Recognizing Suicidal Subtypes in Clinical Practice

www.suicidaliteit.nl

Workshop: Remco de Winter

ESSSB21 augusth 26th Vilnius



SuPreMH

SUICIDE PREVENTION IN MENTAL HEALTH

GGZ Rivierduinen

Het begint bij begrip

Parnassia Groep

VU UNIVERSITY AMSTERDAM

Maastricht University

Contents

• **Explanation of the basics of the model**	9:00–9:30
• **Theory and examples (videos)**	9:30–10:00
• **Research**	10:00–10:30
• **Coffee break**	10:30-10:45
• **Practice (reading / evaluating / voting on case studies)**	10:45–11:50
• **Discussion**	11:50–12:00

TAKE HOME MESSAGES

Suicidality is a heterogeneous phenomenon.

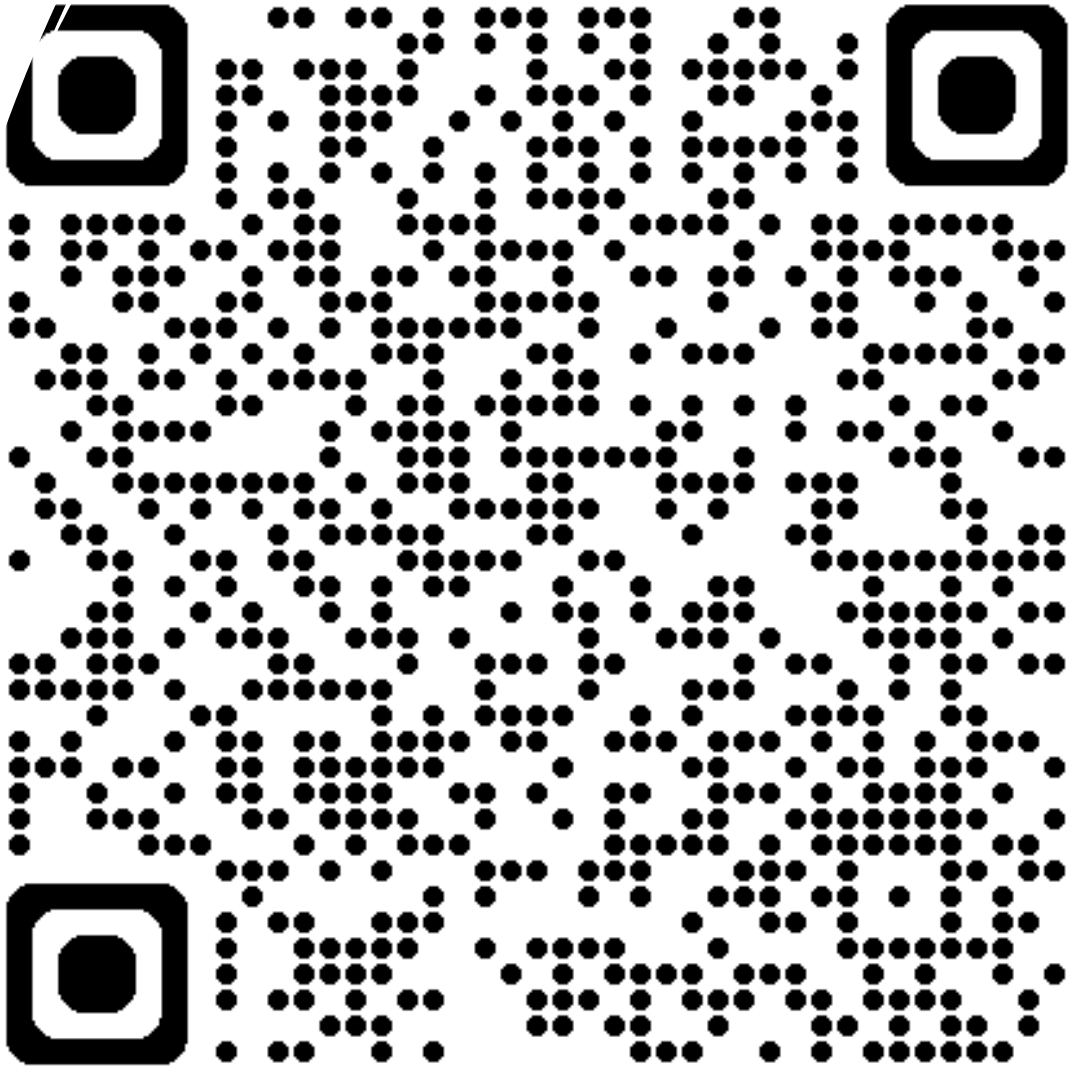
Distinct, clinically suicidal subtypes can be identified.

subtypes have been examined in pilot and follow-up studies assessing consensus and usability as initial steps toward validation

Differentiating of suicidality enables more precise and individualized clinical assessment & treatment!

