SUICIDI Questionnaire

SUICIdality DIfferentiation · Version 3.3

Instrument for differentiating between the entrapment of suicidality types

ASSESSMENT GUIDE & SCORING FORM

Instructions

The purpose of this instrument is to help the user assign suicidality to one of the designated entrapment of suicidality types.

The four types of suicidal entrapment are, respectively:

1) perceptual (behavioral) disintegration (psychosis), (PD)

2) primary depressive cognition (PDC)

3) psychosocial turmoil (PT)

4) inadequate communication and/or coping (IC)

The questionnaires and scoring procedure were evaluated in a pilot study. The results of this study led to some modifications to these instruments, as well as to some adjustments of the instruction manual.

The scores across all entrapment types must total exactly 4 points. For example, if you score 3 points for an entrapment type, you'll have 1 point left to score on one of the other three entrapment types. Theoretically, all four of the entrapment types can be given one point. However, we do want to encourage you to make a choice and consider the exclusion of other types.

When assigning suicidality to an entrapment type, you should primarily judge what best explains the behavior, rather than additional factors that may themselves be reactive. For example, because of a depressive state, someone might have developed more problems, like not being able to check their mail and consequently experiences even more stress. So, it is a good idea to look for the underlying cause of the stress and in this example the reason lies primarily with the depressive cognition. However, it is also possible that someone is in a depressive state, and therefore cannot open their mail, which leads to not paying their rent and ultimately risks losing their home. If this person was not suicidal to begin with, then the consequence of depression can be the cause. In day-to-day life there can naturally be overlap in the causality of the behavior and there can be a dimensional shift. Also, the intention of this model is to explore the etiology of the process of suicidality and to be able to treat it. Furthermore, there is of course the realization that the behavior could be temporary and that it can change over time.

Drug use can increase impulsivity and in turn further activate suicidality. Additionally, certain thoughts can gain more ground. It is therefore important to differentiate between what causes the suicidality and not by what it is evoked. For example, somebody experiences a lot of psychosocial difficulties which originate mainly from a depressive state due to an underlying personality disorder. After using alcohol in combination with cocaine, this person becomes dysphoric and threatens to harm themself, because everything is so horrible and everyone leaves them in the lurch. It seems therefore that particularly a combination of entrapment types best describes this case, but that communication probably will be the main descriptor. When someone has taken hallucinogenic mushrooms and then experiences hallucinations in which this person must die to be able to enter the realm of

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shadows, then perceptual disintegration will be the main entrapment type assigned to this case. Naturally, this person might already be experiencing long-term underlying stress, but the suicidality is primarily evoked by drug use and not really amplified.

Please specify if the suicidality stems primarily from drug use (or possibly a somatic cause) or if it clearly relates to the lowering of the threshold for suicidality.

Description of the entrapment types

(PD) Perceptual disintegration (psychotically disturbed perception and/or behavior)

The suicidality originates from psychosis, which can often be accompanied by affective (depressive) dysregulation or can be largely affected by it. Usually the psychotic state has only been present for a short time (days or weeks rather than months) and it is notable, because of its severity. It may originate from depressogenic cognition, but in that case the severity has developed to such a level that it can be seen as a mood-congruent or mood-incongruent psychotic state. The suffering can be understood, but the severity cannot be perceived by the examiner. A classic state is a depression with mood-congruent psychotic features. However, it can also appear among people who, while in a psychotic state, receive instructions to hurt or kill themselves.

Examples of perceptual disintegration

Case 1a

A man of 25-29 years of age, who is known to be suffering from Schizophrenia for the past five years, is assessed. He has been smoking a lot of Cannabis recently and during the last couple of weeks he has been hearing the voice of ‘ Lucifer’. Additionally, his treatment team is not sure whether he has been taking his medication regularly. Around five times a day the voice says to him that he smells and that there will be a great solution for the world order if he dies by jumping from the 3rd floor.

