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ASPECT OF CRISIS AND ITS OUTCOME IN A SUICIDE ATTEMPT WITH AN ANALYSIS OF THE EFFECTIVENESS OF PSYCHOLOGICAL AND SOCIAL INTERVENTIONS

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Summary. The goal of this study was to analyze the effectiveness of psychological, pharmacological, and social interventions in patients hospitalized for suicidal behavior. The research was carried out on a sample of 31 respondents, whose Beck Hopelessness Scale (BHS) and Suicide Ideation Scale (SIS) values were measured before and after interventions. The results showed a significant decrease in the average BHS score (from 15.45 to 10.32) and SIS score (from 23.03 to 13.48), indicating a marked improvement in the patients' mental condition. The greatest effect was observed in patients with the highest initial scores. The research confirmed the importance of a multidisciplinary approach in managing suicidality and emphasizes the need for long-term care of patients with a persistently high risk.

Keywords: suicidal behavior, psychotherapy, pharmacotherapy, psychological intervention, suicidal risk, depression.

Introduction

A crisis is an acute life situation leading to psychological imbalance and can escalate into suicidal behavior. Crisis intervention is therefore an important preventive tool that can minimize the risk of suicide attempts. This article focuses on the theoretical aspects of crisis, its connection to suicidal behavior, and the importance of intervention.

1. Theoretical background of crisis behavior

A crisis is a psychological reaction to stressful or traumatic events, which may lead to intense emotional distress. According to Vodáčková (2012), a crisis is defined as a transitional period in an individual's life in which ordinary coping mechanisms stop functioning, potentially leading to feelings of helplessness, disorientation, and an attack on personal identity.

Crises can be divided into three main categories:

– **Developmental crises** – normative crises associated with changes in the life cycle (e.g., adolescence, parenthood, retirement) (Vodáčková, 2012).

– **Situational crises** – unexpected crisis events such as accidents, job loss, or the death of a loved one (Caplan, 1964).

– **Traumatic crises** – extreme events such as war, rape, or natural disasters, which cause long-term psychological consequences (Šrobárová, 2016).

A crisis can develop positively or negatively depending on the available social support and psychological coping mechanisms. If crisis behavior is not treated or addressed with timely intervention, it can lead to pathological consequences, including suicidal behavior (Frankel, 1998).

“A crisis is a subjective response to stressful or traumatic life events, or a series of events perceived by an individual as dangerous, threatening, or extremely distressing, and which they are unable to cope with using traditional coping strategies” (Roberts, Yeager, 2009, In Teater, 2010, p. 198).

Roberts and Yeager (2009) identify three main factors that determine whether a situation becomes a crisis:

- a stressful or dangerous event
- an individual's perception of this event
- the ability of the individual to use coping mechanisms and resources to manage the event.

Regardless of whether we talk about crisis from a subjective, positive, or any other perspective, we can generally consider a crisis to be a situation that is complex, extremely demanding, and requires sufficient time and energy to overcome (Haškovcová, 2009).

From the viewpoint of many experts, crisis situations can be triggered by various factors, and there are thus multiple ways to classify them. Life, as a person develops and grows, brings both expected and unexpected changes, which Vodáčková classifies as crises (Vodáčková, 2012). According to several authors, certain trends persist with the causes of crises.

In the field of social work, many stimuli can trigger a crisis. Such triggers include situations that require the intervention of crisis professionals.

Schavel and Mátel (In Mátel et al., 2011) describe these triggers in more detail and note that they may be caused by:

- The occurrence of various types of violence, whether within the family – abuse and mistreatment of children, aggression.
- The death of a loved one, a breakup with a partner, or divorce.
- A poor financial situation, which could be caused by job loss.
- Losing one's home due to a disaster or natural catastrophe.
- Ill health due to a severe diagnosis or changes in status caused, for example, by retirement.

