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Motivational Interviewing for Means Restriction Counseling With Patients at Risk for Suicide

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The restriction of potentially lethal means during periods of high risk has been identified as one of the more promising suicide prevention strategies. The purpose of this paper is to introduce clinicians to means restriction counseling and to describe a Motivational Interviewing (MI) based approach for use with ambivalent or challenging patients. This paper examines empirical support behind legislative efforts for means restriction along with the limitations. It explains the need for means restriction counseling with adults and requisite challenges. For patients who are reluctant, it describes an MI-based approach to means restriction counseling and provides a case example. By the end of the paper, readers should be aware of the potential importance of means restriction counseling and the possible use of an MI-based approach with challenging patients. Means restriction counseling is a promising clinical intervention for suicidal patients and research on MI-based and other approaches is sorely needed.

Suicide experts have identified means restriction as one of the most promising suicide prevention strategies (Mann et al., 2005). However, many clinicians do not fully appreciate the potential impact of means restriction counseling or know how to approach their patients or clinic populations to reduce access to lethal means. Many empirically supported suicide interventions include means restriction components and practical protocols addressing means restrictions have been developed for clinicians (Bryan, Stone, & Rudd, 2011; Linehan, 1993; Wenzel, Brown, & Beck, 2009). However, guidance and research focusing on overcoming both real and perceived barriers to implementing means restriction with general clinical or high-risk populations is scarce. In particular, many clinicians are unaware of the importance of means restriction in suicide prevention, and there is little guidance regarding how to successfully engage ambivalent or reluctant patients in discussions about restricting their access to potentially lethal means such as firearms. The purpose of this paper is to alert clinicians about the importance of means restriction, explore the rationale behind using motivational interviewing (MI) for means restriction counseling, and provide clinicians with a more detailed description of an MI-based approach to means-restriction counseling.

Keywords: suicide prevention; means restriction; motivational interviewing

Means Restriction

The argument for means restriction counseling is based upon a few key principles. The first principle is that moments of elevated suicide risk are often brief and fleeting. In a case-control study of 153 attempters, 24% decided to make an attempt less than 5 minutes before the event, and 70% less than an hour before (Simon et al., 2001). The short latency of risk is important because reducing risk during these brief periods has the potential for long-term effects as only 10% of individuals who make medically serious attempts make a subsequent attempt that results in death (Owens, Horrocks, & House, 2002). Of those who do die from suicide, almost 30% use the same method as the initial attempt (O'Donnell, Arthur, & Farmer, 1994; Seiden, 1978). The second principle is that the preferred method of suicide is often a function of convenience. Pesticides, for instance, are frequently used in rural China where they are regularly stored in living quarters (Eddleston & Phillips, 2004; Phillips et al., 2002), but rarely used in countries such as the U.S. where they are less common (Gunnell, Eddleston, Phillips, & Konradsen, 2007). Similarly, firearms account for the

majority of suicides in the U.S. with its liberal ownership laws, but are rare in the U.K. due to its more restrictive policies (Daigle, 2005). Third, while complete removal of access to lethal means is preferred, increasing the barriers between individuals and their preferred means may also reduce risk. When considering firearm-related suicide, eliminating access results in the greatest reduction of risk, but increasing barriers to access by storing guns unloaded, using trigger locks, locking gun cabinets, or storing firearms and ammunition separately has also been shown to reduce the odds of death by suicide (Conwell et al., 2002; Miller, Azrael, Hemenway, & Vriniotis, 2005; Shenassa, Rogers, Spalding, & Roberts, 2004). Thus, making an individual's preferred means for a suicide attempt more difficult to acquire during high-risk periods has potential to reduce suicide deaths.

Legislation to eliminate access to preferred means or render them inconvenient supports the potential of means restriction. In addition to reduced suicide following changes in packaging in the U.K., the U.K. suicide rate also fell dramatically when nontoxic natural North Sea gas replaced toxic coal gas in domestic gas supplies (Kreitman, 1976). Similar findings have been observed following restrictions for gas-related poisonings in the U.S. and Japan (Lester & Abe, 1989; Lester, 1990), drug availability in the U.K., Australia, and Japan (Hawton et al., 2001; Hawton, 2002; Oliver & Hetzel, 1972; Whitlock, 1975; Yamasawa, Nishimukai, Ohbora, & Inoue, 1980), firearm ownership in Canada, New Zealand, and the U.S. (Beautrais, Fergusson, & Horwood, 2006; Bridges, 2004; Carrington & Moyer, 1994; Leenaars, Moksony, Lester, & Wenckstern, 2003; Loftin, McDowall, Wiersema, & Cottey, 1991; Rodriguez Andres & Hempstead, 2011), pesticides in Sri-Lanka (Gunnell, Eddleston, Phillips and Konradsen, 2007, Gunnell, Fernando, et al., 2007), and bridge access in the U.S. (Lester, 1993). The mechanism by which means restriction works is unclear, but reducing access to highly lethal means (e.g., carbon monoxide) may increase use of easily available but less lethal methods (e.g., medications), increasing the probability of survival (Hawton et al., 2004). Although these findings come from retrospective case-control studies or quasi-experimental studies, they provide compelling support for means restriction.