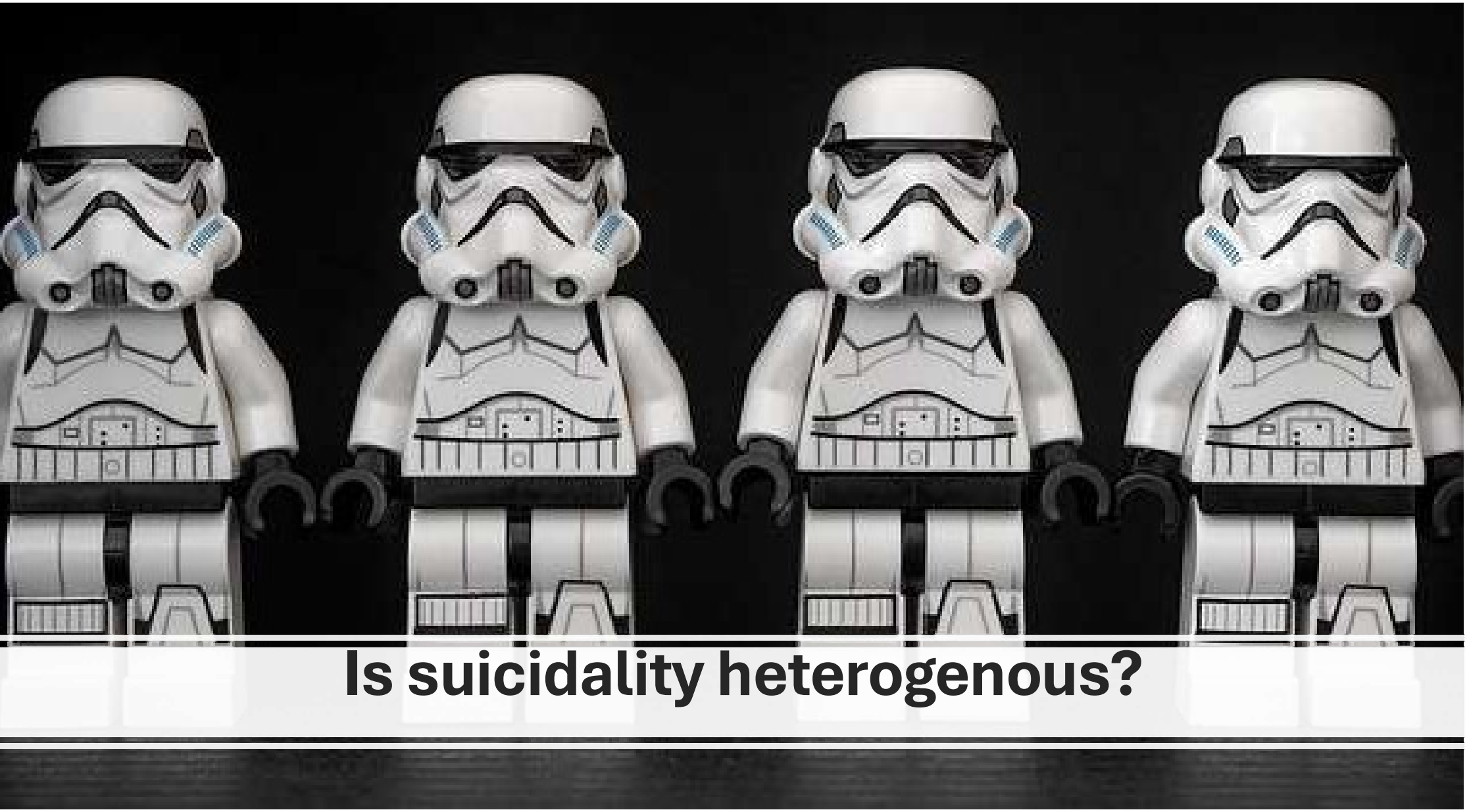
Suicidaliteit.nl

- **Background and Theoretical Framework**
- **Practical Training Materials**
- **SUICIDI Questionnaire**
- **Peer-reviewed Publications**



