Practice Innovations

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Integrating Trauma-Informed Principles Into Suicide Prevention, Intervention, and Postvention

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There are elevated rates of trauma in individuals with suicidal thoughts and behaviors, and individuals with suicidality or bereaved by suicide have an increased risk of trauma. Due to this relationship between trauma and suicide, there is a consensus from experts that suicide prevention work must be trauma-informed. Currently, there is a dearth of research on trauma-informed programs and interventions for those thinking of suicide or supports for individuals bereaved by suicide, leaving service providers without guidance on trauma-informed practices with suicide, and individuals with co-occurring traumatic stress and suicidal thoughts and behaviors without access to trauma-informed services. This article uses the framework of Substance Abuse and Mental Health Services Administration's trauma-informed principles to provide guidance to organizations on the application of trauma-informed practices in their work in suicide prevention, with individuals experiencing suicidal thoughts and behaviors and with suicide loss survivors. Systemic barriers and concerns are also discussed.

Clinical Impact Statement
Using Substance Abuse and Mental Health Service's principles of trauma-informed care, this article provides a trauma-informed framework for suicide prevention, intervention, and postvention work that can be applied across a diversity of settings and used by service providers in a variety of clinical and nonclinical roles.

Keywords: suicide, trauma, trauma-informed care

Both suicide and trauma are significant public health issues that lead to distress and psychological pain, and there is a strong two-way relationship between the two experiences. Many individuals with suicidal thoughts and behaviors have a history of trauma (Dube et al., 2001; O'Connor, 2021; Ong et al., 2021), and suicidal behaviors elevate an individual's risk of trauma due to the traumatic nature of an attempt or iatrogenic interventions (Stanley, Boffa, & Joiner, 2019; Sweeney et al., 2018; Ward-Ciesielski & Rizvi, 2021). Further, suicide attempts and suicide deaths are traumatic for family and friends (J. R. Jordan, 2020). Although this relationship is well known, suicidology's roots in the biomedical paradigm have led to a model of suicide prevention that "considers distressed conditions as a pathology and does not emphasize enough the social, political, and historical contexts that can have an important role in causing human suffering." (Berman et al., 2021, p. 168). This current model of suicide prevention, which treats individuals' mental health issues and medicalizes suicidality, is not working (Silverman & Berman, 2020). After a brief decline during the COVID-19 pandemic, suicide rates rose 4% from 2020 to 2021 (Curtin et al., 2022). Individuals with lived experience with suicide have shared the harm they experience due to current treatment models for suicide, including the

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use of emergency departments and psychiatric hospitals (Freedenthal, 2018; Hom et al., 2021; Inscoe et al., 2022; Stefan & Cain, 2017). Individuals are traumatized by interventions meant to help them (Stefan & Cain, 2017; Ward-Ciesielski & Rizvi, 2021), and suicide loss survivors are faced with a dearth of support services that recognize or address their trauma (J. R. Jordan, 2020). There is an urgent need to reframe and reconstruct current suicide-focused research and practice. Experts in the field of suicidology have emphasized the importance of a trauma-informed approach that understands the prevalence of trauma and its relationship to suicide, recognizes the impact of trauma and the ways a system must be responsive to these needs, avoids traumatization, and values the feedback of those with lived experience (Asarnow et al., 2020; Berman et al., 2021; Freedenthal, 2018; Inscoe et al., 2022; O'Connor, 2021; O'Neill et al., 2021).

In recent years, best practices in working with individuals with suicidal thoughts and behaviors have moved away from coercive approaches, emphasizing collaborative, strengths-based work (Labouliere et al., 2018; Sweeney et al., 2018; Tunno et al., 2021). Even so, concern for an individual's immediate physical safety can shift interventions toward directive, coercive, and adversarial approaches, which can increase stigma, exacerbate traumatic stress, decrease access to services, and make individuals less willing to disclose suicidal thoughts and behaviors in the future (Fogarty et al., 2021; O'Neill et al., 2021). Agency policies or concern about legal liability may inadvertently encourage or require these directive approaches (Borecky et al., 2019; O'Neill et al., 2021). It is time to critically reflect on current practice across settings and consider the ways in which current practice is not trauma-informed and therefore may not be meeting the needs of the individuals served by the agency or organization—or may even be causing harm (Asarnow et al., 2020; Borecky et al., 2019).