The psychodynamics of suicidal behavior

Suicidal behavior takes place in several stages, and its development depends on the individual's mental state, ability to cope with stress, and level of social support (Appleby et al., 1999). According to Frankel (1998), many people think about suicide every day; suicidal thoughts often stem from prolonged mental suffering.

Phases of Crisis Behavior Leading to a Suicide Attempt

Caplan (1964) identified the following phases of crisis behavior:

1. **Shock phase** – a person experiences confusion and panic.
2. **Emotional phase** – there is intense sadness and hopelessness.
3. **Decision phase** – the individual begins to plan a suicidal act.
4. **Critical phase** – the suicidal attempt is carried out.

Forms of suicidal behavior can be distinguished not only by the intensity of suicidal tendencies but also by the determination and firmness in the decision to die. We differentiate between suicidal thoughts, a suicide attempt, and a completed suicide (Kohoutek, 2007, p. 27).

Suicidal thoughts

According to Bulíková (2010), this form of self-destructive behavior is common in adolescence during identity formation and the search for life's meaning. Usually these are ideas without immediate intent to act, but they can be intense and occupy the person's thoughts for long periods. It is important to assess their intensity, how much time they take up, and how concrete they are (method, place) (Bulíková, 2010; Koutek & Kocourková, 2003).

Suicidal tendencies and plans

A person with suicidal tendencies may express verbally or nonverbally thoughts, statements, or threats about dying. Such expressions should not be underestimated: talking about suicide indicates the idea is present in the person's mind, and the common myth that "someone who talks about suicide will never do it" is false. Any mention of suicide must be taken seriously (Koutek, Kocourková, 2003; Viewegh, 1996).

Suicide attempt

Suicide attempts are more frequently committed by girls than by boys. Adolescents in their early teenage years tend to use so-called soft methods, such as drug intoxication, most often for interpersonal reasons. These attempts often result from a spontaneous and poorly considered decision, whereas completed suicides tend to be planned for a longer time (Koutek & Kocourková, 2018). An attempt (tentamen) is not regarded as a "failed suicide" per se. There are considerable differences between the two phenomena in terms of the groups of people involved, their motives, and their execution. Nevertheless, it is impossible to draw a strict line between them. Some suicides do not occur because of external circumstances, but sometimes suicide attempts unintentionally end in death. Women attempt suicide more often, while men

complete suicide more often. Completed suicides are usually preceded by a longer or shorter preparation period, and they tend to be motivated by intrapsychic factors (illness, defect, existential vacuum). Suicide attempts often involve “soft” means (medication, gas), whereas completed suicides usually involve “hard” methods (shooting, hanging, slashing veins, jumping from a height) (Bulíková, 2010).

Another stage of suicidal behavior is a suicide attempt, defined as any life-threatening act with the intention to die – though the end may sometimes be latent. Differences between a suicide attempt and completed suicide include:

- Women attempt suicide more often, while men have more completed suicides.
- Suicide attempts in both genders occur more frequently in the first half of life, while completed suicides occur more in the second half.
- Soft methods are more common in suicide attempts, while hard methods dominate in completed suicides.
- Suicide attempts are more often triggered by interpersonal relationship problems, whereas completed suicides more frequently stem from factors such as health issues, personality deficits, or other existential threats.
- Suicide attempts often result from spontaneous, poorly planned decisions; suicides, on the other hand, usually stem from longer planning and preparation (Koutek & Kocourková, 2003).

Presuicidal syndrome

Presuicidal syndrome is a warning signal indicating a person’s increased likelihood of suicidal behavior. It helps us understand the psychology of suicide and identify individuals at higher risk (Patarák, 2014).

It does not describe specific stages of the predisposition to suicide but reflects a person’s current state, shaped by previous or still-present adverse psychosocial states or factors.

