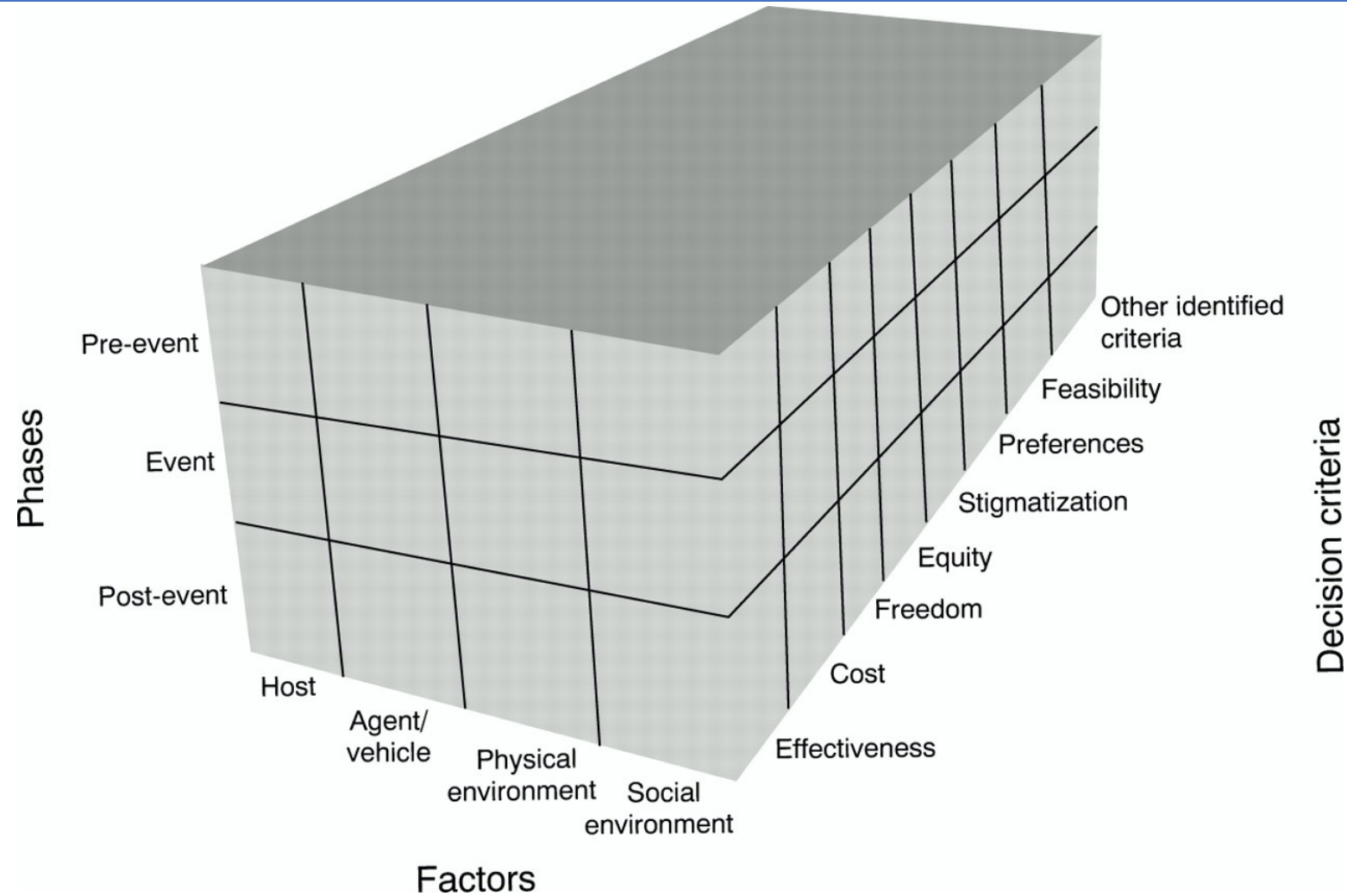


What Makes Suicide Crisis Coping Plans Effective? Science and Expert Opinion

Stephen O'Connor, PhD

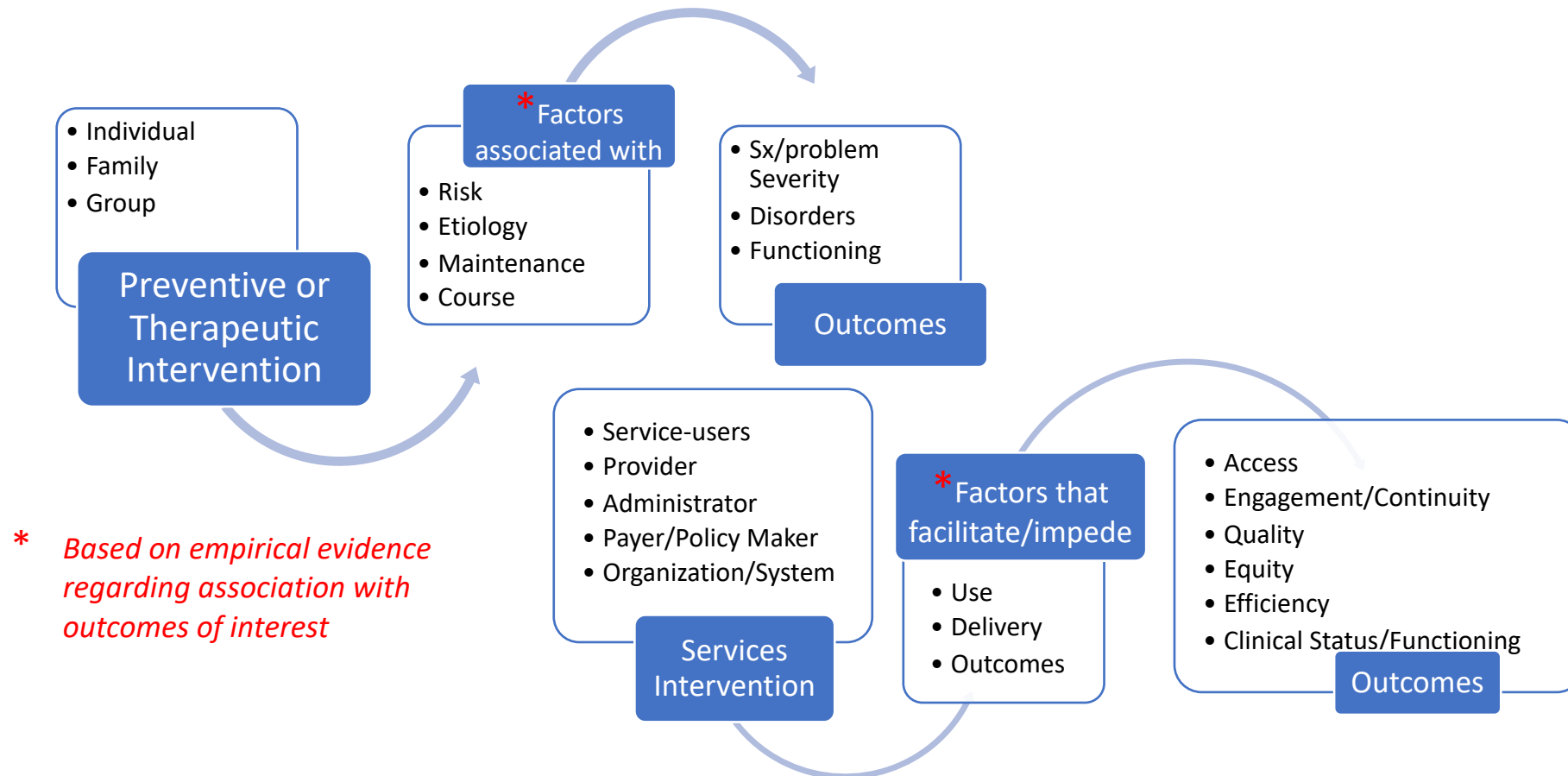
Three dimensional Haddon matrix



Consider What to Target with a Brief Intervention

Experimental Therapeutics....

