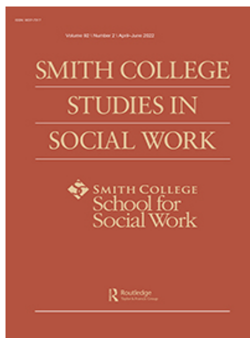

Smith College Studies in Social Work

Routledge
Taylor & Francis Group

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wscs20

Trauma-Informed Clinical Practice with Clients with Suicidal Thoughts and Behaviors

Rebecca G. Mirick, Joanna Bridger & James McCauley

To cite this article: Rebecca G. Mirick, Joanna Bridger & James McCauley (2022): Trauma-Informed Clinical Practice with Clients with Suicidal Thoughts and Behaviors, Smith College Studies in Social Work, DOI: 10.1080/00377317.2022.2104778

To link to this article: https://doi.org/10.1080/00377317.2022.2104778

Published online: 27 Jul 2022.

Submit your article to this journal

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=wscs20

SMITH COLLEGE STUDIES IN SOCIAL WORK
https://doi.org/10.1080/00377317.2022.2104778

Trauma-Informed Clinical Practice with Clients with Suicidal Thoughts and Behaviors

Rebecca G. Mirick[a], Joanna Bridger[b], and James McCauley[c]

[a]School of Social Work, Salem State University, Salem, Massachusetts, USA; [b]Safety, Hope, & Healing Counseling & Consulting, Watertown, Massachusetts, USA; [c]Riverside Trauma Center, Dedham, Massachusetts, USA

ABSTRACT

In 2020, almost 46,000 individuals in the United States died from suicide, 1.2 million adults made a suicide attempt, and 12.2 million had serious suicidal thoughts. Clinicians in diverse practice settings will work with clients experiencing suicidal thoughts and behaviors. Due to a strong association between trauma and suicidality, suicidology experts have recommended the use of trauma-informed practice when working with clients with suicidal thoughts and behaviors. However, although there are guidelines for trauma-informed care and for working with clients with suicidality, there are no models, explanations, or discussions about how clinicians can provide trauma-informed care in their work with individuals with suicidal thoughts and behaviors. This conceptual paper describes examples of the application of the Substance Abuse and Mental Health Services Administration (SAMHSA)'s trauma-informed care principles to clinical work with individuals with suicidal thoughts and behaviors. Strategies are provided for each of the guiding principles, and case examples used to illustrate strategies, barriers, and potential pitfalls.

ARTICLE HISTORY
Received 28 March 2022
Accepted 18 July 2022

KEYWORDS
Suicide prevention; trauma-informed care; clinical practice; suicide; trauma

In clinical practice, both trauma and suicide frequently emerge as presenting problems and in client histories. This is unsurprising because there is a strong relationship between trauma and suicide. Trauma elevates the risk of suicidal thoughts and behaviors (Dube et al., 2001; Nock et al., 2008; Ong et al., 2021). Adverse childhood experiences are strongly associated with suicide attempts in adolescence and adulthood (Dube et al., 2001). This effect is cumulative, and the elevated risk of a suicide attempt increases with the number of adverse childhood experiences. As with childhood trauma, traumatic experiences in adulthood, including discrimination, marginalization, and racial trauma, are also associated with an increased risk of suicidality (Assari et al., 2017; Bryant-Davis, 2007; Comas-Díaz et al., 2019; Madubata et al., 2022). In addition, suicide leads to traumatic experiences, both for family members whose loved ones engage in suicidal behaviors and for individuals with suicidal thoughts

CONTACT Rebecca G. Mirick rmirick@salemstate.edu School of Social Work, Salem State University, 352 Lafayette St, Salem, Massachusetts 01970, USA

© 2022 Taylor & Francis

and behaviors, through coercive, invasive, or retraumatizing clinical or medical interventions (Blanchard & Farber, 2020; Fogarty et al., 2021; Ward Ciesielski & Rizvi, 2021). One study found that almost half of suicide attempt survivors had PTSD symptoms following an attempt (Bill et al., 2012).

Despite this strong association, the topics of suicide and trauma are typically discussed, researched, and taught separately, with limited attention to the clinical practice implications of the intersection of the two issues. As a result, although the need for a trauma-informed approach to suicide has been identified, there is very little guidance on how to understand, conceptualize, and engage in trauma-informed suicide prevention. Illustrated by case studies, this paper will explore current practice with individuals with suicidal thoughts and behaviors, presenting strategies rooted in Substance Abuse and Mental Health Services Administration's (2014) trauma-informed principles. While trauma-informed care encompasses both organizational and direct service practices (Menschner & Maul, 2016), this discussion will focus on clinical practice.

Background

Clinicians and researchers use multiple definitions of trauma (Menschner & Maul, 2016). Some clinicians may erroneously equate trauma with a diagnosis of PTSD. Substance Abuse and Mental Health Services Administration (2014) defines trauma as:

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (p. 7)

It is a person's experience of an event that determines whether it is traumatic (Substance Abuse and Mental Health Services Administration, 2014). It is important to recognize the wide range of experiences which can be experienced as traumatic, including early childhood adversity, adulthood events, and experiences of discrimination and oppression based on social identity, such as racism, homophobia, or transphobia. Historical trauma is also believed to impact psychological stress and suicidality (Brown-Rice, 2013).