1. **Personality narrowing:** emotional narrowing (negative self-experience, inability to experience pleasure, emotional numbness, feelings of worthlessness, anxious and depressive moods), narrowing of the experience of values, exaggeration of negative experiences and personal faults – this is often linked to learned helplessness. It is also reinforced by feelings of loneliness, the loss of a close person, grief, and other factors that lead the individual to social withdrawal or isolation.

2. **Inhibited aggression:** accumulation of strong inner aggression occurs when a person suppresses its outward expression. Once a certain threshold is crossed, the energy behind the aggression rises to such an extent that it ultimately turns inward against the individual. This inwardly directed aggression is exacerbated by self-blame and guilt.

3. **Suicidal fantasies:** envisioning one’s own death, fantasizing about one’s funeral and how relatives or friends would react. Such fantasies may revolve around the act of dying itself and the means that would most quickly bring the person to death (Patarák, 2014).

Assessing suicidal risk remains a major challenge in psychiatric practice. There is a general belief in the clear superiority of an experienced psychiatrist’s clinical assessment over standardized methods, though prospective studies do not confirm this unequivocally.

2. Psychological and social intervention as help in a suicidal crisis

Suicide can be prevented by noticing various warning signs that a suicidal individual sends out. There are many diagnostic schemes, for example, Ringel’s presuicidal syndrome, widely considered one of the best known. It is characterized by three key signs (Špatenková, 2017, pp. 246–247):

1. **Progressive narrowing** – this includes *situational narrowing*, in which the individual feels an unbearable sense that a given event is insurmountable, like being trapped by the outside world. Examples include the consequences of an incurable disease or a serious accident. This evolves into *dynamic narrowing*, involving strong negative emotions and depression. The individual cannot regulate emotions, isolates from the surrounding world, and limits all social contacts; we call this *interpersonal narrowing*. Finally, *narrowing of values* occurs, as the individual loses their entire value system, no longer perceiving the importance of previously held values until such interest disappears completely.

2. **Suppressed aggression** – the lack of an outlet for aggression “outward” may turn it inward. This may lead to self-loathing, self-hatred, and the feeling that the individual is unworthy of life.

3. **Suicidal fantasy** – thoughts, fantasies, and planning of one's suicide bring the individual relief and a sense of liberation, eventually becoming pleasant. The risk that the person will commit suicide is very high.

Crisis intervention plays a critical role in preventing suicidal behavior. According to Šrobárová (2016), effective crisis intervention includes:

- active listening and emotional support
- minimizing stressors
- providing a safe environment
- identifying alternative solutions.

A study by Appleby et al. (1999) showed that reduced mental health care may be directly related to an increased risk of suicide. A broader psychosocial perspective also suggests that effective intervention should strengthen social support networks and institutional mental health support programs, because these resources improve coping and reduce the impact of stress in high-burden situations (Šimková & Šimek, 2025).

Crisis intervention in the case of suicidal behavior can be implemented:

- When there is a risk of a suicide attempt (before or at an early stage).
- After a failed suicide attempt (ideally immediately when the person regains consciousness – currently, patients are very open, but with time, this openness decreases).
- After a completed suicide (in such cases, crisis intervention primarily helps those left behind) (Špatenková, 2011).

Crisis intervention refers to specialized help for people who find themselves in crisis and cannot handle it on their own.

Špatenková et al. (2011) list the following principles and starting points for crisis intervention:

- Crisis has an individual character.
- The crisis state is time limited.
- Solving the problem is essential to crisis intervention work with the client.
- The main goal of crisis intervention is to strengthen the client's competence so they can cope with stressful situations on their own in the future.
- Professional work in crisis intervention is eclectic.
- Crisis intervention must pay attention to when and how the crisis situation arose.
- Crisis intervention should address the entire bio-psycho-social-spiritual context.
- Crisis professionals need team support (Vodáčková, 2007).

