# “Overlap” tussen subtypen van suïcidaliteit

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www.suicidaliteit.nl

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GGZ Rivierduinen
Het begint bij begrip

# Disclosure

| | |
|---|---|
| (potentiële) belangenverstrengeling | Geen |
| Voor bijeenkomst mogelijk relevante relaties met bedrijven | |
| • Sponsoring of onderzoeksgeld<br>• Honorarium of andere (financiële) vergoeding<br>• Aandeelhouder<br>• Andere relatie, namelijk … | • ZonMw 2 subsidies<br>• Betaalde lecture zonder productbenoeming Janssen-Cilag<br>• Geen<br>• Geen |

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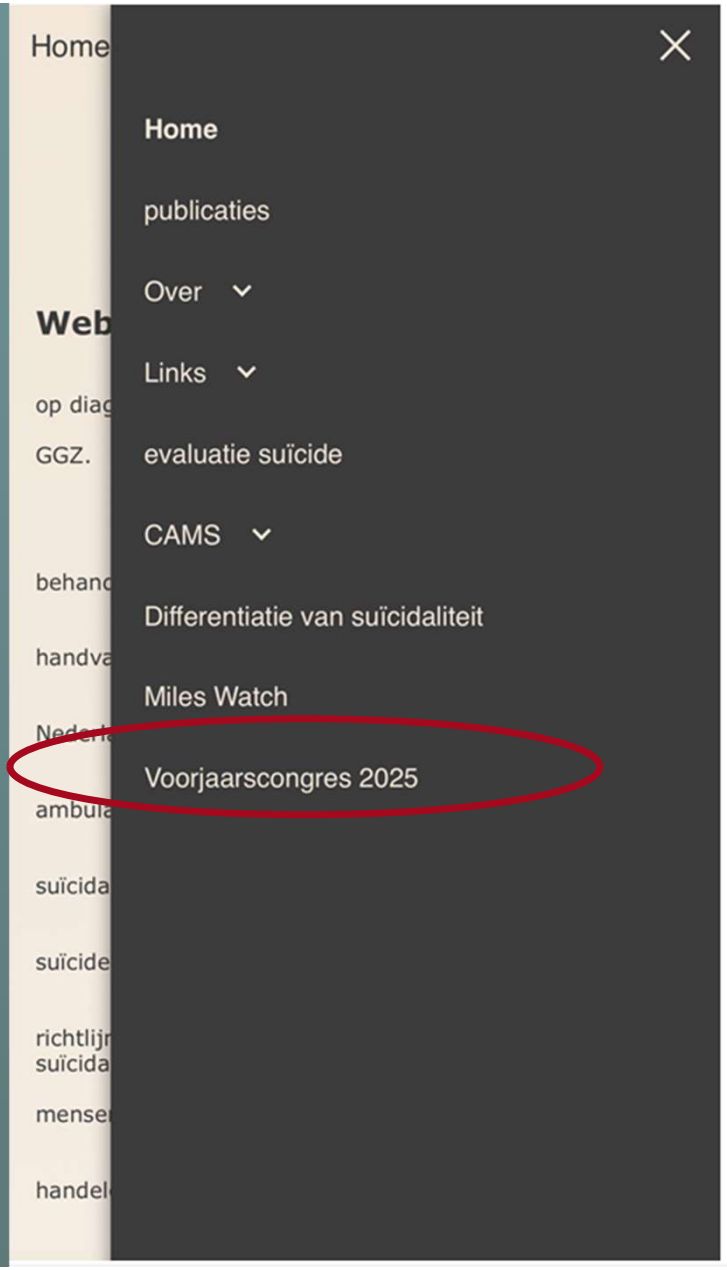


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# Subtyperen van suïcidaliteit?

