AMERICAN PSYCHOLOGICAL ASSOCIATION

Professional Psychology: Research and Practice

ISSN: 0735-7028

2022, Vol. 53, No. 1, 33–41
https://doi.org/10.1037/pro0000427

Why Does Safety Planning Prevent Suicidal Behavior?

Megan L. Rogers[1], Anna R. Gai[2], Amy Lieberman[2], Katherine Musacchio Schafer[2], and Thomas E. Joiner[2]
[1] Icahn School of Medicine, Mount Sinai Beth Israel
[2] Department of Psychology, Florida State University

Safety planning interventions have demonstrated efficacy in reducing suicidal ideation, suicide attempts, and death by suicide. Less is known, however, about potential mechanisms underlying the effectiveness of safety plans. The present manuscript provides an overview of the steps involved in safety planning, reviews literature demonstrating its efficacy, and proposes seven potential factors that may explain why safety planning works: providing distraction, increasing connection, promoting autonomy, building competence, reducing engagement in impulsive urges, hindering engagement in suicidal behavior, and reducing cognitive load. By improving our understanding of why safety planning is effective, future work may be able to enhance, or augment, safety planning to further increase its efficacy and, ultimately, to save lives.

Public Significance Statement
This manuscript provides an overview of two safety planning interventions—Crisis Response Planning and Safety Planning Intervention—and proposes seven potential reasons why these interventions may be effective in managing suicidal thoughts and urges and preventing suicidal behavior.

Keywords: safety plan, suicide, distraction, connection, autonomy

Suicide is a leading cause of death within the United States, with over 47,000 deaths attributable to suicide in 2019 (Centers for Disease Control and Prevention, 2020). Given the magnitude of this public health concern, accurate and efficacious suicide risk assessment and intervention are crucial. Empirically supported interventions for suicidal thoughts and behaviors exist, most notably Dialectical Behavioral Therapy (DBT; Linehan, 1993) and the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006); however, these treatments typically involve repeated and relatively longer term care with a mental health provider and are not necessarily implemented optimally (DeCou et al., 2019).[1] The efficacy of these interventions is limited in emergency departments and other acute care settings in which suicidal individuals often present to care, however. Although most suicidal individuals who present in these settings are subsequently referred to follow-up outpatient providers (Allen et al., 2002), a notable proportion of patients with suicidal thoughts or intentions refuse or do not attend outpatient treatment (Granboulan et al., 2001; Krulee & Hales, 1988), attend only 1 week

[1] It is worth noting that CAMS can be modified for use in acute settings as a brief single-session intervention that includes an initial assessment of relevant risk factors, warning signs, reasons for living and dying, and the nature of suicidal ideation and behaviors through the Suicide Status Form, as well as provision of resources, identification of "drivers" of one's wish to die, and safety planning (Jobes, 2006; Jobes et al., 2018). However, to our knowledge, this single-session adaptation has not yet been empirically examined (Swift et al., 2021).

This article was published Online First October 21, 2021.
Megan L. Rogers https://orcid.org/0000-0002-4969-7035
Anna R. Gai https://orcid.org/0000-0001-9329-1641
Amy Lieberman https://orcid.org/0000-0002-0255-3181

Megan L. Rogers received her PhD in clinical psychology from Florida State University and is a current postdoctoral fellow at Mount Sinai Beth Israel. Her primary area of professional interest includes transdiagnostic short-term risk factors for suicidal thoughts and behaviors.

Anna R. Gai received her M.S. in clinical psychology from the Florida State University. She is currently a doctoral candidate in the clinical psychology PhD program at Florida State University. Her area of professional interest is the understanding and prevention of suicidal behaviors, particularly within special populations, such as first responders and military service members and their families.

Amy Lieberman received her BS at Northwestern University with a double-major in Psychology and Human Development. She is currently a clinical psychology PhD student at Florida State University in the Laboratory for the Study and Prevention of Suicide-Related Conditions and Behaviors. Her specific areas of interest surround suicidality in psychosis populations.

Katherine Musacchio Schafer received her M.S. in clinical psychology from the Florida State University. She also received her M.Ed. from Vanderbilt University. Her areas of professional interest include the identification and treatment of risk factors of suicide-related outcomes.

