The 'Truth' About Suicide

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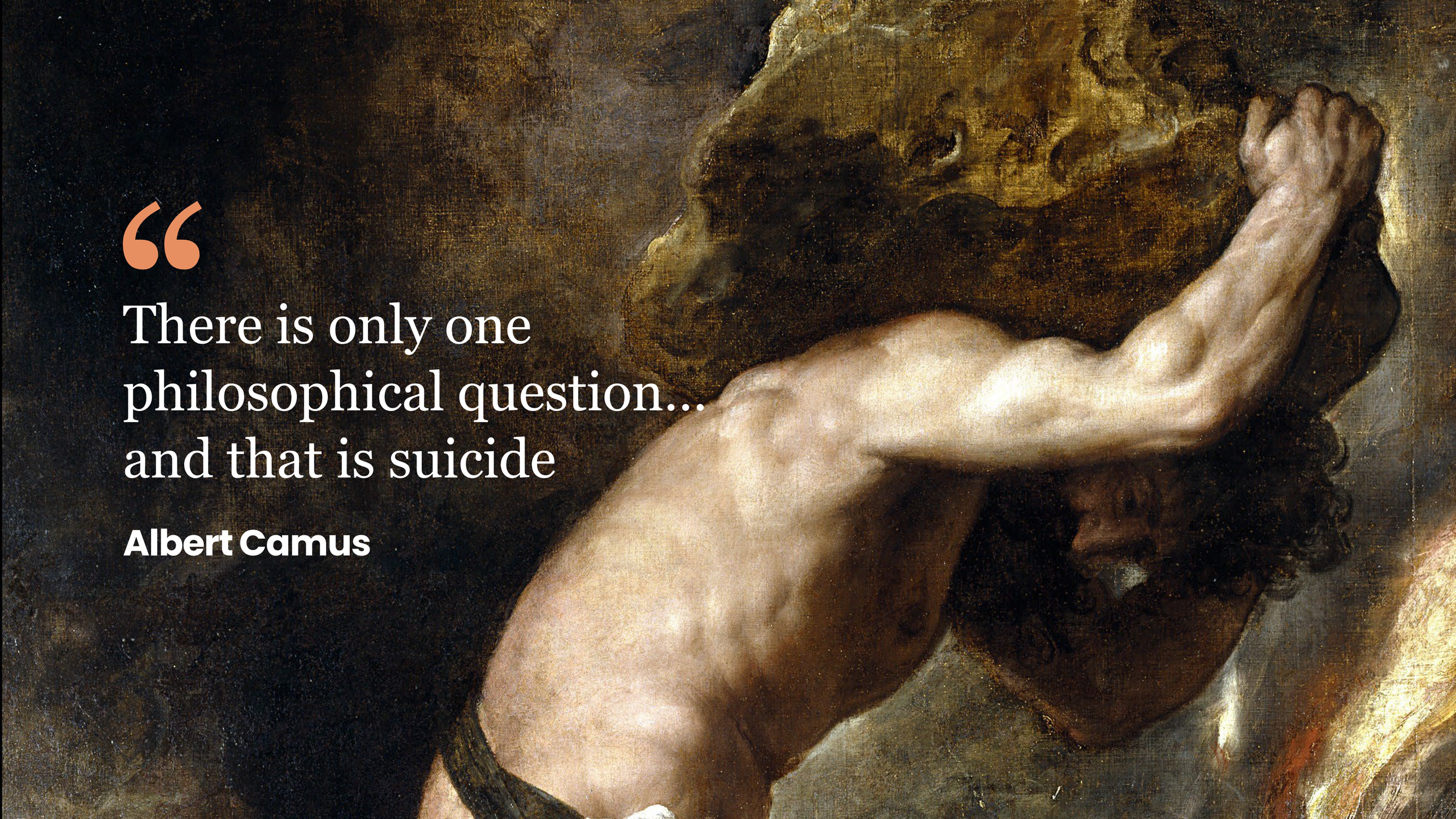
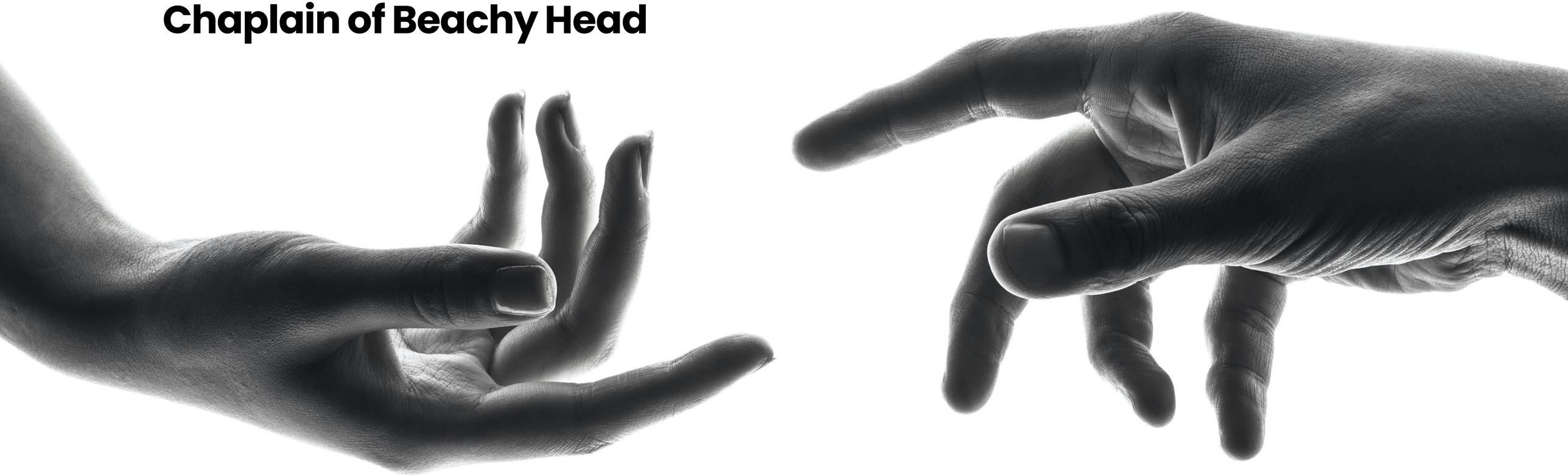
Consultant Psychiatrist, Psychoanalyst, Group Analyst | Chair of the Royal College of Psychiatrists Working Group on the Effect of Suicide and Homicide on Clinicians | Vice-Chair Psychotherapy Faculty | Co Chair of the Patient Safety Group


