Differentiation of Suicidal Behaviour

a practical clinical approach

THE 3TH SUICIDE PREVENTION CONGRESS OF ABEPS ONLINE

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No Conflict of Interest

Take Home message

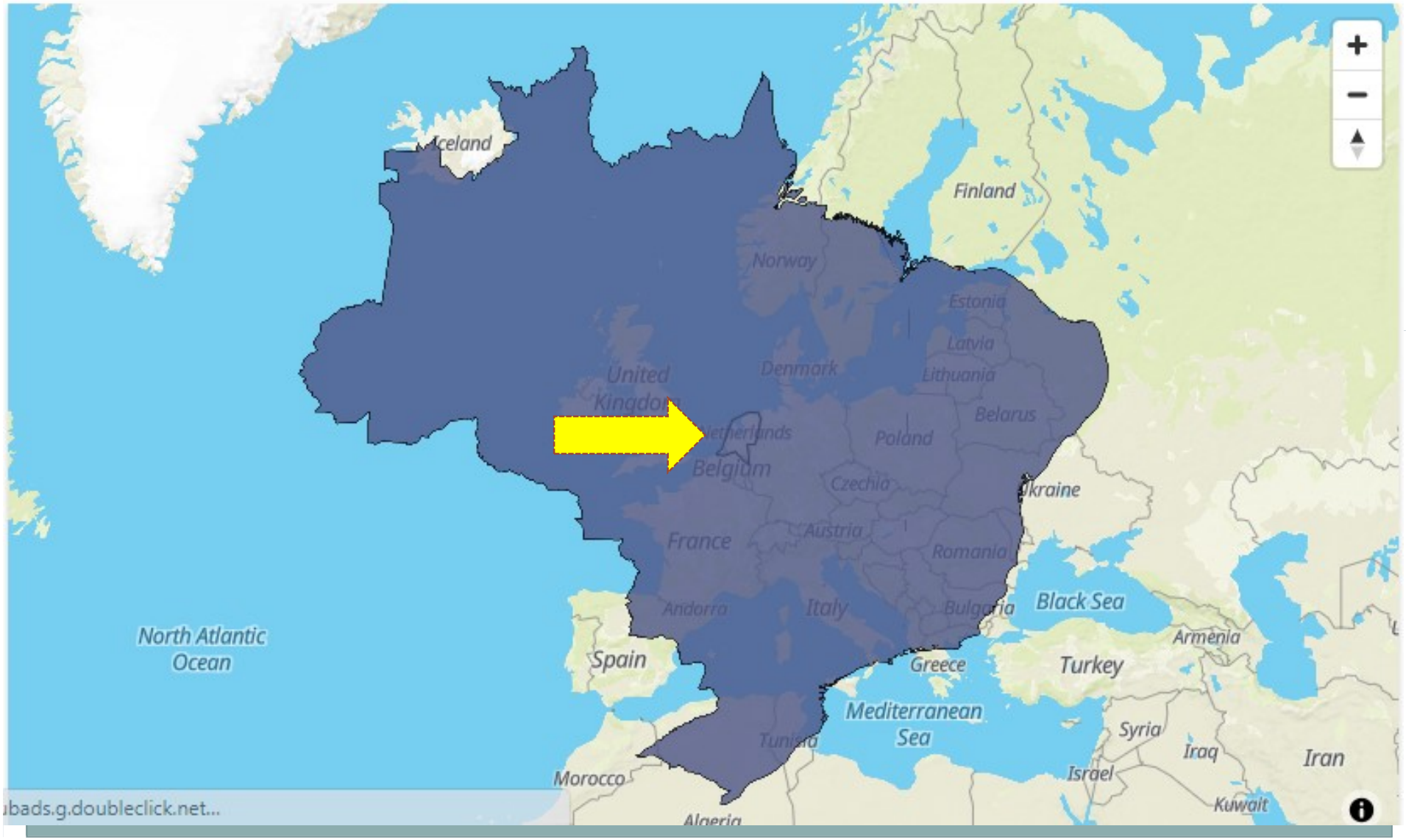
1. Suicidal behaviour = a heterogenous concept?
2. Different suicidal behaviour during different conditions/treatment settings?
3. More tailor made assessment, responsibility and treatment when better differentiation of suicidal behaviour

