Mental Health Providers: Are We Part of the Solution or Part of the Problem? Lessons Learned on the Trauma of a Suicide Attempt

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Abstract: This paper focuses on the often-neglected recognition of client and care provider trauma associated with a suicide attempt or death. After the death of a group member, clinicians and peer facilitators of a group intervention for people who had made recurrent attempts were invited to share their narratives. The "before-during-after" experiences identified that anxiety, post-traumatic stress, and/or moral injury are to be considered when providing assessment and care for the person who has made a suicide attempt. Attending in a trauma-informed way to the subjective and unique experience and responses of the client can ameliorate worsening ideation or further attempts. Trauma-informed care further encourages a mutual and collaborative understanding of the attempt to support agency, strengths, and skills possessed even within the context of the traumatic event.

***Keywords*:** peers with lived/living experience, clinician impact, moral injury, post-traumatic stress

Introduction

In the aftermath of losing a group member, the peer and interprofessional facilitation team members of Skills for Safer Living (SfSL): A Psychosocial/Psychoeducational Intervention for People Experiencing Suicide-Related Thoughts and Behaviours met outside of the weekly supervision session to process the event. "Suicide is a traumatic event" was a reflection made by a peer co-facilitator who had survived multiple suicide attempts. Peer facilitators with lived/living experience asked, "How did I manage to survive?" as they reflected on their experienced trauma of surviving a suicide attempt. The discussion that ensued was the recognition that for the most part, clinicians did not usually work from the perspective of understanding a suicide attempt as a traumatic event in and of itself. Rather, professional education neglects to speak of suicide from the perspective of those who experience suicide ideation or attempts. This in turn objectifies the suicide experience and its sequelae, thus minimizing its emotional impact on both the care provider and the person with suicide-related thoughts or attempts. This paper is a collaboration with people with lived/living experience (PWLE) who participated in SfSL as group members—and some who went on to become peer co-facilitators. The following reflections will focus on the impact of a suicide attempt or death on us, the team of authors composed of PWLE and professionals, proposing the need to recognize suicide-related thoughts or behaviours as trauma.

It is estimated that for each death by suicide, another 25 to 30 people will attempt to end their lives such that approximately 17.5 million people worldwide will attempt in a given year (Public Health Agency of Canada, 2019; World Health Organization, 2021). A death by suicide is a traumatic event for those left behind (Andriessen et al., 2020; Young et al., 2012); yet, little

attention has been given to the traumatic experience of the people who have survived an attempt or multiple attempts (Stanley et al., 2018), nor the impact on care providers.

Literature Review

What Do We Know About Suicide-Related Behaviours?

The complexity of suicide defies prediction on an individual level (Klonsky, 2019) yet risk of recurrence of attempts can include previous suicide attempt(s) and recent discharge from an emergency department (ED) or psychiatric inpatient admission (Knesper et al., 2010). Ahmedani and colleagues (2014) reported that over one-third of people who had died by suicide were undiagnosed with a mental health or substance misuse diagnosis and had been assessed in an ED within the year of their death. Adequate follow-up care of people seen in the ED for suicidality is an ongoing challenge (Hunter et al., 2018; McInerney et al., 2020).

Suicide and Trauma

Trauma is defined as a result from the following:

> 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. (Substance Abuse and Mental Health Services Administration, 2014, p. 7)

Bill et al. (2012) suggests that those surviving a suicide attempt experience "a severe trauma" (p. 1) likely to induce PTSD; yet, trauma symptoms could be missed because of a primary focus on the symptoms of a psychiatric diagnosis (Wulsin & Goldman, 1993). Stanley and colleagues (2019) reported probable suicide attempt–related PTSD in 27.5 percent of those who attempted suicide, while O'Connor and colleagues (2021) identified a need for addressing post-traumatic stress symptoms after a medically serious suicide attempt; finding that those experiencing these symptoms exhibited continued risk factors—greater suicide ideation, thwarted belongingness, and perceived burdensomeness at one month and three months post discharge from the attempt. Stanley et al. (2019) argued that a suicide attempt is a catalyst for PTSD, stating that the constant convergence of traumatic reminders, avoidance behaviours, and maladaptive cognitive-emotional appraisals of trauma-relevant stimuli operated in a feedback loop that prompts and maintains PTSD symptoms. They further suggested that moral injury may arise from the dissonance between one's choices during the trauma of a suicide attempt and their moral code or belief system.