Means Restriction Counseling With Adults

Legislators cannot limit access to every possible means and clinicians must work with their patients and clinic populations to reduce access to lethal means during high-risk periods. The Harvard Injury Control Research Center (www.hsph.harvard.edu/means-matter) advises clinicians to (a) assess whether individuals at risk for suicide have access to lethal means such as firearms, and (b) work with them, their families, and support systems to limit their access until they no longer feel suicidal. Unfortunately, clinicians are often unaware of the importance of means restriction or do not believe in its efficacy, and many fail to assess patients' access to potentially lethal means (Price, Kinnison, Dake, Thompson, & Price, 2007; Slovak, Brewer, & Carlson, 2008). A recent investigation of emergency department providers found that less than half believed that the majority of suicides were preventable (Betz et al., 2013). In a survey of emergency department nurses, only 28% reported engaging in means restriction counseling and only 18% reported working on units where means restriction counseling was standard practice (Grossman, Dontes, Kruesi, Pennington, & Fendrich, 2003). A survey of social workers showed that only 22% believed that means restriction counseling was important (Slovak et al., 2008).

The Example of Firearm Ownership

The widespread reluctance by clinicians to conduct means restriction counseling may be particularly problematic when they are faced with high-risk patients with access to firearms. In 2009, firearms were used in 51% of U.S. suicides, slightly more than all other methods combined (Centers for Disease Control and Prevention, 2012). Both case-control and ecological studies confirm that firearm ownership is associated with increased risk for suicide (Hemenway & Miller, 2002; Miller, Azrael, & Hemenway, 2002; Miller & Hemenway, 1999), and suggest that risk extends to all family members (Brent, Perper, Moritz, Baugher, & Allman, 1993). In fact, in 2009, U.S. citizens were over 1.5 times more likely to die by firearm through suicide (SMR = 5.92 age-adjusted) than homicide (SMR = 3.77 age-adjusted; Centers for Disease Control and Prevention, 2012). One reason for the high rate of firearm suicides is that firearm attempts are the most lethal of standard methods. In one study, 92% of firearm attempts resulted in death, compared to 78% of carbon monoxide poisonings and hangings, 67% of drownings, and 23% of drug overdose attempts (Chapdelaine, Samson, Kimberley, & Viau, 1991). However, there are ways to reduce firearm-related risk, such as eliminating access or reducing it through utilizing safe storage practices (Conwell et al., 2002; Miller, Azrael, Hemenway, & Vriniotis, 2005; Shenassa, Rogers, Spalding, & Roberts, 2004).

Despite the risk associated with firearm access, clinicians are often reluctant to approach patients about means restriction that extends to firearms. In a recent investigation of emergency department providers, 67% of nurses and 44% of physicians believed that means restriction would not prevent the majority of firearm suicides (Betz et al., 2013). Although 67% of providers reported assessing firearm access when a suicidal patient voiced a firearm plan, only 21% to 22% reported assessing access when a suicidal patient did not. In a survey of emergency department personnel, 52% reported rarely or never asking suicidal

patients about firearm access (Betz, Barber, & Miller, 2010). Although some clinicians are simply not aware of the risk associated with firearm access, others do not believe they can influence their clients' decision regarding level of access. In one survey, clinicians estimated that less than 50% of clients would be willing to unload and lock up their firearms and only 25% would be willing to dispose of them (Price et al., 2007).

One reason that clinicians may believe that their suicidal patients will be unwilling to give up their access to firearms is that they've come across patients who defend their right to maintain access. Some patients may explain that firearm access presents a potential means of escape from overwhelming emotional or physical pain. Others may argue that they are unwilling to give up their second amendment right to bear arms. Those who are military, law enforcement, or rural workers (e.g., farmers, ranchers) may explain that they need access to firearms to perform their occupational tasks. Still others may describe personal reasons—for example, owning a firearm is a rite of passage in many parts of the U.S., and individuals living in dangerous urban environments and veterans suffering from PTSD may feel that their firearms provide protection from real or feared threats. When confronted with these and other reasons to maintain access, clinicians may feel that there is no hope for means restriction or feel uncertain about their ability to effectively explore the issue.