So what constitutes a viable target?



Regarding Conceptual Models of Risk

- What targets are involved in risk reduction?
- Environmental alterations?
- Skills acquisition?
- Attachment to a provider?
- Adapted cognitions?
- Generating hope/acceptance/insight?
- Increasing desire to live/attachment to reasons for living?
- Improving readiness/willingness to engage in inpatient and/or outpatient treatment?
- Must the intervention be linked to a cueing event?
- How important is the context in which the intervention is delivered in relation to a positive outcome for the patient?
 - setting, timing, service delivery, care provider

The Ultimate Goal

- How do we find the “sweet spot” where we are:
 - Matching patient preferences
 - Maximizing the population impact of our interventions
 - Providing the appropriate “dose” that will lead to significant improvements
 - Introducing new approaches that can be scaled up rapidly and maintained
 - Delivering an intervention that maps onto the key aspects of a conceptual model



What Makes Suicide Crisis Coping Plans Effective? Science and Expert Opinion

Barbara Stanley, Ph.D.
Professor of Medical Psychology
Department of Psychiatry
Columbia University

Director
Suicide Prevention Training, Implementation and
Evaluation Program
Center for Practice Innovations
New York State Psychiatric Institute

Safety Planning Intervention

Stanley & Brown

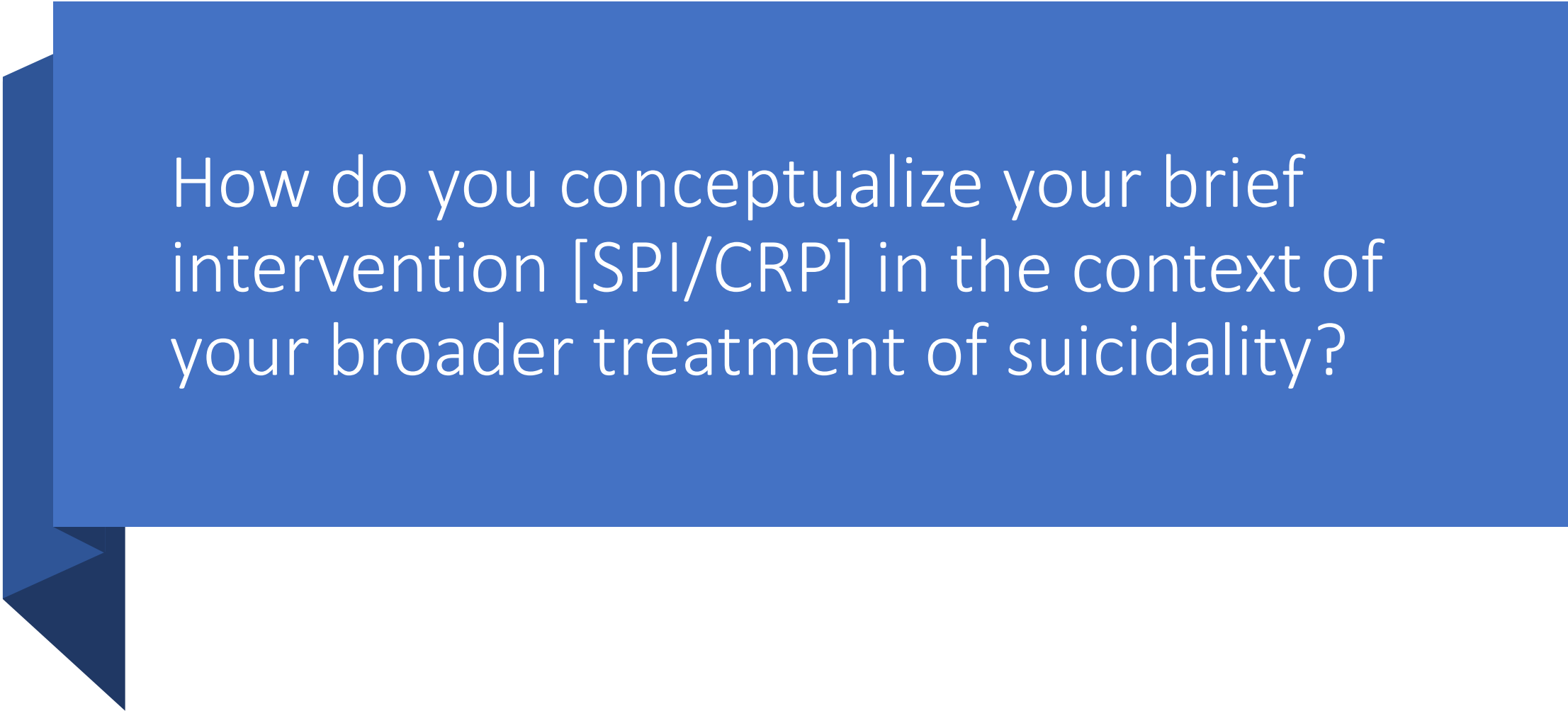
- Safety plan = emergency plan
- Acute risk exacerbation = emergency
- Prioritized written list of:
 - *warning signs*
 - *coping strategies*
 - *resources to use during a suicidal crisis*
- Relies heavily on distraction tactics

SAFETY PLAN	
Step 1: Warning signs:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Place _____
4.	Place _____
Step 4: People whom I can ask for help:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Name _____ Phone _____
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4.	Local Emergency Service _____ Emergency Services Address _____ Emergency Services Phone _____
Making the environment safe:	
1.	_____
2.	_____
Reproduced with permission (© 2013 Stanley & Brown). www.suicidesafetyplan.com	
Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. <i>Cognitive and Behavioral Practice</i> , 19, 256-284	