Moral injury has been described as a particular trauma syndrome that includes psychological, existential, behavioural, and interpersonal issues that emerge following perceived violations of deep moral beliefs by (i) oneself or (ii) trusted individuals (Jinkerson, 2016). Core and secondary symptoms can arise if the resulting moral dissonance remains unresolved: Core symptoms can include guilt and shame—for the behaviour or for causing pain to others; as a result of the actions and words of others; spiritual/existential conflict including the subjective

loss (or questioning) of meaning in life; and a loss of trust in self, others, and/or transcendental/ultimate beings (Jinkerson, 2016). Secondary symptomatic features include (a) depression, (b) anxiety, (c) anger, (d) re-experiencing the moral conflict, (e) self-harm, including suicide-related thoughts or attempts and/or substance misuse, and (f) social problems such as isolation or other interpersonal challenges (Bryan et al., 2018; Jinkerson, 2016). Survivors of suicide attempts often report that their thoughts or behaviors are often in contradiction to the moral code of their religion, culture, family values, or expectations of themselves (Jinkerson, 2016).

Method

Peer facilitators with living/lived experience of recurrent suicide attempts and professionals delivering Skills for Safer Living (SfSL) were invited to explore and share, to the degree they felt comfortable, their experience with suicide as a traumatic event. SfSL is a 20-week group intervention initially created for people who have experienced repeated suicide attempts. With underpinnings of an emotion-focused narrative base, participants are invited to engage with the possibility of giving themselves permission to choose not to die at this time in order to come to an understanding of the intense feelings driving thoughts and behaviours related to suicide. Over the 20 weeks, participants are taught skills and concepts related to understanding what feels safe for them; coping strategies to keep themselves safer; emotional literacy; and problem-solving and communications related to relationships, boundaries, and keeping oneself as safe as possible—all under the umbrella of choices and moments of control. Peer co-facilitators have completed two 20-week cycles of the group and are an integral part of the integrated and mandatory interprofessional weekly facilitator supervision group.

A psychiatrist, a psychiatric emergency nurse, a social work–suicide interventionist, and three PWLE consented to participate in the writing of this paper. Authors wrote their initial thoughts and experiences, which were read by the first author (Bergmans), who then collated and organized them into emerging themes. Co-authors were then invited to further elucidate their thoughts and experiences based on the identified and agreed upon themes. Following the World Medical Association Declaration of Helsinki (Resneck, 2025), support was offered to co-authors with lived/living experience to mitigate any challenges experienced while participating in the writing of this paper. Sections in block quotes represent the lived experiences and thoughts of team members. Reflections and comments have been de-identified at the request of team members who are aware of the stigma surrounding this discussion and the impact it may have in their current academic positions and employment pursuits. The following initialisms are used to identify speakers: PCF1 and PCF2 (peer co-facilitators); P (intervention participant); MD (psychiatrist); RN (psychiatric emergency nurse); and SW (social work–suicide interventionist). The themes that emerged—under which this paper is organized—follow the "before," "during," and "after" an attempt.

Discussion

Suicide-Related Thoughts and Behaviours

Suicide attempts have a before, during and after.

> PCF1: I don't know if there's an alternate version of my story where surviving suicide attempts isn't traumatic. It wasn't just the attempt itself each time. It was what came before and after it too: the complete powerlessness and desperation leading up to it; how people responded, or didn't respond, both before and after; the shock of living, only to find my pain and isolation worsening.

Before

Before an attempt occurs, the myriad of risk factors such as distal factors like childhood abuse (Lesage et al., 2017) may have occurred; however, not everyone will be able to talk about their previous or current story.

> PCF1: I don't know how to tell this story. I don't think of it as a coherent story with a beginning, middle, and end. It feels broken, like pieces of a shattered bowl that need to be glued back together. I don't think I've gotten that far yet.

A diagnosis of a mental or physical health illness can be a trauma that leads to a suicide attempt (Chan et al., 2018; Mueser et al., 2010) and for others, situations like relationship problems, legal matters, or housing insecurity—without an indication of a mental health diagnosis—have been associated to deaths by suicide (Stone et al., 2018). The story and experience of each person is unique regardless of a diagnosis and, if such attention is not given to the experiences of hurt, the pain of childhood trauma, illness, or the possibility of care providers being complicit in exacerbating or creating the trauma of abandonment, then isolation and devaluation are possibilities:

> PCF1: An avalanche of traumas … seemed to lead inevitably to suicide: my dad's abuse; my mom's neglectful response; … my serious illness and the hurtful responses to that.

