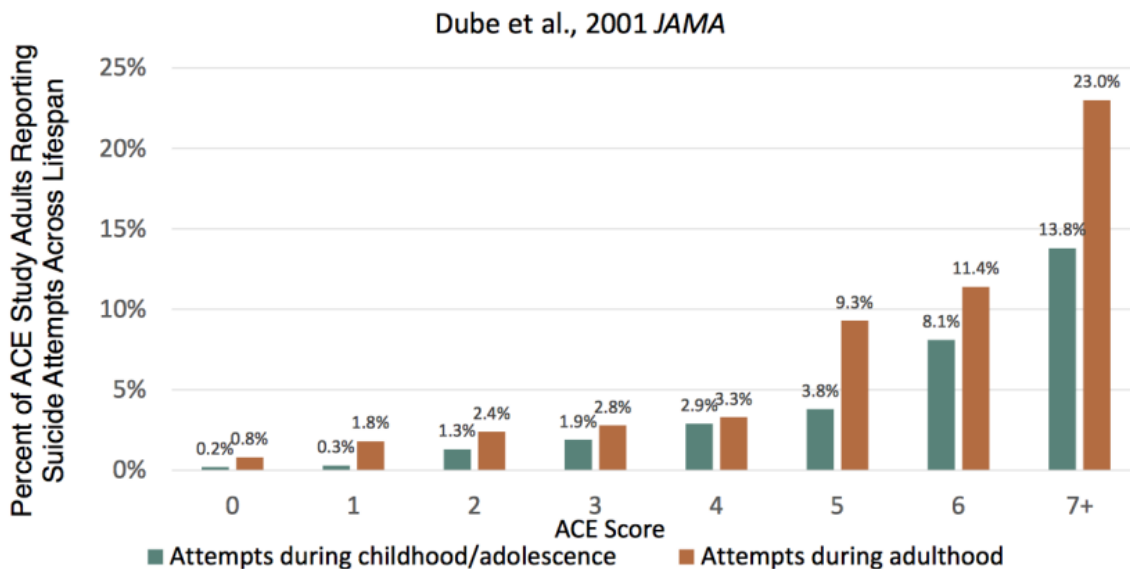


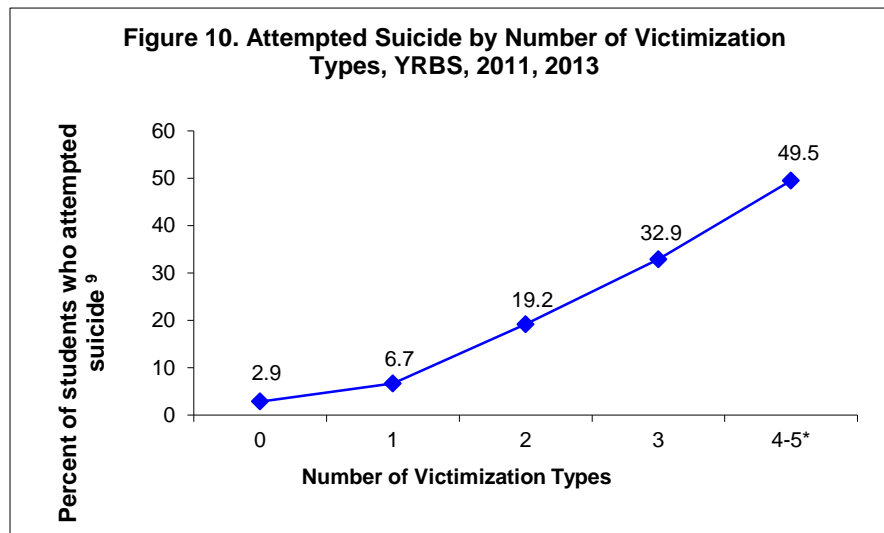
Trauma and Suicide

Riverside Trauma Center has been providing trauma response and suicide prevention and postvention services since its inception. While we have always recognized the overlaps between trauma and suicide, there is a growing recognition the two phenomena—which have traditionally been approached as largely separate areas in terms of assessment, treatment, study, etc.—are more connected and interwoven than people working in either field had previously acknowledged. Riverside Trauma Center is moving towards integrating our work in these fields to reflect this emerging knowledge.