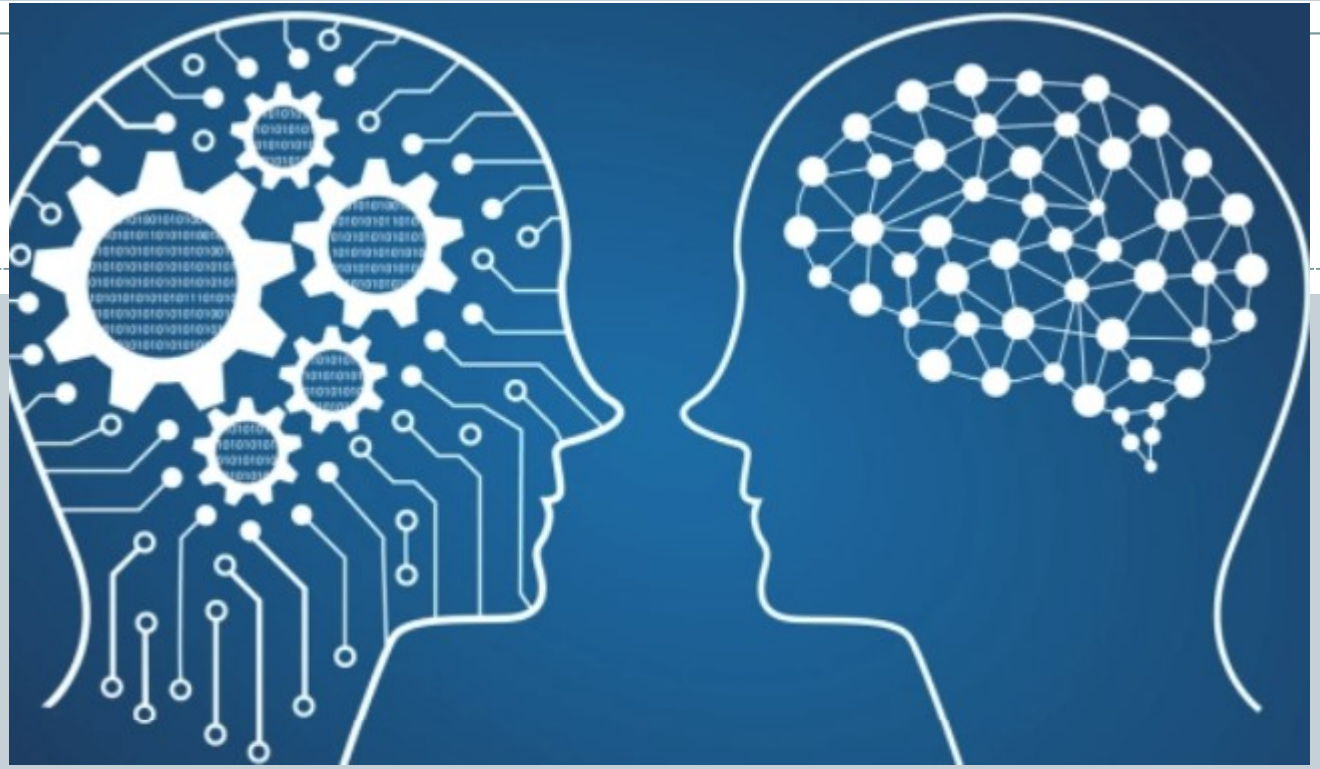
Neth ands

- 17.2 million inhabitants
- Within top 15 richest countries (↓)
- Top 30 safest places
- 7th place happiness population (↓) *(WHR)*
- High density psychiatrists (1:5600)
- Suicide rate 1:11.03 overall (2019)
  - Since 10 years >30% increase in suicides

Netherlands is about 205 times *smaller* than Brazil.

Brazil is approximately 8,515,770 sq km, while Netherlands is approximately 41,543 sq km, making Netherlands **0.49% the size** of Brazil. Meanwhile, the *population* of Brazil is ~207.4 million people (190.3 million *fewer* people live in Netherlands). We have positioned the outline of Brazil near your home location of Leiderdorp, ZH, Netherlands.





?

