Clinical Subtypes of Suicidality and Relationships With Clinical and Demographic Data

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Disclosure

(potential) conflict of interest	None
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• Stockholder	• None

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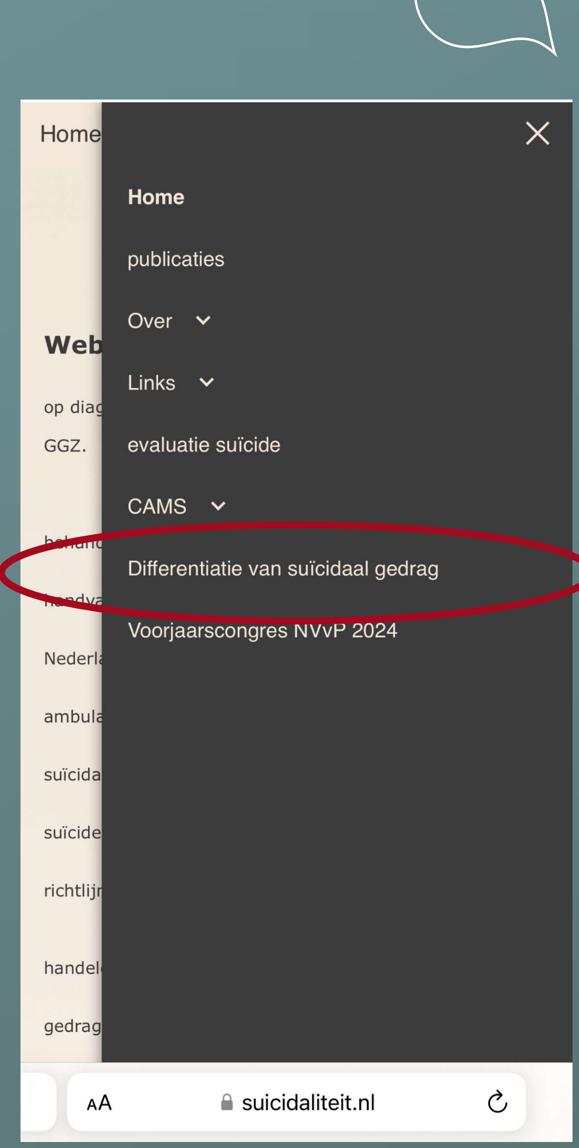


GGZ Rivierduinen
Het begint bij begrip

Why clinical differentiation for suicidality?

Different subtypes:

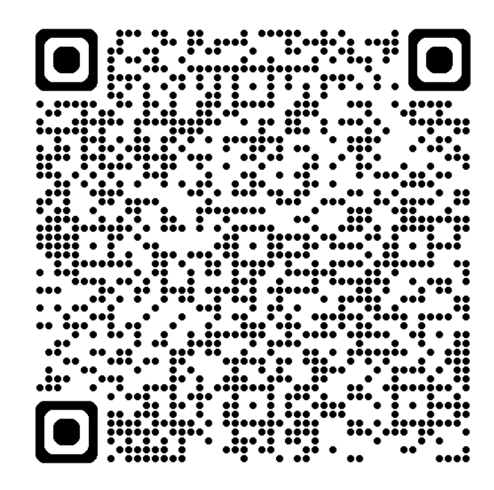
1. For acute action and responsibility?
2. Kind of treatment/"Personalised medicine"
3. Setting of treatment location
4. Responsibility and legal consequences
5. Clinical risk assessment
6. Science (suicidality and relations)

Genetics, Biology, Neuro-imaging, Dimensions of Psychopathology/personality, Endophenotypes, etc.

Since 2012 development suicidal subtypes

(differentiation of underlying entrapment)

No time for explanation......!



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

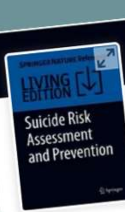
Psychosocial Turmoil (PT)

- Experiencing serious loss
- Reactive depressive thoughts

Inadequate Coping (IC)

- inadequate coping/communication/ emphasising emotional pain
- Entrapment counsellors

Short explanation of subtypes



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

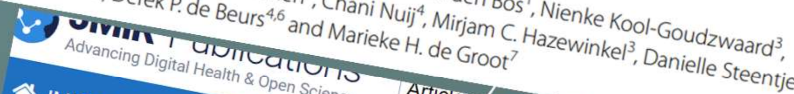
RESEARCH — BMC Psychiatry — Open Access

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]

…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



JMIR Research Protocols — Journal Information — Browse Journal

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Preprints (earlier versions) of this paper are available at https://preprints.jmir.org/preprint/45438, first published December 31, 2022.