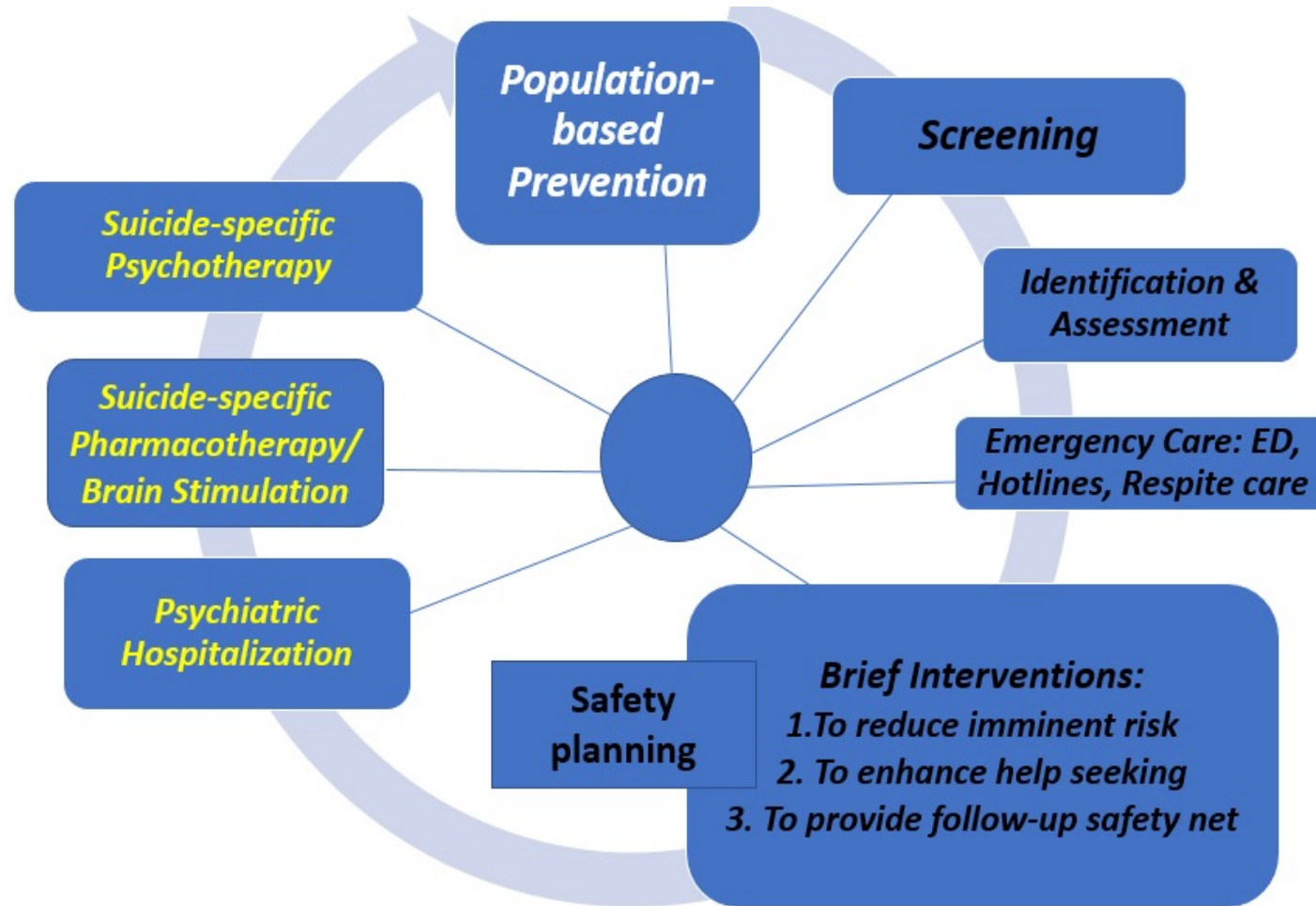
Plane Safety Card

We all need to know what to do in an emergency



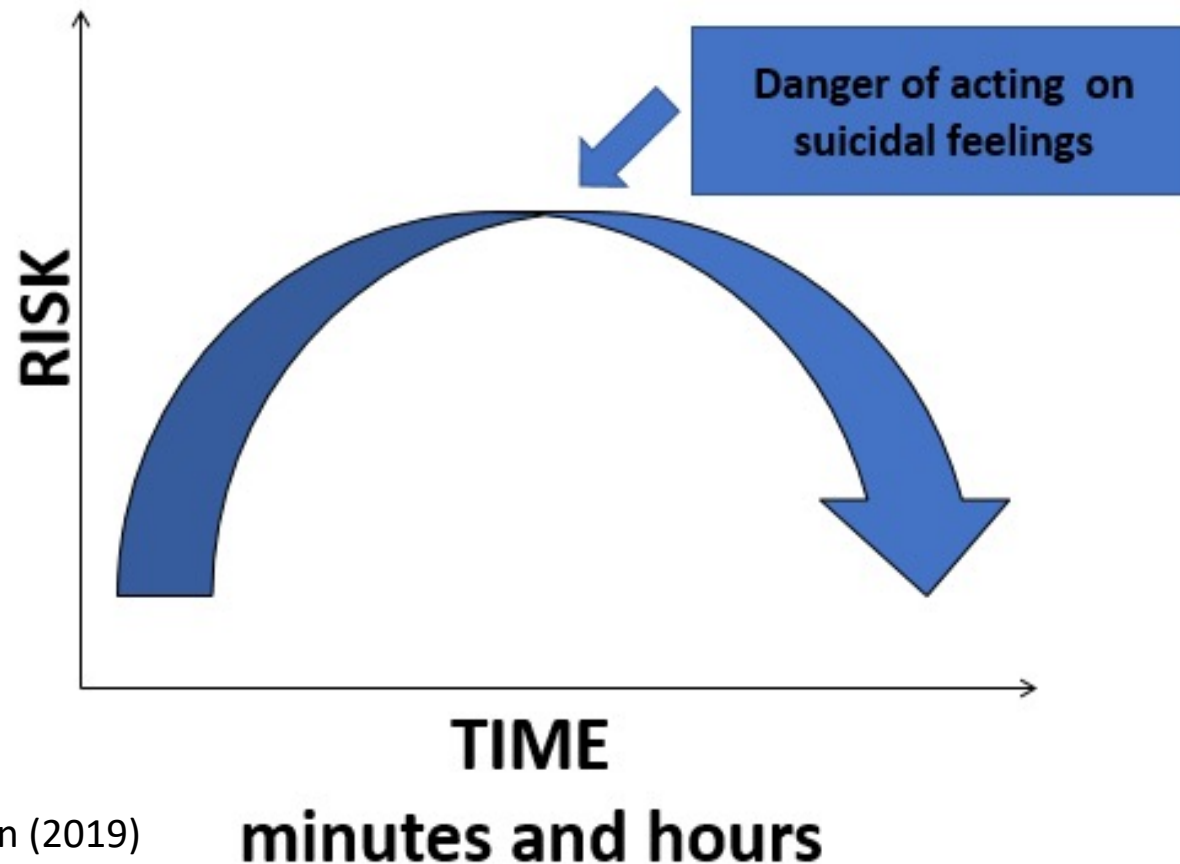
How do you conceptualize your brief intervention [SPI/CRP] in the context of your broader treatment of suicidality?

Suicide Prevention Components



Acute Suicide Risk Fluctuates Over Time:

Treatments: Brief Crisis Interventions, Fast-acting Medications, Emergency Care



Elevated, More *Chronic* Suicide Risk

e.g. Depression, SUD, PTSD, Hopelessness,
Persistent Stressors:

