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THERAPEUTIC MECHANISM AND EFFECTIVENESS OF THE SINGLE-SESSION SUICIDE CRISIS INTERVENTION

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Abstract

Background: The research of the Single Session Therapy in the suicide intervention mainly adopted quantitative studies in the past but lacked qualitative data to understand the meaning of the effect. Therefore, we conducted in-depth interviews to collect the data for the Single-Session Suicide Crisis Intervention (SSSCI) change mechanism and evaluate its effects. **Methods:** The study implemented mixed methods research in which qualitative analysis was the primary research method, and quantitative analysis was auxiliary to support the findings of qualitative research, excluded patients with more than two psychiatric hospitalizations and who had been diagnosed with personality disorders, finally recruiting nine suicide clients. **Results:** Qualitative data can be integrated into three levels: the individual, the relationship, and the spirituality level. The test of before and after depression and living and coping with beliefs reached a significant level of .05. With the two tracking scores, the risk of suicide continued to decrease, and the positiveness increased steadily. **Conclusion:** This showed the SSSCI effects on the suicide intervention, and the case reported a multifaceted harvest.

Keywords: Suicide Crisis Intervention; Single Session Therapy; Mixed Methods Research.

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The Single-Session Suicide Crisis Intervention (SSSCI) emphasizes the concept of structural counseling and the occurrence of change, which is mainly derived from the idea of Single Session Therapy (SST) by Talmon in 1990. Kaffman (1995) believed that the beginning of the counseling represents the possibility of change and strengthens the belief that change will occur at the end of the counseling. Most research showed that nearly half or more clients tended to receive one to two treatments, and less than 50% of clients receive three to four treatments or more (Mackenzie, 1991; Rosenbaum et al., 1990; Young et al., 2012).

SST is a service orientation, not a treatment model, meaning practitioners can adopt individualized treatment styles but integrate the spirit and principles of SST. Rosenbaum et al. (1990) pointed out that any treatment approach can be applied to SST, as long as it follows that each time is the last time and has a complete and independent spirit and structure (Cox & Campbell, 2003). In the same way, Bloom (2001) pointed out the perspective of the ceiling effect of change, suggesting that the space for change is limited and that the first treatment session can exert the most significant benefit. The number of treatments for a typical SST is one (Rosenbaum et al., 1990), and the average number of SST is three (Gelso & Johnson, 1983). The therapist regards each treatment as only one and agrees that one treatment can be effective.

Cameron (2007) pointed out that SST was particularly suitable for people who felt trapped and struggled to change. Perkins (2006) proposed a two-hour treatment approach appropriate to cover both assessment and treatment. Traditional treatment focuses on evaluation at the initial stage and treatment at the back end. Perkins further put forward the advantages of SST, such as early assessment and treatment, empowering clients to increase confidence in solving problems, and more cost-effective considerations. Boyhan (1996) stated in a literature review article that nearly half of the clients receiving SST require more time treatments, and Campbell (2012) further proposed that therapists who have experienced and were familiar with various psychotherapy techniques were the most appropriate to perform SST.

Hopkins et al. (2017) indicated that young people and their families believe that their mental health and well-being improved after the single session therapy intervention, especially with mothers rating the young person's improvement most highly. Single session therapy effectively enhances young people’s personal, interpersonal, social, and overall well-being receiving mental health services. Lamprecht et al. (2007) focused on patients who had received emergency care due to self-harm for the first time and performed SST focused on problem-solving treatment. They found that only two out of 32 patients reappeared in the emergency room due to self-harm within one year (6.25%), showing that the recurrence rate of the emergency room due to self-injury had decreased. Therefore, Simpson (2019) suggested that single-session crisis intervention complements the traditional expectations of emergency psychiatric evaluations by providing clinicians with a way to treat symptoms of anxiety and depression in the emergency departments. This

model may also assist in treating psychiatric inpatients and encourage further psychotherapy studies in the emergency setting.