Trauma can be understood as an experience that is too much, too fast, or too soon for an individual's nervous system, resulting in the chronic activation of their stress response system. Traumatic stress impacts the development and functioning of the brain and body, capacity to maintain healthy relationships, and overall physical and mental health (Substance Abuse and Mental Health Services Administration, 2014).

Early adversity and trauma lead to the sensitization of the stress response system. This increases the likelihood of developing stress related disorders and elevates the risk of suicidality occurring in response to stressors later in life (Eisenlohr-Mohl et al., 2018; O'Connor et al., 2018). This is true even for events that occur early in life before the ability to create verbal memories. When working with individuals with suicidal thoughts and behaviors, it is important that this awareness and understanding guides clinical interventions.

Trauma-informed practice

Trauma-informed practice is distinct from trauma-focused therapy (Levenson, 2017). It is not a treatment modality, but a perspective based on an awareness of the prevalence of trauma, coping strategies for trauma, and the psychological and physiological impact of trauma across the lifespan (Levenson, 2017). There are many models for trauma-informed care but currently no universal agreement on the meaning of the concept. Perry (2021) states:

> In the past, most of these perspectives have not included any significant understanding of development, stress, or trauma or the interrelated issues that can cause distress or trauma such as implicit bias, racism, and misogyny. But with so much new research emerging about these areas and these issues, it's become clear that our systems can't ignore them. And as each system has grappled with what 'trauma-informed' means, they've used their own particular lens - their own worldview. The result is that defining the term has been a challenge. Like the word trauma, it's been used by many different groups in many different ways (p. 217-218).

At its core, trauma-informed care is a universal prevention strategy that assumes an individual's behaviors are adaptations in the context of their life experiences. It aims to avoid re-traumatization and create safe healing environments. Recognizing the value and healing power of relationships, trauma-informed clinicians prioritize the development of working relationships characterized by trust, collaboration, and compassion (Levenson, 2017, 2020; Menschner & Maul, 2016). Within these relationships, clinicians share their knowledge about the psychological and physiological impact of trauma. This psychoeducation normalizes presenting problems, including suicidality, and reframes maladaptive behaviors into coping skills that demonstrate resilience while simultaneously creating hope about the possibility of change and healing.

The core principles of a trauma-informed approach

Andy is a 12-year-old boy with a history of early childhood trauma. He has been hospitalized multiple times due to suicidal thoughts and behaviors. Andy currently attends a therapeutic day school and receives outpatient therapy and

psychiatry. In addition to suicidal thoughts and behaviors, Andy engages in problematic sexual behaviors that have led to his removal from multiple programs. Despite prescribed appetite suppressants, Andy eats to excess, and the resulting obesity has contributed to multiple health problems. Although Andy has received treatment for each of these issues, his suicidal thoughts and behaviors, overeating, and sexual behaviors continue to cause significant problems. Andy sees himself as a "bad kid" and has little hope for change. Although his providers have always understood that Andy's history of early trauma is the root of his current challenges, they just recently began to use a trauma-informed approach with Andy. As a result, they began to teach Andy about trauma and its impact on the brain and behavior, explaining that problematic behaviors often emerge from the types of life experiences that he has had. Andy and his providers know that it will be a lot of work for him to rewire his brain and his stress response system, but for the first time, instead of seeing himself as bad or broken, Andy is starting to understand the adaptations his body and brain made to survive his early trauma and to see himself as resilient.

This case study illustrates the shift to a trauma-informed approach. Before this shift, Andy's service providers understood his suicidality, sexual behaviors, and overeating as the result of early trauma, but had not shared this understanding with Andy. Andy lacked any knowledge of the physiological impacts of early trauma or the ways that early trauma impacts relationship development, sexual development, and the capacity to feel a sense of satiety. As a result, Andy had an internal narrative of being "bad," creating a sense of shame that drove his suicidality. As the team moved to a trauma-informed approach, they stopped treating each of Andy's symptoms individually. Instead, they explained to Andy the relationship between early trauma and his current symptoms. Additionally, they began to include Andy as part of the treatment team and were transparent about the treatment plan and decision-making process. This empowered Andy, helped him feel in control, and supported his ability to form healing relationships with his service providers.

A trauma-informed approach to suicide

Although there has been a call for service providers and organizations to use a trauma-informed approach when working with clients with suicidal thoughts and behaviors (Bent-Goodley, 2019; Levenson, 2017, 2020; Morrison et al., 2015), currently there is no suicide-specific model to guide this work. In the United States, the most widely used guidelines are the SAMHSA principles of trauma-informed care (TIC; Substance Abuse and Mental Health Services Administration, 2014). These guiding principles provide a framework for work with clients. The six key principles are: safety, trustworthiness and transparency, peer support, collaboration and mutuality,

empowerment, voice, and choice, and cultural, historical, and gender issues. The following sections will explicitly describe approaches and strategies for suicide-focused work based on these principles of trauma-informed care. This model can be applied to all clients with suicidality, regardless of whether the clinician is aware of trauma, or if the client identifies with having a history of trauma.