**Treatment: Disorder-specific and Suicide-specific
Psychotherapy, Medication**



Suicide Risk Components

Chronic

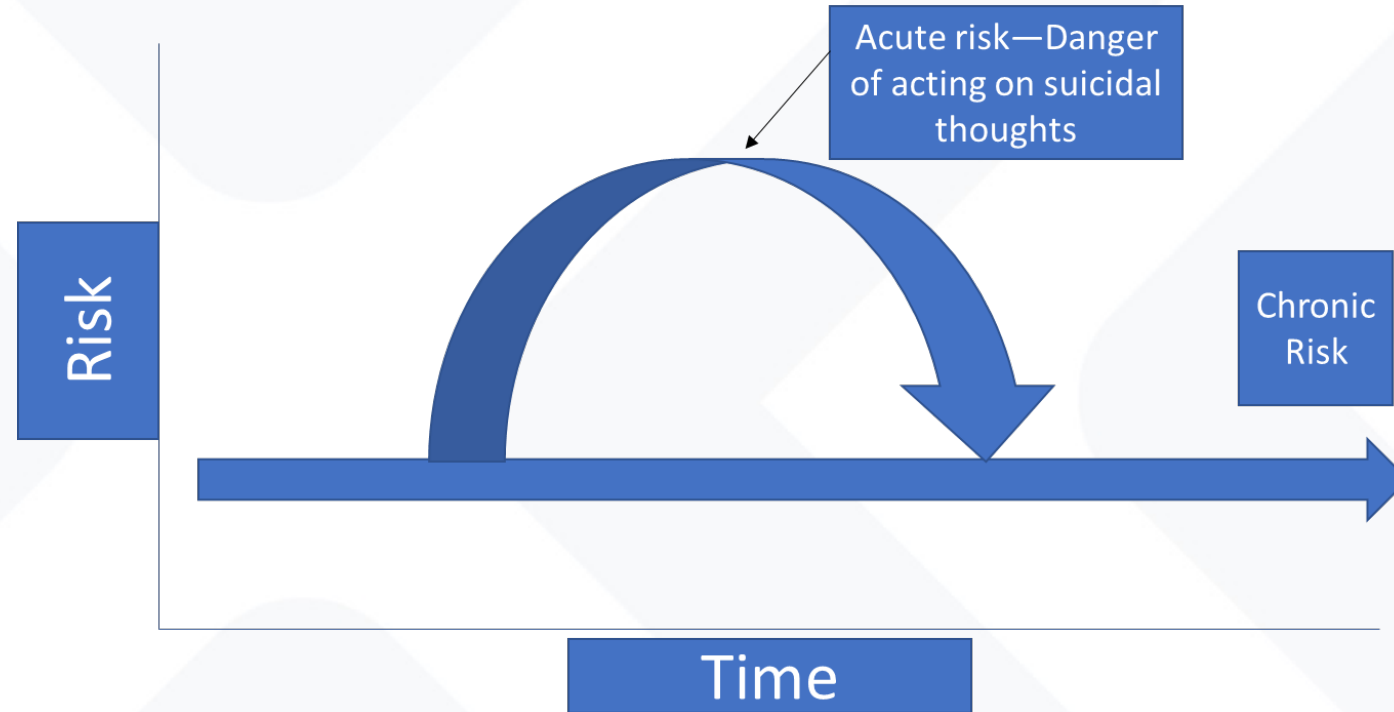
Examples:

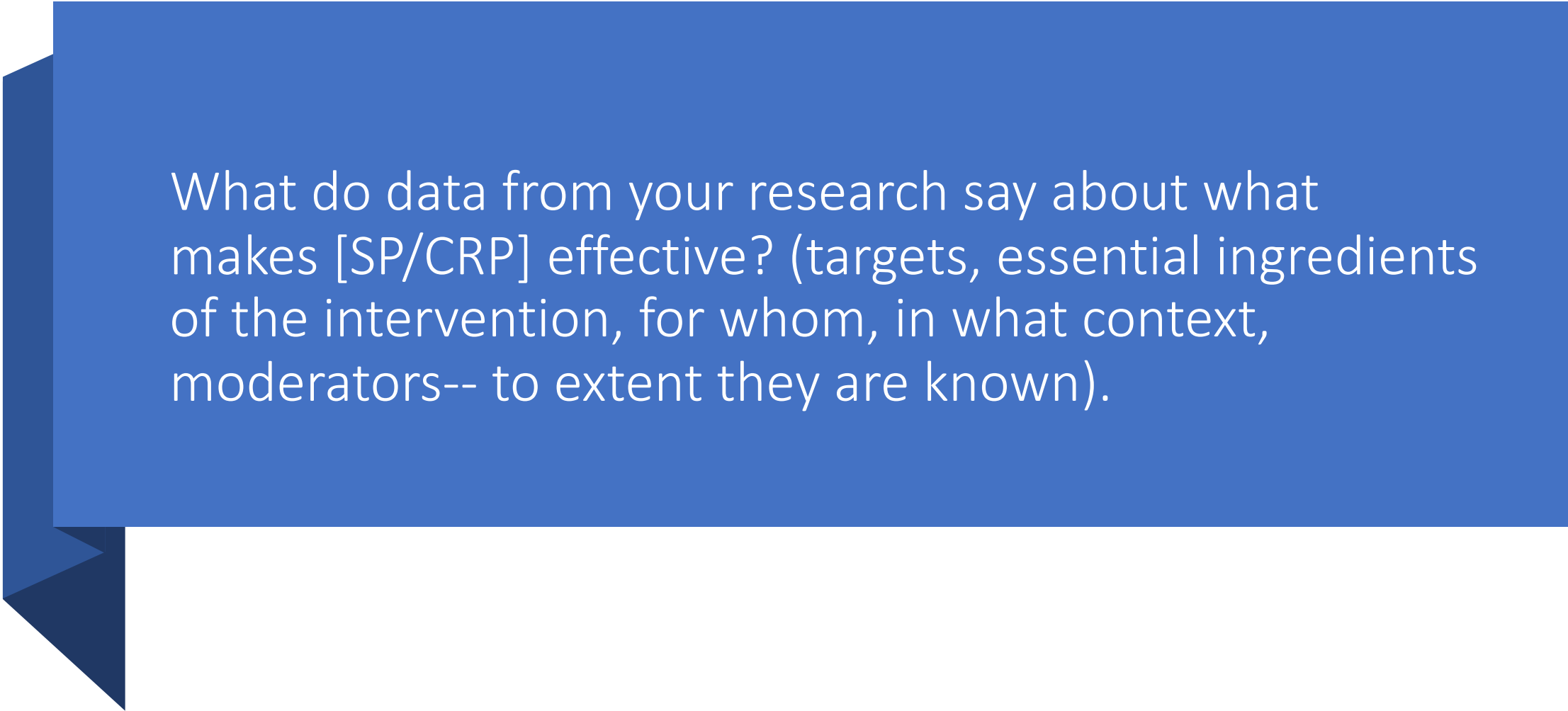
Depression
Severe Stressors
Hopelessness

Acute

Example:

Triggers





What do data from your research say about what makes [SP/CRP] effective? (targets, essential ingredients of the intervention, for whom, in what context, moderators-- to extent they are known).

JAMA Psychiatry | [Original Investigation](#)

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Brenner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MMA; Kelly L. Green, PhD

IMPORTANCE Suicidal behavior is a major public health problem in the United States. The suicide rate has steadily increased over the past 2 decades; middle-aged men and military veterans are at particularly high risk. There is a dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care.

OBJECTIVE To determine whether the Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.

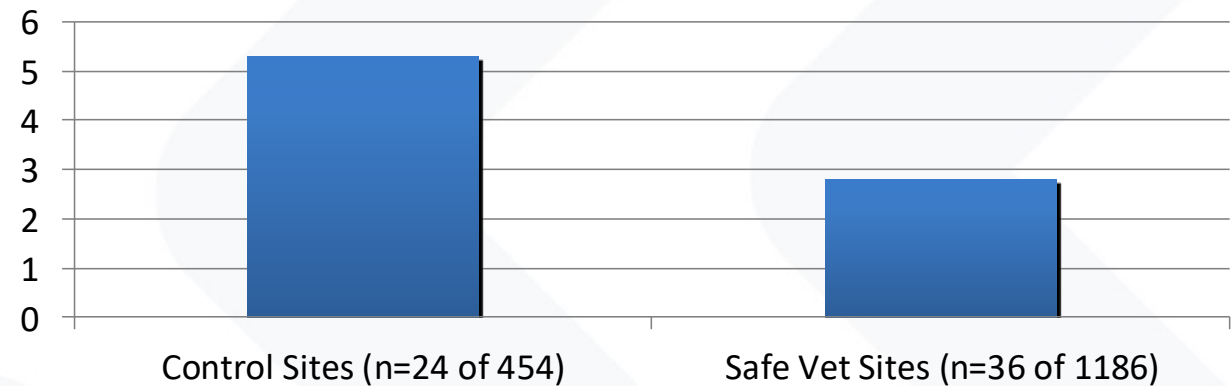
[+ Author Audio Interview](#)

Is SPI effective?