There are many evidence-based practice models for working with individuals who have experienced trauma (Menschner & Maul, 2016; e.g., eye movement desensitization and reprocessing [EMDR], trauma-focused cognitive behavior therapy [TF-CBT], dialectical behavior therapy [DBT]). Alternatively, there are some evidence-based approaches for treating suicidality that adhere to some of trauma-informed principles (e.g., collaboration), but are not trauma-focused treatment nor do they follow a comprehensive trauma-informed approach (e.g., collaborative assessment and management of suicidality [CAMS]). Currently, there is no model for a trauma-informed approach to working with suicidality (Inscoe et al., 2022). This article will highlight the need for such an approach and outline guidelines for a trauma-informed approach across suicide prevention, intervention, and postvention.

Trauma-Informed Care

Trauma-informed care is a perspective or lens through which the service provider approaches their work with all individuals, regardless of a known trauma history. It is not a treatment approach or intervention, and its focus is not on processing or treating trauma. It is "both an organizational and clinical practice that recognizes the complex impact trauma has on both patients and providers" (Menschner & Maul, 2016, p. 3). Trauma-informed organizations train both clinical and nonclinical staff (e.g., school staff and teachers, child protection workers, and after-school service providers) in providing services that realize the prevalence and impact of trauma, recognize the symptoms of trauma and the ways that trauma can impact an individual across the lifespan, respond to individuals with an integration of this knowledge into practice and policies, and actively work to resist retraumatization, understanding the typical practices can trigger a stress response for individuals with a history of trauma (Menschner & Maul, 2016; SAMHSA, 2014).

Trauma-informed principles can be applied to a diversity of settings, ranging from a middle school classroom, inpatient hospital floor, support group for suicide loss survivors, or parenting skills group. Many types of agencies and organizations can shift their practices and policies so both the services provided and the organization itself are trauma-informed (Menschner & Maul, 2016). Although not all individuals served by the agency have experienced trauma, using a trauma-informed approach increases inclusion for individuals with a trauma history and will not be harmful to those that do not. For example, some organizations screen for trauma events and/or symptoms (Menschner & Maul, 2016), using a trauma-informed approach to the screening process.

Six principles guide SAMHSA's model of trauma-informed care: safety; trustworthiness and transparency; peer support; collaboration, and mutuality; empowerment, voice, and choice; and awareness and inclusion of cultural, historical, and gender issues (SAMHSA, 2012). These principles are integrated throughout an organization's culture, physical space, and policies, as well as service providers' interactions and work with individuals. Trauma-informed care uses these principles in conjunction with an awareness of the prevalence of trauma and its impact across the lifespan, integrates this knowledge into all interactions with individuals, and consciously avoids retraumatization. In suicide-focused work, this means bringing an awareness of the prevalence of trauma and knowledge about the impact of trauma into suicide prevention programs, work with individuals experiencing suicidal thoughts and behaviors, including crisis teams, emergency rooms, and outpatient therapy settings, and into work with family and friends who have been bereaved by the suicide death of a loved one or organizations such as workplaces or schools that have experienced a suicide death. The following section will describe the application of the six principles to suicide-focused work, identifying trauma-informed approaches, situations in which the risk of retraumatization is high, and barriers to this work.