- Voor het direct handelen
- Behandeling lange termijn
- Setting van behandel locatie
- “Personalized medicine”
- Verantwoordelijkheid en juridische consequenties
- Klinische risicotaxatie
- Wetenschap
  - *Genetica, Biologie, Beeldvormend, Dimensies Psychopahologie/persoonlijkheid, Endofenotypes, etc..*

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# Klinische subtypen

"model van de Winter & de Groot"

- **P**erceptuele **D**esintegratie(PD)(psychose),
- **P**rimaire **D**epressieve **C**ognitie (PDC) (affectief),
- **P**sychosociale" **T**urmoil" (PT) (plotseling) ,
- **I**nadequate **C**oping/communicatie (IC)

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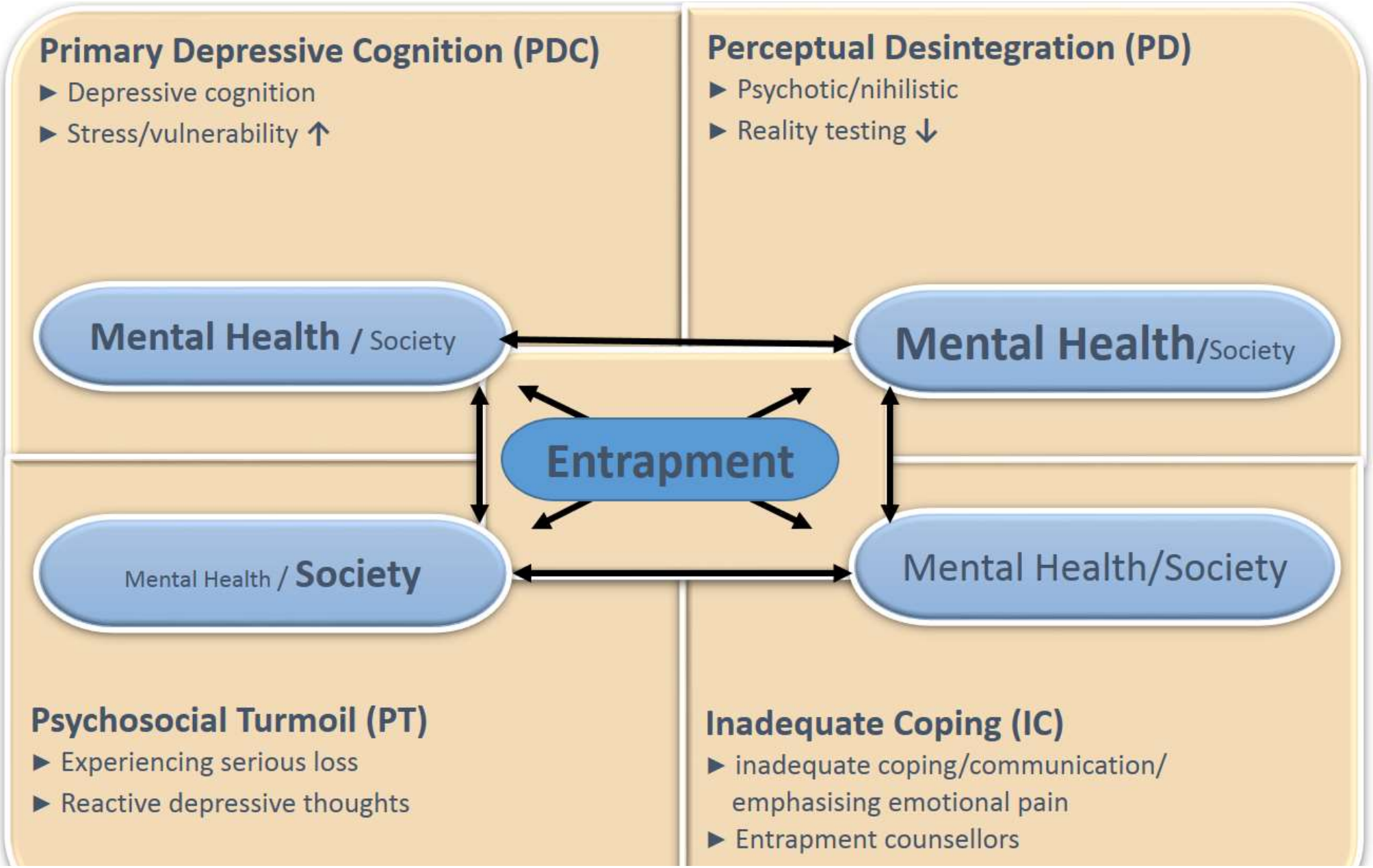
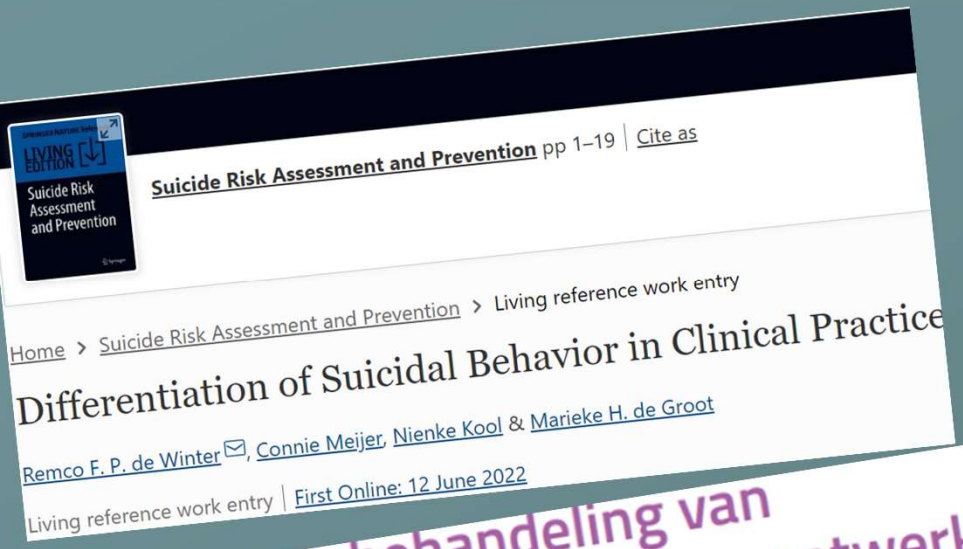