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

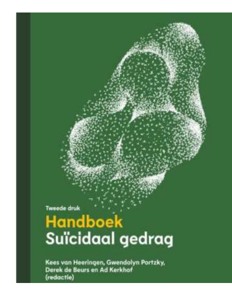
Remco F P de Winter 1, 2, 3; Connie M Meijer 4; John H Enterman 5; Nienke Kool-Goudzwaard 5; Manuela Gemen 1; Anne T van den Bos 1; Danielle Steentjes 1; Gabrielle E van Son 1; Mirjam C Hazewinkel 5; Derek P de Beurs 2, 6; Marieke H de Groot 7

Article

20 Beoordeling van het suïciderisico

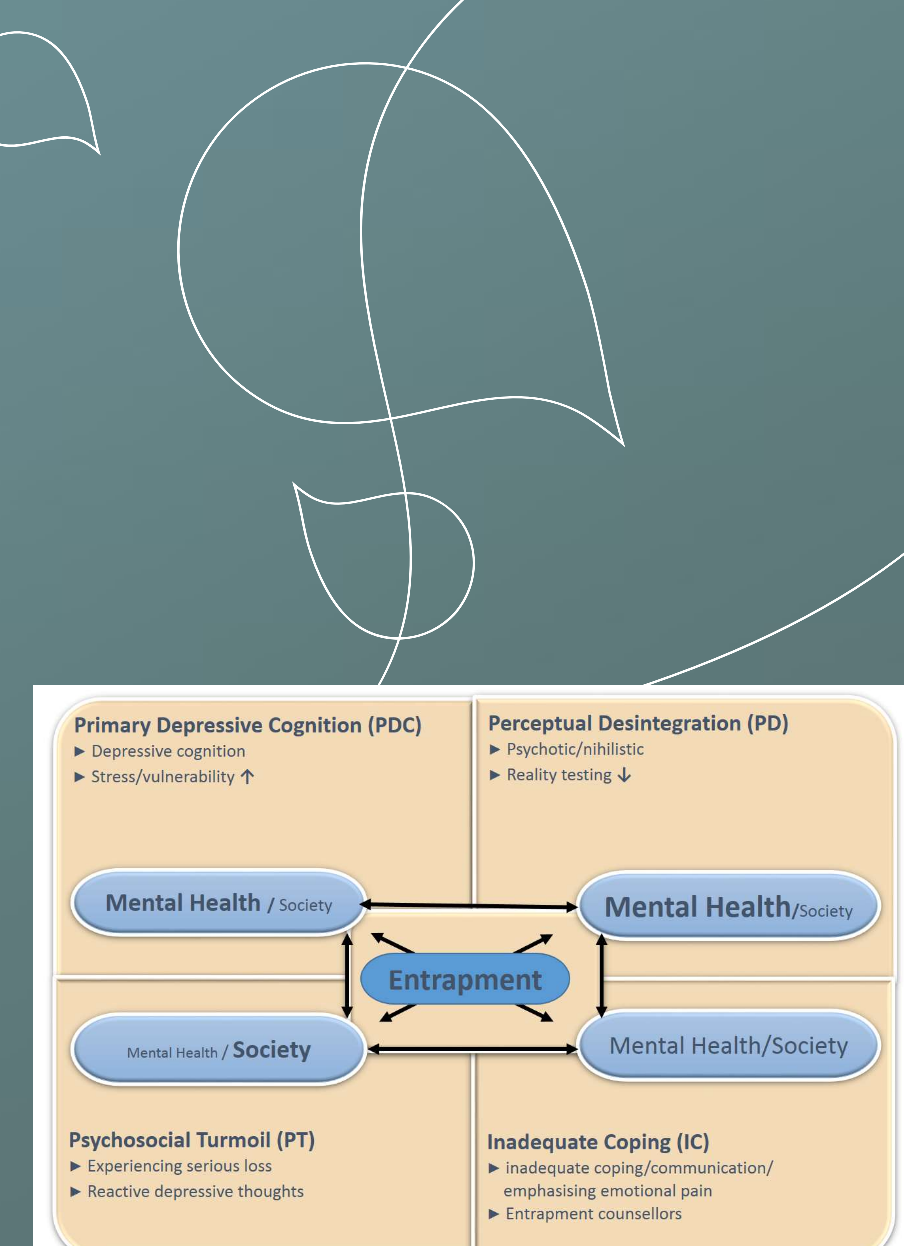
Marieke de Groot en Remco de Winte…

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…



subtypes

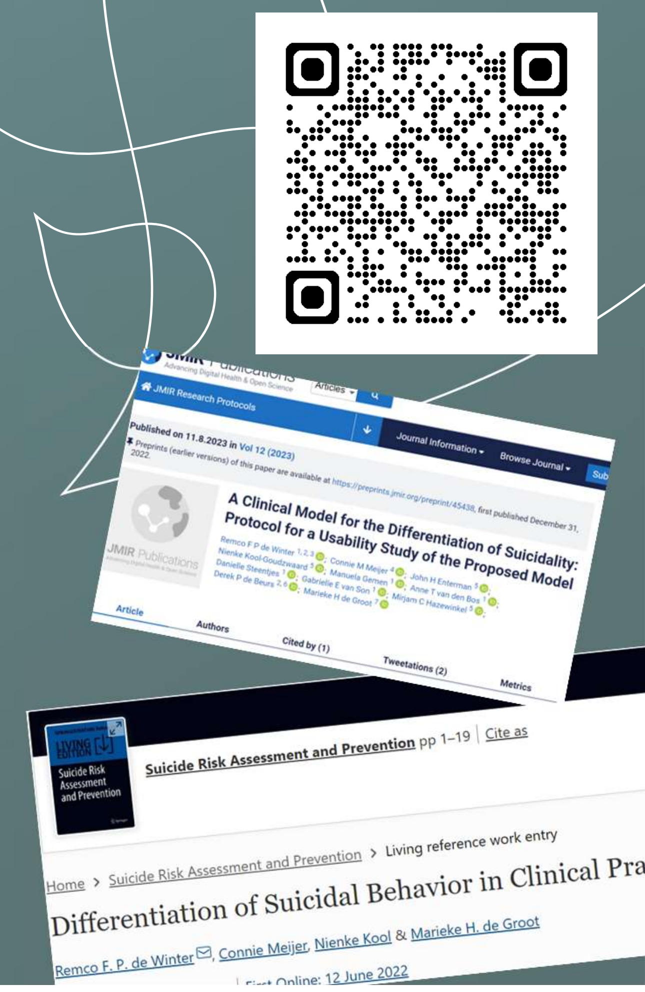
- Perceptual Disintegration(PD),
- Primary Depressive Cognition (PDC),
- Psychosocial “ Turmoil” (PT),
- Inadequate Coping/communication (IC)



Former stated demographic & clinical hypotheses (no time........)

Subtypes differ for

1. Severity (scale)
2. Policy
3. Duration
