation, but not accompanied by a suicide attempt or completion may have a protective effect, which is '*Papageno effect*'. But such protective reporting mostly comes in a 'Thematic frame' (i.e., in Editorial or Ed-Op pages), and eventually reduces the quantities of sensationalist reporting and the so-called 'newsworthiness'. It has been found that in newspapers, a presentation or a true story of how individuals had overcome suicide thoughts may increase and emphasize the concept of 'going on living' (Niederkrotenthaler et al., 2010). Simultaneously, self-motivating and 'think it again' based approaches become more successful when newspapers, televisions, and films portray the stories of people who avoided suicidal thoughts and instead used practical coping mechanisms in difficult situations of their lives.

3 Media and Suicide in Bangladesh

In South Asia, one of the world's most densely populated regions, media reporting of suicide is imbalanced. In Bangladesh, the situation is considerably worse due to poor and irresponsible inspection before publishing such incidents (Arafat, Kar et al., 2020). Both print media and online media are seen widely as popular means of disseminating information (Azad, 2021). In 2022, nationally (based in the capital city, Dhaka), there were 41 registered English language newspapers, 217 Bangla newspapers, and more than 100 online news portals (Department of Films and Publications, 2022; USAID, 2022). There is always an explicit difference between newspaper circulation in urban and rural areas of Bangladesh, depending on the literacy rate and purchasing capability. Again, compared to the previous two decades, the overall newspaper (print version) circulation throughout the country is getting low because of the 24-h television news broadcast, easily accessible internet service, and faster news availability through online news portals and social media. The readership rates have also been declining since the last decade, i.e., readership rates were

26.9% in 2011, 25.6% in 2015, and 23.8% in 2016, with a dramatic decline after 2018 (nearly 15%) (Azad, 2021). Unlike the Bangla newspapers, both the circulation and readership rates are significantly lower for English dailies. In total, the daily circulation of Bangla newspapers is around 1.5 million copies, whereas 10 leading national dailies possessed over 90% of the total circulation. Contrarily, the circulation of English newspapers is around 70,000, and among them, *The Daily Star* has a major share of (77%) of the total English circulation (Department of Films and Publications, 2022; Azad, 2021).

In terms of circulation, to date (September, 2022), *Daily Bangladesh Pratidin* (521,211/day), *Daily Prothom Alo* (321,841/day), *Daily Jugantor* (290,250/day), *Daily Ittefaq* (290,200/day), and *Daily Janakantha* (290,200/day) are the top five circulated Bangla newspapers; and the *Daily Star* (29,450/day), the *Financial Express* (22,500/day), and *Daily Sun* (22,000/day) are the top three circulated English newspapers in Bangladesh (Department of Films and Publications, 2022). Since the circulation of some leading newspapers is stable and still significant, the print press is considered as the most influential and traditional media of information sharing and plays a crucial role in opinion-building throughout the society. Based on this fact, social scientists, media experts, and policymakers have recently investigated the quality and style of these media reporting on suicide or any other socially sensitive events. According to these investigations, it was found that misinformation can be spread by the poor media reporting style; for example, by providing simplified, mono-causal explanations that indicate suicide is a solution to immediate triggers rather than being associated with a complex array of proximal and distal risk factors (e.g., psychiatric disorder, child sexual abuse, and social/religious attitudes toward suicide) (Anik et al., 2021; Hawton and Heeringen, 2009).

In the last 5 years, several studies using data from newspaper reports (Shah et al., 2017; Arafat et al., 2019; Arafat, Khan et al., 2020; Arafat, Mali et al., 2020b; Arafat, Kar et al., 2020) have assessed the quality of media coverage on suicidal behavior in Bangladesh (including print and online platform). These studies are considered the most circulated daily national newspapers (both Bangla and English) in Bangladesh. While assessing the quality of suicide reporting in terms of print media, online news portals, Bangla vs. English media, and movies and/or dramas, these studies focused on the likelihood and/or presence of revealing the identity of the suicide victims (likenames and addresses) and their occupations; mentioning the details of suicide methods; indicating the occurrence places and time; discussing the leading factors and life events; describing suicide notes; mono-causality; using the term "suicide" in the headline; printing the pictures of the events, etc.

On the other hand, due to the unavailability of a suicide central database in Bangladesh, many social scientists conduct suicide-related research based on the media-reported suicide data (Arafat, 2019). The reported suicide rates and characteristics of suicidal behaviors in media are not entirely representative of actual suicides in the broader population (Armstrong et al., 2019).

Studies showed that suicides involving women, aged under 30 years, divorced or widowed males, unmarried females, students, and those using lethal suicide methods were significantly over-reported in print media, relative to their occurrence in the broader population (Armstrong et al., 2019). These types of discrepancies may lead the mass population to develop misunderstandings about current suicidal behavior in their society. Therefore, the accuracy of newspapers' suicide reporting as well as studies that have been done using media-based suicide data must be viewed with caution.

3.1 Quality of Suicide Reporting in Print Media

In order to determine the newspaper representation of suicidal behavior, Arafat , Khan et al. (2020) assessed the content quality of suicide cases reported in six daily newspapers in Bangladesh. Their study found on average, that these newspapers publish at least two suicide cases daily, and the mean length of those articles was 11.3 sentences. In the story details, almost all the articles mentioned suicide methods, and more than three-fourths of the articles reported how those methods were employed during the act. Another study (Arafat, Mali et al., 2020b) showed that among the 403 suicide reports from six daily Bangladeshi newspapers, 92% stated the name of the deceased person and 82% mentioned their occupation. Additionally, description of the suicidal method (71%), 'suicide' in the headline (46%), mention of life events (21%), and report on mono-causality (16%) were also prominently stated in the news stories (Arafat, Mali et al., 2020b). None of the studies mentioned any potentially helpful reporting practices, such as expert opinion from a mental health professional, thematic reporting/statistics related to suicide, mentioning a suicide prevention program/support service, or any contact details for a suicide support service, etc., among their selected suicide news stories (Arafat, Khan et al., 2020; Arafat, Mali et al., 2020b). Such reporting approaches are unintentionally conveying the message of suicide execution methods to vulnerable populations who may be experiencing suicide ideation while missing opportunities to educate and raise awareness of the public against suicide.

3.2 Quality of Suicide Reporting in Online News Portals

Due to the rapid digitization in Bangladesh, a recent boom in online media portals has been observed. A few studies have analyzed the quality of suicide coverage in online news portals. Arafat et al. (2019) analyzed published contents of eight Bangla online news portals that focused on the availability of suicide news, and found that nearly 85% of the reports were related to suicide, with 93% reporting a single suicide. 95% of the stories mentioned the means and methods of suicide, and about 70% highlighted the deceased person's life circumstances that led them to the ultimate decision. Approximately, 20% of the news portals mentioned the means and methods of suicide in the headlines, and 32% described the life events of the deceased person in the headline.

14% of news portals presented the photo of suicide victims, which was rare in print media. Another study from Bangladesh reviewed four online news portals (Arafat, Mali et al., 2020a). It was observed there was significant non-adherence to WHO recommended suicide reporting guidelines and potentially detrimental and harmful aspects, such as the victim's identity and occupation, the method used, and the deceased's pictures were explicitly disclosed (Arafat, Mali et al., 2020a). Both studies (Arafat et al., 2019; Arafat, Mali et al., 2020a) showed that there was no inclusion of expert comment, stress coping strategies, preventative program, educative information for people, or help-seeking contact information (i.e., address or phone number of a help center) provided in any of the news stories. Therefore, one can imagine how poorly and unethically the online news portals are continuously reporting on suicidal behavior in Bangladesh if compared with any standard suicide reporting guidelines.

3.3 Bangla vs. English Daily Newspapers

In Bangladesh, apart from the number of circulation and readership rates, there are some distinguishing features and qualities between Bangla- and English-language newspapers, regarding suicide. Bangla-language newspapers usually publish more suicide-related stories on daily basis compared to English-language newspapers (Arafat et al., 2019; Arafat, Khan et al., 2020; Arafat, Mali et al., 2020b). For example, in 2017, nearly 40% of suicide articles were reported in just *The Daily Jugantor* (Bangla-language newspaper), whereas one of the leading English-language newspapers (*The Daily Star*) published only 6.1% (Arafat, Khan et al., 2020). Additionally, Bangla-language newspapers tend to publish particular suicide cases repeatedly or more than one time, which is rarely found in English-language newspapers. However, there are some other underlying factors that make a significant difference between the qualities of Bangla- and English-language newspaper coverage styles. Firstly, we can consider the relationship between readability and readers of a newspaper agency. In Bangladesh, newspaper content quality and business success are not linearly correlated (Genilo et al., 2016). Again, the Bangla and English newspapers have separate readership bases (Azad, 2021). People from all socioeconomic statuses, either from rural or urban, with minimum literacy, read Bangla newspapers; whereas English language papers are read by educated urban readers. So when a journalist and/or an editor from an English newspaper try to report sensitive issues (like suicide), they become more concerned and rigorous about the quality of the content and try to follow any relevant guidelines. That is why English newspapers in Bangladesh might have a small circulation, but most importantly, they have educative value and a big impact on social development (Genilo et al., 2016). On the other hand, the number of circulation matters for most of the Bangla news agencies. It is well known that story sensationalization increases newsworthiness, which ultimately increases overall readability. Since a small amount of readability

augmentation can greatly increase the circulation of a newspaper, most journalists and news agencies just focus on the quantity of episodic news coverage, rather than the quality and thorough evaluation of their reporting style. That is why, in most sensitive cases like suicide or child sexual abuse, Bangla newspapers frequently try to create a false hype and sensation of that event by publishing the unethical details of the incident (Anik et al., 2021; Arafat et al., 2019). Secondly, although WHO have proposed some general guidelines on suicide reporting for journalists, none of the news organizations in Bangladesh have established their own code of conduct or guidelines on how suicide reporting should be. Additionally, a considerable proportion of local journalists are unaware that there are any suicide reporting guidelines for media professionals. But there is a plausible reason behind the fact. Training and short courses on regular basis can help journalists, editors, and gatekeepers to become well-concerned regarding the existing suicide prevention activities in Bangladesh. Where most of the English news organizations offer training and workshop to their journalists to upgrade their credentials and globalize their reporting style, such proactive approaches are rarely found among local newspaper agencies (Hossain and Islam, 2012; USAID, 2022). So a large number of local journalists remain unaware of the suicide reporting guidelines, and eventually, they report suicidal behavior in a careless-sensational manner. For these reasons, unlike English newspapers, Bangla newspapers tend to report suicide cases with unnecessary terrible details and fail to adhere preventive approaches to educate the population about suicide.

3.4 Suicide Depiction in Bangla Motion Pictures

Suicidal behavior has commonly been depicted in Bangla movies and dramas. Arafat, Jalil et al. (2022) recently conducted a study where Bangla movies and dramas with suicidal scenes and scripts were searched on YouTube. They found that in movies and dramas, younger adults were the prominent victims; suicidal attempts (both fatal and non-fatal) were commonly depicted in the leading roles (i.e. heroes and heroines); hanging followed by jumping in front of the train was frequently shown as the suicide method; home was the commonest place of attempts; and females played the roles of taking most suicide attempts. Bangla movies showed that premarital/extramarital affairs and sexual harassment were the most prominent causes of suicide. Some movies depicted the scene of attempts being carried out, and a quarter of the contents normalized or justified the suicide attempts in their stories. None of the movies/dramas educated the public about the preventive aspects of suicide; only a negligible number of contents featured anecdotes on coping techniques with life difficulties or suicidal ideas and how to get support from psychologists or any tele-counseling centers (Arafat, Jalil et al., 2022).

4 Media Reporting Guidelines

WHO has stressed on positive and responsible coverage of suicide cases which encourages help-seeking behavior, raises awareness of suicide prevention, provides experiences of people who have overcome suicidal thoughts, or promotes coping methods that can help reduce suicides and suicidal behavior (World Health Organization and International Association for Suicide Prevention, 2017). Recently, both general and country-specific media guidelines have been developed for the concerning bodies of media organizations and professionals, which are applicable to reporting across all types of media. Along with the general guidelines provided by WHO and other similar organizations, another India-based international research organization SPIRIT (Suicide Prevention and Implementation Research Initiative (SPIRIT), 2021), has compiled and adapted some worldwide established suicide reporting guidelines in media. However, some of the well-recognized suicide reporting guidelines documented across the world have been mentioned as follows:

1. *Document*: Preventing suicide: a resource for media professionals, update 2017;
   Organization: World Health Organization; *Year*: 2017
2. *Document*: Reporting suicide and mental Illness: A Mind-frame resource for media professionals; *Organization*: Hunter Institute of Mental Health, Newcastle; *Year*: 2014
3. *Document*: Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper; *Organization*: Canadian Psychiatric Association; *Year*: 2017
4. *Document*: Journalism Resource Guide on Behavioral Health; *Organization*: The Carter Centre; *Year*: 2016
5. *Document*: Suicide Prevention: Information for Media Professionals; *Organization*: National Institute of Mental Health and Neurosciences, India
6. *Document*: Media Guidelines for Reporting Suicide; *Organization*: Samaritans; *Year*: 2020
7. *Document*: Reporting on Child Suicides; *Organization*: SNEHA- Suicide Prevention Centre, Chennai

4.1 WHO Guidelines

The suicide reporting guidelines, recommended by WHO (in 2017), are generally designed in terms of any form of media coverage. But, particularly some recommendations are more applicable to print media or digital platforms. And, as a limitation, these guidelines do not practically address issues concerning websites, movies, dramas, or stage plays. The following box represents the WHO recommended **do's** and **don'ts** (as guidelines) for media professionals and editors while reporting on suicide events in media (Table 1).

4.1.1 Brief Descriptions of WHO Guidelines

Provide accurate information about where to seek help Suicide-supportive information (such as counseling centers and helplines, suicide prevention and/or awareness centers, 24/7 emergency helplines, official contact addresses of mental health and welfare professionals, and self-help groups) should be mentioned at the end of all suicide coverage. Most importantly, those mentioned addresses or contact information should be regularly checked to ensure accuracy. And, one phone number or one contact address/website should be provided rather than a long list of potential resources, since it could be counter-productive.

Educate the public about the facts of suicide and suicide prevention, without spreading myths Media reports that repeatedly publish misconceptions and/or myths about suicide can trigger imitative behavior among the mass population. So, along with leading the facts about suicide while discussing suicide, it is also important to report on how to prevent suicide, and how

Table 1 Major excerpt of WHO media guidelines

Dos	*Don'ts*
• Do provide accurate information about where to seek help • Do educate the public about the facts of suicide and suicide prevention, without spreading myths • Do report stories of how to cope with life stressors or suicidal thoughts, and how to get help • Do apply particular caution when reporting celebrity suicides • Do apply caution when interviewing bereaved family or friends • Do recognize that media professionals themselves may be affected by stories about suicide	• Don't place stories about suicide prominently and don't unduly repeat such stories • Don't use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems • Don't explicitly describe the method used • Don't provide details about the site/location • Don't use sensational headlines • Don't use photographs, video footage or social media links

Source World Health Organization and International Association for Suicide Prevention (2017)

suicidal people and/or their families can seek help, about the accessibility of that help.