BRIDGING

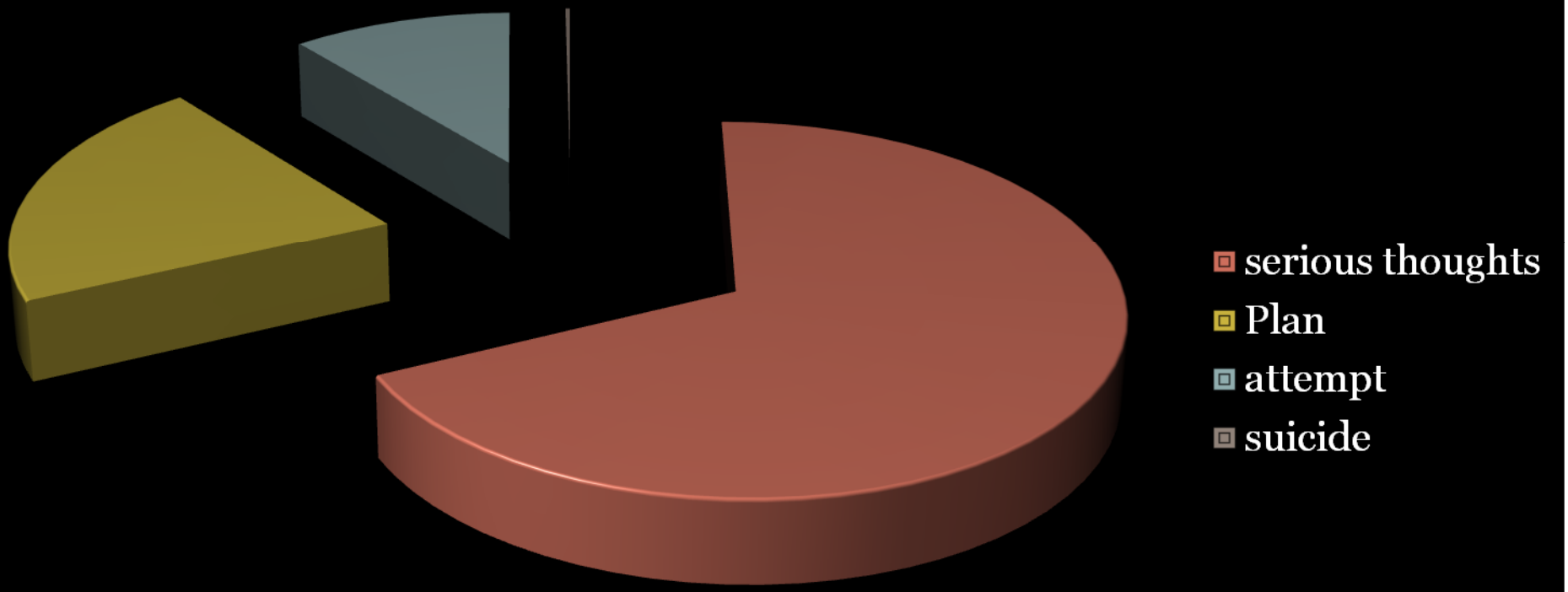
DIFFERENCES

?


PRAÇA CANTÃO

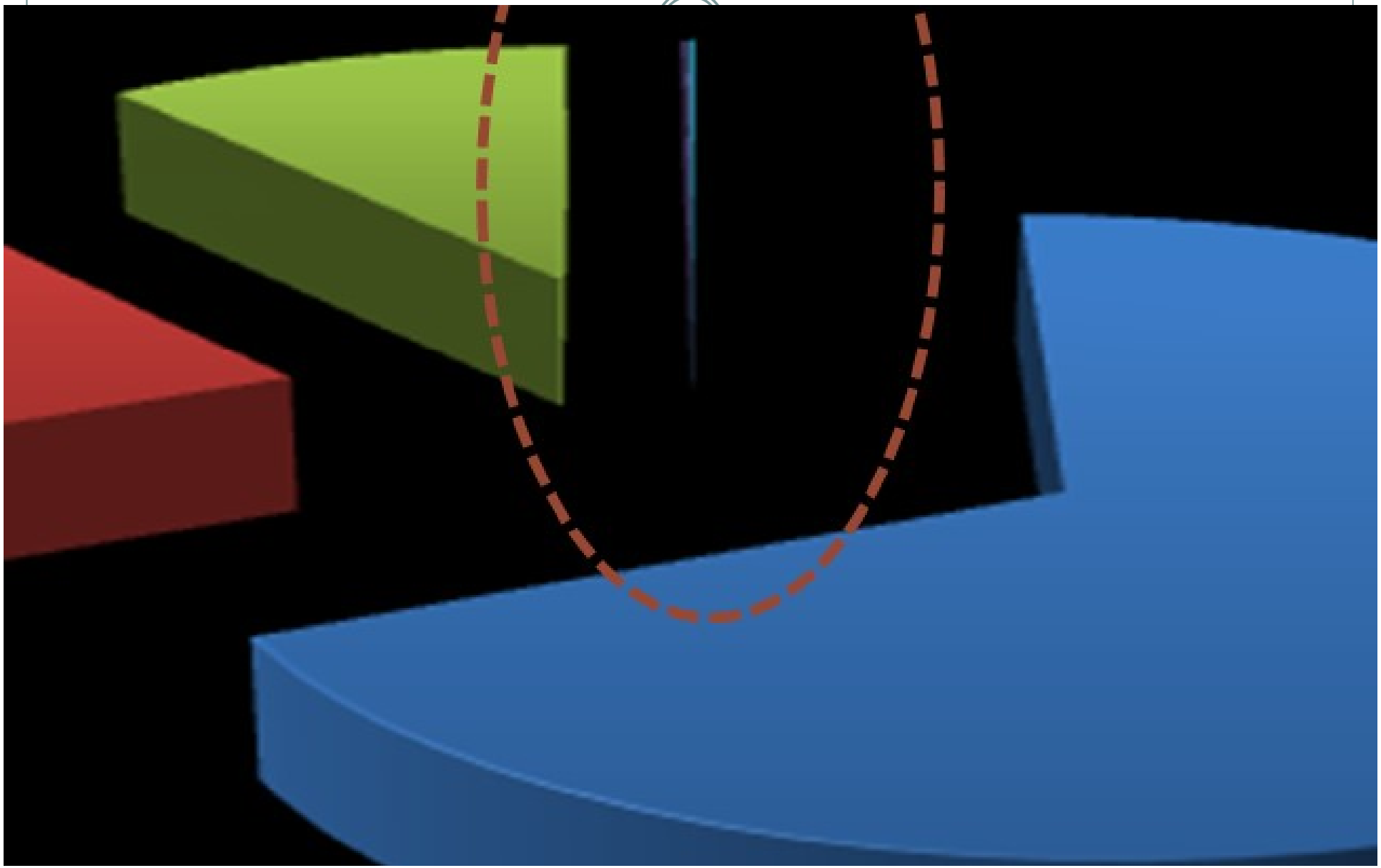
- In 2017, approximately 12.5 thousand suicides were reported in Brazil (209 million citizens)
  - 6:100.000
- In 2017, approximately 1.9 thousand suicides were reported in Netherlands (17.2 million citizens)
  - 11:100.000
- Registration (Netherlands more accurate?)

