Differentiation of Suicidal Behaviour

a practical clinical approach

THE 3TH SUICIDE PREVENTION CONGRESS OF ABEPS ONLINE

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WWW.SUICIDALITEIT.NL

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VU

UNIVERSITY AMSTERDAM
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
Netherlands

- 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.
• 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

- Serious thoughts
- Plan
- Attempt
- Suicide
• 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 registered in MH
  - World <30%

- When dead too late for MH....

- Selection of specific suicidal behaviour?
17% of suicides short term expected?
Suicide in mental Health

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


- 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 really 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
Rare research on heterogeneity/differentiation suicidal behavior!

<table>
<thead>
<tr>
<th>PubMed Search results</th>
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<tbody>
<tr>
<td>Differentiation AND suicidal 01-01-1998 - 01-01-2019 (English abstracts)</td>
<td>PubMed Search results 644 all, reviews 236</td>
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<tr>
<td>all</td>
<td>2</td>
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<tr>
<td>reviews</td>
<td>1</td>
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</tbody>
</table>

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

Wołodzko & 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)
<table>
<thead>
<tr>
<th>Primary Depressive Cognition</th>
<th>Perceptual Disintegration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depression</td>
<td>• Psychotic (depression)</td>
</tr>
<tr>
<td>• Stress sensitivity↑↑</td>
<td>• lose sense of reality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial Entrapment</th>
<th>Inadequate Communication</th>
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<tbody>
<tr>
<td>• Serious loss experience</td>
<td>• Conditioning/coping</td>
</tr>
<tr>
<td>• Short-lived depressive thoughts</td>
<td>• Psychological pain</td>
</tr>
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<td></td>
<td>• Entrapment counselors</td>
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</table>
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.
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?

Psychosocial Entrapment
- Experiencing serious loss
- Reactive depressive thoughts
- Short duration?

"Rumination"

Inadequate Communication
- Inadequate coping
- Psychological pain
- Entrapment counsellors
- Medium duration on chronic?

Mental Health/society

MH/society

MH<>society
Modifiers in model

- Substance abuse modifier for all
- Organic/somatic explanations
Questionnaire

1) Perceptual Disintegration (Disintegration perception & psychosis)
   Score
   0 = not present.
   1 = Psychosis has relevance to suicidal, but most of it can be explained by something else.
   2 = largely explained by psychosis.

2) Primary Depressive Cognition
   Score
   0 = not present
   1 = Societal has a relationship with long standing depressive cognition or appears to be unrelated to 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 symptomology and suicidality or a sudden onset.

3) Psychosocial Entrapment
   Score
   0 = not present.
   1 = Societal appears to have a direct reactive relationship to recent events. There may be other explanations for emergence of suicidal.
   2 = Mostly explained by event with perceived serious loss, humiliation or imminent threat. There may be depression symptoms however they have existed less than 2 weeks and without abnormal thought content. Suicidal is not used as a way to communicate distress.

4) Inadequate Coping (communication)
   Score
   0 = not present.
   1 = Suicidal is suspect of being used to suffer or for other purposes. Suicidal 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 of suicidal and the immediate, reactive and expected response. A depressive or psychotic disorder has been excluded.
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

<table>
<thead>
<tr>
<th>differentiatie</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<td>.4</td>
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<tr>
<td>Total</td>
<td>500</td>
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</tbody>
</table>
Psycho-social contributing factors and suicidal behaviour of patients who committed suicide between March 2016 and March 2017
Adult mental health services

April 2018

Sussex Partnership
NHS Foundation Trust
Better differentiation better tailormade treatment?
Better risk taxation?
Better delineation of responsibilities?
Borders of treatment of MH
Responsibility society/community
info@suicidaliteit.nl

www.suicidaliteit.nl

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