Primary Depressive Cognition (PDC)
► Depressive cognition
► Stress/vulnerability ↑
Perceptual Desintegration (PD)
► Psychotic/nihilistic
► Reality testing ↓
Mental Health / Society
Mental Health/Society
Entrapment
Mental Health / Society
Mental Health/Society
Psychosocial Turmoil (PT)
► Experiencing serious loss
► Reactive depressive thoughts
Inadequate Coping (IC)
► inadequate coping/communication/ emphasising emotional pain
► Entrapment counsellors

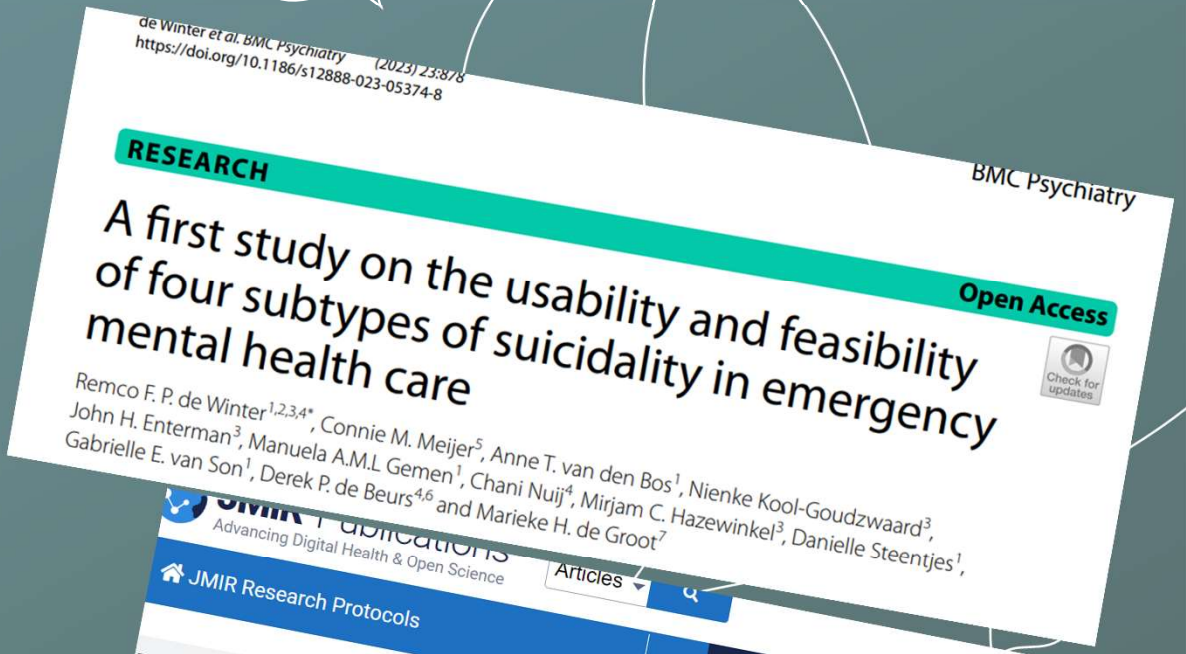
# Literatuur


Suicide Risk Assessment and Prevention pp 1–19 | Cite as
Home > Suicide Risk Assessment and Prevention > Living reference work entry
Differentiation of Suicidal Behavior in Clinical Practice
Remco F. P. de Winter, Connie Meijer, Nienke Kool & Marieke H. de Groot
Living reference work entry | First Online: 12 June 2022


iagnostiek en behandeling van
uïcidaliteit; een kwestie van maatwerk
.H.J.E. Mennen, S.P.A. Rasing, R.F.P. de Winter, M. van den Bogaard, M. van den Berg,
M. van Rossum, D.H.M. Creemers


20 Beoordeling van het suïciderisico
Marieke de Groot en Remco de Winte
1 Meetinstrumenten
1.1 Wat is suïcidaal gedrag?
1.2 Problemen met de validiteit
2 Klinisch onderzoek voor beoordel
2.1 Het belang van werken van