Report stories of how to cope with life stressors or suicidal thoughts, and how to get help Reporting on the personal accounts of individuals who overcame adversity and suicidality may inspire others in challenging and stressful life situations to follow similar positive coping mechanisms. Stories that integrate educative materials typically help people to focus on the positive sides of their lives, overcome their suicidal thoughts, and the ways to get help for the suicidal ones.

Apply particular caution when reporting celebrity suicides Reporting on celebrity suicides increases newsworthiness and readership for a specific point in time. But these reports induce vulnerable people toward copycat suicides. Hence, while reporting on celebrity suicides, specific points need to be taken care of. For instance, reporting style should not glamourize the suicide, avoid the description of the suicide method, and stop misinterpreting the cause of suicide/death. Instead of that, the focus should be on how that celebrity contributed to the community, and how their departure negatively affected others.

Apply caution when interviewing bereaved family or friends Several key considerations should be cautiously followed when collecting information from the family, friends, and others who have been bereaved by suicide and/or who may be in a grieving situation. For example, respect for the privacy of the relatives and friends of the deceased person instead of dramatizing the actual story, and disclosure of personal information or description of suicide notes (that might be unknown to the bereaved friends and families) should be avoided.

Recognize that media professionals themselves may be affected by stories about suicide As human beings, it is not uncommon that journalists from any setting can be resonated by their own experiences while reporting a suicide story. It is one of the obligations of media organizations to ensure the necessary support (such as debriefing opportunities) and mentoring arrangements (could be psychological counseling too) for the media professionals.

Do not place stories about suicide prominently and do not unduly repeat such stories In terms of print and online news media, suicidal stories should be presented on the inside pages, rather than on the front page highlighting the term 'suicide' in the headlines. On the other hand, for broadcast stories, news on suicide should be allocated either in the second or third break of television news, rather than as the lead item. Again, news editors and gatekeepers should be cautious during publication or broadcasting regarding the repetition or updating of the original story.

Do not use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems The presentation style and the reporting

language have a significant influence on a society's suicidal behavior. That is why reports on 'suicide rates' for a specific time period (thematic frame) is more preferable to reports on specific suicide detail (episodic frame). Suicide reports using thematic frames help people to convey the message that suicide is a public health problem, and indicate the risk factors, along with educating the public on suicide prevention mechanisms. On the other hand, the usage of 'successful suicide' or 'unsuccessful suicide' should be avoided, since they imply that suicide is a desirable outcome. Additionally, the term 'committed suicide' implies criminality, though suicide is not a criminal offense in most of the countries worldwide. In such cases, terms like 'died by suicide' or 'took his/her life' could be a better fit.

Do not explicitly describe the method used Any type of description or discussion of the method, such as name and number of the drugs taken for suicide, used tool (towel, knife, or blade, etc.), or any novel method that was applied for taking life, should be avoided in the coverage. Because this type of information might trigger a susceptible individual to follow and accelerate the suicidal behavior.

Do not provide details about the site/location Similar to the description of suicide method, indicating the suicide occurrence place, sometimes titled a "suicide site" (e.g., a bridge, a tall building, a residential well, a cliff or a railway station or crossing where suicidal acts have occurred) can influence the vulnerable person to imitate the act. Hence, media professionals should carefully report about the locations (if necessary) by not using sensationalist language to describe them or without mentioning the number of incidents that occurred at that location.

Do not use sensational headlines Since news headlines are aimed to attract the readers' attention by providing the abstract of a story in as few words as possible, the application of words like "suicide" should not be used in the headlines. At the same time, applying detailed references to the method or site of the suicide should be discouraged.

Do not use photographs, video footage or digital media links In terms of suicidal deaths, photographs, video footage, and social media or YouTube links of the suicide scenes along with the suicide location and/or method should not be reported in newspapers and/or TV. And, the disclosure of the deceased person (by suicide) should be discouraged or handled with great caution; i.e., placing the picture obscurely within the text, or not glamorizing the individual or suicidal act. And, suicide notes, final text messages, call records, social media posts or emails of the deceased persons should be kept hidden from the public.

4.2 Suicide Reporting Guidelines in Media: Bangladesh Perspective

In a critical review study, where media coverage on suicide across some countries (Bangladesh, Canada, India, Ireland, Netherlands, Slovenia, South Korea,

Sri Lanka, and UK) was investigated, it was revealed that there were no help-seeking information and contact address (0%) available in the Bangladeshi and Sri Lankan suicide news stories (Stack, 2020). And, based on the recent findings (Arafat et al., 2019; Arafat, Kar et al., 2020; Arafat, Khan et al., 2020; Arafat, Mali et al., 2020b), none of the newspapers were found to follow the WHO guidelines while reporting suicide cases in the newspapers, regardless the print and/or online media. However, to improve the quality of media coverage of suicide cases in accordance with WHO guidelines, over the past five years, media experts, policymakers, and mental health experts from both government and nongovernmental organizations have been organizing training sessions and workshops targeting the media professionals of Bangladesh.

On September 2017, a 3 h training was conducted in Cox's Bazar among the local journalist regarding media reporting of suicide conducted by Humanity and Inclusion, an international NGO under the *Mental Health and Psychosocial Support (MHPSS)* program. In the training session, general physicians, mental health experts, counselors, and other health govt. and NGO professionals were the moderators who trained the local media professionals to assess and manage the mental health condition and suicidal behavior reporting using the Mental Health Gap Action Programme intervention guidelines (Momotaz et al., 2019).

In 2018, to motivate Bangladeshi journalists and encourage them on responsible reporting of suicide, WHO and the *National Institute of Mental Health* (NIMH, Bangladesh) conducted several workshops where media professionals, especially journalists and editors, from print and electronic media were present (WHO Bangladesh, 2018). In those workshops, the organizers trained media professionals on the WHO suicide prevention guidelines (World Health Organization and International Association for Suicide Prevention, 2017), i.e., the "Dos" and "Don'ts" to ensure safe and responsible media coverage of suicides in Bangladesh.

Again, in 2022, the World Health Organization (WHO) with the collaboration of the Directorate General of Health Services (DGHS), and the NIMH conducted three workshops (from 3 to 5 July 2022) with media professionals from more than 60 print and electronic and online media of Bangladesh (WHO Bangladesh, 2022). The prime agenda of the workshops was to enhance the awareness and capacity building of media professionals for appropriate reporting style of suicide news stories. Specifically, media professionals from the national English dailies (e.g., *The Daily Star*, *The Daily Sun*, *The New Age*, and *The Financial Express*), Bangla dailies (e.g., *Daily Prothom Alo, Bhorer Kagoj*, *Shmokaal*, *Bangladesh Protidin*, *Kaler Kantha*, *Jugantar*, and *Shangbad*), Bangla online news portals (e.g., *Bangla Tribune*, *BD News 24.com*, *Barta 24*, and *Jagonews 24*), and the electronic media (e.g., *Bangladesh National TV*, *71 TV*, *Nagorik*, *Boishakhi*, *ATN News*, *Ekkator TV*, *Banglavision TV*, *RTV*, and *GTV*) participated in the training workshop (WHO Bangladesh, 2022).

5 Challenges of Sensible Media Reporting in Bangladesh

Implementation of media guidelines while reporting suicide cases could be one of the effective approaches to reduce the possibility of copycat suicide in Bangladesh. Apart from the suicide reporting guideline implementation, there are several reasons in countries like Bangladesh behind such sensationalized and careless media coverage of suicide. However, the challenges faced by media professionals in reporting suicide cases with proper guidelines are outlined below.

5.1 No National Suicide Database

Though global databases, such as *World Population Review*, *World Bank*, *World Life Expectancy*, WHO, etc., record country-specific suicide rates, to date in Bangladesh, there is no central suicide database that could record suicide rates as well as causes, means, age, and sex-specific suicidal behavior, number of suicide attempts, etc., at the community level. Contrarily, there are many countries that have taken initiatives to preserve population base statistics on suicide at a smaller scale. Even in India, they have crime and suicide-related statistics published by the National Crime Records Bureau (NCRB) each year. That is why it is hard for Bangladeshi media professionals to write statistics or evidence-based suicide reports in a thematic framework. Since most of the details of the suicide reports we read are gathered from the family members, neighbors and workmates of the deceased, or police personnel, the news is portrayed from sociocultural, personal, and legal perspectives rather than psychological information (Arafat et al., 2021).

5.2 No Established Suicide Prevention Policies

Bangladesh also lacks suicide prevention strategies or policies. Existing government and nongovernment intervening programs for suicide prevention are extremely restricted, fragmented, and nearly invisible. Though a few suicide prevention action plans have been proposed, they are not officially established and validated (Arafat, 2018; Khan et al., 2021). Again, most of the suicide incidents are covered by criminal reporters. So, it would be a questionable approach if any reporter provides suicide prevention measurements in his/her own style.

5.3 Lack of Collaboration with Mental Health Professionals

Because of the shortage of mental health specialists in comparison to the population's mental health requirements, regular collaboration and discussion of media personnel with mental health professionals appears to be difficult while

producing any suicide coverage. At the same time, limited motivation, unavailability, and disinclination of mental health professionals, the scope of research in suicidal behavior is becoming narrower. Consequently, media professionals remain in the dark about how to convey suicide preventive strategies, coping mechanisms, and help-seeking messages while reporting suicide in print media and Television.

5.4 Negligence of Applying Suicide Reporting Guidelines in Local Media

Suicide reporting guidelines, recommended by WHO, are not properly reflected in national dailies, let alone in local newspapers. Though there have been a few workshops to provide training on how to report suicidal cases in media, the participants were mostly from the media platforms at the national level. Hardly any journalists from the local newspaper (either online or print version) participated in such workshops. That is why in Bangladeshi local newspapers, the quality of suicide news coverage is very low and indicating the frequent negligence of WHO reporting guidelines (Arafat, Khan et al., 2020).

5.5 Under-Estimation of Actual Suicide Rates in Media

Similar to other developing nations, suicide rates are under-estimated in Bangladesh due to the lack of adequate statistics and a central suicide database (Arafat, 2019; Armstrong et al., 2019). That is, the actual rate of suicide in Bangladesh is yet to come out and quality data remains a real challenge for the media experts, policymakers, researchers, and journalists to conduct scientific analyses using the actual data, to write suicide cases in the thematic frame, and to propose sustainable suicide reporting policies (Arafat, 2019).

5.6 Criminalized Legal Status

Since the act of suicide or suicide attempts is considered as a punishable criminal act in Bangladesh (The Penal Code, 1860; Act no. XLV, Chapter 309), crime reporters mostly cover suicide news stories in print and online media platforms. As a result, suicide is stigmatized, neglected, and the reporting style of suicidal behavior is overlooked from the mental health perspectives as well as the suicide reporting guidelines in media.

5.7 Ignoring the Social Variables Influencing Suicidality

In terms of suicide-provoking socioeconomic factors in Bangladesh (i.e., younger age, failure in examinations, family history of suicide, substance usage, problem in workplace, financial debts, one-sided affair and/or breakups, domestic violence, divorce, and mental illness), the media should place

a greater emphasis on the social reasons that led to the individual's suicide (Arafat et al., 2021; Arafat, 2019). This will also shift suicide from the sphere of mental disease to that of a 'social sickness', perhaps de-stigmatizing help-seeking. On the other hand, the media should highlight the relevance of local protective factors in lowering the risk of suicidal behavior. For example, it is believed that religious affiliation could be one of the important protective factors, particularly in Muslim countries, to discourage any attempt or act of suicide. But, this circumstance might also be contradictory (Hendin and World Health Organization, 2008). Hence, public should be informed by the media about local study findings on suicide that are relevant to their area.

6 Recommendations

In the National Mental Health Strategic Plan (2020–2030) of Bangladesh, the Ministry of Health and Family Welfare's Department of Non-Communicable Diseases has proposed to take action on the development of 'National Suicide Prevention Program' and the establishment of 'National Suicide Registry' (Department of Non-Communicable Diseases, 2020). Hence, the following recommendations might be worth considering while developing the National Suicide Prevention Policy, along with the improvements and expansions based on the feedback from media professionals and experts.

6.1 Adaptation of Suicide Reporting Guidelines

Journalists should cover suicide stories following the WHO-provided guidelines. At the same time, there are three considerations that journalists should keep in their mind (Sinyor et al., 2018): (a) Weigh the newsworthiness of the story against the public's need to be warned about possible contagion risk; (b) Take into account the impact of the report on those mentally vulnerable individuals who are thinking of suicide or potentially at-risk for suicide; and (c) A long-form reporting approach should be used to cover the issue since it gives journalists the chance to engage in nuanced conversation and may help them to avoid oversimplifying the leading factors of suicide.

6.2 Multisectoral Collaboration

Since journalists are the experts in their area, they must take the lead in responsible suicide reporting. But media organizations and authorities should have frequent meetings, roundtable discussions, and forums to discuss suicide and its reporting style in collaboration with mental health professionals on a regular basis. At the same time, multisectoral collaboration should be established by media professionals along with clinicians, social scientists, researchers, donors, social workers, voluntary organizations, nongovernmental organization, government, and/or any local organization connected with suicidality in Bangladesh.

6.3 Decriminalization

Decriminalization of suicide would help to de-stigmatize the existing problem, encourage appropriate care-seeking behaviors for suicidality, and eliminate unnecessary legal harassment. Because, already in many Asian countries, there have been changes in the legal system to decriminalize suicide and it has been considered an immediate priority (Suryadevara and Tandon, 2018). Finding out the appropriate prevention strategy along with decriminalization of suicide is immediately necessary to formulate, initiate, implement, and evaluate its effectiveness.

6.4 Health Reporters, Not Crime Reporters, Should Cover Suicide Stories

Since crime reporters exclusively use unnecessary details, including photos and description of the method and/or situation of the event; health reporters are more suitable to cover suicide stories by avoiding the glorification of suicide (especially for celebrity cases) and the content of suicide notes (Sinyor et al., 2018). Additionally, health reports are aware of the public health issues and they are most likely to report suicidal behaviors with help-seeking measurements. Hence, this practice will minimize the possibility of detrimental suicide reporting practices, and contrarily, it can make a positive contribution to suicide prevention in a country.

6.5 Training for the Journalists

Journalism schools and media organizations should incorporate teaching and training sessions on how to report suicide responsibly and respectfully, with an emphasis on ethics and social justice. Additionally, to make these ethical reporting practices sustainable, such training sessions and workshops should be conducted both for national and local (district level) journalists.

7 Conclusion

In this chapter, the role of media on suicidality, the quality of current suicide reporting style in media, the utilization of suicide reporting guidelines by media professionals, and the challenges of suicide reporting in media along with some recommendations have been discussed. While reporting on suicide cases, media professionals frequently reveal the identity of the suicide victims; mention the details of suicide methods; indicate the occurrence place and time; discuss the leading factors and life events; mono-causality; and used the term "suicide" in the headline to sensationalize and/or glorify the suicidal deaths. Such reporting approaches are unintentionally enhancing the likelihood of contagion suicides. Surprisingly, there were no expert comments, stress coping

strategies, preventative programs, educative information for people, or help-seeking contact information, etc., provided in any of the news stories that could effectively reduce the suicide rates and suicidal thoughts among the vulnerable individuals. Additionally, none of the newspapers (either print or online) followed the WHO guidelines while reporting suicide cases. Again, due to the lack of adequate statistics and a central suicide database, the actual rate of suicide in Bangladesh is yet to come out and quality data remains a real challenge for media researchers, psychologists, and policymakers. However, these efforts indeed warrant proactive and multisectoral collaboration within the country so that appropriate prevention strategies can be developed and implemented to ensure responsible suicide reporting in media.