Thomas E. Joiner received his Ph.D. in clinical psychology from the University of Texas at Austin, and is The Robert O. Lawton Distinguished Professor of Psychology at Florida State University. Area of professional interest is the understanding and prevention of suicidal behavior.

This work was supported in part by the Military Suicide Research Consortium (MSRC), an effort supported by the Office of the Assistant Secretary of Defense for Health Affairs under Award Nos. (W81XWH-16-20003). Opinions, interpretations, conclusions and recommendations are those of the authors and are not necessarily endorsed by the MSRC or the Department of Defense.

Correspondence concerning this article should be addressed to Megan L. Rogers, Icahn School of Medicine, Mount Sinai Beth Israel, 1-9 Nathan D Perlman Pl, New York, NY 10003, United States. Email: megan.l.rogers4@gmail.com

of treatment postdischarge from the emergency department (Granboulan et al., 2001; O'Brien et al., 1987), or terminate treatment within 3 months (Monti et al., 2003). Thus, the development and implementation of brief psychosocial interventions in acute care settings may improve patient outcomes and save lives. The importance of brief interventions in these acute settings is further underscored by the substantially elevated rates of suicide posthospital discharge (Chung et al., 2017), though these rates can be attenuated somewhat by postdischarge follow-up contacts (Luxton et al., 2013).

In response to the need for brief psychosocial interventions that may aid patients in managing acute periods of arousal and suicidal thoughts and urges (i.e., crises) without engaging in harmful or maladaptive behaviors, two comparable brief interventions were developed and validated: crisis response planning (CRP; Rudd et al., 2004) and safety planning intervention (SPI; Stanley & Brown, 2012). Each of these interventions involves the creation of a safety plan: written individualized steps for patients to follow during moments of intense emotional distress and/or suicidal crises, when these skills might otherwise be challenging to cognitively access. Both CRP and SPI focus first on self-management strategies (e.g., distracting activities), followed by external sources of intervention (e.g., contacting family/friends for support, outreach to health care providers, accessing crisis services); however, SPI provides an additional emphasis on means safety counseling to further reduce risk of suicidal actions. Designated as a recommended standard for health care systems by the National Action Alliance for Suicide Prevention (2018), CRP/SPI is brief (completed in 20–45 min), can be used across healthcare settings and populations, and is based on the collaborative creation of a safety plan, following a thorough suicide risk assessment.

The purpose of this manuscript is to highlight potential mechanisms underlying safety planning and explore reasons why safety plans are efficacious in reducing the incidence of suicide-related outcomes. We first provide an overview of the steps associated with safety planning and review research examining the efficacy of both CRP and SPI. We then propose and elaborate on potential mechanisms that underlie the utility of safety planning in improving patient outcomes and reducing the severity of suicidal crises and engagement in suicidal behaviors. Finally, we briefly highlight several specific areas in need of further consideration, including the generalizability of safety planning across diverse individuals, the integration and individualization of safety planning across settings and patients, and existing limitations and recommendations for the clinical implementation of, and research on, safety planning. Ultimately, through emphasizing safety planning's potential mechanisms of action, we strive to spur future empirical research to better understand the efficacy of safety planning, with the goal of augmenting these interventions and improving on the benefits that they already provide, thereby reducing the prevalence of suicidal thoughts and behaviors.

Steps Associated With Safety Planning

Safety plans consist of six primary components: (1) recognition of warning signs; (2) use of internal coping strategies; (3) utilizing social contacts as distractions and/or for support in managing the crisis; (4) connecting with mental health professionals or agencies; (5) identifying reasons for living, as noted specifically in CRP; and (6) means safety planning, as noted specifically in SPI. These components are included as part of a comprehensive plan in both CRP and SPI:

1. *Recognition of Warning Signs*: Clinicians and patients first collaboratively identify patient-specific warning signs that typically precede a suicidal crisis. These signs include but are not limited to thoughts (e.g., "I can't deal with this anymore"), images (e.g., scenes of humiliation), physiological sensations (e.g., increased heart rate), affects/moods (e.g., feeling depressed/hopeless), behaviors (e.g., fidgeting, avoidance/withdrawal), and situations that may signal an impending crisis, which if attended to, may signal to a patient times at which the safety plan should be deployed.

