CHAPTER 7

Crisis, Trauma, and Suicide in Bangladesh

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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

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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

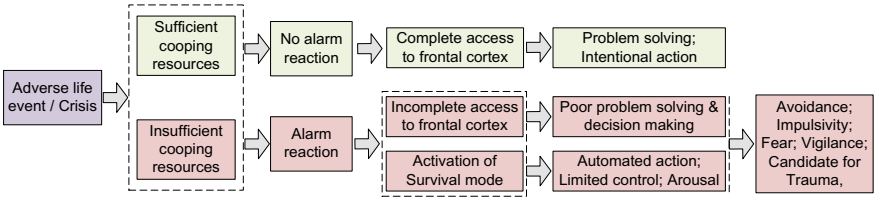

Fig. 1 Schematic diagram depicting the relation between adverse life experience, coping, and outcome

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.

References

American Psychological Association. (2022). *Trauma*. Retrieved October 01, 2022 from https://www.apa.org/topics/trauma

Arafat, S. M. Y. (2019). Current challenges of suicide and future directions of management in Bangladesh: A systematic review. *Global Psychiatry, 2*(1), 9–20. https://doi.org/10.2478/gp-2019-0001

Arafat, S. M. Y., Hussain, F., Zaman, M. S., Tabassum, T., Islam, M. K., Shormi, F. R., … Khan, M. A. S. (2022). Thwarted belongingness, perceived burdensomeness, and acquired capability for suicide among university students of Bangladesh: Scales validation and status assessment. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.1025976

Arafat, S., & Khan, M. M. (2021). Sexual violence and suicide in Bangladesh. *Health Science Reports*, *4*(2), e269. https://doi.org/10.1002/hsr2.269

Arafat, S., Khan, M., Knipe, D., & Khan, M. M. (2021). Population attributable fractions of clinical and social risk factors for suicide in Bangladesh: Finding from a case-control psychological autopsy study. *Brain and Behavior*, *11*(12), e2409. https://doi.org/10.1002/brb3.2409

Arafat, S. M. Y., Mohit, M. A., Mullick, M. S. I., Kabir, R., & Khan, M. M. (2021). Risk factors for suicide in Bangladesh: Case–control psychological autopsy study. *BJPsych Open*, *7*(1), e18, Article e18. https://doi.org/10.1192/bjo.2020.152

Arafat, S., Mohit, M. A., Mullick, M., Khan, M., & Khan, M. M. (2021). Suicide with and without mental disorders: Findings from psychological autopsy study in Bangladesh. *Asian Journal of Psychiatry*, *61*, 102690. https://doi.org/10.1016/j.ajp.2021.102690

Arafat, S. M. Y., Saleem, T., Edwards, T. M., Ali, S. A.-e.-Z., & Khan, M. M. (2022). Suicide prevention in Bangladesh: The role of family. *Brain and Behavior*, *12*(5), e2562. https://doi.org/10.1002/brb3.2562