The application of SST to suicide intervention requires some modifications. We propose a combination of assessment and intervention, using risk assessment and buffer factors, and formulate the following seven stages and 8-procedure framework based on SST. The interlock of each program can be flexibly adjusted according to the patients' situation, and we named it "Single-Session Suicide Crisis Intervention."

The theory and technology of Single-Session Suicide Crisis Intervention (SSSCI) adopts a diverse perspective, which integrates short-term counseling with a focused solution orientation, narrative therapy, client-centered therapy, meaning treatment, and Adler's concepts and techniques. The SSSCI includes seven stages and eight procedures, which were introduced as follows:

1. *Stage one:* Suicide warning and assessment of protection factor.

2. *Stage two:* Establishing a supportive relationship and affirming the help-seeking behavior, including 1.) Establish a therapeutic relationship. 2.) Affirm the case's help-seeking behavior and the courage to face the problem.

3. *Stage three:* Listening to suicide stories and providing empathy and hope, including 3.) Emphasize the possibility of change and strengthen the confidence in problem- solutions.

4. *Stage four:* Exploring alternative solutions, including 4.) Find out the problems that can be solved by counseling.

5. *Stage five:* Find out the case's life meaning and strength of the case, including 5.) Find out the life meaning and power of the case.

6. *Stage six:* Developing short-term and positive actions to enhance positive experiences and the sense of efficacy, including 6.) Put forward tasks that can provide concrete change and practice possible solutions, 7.) Affirm the counseling and the results of the individual's efforts.

7. *Stage seven:* Evaluating the effectiveness of the treatment, tracking, or resource referrals, including 8.) Follow up or consult for the next session.

The SSSCI emphasizes the follow-up after the intervention. The single-session intervention also believes that tracking can help individuals strengthen their growth and change and strengthen their sense of responsibility. If individuals seek counseling again, it does not mean they are not good enough.

Reviewing the previous literature, SST was applied to patients with various problems, mainly adopted quantitative research to achieve positive results, but lacks qualitative data to understand the connotation of the effect. Furthermore, we combined suicide assessment and intervention in a single session to develop the SSSCI for suicide clients and conducted in-depth interviews to collect the experience of the process and curative effects of the consultation; mixed methods research was used to check the effectiveness of the intervention.

Methods

This study aimed to understand the experience and process of a case undergoing the SSSCI. Our study used qualitative data analysis; it also included quantitative data to understand the change mechanism and effectiveness of the treatment; therefore, the mixed methods design was adopted for the research.

Participants

The study subjects were nine suicide risk clients referred from suicide prevention centers, Lifeline International, community counseling centers, school counseling centers, and hospital outpatient clinics. The exclusion criteria included patients with more than two psychiatric hospitalization experiences and who had been diagnosed with personality disorders. Written informed consents were obtained from all participants.

Research Tools

The scale of Suicidal Risk

This study used the ranking compiled by Hsu and Zhong (1997) on suicide risk content, including death ideas, death motives, previous suicide attempts, suicide plans, and end-of-life arrangements. The scale consists of 24 questions scored according to a four-point scale, with a higher score indicating a higher risk of suicide. The internal consistency was in the range of .85-.90. In the validity test, the absolute value of the correlations between the Scale of Suicidal Risk and the "Suicide Probability Scale," "Hopelessness Scale," and "Suicide Propensity Scale" was all greater than .40.

Hopelessness Scale

The hopelessness scale was developed by Eggert et al. (1994) to assess adolescents' mental health, deviant behaviors, social support, school, and family life adaptation, and it has good reliability and validity. The Chinese version was translated by Wang et al. (2006) and passed two tests of cultural suitability and translation equivalence assessments. This questionnaire contains five sub-scales, including support and help, activity, drug knowledge and involvement, and life experience, with a Likert 7-point scale. A higher score indicates a more profound sense of hopelessness. The questionnaire's Cronbach $\alpha = .74$ showed good internal consistency and reliability.