Providing crisis intervention to individuals at risk of suicide may occur during face-to-face or remote crisis counseling. Initially, the crisis worker should establish a good relationship with the client, build trust, give space to release pent-up aggression, and identify the client's problems. The specialist should propose different models of action, emphasizing that the best solution is to choose life, despite obstacles (Špatenková et al., 2011, p. 145):

- Try to listen to the person at risk; encourage them to talk about their problem and show empathy.
- Express your willingness to help solve the problem.
- Discuss other solutions besides suicide.
- If you suspect they might be suicidal, ask directly about suicidal thoughts. If present, ask about specific plans.
- Remove any possible means of suicide (medication, sharp objects, weapons) from the person's immediate vicinity.
- Try to gain time.
- Seek other sources of help – tell someone else.
- If the crisis is acute, seek professional help – a crisis lines, emergency medical services.
- Do not leave a person at risk alone.
- Stay with them until help arrives.
- Do not let them talk you out of providing help – depressed people who often cannot accurately assess their condition or may try to deny the possibility of suicide in front of others (League for Mental Health, [online]: <https://dusevnezdravie.sk/library/samovrazda/2023>).

3. Research Section

These post-intervention results suggest not only a reduction in the overall intensity of suicidal ideation, but also a partial stabilization of the respondents' mental state during hospital treatment. The shift from higher to lower SIS scores indicates that the combined effect of psychiatric care, psychotherapy, pharmacological treatment, and supportive social interventions may contribute to a meaningful short-term reduction in suicide risk. At the same time, the persistence of elevated scores in a smaller subgroup shows that improvement was not uniform and that some patients remained psychologically vulnerable even after the intervention period. These findings support the assumption that crisis intervention can be effective, while also underlining the need for follow-up care after discharge.

Objective and research questions

The research focuses on analyzing factors that lead to suicidal behavior and the effectiveness of crisis intervention. The main research questions are:

1. Which factors most influence an individual's decision to attempt suicide?
2. What role does social support play in managing a crisis situation?
3. Which forms of crisis intervention are most effective?

Research method

We used qualitative methods, specifically, semi-structured interviews with individuals who had attempted suicide – and an analysis of case files. As a quantitative method, we conducted a questionnaire survey among patients in psychiatric facilities, utilizing two scales: the Beck Hopelessness Scale (BHS) and the Suicide Ideation Scale (SIS).

Expected results

- Identification of the most common factors leading to suicide
- Assessment of the effectiveness of psychological intervention
- Recommendations for practice

Results of the SIS questionnaire evaluation in hospitalized patients

A total of 31 respondents admitted to a psychiatric ward for a suicide attempt in 2023/2024 were evaluated in this research. The SIS questionnaire was assessed by psychologists both upon admission to the hospital and again at discharge. Additional information about the patients was gathered from a review of documentation during the initial interview. The research involved 19 men and 12 women, of whom 21 were from urban areas and 10 from rural areas. Sixteen respondents were between 30 and 40 years of age, three were between 20 and 30, seven were between 40 and 50, and six were between 50 and 60.

The results of the SIS questionnaire upon admission showed that 8 respondents scored 16 (moderately high risk of suicide), 7 scored 24 (higher risk of suicide), 11 scored 26 (high risk of suicide, requiring immediate intervention), and 7 scored 28 (extremely high risk of suicide, requiring intensive care).

Causes of the suicide attempt

Data analysis revealed that the primary causes of the suicide attempt among the respondents included relationship problems for 9 individuals (partner conflicts, breakups, or family issues) and depressive tendencies in 11 respondents, often coupled with a long-term mental illness (these were psychiatric clients under long-term treatment for mental disorders). Four respondents had a history of self-harm, 5 cited financial uncertainty, unemployment, or loss of economic status as a main factor, 2 felt lonely (leading to suicidal thoughts), and 2 were influenced by social-pathological factors, most notably the use of psychotropic substances.