Beck, A. T., & Steer, R. A. (1988). *Beck hopelessness scale*. Psychological Corporation.
Beck, A. T., & Steer, R. A. (1993). *Beck scale for suicide ideation (BSS)*. Pearson.
Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the beck depression inventory-II*. Psychological Corporation.
Bhuiyan, A. K. M. I., Sakib, N., Pakpour, A. H., Griffiths, M. D., & Mamun, M. A. (2021). COVID-19-related suicides in Bangladesh due to lockdown and economic factors: Case study evidence from media reports. *International Journal of Mental Health and Addiction*, *19*(6), 2110–2115. https://doi.org/10.1007/s11469-020-00307-y
Carver, C. S. (1997). You want to measure coping but your protocol' too long: Consider the brief cope. *International Journal of Behavioral Medicine*, *4*(1), 92–100. https://doi.org/10.1207/s15327558ijbm0401_6
Castelli Dransart, D. A., Gutjahr, E., Gulfi, A., Kaufmann Didisheim, N., & Séguin, M. (2014). Patient suicide in institutions: Emotional responses and traumatic impact on Swiss mental health professionals. *Death Studies*, *38*(5), 315–321. https://doi.org/10.1080/07481187.2013.766651
Centers for Disease Control and Prevention. (2019). *CERC: Psychology of a crisis*. Atlanta: US Department of Health Human Services
Cloitre, M., & Rosenberg, A. (2006). Sexual revictimization: Risk factors and prevention. In V. C. Follette & J. I. Ruzek (Eds.), *Cognitive-behavioral therapies for trauma* (pp. 321–361). Guilford.
Compas, B. E. (1987). Coping with stress during childhood and adolescence. *Psychological Bulletin*, *101*(3), 393–403. https://doi.org/10.1037/0033-2909.101.3.393
Deeba, F., & Rapee, R. M. (2015). Prevalence of traumatic events and risk for psychological symptoms among community and at-risk children and adolescents from Bangladesh. *Child and Adolescent Mental Health*, *20*(4), 218–224. https://doi.org/10.1111/camh.12093
Ell, K. (1996). Crisis theory and social work practice. In F. J. Turner (Ed.), *Social work treatment* (4th Edn., pp. 168–190). The Free Press.
Feroz, A., Islam, S. N., Reza, S., Rahman, A. M., Sen, J., Mowla, M., & Rahman, M. R. (2012). A community survey on the prevalence of suicidal attempts and deaths in a selected rural area of Bangladesh. *Journal of Medicine*, *13*(1), 3–9. https://doi.org/10.3329/jom.v13i1.10042
Folkman, S., & Lazarus, R. S. (1988). Ways of coping questionnaire: Research edition. Palo Alto, CA: Consulting Psychologists Press.
Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revictimization: The mediating role of coping and trauma symptoms. *Psychology of Women Quarterly*, *33*(3), 308–320. https://doi.org/10.1111/j.1471-6402.2009.01503.x
Glennie, E. J. (2010). Coping and resilience. In J. A. Rosen, E. J. Glennie, B. W. Dalton, J. M. Lennon, & R. N. Bozick (Eds.), *Noncognitive skills in the classroom: New perspectives on educational research* (pp. 169–194). RTI Press.
Gunnell, D., Platt, S., & Hawton, K. (2009). The economic crisis and suicide. *BMJ, 338*, b1891. https://doi.org/10.1136/bmj.b1891
Inscoe, A. B., Donisch, K., Cheek, S., Stokes, C., Goldston, D. B., & Asarnow, J. R. (2022). Trauma-informed care for youth suicide prevention: A qualitative analysis of caregivers' perspectives. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*, 653–660. https://doi.org/10.1037/tra0001054

Jenzer, T., Meisel, S. N., Blayney, J. A., Colder, C. R., & Read, J. P. (2020). Reciprocal processes in trauma and coping: Bidirectional effects over a four-year period. *Psychol Trauma*, *12*(2), 207–218. https://doi.org/10.1037/tra0000500

Jobes, D. A., Jacoby, A. M., Cimbolic, P., & Hustead, L. A. T. (1997). Assessment and treatment of suicidal clients in a university counseling center. *Journal of Counseling Psychology*, *44*, 368–377. https://doi.org/10.1037/0022-0167.44.4.368

Josepho, S. A., & Plutchik, R. (1994). Stress, coping, and suicide risk in psychiatric inpatients. *Suicide and Life-Threatening Behavior*, *24*(1), 48–57. https://doi.org/10.1111/j.1943-278X.1994.tb00662.x

Kabir, H., Maple, M., Islam, M. S., & Usher, K. (2019). The current health and wellbeing of the survivors of the Rana Plaza Building Collapse in Bangladesh: A qualitative study. *International Journal of Environmental Research and Public Health, 16*(13), 2342. https://www.mdpi.com/1660-4601/16/13/2342

Khan, A. R., Uddin, H., Shimul, A. K., & Billah, M. (2022). Coronavirus (COVID-19) crisis and suicide in Bangladesh: Some explanations through Durkheim's sociology of suicide. *Journal of Community Positive Practices(3)*, 3–17. https://doi.org/10.35782/JCPP.2022.3.01

Kılınç, M., Arslan, G., Çakar, F. S., & Yıldırım, M. (2022). Psychological maltreatment, coping flexibility, and death obsession during the COVID-19 pandemic: A multi-mediation analysis. *Current Psychology*. https://doi.org/10.1007/s12144-021-02576-9

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kutcher, S., & Chehil, S. (2007). Putting it all together: The tool for assessment of suicide risk (TASR). In S. Kutcher & S. Chehil (Eds.), *Suicide risk management: A manual for health professionals*. Wiley-Blackwell.

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. G. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: Findings from a U.S. Nationally Representative Sample. *Journal of Traumatic Stress*, *28*(3), 183–190. https://doi.org/10.1002/jts.22010

Mamun, M. A. (2021). Suicide and suicidal behaviors in the context of COVID-19 pandemic in Bangladesh: A systematic review. *Psychology Research and Behavior Management, 14*, 695–704. https://doi.org/10.2147/prbm.s315760

Mamun, M. A., & Griffiths, M. D. (2020). PTSD-related suicide six years after the Rana Plaza collapse in Bangladesh. *Psychiatry Research*, *287*, 112645. https://doi.org/10.1016/j.psychres.2019.112645

Navarro-Atienzar, F., Zabala-Baños, C., & Ricarte-Trives, J. J. (2019). Childhood Trauma as a risk factor for suicidal behaviour in prisons. *Revista Española de Sanidad Penitenciaria, 21*(1), 42–51.