Perhaps the clearest way in which they intersect is that each is a significant risk factor for the other. There is strong evidence that trauma increases the risk of suicide as well as the risk of other conditions and behaviors likely to increase risk for suicide. The clearest evidence of this is the CDC's Adverse Childhood Experiences (ACE) study,¹ which found that the relationship between suicide attempts and adverse childhood experiences is "of an order of magnitude that is rarely observed in epidemiology and public health data." Eighty percent (80%) of suicide attempts during childhood/adolescence were found to be attributable to ACEs. Childhood and adolescent suicide attempts increased 51-fold, or 5,100% with seven or more adverse childhood experiences.



The data from the ACE study has been replicated numerous times and is borne out by the data from Massachusetts' Youth Risk Behavior Survey (YRBS),² which found that nearly half of youth who self-reported experiencing either four or five of the types of victimization asked about on the YRBS had an almost 50% chance of having attempted suicide that year.



Source: Massachusetts Youth Risk Behavior Survey, questions on survey in 2011 and 2013, weighted data
* Estimates may be unreliable due to small numbers, interpret with caution

Suicidal thoughts and behaviors can be experienced as traumatic for the person struggling with them. People often report feeling isolated, immobilized, or defective because they are having suicidal thoughts. These reactions are only heightened after an attempt. Bill et al. (2012)³ found that:

46.7% of attempt survivors reported PTSD-like symptoms specifically in response to the suicide attempt and independent from other past traumatic experiences. The risk of developing PTSD after a suicide attempt increased with the severity of the attempt and with the precautions taken to prevent discovery. Our findings suggest that depressed patients surviving a suicide attempt experience a severe trauma likely to induce PTSD.

The experience of trauma and resulting symptoms increase risk for further suicidal thoughts and behaviors (in addition to increasing risk through habituation).

We also know that the loss of a friend or family member can be traumatic (and is a risk factor for suicide) for the people left behind. This is true across cohorts of young people who had different levels of intimacy with the deceased. Brent et al. (2010)⁴ found that "new-onset and exacerbated psychopathologic reactions are common after exposure to the suicide death of a peer." These reactions include increased cases of PTSD.

While it is important to acknowledge that not everyone who is impacted by trauma experiences suicidal thoughts or behaviors, not everyone who considers suicide has a trauma history, and not everyone who loses a loved one or peer to suicide experiences that loss as traumatic, the correlations are significant enough that we need to be paying attention. Perhaps of equal importance is that as we learn more about effective methods for assessing and responding to both trauma and suicide we see more and more connections about what helps people.

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We will often not know who is struggling with experiences of trauma or thoughts of suicide. Trauma-informed approaches which are collaborative and assume injury rather than illness/badness have been shown to be helpful for everyone, regardless of whether or not they have experienced trauma, and they are now considered best practices in responding to people experiencing the impacts of trauma or thoughts of suicide.

Some suggestions for improving care related to both suicide and trauma include:

1. Screening (ideally using collaborative approaches) for traumatic experiences and suicidal thoughts and behaviors (both past and current) during assessment/intake
2. Providing trauma-focused and suicide-focused collaborative treatment options
3. Incorporating peer support and lived experience in meaningful ways
4. Seeking to build trusting, respectful relationships as cornerstone of care
5. Emphasizing the importance and ethical obligation of using self-care strategies for staff and persons served

¹"Adverse Childhood Experiences," Centers for Disease Control and Prevention, www.cdc.gov/violenceprevention/acestudy

²"Massachusetts' Youth Risk Behavior Survey," Massachusetts Department of Elementary and Secondary Education and Centers for Disease Control and Prevention, www.doe.mass.edu/cnp/hprograms/yrbs

³Birgit Bill et al., "Attempted Suicide Related Posttraumatic Stress Disorder in Depression - An Exploratory Study" (2012), www.suicidology-online.com/pdf/SOL-2012-3-138-144.pdf

⁴DA Brent, et al., "Psychiatric Sequelae to the Loss of an Adolescent Peer to Suicide," *Journal of the American Academy of Child & Adolescent Psychiatry*, 1993 May;32(3):509-17. www.ncbi.nlm.nih.gov/pubmed/8496113