Prevalence suicidal behaviour



- When recognition severe suicidal behaviour .....

Purple mental health



Mental health

Mental health (MH): best expertise suicidal behaviour??

- Assessment and taxation in mental health!
- Guidelines?
- Treatment??
- Saving lives???

Suicidal behaviour leading to death

- Mostly no involvement of MH?
  - Netherlands <40% of suicides registrated in MH
  - World <30%
- <u>When dead too late for MH….</u>
- Selection of specific suicidal behaviour?

17% of suicides short term expected?

Suicide in mental Health

- (Dutch) All population: ≈ 11/100.000
- MH population: ≈80-90/100.000
- General population: ≈6-7/100.000

(exclusive MH)

17% improvement in MH gives < 6.8% decrease for all

Suicide and the MH worker

- Giant impact
- Experience > who?
  - responsibility
  - Blaming
  - Burn-out
  - Lawsuits
  - ……
  - **Better treatment**
  - **Zero suicides?**

Suicidal behaviour

- Symptom? Pathological behaviour? Reaction on extreme event? Culture? Unconsious ? Etc?
- Only 2 classifications < suicidal behaviour
- ….
- ….

- **Depressive disorder**
- **Borderline disorder**

Uniformity definitions?

- No differentiation suicidal behaviour (entrapment)

Society has “high” expectations for MH

- Treatment
  - Our range of treatment (and possibilities)!

But also mental health>

- In media?
  - They can do nothing…
  - Are never realy serious
  - Too fast discharge

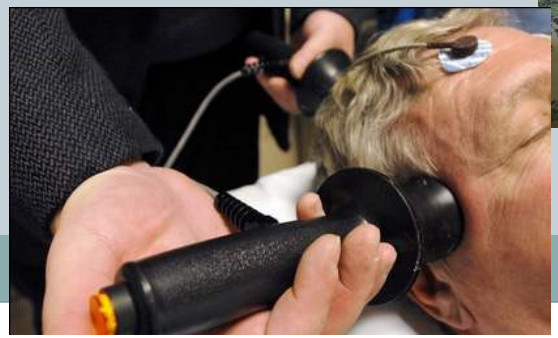
- Lawsuits
  - Court “blaming” (US, Europe
  - Brasil?

Better differentiation

- Als better tailored treatment
  - Psychotherapy
  - medication
  - Treatment in general
  - Guidance outside mental health care
- More consensus about responsibilities
- Less defensive medicine

Guidelines

- Non description of differentiation of Suicidal behaviour?
- Evidence for medication?
  - Clozapine
  - Lithium



(Psycho)therapy

Rare research on heterogeneity/differentiation suicidal behavior!

