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Solution Focused Brief Therapy (SFBT) In the Treatment of Depression and Suicidal Ideation: A Case Study

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ABSTRACT

Young adults pursuing higher education may experience it as a challenging period of transition and are vulnerable to many problems. Suicide is one of the most common reasons for death among young adults. With the increasing number of suicides and attempts among university students, the authorities, administrators and mental health professionals still lack the best knowledge about how to effectively protect students from suicidal thoughts and behaviours. Studies indicate, the traditional crisis intervention and counselling models based at the 'campus counselling centres' need significant modifications in their approach and methodology in the identification and treatment of suicidal behaviours at the ideational level itself. Solution focused therapeutic approach brings about a reorientation from a problem-focused direction to a solution-focused one in psychotherapy which is grounded in a competency-based and resource-based model. In this case study, application of Solution Focused Brief Therapy (SFBT) for a 21-year-old Engineering third-year student presented with mild depression and suicidal ideations after a difficult break-up of a love relationship is described. Six sessions of SFBT intervention, spread over twelve weeks was employed. The suicidal ideation, hopelessness and depression of the client were assessed using self-report measures before and after the intervention, and at three months follow up. Effect of the intervention is examined.

Keywords: Solution Focused Brief Therapy, depression, suicidal ideation, college / university mental health

1. INTRODUCTION

Suicide is one of the most common reasons for death among young adults. However, a great many people who think of suicide are conflicted about executing it. Somebody who is self-destructive may well feel startled, trapped, depressed, hopeless, vulnerable, befuddled, helpless and distressed - and also may be desperate to escape from his or her agony instead of needing to die. Musings about suicide are very normal - the idea is likely to cross the mind of many individuals at some point in their lives.

Although studies suggest that the occurrence of suicide and attempted suicide in student populations is less than in the population at large, the figures are still alarming and increasing. For some, suicide will follow a period of contemplation while for others it is likely to be an impulsive act, perhaps triggered by a major life stress, traumatic experience or by a relatively insignificant event which may be seen as the 'last straw'.

WHO (2017) places on record that close to 8,00,000 people die by suicide every year and has identified it as the second leading cause of death in the age group of 15-29 years. When the age-standardised suicide rate is 10.7 per 100 000 population globally, it is 15.7 for India (WHO, 2016). Adolescence and young adulthood is a time of heightened risk of suicide, and it is one of the leading causes of death among youth in India (Vijayakumar et al., 2005; Aaron et al., 2004). Further, Aaron et al. (2004), among a rural population of south India consisting of 1,08,000 adolescents evaluated the causes of death among and identified that suicide accounted for approximately one-fourth of all deaths among boys and 50-75 % of all deaths among girls aged 10-19 years.

Higher education can be a challenging period of transition where students may feel lost, forlorn, befuddled, anxious, depressed and distressed. Jena & Sidhartha (2004) in their study among adolescents in Delhi, identified 21.7 % suicidal ideation rate. Bholia et al. (2014) in a survey among students attending pre-college school in Bangalore, India identified 25.4% of students having suicidal ideation and a suicidal attempt (lifetime) rate of 12.9%. Female students had higher rates of suicidal ideation and attempts than their male counterparts.

Suicide is an aftereffect of the complex interaction between contextual, organic, psychological and social factors. Also, suicide attempts are related to many risk factors. By a wide margin the most potent risk factor for can be considered as a past suicide attempt. Singh & Joshi (2008) in their study among 250 college students from Haryana, India, concluded that depression and stressful life events are positively associated and are predictive of suicidal ideation. Hawton et al. (1995) in their study among Oxford University students observed that among half of the students who had committed suicide had previously been diagnosed as clinically depressed.

Cherpitel, Borges and Wilcox (2004) studied the relationship between suicide ideation and alcohol consumption among a group of ten thousand youngsters aged nineteen years. Outcomes showed that ratio of mortality by suicide as 8.5 times greater among alcohol users compared to non-users of alcohol. While the relation between suicide and psychological disorders (specifically, mood disorder and substance use disorders) is well established among many other risk factors, numerous suicides happen impulsively as a reaction to a certain crisis such as financial problems, relationship problems etc. Arria et al. (2009) in their study among 1249 first-year college students identified suicidal ideation among 6% of them. 40% students with suicidal ideation, found to have depression based on the standard criteria. Further, alcohol dependence was independently associated the suicidal ideation, low social support and affective dysregulation were identified as major predictors.