Safety

Wanda, an adolescent girl with a history of sexual assault, was working with a clinician at an outpatient clinic associated with a large hospital. Wanda's suicidal thoughts and behaviors intensified over time. One day, Wanda told her clinician about her suicide plan. Together they decided that Wanda should enter the inpatient program associated with the hospital, located across the street from the outpatient clinic. Clinic policy required that an ambulance transport Wanda to the inpatient program. When the EMTs arrived, they strapped Wanda on the stretcher, triggering memories of the sexual assault. After Wanda was discharged from the hospital, she told her clinician that she would no longer talk about her suicidal thoughts because she did not want to be transported by ambulance again. The clinician was concerned about Wanda's feedback and her safety. She suggested that they spend the next session on safety planning to support Wanda's ability to remain physically and emotionally safe. Additionally, she started a conversation with her supervisor about how to change the policy to be more trauma informed.

Safety is the first principle of trauma-informed practice (Substance Abuse and Mental Health Services Administration, 2014). This encompasses relational, emotional, and physical safety. Relational safety is rooted in relationships that are predictable, consistent, reliable, respectful, empathetic, compassionate, genuine, and free of judgment or shame (Bent-Goodley, 2019; Elliott et al., 2005; Levenson, 2020). When clients have suicidal thoughts and behaviors, clinician frustration, exhaustion, and hopelessness can negatively impact these characteristics of the relationship. Due to anxiety and fear, clinicians sometimes choose restrictive interventions that emphasize physical safety over other types of safety and may be traumatic (e.g., involuntary hospitalization; Levenson, 2020; Rudd et al., 2008). Clinicians must recognize and manage these feelings to foster and maintain relational safety. Continuing education in suicide assessment and crisis intervention can be an effective place to learn these skills (Mirick et al., 2016; Mitchell et al., 2020).

Re-traumatization is a significant threat to emotional safety (Substance Abuse and Mental Health Services Administration, 2014). Clinicians must consider factors such as the physical space of the waiting room and office, interpersonal interactions, and the gender of service providers or group members (Substance Abuse and Mental Health Services Administration,

2014). In the example above, Wanda was re-traumatized by the ambulance ride. For a variety of reasons, many clients experience the arrival of emergency responders as a threat to emotional safety. In the United States police violence against people of color has created racial trauma, augmented by the historical trauma of violence against Black Americans (Comas-Díaz et al., 2019; Lipscomb & Ashley, 2020). As a result, police involvement during a crisis feels unsafe. Finding a balance between emotional and physical safety is critical. This task may be challenged by agency policies that prioritize risk reduction, clinician's anxiety about the client's safety, and historical and racial trauma (Fogarty et al., 2021; Rudd et al., 2008).

Trustworthiness and transparency

Gabriel, a 50-year-old man, experienced intense suicidal thoughts following his son's suicide death and began to see a clinician affiliated with a large hospital system. At their first session, the clinician told Gabriel that hospital policy required she call Emergency Services if he disclosed suicidal thoughts and behaviors. This could result in hospitalization. Gabriel went home and told his wife that he could only tell the clinician about his suicidal thoughts if he was willing to be hospitalized. He wanted to quit therapy because he could not talk about his suicidal thoughts, but his wife convinced him to return for a second session. She was frightened she might lose her husband to suicide as she had lost her son. Gabriel shared his concerns with the clinician, who responded with more details and information. She explained that suicidal thoughts were not an uncommon reaction to suicide loss, and that the trauma of the loss can intensify them. She defined the circumstances in which she would consider a higher level of care, emphasizing that the decision would only happen after she discussed it with Gabriel.

The concept of trustworthiness and transparency is the second principle of trauma-informed care (Substance Abuse and Mental Health Services Administration, 2014). Early childhood trauma impacts an individual's ability to form trusting relationships, making it difficult to engage with a clinician (Levenson, 2020). For clients with a history of trauma, asking for help can elicit anxiety, fear, and apprehension, making the initiation of therapy challenging (Levenson, 2017). Therefore, the initial focus of the work is on the development of trust, with a goal of creating a relationship in which the client can share their psychological pain, hopelessness, and suicidal thoughts and behaviors. Clinicians build trust by emphasizing clarity and avoiding ambiguity across all aspects of the work. The informed consent process is clear and in-depth and provides the client with information about the limits of confidentiality (Levenson, 2017). Gabriel's informed consent process was ambiguous and alarming, which made Gabriel want to leave therapy before it began.

If Gabriel had not returned for a second session, the clinician would not have known why Gabriel stopped treatment and Gabriel would not have had access to support.

Peer support

John is a 30-year-old man with a diagnosis of a major mental illness and a history of both trauma and suicidality. John stopped taking his medication because he didn't like the associated weight gain. In the weeks after this decision, John's suicidal thoughts and behaviors intensified, and his community-based team decided to hospitalize him. After being hospitalized, John no longer trusted his team and terminated services. When John was discharged from the hospital his outpatient clinician said she could no longer see him because he needed a "higher level of care" than she could provide. John felt like she had fired him as a client. Without his team and his therapist, he told his worried family, "I have zero support." A family friend invited John to a Peer Recovery program in a nearby community. John found the program very supportive, saying, "I found other people who cared about me and who had been through the same experiences I had been through. They understand me and seeing them get better makes me feel better." From his peers, John learned how trauma was connected to his suicidal thinking. The peer support group eventually gave him the confidence and motivation to try professional mental health services again and he found a new therapist and prescriber. The new service providers used a trauma-informed approach and acknowledged that the peer recovery program was largely responsible for John's recovery. John identified the peer support program as crucial to his recovery, helping him feel safer in his body, life, and relationships.

