Most of us are well-read in the area of trauma and suicidal ideation. Many have front-line experience with both. Others have first-hand knowledge. This article combines all of these sources of information in order to give an account of trauma and suicide from the perspective of a sexual abuse trauma survivor and her therapist. First, this article offers some lessons learned based on our experiences with hospital and crisis interventions. Second, we present a case for why community agencies, psychiatrists, doctors, and family/friends should work together to help suicidal trauma survivors.

**The Hospital Stay**

Severely traumatized individuals maintain a delicate and tenuous balance between numbing and intrusion, control and chaos, and interpersonal connection and alienation. Current traumatic experiences or circumstances that replicate past traumatic events may result in overwhelming intrusive symptoms. For instance, some aspects of hospitalization can actually mimic the frightening experiences of an abusive childhood. This can be especially intense in the case of an involuntary hospitalization as it can be associated with previous abuse involving confinement or threat. These are frequently reality-based fears to which hospital staff must be sensitive if the stay is to be therapeutic.

New relationships may be regarded as frightening and dangerous as the trauma survivor is attempting to adjust to a hospital stay. He/she may engage familiar survival techniques in the face of this actual or perceived threat. In order for the hospital stay to be productive, a general acceptance of trauma-related disorders is essential – namely post-traumatic and dissociation. The hospital’s therapeutic milieu must place a high value on respect and collaboration, as opposed to authoritarian attitudes and control.

Further, adjunctive treatment that is undertaken without the knowledge or consultation of the on-going therapist may lead to fragmentation in the client’s treatment. Splits between helpers often play out the dynamics of secrecy, which the trauma survivor is familiar with from childhood. In addition, adjunctive
treatments that contradict the main treatment approach may cause the traumatized individual to become more symptomatic.

**Combining Assessment and Treatment**

Combining psychiatric assessment and ongoing community treatment makes for better quality care. Trauma survivors are usually only in a hospital setting for a short time and then are discharged into the community. When the hospital and community are fragmented, they ultimately succeed in working against each other, which is counter-intuitive to the trauma survivor’s healing.

It is vital that the main therapist and the hospital staff providing the acute care be in communication around decision-making within the established treatment plan. Continuity of contact between therapist and survivor should be maintained throughout the hospital stay. Ideally, the therapist should continue to be active in treatment planning and implementation. Due to the prominence of trust, betrayal, abandonment issues, the extent of, and reasons for, the therapist's involvement, or non-involvement, should be discussed fully with the survivor. Without active efforts to maintain a unified and coherent treatment approach, it is common for the treatment to flounder. If the hospital is experienced as a frightening and disrespectful place, this may increase the individual’s suicide risk in the future - especially if they need hospitalization again, but refuse to see it as a viable option.

**Hierarchy of Expertise**

The unfortunate reality within our mental health systems is that there exists a hierarchy of expertise. Psychiatry appears to function with the most power and perceived expertise, then community services, followed by the survivor at the bottom. What is most disheartening is that such a linear perspective often results in the trauma survivor’s voice not being solicited or heard. However, despite times of tremendous struggle, trauma survivors often have remarkable coping skills, intuition, resiliency, and the capacity to be highly functioning individuals.
By not having a hierarchy of expertise, trauma survivors can be at the centre – because they are the experts on their lives. By combining everyone’s individual knowledge and expertise, the most accurate assessment of the situation can be reached, followed by a favourable treatment plan with optimal healing.

**Recommendations**

1) Delivering quality care to suicidal trauma survivors requires a cooperative effort by hospital and community health services. An on-going therapist can offer valuable input in formulating a dynamic understanding of the survivor's struggles and needs during a hospital stay. He/she can also act as a liaison with hospital staff, supportive family/friends and other helpers in aftercare planning.

2) Ideally, hospitalized survivors should be provided access to their individual therapist during the course of their stay because therapeutic gains are best realized in an ongoing trusting relationship.

3) Trauma survivors and their on-going supports should be consulted regarding important treatment decisions during an acute care episode. Survivors are likely to better tolerate hospitalization and cooperate more fully with the treatment plan when they and a trusted other are included in the process.

4) Awareness of the root struggles for trauma survivors needs to inform treatment approaches and the hospital environment itself. For this reason, Regional Hospital Authorities should seriously consider separate units for trauma survivors in order to facilitate such specialized treatment.