The need for differentiation of suicidal behaviour in Mental Health.

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Background

In general, suicidal behaviour is defined as a uniform phenomenon and most research into suicidal behaviour has not focused on different types of suicidal behaviour(1,2).
In clinical practice we do recognize different types of suicidal behaviour however those behaviours are not precisely described and/or investigated. Except for making the distinction between acute and chronic suicidal behaviour(3) ,guidelines generally do not differentiate between the different types of suicidal behaviour we see in clinical practice(4).
Improved differentiation of suicidal behaviour would offer a better fit with clinical practice and allow more detailed scientific research. Differentiation will also allow tailored treatment. Finally, differentiation of suicidal behaviour will allow clarification of different responsibilities and more clearly define the level of responsibility for patients, practitioners and providers of mental health care(5).

Purpose

To develop a suicidal behaviour differentiation model that will enable more personalized and tailored diagnosis, treatment and risk assessments(5-7) .Improved differentiation will aide and elevate scientific research.

Methods

Based on a scientific background and clinical experience, a differentiation model has been developed(7, 8) The SUICIdality DIfferentiation **(SUICIDI)** questionnaire is derived from the model. The model has been discussed in meetings with professionals and has been adjusted afterwards(9).

Results

The developed model distinguishes between 4 types of suicidal behaviour **(figure 1)**:

1) Perceptual Disintegration (PD), there is disturbed perception and/or behaviour (psychosis).

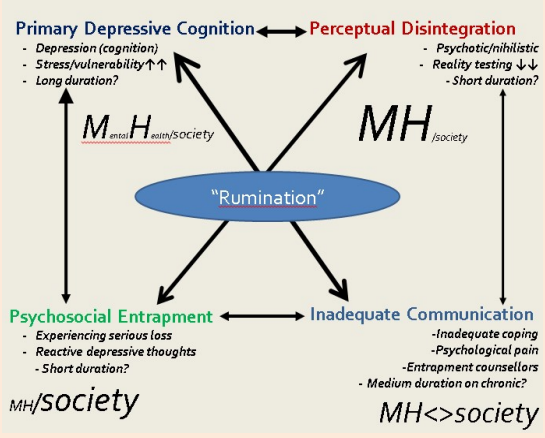
2) Primary Depressive Cognition (PDC), there are mainly depressive cognitions, there is no sudden reactive sadness.

3) Psychosocial Entrapment (PE), mainly explained by an acute reactivity to experience of loss, adversity and/or actual impending doom.

4) Inadequate Communication & Coping (IC), suffering brought on by stress and can be perceive as a way to gain attention and bring on change.

Substance abuse and/or somatic symptoms can be viewed as modifiers whose effect depends on the subtype of suicidal behaviour.

Figure 1 : Four subtypes of suicidal behaviour



Conclusion

Differentiation of suicidal behaviour
-Improves alignment of research, scientific and theoretical findings with clinical practice.
-Enhances individualised/tailored diagnosis and follow-up treatment
It could also be useful for educational purposes and for discussion about responsibility. The model was used in Eastbourne to analyse behaviour preceding suicide(10) . Four psychiatrists and 2 nurses are conducting a validation study in line with the SUICIDI questionnaire(11), on suicidal patients during crisis.

Table 1: Four subtypes and possible relations

Description	Perceptual Disintegration	Primary Depressive Cognition	Psychosocial Entrapment	Inadequate Communication
Severity suicide risk	++++	++	+++	+
Duration	Day's/weeks	Weeks/months	Day's	Day's/hours often exacerbation of chronically suicidal behaviour
Expected course	-Reduction after treatment psychosis	-Reduction symptoms after biological and/or psychological treatment	-Reduction when decrease of tunnel-vision - Reducing when decrease peak of mourning	-Non-specific reduction within hours/day's or after detection or when a can of worms is opened -Risk acute shift to chronic risk and shift to other quadrant
Recurrence	-New psychotic episode -Triggering of trauma	-New affective disturbance	-New episode of psychosocial stress or continuing of severe stress -"Narcissistic" blow	-Interpersonal stress and experienced powerlessness -Lack of external recognition of underlying suffering.
Reassessment of suicide risk	-Several times a day -Continuous during treatment -After recovery -When recurrence of a new episode -Caution during trauma therapy	-Several times a day -Regularly during treatment - After recovery -New episode, when the mood goes down	- Several times a day -Ranging from a few times a day to zero. -'in the aftermath of an acute suicidal episode' --During a new episode of severe psychosocial stress and/or new setback	-After the suicidal episode -When continued or renewed lack of recognition of underlying suffering -During interpersonal stress and experiencing powerlessness
Pharmacotherapy?	-antipsychotics (Clozapine) and/or mood stabilizer (Lithium) - possibly additional benzodiazepines in the event of major anxiety.	-Antidepressant and / or mood stabilizer - Restrained use of benzodiazepines when increased risk of impulsivity -Short-term benzodiazepines for sleep deprivation	-Restrained use of medication - Possibly symptom relief for sleep deprivation and/or great anxiety	Hold back medication when possible (changes in or addition to) pharmacological treatment
Actions during crisis	- Admission (if needed) -IHT if risk is acceptable	Emergency care, -IHT	Short admission	(F)ACT, crisis plan
Follow-up	-Outpatient treatment of psychotic symptoms, -Trauma treatment	Outpatient treatment of depressive symptoms with CBT, CAMS etc..	-General practitioner	-(F)ACT, - Additionally, for example, DGT or CAMS or collaborative care, etc. -Vigilant for change of symptoms
Responsibility patient	- Increase when disintegration reduces	- Increase when symptoms reduce	- Increase when tunnel vision disappears	-Refrain from taking over control, offer maximum support / recognition

Discussion

Differentiation of suicidal behaviour provides more alignment with clinical practice with the possibility of more tailor-made diagnostics and treatment. **Table 1** describes possible theoretical explanations.
The validation process provides tools for refining and makes the model more useful for practice and scientific research.

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See the model on: www.suicidaliteit.nl:
https://suicidaliteit.nl/2018/differentiatiemodel/Subdifferentiatieaugustusl2018.pdf

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