Peer support is the third trauma-informed principle (Substance Abuse and Mental Health Services Administration, 2014). This principle may be the least familiar to clinicians and require a reframing of their role and their perspectives on peer support. Some practitioners hold negative assumptions about peer support, including beliefs that peer specialists lack the skills to talk with clients about suicide or that these discussions will be harmful or triggering to peer specialists (Pfeiffer et al., 2019). Some of these assumptions may stem from a lack of research and practice literature on peer support for suicidality (Pfeiffer et al., 2019). The literature does support the positive impact of peer support for clients with other presenting problems, including the provision of emotional support (Bellamy et al., 2017). Preliminary data suggests that peer support programs may help decrease suicidal thoughts and for clients like John (Schlichthorst et al., 2020).

Trauma-informed clinicians are familiar with local peer support programs, encourage clients to access them, and refer clients to them. These programs include in-person mutual support groups, such as Alternatives to Suicide

(alt2su-nsw.net) or the National Empowerment Center (www.power2u.org). There are websites that share the stories of individuals with lived experience, such as Live Through This (livethroughthis.org) and Now Matters Now (now-mattersnow.org). Additionally, online forums and messaging boards are a source of peer support (Niederkrotenthaler et al., 2016). In the example above, John's referral to peer support came from a family friend. Ideally, John's team would have provided these referrals along with more traditional mental health services.

Collaboration and mutuality

Maribel, an adolescent girl, was hospitalized following a suicide attempt. During discharge planning, the hospital social worker told Maribel's parents to remove all lethal means from the house. The list of lethal means included medications, knives, razors, and any cords or ropes. When her parents requested more specific directions, the social worker reiterated that it was their responsibility to make the environment safe. The parents locked up the medications, kitchen knives, and Maribel's razor. They took down the Christmas lights that hung in her bedroom. When Maribel came home, she found her bedroom transformed. She was unable to shave her legs or help her mom prepare dinner. Maribel was angry and felt her space had been violated. Her parents were confused and unsure how to support her. The next day, Maribel's outpatient clinician met with the family. Recognizing their frustration, she suggested a different approach. Together, all four of them engaged in safety planning, with Maribel as the lead participant in the process. Maribel identified actions she felt were necessary to keep herself safe, her parents and clinician asked questions and made suggestions, and they collaboratively wrote a safety plan to address future escalating suicidal thoughts and behaviors. This plan included limiting access to lethal means. All family members felt more in control and more confident that Maribel would be able to stay safe in at home.

Collaboration is the fourth trauma-informed practice principle (Substance Abuse and Mental Health Services Administration, 2014). Clinicians intentionally encourage collaboration and avoid directive interventions (Levenson, 2017, 2020; Morrison et al., 2015). Collaborative work can be challenging when suicidality is present. It is common for clinicians to develop anxiety and fear about clients' physical safety, responding to these emotions with coercive and controlling interactions intended to prevent a suicide attempt or death (Jobes, 2016). This creates an adversarial relationship, in which the clinician is working to preserve the client's physical safety and the clients wants to end their psychological pain (Jobes & Ballard, 2011). This scenario often elicits feelings of disempowerment and hopelessness from clients. Maintaining collaborative relationships when physical safety is at risk requires clinicians to recognize, acknowledge, and manage their emotional responses

(Fogarty et al., 2021; Rudd et al., 2008). Learning effective skills to safety manage suicidal thoughts and behaviors can maintain physical safety in a more effective, collaborative manner. Supervision and training can support clinicians in this work.

Maribel's hospital social worker engaged in lethal means counseling, a collaborative intervention to reduce access to lethal means (Mann et al., 2005). Although this intervention does not explicitly include trauma, it should be a collaborative process, but the hospital social worker implemented it as a directive intervention. In contrast, the outpatient clinician included lethal means counseling into collaborative safety planning (Stanley & Brown, 2012). Collaborative safety planning has replaced contracting for safety as a best practice in the management of suicidality. Contracting for safety requires the client to promise, perhaps signing a "contract," not to kill themselves. In contrast, a safety plan is a "written, prioritized list of coping strategies and sources of support ... used to alleviate a suicidal crisis" (Stanley & Brown, 2012, p. 256). This list is created collaboratively with the client, using the client's expertise to guide its creation, and is regularly revisited, evaluated, and revised to improve its effectiveness. High quality collaborative safety planning is associated with better outcomes for clients (Gamara et al., 2015). Like lethal means counseling, collaborative safety planning does not explicitly acknowledge trauma, but implemented correctly it is a collaborative, empowering intervention. A clinician can intentionally make safety planning more inclusive of trauma by including an awareness of evocative cues of past trauma in the safety plan.