SPI helps to decrease suicidal behavior

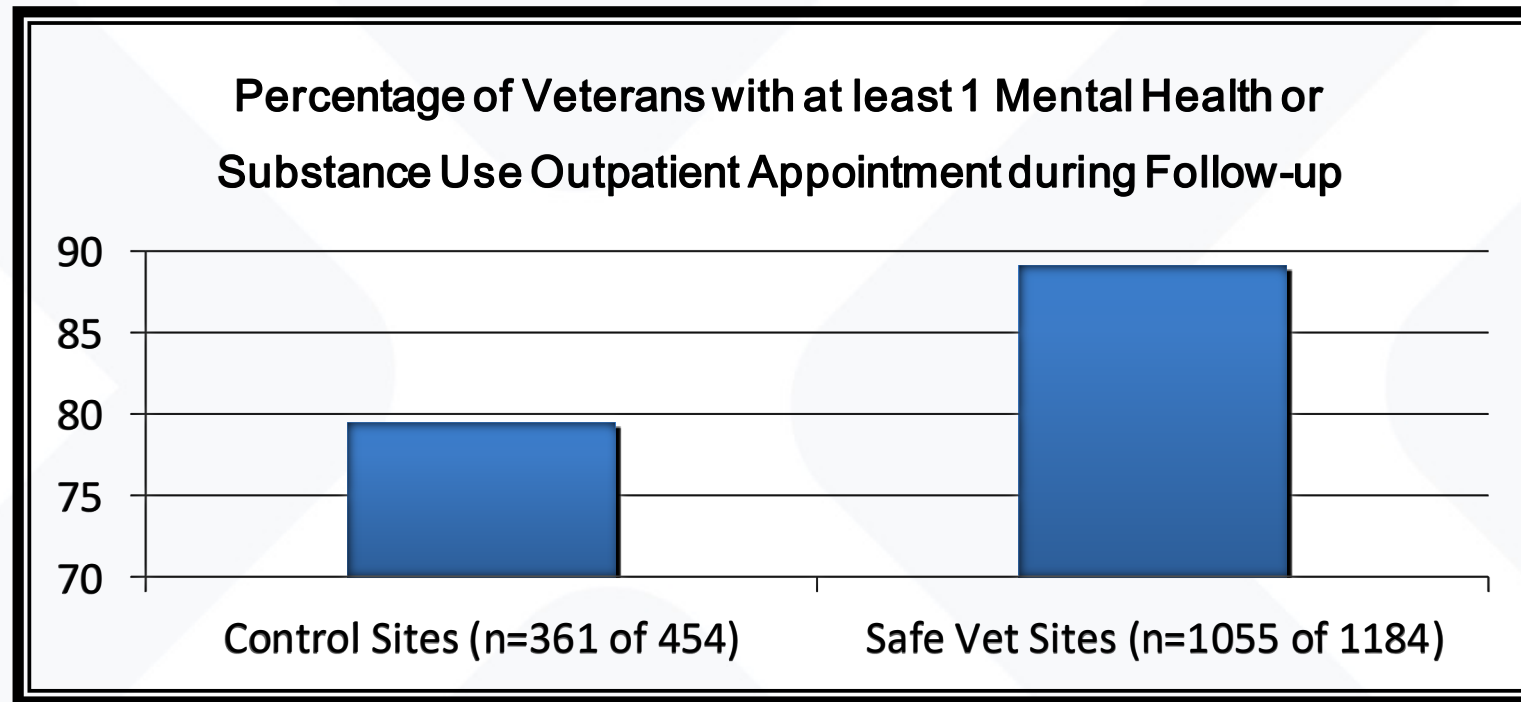
- $\chi^2(1, N = 1640) = 4.72, p = .029$; OR = 0.56, 95% CI: 0.33, 0.95
- ***SPI+ was associated with 45% fewer suicidal behaviors***, approximately halving the odds of suicidal behaviors over 6 months

Percentage of Veterans with SBR during 6-month Follow-up



Does SPI help to increase outpatient treatment?

Engagement During Follow-up



$\chi^2(1, N = 1638) = 25.76, p < .001$; OR = 2.12, 95% CI: 1.57, 2.82

Safety Planning Intervention Evidence-Based Approaches

Problem solving and coping skills diminish during emotional and suicidal crises; emergency plan needed

Individuals may have trouble recognizing when a crisis is beginning to occur

Distraction is an effective short-term strategy to decrease distress and increase emotion regulation

Social support decreases suicidality

Means safety/mean reduction decreases suicidal behavior by placing distance (and time) between the suicidal individual and means

SAFETY PLAN	
Step 1: Warning signs:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1.	Name _____ Phone _____
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3.	Place _____
4.	Place _____
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4.	Local Emergency Service _____ Emergency Services Address _____ Emergency Services Phone _____
Making the environment safe:	
1.	_____
2.	_____
Reproduced with permission (© 2013 Stanley & Brown). www.suicidesafetyplan.com Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. <i>Cognitive and Behavioral Practice</i> , 19, 256-264	

Distracting activities decrease suicidal ideation in the short-term

Coping Strategy	Ideation Change (Single predictor models)		Ideation Change (Multipredictor model)		Perceived Effectiveness (Multipredictor model)	
	Effect	p-value	Effect	p-value	Effect	p-value
Keeping Busy	-0.29	0.0031	-0.23	0.0028	0.19	<.0001
Socializing	-0.24	0.0213	0.02	0.8261	0.081	<.0001
Positive Thinking	-0.38	0.0010	-0.34	0.0022	0.20	<.0001
Doing Something Good for Self	-0.33	0.0032	-0.036	0.7072	0.15	<.0001
Calming	-0.15	0.2055	-0.068	0.5691	0.07	<.0001
Finding Perspective	-0.01	0.9186	0.23	0.0335	0.10	<.0001
Sitting with Feelings Until They Pass	0.11	0.2982	0.15	0.1112	0.08	<.0001

Distraction is effective in coping during crisis

Biological Psychology 128 (2017) 117–124



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Research paper

Distraction coping predicts better cortisol recovery after acute psychosocial stress



Johanna Janson*, Nicolas Rohleder

Chair of Health Psychology, Friedrich-Alexander-University Erlangen-Nürnberg, Nögelsbachstraße 49a, 91052 Erlangen, Germany

ARTICLE INFO

Keywords:

Coping
Distraction
Cortisol
HPA axis
Recovery
Psychosocial stress

ABSTRACT

The aim of this study was to explore whether different manifestations of state coping predict cortisol response and recovery in an acute stress situation. Fifty-nine healthy adults (59.3% female) were exposed to the Trier Social Stress Test (TSST), and salivary cortisol was measured repeatedly before and after stress. Hierarchical linear modeling was used to test for relationships between factor-analytically derived measures of state coping and cortisol response and recovery. Independent of sex, age, BMI, chronic stress and depression, denial coping was related with higher peak levels of cortisol ($\beta = 0.0798$, $SE = 0.0381$, $p = 0.041$) while distraction coping predicted steeper recovery after TSST (linear effect: $\beta = -0.0430$, $SE = 0.0184$, $p = 0.023$) and less pronounced curvature (quadratic effect: $\beta = 0.0043$, $SE = 0.0017$, $p = 0.016$). Our results demonstrate the stress-buffering effect of distraction coping on hypothalamic-pituitary-adrenal (HPA) axis activity in situations without sufficient control.