Case 1 b

A woman of 50-54 years of age is seen in the ER, because she cut herself in her stomach with a box cutter. She is treated with a couple of stitches. She says that she is actually dead and that her intestines are contaminating her children from the blackness of her soul. Her mother, who suffered from dementia and whom she cared for, died 9 months earlier. Also, one of her sons, who has a child whom she cares for twice a week, is filing for divorce. During the past three weeks, her mood is getting worse, she hardly eats and sleeps three hours during the night.

(PDC) Primary depressive cognition

The suicidality stems primarily from a depressive thought process and there are no psychotic features (yet). The depressive state can be present for a while (for example weeks or months). Characteristic is that the thoughts about suicide are part of the cognition and are present every day. There is a very clear suffering, which can be perceived by the examiner through the depressive thought process. A classic state is a depressive disorder, but this may also be part of an anxiety disorder. There can be a feature of a personality disorder mixed in the depressive state, or the depressive state is caused due to a personality disorder and becomes part of a recurring thought pattern in which negative cognitions and/or ‘Beck’s cognitive triad’ can be present (negative views about oneself, negative views about the world and negative views about the future).

Invented examples of primary depressive cognition

Case 2 a

A 45-49 year old man, who is known to suffer from manic-depressive symptoms with psychotic features and traumatic experiences, for which there has been insufficient care and no medication, is seen by the emergency

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clinic for assessment of the mental state and suicidality. The past months there has been an increasing depression, there are no manic episodes anymore, but there are thoughts of suicide and plans, but not yet specific. Therefore, there is more of a long-term heightened suicide risk, but no acute increased danger. Seeing as the patient finds the treatment plan at 'Parnassia' hopeful, he is registered for treatment at 'PsyQ Depression ambulatory care' and in the meantime will receive emergency care, also he was given the phone number of the 'HAP' in case of emergency/panic/crisis/danger to himself.

Case 2 b

A woman of 25-29 years of age has struggled for years and is treated for personality disorder. For months her boyfriend is saying that he can't keep on going on like this and has doubts about their relationship. She doesn't feel like doing anything and has not been to work for four weeks. She has been eating more and gained a lot of weight. She can hardly do anything other than watch Netflix all day, which she finds awful. She feels worthless and a burden for her environment and a big parasite. One night she took ten tablets of Paracetamol and ended up in the ER.

(PT) Psychosocial turmoil (entrapment)

The suicidality stems primarily from a severe loss and/or blow to the ego that leads to a complete upheaval of someone's life. The person experiences enormous guilt, severe shame and/or doesn't dare to look another in the eye anymore or experiences a downfall without being in a psychotic state. There is an unbearable anguish, which leads to a need for release from that pain or the need to not exist anymore, to not be able to feel, or escape, the awful misery or pending dread. Usually, someone has been in this state for a short time (hours/days/weeks). Drug use can be extra provoking. The stress is perceivable for the examiner from the perspective of loss and/or a blow to the ego and there may be slight psychotic features, but one can follow the narrative. Underlying dysregulation of the impulsivity can worsen the state and increase the risk of lethality.

Invented examples primary psychosocial turmoil

Case 3 a

A woman has lent a car and normally she doesn't drive an automatic. She is going to bring her 2 young children to daycare. She parks the car, gets out and has a quick look at her phone. At that moment her car rolls backwards into a canal. Despite her attempts to open the car, after jumping into the water, her children drown. Afterwards she has turned into a woman who does not want to live in any way anymore. Her grief and guilt is unbearable and she wants to stop, because the pain is too great.

Case 3 b

A man of 65-69 years of age celebrates his farewell as financial director of a car company. According to him, he has always given 100% for the company and has let the company grow. He sees this as a great personal accomplishment. He is convinced that the employees will miss him very much and he also hopes that there would be an application for a decoration in the 'Order of Oranje-Nassau', which, he found out during the farewell party, did not happen. On the way home he drove, with a blood alcohol level of 0,5, against a tree. During assessment he said that it has all been for nothing and that all that is left for him to do is sit and wait in old age behind the windowsill.