Handboek
Suïcidaal gedrag


de Winter et al. BMC Psychiatry (2023) 23:878
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RESEARCH
BMC Psychiatry
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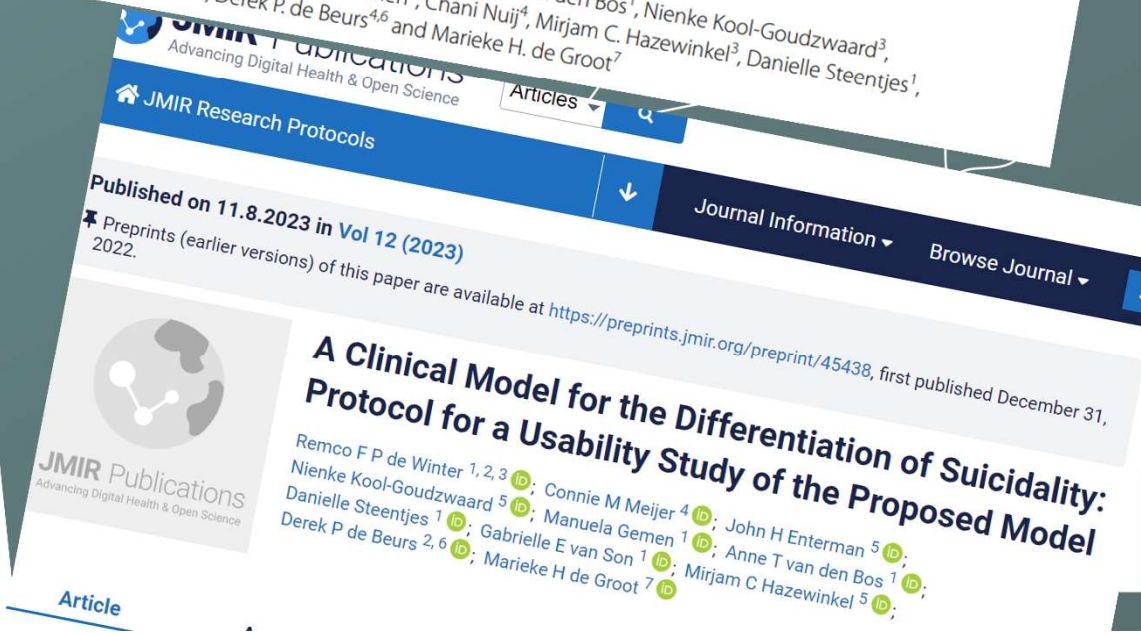
A first study on the usability and feasibility of four subtypes of suicidality in emergency mental health care
Remco F. P. de Winter, Connie M. Meijer, Anne T. van den Bos, Nienke Kool-Goudzwaard, John H. Enterman, Manuela A.M.L Gemen, Chani Nuij, Mirjam C. Hazewinkel, Danielle Steentjes, Gabrielle E. van Son, Derek P. de Beurs and Marieke H. de Groot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Journal Information
Browse Journal
Published on 11.8.2023 in Vol 12 (2023)
Preprints (earlier versions) of this paper are available at https://preprints.jmir.org/preprint/45438, first published December 31, 2022.
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Article
A Clinical Model for the Differentiation of Suicidality: Protocol for a Usability Study of the Proposed Model
Remco F P de Winter, Connie M Meijer, Nienke Kool-Goudzwaard, Manuela Gemen, John H Enterman, Danielle Steentjes, Gabrielle E van Son, Anne T van den Bos, Derek P de Beurs, Marieke H de Groot, Mirjam C Hazewinkel