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CHAPTER 6

Family and Suicide in Bangladesh

Salma Akter Urme, Md. Syful Islam, and N. M. Rabiul Awal Chowdhury

Abstract Suicide is a major preventable public health problem which is still a less prioritized issue in Bangladesh. Bangladesh is yet to develop a national suicide prevention strategy for reducing suicide deaths. There is a dearth of studies that focus on risk factors of suicide that are related to family and the consequences of suicide on close family members in Bangladesh. The common contributing factors of suicidal death are prior suicide attempt, physical and sexual violence, psychiatric disorders mostly depression, loneliness, personality disorders, family disharmony, marital discord, relationship crisis, financial hardship, substance abuse, and unemployment. Prevention strategies of suicide considering the family dynamics need to be explored. Supportive strategies such as hospitalization, engaging family members, gatekeeper interventions, developing awareness raising program, building healthy communication in the family, and postvention as prevention have been proposed by prior studies. In this chapter, we summarize all the relevant literature on family and suicide in Bangladesh and suggest way forward for suicide prevention and future studies in the country.

S. A. Urme (✉) · N. M. R. A. Chowdhury
Department of Anthropology, Comilla University, Cumilla, Bangladesh
e-mail: salmaakterurmee@gmail.com

Md. S. Islam
Department of Population Science, Jatiya Kabi Kazi Nazrul Islam University, Trishal, Mymensingh, Bangladesh

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1 Introduction

The rapid growth of suicidal death has been identified suicide as a public health problem worldwide that implies taking urgent actions to reduce the suicide rates (Mueller et al., 2021). Recent estimates (2021) of suicide found that 703,000 people die by suicide every year worldwide, which represents on average more than 1 death in every 100 deaths occurred by suicide (World Health Organization [WHO], 2021). Globally, suicide is one of the fourth leading causes of death among the young people aged 15–29 years for both male and female (World Health Organization, 2021). It has been estimated that approximately three fourths of suicide deaths occur in lower and middle-income countries (LMICs) due to the greater size of their populations and lack of resources for interventions for preventing suicide (Edwards et al., 2021; World Health Organization, 2021). Currently, suicide is the 4th leading injury-related deaths in Bangladesh (Khan et al., 2021). Despite a growing number of studies on suicidal behaviors in Bangladesh, there is no longitudinal, nationwide, interventional, and epidemiological study on suicide especially on suicide prevention (Arafat, Hussain et al., 2021). Majority of the previous studies explore the individual risk factors of suicide such as depression, substance use, prior suicide attempt, financial crisis, and so on (Frey and Cerel, 2015; Urme et al., 2022). But there is a need to assess the attribution of family in suicide and develop prevention measures to reduce suicidal behavior based on family dynamics (Arafat, Saleem et al., 2022; Edwards et al., 2021; Frey and Cerel, 2015).

Worldwide, the common age range of suicide is 15 to 44 years old, where suicide is rare before the age of 15 (Edwards et al., 2021; Urme et al., 2022). Bangladesh has the highest adolescent fertility rate among the South Asian countries and adolescent pregnancy impacts psychological health which increases the risk of suicide (Li et al., 2021). Family dysfunction, family conflicts, family socio-economic condition, family violence, and family stress are frequently associated with suicide risk behaviors for adolescents (Khan et al., 2020; Randell et al., 2006). A number of studies revealed that more than half of the suicides occurred due to emotional reasons within family (Reza et al., 2014; Shahnaz et al., 2017). Marital disharmony, family stress, extra and pre-marital issues, relationship strife, and poverty were found as most common risk factors within the family environment (Arafat, Hussain et al., 2021; Arafat, Saleem et al., 2022). Although there is a paucity of research on suicide prevention in Bangladesh, supportive and healthy family environment, raising awareness, gatekeeper involvement, identification of protective factors, continuity of care, and increase access to marital therapy were assessed

as prevention methods by engaging family members (Arafat, Saleem et al., 2022). Parental homework check would also be a prevention strategy for suicide among the school-going adolescents in Bangladesh (Khan et al., 2020). As there are no national surveillance system or suicidal database, criminal legal status, and social stigma, most of the suicide cases are underreported (Arafat, 2019; Arafat, Hussain et al., 2021).

Nevertheless, suicide prevention is often a less prioritized issue by governments and policymakers (World Health Organization, 2018). To promote mental health and well-being, suicide is an indicator of *Sustainable Development Goals* (SDGs) 3.4.2 which targets to reduce suicide by 33% in 2030 through enhanced prevention and treatment strategies (Khan et al., 2021). According to the World Health Organization (WHO), the role of family can positively contribute to mental health policies and practices (World Health Organization, 2018), which is especially significant for LMICs including Bangladesh that has a fragile mental health system (Arafat, Saleem et al., 2022; Edwards et al., 2021). Against this backdrop, this chapter will interpret the relationship between suicidal behaviors, within the family context that can be helpful in developing effective suicide prevention programs.

2 Family Structure in Bangladesh

Family is a culturally constructed unit which is a building block of social structure for all societies. Family is defined as a group of people who have interacted and communicated with each other by marriage, blood, or adoption, constructing a single unit and also shared common culture or common beliefs (Arafat, Saleem et al., 2022; Uddin, 2009). In Bangladesh, most of the families are governed by patriarchal lineage and males have the decision-making power where women are dominated by their husbands and as well as their in-law's family members. But through modernization and urbanization, there has been a change as women are involved in employment and playing a more active role in decision-making of families and societies (Arafat, Saleem et al., 2022; Bhandari and Titzmann, 2017; Samad, 2015; Zahangir, 2011).

The family structure and size are also changing in Bangladesh, from extended family to nuclear family because of the participation of women in economic activity which was rare before (Samad, 2015). Another study focused on the changing family patterns in Bangladesh demonstrates that fertility rate is declining by the role of family planning methods in both rural and urban areas. Furthermore, age of marriage is rising by reducing child marriage, increasing awareness about reproductive health, implementation of marriage-related laws, enhancing the education rate, and reducing existing social taboos on early marriage (Samad, 2015). With changing the rate of divorce in Bangladesh, a new family pattern single parenthood has been trending (Afroz, 2019).

The household size has decreased from 5.7 in 1981 to 4.2 in 2019 (Arafat, Saleem et al., 2022). About 35% of women in Bangladesh have experienced

domestic violence at home where their marital age, number of children, decision-making role in family, lack of support from family members, and household food insecurity are associated with this violence (Arafat, Saleem et al., 2022; Haque et al., 2020). Intimate partner violence is associated with such as sexually transmitted infections, long-term pain, perinatal mental health problems, substance abuse, stress, depression, anxiety, and suicide (Haque et al., 2020).

Bangladeshi families have a higher level of solidarity, interconnectedness, and amalgamation between the household members. Parents must look after their children before their marriage and sometimes even after marriage when the children are in an economic crisis in their in-law's household. The children, especially the male children, also take the responsibility of their parents after getting job. Bangladeshi parents decide what their children will do in future and the children follow their instructions without raising any complaints (Arafat, Saleem et al., 2022).

3 Risk Factors for Suicide in Bangladesh Related to Family

We discussed the risk factors for suicide in Bangladesh in the first chapter of this book (Kabir et al., 2023). Here risk factors related to family have been emphasized. The French sociologist *Emile Durkheim* explains that suicide is a social fact which occurs due to less social integration with family, friends and so on, and also lack of social norms and regulations on behavior would force to take lives by suicide (Mueller et al., 2021). Risk factors of suicide related to different aspects of family have not been extensively studied yet by the previously in Bangladesh (Arafat, Hussain et al., 2021). The previously noted common risk factors of suicide are previous suicide attempt, physical and sexual violence, psychiatric disorders (such as depression, anxiety and stress, personality disorders, substance abuse), hopelessness, loneliness, familial psychiatric history, familial suicide predisposition (such as not reared by biological parents, marital discord and family disharmony), relationship problems (like loss of loved one or loss of family relationship), financial hardship, and unemployment (Arafat, Mohit et al., 2021; Shahnaz et al., 2017; Feroz et al., 2012; Reza et al., 2014). Many of the risk factors of suicide are related to familial issues (Arafat, 2019). One study identified that approximately 93% of the participants took their own lives due to familial and marital disputes which were sorted by assessing newspaper contents (Shah et al., 2017). A community-based survey in selected rural areas of Bangladesh showed that 63% of suicide cases occurred due to family issues, among them 57% had a family conflict (Feroz et al., 2012). A case–control study found that 65.5% of suicides occurred due to family events including romantic relationship problem, death of a near kin, academic persecution, financial hardship, marital disharmony, family quarrels, and not reared by biological parents found by a case–control study in rural area of South-West Bangladesh (Reza et al., 2014). An extreme case

of family involvement was noted in 2007 where nine members of a family took their own lives together due to their delusion regarding religion (Selim, 2010). A narrative review study demonstrated that conflict between husband and wife, family discords, widowhood, broken family, and relationship break-ups were the leading causes of suicide (Arafat, 2017). Another study showed that exam failure, suicidal death of close kin, marital dispute, not raised by biological parents were frequently reported as the risk factors for suicidal behavior (Shahnaz et al., 2017). A recent psychological autopsy study found several life events related to family events such as extramarital affair, family conflict, marital discord, broken engagement (Arafat, Mohit et al., 2021). About 40% of the life events were closely related to marital and sexual affairs including conjugal strife, pre-marital romantic relationship, illicit love relationship, forcible wedlock, and contention with kins contribute suicidal ideation (Arafat, Mohit et al., 2021; Arafat, Saleem et al., 2022). In addition, there are also perceived a few risk factors of suicide relevant to parent-children subsystem such as early marriage, academic failure, death of children, romantic relationships, negative parenting, domestic abuse by the parents; and experiencing psychosocial, physical and sexual abuse by teachers or peers in schools (Arafat, Saleem et al., 2022). Another risk factor is sibling subsystems which may be affected by intrafamilial abuse such as sibling conflicts, financial issues, and family business failures (Arafat, Saleem et al., 2022).

4 Role of Family in Suicide Prevention in Bangladesh

Every suicide has impact on a family's well-being in various ways (Shahnaz et al., 2017). In other ways, engaging and involving the family members is vital to develop an effective suicide prevention program. Reducing suicidal tendency family members and care givers may play an important role by creating a supportive family environment, good communications between family members and strong relationships between them (Arafat, Saleem et al., 2022; Edwards et al., 2021). If the deceased person had a friendly environment in his/her family, that individual could share about his/her discomfort which can keep him/her far away from suicide (Edwards et al., 2021; Shahnaz et al., 2017).

A recent qualitative study which focuses on public university students of Bangladesh reported some suicide prevention strategies those are also related to family. For example, parenting skills training and workshops can be arranged at community level, ensuring follow-up care for the suicide attempt survivors by the support of family, raising awareness among all the general people through advertising and representing a drama are urgently needed for diminishing suicidal death (Urme et al., 2022). Stigma and taboo attached to mental health disorder patients and suicide survivors negatively play a role in both post-trauma counseling and suicide prevention (Arafat, Saleem et al., 2022; Shahnaz et al., 2017; Urme et al., 2022). The family-oriented prevention

strategies would be raising awareness, gatekeeper training, identification of protective factors, access to psychiatric services, treatment facilities for suicide patients, continuity of care, access to marital therapy, supportive family environment, and promotion of family interactions (Edwards et al., 2021; Zalsman et al., 2016; Arafat and Kabir, 2017; Arafat, Saleem et al., 2022).

4.1 Raising Awareness

There is a need to organize awareness raising programs regarding suicide and suicide prevention for educating the general population including parents and family members through mass media (Zalsman et al., 2016). Efforts could be aimed to increase suicide literacy, decrease suicide stigma, identification of risky individuals, and available nearby health services. The parents will be more interested to seek mental health treatment for their children when the existing myths are allayed from society (Arafat, Saleem et al., 2022; Edwards et al., 2021). Bangladeshi family prefer to hide the suicidal thought or death due to ignoring the social stigma and legal harassments, so arranging awareness-raising programs at community level would be beneficial (Arafat, Saleem et al., 2022; Arafat, Hussain et al., 2022; Urme et al., 2022).

4.2 Gatekeeper Interventions

Family members can play a role as a gatekeeper as they have a connection with their kin who have suicidal tendency. It is a potential preventive strategy by which the vulnerable populations can be identified (Zalsman et al., 2016). Additionally, family interventions help to identify the warning signs of suicide among the adolescents (Zalsman et al., 2016). So, a formal training for the gatekeepers must be arranged to execute a problem-solving discussion on how to reduce suicidal ideation, attempt, and death.

4.3 Enhancing Healthy Communication in Family

Everyone must have good communication and engagements with the family members by which parent–child conflict and sibling dispute can be reduced in the family environment (Arafat, Saleem et al., 2022; Edwards et al., 2021). An effective and supportive communication between the family members can support them to combat depression, anxiety, hopelessness, and suicidal behavior (Arafat, Saleem et al., 2022).

4.4 Life-Event Focused Couple Counseling

Marital conflict and familial discord are potential life events for the suicide exposures (Arafat, Khan et al., 2021). In addition, the spousal subsystem affects the parent–child or sibling subsystem, so organizing a program for the

couple's need which can be played a prominent role to keep a healthy relationship between family members. From this program, they can be benefitted knowing how to manage marital discords (Arafat, Saleem et al., 2022).

4.5 Follow-Up Care

Hospitalization or follow-up care is urgently needed for the suicide survivors who had prior suicide attempts. In this respect, information from the patients itself and also from close kin members is important to assess the risk factors of suicide (Edwards et al., 2021). Additionally, the time after the discharge from the hospital has been identified as a vulnerable period. Therefore, family members could be careful about the suicidal behavior during this period and should ensure the regular follow-ups.

4.6 Postvention

Suicide survivors are more stigmatized and ostracized by the community people rather than survivors of other types of death that is also true for the deceased persons' parents who lose their child to suicide. After being negatively judged by the society people, the survivors sometimes keep them isolated from any social networks, a process called self-stigmatization, though this situation has been changed over time (Cerel et al., 2008). The family members need care after any suicide attempt (fatal or non-fatal) in the family. Care for the vulnerable family members for keeping them outside of mental health crisis helps to reduce the further risk of suicidal behavior recommended by the WHO (Arafat, 2021; WHO, 2018). But the family members always try to keep secret about their close kin's mental health sickness because they think that the community can stigmatize them for this (Arafat, 2021). Sometimes suicide is contagious, one person can influence by another person's death especially if the deceased person was his/her closed one (Urme et al., 2022). In this regard, postvention is urgently required which can be worked as an effective prevention method.