4. Influence of culture/economic climate
5. "Genetics"
6. Influence of substances
7. Influence of personality
8. Serious life events
9. Primary psychopathology
10. Course
11. Pharmacotherapy
12. Influence of individuals
13. Gender
14. Age
15. Social factors
16. Work
17. Low IQ/educational level



Validation

Subtypes are validly distinguished

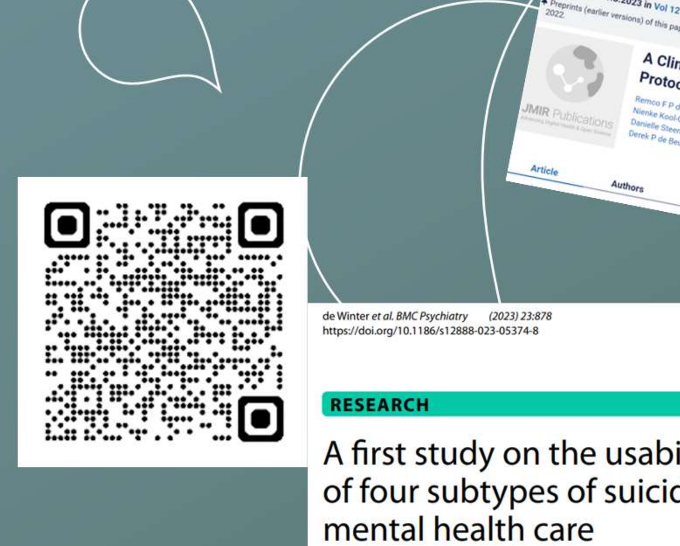
First study (de Winter et al 2023)

-Good-excellent ICC

Second study (de Winter et al in (poster here)

& preparation)

-almost all excellent ICC



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RESEARCH Open Access

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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 report supervised and discussed by consultant psyc RdW. All assessments were discussed and evalu the morning hand-over by a team of at least five health care workers.