Optimizing expectations and distraction leads to lower cortisol levels after acute stress



Stefan Salzmann^{a,*}, Frank Euteneuer^a, Jana Strahler^{b,c}, Johannes A.C. Laferton^{a,d}, Urs M. Nater^{c,e}, Winfried Rief^a

^a Department of Clinical Psychology and Psychotherapy, Philipps University of Marburg, Marburg, Germany

^b Department of Psychotherapy and Systems Neuroscience, Justus-Liebig-University, Giessen, Germany

^c Department of Clinical Biopsychology, Philipps University of Marburg, Marburg, Germany

^d Department of Clinical Psychology and Psychotherapy, Psychologische Hochschule Berlin, Berlin, Germany

^e Department of Clinical Psychology, University of Vienna, Vienna, Austria

ARTICLE INFO

Keywords:

Personal control expectation

Gratitude

Distraction

Stress

Salivary cortisol

Salivary alpha-amylase

ABSTRACT

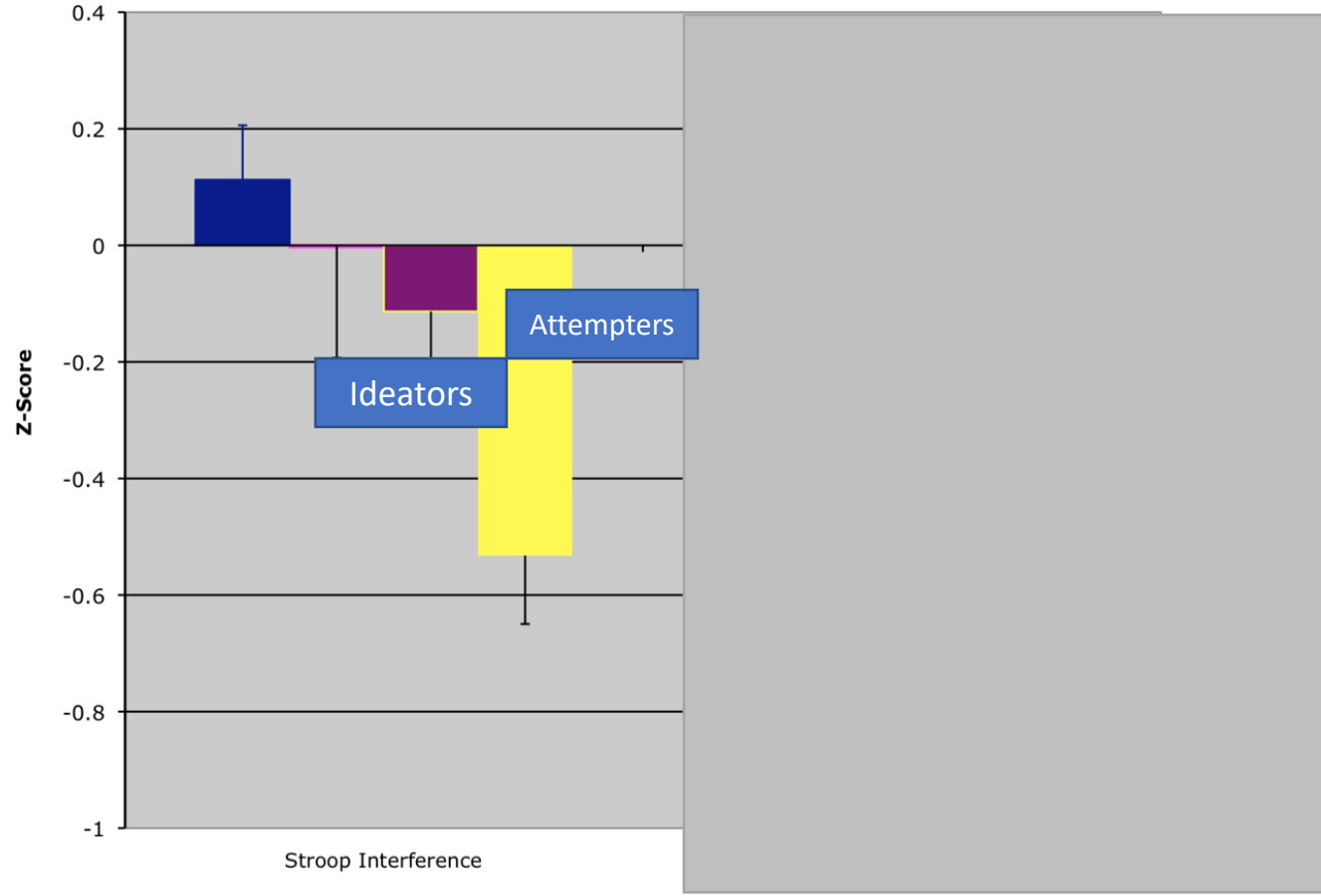
Background: A new approach of psychological interventions prior to stress aiming to optimize expectations may have beneficial effects on a person's health status by reducing physiological stress. The purpose of this experiment was to determine whether a brief psychological intervention designed to optimize personal control expectations prior to acute stress would affect perceived and biological stress responsiveness in comparison to two more established interventions (fostering gratitude or distraction) in a healthy sample.

Methods: 74 healthy participants were randomized to one of three psychological interventions prior to stress: (i) writing about ways to influence stress to optimize personal control expectations (EXPECTATION), (ii) writing a gratitude-letter (GRATITUDE) (iii) or a distraction writing task (DISTRACTION). After completing the intervention, the Maastricht acute stress test was administered to induce (psychosocial and physiological) stress. Assessments took place at baseline, post-intervention (15 min writing task) and after stress induction (additional salivary assessments: 15 and 30 min after stress). Main outcomes were expectations, emotions, perceived stress, salivary cortisol and alpha-amylase. Personality traits (eg, optimism) were assessed at baseline.

Results: EXPECTATION specifically increased personal control expectations ($p = .016$, $d = .72$) and GRATITUDE specifically increased gratitude ($p = .026$, $d = .68$). EXPECTATION and DISTRACTION led to lower cortisol concentrations after stress induction than GRATITUDE (time \times group interaction: $p < .001$, $d = .88$). We detected no intervention effects on alpha-amylase or perceived stress. Optimism moderated intervention effects on cortisol ($p = .023$, $d = .74$).

Conclusions: Brief psychological interventions aiming to optimize expectations or distraction prior to stress reduce the cortisol response in healthy participants after an acute stressor.

Stroop Interference (Attentional Control): Suicide Attempters have poorer performance/attentional control than Suicide Ideators



n's = 107, 50, 81, 138; Keilp et al., in preparation

Practice: How should the state of the science inform practice? As a clinician what are my most important take aways?

- State of science should, of course, inform practice
 - However, science is often limited and clients having a problem with limited science need treatment
 - Offer “best available” science-based care
- Listen to your clients (as opposed to or in addition to theory and models) about what is helpful/effective---
Safety Planning Intervention as a case in point

Policy: How should the state of the science inform regulators like CMS and the JC who want to improve standards of care? e.g., how should guidance be set so it's not ahead of the science; doesn't privilege brief intervention as if it's sufficient treatment?