As designed, both lethal means counseling and safety planning are collaborative interventions and considered best practices in working with individuals with suicidal thoughts and behaviors (Mann et al., 2005; Rudd et al., 2008). In practice, as seen in the example above, both interventions are sometimes implemented in ways that do not reflect fidelity to the intervention, and as a result they are no longer consistent with either trauma-informed practices or best practices in suicide prevention and intervention. While many clinicians report using safety planning with clients with suicidal thoughts and behaviors, their fidelity to the intervention is not well understood (Moscardini et al., 2020). Clinician factors, such as fear for clients' physical safety, or organizational policies, such as mandated safety planning, can shift the process away from any congruence with trauma-informed practices, especially for clinicians who may not have learned these newer suicide interventions in their graduate education (Schmitz et al., 2012). Clinicians may need more training and education on these practices. Available training resources include Counseling on Access to Lethal Means (zerosuicidetraining.edc.org) and Collaborative Safety Planning (suicidesafetyplan.com).

Empowerment, voice, and choice

Marta, a 35-year-old woman with a trauma history, left therapy because the clinician made suicide the focus of therapy after she shared her suicidal thoughts. Suicidal thoughts were not Marta's primary concern and she believed she could keep herself safe. Instead, she wanted to focus on her past trauma. When Marta starting working with a new clinician, she did not talk about her suicidal thoughts and the therapy focused on her trauma history. As therapy progressed, Marta's suicidal thoughts became more intense, and finally she shared them with her clinician. The clinician was conflicted. On one hand, she wanted to value client self-determination and have Marta set the treatment goals. On the other hand, she felt obligated to acknowledge Marta's pain, assess her current safety, and ensure the functioning of her safety plan. The clinician shared her dilemma with Marta, and they agreed on a plan. While Marta's suicidal thoughts remained elevated, they would spend the first half of each session checking in on her suicidality, adjusting the safety plan if needed. The remainder of the time would be spent on trauma-focused work. Both Marta and the clinician felt comfortable with this resolution.

The fifth trauma-informed practice principle is empowerment, voice, and choice (Substance Abuse and Mental Health Services Administration, 2014). A lack of power and control is often part of traumatic experiences and client empowerment supports recovery (Substance Abuse and Mental Health Services Administration, 2014). The clinician can support empowerment through strategies such as checking in, asking permission, soliciting the client's opinion, and including client feedback in the work (Levenson, 2017). Clinicians model the use of strengths-based, non-stigmatizing language around suicide. The American Psychological Association (2021) has provided specific examples of recommended language (e.g., died by suicide in place of "committed suicide" or "successful suicide"). Client empowerment is supported when clinicians teach clients about the impact of trauma on physiology and behavior. This redefines problematic behaviors as adaptive coping in the face of traumatic events, shifting a client's thinking to a strengths-based narrative emphasizing resilience and encouraging self-efficacy (Levenson, 2017). In the example above, Marta's new clinician listened to her treatment goals, and together they determined how to balance self-determination and physical safety in a way that felt alright to both. Finding a successful balance requires a collaboration between clinician and client. It is essential that Marta has control over the treatment process, even when suicidality is present, but also that the clinician feels comfortable with the management of suicide risk (Levenson, 2017).

Empowerment is congruent with best practices in suicide prevention. In February 2000, clinicians with expertise in suicide met in Aeschi, Switzerland to discuss treatment for clients with suicidality. This working group created

practice guidelines (The Aeschi Approach) for clinicians working with individuals with suicidality, including the need to recognize the client's expertise on their own experience (Jobes & Ballard, 2011). Many best practices include a focus on fostering clients' personal sense of agency, including lethal means counseling and safety planning that were discussed in the previous section.

Cultural, historical, and gender issues

Nina, a Black, 22-year-old woman, began therapy with a White clinician to treat her depression. At the first appointment, Nina told her clinician that she was hesitant to start therapy because she did not think it would help her but was there because she could not confide in her family because they did not believe in depression. The clinician did not screen for suicide or trauma. After a few sessions, Nina began to talk about her experiences with discrimination. The clinician responded that perhaps these incidents were not discriminatory, and instead Nina was misreading them. The clinician decided to work on cognitive restructuring due to Nina's "attribution errors" about these incidents. Nina's depression worsened, and she finally disclosed to her therapist that she had been thinking her family would be better off without her. The clinician told her that was not true but still did not ask about suicide. Nina felt even more isolated than before and stopped attending therapy. Several months later, she discovered a directory of Black therapists. On that list, she found a new clinician, a Black woman, who acknowledged and recognized her experiences of racial discrimination, discussed racial trauma, explored the impact of racial violence and discrimination on Black Americans, explained the relationship between racial trauma and suicide, and responded to and supported Nina in managing her suicidal thoughts and behaviors. After working with this clinician for a few weeks, Nina began to feel hopeful that therapy might help her depression.