# Valideringsstudies

Suïcidale patiënten crisisdienst
N = 503

N= 100 voor 2 studies

6 onafhankelijk beoordelaars
- Absolute keuze
- Graduele keuze
  - 4 punten in totaal
  - Verdeeld over subtypen


**Participants and data collection**

Discharge letters to general practitioners of 25 cases of anonymized suicidal patients were independently reviewed by three psychiatrists and three nurses (raters). Using the SUICIDI-2 instrument describing the proposed subtypes, cases were classified by the raters.

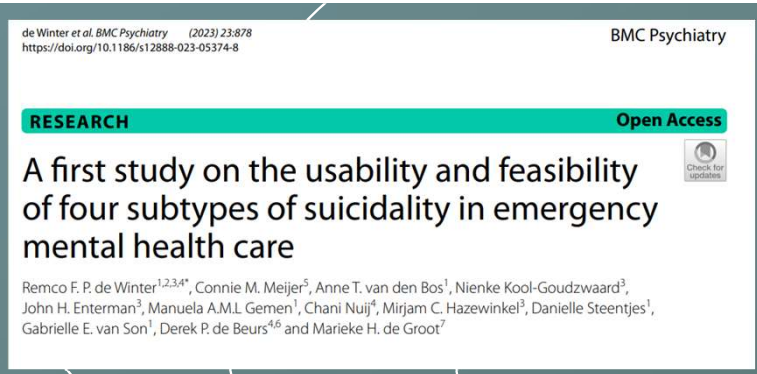
Participants are suicidal patients ($n=25$) assessed by the The Hague outreaching psychiatric emergency service [3]. Under supervision of RdW a detailed report of every assessment was jointly produced by a medical doctor and a mental health nurse, and the reports were supervised and discussed by consultant psychiatrist RdW. All assessments were discussed and evaluated in the morning hand-over by a team of at least five mental health care workers.

Of every case, an anonymized conclusion was prepared for the raters (see also Table 3). A total of 503 cases were included in a database. Only patients who consented to

the discharge letter, signed by RdW, being s
general practitioner and who consented that
for compliant with legal standards of privacy
confidentiality was exchanged, were includ
study, we included the first 25 individual cas
cation due to subsequent assessments of
between January 2018—March 2018. Patien
were safeguarded through case coding, while
as gender, age, marital status and cultural
were documented. The DSM-5 classification
to establish the primary diagnosis and for ev
tional classifications. Cases entered the datab
first assessment.