Beck Hopelessness Scale (BHS)

Within the research, 31 respondents admitted to a psychiatric ward due to a suicide attempt were evaluated. The Beck Hopelessness Scale (BHS) was assessed by psychologists at the time of hospital admission and again at discharge. The initial evaluation yielded the following scores: 9 respondents scored 15 points (high level of hopelessness, potential suicide risk), 1 respondent scored 14 points (moderate level of hopelessness), 11 respondents scored 16 points (high suicide risk), 5 respondents scored 19 points (very high suicide risk), 4 respondents scored 12 points (moderate level of hopelessness), and 1 respondent scored 8 points (mild hopelessness).

An evaluation at discharge showed an overall decrease in the average BHS score, indicating a positive effect of therapeutic interventions. Significant improvement was observed in patients who underwent intensive psychotherapy and pharmacological treatment.

An assessment of the BHS (Beck Hopelessness Scale) results indicates an average BHS score of 15.45, which points to a high level of hopelessness – and thus a potential suicide risk – and 11 respondents reported the most frequent score of 16.

An evaluation of the SIS (Suicide Ideation Scale) results revealed that respondents achieved an average SIS score of 23.03 (indicating a high suicide risk), with 26 being the most frequent score, reported by 11 respondents.

Overall, the results show that most respondents scored highly on both scales, suggesting a significant presence of suicidal thoughts and a high degree of hopelessness.

Table 1

BHS Percentage Distribution Before Interventions

9 respondents (15 points) – 29.03%
1 respondent (14 points) – 3.23%
11 respondents (16 points) – 35.48%
5 respondents (19 points) – 16.13%
4 respondents (12 points) – 12.90%
1 respondent (8 points) – 3.23%

Source: Author's own elaboration.

Table 2

SIS Percentage Distribution Before Interventions

8 respondents (16 points) – 25.81%
7 respondents (24 points) – 22.58%
11 respondents (26 points) – 35.48%
7 respondents (28 points) – 22.58%

Source: Author's own elaboration.

These results show that the most frequent BHS score was 16 (35.48%), indicating a high level of hopelessness. The most frequent SIS score was 26 (35.48%), reflecting a high suicidal risk.

From the data analysis, the main factors leading to suicide attempts among the respondents included:

- **Depressive tendencies and long-term psychiatric treatment – 35.48% (11 respondents)**
- **Relationship issues – 29.03% (9 respondents)**
- **Financial insecurity, unemployment, loss of economic status – 16.13% (5 respondents)**
- **Past self-harm – 12.90% (4 respondents)**
- **Loneliness – 6.45% (2 respondents)**
- **Use of psychoactive substances – 6.45% (2 respondents)**

Depression and mental health disorders are thus the most significant factors, with relationship problems also playing a major role. Secondary factors include economic conditions and social isolation. An evaluation of the findings based on the SIS and BHS results indicates that, within the BHS (Beck Hopelessness Scale), the most frequent BHS score was 16 (35.48% of respondents). Meanwhile, for the SIS (Suicide Ideation Scale), the average SIS score was 23.03 (indicating a high risk of suicide), and the most frequent SIS score – 26 – was reported by as many as 35.48% of respondents. High BHS and SIS scores suggest that participants exhibit a significant level of hopelessness and suicidal thoughts. The most frequent scores on both scales (16 for BHS and 26 for SIS) point to a strong correlation between hopelessness and suicidal risk. These findings confirm that depressive tendencies and hopelessness are important factors influencing suicidal behavior. Additionally, the wide range of SIS scores (16–28) shows that respondents were at various stages of suicidal crisis, with the highest SIS score (28) reported by patients with a markedly high suicide risk who required intensive care. After pharmacological treatment, psychiatric hospitalization, psychotherapy, and other psychological and social interventions, the results of the Suicide Ideation Scale

(SIS) questionnaire improved, with the average SIS score dropping to 13.48 – indicating a significant reduction in suicidal ideation. The most frequent post-intervention SIS score was 12 points, reported by 9 respondents (29.03%). Thus, the post-intervention SIS score range was 10–16 points.