2. *Internal Coping Strategies*: To foster a sense of autonomy and mastery, patients are encouraged to first engage in self-directed coping strategies to address emotional distress and suicide-related thoughts and urges. Such strategies function as a form of distraction that prevent urges and suicidal thoughts from escalating; typically, several (i.e., 4–5) strategies are identified across a variety of domains, including activities that (a) require attention and/or are distracting (e.g., doing chores, completing a puzzle, reading); (b) involve physical activity (e.g., going on a walk or run, playing a sport, playing with a pet); (c) are soothing, calming, and/or sensation-based (e.g., taking a hot or cold shower, listening to calming music, laying under a soft blanket); and/or (d) have worked in the past. Patients are encouraged to repeat these internal coping strategies should intense urges persist. Importantly, patients should be supported in identifying specific and personalized internal coping strategies to increase the likelihood of engagement with the safety plan and further underscore patients' autonomy and sense of mastery.

3. *Social Contacts for Distraction, Support, and/or Assistance in Resolving Crises*: Should internal coping strategies be ineffective in managing one's distress, patients are encouraged to engage in socialization strategies. Such strategies may include socializing (including social activities) with friends or family members and/or visiting healthy social settings (e.g., settings in which socialization occurs naturally, such as a coffee shop, park, or place of worship). Socialization is intended to first serve as a distraction, without explicitly focusing on or revealing one's problems, distress, or suicidal thoughts, and a mechanism for increasing connection and a sense of belongingness with other individuals. Importantly, distraction is intended to be time-limited, active, and intentional, rather than promoting avoidance of distressing thoughts, emotions, and situations. However, either in addition to or including individuals identified for distraction/support more broadly, patients are encouraged to identify individuals with whom they can explicitly discuss their emotions and experiences, and ask for support and assistance in coping with the crisis. In collaboration with clinicians, patients should weigh pros and cons, as well as the likelihood of actually contacting and disclosing to certain individuals, when selecting individuals for this step.

4. Professional and Agency Contacts: Patients are instructed to list the names and phone numbers of professional assistance who they could contact, which may include ongoing treating clinicians, local- and/or national-based agencies, and/or emergency services, should acute distress or suicidal crises continue.

In conjunction with these four steps in developing a safety plan that are consistent across both CRP and SPI, there are unique components emphasized by each safety planning method. Specifically, CRP includes identification of individualized reasons for living (i.e., things that provide a sense of purpose or meaning in life, or that are reasons to not kill oneself; Linehan et al., 1983). Evidence suggests that identifying reasons for living may protect against suicidal ideation and attempts (see Bakhiyi et al., 2016, for systematic review); however, these associations are not always found in longitudinal samples (Brüdern et al., 2018) and may be dependent on a number of contextual factors, such as psychiatric diagnosis, personality features, coping abilities, and social support (Bakhiyi et al., 2016). Within CRP, patients are explicitly instructed to write down reasons for living and keep a physical copy of them on their person. On the other hand, the SPI also incorporates a discussion on means safety, which can be held either before or immediately after the identification of each safety plan step described above. Risk for suicide is magnified when patients report a specific plan for suicide that involves readily accessible and potentially lethal means (Joiner et al., 2003). Means safety interventions limit access to or decrease the lethality of means for suicide (Barber & Miller, 2014; Khazem et al., 2017), with the ultimate goal of mitigating risk of harm to patients. Although total removal of methods is preferred, discussions may include strategies for limiting access or making access to means more difficult (e.g., storing kitchen knives at the top of high cabinets instead of on the counter, using gun locks and storing ammunition separately from firearms, giving medications to a close other for storage). In essence, means safety strategies are devoted to creating physical and psychological (i.e., cognitive accessibility and psychological attachment to specific means for suicide; see Rogers et al., 2019) distance between an at-risk individual and potential suicide methods to reduce the likelihood of these items being used for suicidal behaviors. Overall, although CRP and SPI have minor differences, the primary steps and goals remain consistent.