The final trauma-informed practice principle is awareness of cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration, 2014). Trauma-informed practice requires cultural responsiveness, cultural humility, and an understanding of systemic racism, discrimination, and historical and racial trauma (Bent-Goodley, 2019). Clinicians must consider the ways in which a client's culture interprets, understands, and responds to experiences of trauma (Substance Abuse and Mental Health Services Administration, 2014). Along with influencing the experience of trauma, culture defines, creates meaning, and shapes the expression of suicidality (Chu et al., 2010). Culture impacts risk and protective factors, suicide stigma, and help seeking behaviors (Chu et al., 2010). Working from a perspective of cultural humility, "an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience" (Hook

et al., 2013, p. 1), the clinician listens to the client to develop a better understanding of how their culture understands trauma and suicide. Nina's clinician did not do this work, even when Nina shared that her family "did not believe in depression." Exploring this statement could have uncovered the stereotype that Black women do not experience suicidal thoughts and behaviors, which can limit help-seeking for Black women (Junior, 2021).

An essential component of trauma-informed care is awareness of the impact of discrimination and marginalization on suicidality (Substance Abuse and Mental Health Services Administration, 2014). Racism, sexism, heterosexism, and cissexism negatively impact well-being, causing stress, distress, and suicidality (Assari et al., 2017). To create safe relationships with clients of color like Nina, White clinicians need to understand White privilege, implicit bias, systematic racism, and racial trauma. Instead, many White clinicians avoid discussing race and racism with clients (Sue et al., 2010; Utsey et al., 2005) and, like Nina's clinician, dismiss painful experiences of racism and discrimination (Utsey et al., 2005). Similarly, sexual or gender minority clients need clinicians who understand and can talk about discrimination, trauma, and suicidality in the LGBTQIA community. For Black and Indigenous clients, clinicians need to be aware of the impact of historical trauma, talk to clients about it, and incorporate it into treatment (Comas-Díaz et al., 2019; Lipscomb & Ashley, 2020). Clinicians can use psychoeducation about historical trauma to help clients recognize its impact and honor the grief and loss it has caused (Brown-Rice, 2013). Mistrust and a lack of faith in formal treatment options are natural consequences of historical discrimination and oppression by White governments or medical professionals (Joe et al., 2008). Clinicians who are attuned to historical trauma can recognize cultural mistrust instead of confusing it with resistance or lack of motivation for change.

Conclusion

Although many clinicians use some components of trauma-informed care when working with clients with suicidality, there are systemic and individual barriers to the consistent incorporation of the principles of trauma-informed into clinical work. One barrier is the lack of literature about the integration of trauma-informed approaches into practice with individuals experiencing suicidality. For example, Substance Abuse and Mental Health Services Administration's (2014) trauma-informed care guidelines do not mention suicide. Similarly, guidelines for best practices in suicide prevention rarely reference trauma (Brodsky et al., 2018). Without grounding in the trauma literature, many approaches to suicide have adopted coercive or directive strategies due to fear for the client's physical safety and to minimize risk of liability (Fogarty et al., 2021; Jobes, 2016). This results

in pressured interventions such as involuntary hospitalization at the expense of collaboration, empowerment, and relational safety. Many clients will not disclose suicidality, because they have found that clinicians' respond in ways that are unhelpful, harmful, and retraumatizing (Blanchard & Farber, 2020). More integration between the fields of trauma and suicide is needed. This could include the development of practice guidelines for clinicians, policies supporting universal screening for trauma and suicidality, and an emphasis on research on the intersection between the two fields. A full paradigm shift to a trauma-informed approach is likely to take time and may encounter resistance (Morrison et al., 2015).

In the meantime, clinicians can take immediate actions to root their practice more firmly in trauma-informed care. These actions include collaborative safety planning and lethal means counseling, transparency about policies and procedures, education for both themselves and their clients on the role of trauma in suicidal thoughts and behaviors, prioritizing emotional and relational safety, and participation in professional training on trauma-informed practice with suicidality. The demonstrated link between trauma and suicide is a powerful rationale for using a trauma-informed approach with all clients experiencing suicidal thoughts and behaviors. We know from the research and from the voices of those with lived experience that these changes can prevent re-traumatization and may save lives.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributors

Rebecca G. Mirick, Ph.D., LICSW is an Associate Professor at Salem State University School of Social Work. She has clinical experience providing mental health services to children, adolescents, and adults. She has worked in suicide prevention since 2006, providing training and education, engaging in program evaluation, and researching suicide education and school-based postvention.

Joanna Bridger, LICSW is the founder of Safety, Hope, and Healing Counseling and Consulting. She has extensive experience working with youth, families, adults, and communities that have experienced trauma and loss, and has provided counseling, critical incident response, clinical and organizational consultation, and training for hundreds of families and schools.

James McCauley, LICSW is the Co-Founder and Assistant Program Director of Riverside Trauma Center. He provides mental health support for schools, workplaces, and communities affected by traumatic events and consults with schools and communities on trauma responses. He provides consultations and trainings on suicide postvention services, suicide clusters, and suicide prevention coalitions.