Differentiation AND suicid* *01-01-1998 - 01-01-2018 (English abstracts)*			heterogen* *01-01-1998 - 01-01-2018 (English abstracts)*		
PubMed Search results 320 all, reviews 85			**PubMed Search results 644 all, reviews 236**		
all	0		all	2	
reviews	0		review	1	
			Lopez-Castroman e.a. 2016 1) Impulsive ambivalent, 2) well planned, 3) frequent attempts		
			Ginley & Bagge 2017 1) Major depressive disorder, 2) High internalizing, 3) high externalizing		
			Wolodzko & Kozoszka (polish review) 1) comorbid mental disorders, 2) without mental disorders or mild symptoms, 3) personality disorders externalizing, 4) avoiding contacts, socially withdrawn 5) depressive		

Differentiation suicidal behaviour

- Based on practice and theory
  - Dimensions of psychopathology
    - Psychotic: perceptual disintegration (behavioural disintegration)
    - Depression: emotional dysregulation
  - Dimensions of personality (temperament and character)
    - Impulsivity (novelty seeking, harm avoidance)
    - Cognitive coping (self directedness, cooperativeness)

The Model

Primary Depressive Cognition	Perceptual Disintegration
• Depression • Stress sensitivity↑↑	• Psychotic (depression) • lose sense of reality
Psychosocial Entrapment	**Inadequate Communication**
• Serious loss experience • Short-lived depressive thoughts	• Conditioning/coping • Psychological pain • Entrapment counselers

Perceptual disintegration **PD**

- **Suicidal behavior:**
  - Arises from disturbed perception/psychosis or influenced by a large extent
  - psychosis has a direct relation to the suicidal behavior
  - is mainly explained by psychosis.

  - With a and b it is taken into account that psychosis can be explained by various causes. For example, if a person with a serious loss experience becomes psychotic and suicidal, and psychosis has a direct relation with suicidal behavior.

This can also appear during psychosis and suicidal behavior after substance (ab)use.

Primary Depressive Cognition **PDC**

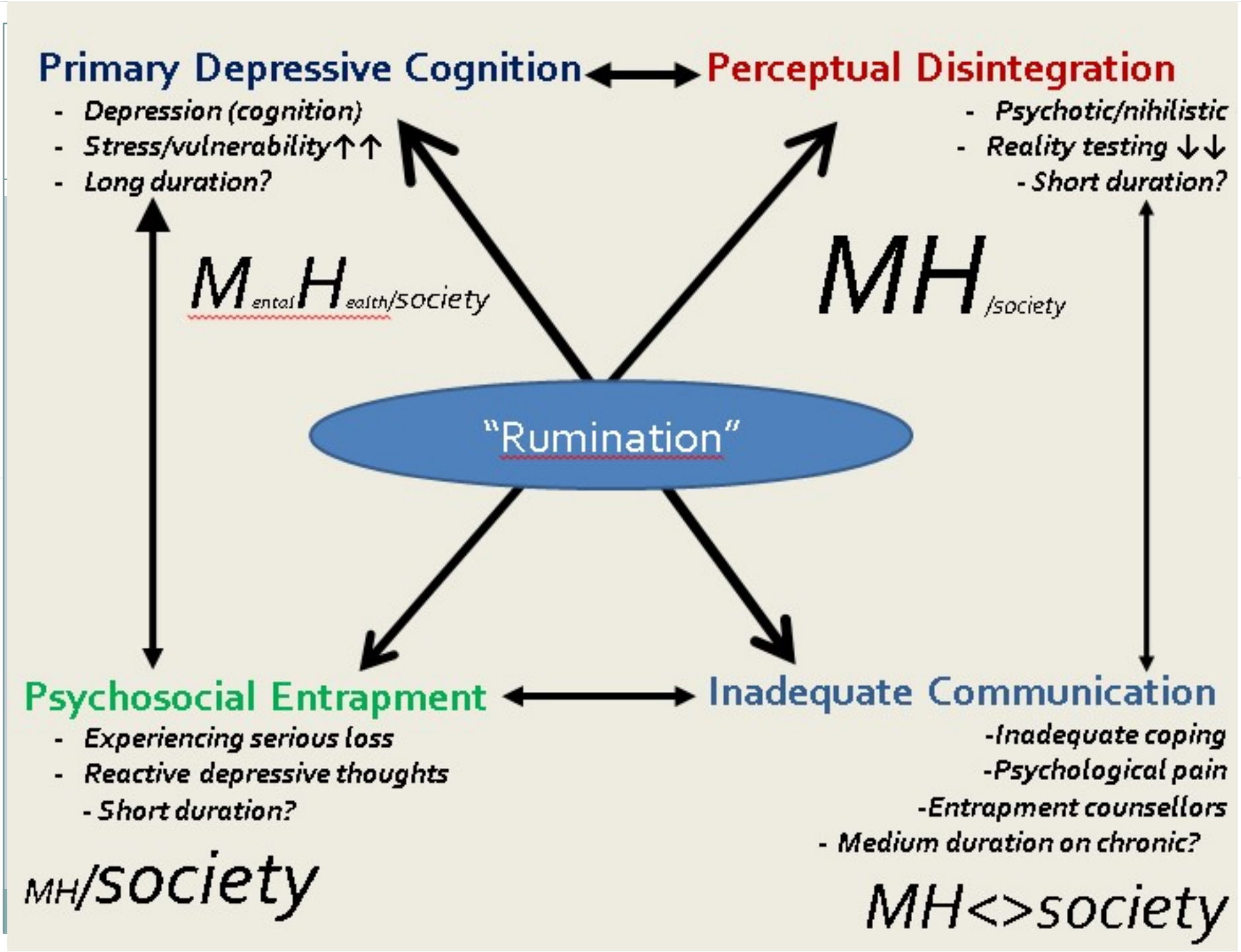
- **Suicidal behavior:**
  - Mainly from depression or primary depressive thoughts are the most important etiology;
  - Has a relationship with longer existing depressive thought or seems directly related to gloom, or the cognition of serious failure;
  - There is no relationship with any psychotic symptomatology and suicidal behavior or a sudden reactive depression