Research examining CRP and SPI suggest that both interventions are efficacious in managing suicidal crises. For instance, in a randomized clinical trial, active duty military personnel who collaboratively created a CRP were 76% less likely to make a suicide attempt during the follow-up period than service members who received treatment as usual (Bryan et al., 2017). Furthermore, the inclusion of reasons for living in CRP, specifically, was associated with increases in positive emotions and quicker reductions in suicidal ideation (Bryan, Mintz, et al., 2018; Rozek et al., 2019), though the inclusion of reasons for living did not incrementally protect against suicide attempts within a 6-month follow-up (Bryan et al., 2017). Likewise, in examination of the SPI, patients presenting to an emergency department who created a safety plan had 45% fewer instances of suicidal behaviors over a 6-month follow-up and more than double the odds of attending at least one outpatient mental health treatment session than patients who did not receive SPI (Stanley et al., 2018). However, no study has explicitly examined the incremental utility of incorporating means safety planning within SPI.

Patient satisfaction regarding the creation and use of CRP/SPIs is also high. In one study, patients found CRP to be highly useful, over 80% of patients retained their written CRP up to 6 months later, and those who completed a CRP were more likely to recall self-management strategies and sources of social support (Bryan, May, et al., 2018). Similarly, both patients and staff members view SPI as acceptable and helpful in increasing safety, preventing suicidal behavior, and increasing treatment engagement (Chesin et al., 2017; Stanley et al., 2016). Overall, there is no direct empirical comparison of these two methods to date, precluding determinations of the superiority of one method over the other.

Beyond the empirical evidence underlying the efficacy of safety planning in managing suicidal crises, there are several additional strengths, including its brevity, relative ease of clinician training and implementation across settings, and ability to serve as a standalone intervention in cases in which follow-up treatment may not be provided, available, or accessed. Further, given the need to proceed with care in the face of current and potential epidemics and pandemics by employing physical distancing during sessions, safety planning is attractive in that it can easily be delivered via telehealth. As we alluded to previously, however, less is known about the potential mechanisms underlying the utility of safety planning. In the remainder of this manuscript, we highlight and elaborate on several avenues through which we speculate safety planning may improve patient outcomes, reduce the severity of suicidal crises, and decrease engagement in suicidal behaviors. These mechanisms include providing distraction, increasing connection, fostering autonomy, building competence, reducing engagement in impulsive urges, creating additional barriers to engaging in suicidal behavior, and reducing patients' cognitive load.

Proposed Mechanisms for Safety Planning

Based on a literature review of articles summarizing the tenets of safety planning and its empirical evidence (e.g., Bryan et al., 2017; Stanley et al., 2018), as well as our own clinical experiences and consensus/discussion, we propose seven candidate mechanisms that we believe may be foundational to the efficacy of safety planning. We emphasize, however, that this list is preliminary and not intended to be exhaustive; additional mechanisms may emerge through future research, and some of these proposed mechanisms may not be supported through subsequent empirical work. Indeed, a primary aim of this manuscript is to describe the rationale behind each proposed mechanism to encourage and spur future qualitative and quantitative work that directly identify and empirically examine these mechanisms.

Providing Distraction

Two of six steps in safety planning are devoted entirely to distraction from emotional urges and suicidal thoughts (i.e., engaging in internal coping strategies and reaching out to social contacts for distraction and support). Accordingly, the developers of both CRP and SPI implicitly highlighted the relative importance of distraction as a mechanism involved in maintaining patient safety. These steps specifically instructed patients—whether on their own or with the help of loved ones—to involve themselves mindfully in

internal and/or external activities designed to distract from crises. Humans experience finite cognitive resources (Franconeri et al., 2013; Norman & Bobrow, 1975), and as demands on these resources increase, cognitive performance decreases. As such, and consistent with capacity theory (Kahneman, 1973), which proposes that using one's capacity of cognitive resources for one activity limits attention and information-processing for other stimuli, the goal of distraction is for patients to allocate the lion's share of cognitive resources to other thoughts and behaviors at the exclusion of one's distress and/or suicidal ideation. Following this diversion of cognitive resources, the likelihood that patients will perseverate on, seek out, or use lethal means to engage in suicidal behaviors is thought to diminish. Importantly, evidence suggests that the efficacy of distraction relates to a multitude of factors, including qualities of the distractor, qualities of the crisis, and individual differences (Johnson, 2005), further underscoring the necessity of personalizing coping strategies and distractors to individual patients and situations.