“
There is only one philosophical question... and that is suicide
Albert Camus


The only way out
is through

“To help a truly suicidal person you have to approach them with an open heart…

Chaplain of Beachy Head



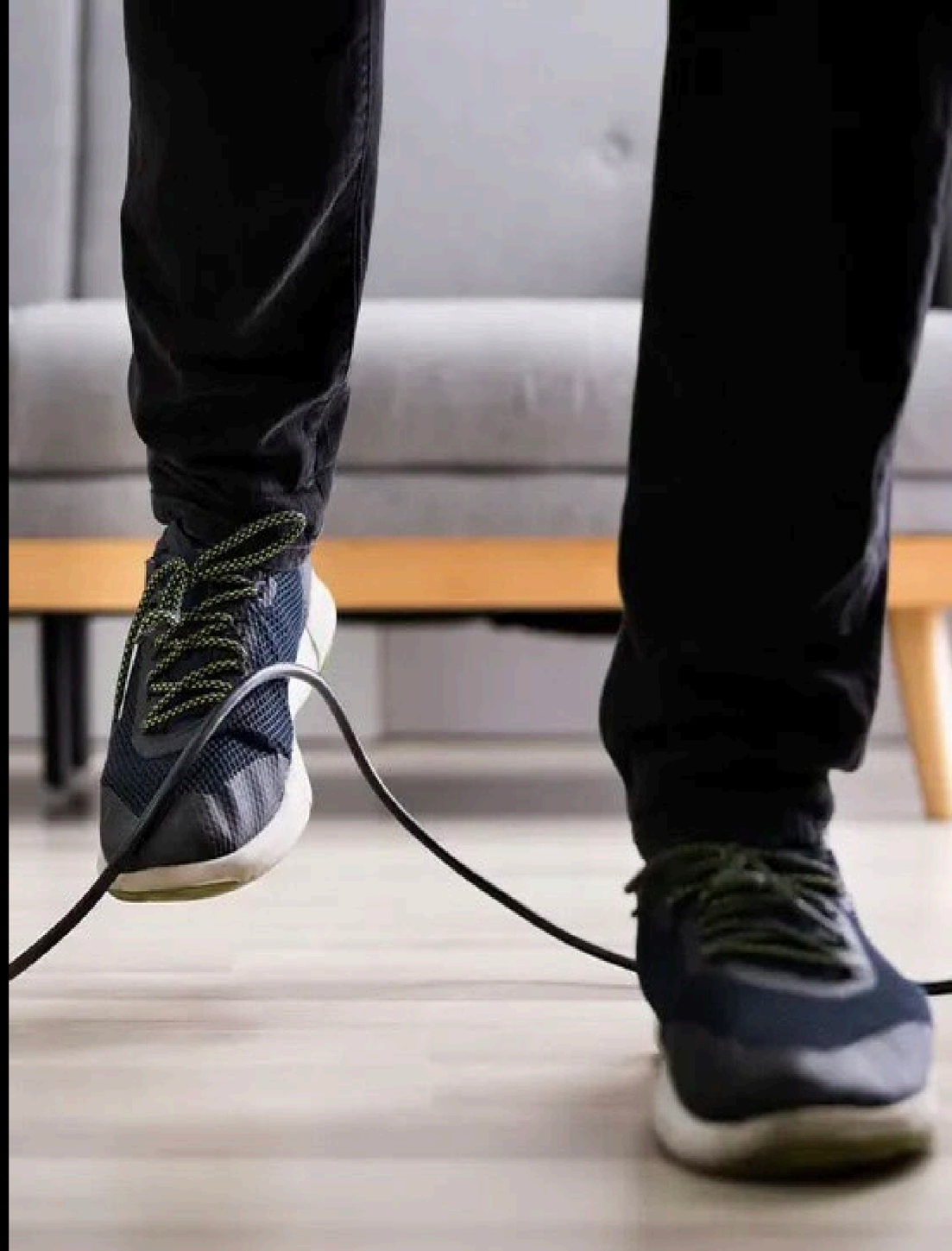
My Experience

- Suicide Lead: for Barnet Enfield & Haringey MHT
- Serious incident review group chair Haringey MHT
- British Transport Police Suicide Prevention Team: Clinical Lead
- Haringey Suicide Prevention Group: Founder member
- Suicide Group for Consultants for 13 years
- Coroners Office reviewing all suicides + audits, other data review
- RCPsych: Chair Patient Safety Group & Working Group for the Effect of Patient Suicide and Homicide on Psychiatrists. Suicide Strategy Nationally for Priory Group
- Research with Oxford Centre for Suicide Research- Bulletin paper, Booklet for support.
- Writing national guidance for mental health organisations

Truths
About Suicide

1.
Suicide is not an accident

- Suicide is not an accident
- It is a result of complex universal unconscious mental mechanisms that we do not understand
- It can be highly determined



2.