Taiwanese Depression Screening Questionnaire

The "Taiwanese Depression Screening Questionnaire" (TDSQ) developed by Lee (1999) is used to assess the degree of depression in a case. The scale is a localized Taiwanese depression screening questionnaire and contains culturally

characteristic phrases. The questionnaire's Cronbach α = .90 showed good internal consistency and reliability. It was a culturally sensitive and applicable depression screening questionnaire used by the native Taiwanese.

The Reasons for Living Inventory

The Reasons for Living Inventory was developed by Chang (2008) and uses the Reasons for Living Inventory developed by Linehan et al. (1983) as the basis for scale development. The assessment and the localized Reasons for Staying Alive inventory developed by Kao (1998) appropriately included infeasible test questions to expand the richness and completeness of the scale. Six sub-scale were constructed, namely, living and coping with beliefs; responsibility to relatives, friends, and family; fear of suicide; fear of social evaluation; caring for children; and moral controversy; the total explained variance was 55.58%, and the internal consistency coefficient of each dimension ranged from .73 to .95.

Interview Outline

Semi-structured in-depth interviews were used to ensure that the discussions did not deviate from the research questions. There were four directions, and the clients were gradually guided through multiple interactive modes to share the history and experience of SSSCI. The contents included: 1) What factors slowed down the suicide crisis in counseling? 2) What factors improved the chances of living in counseling? 3) How and why was the SSSCI effective? 4) What were the benefits of SSSCI?

Statistical Methods

Qualitative Data Analysis

The researcher carefully read the content of each verbatim manuscript, referred to the interview log, did not presuppose any position, used sentence-by-sentence or paragraph-by-paragraph analysis, conceptualized meaningful data, and utilized naming codes. Lieblich et al. (1998) proposed the strategy and steps of the "category-content" analysis method 1998. In addition, two researchers were arranged to compare the data.

Quantitative Data

SPSS version 21.0 statistical package software was used for analysis, including descriptive statistics, the Mann-Whitney U test for independent sample difference test, and the Wilcoxon matched-pairs signed-ranks test for dependent sample difference test. The statistical significance level was set as α = .01.

Results

Demographic Variables

The average age of the participants was 33.89 years old, and the age range was 15 to 52 years old. Female members were the majority, accounting for 66.7%; college graduates accounted for the majority education level, accounting for 66.7%. The detailed information was as shown in Table 1.

Table 1. Demographic data (N=9)

		N	%
Gender	male	3	33.3
	female	6	66.7
Education	primary school	1	11.1
	Middle school	1	11.1
	junior high school	1	11.1
	College/university	6	66.7
Number of children	0	5	55.6
	1	1	11.1
	2	2	22.1
	3	0	0.0
	4	1	11.1
Marriage	unmarried	5	55.6
	married	3	33.3
	divorced	1	11.1
Religion	No	2	22.2
	Taoism	2	22.2
	Buddhism	2	22.2
	Believe in God but no specific religion	3	33.3
Live alone	No	7	77.8
	Yes	2	22.2
Family psychiatric history	No	7	77.8
	Yes	2	22.2
Psychiatric medical history	No	1	11.1
	Yes	8	88.9
Drinking recently	No	8	88.9
	Yes	1	11.1

The therapeutic mechanism of Single-Session Suicide Crisis Intervention

The aspects of the participants' perceptions and gains in the counseling included what had changed and how to influence these changes. Qualitative data analysis was based on three parts: the personal level, the relationship level, and the spiritual level. The data was organized at three levels: emotion (experience), cognition, and behavior at the personal level. The qualitative data are summarized in Table 2. please see Appendix I： The connotations for the therapeutic mechanism of single-session suicide crisis intervention for detailed interview information.