Notwithstanding the benefits of distraction strategies, there are some potentially worrisome drawbacks of using distraction to manage emotional and suicidal crises. Although helpful in managing short-term situations, distraction—which is intended to be active, time-limited, and intentional—often leads to cognitive and/or behavioral avoidance. Avoidance constitutes a major maintaining factor in symptoms of psychopathology (e.g., social anxiety; Hofmann, 2007) and precludes problem-solving strategies if done in excess. Further, both thought and emotional suppression have been positively associated with suicidal ideation and attempts (Kaplow et al., 2014; Najmi et al., 2007; Pettit et al., 2009), likely in part due to a tendency for suppressed thoughts and emotions to have a "rebound effect" and resurge with more intense preoccupation than was initially experienced (Wegner et al., 1987). Likewise, past research has indicated that individuals who combine distraction with avoidance tend to have poorer well-being than individuals who combine distraction with acceptance (Wolgast & Lundh, 2017). Thus, tailoring distraction strategies in an intentional manner to ensure that activities are time-limited, foster acceptance, and lead to other skills use to address specific situations and cognitions may ultimately further increase the efficacy of distraction within safety planning.

Increasing Connection

A thwarted sense of social belonging, or connection, is proposed to underlie suicidal thoughts and behaviors (Chu et al., 2017; Van Orden et al., 2010). Humans have a fundamental need to belong (Baumeister & Leary, 1995) that, when left unfilled, leads to a multitude of negative health outcomes, including increased mortality by all causes, including suicide (Holt-Lunstad et al., 2015). Research supports the role of connection in reducing suicide risk. For instance, receiving non-demanding, caring letters or text messages from others—including healthcare workers or researchers—has been associated with reductions in suicidal ideation, suicide attempts, and death by suicide (Comtois et al., 2019; Luxton et al., 2013; Motto & Bostrom, 2001). Improved social connectedness with peers, family, and the community has also been linked to decreases in suicidal ideation and behavior across the lifespan (Czyz et al., 2012; Fässberg et al., 2012). Two of six steps in safety planning are explicitly dedicated to building connections with friends, family members, and/or acquaintances, either by distracting with social activities (Step 3) or discussing the contents of one's emotional state and soliciting assistance (Step 4). Consistent with research indicating that momentary perceptions of social support negatively covaries with suicidal ideation over time (Coppersmith et al., 2019), safety planning likely buffers against suicidal actions through increasing individuals' connections with others and engagement in meaningful activities and/or discussions. Among patients who are physically isolated, have limited or no social supports, and/or who are unwilling to reach out to others due to fears of being a burden, encouraging any alternate activity that may serve to increase connectedness may be beneficial. Such activities could include posting or commenting on an online forum related to a topic of interest, or volunteering and contributing to society, nature, and the world (e.g., at an animal shelter, picking up trash around the community). Finally, connecting with mental health professionals and agencies (Step 5) may also foster an increased sense of connection with the world, as evidenced by studies on Caring Contacts (Motto & Bostrom, 2001).

Fostering Autonomy

Another potential primary mechanism underlying the efficacy of safety planning is the promotion of autonomy, in which patients independently feel empowered to keep themselves safe from lethal means and reduce their distress. Importantly, autonomy is encouraged both during the creation of the safety plan and during its implementation in times of crisis. From the outset, creating a safety plan allows patients to play a central role in their treatment. Generally, mental health professionals hold considerable power to decide what options patients have, and intentional or unintentional biases may adversely impact opportunities for patients' voices and preferences to be heard and accounted for (Pelto-Piri et al., 2013). The power imbalance that subsequently often arises when patients are expected to comply with clinicians' professional recommendations without providing input may strip patients of their autonomy and right to contribute to decisions pertaining to their health. On the other hand, shared decision-making, mutual respect, and cooperation—in essence, core features of the collaborative development of a safety plan (Bryan, Mintz, et al., 2018; Rudd et al., 2004; Stanley & Brown, 2012)—promote self-determination and successful mental health treatment (Pelto-Piri et al., 2013), highlighting the essential nature of patient autonomy in mental healthcare settings (Katsakou & Priebe, 2007). Thus, the creation of a safety plan may reinstill a sense of independence by allowing patients the opportunity to actively participate in decision-making, promoting a sense of value and capability, and empowering patients to recognize both their worth and their strengths.