References

American Psychological Association. (2021). *Equity, diversity, and inclusion: Inclusive language guidelines*. https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines.pdf

Assari, S., Moghani Lankarani, M., & Caldwell, C. H. (2017). Discrimination increases suicidal ideation in Black adolescents regardless of ethnicity and gender. *Behavioral Sciences*, *7*(4), 75–85. https://doi.org/10.3390/bs7040075

Bellamy, C., Schmutte, T., & Davidson, L. (2017). An update on the growing evidence base for peer support. *Mental Health and Social Inclusion*, *21*(3), 161–167. https://doi.org/10.1108/MHSI-03-2017-0014

Bent-Goodley, T. B. (2019). The necessity of trauma-informed practice in contemporary social work [Editorial]. *Social Work*, *64*(1), 5–8. https://doi.org/10.1093/sw/swy056

Bill, B., Ipsch, L., Lucae, S., Pfister, H., Maragkos, M., Ising, M., & Bronisch, T. (2012). Attempted suicide related posttraumatic stress disorder in depression: An exploratory study. *Suicidology Online*, *3*, 138–144.

Blanchard, M., & Farber, B. A. (2020). "It is never okay to talk about suicide": Patients' reasons for concealing suicidal ideation in psychotherapy. *Psychotherapy Research*, *30*(1), 124–136. https://doi.org/10.1080/10503307.2018.1543977

Brodsky, B. S., Spruch-Feiner, A., & Stanley, B. (2018). The zero-suicide model: Applying evidence-based suicide prevention practices to clinical care. *Frontiers in Psychiatry*, *9*, 33. https://doi.org/10.3389/fpsyt.2018.00033

Brown-Rice, K. (2013). Examining the theory of historical trauma among Native Americans. *Professional Counselor*, *3*(3), 117–130. https://doi.org/10.15241/kbr.3.3.117

Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic stress. *Counseling Psychologist*, *35*(1), 135–143. https://doi.org/10.1177/0011000006295152

Chu, J. P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of suicide. *Applied and Preventive Psychology*, *14*(1–4), 25–40. https://doi.org/10.1016/j.appsy.2011.11.001

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, *74*(1), 1–5. https://doi.org/10.1037/amp0000442

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the adverse childhood experiences study. *JAMA*, *286*(24), 3089–3096. https://doi.org/10.1001/jama.286.24.3089

Eisenlohr-Mohl, T. A., Miller, A. B., Giletta, M., Hastings, P. D., Rudolph, K. D., Nock, M. K., & Prinstein, M. J. (2018). HPA axis response and psychosocial stress as interactive predictors of suicidal ideation and behaviors in adolescent females: A multilevel diathesis-stress framework. *Neuropsychopharmacology*, *43*(13), 2564–2571. https://doi.org/10.1038/s41386-018-0206-6

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma denied: Principles and implementation of trauma informed services for women. *Journal of Community Psychology*, *33*(4), 461–477. https://doi.org/10.1002/jcop.20063

Fogarty, B., Houghton, S., Galavan, E., & O'Súilleabháin, P. S. (2021). Clinicians' experience of collaboration in the treatment of suicidal clients within the Collaborative Assessment and Management of Suicidality Framework. *OMEGA-Journal of Death and Dying*, 003022282110205. Advance Online Publication. https://doi.org/10.1177/00302228211020579

Gamarra, J. M., Luciano, M. T., Gradus, J. L., & Stirman, S. W. (2015). Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA healthcare system. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *36*(6), 433–439. https://doi.org/10.1027/0227-5910/a000345

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr, & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. https://doi.org/10.1037/a0032595

Jobes, D. A., & Ballard, E. D. (2011). The therapist and the suicidal patient. In K. Michel & D. A. Jobes (Eds.), *Building a therapeutic alliance with the suicidal patient* (pp. 51–62). American Psychological Association. https://doi.org/10.1037/12303-003

Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach*. Guilford Publications.

Joe, S., Canetto, S. S., & Romer, D. (2008). Advancing prevention research on the role of culture in suicide prevention. *Suicide and Life-Threatening Behavior*, *38*(3), 354–362. https://doi.org/10.1521/suli.2008.38.3.354

Junior, N. (2021). Don't we hurt like you? Examining the lack of portrayals of African American women and mental health. In J. Hollenbach & R. A. McDonald (Eds.), *Re/Imagining depression* (pp. 111–118). Palgrave Macmillan.

Levenson, J. (2017). Trauma-informed social work practice. *Social Work*, *62*(2), 105–113. https://doi.org/10.1093/sw/swx001

Levenson, J. (2020). Translating trauma-informed principles into social work practice. *Social Work*, *65*(3), 288–298. https://doi.org/10.1093/sw/swaa020

Lipscomb, A. E., & Ashley, W. (2020). Surviving being Black and a clinician during a dual pandemic: Personal and professional challenges in a disease and racial crisis. *Smith College Studies in Social Work*, *90*(4), 221–236. https://doi.org/10.1080/00377317.2020.1834489

Madubata, I., Spivey, L. A., Alvarez, G. M., Neblett, E. W., & Prinstein, M. J. (2022). Forms of racial/ethnic discrimination and suicidal ideation: A prospective examination of African American and Latinx Youth. *Journal of Clinical Child & Adolescent Psychology*, *55*(1), 23–31. https://doi.org/10.1080/15374416.2019.1655756

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mehlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., . . . Hendin, H. (2005). Suicide prevention strategies: A systemic review. *JAMA*, *294*(16), 2064–2074. https://doi.org/10.1001/jama.294.16.2064