5 Conclusions

This chapter examines the relationship between the risk factors of suicide that are relevant to family, which can be helpful for developing and implementing effective suicide prevention strategies in Bangladesh. The common reasons behind self-destruction related to family such as marital discord, familial disharmony, extramarital affair, pre-marital love relationship, conflicts with family members, or weak interrelation with them should be taken into account for developing suicide prevention programs where family members have roles and responsibilities. This chapter discusses the potential areas of involvement of family members while considering the suicide prevention.

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CHAPTER 7

Crisis, Trauma, and Suicide in Bangladesh

Muhammad Kamruzzaman Mozumder

Abstract Suicide generally is attempted in the context of severe distress experienced by a person. Such distresses generally interfere with the person's ability to cope effectively and either trigger or enhance a sense of hopelessness and helplessness, giving way to suicidal thoughts. Experience of crisis and trauma can significantly contribute to the perception of distress and the development of dysfunctional coping strategies which is often linked with suicidality. This chapter will focus on understanding the connection between crisis, trauma, and suicide in Bangladesh context. Recent reports and estimates suggest that most of the victims of suicide are in their youth in Bangladesh. This chapter may help the researchers, activists, and policymakers to contribute towards devising evidence-informed strategies to curb the problem.

Keywords Suicide in Bangladesh · Trauma · Crisis · Suicide prevention · Life events

M. K. Mozumder (✉)
Department of Clinical Psychology, University of Dhaka, Dhaka, Bangladesh
e-mail: mozumder@du.ac.bd

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1 Crisis and Suicide

Individuals with a history of suicidal behavior can be generally classified into two broad categories, individuals with relatively persisting thoughts of suicide and individuals with impulsive or spur-of-the-moment thoughts of suicide. Irrespective of such classification, crisis plays an important role in generating suicidal thoughts and attempting suicide. This connection between crisis and suicide is well reflected in the naming, approach, and methods used in suicide prevention services.

Crisis can be defined as "acute emotional upset in an individual's usual steady state, accompanied by a perceived breakdown of his or her usual coping abilities" (Ell, 1996). Crisis can originate from the reaction to external events or from internal conflicts between psychological systems. A crisis is closely associated with a certain state of mind which include shock, fear, anxiety, uncertainty, hopelessness, helplessness, and denial (Centers for Disease Control and Prevention, 2019). These same features are also common among suicidal individuals. Increased suicidality with different types of crises has been well-reported and researched. Economic crisis and unemployment are one of the strongest contributors to suicidality (see Gunnell et al., 2009). Crisis in the form of relationship problems and financial problems has been reported to be associated with suicide in Bangladesh (Feroz et al., 2012; Reza et al., 2014; Arafat, 2019; Arafat, Mohit, et al., 2021; Arafat, Khan, et al., 2021). Other forms of crisis, such as academic failure, failure in business, being a victim of sexual harassment, the death of a spouse, and divorce, have also been linked with suicidality in Bangladesh (Arafat, Mohit, et al., 2021; Arafat, 2019).

In recent times, the link between the pandemic-induced crisis and suicide in Bangladesh has been studied by researchers from multiple disciplines. The crisis related to the recent COVID-19 pandemic has been reported to contribute to suicide among individuals across different districts of Bangladesh. Khan et al. (2022) analyzed several such suicidal cases using Durkheim's sociological perspective, where they found these COVID-related suicide and suicide attempts in Bangladesh to fall under the egoistic, anomic, and fatalistic categories. The cases reported by them indicated the presence of crisis in several aspects of life, including adverse interpersonal comments, failure to cope with restrictions, state of uncertainty, financial hardship, and failure to fulfill basic needs (hunger). Similar findings on suicide from a social and economic crisis during the COVID-19 pandemic have been reported by other researchers from Bangladesh (Bhuiyan et al., 2021; Mamun, 2021).

Exposure to and experience of crisis usually cause significant distress. When due to limited coping resources, the person feels overwhelmed by the crisis, it can result in trauma which is another marker for suicidality for many individuals. A crisis is generally conceptualized as a transient state, while trauma is reported as a comparatively longer-lasting emotional state. The development of psychological trauma from exposure to crisis depends on several vulnerabilities in the individuals, which include the presence of chronic stressors in life,

pre-existing mental illness, limited problem-solving skills, and poor coping. Due to the persistent nature of distress in trauma, a person with trauma may often be more like to attempt suicide repeatedly.

2 Trauma and Suicide

Risk factors of suicide are generally understudied in Bangladesh. However, distressing life events, sexual abuse, psychiatric illness, and previous attempts have been found as major risk factors for suicide in this context (Arafat, Mohit, et al., 2021; Arafat, Saleem, et al., 2022; Arafat, 2019). Having experienced stressful life events in the past year has also been found to be a significant risk factor for suicide ideation, planning, and attempts in Bangladesh (Rasheduzzaman et al., 2022). The connection between trauma and suicidal ideation or attempt has been well established through research in the international context (LeBouthillier et al., 2015; Whiteman et al., 2019). Due to the lack of research evidence, the exact magnitude of trauma-induced suicide cannot be ascertained in Bangladesh. However, with evidence of the connection between suicidality and the experience of distressing life events in Bangladesh (Rasheduzzaman et al., 2022), it is not difficult to assume that trauma may have a greater impact on suicidality in this context. Experience from clinical practices and anecdotal evidence also suggests the presence of trauma in inducing suicidal ideation and attempt in the Bangladesh context (Mamun and Griffiths, 2020). Association between a traumatic event and suicide ideation in Bangladeshi individuals has been reported by Rahman et al. (2022). Kabir et al. (2019) demonstrated the presence of suicidal thoughts among individuals with trauma from the infamous *Rana Plaza* building collapse in Bangladesh.

Despite the wide acceptability of the connectivity between trauma and suicide, most theories of suicide fall short of explaining this relationship. The *interpersonal theory of suicide* (IPTS; Van Orden et al., 2010) introduces three concepts associated with suicide attempts which can be used to explain the connection between trauma and suicide. The first of the three concepts, *thwarted belongingness,* indicates a limited sense of belongingness with others which are often caused by the known traumatic risk factors of suicide, namely social isolation, family conflict, shame, or childhood abuse. As per the theory, the sense of thwarted belongingness, along with *perceived burdensomeness* (the second concept in IPTS), creates passive suicidal ideation in the person. With a prolonged experience of thwarted belongingness and perceived burdensomeness, the person moves gradually towards active suicide ideation. The third concept, i.e., *capability for suicide,* suggests that the person must have the capacity to actually attempt suicide. It requires the person to overcome the fear of attempting suicide. Those with trauma often have repeated physically and psychologically painful experiences and exposure to dreadful events. The experience of trauma may be perceived as more painful or terrifying than the pain and fear associated with attempting suicide, thus helping the person move

to attempt from ideation (Smith et al., 2016). In a Bangladeshi study, Arafat, Hussain et al. (2022) found higher perceived burdensomeness among females and higher thwarted belongingness among those with past suicide attempts.

A common feature among suicidal cases is their lack of coping resources. All suicidal cases demonstrate a severe level of distress and/or helplessness associated with their life circumstances, be it an external distressing event, personal psychological problem, internal existential crisis, or a combination of all of these. A person with access to well-developed coping strategies can handle these stressors appropriately. However, those with poor coping resources often experience trauma and helplessness. Repeated and persistent exposure to such distress and trauma can result in hopelessness which is well-recognized as a key indicator of suicidal thoughts and behavior. Therefore, coping can be seen as a common link between suicide and trauma.

3 Coping and Trauma

Psychological trauma can be defined as an emotional response to dreadful life events (American Psychological Association, 2022). However, the experience of trauma is not limited to emotional response; it is also closely associated with cognitive, behavioral, and physiological responses of the individual experiencing the traumatic events. Although closely connected, all exposure to traumatic events may not result in trauma for a person. A country-wide survey in Bangladesh indicated that 96% of the children with experience at least one traumatic event, while the average score of measure for post-traumatic stress disorder (PTSD) was below the cutoff value (Deeba and Rapee, 2015).

Due to the unusual and dreadful nature of the life events involved in trauma, it is generally associated with intense stress and taxes on the person's coping resources, which explains the individual variations of trauma experience even from exposure to the same dreadful life events. There is numerous research evidence indicating close ties between trauma and coping skills (Jenzer et al., 2020). When exposed to distressing events, individuals with poor coping skills are more likely to have trauma reactions. On the other hand, exposure to traumatic events has been found to cause poorer coping among individuals.

Coping helps protect a person from adverse internal emotional, cognitive, or physiological states generated from either internal or external sources. Researchers tried to categorize qualitative differences among the varied coping strategies used by human beings (Carver, 1997; Folkman and Lazarus, 1988). These different types are often broadly clustered under functional or dysfunctional coping approaches. Irrespective of the functionality, all types of coping are aimed at protecting the person's well-being from distress, or at an extreme level, from trauma.

Among all the species in the animal kingdom, humans have been the most powerful in terms of having control over their surroundings. This sense of agency can be Achilles' heel for humankind. While enjoying the experiences

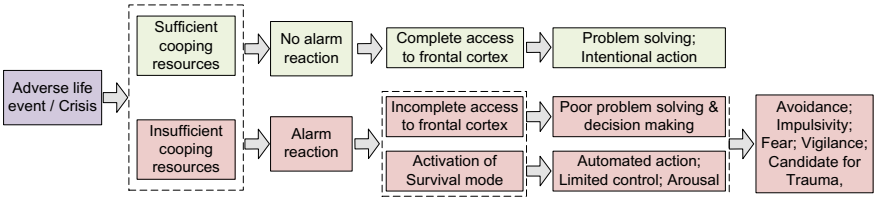

Fig. 1 Schematic diagram depicting the relation between adverse life experience, coping, and outcome

of agency, we have very little preparation for coping with moments when our agency is lost. Dreadful incidents thus brought forth such moments where we find a lack of agency and feel threatened. Threat perception triggers survival instincts and arouses the sympathetic nervous system. This process alters the allocation of energy in different regions of the brain resulting in increased activities in the sub-cortical brain (survival brain) while decreased activity in the cerebral cortex (thinking center). With the survival brain being in control, it initiates a series of bodily reactions, including rapid breathing to increase oxygen intake, faster heart beating to help circulate the oxygen to the mitochondrion throughout the body, and increasing muscle tension to move fast. While our biology frantically tries to avert the threat, our mind goes blank due to reduced activities in the frontal cortex resulting in helplessness and strengthening of the threat perception. This process of intense stress serves as the basis for trauma.

When a person has sufficient coping resources, he or she is less likely to feel threatened compared to one with insufficient resources in dreadful life circumstances (see Fig. 1). People with well-developed coping resources are, therefore, more likely to make a proper decision and to stay in control of their internal state and hence less likely to develop trauma.

4 Triadic Relationship Between Trauma, Coping, and Suicide

Glennie (2010) nicely coined, "Coping skills are intentional responses to resolve stress that are distinct from involuntary reactions". Coping resources are known to have an important role in providing a reason for living, which is inversely related to suicidality (Yi et al., 2021). Several negative coping styles, such as suppression, denial, addiction, and behavioral disengagement, have been shown to be associated with suicidality (Josepho and Plutchik, 1994; Yi et al., 2021). Similar coping styles, such as disengagement and avoidant coping, have been found to be associated with trauma (Fortier et al., 2009; Sheerin et al., 2018). Coping resources often mediate the relationship between suicidality and traumatic experiences. Kılınç et al. (2022) demonstrated the

mediating role of coping flexibility in the relationship between psychological maltreatment and death obsession during the COVID-19 pandemic. In another study, Whiteman et al. (2019) demonstrated the link between trauma, cognitive distortion, and suicidality. Apart from the direct effect of trauma on suicide ideation, they also found that trauma contributes to cognitive distortion, which in turn contributes to suicidal ideation (Whiteman et al., 2019).

Development of coping skills starts very early in childhood when an infant is required to develop skills to adapt to numerous challenges and the potential threat that he or she faces (Compas, 1987). Coping skills developed in childhood shape our ongoing coping and responses to our surroundings. Severely adverse experiences in childhood often leave the child with inadequate coping resources, the scar of trauma, and the possibility of experiencing future victimization and trauma (see Cloitre and Rosenberg, 2006). History of childhood abuse has been found to result in copying difficulties such as emotional dysregulation, affective labiality, and socially inappropriate expression of emotion (Shields and Cicchetti, 1998). Childhood sexual abuse has also been found to increase suicidality. Study findings suggest that one-third of the youth with experience of childhood sexual abuse attempt suicide, while approximately half experience suicidal ideation from the abuse (Plunkett et al., 2001). The case–control psychological autopsy study of Bangladesh identified that sexual abuse was attributed to twelve suicides in females and among these twelve females, more than 91% ($n = 11$) were adolescents (Arafat, Mohit, Mullick, Khan, and Khan, 2021). The study also revealed that 40% of the life events were related to sexual and marital issues (Arafat and Khan, 2021). Childhood trauma has also been linked with suicide among prisoners (Navarro-Atienzar et al., 2019).

5 The Traumatic Impact of Suicide

There is a circular relationship between trauma and suicide. Similar to the impact of trauma in triggering suicide and suicidal thoughts, the impact of suicide is well-reported for its ability to trigger trauma reactions in others. Any form of death can be traumatic. However, exposure to death from suicide can be especially traumatic due to the often violent nature of the suicidal death (Spillane et al., 2018). The loss of family members or loved ones from suicide can also be traumatic. Exposure to suicide in the family can also initiate suicidal ideation among other members of the family (Pereira and Campos, 2022). A recent study on the university student population indicated that the history of suicide attempts in the family is a significant risk factor for both suicide ideation and suicide attempt in Bangladesh (Rasheduzzaman et al., 2022).

Research findings indicate the initiation of trauma reactions among mental health professionals who experience suicide in their clients (Castelli Dransart et al., 2014). The person attempting suicide can also experience trauma from the attempt (see Stanley et al., 2019). Suicidal behavior is considered a criminal offence in Bangladesh (Arafat, 2019). Therefore, surviving attempted

suicide can cause additional stress to the person as well as the family members. Despite the gradual move toward individualism, the society and families in Bangladesh are still connected to the ideas of collectivism, where people are, to some extent, accountable to the larger system. This connection with the larger system (e.g., society, extended family) and stigmas ingrained in the system often put an added burden on the person and/or the family affected by suicide.

6 Assessment of Trauma in Suicidality: Missing Links

The instruments used for assessing suicidal risk can be categorized into three groups. Firstly, there are tools such as the *Beck Hopelessness Scale* (BHS; Beck and Steer, 1988), the *Beck Depression Inventory-II* (BDI-II; Beck et al., 1996), and the *Patient Health Questionnaire* (PHQ-9; Kroenke et al., 2001), which are used for assessing different psychological constructs and indirectly indicates suicide risk. The second category of tools includes instruments that assess suicidality directly by using items exclusively on suicide and death. These include the *Suicidal Ideation Questionnaire* (SIQ; Reynolds, 1987) and *Beck Scale for Suicide Ideation* (BSS; Beck and Steer, 1993). Thirdly, there are instruments that assess the risk of suicide through a combination of items assessing the risk factors and suicidality. These include the *Tool for Assessment of Suicide Risk* (TASR; Kutcher and Chehil, 2007) and the suicide *Risk Assessment Matrix* (World Health Organization, 2009).