Principle #1: Safety

The foundation of trauma-informed work is safety. Safety has multiple dimensions, including feelings of physical safety, emotional safety, and relational safety (SAMHSA, 2012). Safety is not limited to the physical environment and an individual's physical safety. It also encompasses the avoidance of triggers and retraumatization and the creation of a relationship characterized by consistency, dependability, predictability, empathy, compassion, trustworthiness, and an ability to share psychological pain (SAMHSA, 2012). Although these characteristics are the foundation of helping relationships, sometimes when an individual shares suicidal thoughts and behaviors, these relationships shift due to anxiety about the individual's immediate physical safety. Anxiety can lead to overreaction and referral to a higher level of care than is necessary (Fogarty et al., 2021; O'Neill et al., 2021). For example, schools often send students with suicidal thoughts to an emergency room, even when their level of risk does not warrant that response. Some organizations have policies that support this type of response.

Trauma-informed care highlights the avoidance of retraumatization. Examples of situations with the potential to be retraumatizing include dismissive or reactive responses to disclosures of suicidality, interventions such as transportation to the emergency room or calling 911, emergency room care, and hospitalization (Inscoe et al., 2022; Sweeney et al., 2018; Ward-Ciesielski & Rizvi, 2021). Service provider reactivity can stigmatize suicidality and compromise long-term safety if the intervention is ineffective, disrupts the relationship, discourages future disclosures of suicidality, or triggers a traumatic stress response (O'Neill et al., 2021; Ward-Ciesielski & Rizvi, 2021). Interventions for suicidality such as hospitalization or use of emergency services can elevate suicide risk and cause retraumatization for some individuals (Chung et al., 2019; Guzman et al., 2018; J. T. Jordan & McNiel, 2020). To avoid unnecessary referrals, individuals who disclose suicidal thoughts and behaviors should be referred to a mental health professional, ideally one with whom they already have a relationship, who is competent in the assessment of suicide risk, which is not the case in all settings (Inscoe et al., 2022; O'Neill et al., 2021; Schmitz et al., 2018). Many service providers, even those who are clinically trained, will need additional education to do a trauma-informed assessment with individuals with suicidal thoughts and behaviors (Inscoe et al., 2022).

Using a trauma-informed approach, a service provider responds empathetically and calmly to a client's disclosure of suicidal thoughts, supporting relational safety. If the service provider is not a clinician (e.g., teacher, DCF worker, residential staff), they can listen and stay with the individual until they can be assessed by a clinician. With a focus on physical safety, the clinician can assess the level of risk, understanding that this assessment is best completed within a safe relationship rather than by an outside service provider. Intervention should occur in the least restrictive setting possible (Zero Suicide, n.d.). Hospitalization, typically considered the most restrictive setting, should only be used when the assessment identifies an acute risk that cannot be managed in the current setting (Zero Suicide, n.d.). While using a high threshold

for hospitalization can increase service provider anxiety regarding liability, service providers can protect themselves from liability by using evidence-based approaches to assess and treat at-risk individuals, always clearly documenting their decision-making (Stanley et al., 2019). These actions can be supported by regularly attending training on current best practices in working with individuals with suicidal thoughts and behaviors (Stanley et al., 2019).

If the evaluating clinician determines that the risk requires referral to an emergency department, the service provider can encourage this to be done in a way that emphasizes safety and minimizes the risk of retraumatization. For example, the service provider can have a family member or friend accompany the client, allow caregivers to remain with children, avoid strapping clients to gurneys, permit individuals to remain clothed, and discourage service providers from asking for potentially activating details of traumatic experiences (Inscoe et al., 2022; Stefan & Cain, 2017).