Suicidality and impact

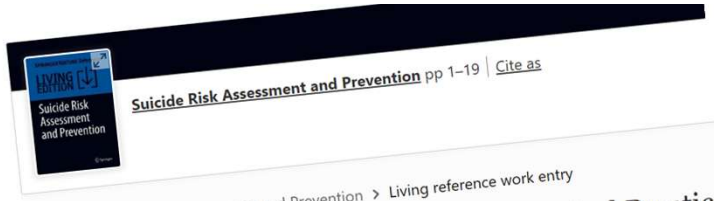
- Suicide most worse outcome in mental health
- Suicidality often emotionally intense and highly activating.
- May trigger panic in family members, bystanders, and even healthcare professionals. Creating pressure to act quickly.
- Strong sense of urgency: *"Something has to be done now."*
- Professionals may experience freezing/paralysis in policy.
- Differences in policy?
- It can also evoke agitation and countertransference



Is suicidality heterogenous?

Need for clinically useful subtypes of suicidality?

- No clear distinction in literature, research, or clinical guidelines
- A need for a common clinical language
- Better identification for the most appropriate treatment setting
- Different treatment options – personalized medicine
- Different levels of clinical responsibility and legal implications
- Improved clinical risk assessment
- Advancing scientific research



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

de Winter et al. BMC Psychiatry (2023) 23:878
https://doi.org/10.1186/s12888-023-05374-8

RESEARCH

BMC Psychiatry

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]

frontiers in Psychiatry

TYPE Original Research
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Check for updates

OPEN ACCESS

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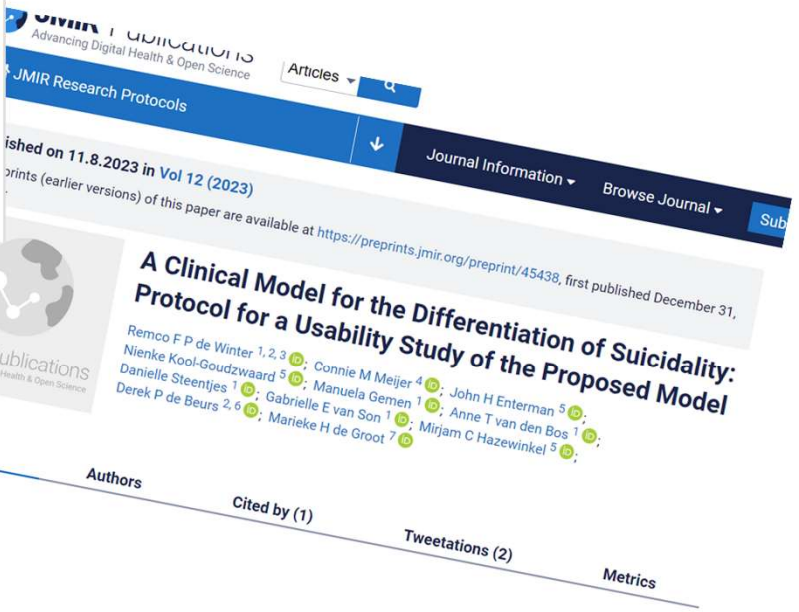
Identifying subtypes of suicidality: a second larger consensus study in emergency clinical psychiatric practice

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



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ished on 11.8.2023 in Vol 12 (2023)

prints (earlier versions) of this paper are available at https://preprints.jmir.org/preprint/45438, first published December 31,

A Clinical Model for the Differentiation of Suicidality: Protocol for a Usability Study of the Proposed Model