The following definition of suicidality
"behaviours including suicidal thoughts, su
suicide attempts and completed suicide". Th
used for attempted suicide was: "Any non-f
behaviour, such as intentional self-poisoning

**Table 3** All absolute scores for all 6 raters


de Winter et al. BMC Psychiatry (2023) 23:878
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BMC Psychiatry

RESEARCH Open Access

A first study on the usability and feasibility of four subtypes of suicidality in emergency mental health care

Remco F. P. de Winter[1,2,3,4*], Connie M. Meijer[5], Anne T. van den Bos[1], Nienke Kool-Goudzwaard[3], John H. Enterman[3], Manuela A.M.L Gemen[1], Chani Nuij[4], Mirjam C. Hazewinkel[3], Danielle Steentjes[1], Gabrielle E. van Son[1], Derek P. de Beurs[4,6] and Marieke H. de Groot[7]

| ICC VALUES AND RELIABILITY | |
|---|---|
| < 0.5 | Slecht |
| ≥ 0.5 – 0.75 | Matig |
| ≥ 0.75 – 0.9 | Goed |
| ≥ 0.90 | Excellent |


**Ethical Considerations**

The Medical Research Ethics Committee Leiden the Hague Delft involving the Human Subjects Act (*Wet medisch-wetenschappelijk onderzoek met mensen*) was consulted prior to the start of this study. The committee decided in 2020 that no approval was needed (G21.021/PV/pv). The medical directorates and privacy officers of the Mental Health Institute Rivierduinen and Parnassia Mental Health Institute approved the study, and both institutes financed the study [3].

# Twee studies

## 25 casus gepubliceerd

*Goed tot excellente ICC*
*(95% CI) Onderste grens: moderate t/m voldoende*

| Average measure | ICC | 95% CI lower bound | 95% CI upper bound | Value | Cronbach Alpha |
|---|---|---|---|---|---|
| All types (dichotomous score) | ,854 | ,743 | ,927 | 7,795 | ,872 |
| Absolute Perceptual (PD) | .836 | ..713 | .918 | 6.930 | .844 |
| Absolute Depressive (PDC) | .913 | .848 | .957 | 11.861 | .916 |
| Absolute Turmoil (PT) | .821 | .683 | .911 | 5.436 | .816 |
| Absolute Communication (IC) | .820 | .586 | .910 | 6.000 | .823 |
| Dimensional score (0–4) | | | | | |
| Perceptual (PD) TA | ,834 | ,710 | ,917 | 6,478 | ,846 |
| Depressive (PDC) TA | ,932 | ,880 | ,966 | 14,70 | ,932 |
| Turmoil (PT) TA | ,892 | ,809 | ,946 | 9,992 | ,932 |
| Communication (IC) TA | ,823 | ,690 | ,912 | 6,327 | ,842 |
| Dimensional score SUICIDI questionnaire (0–2) | | | | | |
| Perceptual (PD) SUICIDI | ,802 | ,654 | ,901 | 5,535 | ,819 |
| Depressive (PDC) SUICIDI | ,871 | ,774 | ,936 | 8,447 | ,882 |
| Turmoil (PT) SUICIDI | ,851 | ,740 | ,926 | 7,328 | ,864 |
| Communication (IC) SUICIDI | ,790 | ,634 | ,895 | 5,150 | ,806 |

## 75 cases *manuscript under review*

*Bijna alle subtypen excellente ICC*
*(95% CI) onderste grens goed t/m excellent*

| Average measure | ICC | 95% CI lower boundary | 95% CI upper boundary | Value | Crohnbach Alpha |
|---|---|---|---|---|---|
| Absolute agreement All types | 0·947 | 0·926 | 0·964 | 18·96 | 0·947 |
| Absolute agreement | | | | | |
| Perceptual Disintegration (PD) | 0·959 | 0·942 | 0·972 | 24·85 | 0·960 |
| Primary Depressive Cognition (PDC) | 0·918 | 0·885 | 0·944 | 12·84 | 0·922 |
| Psychosocial Turmoil (PT) | 0·832 | 0·764 | 0·885 | 6·45 | 0·845 |
| Inadequate Coping (IC) | 0·891 | 0·848 | 0·925 | 9.51 | 0·895 |
| Dimensional agreement | | | | | |
| Perceptual Disintegration (PDI | 0·972 | 0·960 | 0·981 | 36·70 | 0·973 |
| Primary Depressive Cognition (PDC) | 0·952 | 0·932 | 0·968 | 23·30 | 0·957 |
| Psychosocial Turmoil (PT | 0·883 | 0·830 | 0·922 | 10·11 | 0·901 |
| adequate Coping (IC) SUICIDI | 0·924 | 0·893 | 0·948 | 13·68 | 0·927 |