> PCF2: All of my attempts, without exclusion, happened under the influence. … My more obvious traumas are connected to my childhood experiences, and their relationship to my addictions and self-harming behaviours have been the primary focus of staying healthy and safe the last few years.

> P: One major source of trauma for me was the ongoing absence of any social support system. My family would not acknowledge my struggles in any way, including flat-out denials of previous suicide attempts. With no one else to hear me, being risk assessed and discharged by a clinical team at the ED was just one more experience of someone telling me my reality, my struggles, did not exist at all.

Pompili (2018) has offered that there is a need to refocus suicide risk assessments that includes the mental pain experienced by the individual. This would suggest clinicians require an understanding of the painful experiences and emotions of the uniquely subjective meaning and function of suicide-related thoughts and behaviours experienced by an individual.

During

Inpatient admission has been identified as "depersonalizing, threatening, and socially alienating … perceive[d] as a personal failure" (Knoll, 2012, para. 8) and "profoundly traumatic" with "the resurgence of feelings of imprisonment and being trapped … experienced during the traumatic event that originally triggered … suicidal crisis" (Hibbins, 2018, para. 6).

> P: They [ED care providers] ask you why you are here, then they ask you if you have used your skills. Then they hand you the suicide crisis sheet, then they attempt to steer you out to a family doctor, then you are discharged. Nowhere in there is any time spent exploring your status or experience. [There is] no tolerance for the patient to be agitated, crying, afraid, disoriented—[they] are met with threatening behavior by staff. Statements like: "I see patients every day that are much worse off than you, you are just having trouble coping" or "Why are you not using your skills? If you were using your skills you would be able to cope with this on your own. You have great psychiatric supports compared to most patients. Why are you here?"

This reflection of receiving no treatment—and no attempts to understand lived experience—can send perceived messages: "You're wasting my time," or "You should be able to figure this out yourself." Dismissiveness on the part of clinicians can add to or recreate the emotional memories and experiences of previous traumas and neglect and/or create a sense of futility in reaching out for help in the future.

The emergency department psychiatric nurse recalls,

> RN: [There were] many emotions sweeping through me when I worked with a patient surviving a suicide attempt. Sadness for the patient who felt this was the only option. Helplessness and powerlessness because I did not have the answers to change things. My fear and judgment led me to behave unsupportively and compounded patients' traumatic experiences. I blamed the patient when I was frustrated, dismissed them when I felt inadequate. Yet, I had hope that something would change, and my patient can hold hope for themselves.

Poor treatment after surviving a suicide attempt can exacerbate personal trauma (Brousseau-Paradis et al., 2024; Greenwald et al., 2023). "ED wait times, mechanical or chemical restraints can enhance a patient's feelings of hopelessness or abandonment and be traumatic to the patient" (Betz & Boudreaux, 2016, p. 276). The stigma surrounding self-injurious behaviour may be a contributor to inadequate assessment or treatment being given (Betz et al., 2013).

Our social work–suicide interventionist remembers,

> SW: A colleague called late in the evening informing me my client had made an attempt that "didn't look good." She had visited multiple hospital emergency rooms across the city over the course of the week, being discharged from each within a few hours. She survived and now permanently uses a wheelchair. I felt angry with my colleagues who could have admitted her, frustrated at the system in which I felt helpless in providing adequate care, sad for a life that had so much possibility now being significantly altered and yes, guilty, for what I couldn't do, should maybe have tried to do, for wishing it was different. Despite having a solid set of skills, knowing the risk, I did not have the power or mandate to admit her when I saw her in the ED. The colleagues who did have the power were certain it was "just the same old, same old." I retreated. I did not visit her; in public spaces I avoided her, I felt shame. I had no words, just tears.

Betz and colleagues (2013) report that of the providers participating in their study, many "did not feel they had the skills to assess risk severity or provide brief counseling or a safety plan for patients" (p. 6) and that "healthcare providers are susceptible to the same biases toward persons with mental illness that are still common in general society, as well as additional issues related to frustration or discomfort with, or dislike or misunderstanding of, suicidal patients" (p. 7). Clinicians need to be aware of their own emotions and reactions regarding the assessment of suicide risk in order to overcome any potential barriers that might include curtailed assessments, stigmatizing comments, or dismissiveness so as to not further traumatize or increase shame for someone who is already in deep emotional pain (Pompili, 2018, 2024).