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

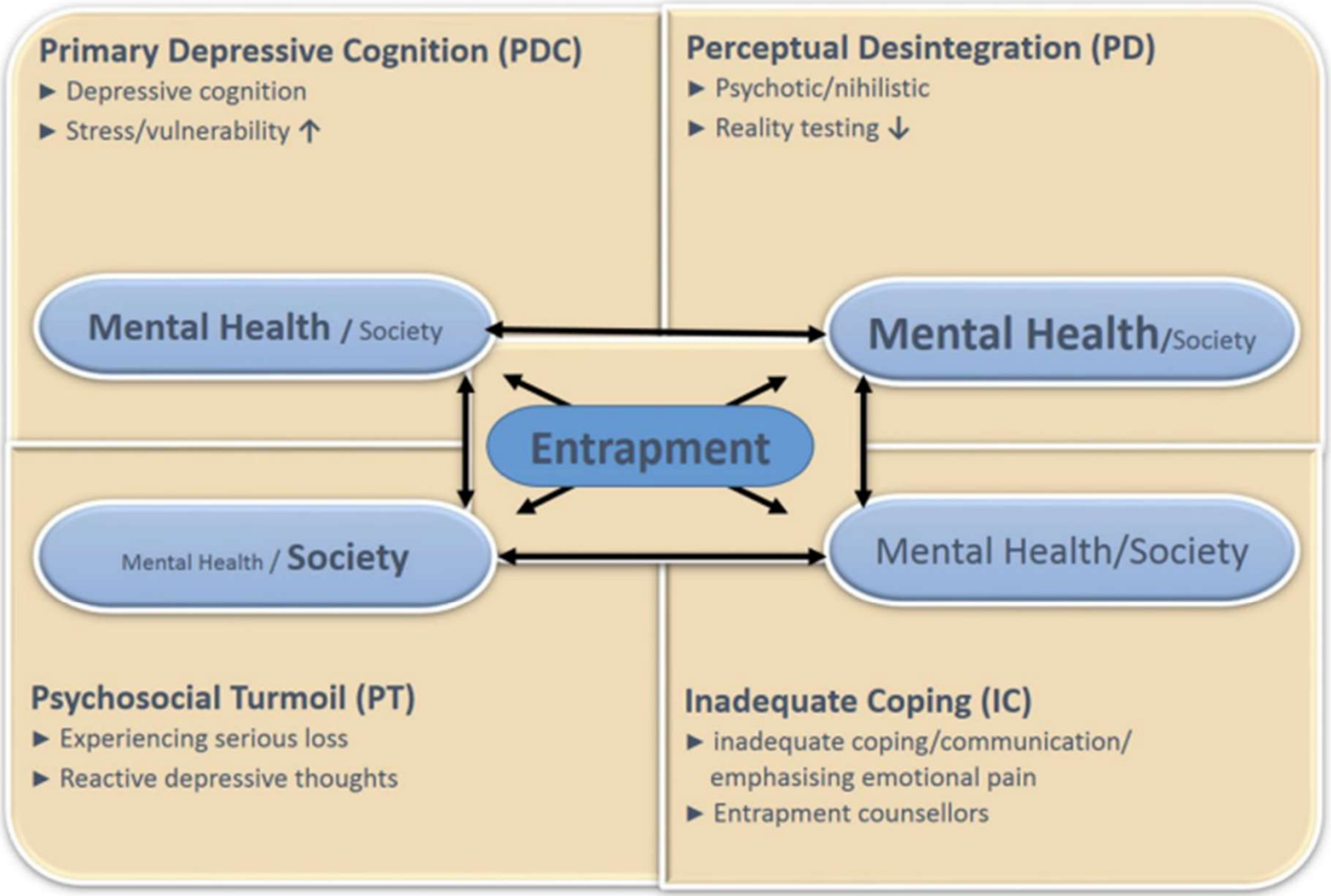
Article | Authors | Cited by (1) | Tweetations (2) | Metrics

20 Beoordeling van het suïciderisico

Marieke de Groot en Remco de Winter

1 Meetinstrumenten
1.1 Wat is suïcidaal gedrag?
1.2 Problemen met de validiteit
2 Klinisch onderzoek voor beoordeling suïciderisico
2.1 Het belang van werken vanuit een theoretisch kader
2.2 Stress-kwetsbaarheid en entrapment als denkraam voor klinisch onderzoek
2.3 Systematisch onderzoek aan de hand van het CASE-interview
2.4 Samenwerken met naasten bij beoordeling suïciderisico
3 Perspectief op verbetering van beoordeling suïciderisico
3.1 Effectiviteit van beoordeling suïciderisico
3.2 Differentiatie van suïcidaal gedrag
3.3 Differentiatie van suïcidale toestanden als strategie voor effectievere diagnostiek

Theory 4 clinical suicidal subtypes



Clinical description suicidal subtypes

- Perceptual desintegration (PD),
- Primary depressive cognition (PDC),
- Psychosocial “Turmoil” (PT),
- Inadequate coping/communication (IC)

PERCEPTUAL DESINTEGRATION

- Psychotic features
- Nihilism

- Also: psychotic fear, serious derealisation, Mood(in)congruent, etc.