Table 2. Summary of the experience and feedback of the single session suicide crisis intervention

Level	Theme	Category
3.2.1 Personal level		
Emotion (Experience)	A. Emotional relief	
	B. Energy enhancement and cherishing the current life	
Cognitive	A. Letting go of control through self-understanding, self-acceptance and learning	(1) Self-understanding
		(2) Accept weaknesses and deficiencies
		(3) Handle business in a soft and flexible way
	B. Motivation and self-encouragement to make changes through the struggle to survive	
	C. Learning multiple perspectives and loosening rigid ideas	
	D. Reinterpretation of the predicament and transformation of perspective	
	E. Finding a sense of positiveness from the experience of others	
	F. Repositioning the value and sequence of life	
Behaviour	A. Actively taking medication in accordance with the doctor's advice	
	B. Arranging pleasurable activities to enhance the sense of positiveness	
	C. Using clear and specific treatment strategies	
	D. Facing a dilemma	
3.2.2 Relationship level		
	A. Social support	
	B. Concern for family and support for friends	
3.2.3 Spiritual level		
	A. Experiencing the mission and meaning of life	
	B. Having a new perspective on death	

The Trend of Suicide Risk for All Participants

The suicide risk after receiving the SSSCI was reduced, especially after the first session. The subsequent sessions strengthened the previous session. The first

session of suicide intervention was practical, and the next sessions had an enhanced effect. The application of the SSSCI to suicide clients had a good product. The figure shows below.

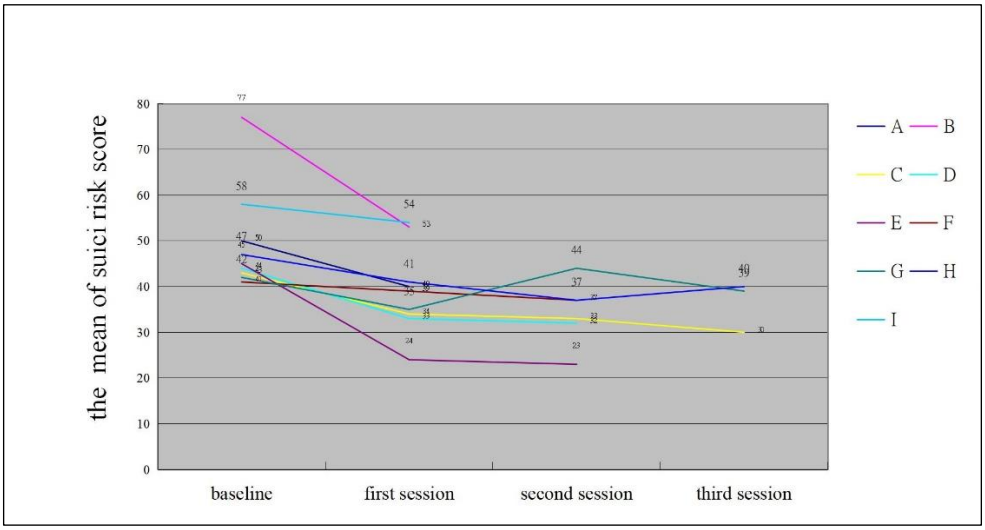

Figure 1. Suicide risk trend for all participants

Effectiveness of the Single-Session Suicide Crisis Intervention

Test of the Difference between Depression, Hopelessness, and Reasons for Living

As shown in Table 3, the significance test of the SSSCI before and after depression (z= -1.99, p = .046) and living and coping with beliefs (z= -2.20, p= .028) reached a significant level of .05. At the same time, the other variables were not significant before and after the test.