With the increasing number of suicides and attempts among university students, the authorities, administrators and mental health professionals still lack the best knowledge about how to effectively protect students from suicidal thoughts and behaviours. The traditional crisis intervention and counselling models based at the 'campus counselling centres' cannot be completely relied upon (Drum et al. 2009) or need significant modifications in their approach and methodology in the identification and treatment of suicidal behaviours at the ideational level itself. According to Golden & Peterson (2010), most people who attempt suicide spends a great deal of time in contemplating it or having significant distressing suicidal ideation. There are also studies which show that nearly 80% of the students who die by suicide never receive services in the

campus counselling centre (Drum et al., 2009; Gallagher, 2006; Kisch, Leino, & Silverman, 2005; Schwartz, 2006).

Interventions targeting certain risk factors present may be helpful in preventing further attempts. In that context, Cognitive Behavioral Therapy (CBT) is a widely used approach which challenges the maladaptive beliefs and increases problem-solving skills and competence. Alavi et al. (2013) in their research evaluated the effectiveness of CBT for suicide prevention by targeting suicidal ideation and hopelessness among adolescents with a history of at least one suicidal attempt and had concluded it as efficacious. Similarly, the third wave of CBT which includes Dialectical Behavior Therapy, Acceptance and Commitment Therapy and other Mindfulness-Based approaches may also be considered as safe, simply describing the core principles outlining the approach they offer to individuals with suicidal ideation.

Suicide attempts and ideations are among the most difficult and alarming issues that counsellors and therapists experience in work. Unfortunately, for suicide prevention, there is no standardised empirically supported effective method. A postal survey by Kroll (2000) among Psychiatrists, confirms a high rate of individuals committed or made serious attempts even after entering into a no-suicide contract with their treatment provider. This suggests that we should keep on looking for more viable and effective methods for working with suicidal individuals.

Solution Focused Brief Therapy (SFBT) is developed based on more than thirty years of theoretical expansion, clinical practice, and empirical research initiated by Kim Berg, de Shazer and their colleagues. This approach brings about a reorientation from a problem-focused direction to a solution-focused one in psychotherapy which is grounded in a competency-based and resource-based model. The primary focus being the enhancement of client's strengths, this approach analyses positive exceptions in the client's experiences as opposed to problem patterns and elaboration on preferred future and goals instead of problems from the past. The emphasis is on where client's need to go, instead of where they have been. SFBT is a therapeutic approach to working with individuals who present with suicidal ideation that can bring in a positive change in a person's level of hopelessness, mood state, and distress (Kondrat & Teater, 2010).

John Hendon, a psychologist in the National Health Service (NHS), UK, has extensively used solution focused approach in working with suicidal clients. In the book 'Preventing Suicide: The Solution Focused Approach', Hendon (2008) details a very systematic and practical ways to provide intervention for a suicidal client. He emphasises on the role of hopelessness in leading a person to suicidal ideation and attempts and highlights the importance of addressing it directly from the very first encounter. Later Solution Focused Brief Therapy Association (2013) came up with a more systematic manual for working with individuals using SFBT. In the present study, the author has used insights from Hendon's book and SFBT manual in designing the sessions.

2. CASE SUMMARY

Kiran (not the real name), a 21-year-old Engineering third-year student approached the University Counseling Centre at the Central University of Karnataka, Kalaburagi (India). She came to the centre seeking help after a difficult break-up that affected

her academic performance, personal and social life. She is the second child of a middle-class family, staying in the hostel and goes back home (to a different city) during the holidays. The patient signed an informed consent before enrolling in the treatment. The initial interview and psychiatric evaluation revealed that she had no prior history of depression or other psychiatric conditions. The presenting complaints included depressed mood, suicidal ideas, difficulty in falling asleep, continuous thoughts regarding the broken relationship, feelings of guilt, and anger towards self which were temporally associated with the dissolution of a one-year-old dysfunctional relationship. Kiran felt personally responsible for the conflicts occurred with her partner which resulted in their break-up and believed that she would never be able to get into a relationship again, had trouble concentrating and diminished interest in activities that she used to enjoy earlier. The client was not willing to take medicines, and she preferred psychotherapy. After initial intake, the client was referred to a Psychiatrist as part of the institutional norms of risk assessments.