Moreover, following the development of a safety plan, patients have total autonomy in choosing if, when, and how to follow the outlined steps. This approach encourages the use of alternative coping strategies rather than potentially lethal means, allowing patients to begin to view treatment largely in terms of their own, relatively unintimidating, coping mechanisms. For instance, if patients are able to begin thinking of treatment as including activities like reading, walking in the park, completing crafting projects, or speaking with a trusted friend or family member, patients may be more open to engaging in these strategies before a crisis occurs. Similarly, as it pertains to the means safety counseling section of a safety plan recommended by Stanley and Brown (2012), patients

have autonomy in deciding how to engage in safe storage practices for potential means. For instance, although the goal of means safety counseling is to encourage the complete removal of access to means, either permanently or temporarily, discussions around safer storage practices, ultimately dependent on the patient's autonomy, can be conducted with flexibility. Furthermore, if patients are able to understand the goals of safety planning as generating strategies as they relate to distraction, coping, interpersonal support, and crisis intervention, then they have the autonomy to create new safety plans if the original plan becomes outdated. Indeed, many clinicians view safety plans as "living documents" that are updated as patients' circumstances (e.g., interpersonal relationships) change over time. Finally, theories of suicide have spoken to the role of autonomy in suicidal patients. For example, the interpersonal theory of suicide (Chu et al., 2017) hypothesizes that the perception of being a burden on one's friends and family—likely experienced when individuals lack autonomy—leads to the development of suicidal ideation. In essence, perceived burdensomeness is an antithesis of contribution, and contributing to others and the world involves both self-efficacy and autonomy. It is possible then, that as safety plans foster a sense of autonomy in patients, their feelings of being a burden on loved ones are reduced, thus quelling thoughts of suicide.

Building Competence

Similar to the notion of autonomy, safety planning introduces patients to a meaningful sense of competence, which may account, in part, for the efficacy of the intervention. By encouraging patients to identify strategies that work best for them, safety planning equips individuals with the skills needed to cope productively and independently, thereby increasing engagement, emphasizing their own abilities, and ultimately, building mastery (Linehan, 1993). Increasing confidence through perceptions of mastery and competence may motivate suicidal individuals to continue to engage in self-care through difficult times. For example, should an individual choose to dispose of pharmacological drugs that could be used for lethal means in exchange for purchasing puzzles, books, and candles used for self-soothing and distraction, they intentionally, actively, and quite pragmatically take control of their own life. When accompanied by perceptions of autonomy, patients who feel capable and competent in their ability to stay safe may feel increasingly motivated via an elevated sense of responsibility to themselves. Moreover, intrinsic motivation is increased by positive verbal feedback (Deci et al., 1999); thus, clinicians who overtly support patients' treatment-related behaviors, particularly interaction with one's safety plan, may provide exactly the type of encouragement patients need to feel confident in their ability to follow the safety plan.

Reducing Engagement in Impulsive Urges

Extant research suggests that suicidal ideation fluctuates substantially over the course of hours to days (Kleiman et al., 2017), that suicidal crises tend to be relatively brief in nature (Rogers et al., 2017), and that the progression from suicidal ideations to actions can be, in some circumstances, rapid (i.e., 86.5% of proximal planning steps taking place within 1 week of a suicide attempt, 66.6% within 12 hr of a suicide attempt; Millner et al., 2017). Another potential mechanism underlying the efficacy of safety planning is its utility in delaying and forestalling suicidal (or other maladaptive) actions while a crisis abates. The steps in a safety plan are designed to take several hours to complete, in part due to the number of steps and activities involved. Although the nature of "impulsive" suicide attempts is contested in the literature (Anestis et al., 2014; May & Klonsky, 2016), one possibility is that the amount of time that elapses while completing the steps on a safety plan is effective in reducing patients' suicidal intent and, thereby, suicidal behaviors.