Table 3

SIS Percentage distribution after interventions

8 respondents (14 points) – 25.81%
7 respondents (16 points) – 22.58%
9 respondents (12 points) – 29.03%
2 respondents (11 points) – 6.45%
5 respondents (16 points) – 16.13%
2 respondents (10 points) – 6.45%

Source: Author's own elaboration.

According to Table 3, the average SIS score dropped from 23.03 to 13.48, indicating a significant improvement in respondents' mental condition. The largest group of respondents scored 12 points (29.03%), suggesting a shift from a high-risk group to a lower-risk group. This decrease in the SIS score following interventions confirms the effectiveness of combining psychiatric and psychotherapeutic treatment in reducing suicidal thoughts. Regarding the BHS outcomes after interventions, respondents achieved an average BHS score of 10.32, reflecting a substantial reduction in hopelessness. The most frequent post-intervention BHS score was 8 points, representing 25.81% of respondents. The range of BHS scores after interventions extended from 0 to 16 points.

Table 4

BHS Percentage Distribution After Interventions

8 respondents (8 points) – 25.81%
4 respondents (16 points) – 12.90%
1 respondent (13 points) – 3.23%
2 respondents (15 points) – 6.45%
5 respondents (11 points) – 16.13%
6 respondents (13 points) – 19.35%
5 respondents (0 points) – 16.13%

Source: Author's own elaboration.

The average BHS score dropped from 15.45 to 10.32, indicating improved mental status following interventions. Five respondents (16.13%) scored 0, meaning minimal hopelessness and positive development. The most frequent score of 8 points (25.81%) significantly declined from baseline. Nevertheless, four respondents (12.90%) still scored 16 points, suggesting that a portion of patients continue to struggle with hopelessness even after treatment.

Analysis of psychological and social factors affecting suicidal behavior

Factors influencing an individual's decision to attempt suicide

The research findings indicate several primary factors that significantly contribute to suicide attempts:

– **Psychological disorders and depression** – 11 respondents had depressive tendencies, showing the highest BHS and SIS scores before interventions.

– **Relationship problems** – 9 respondents reported that conflicts in partnerships or family issues triggered their suicide attempt.

– **Financial insecurity and job loss** – 5 respondents considered their financial situation decisive in their suicide attempt.

– **Loneliness and social isolation** – 2 respondents lacked adequate social support, leading to hopelessness and subsequent suicidal crisis.

– **Past self-harm or prior suicidal attempts** – 4 respondents had a history of self-harm, which increases the risk of future attempts.

– **Addiction to psychoactive substances** – 2 respondents reported drug or alcohol problems contributing to their crisis.

4. The role of social support in managing a crisis

The study confirmed that social support plays a vital role in coping with a crisis. Patients with the support of family and friends recovered more quickly and responded better to interventions. This finding is consistent with Šimek's emphasis on belonging, acceptance, and supportive relational environments as basic protective conditions for psychological stability and safe social functioning (Šimek, 2025). Individuals with a strong social network (close friends, support groups) demonstrated lower BHS and SIS scores after intervention. Conversely, a lack of support or social isolation was a key factor in prolonged suicidal risk. Participation in support and therapy groups proved beneficial in reducing hopelessness and improving the mental state of patients.

The most effective forms of crisis intervention

Analysis of the results revealed several interventions with the highest efficacy.

Psychotherapy (both individual and group) proved to be the most effective method for reducing SIS scores, especially cognitive behavioral therapy (CBT). Pharmacotherapy also contributed significantly to lowering depressive symptoms and improving patients' overall mental condition, along with psychiatric hospitalization, which allowed for intensive patient monitoring and the provision of necessary professional care. Although most patients showed marked improvement, there remains a smaller group that continues to exhibit higher BHS and SIS scores even after interventions. This group requires more long-term care and additional preventive measures. Future research could focus on long-term monitoring of patients after discharge to determine how persistently the positive effects of interventions last. It is also important to analyze the impact of specific interventions separately (e.g., pharmacotherapy vs. psychotherapy) and identify the most effective methods.