Assessment of depression and hopelessness is at the core of many instruments that assess suicide. However, the assessment of suicide seems to ignore the need for the inclusion of items on trauma. Only a few assessment tools, such as the *Suicide Status Form* (SSF; Jobes et al., 1997), came a little close by including items about distress. Ignoring trauma in the assessment of suicide may have many fold impacts. Firstly, the sole assessment of suicide will provide only a partial conceptualization of the case resulting in inadequate formulation and a subsequent narrow intervention plan. Secondly, ongoing trauma affects information processing and interaction of the person with the environment; if left unaccounted for, it has the potential to bring detrimental consequences to therapy. Thirdly, addressing suicide without managing the trauma may generate only transient outcomes. As the vulnerability will still be there, the person may continue with repeated suicidal attempts rendering unnecessary duplication of work. Finally, unmanaged trauma has a pervasive negative impact on the overall well-being of the person. Therefore, leaving the person with unmanaged trauma is morally and ethically unacceptable.

7 Trauma-Informed Suicide Prevention in Bangladesh

A thorough assessment of trauma along with suicidality is essential for the proper management of suicide cases. Additionally, working with suicidal cognition and behavior may increase the risk of re-traumatization if the service provider is unaware or ignorant about the ongoing or past trauma of the patient. Inscoe et al. (2022) provided a detailed qualitative analysis of trauma-informed youth suicide prevention. They emphasized involving the caregiver in the intervention, providing psychoeducation, building therapeutic alliance (utilizing clinician authenticity, genuineness, and warmth), and the therapist being oriented about and being able to recognize trauma (Inscoe et al., 2022).

Ensuring trauma-informed suicide management in clinical practice poses some major challenges for Bangladesh. Becoming a trauma-informed therapist requires not only knowledge and awareness but also more mindset and preparation to become one. As suggested by the Substance Abuse and Mental Health Services Administration (2014), it requires the active involvement of the service providers in terms of realizing the widespread impact of trauma, recognizing signs of trauma, responding to trauma with the integration of knowledge and policies, and being focused in resisting re-traumatization. Being a resource-constrained country, Bangladesh has an extremely high (92%) mental health treatment gap (World Health Organization, 2020). One of the prime reasons for this treatment gap is the limited availability of professionals. With extremely high patient loads in government hospitals, the average per-patient consultation time for a psychiatrist is generally less than 10 minutes. Although clinical psychologists generally maintain the standard of a 50-minute consultation time, the waiting time to get their appointment is often too long. Therefore, limited access to qualified mental health professionals and getting the sufficient time needed for intensive trauma-focused suicide management can be challenging in Bangladesh.

Suicide prevention helplines are doing a good job of providing support to individuals with crisis, trauma, and suicidal ideation in Bangladesh. Most notable among these is *Kan Pete Roi*, a volunteer-based non-government organization that provides telephone crisis support services. Trained volunteers provide a listening ear with basic psychological support to intervene in the immediate crisis that the callers present with. The government also has a generic 999 telephone-based service for all citizens, as well as a specific "women and children, focused toll-free 109 telephone-based service that addresses crisis and plays a significant role in preventing suicide in Bangladesh. Nonetheless, these telephone-based services with partially trained volunteers and staff are limited in dealing with and healing trauma.

Incorporation of a detailed orientation on trauma as well as on suicide needs to be incorporated into mental health professional training programs in Bangladesh. Training programs in clinical psychology, counseling psychology,

and education psychology have been recently seen to arrange sporadic orientation training on the assessment and management of suicide and trauma. However, regularization of these trainings and organizing these as part of continuing professional development through professional associations would be of real value.

8 Conclusion

Immediate adverse life events, trauma, and crises are closely associated with suicide and suicidal behavior in Bangladesh. Sadly, at the same time, informal social support is declining with urbanization and other transition in society. Despite the lack of research evidence, it seems likely that clinicians in Bangladesh will have to deal with increasingly more cases with a dual presentation of suicide and trauma in the coming days. Dialogues around suicide and trauma are hugely important for ensuring trauma-informed suicide management. Participation of stakeholders from all spheres of the society is warranted to ensure a holistic approach to reduce the crisis-related suicides in the country.

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CHAPTER 8

Suicide Research in Bangladesh

Md. Saleh Uddin

Abstract Suicide is one of the important issues that has been not considered a focus of public health interventions in Bangladesh. The overall information of this chapter will help to detect unexplored areas of suicide in Bangladesh and show the direction of future research domains which will be helpful to develop effective local suicide prevention policies, strategies, and interventions. It has been found that suicide researchers collected data from injury death record reviews, autopsy record reviews, death registry reviews, news or media report analyses, and case reports. S. M. Y Arafat authored the highest number of papers on suicide in Bangladesh according to Scopus databases from inception to 2022. Currently, there is no available national suicide data-keeping system, suicide research focusing on psychopathology, integrated interventions or prevention programs which are urgent needs for Bangladesh.

Keywords Suicide in Bangladesh · Suicide · Research · Suicide research · Bibliometric analysis

Md. S. Uddin (✉)
Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka, Bangladesh
e-mail: mohammad.salehuddin@gmail.com

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1 Introduction

Suicide is one of the predominant causes of mortality comparing other conditions like malaria, *Human Immune Deficiency*virus (HIV) infection, Breast carcinoma, War, or homicide, and in 2019, nine people died per 100,000 population worldwide (World Health Organization, 2021a, b). The diverse epidemiological characteristics of suicide in Asia represent the complex interaction among cultures or customs, the transformation toward urban life, easy access to measures to commit suicide, and social permission or limitations. Following African nations (11.2/100,000 age-standardized), South East Asian countries are at the top of the list of suicide rates (10/100,000, age-standardized) (World Health Organization, 2021a, b). Bangladesh is one of the low- and middle-income countries (LMIC) with almost a 168.22 million people where in 2018, 572,600 deaths were caused by non-communicable diseases or NCDs (Cardiovascular diseases, Cancer, Chronic Respiratory Diseases, Diabetes, and others) which contributes 67% of total mortality of the country (Health Bulletin, 2020). Unfortunately, the existing NCD data lacks suicide information which may change the overall NCD-related mortality scenario in Bangladesh and will be helpful to approach towards developing a national suicide prevention strategy. This compilation of research findings also revealed that national suicide studies on education, awareness or literacy, epidemiology, psychopathology, prevention, and impact (or burden) have yet not been explored without which an effective suicide prevention policy or strategy could not be possible to formulate in the future. Prioritizing the research domains and capacity building could be the main issues without which authentic nationwide suicide data may not be revealed. This chapter is aimed to assess the overall suicide research in Bangladesh and enable the reader to know what has been done following the independence (1972–2022) of Bangladesh in the field of suicide research.

2 Research on Suicide in Bangladesh

2.1 Period: 1972–1999

In the early decades of Bangladesh (1971–1999), a few suicide research was noted that provide important information about local characteristics of suicide. A retrospective study of death reports (due to injuries and induced abortion) review conducted from 1976 to 1986 among women of 15–44 years in *Matlab*, a sub-district of Bangladesh found that 4.91% of total death (n = 1139) happened due to suicide (n = 56) where the methods of suicide were poisoning (39) and hanging (n = 17) (Fauveau and Blanchet, 1989). In another study in the same geographical area, the data has been collected longitudinally from 1982 to 1998 to observe the death due to violence regardless of gender among 15–44 and revealed that female suicide rate was more among females than males (1.3 vs. 0.8 per 10,000 person-years) (Ahmed et al., 2004). It reported a total of 160 suicides among 1297 deaths due

to violence. A study of autopsy findings at the *Forensic Medicine Department* of *Sir Salimullah Medical College*, Dhaka was conducted over a decade (1988–1997) to overview the cause of unnatural death. It reported that apart from other reasons (accidents and homicide) for death, 18% of the deaths happened due to suicide (Islam and Islam, 2003). Another study attempted to explore the risk factors of violent death in rural Bangladesh where researchers followed up the population of nearly 62,000 in 10 districts of the country during 1990–1999. The study revealed that there were significant differences in the sociodemographic context where the probability of victim of violent death was 61.2 per 100,000 if the person is very young, male, poor, illiterate, and Muslim (Hadi, 2005). Finally, another study was conducted all over the country and collected data from 60 districts from 3702 public health facilities to identify the characteristics of injury-related death among women of 10–50 years from 1996 to 1997 timeframe and found that among the total of 28,998 deaths. It reported that 23% of deaths were due to intentional or unintentional injury and among them, half (3317) were due to suicide. Regarding suicide information, poisoning and hanging was the most commonest measure and among all the suicide victims 71% were below 30 years, predominantly married, with rural and low economic background, and 06% of them were pregnant (Yusuf et al., 2000).

2.2 Period: 2000–2019

2.2.1 Community Study

In an observational study, researchers aimed to overview the changes in the pattern of death among females aged 15–49 years by using the information from nationally representative surveys of 2001 and 2010. Three physicians explored the medical cause of death by verbal autopsy (VA) and found that the cause of death has been shifted from communicable to noncommunicable disease (NCD). Among NCDs, suicide and deaths due to violence were the prominent cause of death among teenage girls (Nahar et al. 2015). Another community-based survey was carried out from December 2009 to March 2010 at Mominpur union under SadarUpazilla of district *Chuadanga* where 12,422 people were interviewed from 3,551 residences. The study revealed that the suicide rate was 128.8 per 100,000 population where cases were predominantly female (male: female 1:4), below thirty years (20–29 years) (42.9%), low-income group (45.7%), married and had family discord (Feroz et al., 2012). In another study, according to Khan et al (2020), the rate of suicide attempts and suicide in *Jhenaidah*, during 2010–2018 was 136.35/100,000 and 20.6/100,000 consecutively and poisoning was the most common method of suicide attempt or suicide among victims (Khan, Ratele et al., 2020). Another census was conducted in June–November 2013, in the rural area (51 unions) to evaluate the reason for death related to injury and it was found that most of the suicide cases were female and belongs to the 15–24 age group (Alonge et al., 2017). Sharmin Salam et al. (2017)

conducted similar research for 06 months (June–November, 2013) in rural areas to assess fatal and non-fatal suicide. They found that fatal and non-fatal suicide rates were 3.29 and 9.86 per 100,000 person-years (PY), respectively. Among the deceased, married adolescents were twenty-two times more likely to die by suicide comparing unmarried people and illiterate daily workers were sixteen times more likely to die by suicide than educated students. Most importantly the common methods of suicide were, hanging and poisoning (Sharmin Salam et al., 2017). In a recent study, it revealed that there is a high incidence of acute poisoning in *Jashore* with a significant amount of death toll where *Organo Phosphorus Compound* (OPC) is the most common agent of poisoning deliberately due to its easy availability (Acherjya et al., 2020). Unfortunately, the financial burden (on family and government) of poisoning case treatment has not been estimated on a large scale although a cross-sectional study conducted in *Chattogram (Chittagong) medical college hospital* in 2016 to assess the agrochemical poisoning treatment expenditure by patients and the cost analysis by Verma et al. (2017). The study noted that it takes three times more money than their monthly expenses (Verma et al., 2017).

2.2.2 Medicolegal Autopsy Report Review

Due to the lack of a national suicide data-keeping system, autopsy report review becomes one of the feasible ways to explore suicide information in Bangladesh. In 2005, an autopsy review of a total of 557 cases was conducted in *Mymensingh Medical College* mortuary to assess the typical and atypical hanging (Talukder et al., 2008). Such findings of hanging knots could be helpful data in the future to resolve cases in a forensic context whether it's homicidal or suicidal. Another review was conducted at *Mymensingh Medical College* morgue, from January 2007–December 2008. It was found that among 1862 autopsy cases, 692 (37.16%) were identified as OPC poisoning cases which were the main cause of suicide apart from other outcomes and the 21–30 years age group was the highest in number and suicide victims were predominantly 401(57.8%) males (Quader et al., 2010). Another retrospective study was done at *Chattogram Medical College* morgue from January 2014 to December 2016 to reveal the causative factors and injury pattern of cutthroat wounds. It assessed 106 cases of cutthroat wounds from 7300 medico-legal autopsies where most of the victims were male (74 cases), the most affected age groups were 21–30 years (both male & female) and homicides (91) and suicide (13) was the major cause of death (Akber et al., 2021). In another study, a total of 114 organophosphorus poisoning cases autopsied at the *Sir Salimullah Medical College* morgue, were analyzed during the period from January 2016 to December 2017. Male predominance was noted to account for 75% of total cases compared to females' 25% of cases and the most common age group involved was 21–30 years 31% and lower socioeconomic status (Sumon et al., 2021).

2.2.3 *Injury Death Record Review*

An epidemiological study conducted among 819,429 people of all ages to identify the characteristics of injury-related death in 2003 found that adolescent females (10–19 years) are the most vulnerable age group. The overall suicide rate found in this huge sample was 7.3 per 100,000 per year which was 17 times higher in rural people comparing urban setups. The majority of suicide deaths were from low socioeconomic backgrounds, illiterate, and poisoned themselves (Mashreky et al., 2013). Other death report reviews (2001–2017) found that among 3433 dowry-related death, 231 was suicide and among 750 deaths (2014–2017), 31 were due to suicide (Rahman, 2018). A nationwide cross-sectional survey on injury death was conducted between March and June 2016 and identified suicide as the leading cause of injury deaths in Bangladesh and every year, an estimated 23,868 people die due to suicide in Bangladesh (14.7/100,000 population per year). The incidences were peak in late adolescents, females predominant, mostly in residence (71%), and poisoning (73.9%) and hanging were the methods of suicide (Chowdhury, Mashreky, et al. 2018). An unnatural death review of *Thakurgaon* district conducted from 2014 to 2018 revealed that 840 suicidal deaths occurred during this period where the mean suicide rate was 12.17 per 100,000 per year most of the victims were below 30 years of age (57.02%), and 55.12% females. Hanging was found as the most commonly used method (73.1%) followed by poisoning (25.15%), jumping in front of the train, and burning. Interestingly, incidences were peak in March and August of a calendar year (Arafat and Karmakar, 2019).

2.2.4 *Case–Control Study*

In 2013 a case–control study to find the risk factors of suicide in the southwest part of rural Bangladesh found that young, married, females, from unitary families, with low economic backgrounds are more vulnerable to dying by suicide or parasuicide (Reza et al., 2014).