You will never know why someone has died by suicide

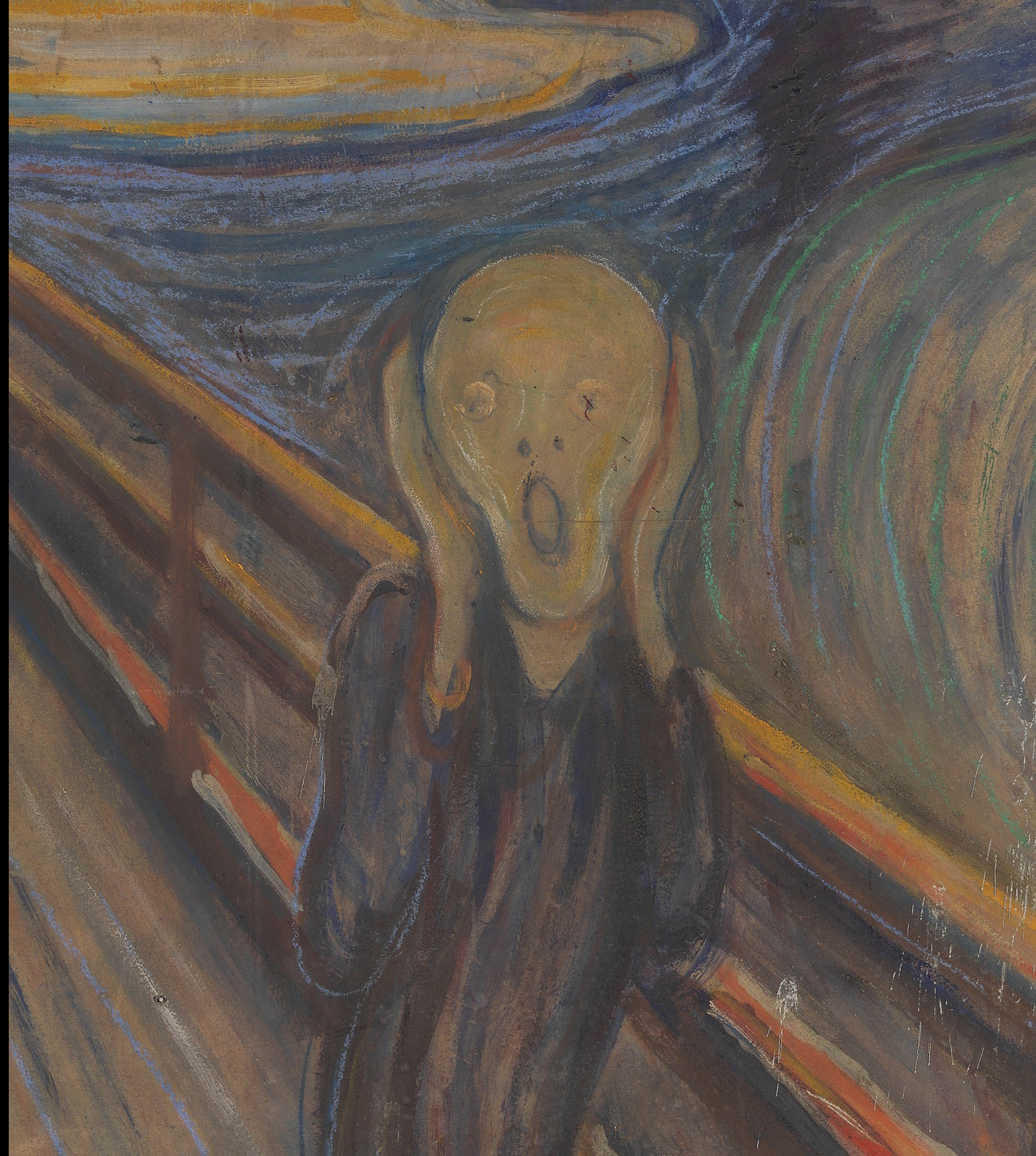
3.

Impulsive vs premeditated

4.
You do not know what is going on in someone else's mind

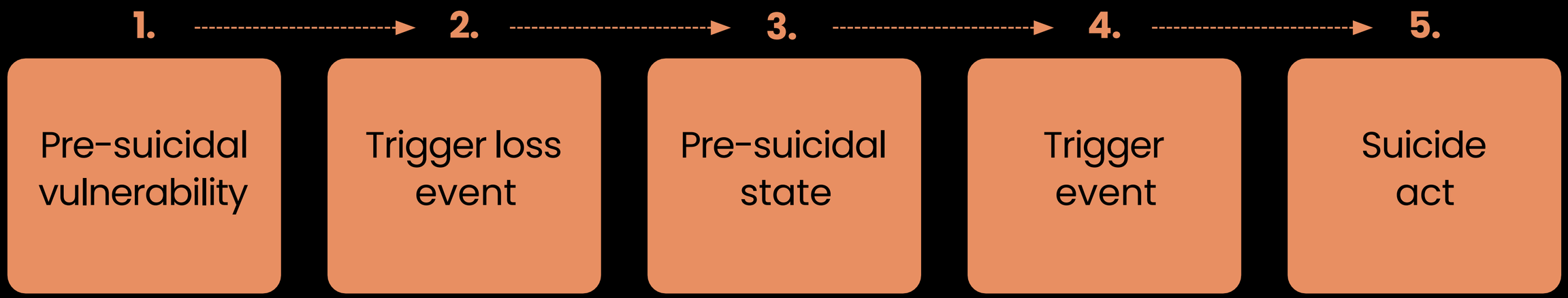
5.