(IC) Inadequate communication and/or coping

The suicidality stems from a severe feeling of suffering and not being able to communicate this properly. There is difficulty with formulating an adequate request for help and one seems to be hoping for a solution by demonstrating suicidality. This behavior usually exists for a longer period (months) and fluctuates severely. This type of a more chronic suicidality is often seen as part of a personality disorder, such as a borderline personality disorder. Also, drug use can be an important provoking factor. The suicidality is perceived as externalizing and

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fake and it can make healthcare professionals feel trapped. The behavior can coincide with experiences of loss with which the powerlessness is externalized and not internalized. Often the support system is also exhausted and healthcare professionals are viewed as failing. The risk is that healthcare professionals feel manipulated and the person being assessed feels like they are not taken seriously which leads to an amplification of the behavior, that is accompanied by an increased risk for suicide. The person is genuinely suffering. Suicide can take place as the ultimate communication about the misjudgment of the person. (Especially recognizing and exploring the countertransference and offering help to the underlying motivators of suicidality are essential with this type.)

Invented examples of inadequate communication and/or coping

Case 4 a

A 25-29 year old man is yet again fired from his job. He has had multiple jobs in the last year and keeps getting in arguments and feels misjudged. His mood changes daily. As a child he developed an insecure attachment and has been to multiple children's homes, where there was also abuse. He has been admitted multiple times for brief periods and often leaves unhappy. He feels left and abandoned by everyone. He calls the police and says that he is standing on the balcony with a rope. When the emergency team arrives, he is angry, screams and scolds at them that they can never do anything for him. There is an argument and patient is sent on his way and the next day there is a message saying that he has passed away after hanging himself.

Case 4 b

A 60-64 year old man who is known to suffer from Schizophrenia and a gambling addiction, receives care from a community treatment team. Patient has been evicted today from the housing of \. The decision has eventually been made in consultation with the managing board and is unavoidable. Patient has not been keeping to his agreements for some time, and shows aggressive behavior for a long period of time and he is causing disturbance. He has had multiple warnings. Patient came to the shelter, but did not want to sleep in a room with other people, after which he uttered intentions pertaining to suicide. During assessment, no psychotic features were seen, nor defect symptoms which could explain his behavior. There are no previous suicide attempts known in his past and the suicidal behavior seems to be used to get his way. The information is supported by housing personnel and therapist.

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Scoring criteria

SUICIDI 3.3 · Detailed rating anchors

(Score as precisely as possible, overlap is possible if 3 or lower is the maximum score for 1 item)

1) (PD) Perceptual (behavioral) disintegration (psychosis) SUICIDI

The suicidality is explained by the disintegration of perception and/or behavior (psychosis) and is, for the most part, not perceivable as realistic.

0 = completely absent

1 = the suicidality can (for a small part) be related to disintegration of the perception and/or behavior (psychosis), but is mainly caused by something else.

2 = the suicidality is related to disintegration of the perception and/or behavior (psychosis), but is mainly caused by something else.

3 = the suicidality is mainly caused by disintegration of the perception and/or behavior (psychosis) and it is for a large part not perceivable as realistic. But there is uncertainty and there could also be some influence from another cause.

4 = the suicidality is mainly caused by disintegration of the perception and/or behavior (psychosis) and it is for a large part not perceivable as realistic.

Here is also taken into account that the psychosis can be caused by different things. For example: someone who has experienced a severe loss and has clearly become psychotic and suicidal, then the psychosis is the cause and a ‘ 4’ must be scored. This is also the case for a psychotic state and suicidality that are evoked by the use of hallucinogenic drugs (i.e. LSD), other drugs often generate a change in perception, but this does not count as psychotic dysregulation and is scored with a ‘ 0’ .

2) (PDC) Primary depressive cognition SUICIDI

0 = completely absent

1 = the suicidality is possibly related to a depressive thought process or is related to sadness, the feeling of failing or falling short. However, a primary depression is not present, because there are too many factors or it is obviously reactive and has been present for too short a time.

2 = the suicidality is related to a depressive thought process or is related to sadness, the feeling of failing or falling short. However, a primary depression is not the most important reason, because there are too many factors.