- Possible substance-related aetiology



Perceptual desintegration?

https://youtu.be/qD3z9giBC6o

PRIMARY DESPRESSIVE COGNITION

- Suicidality arises from persistent depressive cognition
- Remains understandable in the context of a non-psychotic depression
- Characterized by daily suicidal thoughts and marked psychological distress
- Occurs in depressive disorders, but also in anxiety disorders or autism
- May be intertwined with or also caused by personality disorders.



Primary depressive cognition?

https://youtu.be/0pwjnLMpE28

PSYCHOSOCIAL TURMOIL

- Ego-related suicidality following severe loss or adversity (internalizing/externalizing)
- Characterized by unbearable anxiety, guilt, and shame accompanied by a need for relief
- Usually short-lived (hours/days) (substance use could be provoking)
- Primarily explained by acute stress.
- Underlying deficits in impulse regulation increase risk of a fatal outcome.



Psychosocial Turmoil?

https://youtu.be/p5-JOmrWX2Q?si=YGOdC8pE2e1Vm402

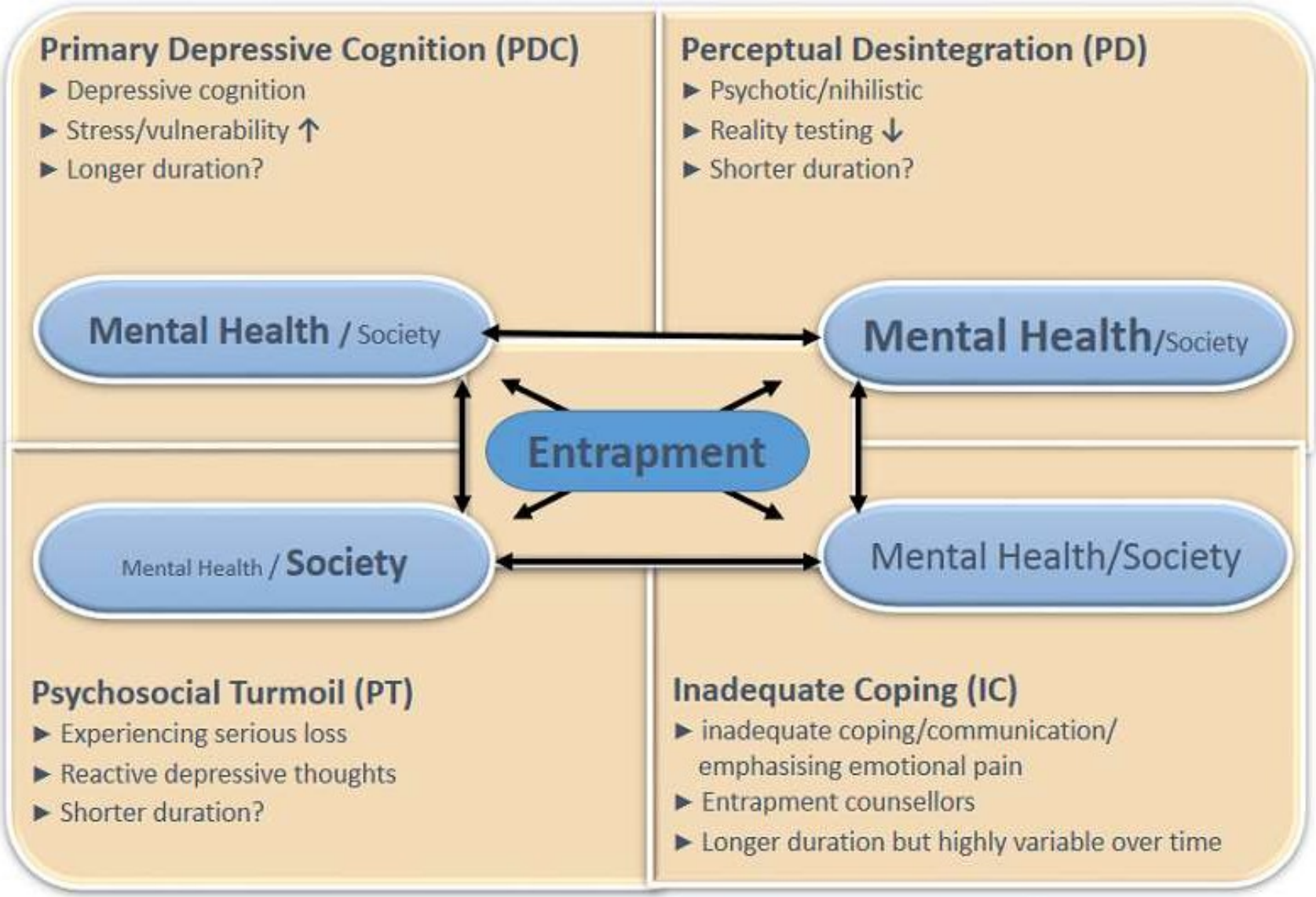
INADEQUATE COPING