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

general practitioner and who consented that informatio for compliant with legal standards of privacy and patien confidentiality was exchanged, were included. For thi study, we included the first 25 individual cases (no dupli cation due to subsequent assessments of one patien between January 2018—March 2018. Patients identitie were safeguarded through case coding, while details suc as gender, age, marital status and cultural backgroun were documented. The DSM-5 classification [5] was use

Table 3 All absolute scores for all 6 raters

ICC	VALUES AND RELIABILITY
< 0.5	None
≥ 0.5 – 0.75	Moderate
≥ 0.75 – 0.9	Good
≥ 0.90	Excellent

Subtypes clinical and demographic disticnctive?

503 suïcidal patients outreach psychiatric emergency service

Uitgebreid gedocumenteerd

Ingedeeld in subtypen

32 variabels

T-tests, Chi-square

Bonferroni-correction significance 0.05/32 = 0.0015

< 0.0015 significant

<0.05 ≋

< 0.01 ≈

> 0.05 =

Het vóórkomen van suïcidaal gedrag en suïcidepogingen bij de psychiatrische crisisdienst

R.F.P. DE WINTER, M.H. DE GROOT, M. VAN DASSEN, M.L. DEEN, D.P. DE BEURS

Research Trends

Outreach Psychiatric Emergency Service

Characteristics of Patients With Suicidal Behavior and Subsequent Policy

Remco F. P. de Winter[1,2,3], Mirjam C. Hazewinkel[3], Roland van de Sande[3,5], Derek P. de Beurs[4], and Marieke H. de Groot[2]

Clinical data	**Mean or %/(SD) N = 503**	**Perceptual disintegration** *(n = 69, 13.7%)*	**primary depressive cognition** *(n = 186, 37%)*	**Psychosocial "turmoil"** *(n = 97, 19.3%)*	**inadequate coping** *(n = 153, 30.4%)*
Primary axis 1	70.6%	↑ $p = 0.017$	↑ $p < 0.001$	↓ $p < 0.001$	↓ $p < 0.001$
Primary personality disorder	11%	↓ $p = 0.002$	↓ $p = 0.014$	ns	↑ $p < 0.001$
Primary substance abuse	9.5%	↓ $p = 0.014$	↓ $p < 0.001$	↑ $p < 0.001$	↑ $p < 0.001$
No disorder	8.9%	↓ $p = 0.048$	↑ $p = 0.017$	↓ $p = 0.001$	ns
Actual in treatment	36.7%	ns	↓ $p = 0.01$	↓ $p < 0.001$	↑ $p < 0.001$
Recurrent consult	22.6%	ns	↓ $p = 0.004$	↓ $p < 0.001$	↑ $p < 0.001$
Duration suicidality in days (SD)	21.3 (37.5)	↓ $p < 0.001$	↑ $p < 0.001$	↓ $p < 0.001$	↓ $p = 0.017$
Attempt	35.5%	ns	↓ $p < 0.001$	↑ $p = 0.025$	↑ $p = 0.002$
Attempt intentional lethal	11.1%	↑ $p = 0.017$	ns	ns	↓ $p < 0.001$
Former attempt	43.1%	↓ $p = 0.018$	↓ $p = 0.001$	↓ $p < 0.001$	↑ $p < 0.001$
Admission	29.2%	ns	ns	↓ $p < 0.001$	ns
Involuntary admission	8.9%	↑ $p < 0.001$	↓ $p = 0.001$	↓ $p = 0.008$	ns
Intensive Home treatment	13.1%	ns	ns	ns	ns
Psychosocial stressors	2.3 (0.99)	↓ $p < 0.001$	↓ $p = 0.023$	↑ $p < 0.001$	ns
Family history	28%	↓ $p = 0.014$	↑ $p = 0.044$	ns	ns
Low IQ	8%	ns	↓ $p < 0.001$	ns	↑ $p < 0.001$
Psycho pharm	63%	ns	ns	↓ $p = 0.004$	↑ $p = 0.034$
Antidepressant	31.6%	ns	ns	↓ $p = 0.01$	ns
Antipsychotic	14.6%	↑ $p < 0.001$	↓ $p = 0.014$	ns	ns
Mood stabilisator	5%	ns	ns	ns	ns
Benzodiazepine	51%	ns	ns	ns	ns
Morfine mimeticum	5.6%	ns	ns	ns	ns
Actual substance abuse	25.8%	ns	↓ $p < 0.001$	↑ $p = 0.047$	↑ $p < 0.001$
Demographic data					
Gender (woman)	58%	↓ $p = 0.001$	↑ $p < 0.001$	ns	ns
Age	38.3 (15.9)	ns	ns	ns	ns
Dutch etnicity	54.9%	ns	ns	ns	ns
In bound relation	26.3%	ns	ns	ns	↓ $p = 0.045$
Having children	38.6%	ns	ns	ns	ns
Children at home	20%	ns	↑ $p = 0.044$	ns	↓ $p = 0.013$
Labour	29.4%	ns	↑ $p < 0.001$	↑ $p = 0.017$	ns
LHBTQ	6%	ns	↑ $p = 0.012$	ns	ns
Education	1.93 (0.96)	ns	↑ $p < 0.001$	ns	↓ $p < 0.001$