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Center for Health Care Strategies, Inc. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Mirick, R. G., Bridger, J., McCauley, J., & Berkowitz, L. (2016). Continuing education on suicide assessment and crisis intervention for social workers and other mental health professionals: A follow-up study. *Journal of Teaching in Social Work*, *36*(4), 363–379. https://doi.org/10.1080/08841233.2016.1200171

Mitchell, S. M., Taylor, N. J., Jahn, D. R., Roush, J. F., Brown, S. L., Ries, R., & Quinnett, P. (2020). Suicide-related training, self-efficacy, and mental health care providers' reactions toward suicidal individuals. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *41*(5), 1–8. https://doi.org/10.1027/0227-5910/a000647

Morrison, L., Alcantara, A., Conover, K., Salerno, A., Cleek, A., Parker, G., & McKay, M. (2015). *Harnessing the learning community model to integrate trauma-informed care principles in service organizations*. McSilver Institute for Poverty Policy and Research. https://www.fatherhood.gov/sites/default/files/resource_files/e000003231.pdf

Moscardini, E. H., Hill, R. M., Dodd, C. G., Do, C., Kaplow, J. B., & Tucker, R. P. (2020). Suicide safety planning: Clinician training, comfort, and safety plan utilization. *International Journal of Environmental Research and Public Health*, *17*(18), 6444. https://doi.org/10.3390/ijerph17186444

Niederkrotenthaler, T., Gould, M., Sonneck, G., Stack, S., & Till, B. (2016). Predictors of psychological improvement on non-professional suicide message boards. *Psychological Medicine*, *46*(16), 3429–3442. https://doi.org/10.1017/S003329171600221X

Nock, M. K., Borges, G., Bromet, E. J., Williams, D., Angermeyer, M., Beautrais, A., Bruffaerts, R., Chiu, W. T., de Girolamo, G., Gluzman, S., de Graaf, R., Gureje, O., Haro, J. M., Huang, Y., Karam, E., Kessler, R. C., Lepine, J. P., Levinson, D., Medina-Mora, M. E., . . . Williams, D. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans, and attempts. *British Journal of Psychiatry*, *193*(2), 98–105. https://doi.org/10.1192/bjp.bp.107.040113

O'Connor, D. B., Green, J. A., Ferguson, E., O'Carroll, R. E., & O'Connor, R. C. (2018). Effects of childhood trauma on cortisol levels in suicide attempters. *Psychoneuroendocrinology*, *88*, 9–16. https://doi.org/10.1016/j.psyneuen.2017.11.004

Ong, M. S., Lakoma, M., Gees Bhosrekar, S., Hickok, J., McLean, L., Murphy, M., Poland, R. E., Purtell, N., & Ross-Degnan, D. (2021). Risk factors for suicide attempt in children, adolescents, and young adults hospitalized for mental health disorders. *Child and Adolescent Mental Health*, *26*(2), 134–142. https://doi.org/10.1111/camh.12400

Pfeiffer, P. N., King, C., Ilgen, M., Ganoczy, D., Clive, R., Garlick, J., Abraham, K., Kim, H. M., Vega, E., Ahmedani, B., & Valenstein, M. (2019). Development and pilot study of a suicide prevention intervention delivered by peer support specialists. *Psychological Services*, *16*(3), 360–371. https://doi.org/10.1037/ser0000257

Rudd, M. D., Cukrowicz, K. C., & Bryan, C. J. (2008). Core competencies in suicide risk assessment and management: Implications for supervision. *Training and Education in Professional Psychology*, *2*(4), 219–228. https://doi.org/10.1037/1931-3918.2.4.219

Schlichthorst, M., Ozols, I., Reifels, L., & Morgan, A. (2020). Lived experience peer support programs for suicide prevention: a systematic scoping review. *International Journal of Mental Health Systems*, *14*(1), 1–12. https://doi.org/10.1186/s13033-020-00396-1

Schmitz, W. J., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., Simpson, S., & Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in U. S. mental health training. *Suicide and Life-Threatening Behavior*, *42*(3), 292–304. https://doi.org/10.1111/j.1943-278X.2012.00090.x

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, *19*(2), 256–264. https://doi.org/10.1016/j.cbpra.2011.01.001

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in behavioral health services. Treatment Improvement Protocol (TIP) series 57. In *HHS publication no. (SMA)* (pp. 13–4801).

Sue, D. W., Rivera, D. P., Capodilupo, C. M., Lin, A. I., & Torino, G. C. (2010). Racial dialogues and White trainee fears: Implications for education and training. *Cultural Diversity and Ethnic Minority Psychology*, *16*(2), 206–214. https://doi.org/10.1037/a0016112

Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist*, *33*(4), 449–478. https://doi.org/10.1177/0011000004269058

Ward Ciesielski, E. F., & Rizvi, S. L. (2021). The potential iatrogenic effects of psychiatric hospitalizations for suicidal behavior: A critical review and recommendations for research. *Clinical Psychology: Science and Practice*, *28*(1), 60–71. https://doi.org/10.1111/cpsp.12332

Winfrey, O., & Perry, B. D. (2021). *What happened to you? Conversations on trauma, resilience, and healing*. Flatiron books.