3 = the suicidality is mainly explained by a depressive thought process. There is no psychotic symptomatology and there is no suddenly appearing reactive sadness. (Chronic stress is present and extra stressors can worsen it, but is not the cause). However, there is uncertainty and there could also be some influence from another cause.

4 = the suicidality is mainly explained by a depressive thought process. There is no psychotic symptomatology and there is no suddenly appearing reactive sadness. (Chronic stress is present and extra stressors can worsen it, but depression is the primary etiology).

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3) (PT) Psychosocial turmoil SUICIDI

0 = completely absent

1 = the suicidality is possibly a reaction to a sudden event that has to do with loss. However, there are mainly other explanations that caused suicidality, such as a long existing depressive state.

2 = the suicidality is a reaction to a sudden event that has to do with loss. However, there are too many other explanations that caused suicidality, such as a long existing depressive state.

3 = the suicidality can mainly be explained due to an experience of loss, a blow to the ego or a realistic pending doom. There can be depressive features, but these have been present for less than two weeks. The negative thought process is not related to psychosis. The suicidality does not seem to be instrumental to bring others to make changes. It is mainly viewed as acute stress (can also be acute on chronic). However, there is uncertainty and there could also be some influence from another cause.

4 = the suicidality can completely be explained due to an experience of loss, a blow to the ego or a realistic pending doom. There can be depressive features, but these have been present for less than two weeks. The negative thought process is not related to psychosis. The suicidality does not seem to be instrumental to bring others to make changes. (Especially acute stress and not clearly explainable by accompanying chronic stress with a clear affective dysregulation)

4) (IC) inadequate communication and/or coping SUICIDI

0 = completely absent

1 = the suicidality seems to be partly explained by emphasizing suffering and/or instrumental in possibly bringing others to make changes. The thoughts of suicide give the impression that the person is partly not able to communicate the suffering properly. There is, however, a lot of uncertainty.

2 = the suicidality seems to be explained by emphasizing suffering and/or instrumental in possibly bringing others to make changes. The thoughts of suicide give the impression that the person is not able to communicate their suffering in a constructive way. However, there is great uncertainty and it could also be caused by other underlying reasons.

3 = the suicidality is clearly related to emphasizing suffering and/or being instrumental in possibly bringing others to make changes. A depressive or psychotic state is probably excluded, but could be present underneath. It can coincide with loss, but it is not realistically perceivable, secondary affective symptoms are possible. The suffering is perceivable, but especially the communication causes the suicidal process. There is, however, uncertainty.

4 = the suicidality is very clearly related to emphasizing suffering and/or being instrumental in possibly bringing others to make changes. A depressive or psychotic disorder is, for the current presentation of suicidality, excluded, but may be present underneath. It can coincide with loss, but it is not realistically perceivable as primary reason, secondary affective symptoms are possible. The suffering is perceivable, but the communication in particular causes the suicidal process.

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SUICIDI 3.3 · Scoring sheet

Printable assessment form · Mark one absolute subtype and allocate exactly four points across the four subtypes.

Case ID: _____ Assessment date: _____

Assessor: _____

TA score

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

Subtype assessment

#	Subtype	TA score (0–4)	Absolute choice (✓ only one)
1	Perceptual disintegration (PD)	_____	☐
2	Primary depressive cognition (PDC)	_____	☐
3	Severe psychosocial turmoil (PT)	_____	☐
4	Inadequate communication / coping (IC)	_____	☐
	TOTAL — must equal 4	_____ / 4	

Additional information (optional)

Clear suicidality: ☐ Yes ☐ No

Suicide attempt: ☐ Yes ☐ No If yes, specify: _____

Previous suicide attempt: ☐ Yes ☐ No ☐ Unknown

Sex: ☐ Male ☐ Female Age: _____

Policy / disposition (circle): regular care / emergency care / intensive home treatment / admission (with or without measure) / wait and see / none

Psychiatric history: ☐ Yes ☐ No ☐ Unknown

Drug use during the period of suicidality: ☐ Yes ☐ No

Crisis diagnosis: _____

_____

Scoring check: ☐ Total = 4 ☐ Exactly one absolute choice marked

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