Principle #2: Trustworthiness and Transparency

The second principle of trauma-informed care is the concept of trustworthiness and transparency (SAMHSA, 2014). Trauma disrupts feelings of trust and safety. When individuals have been hurt by those close to them, they may be reluctant or unwilling to trust others or to believe that an organization or agency is a safe place. This adaptive response to trauma can make relationship development challenging, so one of the first tasks in trauma-informed care is to develop a trusting relationship (SAMHSA, 2014). This process may be slow when an individual has a history of trauma and service providers, including teachers, first responders, and hospital staff, should intentionally use strategies to develop trust (Levenson, 2017; SAMHSA, 2014). These strategies include clear, unambiguous communication, using respectful, nonstigmatizing language about suicide and trauma, setting clear boundaries, being transparent about the reasons for questions, practices, and agency policies, and being open about decision making (Levenson, 2017; SAMHSA, 2014). Further, service providers develop trust by fully recognizing and welcoming a client's identity. For example, the research demonstrates that for transgender and gender nonconforming youth, the use of their chosen name decreases suicidal thoughts and behaviors (Russell et al., 2018). The more contexts in which the correct name was used (e.g., schools, work, home, friends), the larger the impact on suicidality. Teachers, hospital intake workers, and child protection works should routinely ask about and use correct pronouns and chosen names. Mental health providers should advocate for the use of correct names and pronouns with adults in a child's life, such as teachers, parents, principals, and health care providers, if this is not already occurring.

Service providers should clearly inform clients of the consequences of disclosing suicidality, not just in a clinical relationship but also in organizations such as schools, group homes, crisis lines, and other nonclinical settings. For example, individuals calling a crisis line with an active rescue policy need to know police could be activated. Students in schools should be aware that their parents will be contacted. Organizational policies need to be easily accessible and straightforward, using language that can be read and understood by consumers. These policies should acknowledge the prevalence of suicide and trauma, recognize the intersection between the two, and support a thoughtful response to a disclosure of suicide. For example, intake procedures for clients that include universal screening for both trauma and suicide provide a good foundation for a trusting and transparent relationship (Labouliere et al., 2018; Menschner & Maul, 2016; SAMHSA, 2014; Tunno et al., 2021).

Principle #3: Peer Support

The third principle of trauma-informed care is peer support. Peers are individuals sharing similar life experiences who provide "social, instrumental, or emotional support" (Barlow et al., 2010, p. 917). Suicide-related peer support programs use peers with various similarities to clients, including social identity (e.g., race, gender identity), occupation (e.g., firefighter, first responder), or shared diagnosis or life experience (e.g., suicide attempt survivor, suicide loss survivor) (Bowersox et al., 2021).

Peer support has been effectively implemented in suicide prevention. Examples of suicide prevention programs delivered by peers include crisis support, gatekeeper education, and support groups (Bowersox et al., 2021). Some programs have utilized occupational peers. For example,

in Houston, a group of active-duty firefighters were trained to teach their peers about suicide and support peers who wanted to access psychological supports (Finney et al., 2015). Other programs have trained peers with lived experience with suicide, including warm lines (i.e., a peer run line that offers listening and support) and programs like the Peers for Valued Living (PREVAIL) program, to support individuals at elevated risk of suicide (Pfeiffer et al., 2019).

Peer support postvention programs can be valuable and effective supports for suicide loss survivors, who often desire and benefit from support from those with lived experience with suicide loss (Dyregrov, 2002; Higgins et al., 2022; McMenamy et al., 2008). These programs include face-to-face groups, online groups and forums, and one-on-one peer support. Overall, these programs positively impact suicide loss survivors, and participants report better coping and problem solving, feelings of empowerment, less self-blame, and stigma, and more hope and connectedness (Higgins et al., 2022). Further, peer support programs help loss survivors with meaning-making (Hagström, 2016) and reduce grief reactions (Barlow et al., 2010).

Trauma-informed service providers recognize the value of peer support in suicide prevention and postvention programs. There are many ways that service providers can support suicide prevention and postvention peer-based programs. These strategies include building connections and collaborations with local programs, regularly referring to them, and advocating for their organization to partner with organizations doing this work or create their own peer support programs. Some national organizations doing peer support work include Alliance of Hope (https://allianceofhope.org/) and Samaritans, USA (http://samaritansusa.org/). Additionally, service providers can listen to the narratives of individuals with lived experience of suicide and trauma, and use this knowledge to design, implement, and evaluate prevention, intervention, and postvention programs, and consider how both suicide and trauma could be more effectively addressed in their organizations in ways that are nonstigmatizing and resist retraumatization.