> P: Despite the inexpert nature of a suicide risk assessment, individuals presenting in the ED with suicidal ideation are met with professionals who deliver their risk assessments with complete certainty, usually turning away the suicidal individual with the advice to "come back if it gets worse." Like gatekeepers, risk assessing personnel advise suicidal individuals that "this may feel like a rejection, but it's the best thing for everyone," as if it is more important to never provide services for an individual who will not go on to end their life, than it is to potentially save a life, devising a plan that does more than just hope for safety. The last time I came to the ED for suicidality, I had a panic attack when discharged. I was then forcibly dragged from the hospital by security staff, shaking all over and unable to catch my breath through the panic. I promised myself that day that I would rather die than ever come back to the ED again. I've never been back. I'm afraid for the next time I'm in crisis.

Our psychiatrist notes,

> MD: Many of my colleagues have reported a sense of powerlessness in their interactions with those presenting in a suicidal crisis. Their training has prepared them for a diagnose and treatment model and they often feel ill-equipped for the emotional intensity of such presentations. While I've had similar concerns, I've found that being really present with a person in crisis, offering support and compassion can be one small step towards a collaborative treatment plan.

After

Surviving a suicide attempt is not always a relief.

> PCF1: It felt like the attempt created this giant sinkhole that sucked so many other things along with it into the darkness.
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> PCF2: I wasn't conscious. I was out for two days. I wasn't even there. And for the other attempts previously and following, it's strange, I almost don't feel as though they were traumatic for me; I was just living it, in the moment. It was normal for me at the time. With more time and distance from the event, I'm starting to process my own personal trauma around the attempt(s); whereas prior it seemed to be much more traumatic for those around me—which I suppose is part of living in fight-or-flight brain. Ultimately the memories of the event(s) are still patchy, and I have very overwhelming moments where I sit back and say, "Holy f***, I could be dead right now!" That in itself is an absolutely terrifying premise to accept and process from where I sit seven-eight years later, in a place of great contentment with life. An awareness, or acceptance of, my own trauma in the whole thing is a lot more clear now—and perhaps some of that can be attributed to the passage of time and being at a safe enough distance to reflect on my own experience. It's almost as though the person who went through the experiences is someone I no longer even recognize—though I can absolutely have compassion and understanding for them.

Unique reflections occur upon returning home after an attempt:

> PCF1: What scares me most is what happened to my body, what was done to it, without my knowledge. … I saw blood streaked on the walls in my hallway, on the floor and sink and toilet in my bathroom, on the sheets in my bedroom. It was mine, but I have no memory of going anywhere other than my kitchen. It felt like watching a scene from a horror movie where the lights go off and, when they turn back on, someone's dead. I hadn't died, but it felt like I had lost a vital part of me, without my noticing. Out of the hospital, I wondered every day if that was the day I'd die.
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> P: The first time I woke up, alone in my apartment after having made an attempt the night before, my desolation at finding myself alive was incredible. I felt like I was apart from all of humanity, walking around in a dark world of my own, where my life mattered so little that no one would even know about my attempt, since I had not been discovered and thereby received no emergency services. I had been to the hospital directly before my attempt, and was turned away. For days after the attempt, I lived in a dissociative twilight where I couldn't process the fact that I had almost died, nobody knew, and the world went on as if nothing had ever happened. (P)

Further trauma following a suicide attempt can result from the shock that the survivor did what they did; that their intended outcome did not occur; from the reactions of healthcare providers, family, and friends; and, for some, flashbacks or memories of the event. Unintentional memories

of the time and place of the attempt—simply seeing a scar—can, years later, still carry an impact:

> PCF1: In my kitchen where I stood in that moment. I hate standing there now. After, I bought disposable utensils and started reusing the same uncleaned cups over and over again. I threw my dirty dishes in the trash instead of washing them. Just days ago, I cleaned my sink for the first time in over three and a half years, the first time since I attempted while standing there.