Everyone is shocked and surprised by the death



6.
Suicide result from an incapacity to mourn

Pathway to Suicide



7.
Suicide is a human condition not a mental health condition

8.
Suicide prevention challenging in any individual case but not on a population or conceptual level

9.
Suicide is an acting out event

You act out when you cannot put your emotional experience into words

“

An act like this is prepared within the silence of the heart, as is a great work of art. The man himself is ignorant of it. One evening he pulls the trigger or jumps

Albert Camus

Facts or Truths about suicide

1. Suicide is not an accident
2. You will never know why someone died by suicide
3. It is either impulsive or premeditated
4. You do not know what is going on in someon elses mind.
5. Everybody is shocked by the death
6. Suicide appears to result from an incapacity to mourn
7. Suicide is a human condition and not a mental health condition
8. Suicide prevention is a public health issue and talking about it reduces the risk
9. Suicide is an acting out event

10.
No one is to blame for someones death by suicide

- Blame is a non-mentalizing word
- It only allows for one - and the complexity and uncertainty of the situation are not considered.
- Responsibility is a mentalizing word

It’s is our belief that we can predict and prevent individual suicide that makes us the architect of our own downfall following the suicide of a patient.
We then take suicide of a patient as our own failure
The truly suicidal then pose a risk to us
…and It makes us less likely to approach them with an open heart

https://www.cambridge.org/core/journals/bjpsych-bulletin/article/eight-truths-about-suicide/36D1872261E290945E245143BECC6260

Eight ‘truths’ about suicide

Published online by Cambridge University Press: **14 September 2023**

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Abstract

This paper summarises themes that have emerged from 14 years of study of suicide and work with those bereaved. It is based on a talk given in many clinical settings over the past 10 years. I describe my own emotional journey following impactful deaths and summarise personal ‘truths’ about suicide that have emerged over time. Case studies used for illustration are composites taken from clinical practice; accounts of relatives and other survivors of suicide; and data taken from many sources including suicide audits in mental health organisations, the police and transport services, and from the examination of coroners’ records. The intention is to assist open dialogue about the nature of suicide, to contribute to the understanding of the impact on those bereaved and to encourage open-hearted clinical engagement with those who are suicidal.

The Impact of Suicide on the Mind of the Bereaved (Including Clinicians)

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The contact with suicide and what it means

- Shocking annihilatory loss
- Uncertainty
- Fracturing of fragile construct of life
- Projected into by the person who has died- suicide acting out
- Complex bereavement
- Leads to a fragmentation of the mind
- Delusion generated

‘the delusion is found applied like a patch over the place where originally a rent had appeared in the ego's relation to the external world’.

Freud: Neurosis and Psychosis

PATTERN OF RESPONSE

- Initially shocked
- Within short space of time a delusional narrative is constructed
- The bereaved as the protagonist
- Obsessional ‘I have made a mistake – I am to blame’
- Guilt/shame/humiliation
- Important transitional point- sensitive to external response
- Gradually more realistic development

Clinicians suffer Disenfranchised grief

- There is not enough grief to go round
- “I have no right to feel grief because the families grief is so much worse”
- “If I ask for any space for my feelings then it will take away, or compete with, the families grief”

OUR OMNIPOTENT ROLE

- We see our task as doing the impossible
- Controlling what cannot be controlled
- Predicting and preventing individual suicide - at all costs
- Even though there is no evidence that this can be achieved
- AT THE COST OF OUR PRIMARY TASK

RC PSYCH
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CR234

Guidance for mental health organisations regarding staff support following the death of a patient by suicide

A prevention and postvention framework

July 2022

COLLEGE REPORT

Aims of New Guidance

1. Recommend evidenced-based and best practice interventions to:
    1. mitigate the impact of a patient death by suicide
    2. improve the sustainability of mental health services increase staff wellbeing, progression with training, resilience and retention.
    3. assist mental health and training organisations in their legal obligation of duty of care for their employees
2. Increase awareness of the impact that a death of a patient by suicide can have on professionals and to:
    1. encourage transparent and open dialogue about the impact on staff of working with suicide risk and death.
    2. facilitate expansion of suicide prevention and awareness training to include preparation for the emotional effects and the processes that follow the death of a patient by suicide.
3. Help support cultural transformation:
    1. from one where individual clinicians may feel isolated and personally held responsible following a death, to a systemic understanding about the uncertainty and complex aetiology of suicide and its consequences on staff.
4. Improve the quality of patient care: by helping staff feel less anxious working with suicidality and in this way maintain their capacity to think clearly and provide safe, high-quality, care.
5. Increase the possibility of truly learning from these tragic events. To learn takes time, space for reflection and freedom from persecution.