Principle #4: Collaboration and Mutuality

The fourth principle of trauma-informed care is collaboration and mutuality. Both trauma-informed care and best practices in suicide prevention emphasize the need for collaboration and mutuality (Labouliere et al., 2018; Michel & Jobes, 2011; Tunno et al., 2021). When working with children, this collaboration also extends to parents and guardians. The service provider and client work in partnership, even when suicidal thoughts and behaviors occur. Collaboration supports relational safety and provides individuals with a feeling of agency and control in the treatment (Tunno et al., 2021).

Service providers share power with clients by actively involving clients in the treatment planning and decision-making process, reminding clients that they can choose not to engage in a treatment intervention or respond to a question, and asking clients' permission to engage in an exercise, try an intervention, or ask about a topic in more depth. This type of power-sharing may be more challenging in settings that embrace and support a power differential between the service provider and client, such as schools, correction facilities, or child protection agencies. Even in these types of organizations, providers strive to minimize the power differentials and, at minimum, acknowledge the potential to recreate the power dynamics experienced in previous traumatic relationships. Collaboration applies not just to the individual relationship between service provider and client, but also extends to collaborations with relevant organizations and agencies that may support clients, developing relationships and connections across systems of care to ensure clients can access trauma-informed services and trauma treatment (SAMHSA, 2014).

Principle #5: Empowerment, Voice, and Choice

Empowerment, voice, and choice are the fifth trauma-informed principle. As a result of trauma, many individuals have experienced feelings of powerlessness and loss of control. Trauma-informed care supports clients in gaining back a sense of control over their lives (Levenson, 2017; SAMHSA, 2014), even in a crisis when suicidal thoughts and behaviors are present (Tunno et al., 2021). Service providers avoid coercive or directive approaches, supporting clients in making decisions about the focus of treatment, the disclosure of information, and treatment options (Levenson, 2017; SAMHSA, 2014; Sweeney et al., 2018).

Examples of empowering approaches to suicide prevention include community-based participatory approaches (Haddad et al., 2020; Kral & Kidd, 2018), an evaluation process for programs that solicits client feedback, and psychoeducation on trauma, suicide, and their co-occurrence across the spectrum of suicide prevention, intervention, and postvention (Levenson, 2017). Family members can benefit from empowerment approaches, as the task of supporting a loved one with suicidal thoughts and behaviors can lead to feelings of powerlessness (Grant et al., 2015). Like all trauma-informed principles, empowerment also extends to organizations. In trauma-informed organizations, employees feel empowered, can make good treatment decisions with clients, and effectively engage in practice (SAMHSA, 2014).

Principle #6: Cultural, Historical, and Gender Issues

The final trauma-informed principle is the awareness of cultural, historical, and gender issues. This is a broad principle that encompasses cultural barriers to treatment, cultural understandings of suicide and trauma, racial and historical trauma, and the role of discrimination in trauma, suicidality, and access to services. Service providers approach the work with the knowledge that culture impacts risk and protective factors, idioms of distress, and narratives of both suicide and trauma (Chu et al., 2010; Marraccini et al., 2022; SAMHSA, 2012).

Suicide prevention programs, treatment providers, and supports for suicide loss survivors are knowledgeable about experiences of racial and historical trauma, the negative impact of these experiences on physical and mental health, including suicidality (Cénat, 2020), and the elevated risk of retraumatization for clients who have had these experiences (SAMHSA, 2012). For instance, due to racism, racial trauma, and the sociopolitical context of police violence against people of color, calling 911 when a client is in crisis can elicit a traumatic stress response for a Black client (Walker, 2020). Organizations should intentionally move away from research and practice that focuses on the experiences of White individuals (Marraccini et al., 2022). There is a need for more evidence-based culturally sensitive prevention, intervention, and postvention programs, including those specifically tailored for the nonhomogenous groups unified under the LGBTQIA+ umbrella (Russon et al., 2022).