The emotional and psychological impact(s) of the attempt are often ignored even in discussions regarding violent means (Hadjizacharia et al., 2010; Giner et al., 2014; Persett et al., 2022). Finding empathy or identifying with the distress communicated in the behaviour is challenging (Lachal et al., 2015). Seldom is the impact on the person themselves or the professionals attending to the injuries discussed. In not naming or discussing the ensuing shame reactions, including feelings of failure, exposure, impulses to hide or flee, being ignored or living with an "invisible family" (Tzeng et al., 2010, p. 1), such thoughts, feelings and experiences remain internal, potentially contributing to an exacerbation of symptoms of PTSD or moral injury and a contributor to ongoing suicide risk. It is in the aftermath of survival of "what felt normal at the time" (PCF2); in learning about the effect of an attempt on those who care, subsequently living with the shame; in the guilt of being someone who would never intentionally hurt another person and having hurt them anyway that leaves a lingering cautious fear. Caregivers can again potentially, often unintentionally, contribute to the ongoing risk and symptomology of the trauma of a suicide attempt by their silence in not speaking about the effects of the event after it has occurred.

> PCF2: Very often [I] think of the trauma my spouse at the time experienced when she was calling 9-1-1 and consulting with police to have me checked on; seeing me unconscious in four-point restraints in the hospital, and subsequently never knowing what my condition may be if I've fallen off the radar—regardless of how much time may have passed since I had been sober or on a safer path without suicide attempts. … I'm scared of the things I'd have to do to survive such a state again, if I were to survive.

Trauma-Informed Care

The core guiding principles of trauma-informed care emphasize understanding the person outside of the problem or symptom(s) and include acknowledgement, safety, trustworthiness, transparency, choice and control, relational and collaborative approaches, recognition of historical and cultural issues, the clinician's understanding of their own social position and intersectionality, history and reactions, and strengths-based empowerment modalities (The Jean Tweed Centre, 2013; Substance Abuse and Mental Health Services Administration, 2014). Understanding the "wounded soul" (Boudreau, 2011, p. 749) in relation to moral injury and/or PTSD and the experience of the person in their pain is one way to begin every interaction. As McGinley and Rimmer (1993) state, "it may be difficult to remain reflective and imaginative and be able to convey … we have an interest in trying to understand [them] rather than to assess [them] or to try to find ways of getting rid of [them]." (p. 56)

Trauma-informed practices are not specifically designed to treat trauma—rather, they are cognizant of and sensitive to trauma-related issues. Behaviours that are challenging may be responses to the difficult experience a person is undergoing whereby suicide is seen as the only option. In the depths of their pain, or "emotional salad spinner," they may have no words to speak the language of feelings or provide a "coherent story." It is their behaviour that is trying to tell the "story" (Bergmans et al., 2020). Similarly, challenging behaviours after the attempt may speak to the frustration, anger, despair or disbelief at having survived the attempt or, for others, guilt and shame about having engaged in the attempt or in reaction to the responses received.

Moving Forward in Care

Clinicians can begin intervention understanding that the person who has attempted to end their life—or is at a crossroads of wanting to end their life—has experienced a traumatic event. They are experiencing what Shneidman (1993) termed "psychache" (p. 145), a perceived intolerable situation/intensity of feelings for which there is the belief that there is no other option than to die. A significant moment for one participant after an attempt was when the emergency room psychiatrist sat down and said, "I have big ears. I'm here to listen." Novick (2018) advocates against "quantifiable click-boxes" and "scripted" interactions in favour of a "quieter mode of doctoring," which allows doctors "to sit back and listen" (pp. 2093–2094), advocating for the need for providers to hear "the subjective experiences of our patients" (Pompili, 2018, p. 475). Discussing the despair at the time of an attempt and responses to survival is important to assist in understanding the degree of trauma a person experienced in the time before, during, and after an attempt, as the subjective affective state of desperation was significantly evidenced in those who died by suicide (Hendin et al., 2011).