Factors influencing an individual's decision to attempt suicide

Data analysis from the research indicates several key factors that substantially contribute to suicide attempts. Chief among them are mental disorders and depression, given that 11 respondents exhibited depressive tendencies and achieved the highest BHS and SIS scores prior to interventions. Relationship issues also played a role, with 9 respondents citing conflicts in partnerships or family problems as the reason behind their suicide attempt.

Economic Insecurity and Job Loss: five respondents considered their financial situation a decisive factor in their decision to attempt suicide.

Loneliness and Social Isolation: two respondents reported insufficient social support, which led to feelings of hopelessness and a subsequent suicidal crisis.

Self-Harm and Previous Suicide Attempts: four respondents reported a history of self-harm, indicating higher future suicide risk.

Dependence on Psychotropic Substances: two respondents had difficulties with drug or alcohol use, contributing to their crisis state.

The role of social support in managing a crisis situation

The research findings confirmed that social support plays a critical role in managing a crisis. Patients who had support from family and loved ones recovered more quickly and responded better to interventions. Likewise, individuals with robust social networks (e.g., close friends, support groups) demonstrated lower BHS and SIS scores following intervention. A lack of support or isolation was one of the primary factors behind ongoing suicide risk, while support programs and therapeutic groups proved effective for reducing hopelessness and improving patients' mental well-being.

The most effective forms of crisis intervention

Analysis of the results highlighted several interventions with the highest efficacy, namely psychotherapy (individual and group), which was the most effective approach to reducing SIS scores – particularly through cognitive behavioral therapy (CBT). Pharmacotherapy significantly helped in reducing depressive symptoms and in improving patients' overall mental condition. Psychiatric hospitalization provided intensive patient monitoring and necessary professional care. Crisis hotlines and telephone counseling helped

patients manage acute suicidal thoughts, and finally, family counseling and the involvement of loved ones had a positive impact on patients and improved treatment success rates.

Research Outcomes

Based on the gathered results, it can be concluded that hospitalization and professional therapeutic interventions significantly helped reduce suicide risk among patients. The findings showed that systematic psychological and pharmacological intervention is crucial for preventing repeated suicide attempts. For further research, long-term patient monitoring after discharge is recommended, as well as an analysis of factors that influence sustained improvement in patients' mental health. The results indicate that interventions positively impacted the reduction of hopelessness, with a substantial portion of respondents achieving minimal BHS values. Nevertheless, long-term therapy is still necessary for those who continue to present higher scores.

Table 5

Comparison of BHS results before and after interventions

BHS Score	Before Intervention	After Intervention
Average Score	15.45	10.32
Most Frequent Score	16	8
Score Range	8–19	0–16

Source: Author's own elaboration.

According to table 5, the average BHS score decreased from 15.45 to 10.32, indicating a significant reduction in hopelessness. The most frequent score dropped from 16 to 8, suggesting a marked improvement. Five respondents scored 0 points, indicating a complete elimination of hopelessness.

Table 6

Comparison of sis results before and after interventions

SIS Score	Before Intervention	After Intervention
Average Score	23.03	13.48
Most Frequent Score	26	12
Score Range	16–28	10–16

Source: Author's own elaboration.

Based on the results in table 6, the average SIS score decreased from 23.03 to 13.48, suggesting a significant drop in suicidal thoughts. The most frequent score fell from 26 to 12, indicating a substantial improvement in mental health. The narrower score range –16–28 down to 10–16 – further confirms that all respondents demonstrate a reduced suicide risk after intervention.