Trauma-informed care requires awareness and acknowledgment of the role of discrimination in trauma, suicide, and access to treatment. Experiences of discrimination, marginalization, and microaggressions are associated with an elevated risk of suicidal thoughts and behaviors (Assari et al., 2017; Busby et al., 2020; O'Keefe et al., 2015; Parr & Howe, 2019). Individuals from traditionally marginalized groups are at elevated risk of traumatic experiences due to racism, heterosexism, and cissexism, and these experiences of discrimination often occur within treatment relationships or helping organizations such as schools, hospitals, or child welfare agencies (Cénat, 2020; Ellis, 2020; Kcomt, 2019). For instance, one in 20 transgender individuals report healthcare providers using harsh or abusive language toward them in the past year and more than one-quarter have been denied health care due to their gender identity (Kcomt, 2019). In another example, Black clients were found to be disproportionately more likely to experience coercive and disempowering interventions such as involuntary hospitalizations (Cénat, 2020). Research demonstrates that both college students of color and LGBTQIA+ students are more likely to experience barriers to treatment due to these concerns than White students (Horwitz et al., 2020). Trauma-informed service providers directly acknowledge and work to mitigate these issues with the individuals they serve.

Case Examples

Trauma-informed care can be integrated into the spectrum of suicide-focused work: prevention, intervention, and postvention. Many settings are not clinical settings, but none-the-less can implement trauma-informed principles. The following section will offer case study examples focused on prevention, intervention, and postvention.

Prevention

Emilia is a first-year high school English teacher. Her 9th grade English class is reading Romeo and Juliet. One day, the class becomes engaged in a discussion about the play, sharing their thoughts and experiences with suicide. As this discussion went on, Emilia feels increasingly uncomfortable, as she feels unprepared to talk to

her students about suicide. She notices one student, Rosie, becomes very engaged in the discussion. She knows Rosie is currently living in foster care, and that her mother died last year, but does not know her well. As the discussion wraps up, Rosie shares that she made a suicide attempt the day before. Emilia does not know what to do, so ends the discussion abruptly and sends Rosie to the office. She consults with the principal, who is concerned that talking more about suicide will lead to more disclosures of suicidal thoughts and behaviors. Therefore, she tells Emilia not to follow-up with Rosie or the class, but just continue with the planned lesson the next day. Emilia is worried about Rosie, and anxious about the next book in the curriculum, as it also includes childhood trauma and suicide.

Trauma-informed organizations create a culture that is knowledgeable about trauma, its prevalence, and its impact on health, behavior, and learning (Tunno et al., 2021). Service providers are prepared for disclosures of suicidality and/or trauma, and their responses are empathetic and compassionate, avoid retraumatization, and educate and support universal prevention efforts. In this vignette, a trauma-informed approach would include education for the teacher on both trauma and suicide, awareness of the high prevalence of trauma and suicidal thoughts in youth, and a plan to respond to disclosures of suicidality in a way that is supportive, validating, and respectful. In contrast, shutting down conversations about suicide and trauma risks stigmatizing the topics and discouraging student help-seeking. Open communication between teachers, counselors, and administrators about the timing of suicide and trauma-related content in the classroom, clear trauma-informed protocols for responding to disclosures in the classroom, and support for teachers to have this discussion would have supported Emilia, Rosie, and all the students in the class. The school missed an opportunity to teach about suicide, problem-solving skills, and risk factors for suicidality, and foster a classroom environment in which suicidality can be openly discussed. With approximately one in five high school students reporting suicidal thoughts and behaviors in the past 12 months (Underwood et al., 2020), there are likely multiple students with lived experience who would directly benefit from more education about suicide and help-seeking. Intentionally timing *Romeo and Juliet* with a school-wide suicide prevention program would support the English teachers and provide a framework for students to talk about suicide, mental health, and how to support a friend.