2.2.5 *Case Reports*

A report of copper sulphate poisoning was published in 1994 based on cases from the southern region of the country (Ahasan et al., 1994). A case of nine members of a family died by suicide reported in 2007 which was due to their shared delusion of anti-religious faith according to experts' analysis of their story and suicidal notes (Selim, 2010). Another case of suicide of 30 years of unmarried female medical graduate died by intravenous Kerosene (a volatile hydrocarbon, used as fuel during cooking or lamp in rural areas) along with a sedative (midazolam) and antidepressant (amitriptyline). Probably pre-existing could be her introverted personality, her boyfriend's betrayal, and chronic *Major Depressive Disorder* diagnosed by a psychiatrist though she didn't adhere to medications or psychotherapy (Arafat, 2018). Another 04 cases of suicide at the University of Dhaka in November 2018 were reported where all of them were female students and the recent stressors were: love

affairs relationships and academic issues (Arafat and Al Mamun, 2019). A case of suicide was reported 6 years of the Rana Plaza disaster (that happened in 2013) in which a young adult male survivor committed suicide and following the psychological autopsy of that case, PTSD was found associated (Mamun and Griffiths, 2020a). Another case of suicide by a college student by Gunshot and experts mentioned the student's mental health condition (depression), game addiction, academic stress, and bully could be the possible correlates of such incidence (Mamun and Griffiths, 2020b).

2.2.6 Media Report Analysis

In a study conducted in 2019, researchers reviewed the social media responses to suicide and found that peoples express their feeling in nine different ways these are: "angry, sadness, surprise, irony, ridicule, judgmental, justification, speculation, and miscellaneous" (Al-Zaman and Or Rashid, 2022). In a report analysis (01 November 2018–31 October 2019) of a total of 199 reports 91% (181) reported about completed suicides where the identity and image of the deceased and method of suicide were mentioned in detail. Moreover, none of the reports contained any educational content or expert opinion regarding suicide information (prevalence, cause, prevention intervention) (Arafat et al., 2020). Similar findings (like unavailable awareness building contents) were also observed in another content analysis of 403 reports (01 November 2018–31 October 2019) (Arafat et al., 2020).

A news report analysis conducted between November 2016 and April 2017, found that most of the deceased (61%) are young adults (below 30 years and females (58%). Moreover, similar to other studies rural background and family discord were the two commonest social factors associated with these suicides, and hanging was the commonest method of suicide (Shah et al., 2017). Following this study, other analysis findings showed aligned directions regarding age, sex, stressors, and type of methods. For example, an online news portal suicide report analysis revealed that most of the victims are below 30 years, female, students, unmarried, hanged (60%), and having stressors like relational issues, marital and family discords, and own residence was a place of incidence (Arafat et al., 2018). A similar trend of findings was also observed in another 12 months study, where the author added new information on the timing of incidences as two peaks of cases were reported in April and November (Arafat et al., 2019).

2.2.7 Suicide Prevention

Currently, there is no suicide prevention program nationwide which is vital to reduce the negative impact on the community. Pesticide poisoning is one of the commonest methods in Bangladesh and the ban on WHO Class I toxicity of Highly Hazardous Pesticides (HHPs) from agriculture in 2000 has significantly reduced the mortality rate of suicide due to pesticide intake (Chowdhury, Dewan et al., 2018). Another initiative of the crisis phone helpline (Ears to listen) analyzed their five years call characteristics (N =

14,344) and found that among the callers, about 50% are male, predominantly between the ages of 20–39, and most of them do not have suicidal ideation or thoughts. It was revealed that the most common cause of calls is crises due to relational problems, mental health conditions or addiction, and emotional issues. Though a small portion of callers mentioned clearly suicidal thoughts, there was no follow-up data analysis to compare whether such phone intervention reduced or prevented suicidal rate or suicidality (Iqbal et al., 2019). In correspondence, the author proposed about use of Facebook to predict suicidal intention, and provide intervention after detecting the issue through such social media (Facebook) based suicide prevention intervention yet not been designed and applied to test its effectiveness by the researcher (Soron, 2019).

2.3 Period: 2020–2022

2.3.1 Case Control Study

The first case control-control psychological autopsy study was published in 2020 and conducted by Arafat, Mohit et al. (2021). Kins of 100 suicides and 100 age, sex, matched were interviewed to assess the risk factors for suicide in the country. The study was conducted in Dhaka city. It found pre-existing psychiatric disorder, past attempts, life-events, social isolation, sexual harassment, unemployment, substance abuse, and unemployment as risk factors for suicide.

2.3.2 Case Report

Newspapers reported many incidences of suicide among community people during the pandemic situation and in a case report researcher mentioned about 6 suicide cases all of which were related to the financial crisis (Bhuiyan et al., 2021). A case of suicide by hanging of a 40-year-old woman reported during the Covid-19 pandemic during her hospital stay and was told by the other admitted patients and their caregivers that health staff didn't provide her treatment due to fear of Covid-19 contamination (Mamun, Bodrud-Doza et al., 2020). Another rare case of university students and his mothers' suicide together was reported when they took poisonous gas tablets in a nearby wood. This unfortunate event happened due to a disagreement between the father regarding the mode of exam (online vs offline) appearance and the son, where the mother was also scolded by his father (Mamun, Chandrima et al., 2020). The third case report of suicide victim was 36 years male who was avoided and neglected by the local people as he was experiencing cough and fever though the autopsy report revealed that he was not infected by Covid-19 (Mamun and Griffiths, 2020c).

2.3.3 *Media Report Analysis*

During the Covid-19 pandemic lockdown, people could not able to go outside and a significant review work regarding suicide has been produced in this critical situation. In a news report analysis (from March 2020 to March 2021) researcher found 201 reports and among them 50 reports (24.9%) of 80 apparent suicides in the community took place and stressors like ongoing family discord, psychological or sexual abuse, financial stress, and stigma regarding Covid-19 mentioned (Ashraf et al., 2021).

Students were another group in the society who became vulnerable psychologically during the Covid-19 situation. A students' suicide report analysis(from January to December, 2020) revealed that most of the students (73.2%) age was 11–20 years, female (67.9%), secondary level of education (44.7%), "hanging" as a measure, immediate stressors like: relationship issues (romantic), family discords and September was the month of peak incidences (Sultana, 2022). In a student's suicide-related media report ($N = 127$) (from March 2020 to March 2021) researcher used Arc-GIS (which is a geospatial software to view, edit, manage and analyse geographical data) to trace the location of suicide over the country. The analysis found that the events mostly took place in the capital city Dhaka and the northern part of Bangladesh (*Jaipurhat, Bagura, Jamalpur, Mymensingh, and Netra Kona*) and deceased persons were predominantly female (72.4%), 14–18 years age group (42.5%) and hanging (79.5%) as methods. Among all, more than half (58.10%) of the students had stressors like: relational discord, emotional problems, refusal of love proposal, discord with family, and disappointing academic performance (Mamun et al., 2021).

Another cross-country (India and Bangladesh) news report analysis (June 14–21, 2020) found mostly homogenous findings which are suggestive of poor-quality suicide reporting. The reports commonly disclose the identity of decedents and methods of suicide in detail and do not include any contents which can educate people in this context. There was a significant relationship between Indian females with life events and attaching photograph with reports were common in Bangladeshi reports unlike Indian counterpart. Mental health literacy contents (Menon et al., 2020). Moreover, Kar et al. (2021) found in other news report analysis that, "hanging" as a method of suicide significantly raised comparing pre lockdown state in both Bangladesh and India, though males are higher in number in India unlikely in Bangladesh (Kar et al., 2021).

2.3.4 *Others*

In several studies it was proved that mental health literacy or awareness increased help-seeking behaviour among people though in Bangladesh such a domain in suicide research not explored yet. Recently, Arafat et and his colleagues validated the *Literacy of Suicide Scale* (LOSS-B) and the *Stigma of Suicide Scale* (SOSS-B) in Bangla which could be helpful to assess people's awareness about suicide and related stigma in the future (Arafat, Hussain et al., 2022).

3 Bibliometric Analysis

Bibliometric analysis is a quick and brief method of analyzing research-related information regarding a particular topic. In a recent review of 44 empirical studies in Bangladesh over the last two-decade (2001–2020), Arafat et al. (2021) found that most of the research adopted applied interview (34.1%) technique and secondary data analysis (31.8%) along with few qualitative researches (6.8%) (Arafat, Hussain et al., 2021). There are very few databases which have an in-built option to observe the bibliometric analysis and among them most popular database is Scopus. Author aimed to overview the suicide-related publications in Bangladesh and searched this database by the keywords: "suicide" "Bangladesh" to review regarding research trend in terms of the researcher, type of research, affiliations, and citations. The analysis found that the total number of research articles published is 163 from the year 1989 to 2022 and the first research explored the death of Bangladeshi rural women due to injuries and violence.

Though suicide researches done irregularly, it started to rise significantly from 2016 onward and surprisingly in the last three years (2020–2022), 63.2% ($n = 101$) of articles related to suicide were published (Arafat, Hussain et al., 2021) (Fig. 1). In terms of research types conducted in Bangladesh, 63.2% are original research, 24.5% is a letter to the editor, 8.0% is review work and 4.3% are others (grey literature like conference paper, reports/notes, etc.). Among the top three researchers found are Arafat, S. M. Y. ($n = 36$), Mamun, M. A. ($n = 28$), and Griffiths, M. D. ($n = 17$) who have contributed almost half (49.6%) of suicide research in Bangladesh. In terms of top five organisations involved in the relevant research are *Jahangirnagar University* ($n = 35$), *CHINTA Research Bangladesh* ($n = 27$), *Bangabandhu Sheikh Mujib Medical University* (BSMMU) ($n = 26$), *Enam Medical College and Hospital* ($n = 23$) and *International Centre of Diarrhoeal Disease Research, Bangladesh* (ICDDR, B) ($n = 18$) and they contributed 79.14% of the suicide research. Regarding the number of citations, top three cited articles (which having citations more than 100) were published during 2020–2021, and Mamun, M.A. is the common contributor in these researches as the first author ($n = 1$, citations in one article = 331) and as a last author ($n = 2$ citations in two articles = 143 and 130). As the analysis is based on Scopus database indexing of articles, studies that have been indexed in other databases are not available here and may not reflect the full view of the Bangladeshi suicide research scenario. But this bibliometric analysis has provided a brief picture of recent suicide research of Bangladesh.

4 Research Gaps in Suicide of Bangladesh

This description of Bangladeshi suicide research clearly shows that, studies conducted in different zone, timeline with diverse research designs. It shows that the method of suicide has been changed over the last five years (from

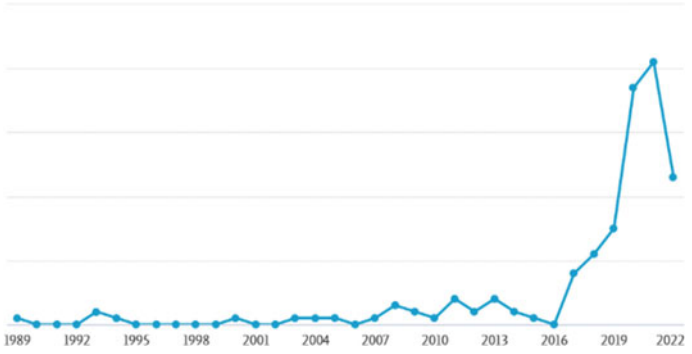

Fig. 1 Trend of published articles on suicide in Bangladesh found in Scopus

poisoning to hanging) though other factors like: female, young adult, low economic background, and life events remain constant. The suicide researches related to magnitude, psychopathology, burden, and preventive interventions need to be explored in the upcoming days.

5 Challenges of Suicide Research in Bangladesh

Although being a developing nation with a lack of research resource (financial and infrastructural), interestingly many researchers have been contributed significantly regarding suicide issues in Bangladesh from a very early period to recent time. According to Arafat (2021), as an individual researcher, four challenges have been identified during case control study in Bangladesh and these are: (a) get the list of suicides (as there is no national directory) (b) to conduct interview from proxy respondents (as suicide considered crime here, people hesitate to disclose information) (c) to get documents (medical records, autopsy reports) and (d) poor help-seeking from mental health professionals (Arafat, 2021). It proves that developing smart suicide directory, electronic medical record (EMR) system, liaison between police with health departments, and awareness of mental health among community are important areas which will facilitate suicide research in future. Apart from these, suicide researchers themselves need a vibrant platform to set a specific suicide research plan and at the same time stakeholders need to involve different ministries (home, law, health, science & technology, information & broadcasting, education, sports, religion, cultural affairs, etc.) to formulate work plan to extract suicide findings and develop an effective suicide prevention measure.

6 Conclusion

The existing suicide researches are heterogenous in terms of geographical distribution, sample size, methodology, and analysis. Moreover, areas like magnitude, psychopathology, impact, and preventive interventions are yet

unexplored. In future, suicide researchers may consider those areas to synthesise evidence that will help to an overall impression of suicide research in Bangladesh.

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CHAPTER 9

Suicide Prevention in Bangladesh: Current Status and Way Forward

Mohima Benojir Hoque

Abstract Suicide is a public health problem for both the developed and developing world. Like many other developing countries, it is a problem with less focus in Bangladesh. A few initiatives are taken to prevent suicide in the country such as two *Suicide Prevention Clinic*s, *Kaan Pete Roi*, a helpline, *Society for Voluntary Activities, Brighter Tomorrow Foundation* and *Society for Suicide Prevention Bangladesh*. However, the current prevention strategies lag behind when compared to the World Health Organization proposed components for a national suicide prevention strategy. More empirical studies, responsible media reporting, crisis intervention, the national database for suicide, raising awareness, adequate mental health support, means restriction, decriminalization, national suicide prevention strategy, and comprehensive and integrated efforts are warranted among different sectors of society for the prevention of suicide in Bangladesh. The chapter discusses the current scenario and future way outs for suicide prevention in the country.

Keywords Suicide in Bangladesh · Suicide prevention · Responsible media reporting · Suicide prevention clinic · Risk factors · Decriminalization

M. B. Hoque (✉)
Department of Public Health, ASA University Bangladesh, Dhaka, Bangladesh
e-mail: mohimabenojir@gmail.com

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1 Introduction

Globally, more than 700,000 people died by suicide in 2019. It is a serious public health problem in high-income countries (HICs) as well as predominantly in lower and middle-income (LMICs) countries where 77% of the suicides occurred worldwide in 2019 (WHO, 2021a). One person dies in every 40 s because of suicide, and many more attempt to suicide all over the world (WHO, 2014). It is the top twenty leading causes of death worldwide which is more than malaria, breast cancer, war, and homicide. It is the fourth leading cause of death among the individual with 15-to-29-year of age. Globally, suicides among young people account for nearly 25% of all suicides (WHO, 2021a). Although suicide is a sensitive issue, it is under-reported in some countries. Even the countries which have good data record, suicide have often been classified differently such as an accident or other reasons of death. Suicide registration is a difficult process comprising a number of different persons including law enforcement authorities. This chapter begins with the global context of suicide and encompasses how suicide prevention gets global attention, strategic approaches of suicide prevention, the risk factors of suicide in Bangladesh, overview of current situation of suicide prevention in Bangladesh, the readiness of national suicide prevention strategies, challenges of suicide prevention in Bangladesh and future way outs for suicide prevention in Bangladesh.