Psychosocial Entrapment **PE**

- **Suicidal behavior:**
  - Very reactive and situation-bound, a direct reaction to serious loss experience and/or serious injury and experience of completely cramped;
  - Mainly explained by seriously experienced loss experience, injury or real impending doom (can exist with long-standing depressive symptoms < two weeks and no psychosis;
  - Is not used as a means of communication about suffering.

Inadequate Coping (Communication) **IC**

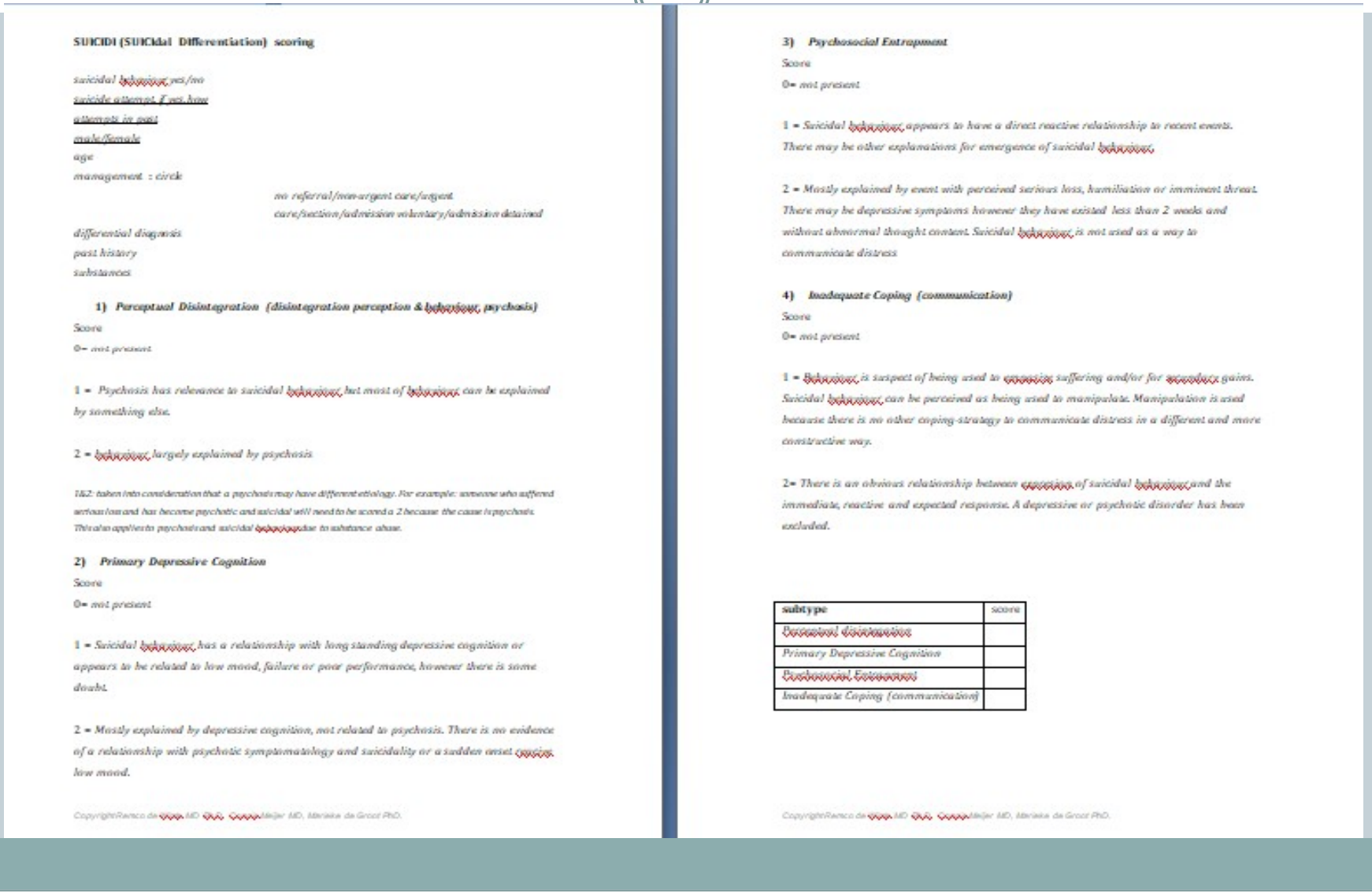
- **Suicidal behavior:**
  - does not arise from a depressive or psychotic disorder
  - arises mainly from another underlying suffering than described in other types
  - Is expressed to emphasize pressure of suffering and/or to get something done from someone else. This coping strategy can be seen as an expression of the inability to communicate needs, wishes and desires in a different, more constructive way.
  - is connected with the expectation that the response to suicidal behavior can offer a direct solution. Avoid the term `manipulation`