Table 3. The difference test of depression, hopelessness, and reason to survive

Variables	M Post/ Pre	S.D. Post/ Pre	Mean Rank Post/ Pre	Rank Sum Post/ Pre	z	*p*
Depression	25.17/35.17	18.25/15.25	4.00/1.00	20.00/1.00	-1.99	.046*
Hopelessness	5.83/8.00	3.54/2.61	4.00/1.50	12.00/3.00	-1.23	.221
Reason to living						
Living and coping beliefs	95/84	15.95/19.60	0.00/3.50	0.00/21.00	-2.20	.028*
Responsibility to friends/ family	32/31	5.01/4.34	2.00/3.67	4.00/11.00	-.96	.336

Variables	M Post/ Pre	S.D. Post/ Pre	Mean Rank Post/ Pre	Rank Sum Post/ Pre	z	*p*
Fear of suicide	22.67/22.33	5.47/5.82	0.00/1.500	0.00/3.00	-1.41	.157
Fear of social evaluation	12.17/13.67	4.02/3.67	2.50/0.00	10.00/0.00	-1.84	.066
Care for children	11.17/11.33	6.79/6.02	1.50/3.00	3.00/3.00	0.00	1
Moral controversy	7.17/7.67	3.66/3.56	3.00/2.00	6.00/4.00	-.378	.705

* $P < .05$; ** $P < .01$

Single-Session Suicide Crisis Intervention Tracking

First Tracking Point (2 months after the end)

The tracking results found that the average score of suicide risk was 3; the sense of the meaning of life was 5.29; the courage to face the problem was 6.43, and the alternative problem- solution was 5.14 (see figure 2). The average score for positive sense was 5.62 (the min. score = 2.67, the max. =10).

Second Tracking Point (8months after the end)

The second tracking point found that the total average score for suicide risk was 1.86; the sense of the meaning of life was 5.14; the courage to face the problem was 6.86, and the alternative problem- solutions was 6.00 (see Figure 2). The average score for positive sense was 5.57 (the min. score = 3.67, the max. =10).

Overall, at the second tracking, the participants' average score for suicide risk fell to 1.86 points, compared with 10 points when they asked for help, and three points for the first tracking, representing a continuous improvement. In addition, the average for the meaning of life was at a medium level, while the alternative of the problem- solutions and courage to face problems was above medium, indicating that the second tracking was more favorable for the meaning of life, courage to face problems, and the ability of problem- solutions. The participants' self-assessment of positive feelings was medium to medium or above.

Comparison of the Two Tracking Points

The suicide risk at the second tracking was lower than that at the first tracking, and the positive sense was higher than that of the first tracking point. In detail, the positive sense included the meaning of life, the courage to face problems, and problem-solving. The SSSCI continued to reduce the risk of suicide and enhance the understanding of positiveness.