2 How Suicide Prevention Gets Global Attention

In the early 1990s, an imperative document entitled "*Prevention of suicide: guidelines for the formulation and implementation of national strategies*" was published by the *United Nations* (UN) following consultation with a variety of experts and with technical support from the World Health Organization (2018). It is emphasized the need for intersectoral collaboration, multidisciplinary approaches, and continued evaluation and review, and also identified key elements as a necessary means of increasing the effectiveness of suicide prevention strategies (WHO, 2018). In 2014, WHO published its first-ever world suicide prevention report "*Preventing suicide: a global imperative*" (WHO, 2014). In this report, WHO made a call to action for countries to employ a multisectoral approach which addresses suicide in a comprehensive manner. Currently, some forty countries at every income level have incorporated a state suicide prevention policy and only a few LMICs have accepted a national suicide prevention strategy, although 77% of suicides happen in these countries (WHO, 2021a).

The WHO MiNDbank online platform was created to provide easy and rapid access to global resources, national and regional-level strategies, services, and laws for improving mental health and related areas such as suicide, substance abuse, disability, general health, and human rights. Another global effort to address suicide is the creation of *World Suicide Prevention Day*,

organized by the *International Association for Suicide Prevention (IASP)*. This day is observed worldwide on 10 September each year providing a vital opportunity to raise awareness about suicide prevention (WHO, 2018).

The *WHO Mental Health Action Plan* 2013–2020 was approved by the *World Health Assembly* in 2013 (WHO, 2013). The action plan labels suicide prevention as a priority by reducing suicide rate by 10% within 2020. It is also highlighting suicide as a serious public health problem worldwide and will be prevented with appropriate efforts. National responses to suicide with comprehensive multisectoral suicide prevention strategies are essential to achieving this target. In 2015, the *Sustainable Development Goals* (SDGs), also focused on agenda adopted by the UN General Assembly. The third goal of the SDGs is to safeguard healthy lives and uphold well-being for people of all ages. Again, the target of SDG 3.4.2 is to decrease suicide by 33% through enhanced intervention and prevention in 2030 (Naghavi and Global Burden of Disease Self-Harm Collaborators, 2019; WHO, 2018; Khan et al., 2020).

3 Strategic Approaches of Suicide Prevention

Numerous strategic approaches are suggested for suicide prevention and classified as universal, selected, and indicated (WHO, 2014; Mann et al., 2005; Zalsman et al., 2016; Arafat and Kabir, 2017). Universal suicide prevention strategies are designed to reach the total population with a view to take full advantage of health and reduce suicide risk by eliminating barriers to health care and increasing protective measures for example, societal support and altering the environment (Table 1). Selective strategies mark vulnerable groups of people based on features like age, occupation, sex, or family history. Indicated strategies target another vulnerable group of individuals who have displayed initial signs of suicide potential (WHO, 2014).

Table 1 Strategic Approaches for Suicide Prevention adapted from WHO, 2014

Name of the strategy	*Category*
Mental health policies	UNIVERSAL
Policies to reduce harmful use of alcohol	
Access to health care	
Restriction of access to means	
Responsible media reporting	
Raising awareness about mental health, substance use disorders and suicide	
Interventions for vulnerable groups	SELECTIVE
Gatekeeper training	
Crisis helplines	
Follow-up and community support	INDICATED
Assessment and management of suicidal behaviors	
Assessment and management of mental and substance use disorders	

WHO launched awide-ranging '*Mental Health Action Plan 2013–2020*' in 2013 which persuade the countries to work on the way of their own mental health policies. The plan highlighted some points such as strengthening effective leadership and mental health governance; providing complete, unified, and amicable mental health and participatory community care services; implementing policies for prevention and promotion of mental health and support information systems, evidence-based research for mental health. WHO's Global strategy published a policy and interventions to reduce harmful use of alcohol. And it also provides measures for effective suicide prevention through proper guidance, mindfulness, and potentials, health services' response, community accomplishment, alcohol availability, drink-driving policies, and countermeasures, marketing of alcoholic drinks, minimizing the negative consequences of harmful-drinking and alcohol intoxication, and informally produced alcohol, monitoring, and surveillance. Available treatment for mental and substance use disorders can reduce the risk of suicidal behavior and executing health literacy policies and practices throughout health systems and institutions, and especially at community health centers are the main way to improve access to health-care services in general and mental health care in particular. Pesticide self-poisoning is the most common method of suicide worldwide. So, to prevent suicide limiting access to the means of suicide is effective. The main interventions in restricting access to the means of suicide are access to pesticides, access to firearms, bridges, buildings and railroads, accessibility of poisonous gases, and access to pharmacological agents. Study shows that responsible media reporting of suicide helps to reduce suicide rates. It may play a significant role by avoiding exaggeration and glamorization, using responsible language, avoiding detailed descriptions of suicidal acts, providing educative materials to the public, and mentioning information about suicide prevention services. Awareness raising on mental health, substance use disorders, and suicide may help to condense stigma and negative attitudes among people with a mental disorder. The selected strategic approach includes interventions for vulnerable groups, gatekeeper training, and crisis helplines. A number of vulnerable groups have been identified as having a higher risk of suicide such as persons who have experienced abuse, trauma, conflict or disaster, refugees and migrants, indigenous peoples, prisoners, lesbian, gay, bisexual, transgender, and intersex persons. Sometimes people who are at risk of suicide may not seek help. A "*gatekeeper*" is anyone who is in a position to identify whether someone may be contemplating suicide and the potential gatekeepers are primary, mental, and emergency health service providers, teachers and community leaders, other school staff, police officers, firefighters, and other first responders, spiritual and religious leaders or traditional healers, human resource staff and managers. Crisis helplines are a kind of public call centres which people can turn to when other social support or professional care is unavailable or not preferred. The indicated approach includes community support and follow-up, assessment and management of suicidal behaviours,

and mental and substance use disorders (Zalsman et al., 2016; WHO, 2014; Mann et al., 2005; Arafat and Kabir, 2017).

In 2021, WHO declared an implementation guide for suicide prevention which is known as 'LIVE LIFE' where, LIVE stands for leadership, interventions, vision and evaluation and builds the pillars of LIFE—i.e., the core interventions, which are less means, communication with the media for accountable reporting, life skills development to the younger and primary identification, management and follow-up. The core pillars of LIVE LIFE are situation analysis, multisectoral collaboration, raising awareness and promotion, capacity-building, funding, investigation, monitoring, and assessment (WHO, 2021b).

4 Risk Factors for Suicide in Bangladesh

The foundation of any effective response to prevent suicide is to find out the appropriate risk factors and their mitigation by implementing appropriate interventions. Suicidal behaviors are multifaceted and no single factor is adequate to elucidate a suicidal act. There are various contributing factors and underlying pathways to suicide and a range of options for its prevention. Protective factors are equally important and have been identified as improving resilience. Therefore, to mitigate the identified risk factors is imperative for effective interventions. Consequently, enhancing protective factors is also an important aim of any comprehensive suicide prevention response (WHO, 2018). An ecological model is used to best describe the both risk and protective factors of suicide which can help to take effective measures (WHO, 2014). As, it is multi-factorial, driven by a series of socio-cultural, psychological, economic, biological, and environmental issues, such as financial loss, interpersonal conflict, loneliness, chronic illness, mental health and substance abuse problems, discrimination, and difficulties accessing health care. Given the interplay of factors, multi-sectoral action is essential (WHO, 2014).

We discussed the risk factors for suicide in Bangladesh in Chaps. 1 and 3 of this book (Kabir et al., 2023). In Bangladesh, though the health sector extensively works on different domains of health with the existing resources but still suicide is less focused public health issue (Shah et al., 2017; Arafat, 2017; Arafat et al., 2018). In the country, majority of the suicide cases are found in their early adulthood and the significant risk factors are psychiatric disorder, sexual abuse, previous attempt, immediate life event, unemployment, social isolation, physical abuse, and physical disorder. Other risk factors are emotional issue, relationship events, rape, eve-teasing, and sexual relationship. The study reveals that among the total respondents 61% have psychiatric disorder such as axis I disorder—major depressive disorder (MDD), personality disorder, schizophrenia, and substance misuse. A total 91% have experienced life events such as academic failure, arguments with family member, arguments with spouse, broken engagement, extramarital affair, taking a large loan, spousal

extramarital affair, sexual assault, major personal physical illness, marital separation, business failure, child married, divorce and moving to another city (Arafat, 2019; Arafat, Khan et al., 2021; Arafat, Mohit et al., 2021).

Moreover, it is customarily predominating issue among married women who are young and come from subordinate socio-economic division living in the rural part of the country (Feroz et al., 2012; Shahnaz et al., 2017; Khan et al., 2022; Sharmin Salam et al., 2017). Evidences from several studies reveal that the effects of patriarchal society, early marriage, forced marriage, lower socio-economic status of women, lower female education, divorce, threat to divorce, conflicts with in-laws, forced childbearing, in-fertility, and various forms of exploitation and coercion are significantly linked with suicide and suicidal behaviors among women and girls in the country (Feroz et al., 2012; Arafat, 2019; Sharmin Salam et al., 2017; Khan, Ratele, et al., 2020). Again, people reside in the countryside particularly in *Chuadanga, Jenaidah, Kustia, Meherpur, Jashore, and Chandpur* were more vulnerable to suicide in Bangladesh (Feroz et al., 2012; Shahnaz et al., 2017; Chowdhury et al., 2018; Arafat, 2017, 2019). It is also found that in Bangladesh, the common approaches for suicide and attempt to suicide are hanging and pesticide ingestion (Mashreky et al., 2013; Shahnaz et al., 2017; Arafat et al., 2018; Arafat, 2019; Khan, Ratele, et al., 2020).

5 Overview of Current Situation of Suicide Prevention in Bangladesh

Bangladesh is a densely populated south-east Asian country containing about 171 million inhabitants (World Population Review, 2022). Evidence from a current systematic review showed that the country lacks comprehensive data base of suicide, national suicide surveillance system, strategy for suicide prevention, and experimental study on suicide (Arafat, 2019). Besides, suicide and parasuicide are considered as illegal and social, religious and legal consequences hamper the suicide disclosures (Arafat, 2017; Khan et al., 2020). In Bangladesh, there are a few but sporadic activities on suicide prevention interventions are initiated in different levels with limited resources following variable methods (Arafat, 2018; Khan et al., 2020).

5.1 Mental Health Support—Suicide Prevention Clinics

At present there are two clinics working on suicide prevention in Bangladesh. In 2016, the first *Suicide Prevention Clinic (SPC)* was launched at *Bangabandhu Sheikh Mujib Medical University* (BSMMU) under the *Department of Psychiatry*. The clinic runs on Saturdays and provides psychotherapy for two hours only (Arafat, 2018). It is the only public sector facility to provide treatment to patients with suicidal behavior (Arafat, 2018; Khan et al., 2020). But most of the people are unfamiliar with the existing facility due to insufficient promotional activities and media coverage. The website of the BSMMU

also does not deliver any message about the services of the clinic (Arafat, 2018; Khan et al., 2020). A recent study on the clinic data reveals that about 73% of the respondents were under the age of 25 and approximately 70% were females with depression followed by personality disorder was the most common psychiatric disorder (Shah et al., 2018).

Another *SPC* was started in October 2021 under the department of psychiatry of *Enam Medical College and Hospital (EMCH)* is a private medical college in Dhaka. Here the provision of services from 9 a.m. to 5 p.m. in every working day. There are no other specialized clinical services for suicide prevention in the country. The maximum patients who come to the SPC at BSMMU are referred by the psychiatry outpatient department where as in EMCH the picture is different. Here they receive self-reports because of awareness materials, banner with information of suicide and self-harm. In the country, outpatient departments for mental health services are existent in 72 hospitals but it cannot go without question regarding the availability of any specialist on mental health in all centres apart from medical college hospitals (WHO, 2022). The general physicians who are trained on mental health also not available in all the centres at primary health care facilities of Bangladesh. Consequently, it is difficult to accept that these centres can efficiently handle suicidal behaviour and suicide in the country. It is also to note that none of these individuals in the SPCs has any official training on suicide prevention rather than their inadequate theoretical knowledge.

5.2 Means Restriction–Category 1 Pesticides Ban

The main reason behind the declining of suicide rate globally is to reduce access to exceedingly harmful pesticides (HHPs) byreducing the agricultural use, harmless use and packing, and mainly due to legislation and prohibition of HHPs (Chowdhury et al., 2018). Bangladesh is an agrarian country where pesticide self-poisoning is extremely prevalent for both suicide deaths and attempt to suicide. The government of the country has proclaimed pesticide regulation and banned extremely hazardous pesticides (HHPs) from their use in agriculture over the last two decades (Chowdhury et al., 2018). The regulatory body of the country partially or totally banned 21 hazardous pesticides (WHO class I) during the period from 1996 to 2007 and move towards less harmful WHO toxicity class II, III, and U pesticides. By the year 2000 all kinds of WHO Class I toxicity HHPs were prohibited. During the post–ban period (2001–2014), suicide due to pesticide were decreased to 35,071 in comparison with pre-ban period from 1996 to 2000. It was also evidenced that the decline of unnatural death after banned the HHPs and the number was 76,642. It is found that there is an impact of pesticide legislation on pesticide suicide and unnatural deaths without any detrimental consequence on agricultural output (Chowdhury et al., 2018). So, the country should extremely

consider limited access to pesticides and other deadly means. Also, to ban toxic pesticides used for suicidal ingestion (Chowdhury et al., 2018; Khan et al., 2020).

5.3 Helpline—Kan Pete Roi and National Helpline (999)

In Bangladesh, the only telephonic helpline '*KAAN PETE ROI*' (my ears wait to listen) is established in 2013. It is also known as Bangladesh–Befrienders, an initiative IASP. Nonetheless, the mobile numbers are not widely distributed and unique one, unable to reach 24 h in every day(Iqbal et al., 2019; Arafat, 2018; Khan et al., 2020). The contact numbers used for the hotline seem like a personal number. Again, the services are not available for 24 h in every day as because the activities of this platform are run by volunteers. *SAJIDA Foundation*, a non-government organization works together with this helpline through the *WhatsApp* platform during the COVID-19 pandemic.

The national crisis hotline (999) was launched in December 2017. It is accomplished by the home ministry of Bangladesh and plays a significant role in suicide prevention by saving endangered individuals.

5.4 NGO-SOVA, BTF

There are few organizations that aim to work in preventing suicide in Bangladesh. *Society for Voluntary Activities* (SOVA), a non-government organization, is actively involved with suicide prevention activities in *Jhenaidah*, a suicide-prone district in Bangladesh (Khan et al., 2020). This organization extensively worked in mitigating and resolving the causes related to suicide and attempts to suicide in *Jhenaidah* from 2005 to 2017 under the direct financial backing of *Manuser Jonno Foundation* (foundation for man). In recognition of its highly impressive activities, SOVA achieved an international award (known as Lee Award) from the IASP. Currently, it is not functioning because of not being able to assemble funds from any donor organization for being instrumental (Khan et al., 2020).

Brighter Tomorrow Foundation (BTF) is another NGO established in 2015 with a view to work for public mobilization against suicide, sensitization of reporting in media, celebrating international suicidal prevention day and mental health day (Khan et al., 2020).

5.5 Academic Society—SSPB

The Society for Suicide Prevention Bangladesh (SSPB), an association was founded in 2016 with the ambition to enhance suicide prevention in Bangladesh. Unfortunately, it is struggling to demonstrate noticeable suicide prevention activities. Also, it could not make any national and international collaboration for increasing its activities (Arafat, 2018; Khan et al., 2020).