3. ASSESSMENTS

The client was assessed by an independent clinical psychologist on Beck Depression Inventory- II (BDI-II), Suicidal Ideation Scale (SIS) and Beck Hopelessness Scale (BHS).

3.1 The Beck Depression Inventory-II (BDI-II)

BDI – II (Beck, Steer & Brown, 1996) is a widely used self-report measure for symptoms of depression with 21 items. Each item yields a score ranging from 0 to 3 resulting in a total score ranging from 0 to 63, and a higher score indicates a higher level of depressive symptoms. It has high test-retest reliability ($r = 0.93$) and high internal consistency with Cronbach's $\alpha = 0.91$ (Beck, Steer & Ranieri, 1996).

3.2 The Suicidal Ideation Scale (SIS)

SIS is developed by Sisodia & Bhatnagar (2011), is self-report scale with 25 items and five response categories. The test-retest reliability of the scale is 0.78, and the consistency value is 0.81. The scale was validated against external criteria and the score obtained was 0.74. The total score may range from 25 to 125. A score between 25- 30 indicates a very low suicidal ideation, 31- 45 low suicidal ideation, 46- 105 average suicidal ideation, 106- 120 high suicidal ideation and 121-125 very high suicidal ideation.

3.3 The Beck's Hopelessness Scale (BHS)

BHS, developed by Aaron Beck (1988, 1993) consists of 20 items that measure three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. It has a reliability coefficient of 93 percent and a total coefficient ratio of 39 to 76 percent. The answers are in a true-false format, and higher scores on the inventory indicate higher probability of hopelessness. A score of 0-3 indicates none or minimal level of hopelessness, 4-8 indicate mild level, 9-14 indicate moderate level and a score of 15 and above indicate severe level, a definite suicide risk.

The scores obtained in the assessments (ref. Table 1) indicated mild depressive symptomatology, high suicidal ideation and a moderate level of hopelessness which correlated with the clinical picture. The client reported depressed mood, crying spells, guilt, feelings of anger towards self, suicidal ideas and inability to focus on studies.

4. INFORMED CONSENT AND CONFIDENTIALITY AGREEMENT

Kiran agreed upon working with SFBT model for six sessions with the therapist spread across 12 weeks. The client and the therapist signed an informed consent, and the client was detailed the confidentiality agreement. She also provided details of the local guardian in case of emergency.

5. THERAPIST

The therapist (first author) is a licensed clinical psychologist, and a trained professional in solution focused practices.

6. COURSE OF TREATMENT

The treatment followed the specifications of solution focused therapy treatment manual for working with individuals -2nd Version (Solution Focused Brief Therapy Association, 2013). The intervention was planned for six sessions spread across 12 weeks. The first two sessions were scheduled one week apart (week 1 & 2), and the following three sessions were spaced out at two weeks (week 4, 6 & 8) and the final session four weeks later (week 12). Each session lasted 60 minutes inclusive of 10 minutes session break.

The first session began with establishing a specific behavioural contract which was agreed upon and duly signed the therapist and the client addressing the suicidal behaviour and the emergency drill. Further, the client was educated about depression and psychotherapy in general, and solution focused approach in specific emphasising the importance of working with a goal, taking responsibility for change and eliciting her expectations about her best hopes from therapy.

In response to the miracle question, she responded like, "Ah.. First of all, I'll feel very fresh as I wake up and will not be bothered by those thoughts about him, or the guilty and depressive thoughts about the past. The day will start with a black coffee followed by about half an hour of yoga... I'll be on time for my classes and will be able to concentrate... I'll feel pleasant throughout, and no feelings of anger towards me nor crying spells. I may also spend time with my friends..."