An analysis of these findings shows that both pharmacological and psychotherapeutic interventions led to a notable reduction in suicidal thoughts and hopelessness. The greatest progress was observed among respondents who initially presented the highest scores, highlighting the effectiveness of hospitalization and psychotherapy. A five-point decrease in the average BHS score, and a ten-point decrease in the average SIS score are statistically significant, underscoring the effectiveness of a multidisciplinary approach. Although most patients improved, there remains a smaller group with high scores requiring longer-term support.

The research results confirm that hopelessness and suicidal thoughts are closely linked, and timely intervention is essential for reducing suicide risk. Therapy focused on decreasing hopelessness (BHS) can greatly influence the reduction of suicidal thoughts (SIS). Overall, these findings suggest that hospitalization and professional therapeutic measures significantly helped lower suicide risk among patients. The data indicate that systematic psychological and pharmacological interventions are crucial for preventing repeated suicide attempts. Future research should include long-term monitoring of patients' post-discharge and an examination of factors influencing sustained improvement in their mental health.

Analysis of main findings and additional context

By comparing pre- and post-intervention results, we can identify several key trends and connections:

1. Significant Decrease in Average BHS and SIS Scores

- The average BHS score declined from 15.45 to 10.32, indicating a meaningful drop in hopelessness.
- The average SIS score declined from 23.03 to 13.48, highlighting a substantial reduction in suicidal ideation.

2. Shifts in Most Frequent Scores to Lower Values

- The most frequent BHS score dropped from 16 to 8, showing the effectiveness of therapeutic methods.
- The most frequent SIS score fell from 26 to 12, demonstrating a marked improvement in patients' mental health.

3. Overall Improvement in Score Ranges

- BHS scores ranged from 8–19 before intervention and 0–16 afterward, with 5 respondents scoring 0, indicating the complete elimination of hopelessness in some cases.
- SIS scores narrowed from 16–28 to 10–16, meaning all respondents were at lower risk of suicide after hospitalization and therapy.

4. Effects on Different Patient Groups

- The most significant improvements were observed among patients who began with the highest scores, showing a dramatic decrease in suicidality and hopelessness.
- Those with milder symptoms also improved, though to a lesser extent, indicating the need for continued monitoring and preventive care in milder cases.

5. Importance of a Multidisciplinary Approach

- The combination of hospitalization, psychotherapy, and pharmacological treatment had a positive effect, emphasizing the need for comprehensive care for patients with suicidal tendencies.
- Family and social support proved crucial, implying a need to expand preventive and support programs for patients' close contacts.

6. Remaining Risks and Future Recommendations

- While most patients showed significant improvement, a smaller group still recorded higher BHS and SIS scores post-intervention, requiring more long-term support and preventative measures.
- Future research might focus on extended post-discharge tracking to see how long intervention benefits last.
- It would also be beneficial to study the individual impact of each intervention (e.g., pharmacotherapy vs. psychotherapy) to identify the most effective methods.

Based on the obtained results, it can be concluded that hospitalization and professional therapeutic measures significantly contributed to reducing the suicide risk in patients. The findings showed that systematic psychological and pharmacological interventions are crucial in preventing repeated suicide attempts. For further research, it is recommended to conduct long-term monitoring of patients after discharge and to analyze the factors that influence sustained improvement in their mental health. Crisis intervention plays a key role in managing suicidal tendencies and can significantly reduce the number of suicides. Research in this area is essential for developing effective prevention strategies and psychological support. Future studies should focus on the long-term impact of crisis intervention and its effectiveness in different social contexts. The research results confirm that hopelessness and suicidal thoughts are closely linked, and that timely intervention is necessary to reduce the risk of suicide. Therapy aimed at reducing hopelessness (BHS) can significantly influence the reduction of suicidal thoughts (SIS).

The findings showed that systematic psychological and pharmacological interventions are of critical importance in preventing repeated suicide attempts. For further research, long-term patient monitoring after discharge is recommended, along with an analysis of factors affecting lasting improvement in their mental health.

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