Residual fear of reprisal, shame, and/or guilt for what has occurred is not unusual. Accepting the attempt or thoughts of an attempt can be reframed as understanding the individual is experiencing an overwhelming amount of distress based on current events, past traumas, or a conflation of the two. It is imperative that the clinician not contribute to creating the voluntary or involuntary request for help as another traumatic event—hence, it is incumbent for the clinician to take responsibility for dealing with their personal experiences of outrage, fear, and/or helplessness without perpetrating further stigma, shame, anger, or guilt toward/of the person. Being aware and seeking supervision is recommended (McGinley & Rimmer, 1993). Nonjudgmental vocabulary; a relaxed body; eye contact; a conversational tone; congruency of provider affect with the words they are using; and asking the person about known triggers such as closed doors, dark rooms, or raised voices can aid in providing as physically and psychologically safe environment as possible—the necessary first stage of recovery from trauma (Herman, 1992, 1998/2002; McKay & Shand, 2018). Providing empathic, person-centred care with some basic comforts such as a blanket or juice; explaining what to expect; or checking in on the person to let them know they are not forgotten can help mitigate the fear, guilt, or shame that prolonged silent isolation can create (Bergmans et al., 2009; Betz & Boudreaux, 2016). It is also important for the clinician to know their own triggers and to know how to deal with them in a way that does not impact care (Fischer et al., 2019). Having the person be part of the decision-making in their care and safety planning in conversational collaboration with providers has also been noted as helpful (i.e., Lohani et al., 2024; Pompili, 2024; Schuster et al., 2021).

The parting advice of multiple group members reminds clinicians of the importance of collaboration and conversation in discharge planning:

> P: The most important thing is to be genuine in your person-centred care. Those of us with multiple attempts are well aware of the assessment checklists and have often seen them change over time, without seeing them become any more genuine. We admit we know one distress tolerance skill, and we see you seize this opportunity to prescribe discharge. Open-ended questions like "what is it you think we can do for you today?" are not helpful (and sound frustrated, impatient and dismissive). I am a person in crisis. I don't know what you can do for me today, I may never have experienced anything other than discharge. Offer choices, not a void that the suicidal person has to fill in for you. I might not even know what I need. Never, never promise or suggest help you know you can't give. Listen to our answers. We know you have a checklist and want to discharge us, and that makes many of your attempts at deeper questions such as "what makes today worse?" obvious mechanisms to gather information that will be used to justify our discharge, not our safety. We know that, like [people who use substances], we are unwanted in the ER. We have no idea what we did to earn this dislike. Imagine what it feels like when you intend to end your life, are told to go to the ER or in many cases forced or coerced to go to the ER, and then turned away because you can't explain what's going on in that moment. We don't have the words. We're counting on you to see us. Our behaviour is our last words.
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> MD: Collaborative safety planning is only beginning to be implemented by psychiatrists and often only in specialist centres. Its value, when done collaboratively with the person, for both the patient and the clinician is immeasurable. A document that reflects a possible pathway of care for the person which they can use in further healthcare interactions is an under-recognised personalised care intervention.
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> SW: Key to the creation of a safety plan is that it occurs through conversation with the person. It is a collaboration with a purpose. It can help build an alliance, develop awareness and provides opportunities to discover moments of control, choices and expand the skill set the client may not be able to articulate or perceives themselves as having. It is a vehicle to understanding and helping the person understand their "story" with a person who takes their life and safety seriously. It is an opportunity to validate, support, and encourage. Identifying what might get in the way of acting on the safety plan also allows for the opportunity to discover or articulate what the person already possesses to overcome those hurdles or challenges. It's worth spending the time doing. In engaging in this conversation, most often both of us walk away with a sense of future and "I can do this." Without the conversation and spending the time, I'm not sure what worries, thoughts, feelings I would have. I too am human.

Conclusion

A suicide attempt occurs most often following a complex interplay of events that a person finds inescapable except by considering or attempting suicide. The results of attempting suicide carry

the risk of being experienced as a traumatic event with short-term or long-lasting repercussions related to PTSD or moral injury. In the long-term, the unfulfilled expectation of death; disbelief at having made the attempts; and reactions by care providers, family members, or friends are key elements contributing to the healing of such an event. Trauma-informed care and collaborative safety planning are two interventions that may assist in curtailing or lessening the traumatic impact of a suicide attempt. Approaching suicide-related thoughts or attempts from a trauma-informed lens indicates that the practitioner is taking the person seriously; that the person has something valuable to say and "matters"; and that they are not "invisible," nor is the experience being minimized, devalued, or dismissed. This approach promotes an opportunity to improve engagement with services, placing healing at the forefront as opposed to proliferating those practices which could contribute to re-traumatization.

Further exploration and study into the experience of trauma or moral injury is critical if deeper understanding and meaningful care is to occur for those who attempt suicide and those who provide care to those who are at risk.

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