Increasing Difficulty of Suicidal Behavior

Suicide is a daunting, fearsome, and challenging act, in which individuals must overcome biological instincts for survival (Van Orden et al., 2010). Anything that further hinders engagement in suicidal behavior—on top of how difficult it already is—is beneficial in mitigating suicide risk. In addition to delaying suicidal behavior, the means safety counseling component that is unique to SPI may be efficacious through its ability to increase both physical (Barber & Miller, 2014) and psychological (e.g., cognitive accessibility, fixation; Rogers et al., 2019) distance to potential suicide means. Indeed, capability for suicide is theorized as necessary for the engagement in lethal or near lethal suicide attempts (Klonsky & May, 2015; Van Orden et al., 2010). One facet of capability is practical capability, which references the concrete factors that make a suicide attempt easier (e.g., familiarity with means and their use, as well as access to means). In terms of safety planning, the means safety counseling component targets practical capability directly. As a standalone intervention, means safety, also referred to as means restriction (Stanley et al., 2017), has accumulated empirical evidence in reducing rates of self-injury and suicide (Jin et al., 2016; Yip et al., 2012). Within a safety plan, means safety counseling is another aspect of a comprehensive approach to managing suicide risk, in this case by making suicidal actions more challenging to enact.

Beyond means safety counseling, safety plans may further increase the difficulty associated with suicidal behavior by increasing one's ambivalence toward suicide. Evidence suggests that the majority of individuals with suicidal ideation experience an internal struggle between the wish to live and the wish to die (Kovacs & Beck, 1977), that these states fluctuate substantially over time (Bryan et al., 2016), and that changes in the relative balance of wish to live and wish to die are associated with different trajectories of suicide risk (Goods et al., 2020). Using a safety plan to engage in activities that foster connection, competence, and enjoyment may tip the balance toward a wish to live.

Managing Cognitive Load

Cognitive load is characterized by the amount of working memory resources being utilized (Sweller, 1988); high cognitive loads have been linked to impairments in problem-solving and task performance (Haji et al., 2015; Sweller, 1988). Individuals with suicidal thoughts and urges have a tendency to ruminate on their experiences (Rogers & Joiner, 2017), characterized by a tendency to repetitively and passively perseverate on the causes and consequences of one's distress (Nolen-Hoeksema et al., 2008). These tendencies involve an impaired ability to disengage from negative emotional and cognitive content (Grafton et al., 2016), and in the context of suicidal ideations, may result in an attentional fixation ("tunnel vision") that consists of an overwhelmingly high cognitive

load and a perceived inability to disengage from a suicidal crisis (Shneidman, 1993; Wenzel & Beck, 2008), ultimately leading to a higher likelihood of engaging in suicidal behavior (Cha et al., 2010; Rogers & Joiner, 2018). Following explicitly written steps in a safety plan may facilitate disengagement from suicide-specific attentional fixations or ruminations by both serving as a readily available, written source of information and by interrupting stuck cognitive processes with other activities. In this sense, reducing one's cognitive load is also accomplished through several of the other mechanisms described in this paper: providing distraction, increasing connection, and promoting autonomy (i.e., by providing patients with a sense of control when distressing and suicidal thoughts are often perceived as uncontrollable; Gorday et al., 2018; Nock et al., 2018).

Specific Considerations

We wish to highlight that there are several unknown factors regarding the efficacy of safety planning and these seven proposed mechanisms, including their applicability and generalizability to diverse patients, diagnoses, and treatment settings. All suicidal patients are not the same with regard to prior experiences, presenting problems, and clinical needs, nor should they be treated as identical. Nearly all studies of the CRP/SPI to date have been conducted in either active duty service members (e.g., Bryan et al., 2017), veterans in VA-affiliated medical centers (e.g., Stanley et al., 2016), or emergency departments (e.g., Stanley et al., 2018); much less is known about the comparative efficacy of safety planning in civilians or others of varying sociodemographic characteristics. For instance, how might safety plans need to be tailored across the lifespan (in children vs. adolescents vs. adults vs. older adults); across cultural groups (e.g., individualistic vs. collectivistic cultures); or across racial/ethnic groups (with accumulating evidence pointing to the urgent need to address racial tensions and traumas among people of color; Walker, 2020)? Similarly, mechanisms and implementation of safety planning among those with significant chronic illness or who have other health/mobility concerns (e.g., older adults residing in nursing homes; Reiss & Tishler, 2008), who may have decreased autonomy and increased perceptions of being a burden (Rogers et al., 2021), may vary. Nevertheless, no empirical data exist yet regarding the efficacy and acceptability of safety planning across diverse groups of individuals, highlighting an imperative need for future research in this area.