Intervention

Amaya is a 41-year-old sexual assault survivor who is in therapy at an outpatient mental health center due to depression and anxiety. One day, Amaya shares her suicidal thoughts with her clinician. Together they decide hospitalization is necessary. The outpatient center's policy requires clinicians to call 911 when a client is going to the hospital, even for a voluntary hospitalization. Police officers and EMTs respond to the 911 call. The EMTs strap Amaya on the gurney in the waiting room, as the police officers, clinic staff, and other clients watch. At the Emergency Room, medical staff follow hospital protocol and take Amaya's clothing, giving her a paper gown. This experience triggers Amaya's memories of the sexual assault and she tries to leave the hospital. The Emergency Room assigns a one-to-one aide to Amaya to ensure her physical safety. The aide stays in the room with Amaya, but as a non-medical staff member, is not allowed to talk to her. Amaya's traumatic stress response becomes more overwhelming, and Amaya feels helpless, disempowered, and retraumatized. After a few days, she is discharged from the hospital and tells her clinician she regrets ever having shared her suicidal thoughts.

Interventions with individuals experiencing suicidal thoughts and behaviors are often guided and shaped by risk-averse organizational policies that prioritize physical safety (Sweeney et al., 2018). In this vignette, many of the actions of Amaya's service providers maintain her immediate physical safety at the expense of her emotional safety. This is not unique to Amaya's experience. Inscoe et al. (2022) interviewed parents of youth with suicidal thoughts and behaviors. They reported that emergency rooms and hospitals were the settings least likely to be trauma-informed and most likely to be retraumatizing. A qualitative report of adults' experiences with emergency room visits during a psychiatric crisis found that the experience could be upsetting, disempowering, and traumatizing (Stefan & Cain, 2017). Individuals with a sexual trauma history reported it was upsetting, frightening, and retraumatizing when hospital staff forced them to take off their clothing. Service providers must be

aware that for some, these settings will be retraumatizing instead of healing. A traumatic experience following the disclosure of suicidality discourages future disclosures, threatening long-term physical safety.

Trauma-informed organizations have policies about suicide that intentionally avoid retraumatization (SAMHSA, 2012). These types of policies encourage thorough assessment of an individual before considering hospitalization, the revisiting of collaborative safety plans, and involvement of family when it is appropriate and safe (Michel & Jobes, 2011). Trauma-informed policies require organizations to tolerate more potential risk to immediate physical safety, but better support long-term physical safety as they prevent harm from retraumatization, encourage honest conversations about suicidality without fear of hospitalization, empower clients, and foster safe healing relationships with service providers. This vignette provides an opportunity to consider ways that emergency medical services could be more trauma-informed without compromising physical safety. Some examples include decreasing the number of people watching the ambulance transfer, allowing patients to keep their clothing, training aides to offer support to distressed patients, and providing patients with supportive digital technology like JASPR Health's digital platform (https://jasprhealth.com). Supports such as the activation of coping skills, involvement of family members, or use of alternative mode of transportation to the Emergency Room could decrease a stress activation.

Postvention

Helen is a 55-year-old woman who recently lost her adolescent son to suicide. Her sister, concerned about Helen's intense grief, recommends she sees a local therapist. The therapist comes highly recommended but does not specialize in grief or working with suicide loss survivors. The therapist seems disconcerted by the intensity of Helen's feelings. She often tells Helen "How sad" it is that her son died. Helen finds the therapist's comments simplistic and unhelpful and quits therapy. Frustrated, she describes this experience to a friend, saying, "Of course it is sad my son is dead, but it didn't feel "sad" when my husband found his body. It was traumatic. It didn't feel "sad" that the police asked me the same questions over and over again like it was my fault. It felt surreal and humiliating." Another suicide loss survivor recommends a different therapist who specializes in suicide loss. This therapist listens to Helen's story, explains that suicide death is often traumatic, and describes how trauma impacts individuals' coping, physical and mental functioning, and grieving. Therefore, their work together will begin by addressing the trauma of her son's death, so that Helen can mourn her son and remember him as the kind and generous young man that he was. Helen is relieved that the therapist recognizes and understands her experience.