Primary Depressive Cognition
- Depression (cognition)
- Stress/vulnerability↑↑
- Long duration?
Perceptual Disintegration
- Psychotic/nihilistic
- Reality testing ↓↓
- Short duration?
MH/society
MH/society
"Rumination"
Psychosocial Entrapment
- Experiencing serious loss
- Reactive depressive thoughts
- Short duration?
MH/society
Inadequate Communication
-Inadequate coping
-Psychological pain
-Entrapment counsellors
- Medium duration on chronic?
MH<>society

Modifiers in model

- Substance abuse modificator for all
- Organic/somatic explanations

Questionnaire



SUICIDI (SUICidal Differentiation) scoring

suicidal behaviour yes/no
suicide attempt, if yes how
attempts in past
male/female
age
management : circle
no referral/non-urgent care/urgent care/section/admission voluntary/admission detained
differential diagnosis
past history
substances

1) *Perceptual Disintegration (disintegration perception & behaviour, psychosis)*

Score

0= *not present*

1 = *Psychosis has relevance to suicidal behaviour, but most of behaviour can be explained by something else.*

2 = *behaviour largely explained by psychosis*

1&2: taken into consideration that a psychosis may have different etiology. For example: someone who suffered serious loss and has become psychotic and suicidal will need to be scored a 2 because the cause is psychosis. This also applies to psychosis and suicidal behaviour due to substance abuse.

2) *Primary Depressive Cognition*

Score

0= *not present*

1 = *Suicidal behaviour has a relationship with long standing depressive cognition or appears to be related to low mood, failure or poor performance, however there is some doubt.*

2 = *Mostly explained by depressive cognition, not related to psychosis. There is no evidence of a relationship with psychotic symptomatology and suicidality or a sudden onset versus low mood.*

3) *Psychosocial Entrapment*

Score

0= *not present*

1 = *Suicidal behaviour appears to have a direct reactive relationship to recent events. There may be other explanations for emergence of suicidal behaviour.*

2 = *Mostly explained by event with perceived serious loss, humiliation or imminent threat. There may be depressive symptoms however they have existed less than 2 weeks and without abnormal thought content. Suicidal behaviour is not used as a way to communicate distress*

4) *Inadequate Coping (communication)*

Score

0= *not present*

1 = *Behaviour is suspect of being used to express suffering and/or for secondary gains. Suicidal behaviour can be perceived as being used to manipulate. Manipulation is used because there is no other coping-strategy to communicate distress in a different and more constructive way.*

2= *There is an obvious relationship between expression of suicidal behaviour and the immediate, reactive and expected response. A depressive or psychotic disorder has been excluded.*

subtype	score
Perceptual disintegration	
Primary Depressive Cognition	
Psychosocial Entrapment	
Inadequate Coping (communication)	

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Validation model

- 100 conclusions outreaching emergency psychiatry
- 4 psychiatrists

- "Preliminary" concordance.....
  - **Perceptual Disintegration (PD),**
  - **Primary Depressive Cognition (PDC**
  - **Psychosocial Entrapment (PE),**
  - **Inadequate Communication & Coping (IC)**