- Persistent suicidality due to an inability to communicate psychological distress
- Expression of underlying psychological suffering
- Often related to personality disorders and may be triggered by substances
- Often perceived by professionals as externalizing and manipulative, leading to an exhausted support system.



Inadequate Coping?

https://youtu.be/lURSK3XZ5MA?si=IRToIXM-MrKNjpYE


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

Research findings

Research

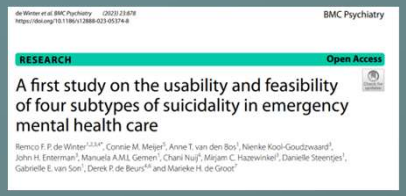
- Database n = 503, emergency psychiatry, The Hague
- • Conclusion letters from The Hague Crisis Service
- • Intraclass correlation coefficient
- 6 raters (3 psychiatrists, 3 nurses)

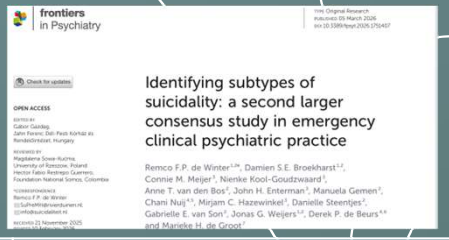
- First step validation
- At least 2 scoring methods:
  - Absolute classification, dimensional scoring

- Feedback based on experience and subsequent revision of the questionnaire (SUICIDI) 3.3

- Extended step for validation nr. 26 - 100
- Questionnaire (SUICIDI) revised to a 0–4 scale
  - Absolute classification, dimensional scoring