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| | | | | | |
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| Communication (IC) TA | 0·924 | 0·893 | 0·948 | 13·68 | 0·927 |

# Hoe zit het met overlap?

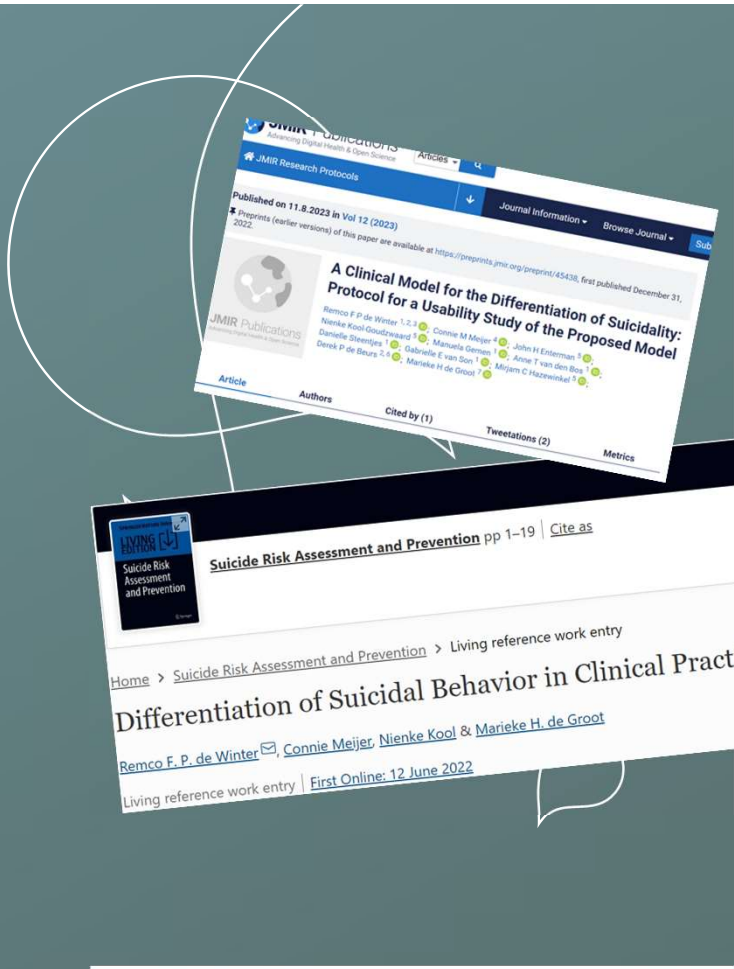
Suptypen zijn gradueel valide afgrensbaar

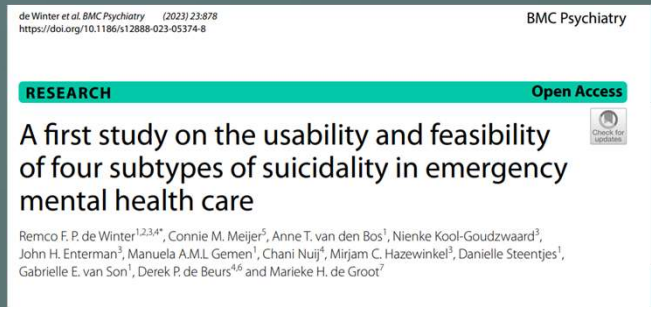
-Maar hoe is co-occurrence verdeeld?