Many service providers are unprepared to work with suicide loss survivors (J. R. Jordan, 2020; Maple et al., 2019). The field of postvention and traumatic loss has been under-researched (J. R. Jordan, 2020) and as a result, practitioners lack access to evidence-based best practices. With a dearth of research and expertise in suicide loss, many suicide loss survivors may have experiences like Helen, finding themselves working with a mental health professional with no expertise in suicide loss, and no recognition of the co-occurrence of traumatic stress and grief. For organizations, such as schools, there are guidelines for responding to a suicide death that emphasize the necessity of a trauma-informed approach (American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, 2018; National Action Alliance, 2015). Another resource is the School Crisis Recovery and Renewal Project that provides trauma-informed training and consultation to schools impacted by suicide deaths and other crises (schoolcrisishealing.org).

A trauma-informed approach to postvention recognizes, as Helen's second therapist did, that suicide loss can be traumatic, especially when individuals were exposed to the scene of the death (J. R. Jordan, 2020; National Action Alliance, 2015). When first responders are not trauma-informed, loss survivors can experience more distress (Duval et al., 2023), as Helen describes. To build a safe and collaborative working relationship with the client, service providers need to understand that suicide loss can be traumatic, recognize the symptoms of trauma, and understand the ways that trauma impacts the presenting issues. Helen experienced her intense distress and grief. In a school, a student may exhibit difficulty concentrating, poor academic performance, disruptive behaviors, or avoidance of reminders of the death. In both settings, loss

survivors are supported by service providers who identify the traumatic experience and help the client understand both trauma and grief, like Helen's second therapist.

Loss survivors need to be able to access knowledgeable, effective supports. Prompt referrals can support suicide loss survivors. For instance, if the first responders who spoke to Helen after her son's death had provided her with referrals to clinicians and/or local peer support groups for suicide loss survivors, she would have been able to access supportive services months sooner (Duval et al., 2023). Service providers form relationships with local organizations, ensuring that their clients can obtain trauma-informed, effective treatment there. This includes organizations offering peer support, which is helpful for many suicide loss survivors (J. R. Jordan, 2020; McMenamy et al., 2008).

Conclusion

Many individuals experience both trauma and suicidal thoughts and behaviors, and the association between suicide and trauma is clear (Dube et al., 2001; O'Connor, 2021; Ong et al., 2021; Stanley et al., 2019). Despite significant efforts in suicide prevention, there has been little progress in reducing the number of suicide deaths nationwide. The implementation of a trauma-informed approach, and its ability to heal the underlying pain and hopelessness driving suicidal thoughts and behaviors, offers hope for an effective strategy at reducing suicide deaths (Asarnow et al., 2020; Myles et al., 2021). It is time for suicide prevention, intervention, and postvention programs to ensure they are providing services and programming that are trauma-informed and resist retraumatizing individuals seeking education, support, and treatment (Inscoe et al., 2022). More research is needed to determine the impact of trauma-informed approaches on outcomes, including suicidal thoughts, behaviors, attempts, and deaths. Even without additional research, the practice literature has clearly demonstrated that a trauma-informed approach supports caring, safe, empowering hopeful, strength-based, and collaborative interventions which intentionally reduce the risk for retraumatization (Levenson, 2017; SAMHSA, 2014). Applying this approach to suicide prevention, intervention, and postvention work offers hope for healing relationships that minimize the ongoing cycle of trauma and suicide.

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