6 Readiness of National Suicide Prevention Strategies

WHO widely explored the importance of developing a national suicide prevention strategy that has numerous benefits such as helps to outlines the scope and magnitude of the problem as well as momentously recognizes that suicidal behavior is a major public health problem. It is also an indicator of the commitment of a government to addressing the issue. It recommends a structural framework incorporating various aspects of suicide prevention and provides authoritative guidance on key evidence-based suicide prevention activities. It helps to identify key stakeholders and allocate specific responsibilities to them. Moreover, it outlines the necessary coordination among these various groups and identifies vital gaps in existing legislation, service provision, and data collection and indicates the human and financial resources required for interventions. It shapes advocacy, awareness-raising and media communications and proposes a robust framework of monitoring and evaluation, thereby instilling a sense of accountability among those in charge of interventions as well as provides a context for a research agenda on suicidal behaviors (WHO, 2018).

According to Arafat (2021), Bangladesh has not formulated a central suicide database and national suicide prevention strategies until now. This section aims to focus on the current status of Bangladesh with regard to establishing national suicide prevention strategies based on 12 components suggested by WHO. Responsible media reporting is a key element of the national suicide prevention strategy but it is poor in quality and unresponsive to Bangladesh. It has no concrete guideline which is obligatory to improve the current status. To sustain nationwide suicide prevention program and awareness raising is an important component. However, few periodic activities are done by some NGOs and from the government level. There is also a lack of structured policies which is necessary to raise awareness among mass population at a satisfactory level. To develop skilled manpower through training and education is a key to articulate suicide prevention strategies but is not outlined yet in Bangladesh. The available treatment facilities for suicide patients are drastically insufficient and as it is an illegal offense the individual with suicide referred to a police case. There is also a lack of fund and political motivation for research on suicide and activities for suicide prevention. The services available for crisis intervention are inadequate according to demand. There is also lacking of institutional support to create a leader for the promotion and prevention of suicide. The government of Bangladesh has banned WHO class I pesticides but policy regarding other methods of means restriction is ignored. As an element of national suicide prevention strategies, it is recommended to take care of the postvention but they are not interested due to the legal status of the society and stigma. Again, stigma, inadequate services and avoidance of the providers may hinder the accessibility of the individual who are vulnerable. To establish a national suicide surveillance is challenging for underreporting and poor quality of data. So, Bangladesh is far off from the components of national suicide prevention strategies suggested by WHO.

7 Challenges of Suicide Prevention in Bangladesh

A well-designed suicide prevention strategy may threaten its success and sustainability due to barriers. So, overcoming barriers is crucial and actions need to be well-defined and structured, taking into account the stakeholders involved, the resources available, and the characteristics of the national and local contexts. Considering this in advance may help to avoid barriers and reduce their consequences (WHO, 2018). According to WHO, potential barriers to consider when implementing national suicide prevention strategies are management and logistics to understanding the problem and for actions and interventions, stakeholders for leadership and management, teamwork and collaboration and legislation and policies, financial resources, human resources, multisectoral involvement, data and stigma (WHO, 2018).

From the previous section, it gives an impression that Bangladesh may not rapidly moving forward toward suicide prevention because of the lack effective and comprehensive policy measures to fight suicide and suicidal behavior. Again, the prevention intervention which is available is isolated, segmented, mostly under-performing, under-funded, or not funded. So, there is no visible societal impact. In such a circumstance, it is not surprising for LMICs like Bangladesh to have obstructing factors and challenges (Khan et al., 2020). The significant challenges for suicide prevention in Bangladesh are as follows:

7.1 Criminal Legal Status

According to the Penal Code (1860) section 309, Suicide is considered as criminal offence in Bangladesh. Any person attempts to suicide and activities related with this will be punishable through imprisonment and fine. The member of law enforcement agency has the right to arrest people who endeavoring suicide. In addition, to avoid legal procedure and harassments patient cannot complete treatment and leave the hospital without any prior notice. It is also a stigmatized and discriminated issue in the country (Soron, 2019). However, modification of the legal situation of suicide might be advantageous to decrease societal stigma, unnecessary legal harassment, anxiety to take health services after suicidal comportment (Arafat, 2019; Arafat and Khan, 2019). Decriminalization may help to destigmatize the problem and increase the proper help-seeking behaviors for suicidality as well as demolish the undue legal harassments (Arafat, 2019).

7.2 Poor Quality of Media Reporting

An accountable media reporting is key to a potential national suicide prevention strategy for mass population (WHO, 2017; Zalsman et al., 2016; Niederkrotenthaler et al., 2020). Media play a noteworthy role to raise awareness among the people and change their attitude on suicide and prevention

of suicide. In Bangladesh, there is a lack of enquiry of suicide reporting by media. Thus, general people are misunderstood and misguided of this issue. As suicide is a criminal offence in Bangladesh, media broadcasting of suicide events is undertaken by crime journalists (Arafat, 2019). A study conducted reveals that report of suicide news is placed on the first page of the newspaper and majority reported the methods of suicide with details. About fifty percent of the articles provide monocausal description of suicide incident. Few articles report the place of suicide and suicide note in details and also the impacts of suicide on person with bereaved. It also noted that tremendous lack of supportive reporting features on suicide and views of mental health experts (Arafat et al., 2020). Furthermore, media reports from online portal also deliver data in poor quality on suicidal behavior such as mention victim's name with details, methods of suicide including victim's image. There is no report observe with education and prevention approaches of suicide for mass population (Arafat et al., 2019).

7.3 Poor Data Quality

A reliable source of suicide information is a real challenge in the country and actual rate of suicide is yet to be estimated (Arafat, 2019, 2017; Shah et al., 2017). A countrywide epidemiological study has not been conducted in Bangladesh (Arafat, 2019). The absence of a national suicide prevention strategy, nonexistence of central database, surveillance system for suicide, and extreme stigma is a serious challenge for Bangladesh like many other countries of Southeast Asia (Armstrong and Vijayakumar, 2018; Arafat, 2017).

7.4 Poor Awareness and Suicide Literacy Along with High Suicide Stigma

Study reveals that suicide literacy among the university students of Bangladesh is inadequate and they also have poor knowledge on suicidality and depression. The presence of stigma, legal status of suicide as a criminal offence and lacking of mass education among the people could be the key determinants of poor literacy of suicide that is hamper the help-seeking behavior of suicide in the country (Arafat, Menon et al., 2021). However, they have adequate knowledge on suicide prevention and the role of mental health experts (Arafat et al., 2022). For example, the Prime Minister of Bangladesh gave direction to establish a suicide research institution in *Jhenaidah* in 2014, a suicide prone area, was not established until now. It indicates the lack of knowledge, capacity and unenthusiastic to give priority on suicide prevention (Khan et al., 2020).

7.5 *Inadequate Mental Health Services*

In Bangladesh the available mental health services are drastically inadequate according to the need of the people. A few initiatives are taken for suicide prevention in Bangladesh such as two SPCs are established; one is public with limited hours of service provision and the other is private. The extreme lacking of mental health services are a significant challenge for the national suicide prevention strategy in the country (Arafat, Menon et al., 2021; Arafat et al., 2019; Arafat, 2018).

7.6 *Negligible Budget*

The fund availability for suicide prevention activities, research on suicide, and the mental health services are undoubtedly inadequate. Normally, the budget for mental health is approximately 0.5% of health budgets. There is also a lack of political motivation to introduce a suicide prevention policy which is a timely demand for the country (Arafat, 2021).

8 Suicide Prevention in Bangladesh: Way Forward

'*National suicide prevention strategies: Progress' examples and indicators*' a report launched by WHO in 2018 to support countries with their continued progress in suicide prevention, whilst inspiring others to establish or revise their national suicide prevention strategies. In this situation, Bangladesh should pay attention to global call and formulate a national suicide prevention action plan (Khan et al., 2020). A national suicide database and suicide surveillance is an imperative considerations of Bangladesh. Changes in the legal system to decriminalize suicide in the country should be considered as instantaneous priority, which has been already done in some other parts of the world (Soron, 2019; Arafat, 2019). Decriminalisation may help to destigmatize the problem and increase the proper help-seeking behaviours for suicidality as well as demolish the undue legal harassments (Arafat, 2019). It is an immediate obligation for the country to construct appropriate prevention strategy to formulate, initiate, implement and evaluate its effectiveness. Multisectoral collaboration such as clinicians, social scientist, researchers, funders, media professionals, social workers, voluntary organisations, non-governmental organisation, government, and/or any organisation connected with suicidality is also a key action for the country. International organisations should come forward to cooperate with the country in this regard (Arafat, 2019).

Bangladesh may consult with Bhutan and Sri Lanka as they have effective national prevention strategy and have similar socio-economic and cultural context (Khan et al., 2020; WHO, 2018). In 2015, Bhutan adopted three years action plan from 2015 to 2018 for suicide prevention (Vijayakumar

et al., 2020). This multifaceted action plan necessitates diverse cross-sectoral key stakeholders, sectors, and organizations. A Suicide Prevention Steering Committee (NSPSC) was created under the Ministry of Health to maintain governance and active operation of the plan (WHO, 2018).

8.1 Decriminalization

In many countries decriminalization of suicide is considered as a part of suicide prevention strategy (Suryadevara and Tandon, 2018). The issue is also raised by some other Asian countries (Suryadevara and Tandon, 2018). At present, the decriminaliztion of suicide is a rising issue pronounced by the academicians in Bangladesh. In the country, it is a vital prerequisite for confirming suitable suicide prevention environment (Soron, 2019). However, only decriminalization will not provide any positive impact on suicide prevention in Bangladesh without addressing the other vital issues related to suicide like trustworthy reporting of media on suicidal behavior, suicide surveillance system, national database of suicide, national suicide prevention strategies, empirical research and appropriate policy implementation. This may lead to change the attitude of mass people to suicidality by reducing legal restriction, social stigma and also increase the accessibility to health care.

On the contrary, the recently endorsed *Bangladesh Mental Health Act 2018* does not suggest any clear provision to approach decriminalization of suicide or attempt to suicide but the matter of decriminalization must be prioritized in order that suicidal populations can have their access to treatment instead of punishment (Soron, 2019; Vijayakumar et al., 2020; Khan et al., 2020). Again, Bangladesh is on the way to articulate an inclusive suicide prevention policy or an essential database for suicide prevention in line with the call of WHO (Arafat, 2021). Bangladesh highly needs an inclusive and vigorous mental health strategy that integrates suicide prevention (Khan et al., 2020).

8.2 Media Monitoring

Responsible media reporting of suicide is one of the four pillars of the WHO's *Live Life* suicide prevention framework. Detrimental media reporting transmits contagion risks for people vulnerable to suicide. There is an opportunity to implement media reporting approaches that may have protective effects on the population (WHO, 2021b).

8.3 Intersectoral Collaboration

It is necessary since the risk factors for suicide are linked with many areas. A whole-of-society approach works across government sectors or departments and includes nongovernmental and community groups and facilitates knowledge-sharing, exchange of methodologies and lessons learned, and

sharing of suicide-related data and research under the leadership of government (WHO, 2014). Intersectoral collaborators such as clinicians, social workers, researchers, media professionals, social scientists, voluntary organisations, government and non-governmental organisations connected with suicidality are a keyactorin the country. International organisations should come forward to cooperate with the country in this regard (Arafat, 2019).

8.4 More Funds in Suicide Research

Financing for suicide prevention is often inadequate because of factors such as poor economic conditions, lack of prioritization of suicide as a serious issue, and lack of recognition that suicides are preventable. So, that requests for funds should include a focus on the development and implementation of policies, strategies, and plans (WHO, 2014).

8.5 Raising Awareness

It depends on targets a public audience and an organized process of communication through which draws people's attention to the facts such as suicide is a serious public health issue. Advocacy aims to bring about changes such as decriminalization or a national suicide prevention strategy. Both the strategies can range from a single community to nationwide public communication campaigns such as 'World Suicide Prevention Day'. It may also help to decrease stigma and negative attitudes among people with a mental disorder (WHO, 2014).

8.6 Gate Keeper Training

Sometimes people who are at risk of suicide may not seek help. A "*gatekeeper*" can be useful in such cases to identify the risky individuals and to refer them to mental health services based on it's accessibility and availability (WHO, 2014).

8.7 Improved Quality Data

National suicide database and suicide surveillance is an imperative consideration of Bangladesh to improve the quality of suicide data in Bangladesh. Changes in the legal system to decriminalize suicide in the country should be considered as instantaneous priority to ensure better suicide reporting which in turn will improve the suicide data quality in the country (Arafat, 2019; Suryadevara and Tandon, 2018).

8.8 National Suicide Surveillance System

It can provide data on suicide and self-harm to guide LIVE LIFE interventions and the source of data such as civil registration and vital statistics, health and police records, verbal autopsies, and population-based surveys.

8.9 National Suicide Prevention Strategy

'*National suicide prevention strategies: Progress' examples and indicators*' a report launched by WHO in 2018 to support the countries in suicide prevention with their continued progress, whilst inspiring others to launch or revise their national suicide prevention strategies. In this situation, Bangladesh should pay attention to global call and articulate a national suicide prevention action plan (Khan et al., 2020). It is an immediate obligation for the country to construct appropriate prevention strategy to formulate, initiate, implement and evaluate its effectiveness.

8.9.1 Increased Psychiatric Services

Generally, in the primary care setting depression and other forms of psychiatric disorders are under-treated and under-predictable. Studies from several developed countries revealed that there is a significant association educating of primary care provider and reducing suicide by early identification of depression, substance abuse, and other risk factors for suicide. For example, in Australia, to implement a training program for physician of the primary care level help to increase the diagnosis rate by 130% of suicidal patients. Subsequently, educating physician of the primary health care level for appropriate assessment of depression and evaluation of the risk of suicide is an element of suicide prevention (Mann et al., 2005; Zalsman et al., 2016).

8.9.2 Religious or Spiritual Beliefs

Religious beliefs and spirituality give mental happiness. They inspire people to endure in any kind of difficulties. Generally, people commit suicide when they cannot accept something contrary to their expectation. Most religions prohibit committing suicide and consider it a great sin. Suicide is forbidden in both Judaism and Christianity. It is also forbidden in Islam. Again, spirituality gives mental satisfaction which is very important in abstaining from any kind of harmfulness including suicide. Thus, religion and spirituality can play a vital role in preventing all sorts of destruction including one's own. So, by maintaining religious obligation and spirituality, a society can prevent suicide.

9 Conclusion

In Bangladesh, suicide is a neglected public health issue. The key risk factors are triumphed within the family and the common methods are hanging and poisoning. The criminal legal status, poor quality data, lack of awareness, actual suicide rate, poor quality media reporting, inadequate mental health services, social stigma, negligible budget, and poor coordination among the sectors are real challenge for this part. The mortality rate by suicide was higher among women than men in their productive age and hindered the economic development of the country. Effective and encompassing policy interventions though obtaining a promise from the policymakers is a daunting task. Preventive measures have been in progress but yet to make tracks. Finally, empirical studies, increased psychiatric services through primary care physician education in different levels of health sector, decriminalization and national suicide surveillance are the priority list for the country.

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