Two studies absolute/dimensional





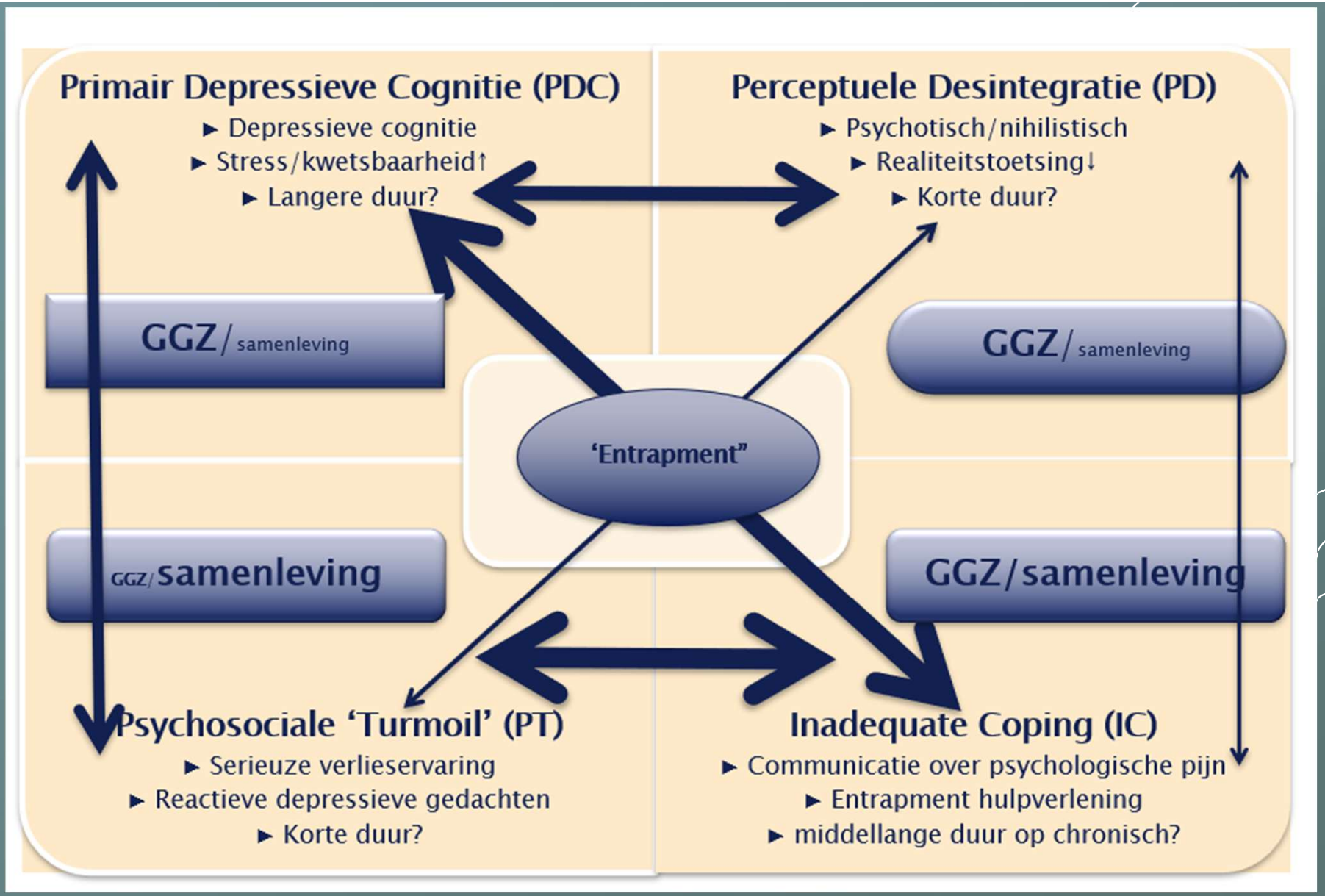
Type	ICC Study 1 *(n 25)* absolute/dimensional	ICC Study 2 *(n =75)* absoluut/dimensioneel
Perceptual desintegration	Good/good	Excellent/excellent
Primary depressive cognition	Excellent/excellent	Excellent/excellent
Psychosocial Turmoil	Good/good	Good/excellent
Inadequate coping	Good/good	Good/excellent

Subtypes (combined emergency psychiatry) 6 raters

- **Primary Depressive Cognition (PDC):** **34,7%**
- **Inadequate Coping/Communicatie (IC):** **32,8%**
- **Psychosocial Turmoil (PT):** **19,9%**
- **Perceptual Disintegration (PD):** **12,6%**

Other studies submitted/in preparation

- **A clinically validated model for differentiating suicidality: a historical comparison**
- **Towards a clinical model to differentiate suicidality: a third validation study'**
- **The co-occurrence of different types of suicidality: a retrospective cross-sectional study**
- **Predicting different subtypes of suicidality: a quantitative study**
- **The predictive value of recent, prior and lifetime suicide attempts across distinct subtypes of suicidality: a quantitative analysis**
- **Psychological Autopsy Study: Identification of Distinct Subtypes of Suicidality in a Post-Mortem Population of Mental Health Care Patients**


Primair Depressieve Cognitie (PDC)
► Depressieve cognitie
► Stress/kwetsbaarheid↑
► Langere duur?
Perceptuele Desintegratie (PD)
► Psychotisch/nihilistisch
► Realiteitstoetsing↓
► Korte duur?
GGZ/ samenleving
GGZ/ samenleving
'Entrapment"
GGZ/samenleving
GGZ/samenleving
Psychosociale 'Turmoil' (PT)
► Serieuze verlieservaring
► Reactieve depressieve gedachten
► Korte duur?
Inadequate Coping (IC)
► Communicatie over psychologische pijn
► Entrapment hulpverlening
► middellange duur op chronisch?