- Regulators work with what they have and make the best judgments in light of the available data; cannot wait around; may temper recommendations
- For some suicidal individuals, a brief intervention may be sufficient; need trials using SMART designs
- More importantly, brief interventions may be all that are all available and accessible
- Clinical reality---clinicians need access to interventions that are relatively easy to learn and apply; suicide-specific psychotherapies are difficult to learn and take considerable time to become proficient;
- Possible remedies:
 - Consider developing/using app-based suicide prevention interventions to aid clinicians
 - Referral network of expert suicide intervention clinicians



Self-Regulation and Crisis Response Planning

Craig J. Bryan, PsyD, ABPP

Stress, Trauma, & Resilience Professor

Department of Psychiatry and Behavioral Health



THE OHIO STATE
UNIVERSITY

WEXNER MEDICAL CENTER

Evolution of the Crisis Response Plan

Dialectical Behavior Therapy

Overview:
Crisis Survival Skills

These are skills for tolerating painful events, urges, and emotions when you cannot make things better right away.

The STOP Skill

Pros and Cons

TIP Your Body Chemistry

Distract with Wise Mind ACCEPTS

Self-Soothe with the Five Senses

Improve the Moment

Brief Cognitive Behavioral Therapy (BCBT)

When I'm acting on my suicidal thoughts by trying to find a gun (or another method to kill myself), I agree to take the following steps:

- Step 1. I will try to identify specifically what's upsetting me.
- Step 2. Write out and review more reasonable responses to my suicidal thoughts, including thoughts about myself, others, and the future.
- Step 3. Review all the conclusions I've come to about these thoughts in the past in my treatment log. For example, that the sexual abuse wasn't my fault and I don't have anything to feel ashamed of.
- Step 4. Try and do the things that help me feel better for at least 30 minutes (listening to music, going to work out, calling my best friend).
- Step 5. Repeat all of the above at least one more time.
- Step 6. If the thoughts continue, get specific, and I find myself preparing to do something, I'll call the emergency call person at (phone number: XXXXXXX).
- Step 7. If I still feel suicidal and don't feel like I can control my behavior, I'll go to the emergency room located at XXXXXXX, phone number; XXXXXXX.

Crisis Response Plan (CRP)

Warning Signs: pacing
feeling irritable
thinking "it'll never get better"

- go for a walk 10 mins
- watch Friends episodes
- play with my dog
- think about my kids
 - vacation to beach in Florida
 - Christmas Day 2012
- call/text my Mom or Jennifer
- call Dr. Brown: 555-555-5555
 - leave msg w/ name, time, phone #
- 1-800-273-TALK
- go to hospital
- call 911

Process Model of Emotion Regulation

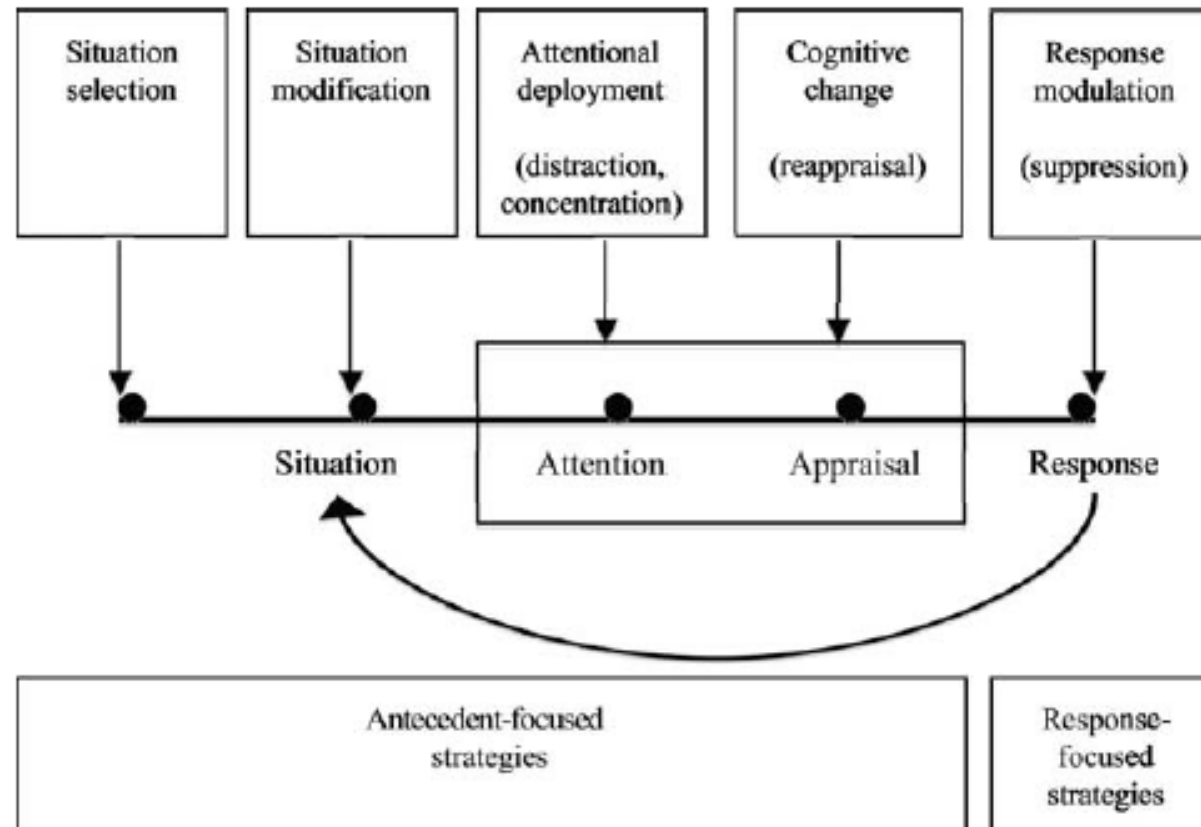


Figure 1. The process model of emotion regulation. Adapted from "Emotion Regulation: Conceptual Foundations," by J. J. Gross and R. A. Thompson, in J. J. Gross (Ed.), *Handbook of Emotion Regulation* (p. 10), 2007, New York, NY: Guilford Press. Copyright 2007 by Guilford Press. Adapted with permission.

Table 3

Sample-Weighted Average Change in Emotions as a Function of Different Emotion Regulation Instructions