-Welke subtypen zijn het beste afgrensbaar

Bij n = 98 (6 beoordelaar dominant subtype)
Bij n = 2 geen dominantie (bv 3 PT en 3 IC)

Verschillend wijzen co-occurrence onderzocht
-Correlatie,
-Binaire logistische regressie,
-Bivariate multinomiale regressie



# Demografie

| | PD | PDC | PT | IC | Overall |
|---|---|---|---|---|---|
| **Frequency** | 10 | 39 | 21 | 28 | 98* |
| n (%) | (10.0%) | (39.0%) | (21.0%) | (28.0%) | (100.0%) |
| **Age** | 45.2 | 40.6 | 39.0 | 40.8 | 41.3 |
| Mean (SD) | (21.5) | (15.5) | (17.1) | (17.5) | (17.2) |
| **Gender** | | | | | |
| Female | 60.0% | 61.5% | 61.9% | 46.4% | 56.0% |
| Male | 40.0% | 38.5% | 38.1% | 53.6% | 44.0% |
| **Prior suicide attempt** | 2 | 12 | 6 | 17 | 37* |
| n (%) | (20.0%) | (30.8%) | (28.6%) | (63.0%) | (39.0%) |

# Correlatie

1. PT & IC relatief vaak in combinatie

2. PT, PD, & PDC als PDC & IC geen combinatie

| | PD | PDC | PT | IC |
|---|---|---|---|---|
| **PD** | - | - | - | - |
| **PDC** | -0.153 | - | - | - |
| **PT** | -0.449*** | -0.436*** | - | - |
| **IC** | -0.184 | -0.541*** | 0.249* | - |

# Binaire logistische regressie

1. PT meest vaak in combinatie
2. IC soms in combinatie
3. PD en PDC meest onafhankelijk

| | Co-Occurence |
|---|---|
| **H4ME subtype** | |
| (ref: PT) | |
| **PD** | -3.199** |
| | (1.012) |
| **PDC** | -1.658* |
| | (0.814) |
| **IC** | -1.253 |
| | (0.859) |
| **Pseudo $R^2$** | 0.180 |
| **N** | 100 |

# Bivariate multinomiale regressie

1. PT vooral in combinatie met IC en lichte mate PDC

2. Geen duidelijke patronen in co-occurrence

| Overlap with | PD | PDC | PT | IC |
|---|---|---|---|---|
| **H4ME subtype** | | | | |
| **PDC** | 1.124 | - | -0.034 | -0.129 |
| | (0.916) | | (0.549) | (0.558) |
| **PT** | - | 1.910* | - | 3.114*** |
| | | (0.915) | | (0.845) |
| **IC** | 0.229 | 1.012 | 1.065 | - |
| | (0.943) | (0.675) | (0.590) | |
| **Pseudo $R^2$** | 0.173-0.346 | | | |
| **N** | 100 | | | |

# Conclusie

- Subtypen zijn onafhankelijk maar er is co-occurrence
- Vooral PT (meest generiek)
- In mindere mate IC
- PD en PDC meest onafhankelijk

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# Discussie

1. Bij overlap dat “gebruiken” wat onderliggend is
2. PD en PDC onafhankelijk
    - onduidelijk of er geen tijdrelatie is
    - Verder onderzoek met ESM & dynamic timewarping
3. PT meeste co-occurrence, verdeeld over IC en PDC
4. Alleen onderzocht in klinische populatie bij crisisdienst
5. Onderzoek bij andere populaties (IHT, HIC en MBT)
6. Onderzoek bij suïcides binnen GGZ en daarbuiten

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# KINDLY THANK YOU FOR YOUR INTEREST
# ARE THERE ANY QUESTIONS?

REVIEWING PRESENTATION?

MORE INFORMATION?

**Remco de Winter, Connie Meijer, Anne van den Bos,**
**Nienke Kool, John Enterman, Manuela Gemen, Mirjam Hazewinkel,**
**Danielle Steentjes, Chani Nuij, Derek de Beurs,**
**Damien Broekharst, Marieke de Groot &**
***Riet Lochy,, Roland van der Sande, Melissa Hoek-Hus, Wilma Neumann, Arjan van den Berg, Mieke Hartgers, Aram van Reijsen, Hazewinkel, Ad Kerkhof***

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