Scaling questions and identifying exceptions were employed in narrowing down and establishing the goals and direction. Specific goals were formulated, and the client was complimented for coming up with the same. On a scale from 1 to 10, where 1 is the worst and 10 is the best, she thought that overall she was at 3 during the first session. Specific scaling question on self-harm elicited a score of 5.5 on a scale from 1 - 10, where 1 was the maximum, and 10 being no intention to harm.

In the second session Kiran reported an improvement of one point both in self-harm intention and overall functioning. Details were elicited on how she managed to keep up the change and what she did differently that contributed to this change in positive direction. Compliments were given, and specific efforts were amplified and appreciated.

Kiran appeared very disturbed as she came for the third session. For scaling questions, she reported similar scores of first session and intention to self-harm was at 4. The results of previous semester exams were out and she had failed in a subject. She reported that this setback precipitated the low scores in scaling questions. Further, the situation was reframed as the therapist focused on how she managed to stay at this

score and did not go further down and how this effort can be continued. Specific goals for coming two weeks were set and agreed upon.

The following sessions, the client, reported gradual improvements and during the fifth session, the client reported reaching the goals that were set during the first session. Therapist explored on how this achieved goals can be maintained. Further, the possible challenges that she might face were also discussed along with how she is planning to face them upon necessity. Therapist complimented for the efforts, changes and the confidence with which she is approaching the situation.

The sixth session, therapist reviewed the progress and evaluated the outcome. The client reported well subjectively on all dimensions in the scaling questions. The suicidal thoughts were no longer present; her mood was better, she was able to focus on the studies better and was involved with friends in many activities. Further, the client was referred to the team of Psychiatrist and Clinical Psychologist who assessed her earlier for post-treatment evaluation. She was also requested to take a follow-up assessment after three months.

6.1 Follow-up

Three months post-treatment, the client reported that she is doing well and was happy about her semester exam results. She spends time with her friends and had joined for an online part time work. The client was referred to the Psychiatrist and Clinical Psychologist for evaluation and it revealed significant improvement clinically as well as on the self-report measures. Scores obtained in the assessment are given in Table 1.

Table 1. Scores for the self-report measures administered at the intake, post-treatment and at 3 months follow-up.

Measures	At intake	Post- treatment	Follow-up
BDI - II	14	4	4
SIS	107	32	27
BHS	13	3	1

BDI- II – Beck Depression Inventory-II; SIS- Suicidal Ideation Scale; BHS: Beck’s Hopelessness Scale.

7. DISCUSSION

With the positive clinical outcomes post-treatment and sustained at 3-months follow-up, Ms. Kiran's case represents a successful example of SFBT beneficial in the treatment of mild depression at large and suicidal ideation in specific. However, since the personal characteristics and baseline level of functioning can contribute largely to the intervention and its success, Ms. Kiran's outcome may not generalise to all depressed and suicidal clients.

As revealed in the National Institute of Mental Health Treatment for Depression Collaborative Research Program (Zuroff & Blatt, 2006), early positive working alliance predicted better adjustment throughout the follow-up and development of enhanced adaptive capacities. Acceptance of the client's goals and letting him set the pace for the process played a crucial role in building the working alliance. The client responded well to the compliments given on the efforts and achievements and was pleased with her progress. The

present case alludes to the use of a solution-focused (as opposed to problem-focused) and future-oriented collaborative approach, with a focus on treatment goals, contributing to better engagement of clients.

Although this approach is promising, the importance of more specific operationalisation of the treatment and the need for a great deal more outcome and process data is recognised. The insights from the present study suggest that SFBT may be considered for further structured evaluation and research as a useful therapeutic approach, which can be applied to clients with suicidal ideation and also may be worthy of further investigation in more extensive trials. But even at this stage of development, clinicians in the field might usefully test the value of some aspects of SFBT in their treatments of individuals with suicidal ideation.

8. ACKNOWLEDGMENTS

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9. CONFLICT OF INTERESTS

None declared

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