Strategy	Experiential				Behavioral				Physiological				Overall			
	<i>d</i>	<i>k</i>	95% CI		χ^2	<i>d</i>	<i>k</i>	95% CI		χ^2	<i>d</i>	<i>k</i>	95% CI		χ^2	
			<i>LL, UL</i>					<i>LL, UL</i>					<i>LL, UL</i>			<i>LL, UL</i>
<i>Attentional deployment</i>	−0.00	205	−0.08, 0.07	340*	−0.12	8	−0.40, 0.16	10	0.00	35	−0.14, 0.15	15	0.00	215	−0.07, 0.07	313*
Distraction: active positive (D1)	0.56	6	0.19, 0.92	5	0.54	1	−0.07, 1.16		0.57	1	−0.78, 1.92		0.47	6	0.11, 0.84	2
Distraction: passive positive (D2)	0.15	9	−0.18, 0.48	7					0.66	1	−0.60, 1.92		0.18	10	−0.14, 0.50	7
Distraction: active neutral (D3)	0.40	20	0.21, 0.60	24					0.20	5	−0.18, 0.58	1	0.38	20	0.21, 0.56	20
Distraction: passive neutral (D4)	0.28	61	0.15, 0.40	85*	−0.19	3	−0.38, −0.01	2	0.10	13	−0.11, 0.31	2	0.23	66	0.12, 0.35	82
Distraction: overall	0.31	96	0.21, 0.41	128*	−0.06	4	−0.47, 0.36	7	0.15	20	−0.04, 0.33	4	0.27	102	0.18, 0.36	119
Concentrate: feelings (C1)	−0.15	40	−0.30, −0.01	53	−0.50	2	−1.62, 0.61	2	−0.42	4	−0.93, 0.10	2	−0.14	42	−0.28, −0.00	51
Concentrate: implications (C2)	−0.37	31	−0.51, −0.23	33					−0.28	6	−0.67, 0.13	0	−0.34	33	−0.48, −0.20	30
Concentrate: mixed (C3)	−0.38	38	−0.54, −0.22	33	−0.06	2	−0.73, 0.61	0	−0.12	5	−0.48, 0.23	2	−0.36	38	−0.51, −0.21	31
Concentrate: overall	−0.28	109	−0.37, −0.19	128	−0.22	4	−0.70, 0.26	3	−0.24	15	−0.47, −0.00	5	−0.26	113	−0.34, −0.18	120
<i>Cognitive change</i>	0.45	91	0.35, 0.56	155*	0.55	13	0.26, 0.85	31*	0.05	36	−0.07, 0.16	19	0.36	99	0.27, 0.45	131*
Reappraise: response (R1)	0.31	30	0.13, 0.49	58*					−0.01	14	−0.20, 0.19	5	0.23	31	0.12, 0.33	29
Reappraise: stimulus (R2)	0.38	24	0.21, 0.55	29	0.57	6	−0.06, 1.21	26	0.14	8	−0.07, 0.36	3	0.36	26	0.21, 0.51	28
Reappraise: perspective (R3)	0.61	31	0.44, 0.78	47*	0.53	7	0.30, 0.77	4	0.01	14	−0.18, 0.20	10	0.45	36	0.30, 0.62	54*
Reappraise: mixed (R4)	0.89	6	0.24, 1.54	9									0.89	6	0.24, 1.54	9
<i>Response modulation</i>	0.03	92	−0.03, 0.10	72	0.90	43	0.73, 1.08	135*	−0.19	34	−0.14, −0.01	15	0.16	102	0.09, 0.24	137*
Suppress: expression (S1)	0.10	49	0.01, 0.18	34	0.97	37	0.77, 1.16	119*	−0.22	25	−0.33, −0.11	9	0.32	56	0.27, 0.42	69
Suppress: experience (S2)	0.03	10	−0.16, 0.22	5					−0.33	4	−0.68, 0.03	0	−0.04	12	−0.21, 0.14	7
Suppress: thoughts (S3)	−0.09	19	−0.23, 0.05	19	−0.13	1	−1.33, 1.08		0.05	1	−0.75, 0.84		−0.12	20	−0.26, 0.01	17
Suppress: mixed (S4)	−0.01	14	−0.17, 0.16	9	0.56	5	0.20, 0.92	6	−0.01	4	−0.25, 0.23	2	0.11	14	−0.05, 0.27	8

Webb TL, Miles E, Sheeran P. Dealing with feeling: a meta-analysis of the effectiveness of strategies derived from the process model of emotion regulation. *Psychol Bull.* 2012;138:775-808.

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			<i>LL, UL</i>	χ^2			<i>LL, UL</i>	χ^2			<i>LL, UL</i>	χ^2			<i>LL, UL</i>	χ^2
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Distraction: passive neutral (D4)	0.28	61	0.15, 0.40	85*	-0.19	3	-0.38, -0.01	2	0.10	13	-0.11, 0.31	2	0.23	66	0.12, 0.35	82
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Reappraise: stimulus (R2)	0.38	24	0.21, 0.55	29	0.57	6	-0.06, 1.21	26	0.14	8	-0.07, 0.36	3	0.36	26	0.21, 0.51	28
Reappraise: perspective (R3)	0.61	31	0.44, 0.78	47*	0.53	7	0.30, 0.77	4	0.01	14	-0.18, 0.20	10	0.45	36	0.30, 0.62	54*
Reappraise: mixed (R4)	0.89	6	0.24, 1.54	9									0.89	6	0.24, 1.54	9
<i>Response modulation</i>	0.03	92	-0.03, 0.10	72	0.90	43	0.73, 1.08	135*	-0.19	34	-0.14, -0.01	15	0.16	102	0.09, 0.24	137*
Suppress: expression (S1)	0.10	49	0.01, 0.18	34	0.97	37	0.77, 1.16	119*	-0.22	25	-0.33, -0.11	9	0.32	56	0.27, 0.42	69
Suppress: experience (S2)	0.03	10	-0.16, 0.22	5					-0.33	4	-0.68, 0.03	0	-0.04	12	-0.21, 0.14	7
Suppress: thoughts (S3)	-0.09	19	-0.23, 0.05	19	-0.13	1	-1.33, 1.08		0.05	1	-0.75, 0.84		-0.12	20	-0.26, 0.01	17
Suppress: mixed (S4)	-0.01	14	-0.17, 0.16	9	0.56	5	0.20, 0.92	6	-0.01	4	-0.25, 0.23	2	0.11	14	-0.05, 0.27	8

Webb TL, Miles E, Sheeran P. Dealing with feeling: a meta-analysis of the effectiveness of strategies derived from the process model of emotion regulation. Psychol Bull. 2012;138:775-808.

The Reasons for Living Task

- What are your reasons for living?
- What gives you a sense of purpose and meaning in life?
- What stands in the way of you killing yourself?

CRP Tips

- Ask the individual to describe their reasons for living in detail to increase their emotional vividness.
- If an individual says they have no reasons for living, reword by asking about what gets in the way of a suicide attempt.

CRP with RFL vs. CRP without RFL

Immediate effects:

- Larger immediate increases in positive emotional states (Bryan, Mintz et al., 2017)
- Significantly lower likelihood of clinician recommending inpatient hospitalization (Bryan, Mintz et al., 2017)

Short-term effects (1 month):

- Significantly larger increases in optimism (Rozek et al., 2018)

Long-term effects (up to 6 months):

- Greater benefit from salutary effects of meaning in life (Bryan, Bryan et al., 2019)
- Significantly larger and faster reductions in suicidal ideation correlated with more frequent use of CRP with RFL (Bryan, May et al., 2018)

STRATEGY OF OUTCOME RESEARCH IN PSYCHOTHERAPY ¹

GORDON L. PAUL

University of Illinois

The current status of psychotherapeutic research is reviewed, concluding that the greatest need is for outcome studies. The major variables and domains involved in psychotherapy are delineated to show where errors have occurred in past investigations, and to serve as a basis for determining the degree of control necessary to answer the varied questions concerning the practice of psychotherapy. Strategic choices for accumulating knowledge are suggested in terms of the selection of variables, criteria, and adequate research designs for a given level of empirical knowledge. Contrary to many current statements, the present methodology of scientific psychology does appear adequate for evaluating psychotherapy; however, the value of different research approaches from case studies to factorial designs must be recognized and used strategically.

What treatment, **by whom**, is most effective for **this** individual with **that** specific problem, and under **which** set of circumstances?

Paperwork and documentation are not interventions

Process and principles are more
important than the content of
documentation



Thank You

craig.bryan@osumc.edu



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