Pereira, A. M., & Campos, R. C. (2022). Exposure to suicide in the family and suicidal ideation in Portugal during the Covid-19 pandemic: The mediating role of unbearable psychache. *British Journal of Clinical Psychology, 61*(3), 598–612. https://doi.org/10.1111/bjc.12325

Plunkett, A., O'Toole, B., Swanston, H., Oates, R. K., Shrimpton, S., & Parkinson, P. (2001). Suicide risk following child sexual abuse. *Ambulatory Pediatrics, 1*(5), 262–266. https://doi.org/10.1367/1539-4409(2001)001<0262:srfcsa>2.0.co;2

Rahman, M. E., Saiful Islam, M., Mamun, M. A., Moonajilin, M. S., & Yi, S. (2022). Prevalence and factors associated with suicidal ideation among university students in Bangladesh. *Archives of Suicide Research, 26*(2), 975–984. https://doi.org/10.1080/13811118.2020.1833800

Rasheduzzaman, M., al-Mamun, F., Hosen, I., Akter, T., Hossain, M., Griffiths, M. D., & Mamun, M. A. (2022). Suicidal behaviors among Bangladeshi university students: Prevalence and risk factors. *PLoS One*, *17*(1), e0262006. https://doi.org/10.1371/journal.pone.0262006

Reynolds, W. M. (1987). *Suicidal ideation questionnaire (SIQ)*. Psychological Assessment Resources.

Reza, A. S., Feroz, A. H. M., Islam, S. N., Karim, M. N., Rabbani, M. G., Shah Alam, M., Rahman, M. M., Rahman, M. R., Ahmed, H. U., Bhowmik, A. D., Khan, M. Z. R., Sarkar, M., Alam, M. T., & Jalal Uddin, M. M. (2014). Risk factors of suicide and para suicide in rural Bangladesh. *Journal of Medicine*, *14*(2), 123–129. https://doi.org/10.3329/jom.v14i2.19653

Sheerin, C. M., Chowdhury, N., Lind, M. J., Kurtz, E. D., Rappaport, L. M., Berenz, E. C., … Amstadter, A. B. (2018). Relation between coping and posttrauma cognitions on PTSD in a combat-trauma population. *Military Psychology, 30*(2), 98–107. https://doi.org/10.1080/08995605.2017.1420980

Shields, A., & Cicchetti, D. (1998). Reactive aggression among maltreated children: The contributions of attention and emotion dysregulation. *Journal of Clinical Child Psychology*, *27*(4), 381–395. https://doi.org/10.1207/s15374424jccp2704_2

Smith, P. N., Kuhlman, S., Wolford-Clevenger, C., Faulk, R., D'Amato, D., & Granato, S. (2016). Interpersonal trauma, posttraumatic stress disorder symptoms, and the interpersonal theory of suicide in women seeking shelter from intimate partner violence. *Journal of Aggression, Maltreatment & Trauma, 25*(8), 812–830. https://doi.org/10.1080/10926771.2016.1214937

Spillane, A., Matvienko-Sikar, K., Larkin, C., Corcoran, P., & Arensman, E. (2018). What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. *BMJ Open*, *8*(1), e019472. https://doi.org/10.1136/bmjopen-2017-019472

Stanley, I. H., Boffa, J. W., & Joiner, T. E. (2019). PTSD from a suicide attempt: Phenomenological and diagnostic considerations. *Psychiatry*, *82*(1), 57–71. https://doi.org/10.1080/00332747.2018.1485373

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a traumainformed approach*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575–600. https://doi.org/10.1037/a0018697

Whiteman, S. E., Kramer, L. B., Petri, J. M., & Weathers, F. W. (2019). Trauma type and suicidal ideation: The mediating effect of cognitive distortions. *Traumatology*, *25*(4), 262–268. https://doi.org/10.1037/trm0000192

World Health Organization. (2009). *HIV counselling handbook for the Asia-Pacific*. WHO Regional Office for South-East Asia. Retrieved October 26, 2022, from https://apps.who.int/iris/handle/10665/205268

World Health Organization. (2020). *Bangladesh: WHO special initiative for mental health, situational assessment*. World Health Organization.Retrieved October 26, 2022, from https://www.who.int/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---bangladesh---2020.pdf?sfvrsn=c2122a0e_2

Yi, S., Chang, E. C., Chang, O. D., Seward, N. J., McAvoy, L. B., Krause, E. R., … Hirsch, J. K. (2021). Coping and suicide in college students. *Crisis*, *42*(1), 5–12. https://doi.org/10.1027/0227-5910/a000662