1. Organisational pastoral suicide lead role

2. Pastoral senior management support

3. Support for the processes following the death

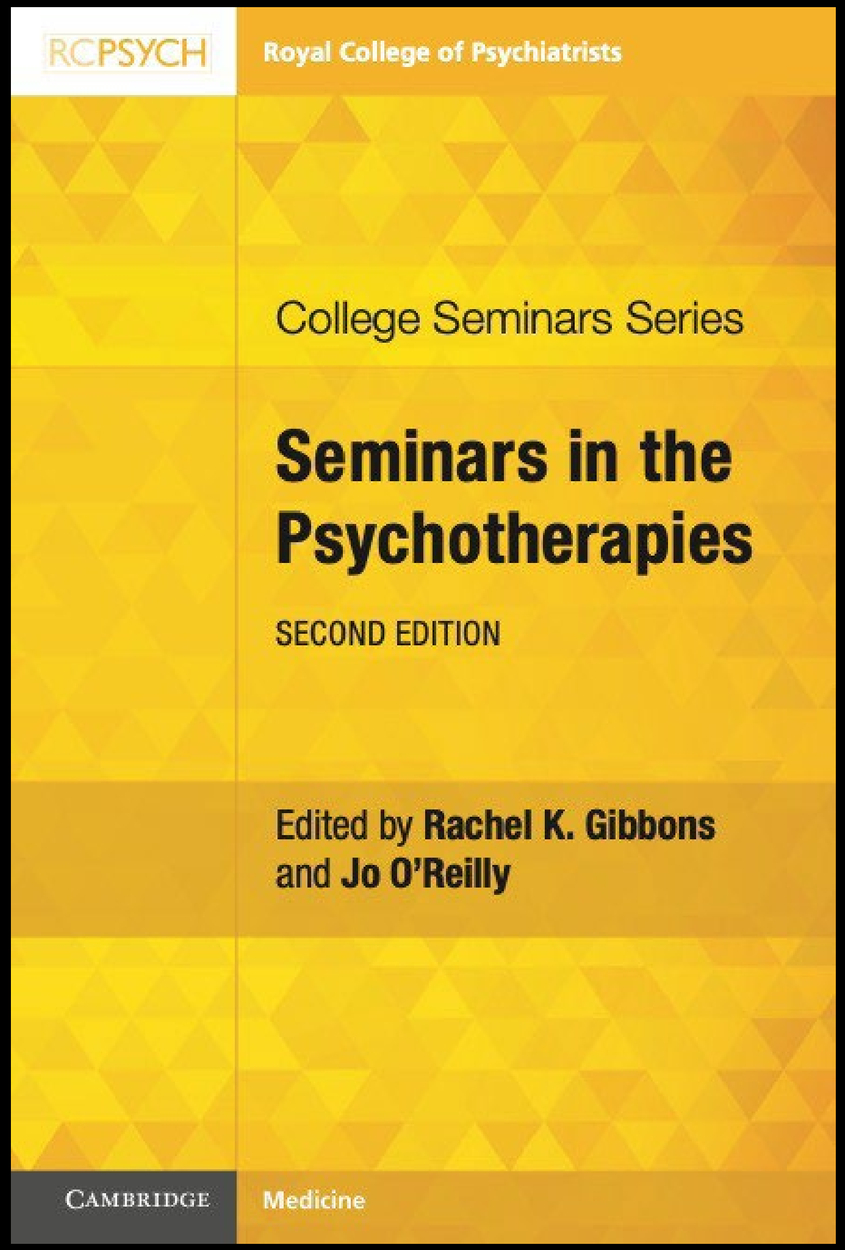
4. Buddy systems and other individual support

5. Group psychological support including a organisational suicide group

6. Family liaison officer (FLO), service or similar

7. Training on the effect of patient suicide on clinicians and on the processes that follow

8. Resource availability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Edited by Rachel K. Gibbons and Jo O'Reilly
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