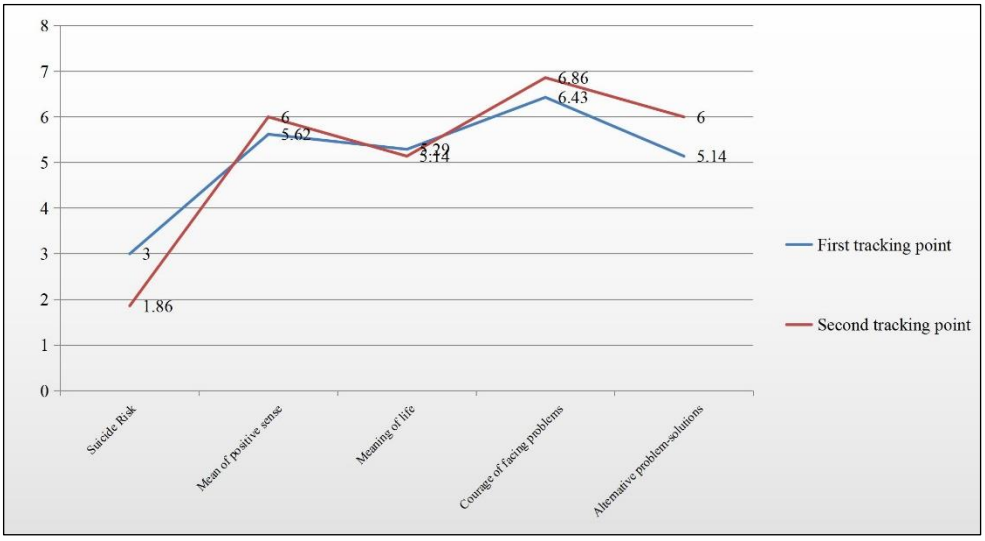

Figure 2. Graph of the scores of the two tracking points

Conclusion and Discussion

The Concept of Single-Session Suicide Crisis Intervention

After reviewing past SST research studies, we developed an SSSCI that combined evaluation and intervention and found that it could effectively reduce the risk of suicide and increase a sense of positiveness. This model required about 90 to 120 minutes. It took the therapeutic relationship as the core to understanding the suicide problem, assisted the case's emotional relief, relieved the suicidal ideation, and found other solutions to the patient's issues to enhance the sense of hope and the meaning of life.

Linehan et al. (1983) developed the Reason for Living Inventory, and they had innovative and completely different views on the study of suicide risk assessment. For the treatment of suicide patients, both clinicians and patients must prepare systematically to eliminate the reasons for wanting to die and, at the same time, devote themselves to cultivating, instilling, and adding more reasons to survive. Therefore, in this study, under the concept of combining the ideas of suicide risk assessment with treatment and examination of the reason for living, it was found that the intervention of the reason for living could effectively reduce the risk of suicide.

As Rudd et al. (2001) mentioned, clinicians need to complete two tasks during the first meeting: the suicide assessment and second: the suicide intervention. Therefore, a clear risk assessment plan can ideally be transformed into a direct, clinically symbolic, and practical decision.

The SSSCI combined the concepts of assessment and intervention in one session. It was found that this was an effective strategy that could meet the needs of suicide crisis clients.

The therapeutic mechanism and Effectiveness of the Single-Session Suicide Crisis Intervention

The qualitative analysis showed that the participants reported that the changes caused by SSSCI came from the emotional level at the personal level, including emotional relief, positive energy enhancement, and cherishing the current life. At the cognitive level, there were enhancements to self -understanding and acceptance, learning to let go of control, experiencing the struggle for a living, generating change motivation and self-encouragement, learning multiple perspectives and loosening rigid ideas, reinterpreting and changing the frame of adversity, finding positive power from the experience of others, and repositioning the value and order of life. At the behavioral level, cooperate with doctors to improve the initiative of taking medicine, specifying specific intervention directions, and learning to deal with frustrations. The relationship level had the support of relatives and friends. The spiritual level included that life has a mission and meaning and a new understanding of life.

The quantitative analysis found that SSSCI can effectively reduce the risk of suicide and depression and improve survival and coping with beliefs. Tracking at two points in time found that the overall risk of suicide at the second tracking was lower than at the first tracking, and the sense of positiveness increased in follow-up tracking, showing that the SSSCI continued to maintain the effect of reducing the risk of suicide and stabilized the positive feeling.

The participants reported that the changes occurred at the individual level of emotion, cognition, and behavior and the relationship level and spiritual level.

The Improvement Rate of the Suicide Risk

The participants in this study had a wide range of complex suicide problems. After the SSSCI, there was a significant effect on reducing the risk of suicide. Four of the nine participants received a single session suicide intervention, and five received two or three sessions.

In terms of the effectiveness of single-session suicide intervention, the average improvement rate of the suicide risk was 21.35%, indicating that only one-session suicide crisis intervention could effectively reduce the risk of suicide. In addition, for the five participants who performed more than two sessions, the improvement rate for the second session was between 3.03~9.76%. Just like the view of maximizing the effect of the SST, the ceiling effect was reached the first time, and the subsequent treatment effect was slowed down.

In summary, the SSSCI can effectively reduce the risk of suicide in the first session. This model could provide a reference for front-line practitioners and effectively mitigate the suicide crisis during the subsequent treatment, especially in workplaces where only a single or limited intervention can be provided; in addition, the suicide treatment during subsequent sessions also has the effect of maintaining the efficacy of the treatment, making the SSSCI an effective model for suicide cases.

Authors note

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Data availability statement: The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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