Table differentiation of suïcidality, clinical and demographical data. n = 503, Bonferroni-correction significance 0.05/32 = 0.0015

Draft 2024 RFP de winter & MH de Groot: Clinical subtypes of suicidality and relationships with demographic and clinical data (in preparation).

psychopathology

Primary axis 1	Personality disorder
PD ≈ ↑	PD ≈ ↓
PDC ↑	PDC ≈ ↓
PT ↓	PT =
IC ↓	IC ↑

Substance abuse

Known substance abuse	During consulation
PD ≈↓	PD =
PDC ↓	**PDC ↓**
PT ↑	PT ≈↑
IC ↑	**IC ↑**

Aspects suicidality

Duration (days)	Ever attempt	Attempt (potential lethal)	Former attempt
PD ↓	PD =	PD ≈↑	PD ≈↓
PDC ↑	**PDC ↓**	PDC =	**PDC ↓**
PT ↓	PT ≈↑	PT =	**PT ↓**
IC ≈↑	IC ≈ ↑	**IC ↓**	**IC ↑**

Policy

Admission	Involuntary admission	Intensive home treatment
PD =	**PD ↑**	PD =
PDC =	**PDC ↓**	PDC =
PT ↓	PT ≈ ↓	PT =
IC =	IC =	IC =

Clinical

Total stressors	Family history	Low IQ/education
PD ↓	PD ≈↓	PD =
PDC ≈ ↓	PDC ≈ ↑	PDC ↓
PT ↑	PT =	PT =
IC =	IC =	IC ↑

Demographic

♀	age	etnicity	In bound relation	Children at home	LHBTQ	Labour
PD ↓	PD =	PD =	PD =	PD =	PD =	PD =
PDC ↑	PDC =	PDC =	PDC =	PDC ≈ ↑	PDC ≈ ↑	PDC ↑
PT =	PT =	PT =	PT =	PT =	PT =	PT≈ ↑
IC =	IC =	IC =	IC ≈ ↓	IC ≈ ↓	IC =	IC =

Conclusions

- Subtypes mainly distinguished for clinical variables
- Previously stated clinical hypotheses are in general not rejected
- Previously stated demographic hypotheses mostly not confirmed

- PT least associated with a psychatric disorder

- Substance mosty associated with PT & IC
- PT & PD "shorter duration" suicidality
- PDC more persistent, (IC trend)
- Former attempts associated with IC

Discussion and future

1. Subtypes are clinical distinguished, (start for PhD traject)

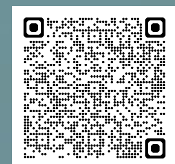
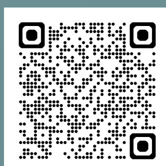
2. Some aspects are insufficient operationalised (culture/conjuncture)

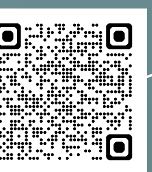
- No division based on demographic aspects (research in different cultures)

3. Bias by history and description?
4. Clinical suicidal subtype research fruitfull?

- *Indication for treatment, Genetics, Biology, network theory, dimensions of personality, Endofenotypes, etc..*

5. Further demarcation in more subtypes?



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, 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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