Additionally, as highlighted by Stanley and Brown (2012), the implementation of safety planning—while proposed to be a useful intervention across settings—will likely vary across patient populations and treatment settings. Patients with emotion dysregulation and impulsivity (e.g., those with borderline personality disorder) may need different emphasis on certain components of the safety plan than those who are withdrawn and avoidant (e.g., those with anxiety disorders). Adaptations are also likely needed for acute (e.g., emergency department) settings versus outpatient clinics, in which safety planning could be augmented through its integration with other interventions (e.g., DBT, CAMS) or modified across sessions. It is plausible that safety planning is more effective in certain settings or when administered in a certain way, though this possibility has yet to be empirically tested. For instance, although teletherapy has demonstrated equivalency to in-person therapy consistently across studies (Carlbring et al., 2018; Novella et al., 2020), there may be differences and unique challenges associated with safety planning via teletherapy. In particular, a printed copy of the identified plan cannot be immediately provided to patients when sessions are conducted virtually; in such cases, using screen-sharing and whiteboard technologies on online platforms that allow the patient and therapist to jointly complete the safety plan and subsequently take a photo on their phones may be one way to overcome this limitation.

Further, we caution that clinicians should not rely on safety planning as a standalone intervention whenever possible. Indeed, it is not our goal to propose that safety planning is superior to established interventions (e.g., cognitive-behavioral therapy, DBT, CAMS) in mitigating suicide risk; rather, it is one brief, empirically-supported, intervention that has numerous avenues through which it may be effective. Other mechanisms may account for decreases in suicidal thoughts and behaviors across other suicide-specific interventions (e.g., problem-solving orientation in CAMS; Jobes, 2006); as such, exploring alternative mechanisms beyond those presented here may also be warranted. Moreover, some patients may be hesitant to create and/or use the safety plan due to current symptoms and psychopathology (e.g., high levels of hopelessness). Engaging in motivational interviewing techniques (Rubak et al., 2005) to identify and mobilize patients' intrinsic values and goals may be essential when patients are unwilling to engage in safety planning to manage such ambivalence. Likewise, some patients may be willing to create a safety plan but are unable to identify specific, personalized strategies to include. Among these individuals, providing several concrete example steps may aid in developing initial options for strategies. However, should patients be unable to identify strategies for particular steps of the safety plan (e.g., internal coping strategies, lacking social contacts or supports), these may be indicated targets for longer term treatment and follow-up, when possible.

Lastly, societal and contextual factors likely play a role in the efficacy and need to tailor safety planning to meet patient needs. Whereas some individuals may have supportive families and communities, in which seeking social support and increasing connection is more readily achievable, this is not always the case. In situations in which nearby connections are unsupportive or unhelpful (e.g., dismissive or critical family members, rural areas without LGBTQ+ supports; c.f., The Trevor Project, 2021), clinicians and patients may need to rely on other forms of support (e.g., online-based communities) or address other potential mechanisms underlying the effectiveness of safety planning (e.g., distraction, autonomy) instead. In contrast, when patients have numerous close and trusted relationships, these connections may be able to be strategically utilized within a safety plan to further increase perceived connectedness. Altogether, future research on safety planning needs to take a multitude of diverse individual, interpersonal, societal, and contextual factors to better optimize safety planning alongside identifying relevant mechanisms.

Conclusions

Overall, the efficacy of safety planning in reducing suicidal thoughts and behaviors has been established empirically. This manuscript provides a discussion of seven potential mechanisms underlying the efficacy of CRP and SPI in mitigating suicidal crises, with the hope of empirically examining, enhancing, and further

developing these interventions. However, it is important to note that the vast majority, if not all, of these potential mechanisms have not been tested empirically. We encourage researchers to examine the roles of distraction, connection, autonomy, competence, delaying actions, hindering engagement in suicidal behavior, and reducing cognitive load in managing suicidal urges and, in turn, reducing the incidence of suicidal behavior among patients who have created safety plans. Should certain factors (e.g., distraction, autonomy) play a relatively larger role than others in explaining the efficacy of safety planning, these factors can then be emphasized and utilized in augmentations of safety planning to further improve its efficacy. A greater understanding of the reasons why safety planning can be effective may help improve the intervention further and, subsequently, save lives.

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Received October 28, 2020
Revision received June 29, 2021
Accepted July 27, 2021 ■