Discussion

- Absolute and dimensional types show initial valid discrimination
- Modification of the SUICIDI scoring system improved performance
- Is further subdivision possible?
- More replication is needed?
- More results are coming

Coffee break
10.30-10.45



Becoming active

practise


13:10
Home
Suïcide preventie in Nederland
Website suïcidaliteit.nl:
-Aandacht voor wetenschappelijk onderzoek gericht op diagnostiek, behandeling en preventie van suïcidaliteit in de GGZ.
-Praktijk verbeteren door introductie EBM handvatten
-Onderzoek naar suïcidaal gedrag en suïcides in Nederland.
- Onderzoek naar verbetering van klinische en ambulante zorg
-Onderzoek naar subtypen en differentiatie van suïcidaliteit.
-Verbeteren van nazorg bij suïcide en leren van suïcides.
- Gebruik van de multidisciplinaire richtlijn/generieke module van diagnostiek en behandeling van suïcidaal gedrag.
-Bevordering van het professioneel praktisch handelen bij suïcidaliteit.
-Introduceren van behandelwijzen voor suïcidaal gedrag.
Deze site is uiteindelijk bedoeld om bij te dragen aan een verbeterde zorg rondom suïcidaal gedrag en dus ook om.... suïcides te kunnen verminderen en/of te voorkomen. Helaas circuleren er op internet ook verschillende websites die hulp bieden bij het uitvoeren van zelfdoding, zelfdoding romantiseren en dit soms zelfs
AA
suicidaliteit.nl



(Conclusion) Casus 1

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assessed as not being elevated. Following consultation with the supervising psychiatrist, she was referred back to her general practitioner for further follow-up. She was provided with two 10 mg tablets of oxazepam to assist with sleep.



TA score

0 Not at all
1 A very small part
2 Partially
3 A great part
4 Entirely (a little doubt is always allowed)

Also cross one subtype which has your main preference. Give your score per item.

	Subtype	**TA score**	***V* absolute choice (1 possibility!)**
1	Perceptual Disintegration		
2	Primary depressive cognition		
3	Psychosocial Turmoil		
4	Inadequate Coping/communication		
	Total always	4	

(Conclusion) Casus 2

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Current help requests: Initiation of antidepressant medication through his regular treating clinician. Consideration of a future detoxification admission. Contact with a new general practitioner (GP). The patient would like to rest for a while longer in the Psychiatric Emergency Service (OVP) and plans to return home in the morning with follow-up care from his regular treatment team.

TA score

0 Not at all
1 A very small part
2 Partially
3 A great part
4 Entirely (a little doubt is always allowed)

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3	Psychosocial Turmoil		
4	Inadequate Coping/communication		
	Total always	4	



(Conclusion) Casus 3





lorazepam. The patient was referred urgently to XXXXX.

TA score

0 Not at all
1 A very small part
2 Partially
3 A great part
4 Entirely (a little doubt is always allowed)

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	Total always	4	

Casus 4



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Het begint bij begrip

psychotic state. There was no apparent insight into her condition or awareness of the need for treatment. Throughout the interview, the patient was dismissive and minimally cooperative. According to police reports, the patient had made suicidal statements and had asked police officers to shoot her. During the psychiatric assessment itself, the patient did not make clear suicidal statements or engage in observable suicidal behaviour. However, she declined to engage in assessment regarding suicidality and did not adequately respond to questions on this topic. Given the overall clinical picture, the suicide risk was assessed as increased.

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https://youtu.be/HtvxH3NH_T8?si=OfrSbEd2mzsV07tr

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More



assessment, the risk of suicide was considered to be very high. It was also considered that feelings of shame related to his contact with psychiatric services might further increase this risk.
Given the severity of the situation and the acute danger of suicide, an involuntary admission order (IBS; emergency compulsory psychiatric admission) was requested and subsequently granted.

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More?



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episode with catatonic features, Intensive Home Treatment (IHT/IBT) was initiated as an interim measure pending psychiatric admission

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More???


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Feedback
&
Discussion

Concluding remarks and questions

- Clinical practice is complex & challenging, is it important to differentiate?
- Applicable to clinical practice?
- Absolute/dimensional types seems to show initial valid discrimination
- Modification of the SUICIDI scoring system improved performance
- Further subdivision possible? But starting simple…
- More replication is needed?
- Further research? But More results are coming….
- Potential pitfalls?

Thanks:

Marieke de Groot, Connie Meyer, Nienke Kool, Riet Lochy, Manuela Gemen, John Enterman, Danielle Steentjes, Anne van den Bos, Roland van der Sande, Melissa Hoek-Hus, Wilma Neumann, Chani Nuij, Arjan van den Berg, Mieke Hartgers, Aram van Reijsen, Gabrielle van Son, Mirjam Hazewinkel, Ad Kerkhof, Derek de Beurs, Damien Broekharst, Rosanne Kop, Fleur van Kaam, Jonas Weijers.

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