Inventarisation emergency psychiatry MH

- Building database
  - N = 498

differentiatie

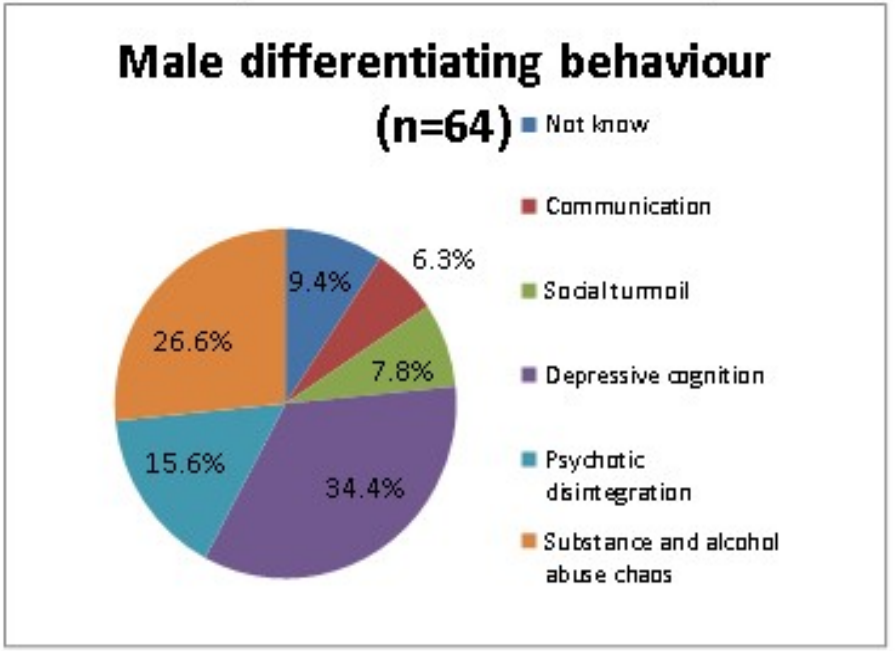
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	perceptueel	66	13,2	13,3	13,3
	depressie	193	38,6	38,8	52,0
	psychosociale turnmoil	91	18,2	18,3	70,3
	communicatie	148	29,6	29,7	100,0
	Total	498	99,6	100,0	
Missing	System	2	,4		
Total		500	100,0		

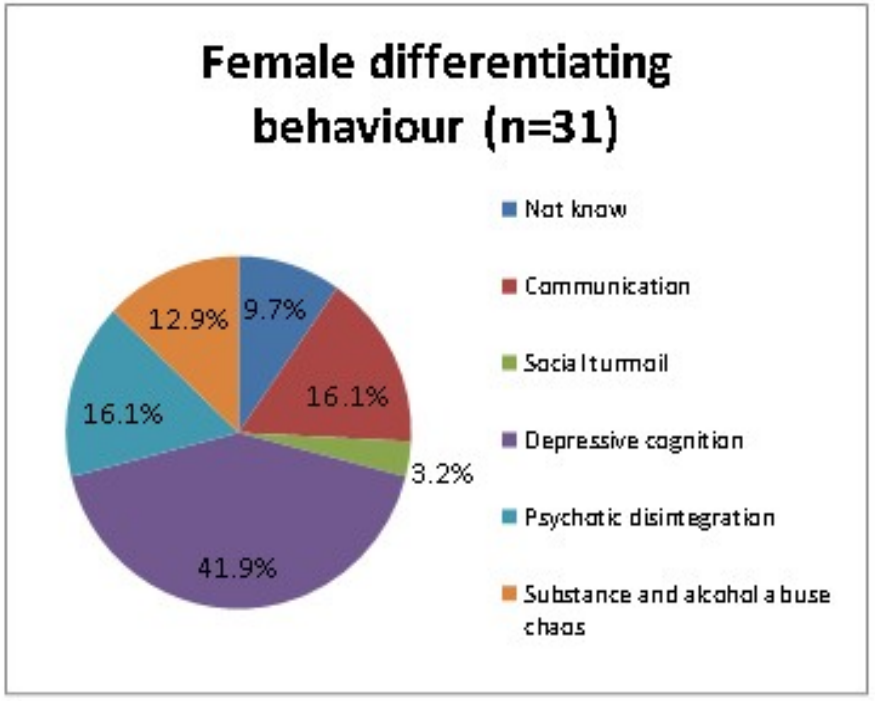
Psycho-social contributing factors and suicidal behaviour of patients who committed suicide between March 2016 and March 2017

Adult mental health services

April 2018

NHS
Sussex Partnership
NHS Foundation Trust





Post its

- Better differentiation better tailormade treatment?
- Better risk taxation?
- Better delineation of responsibilities?
- Borders of treatment of MH
- Responsibility society/community

Questions

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