Available Options

Cognitive behavioral therapy for suicide prevention (Brown, Have, et al., 2005), brief cognitive behavioral therapy for suicide prevention (Rudd et al., 2014), and dialectical behavior therapy (Linehan et al., 2006) have all been found to reduce risk for suicide attempts and include a means restriction counseling component. However, all three interventions require substantial training and resources that may not be available to front-line practitioners or may not be appropriate for all patients or settings. None of the means restriction components has been studied outside of the full treatment, and only one has been described in detail for interested practitioners (Bryan et al., 2011). Although Bryan et al.'s description presented an empirically based and well-thought-out structure for addressing the problem of access to lethal means, it provided limited guidance in what to do when a straightforward approach is ineffective and the patient remains ambivalent, rejecting, or even angry about the suggestion of means restriction. Acknowledging this limitation, it proposed that clinicians should consider using MI to help high-risk patients resolve their ambivalence about means restriction in order to increase their willingness to take precautions.

Why Motivational Interviewing?

MI was originally developed to help patients who were ambivalent about their hazardous substance use identify and explore their motivation and readiness to change (Miller & Rollnick, 1991). One of the reasons MI may be an ideal intervention for this problem is that most people who think about suicide are ambivalent, having both reasons to consider suicide and reasons to continue living (Jobes & Mann, 1999). The desire to live can motivate life-saving behavior, as is evident in individuals who use telephones installed on bridges to contact crisis lines (Glatt, 1987). It may also impact long-term risk as the majority of survivors are glad (36%) or ambivalent (42%) that they survived (Henriques, Wenzel, Brown, & Beck, 2005). In studies of survivors of self-inflicted gunshot wounds and attempters saved by emergency medical treatment, reattempts were rare in the 2 years after the initial attempt (Chapdelaine et al., 1991; Peterson, Peterson, O'Shanick, & Swann, 1985). Reducing the desire to die and strengthening the desire to live may therefore have a profound impact on suicide risk as attempters whose wish to live is greater than their wish to die make less severe attempts (Kovacs & Beck, 1977), and outpatients and attempters whose wish to live is greater than their wish to die are less likely to die by suicide (Brown, Steer, Henriques, & Beck, 2005; Henriques et al., 2005). If people have reasons to live in the face of suicidal thoughts and urges, they may also have reasons to restrict their access to lethal means and take necessary safety precautions. MI is a method that can be used to identify and enhance an individual's motivation to remove or limit their access to lethal means.

Motivational Interviewing

The resolution of ambivalence is a challenging task, particularly when both clinicians and clients have strong feelings about a behavior. Although clinicians may have an opinion about what clients should do, it is critical that these feelings do not interfere with their ability to work with ambivalent clients. One reason for this is that taking one side of an individual's ambivalence often activates the opposite side of their ambivalence, eliciting behavior that is viewed as defensive or resistant. The concept of reactance is helpful in explaining this seemingly paradoxical response (Brehm & Brehm, 1981), and may be particularly salient in means restriction counseling. When individuals feel their freedom is being threatened, they often defend it despite potentially serious consequences. Thus, telling an ambivalent patient that they should restrict their access to firearms may inspire them to defend their right to maintain access. This reaction may be enhanced when there are deep-rooted reasons to defend a behavior, as there often are with firearm access.

There are, however, ways of working with ambivalent patients. MI is a therapeutic approach developed to help clients identify and align with their own reasons for engaging

in a beneficial behavior, and to increase the likelihood that they will engage in such behavior. Originally developed for individuals with alcohol-related problems (Miller & Rollnick, 2012), it has also been applied to other health-related behavior such as diet, exercise, medication compliance, treatment engagement (Hettema, Steele, & Miller, 2005), and continuing to live when thinking about suicide (Britton, Patrick, & Williams, 2011; Britton, Conner, & Maisto, 2012; Britton, Williams, & Conner, 2008). MI takes into consideration both the individual's reasons for changing and not changing, and builds upon their reasons to change. It is thus tailored to each individual who receives the intervention.

Based on client-centered principles, the "spirit" or interpersonal approach taken by MI counselors is based on specific elements that may impact the course and outcome of the therapeutic interaction (Miller & Rollnick, 2012). Of utmost importance to the MI spirit is the *acceptance* of the patient and the patient's perspective. Acceptance is a composite of a number of facets. It requires an inherent belief in the patient's *absolute worth*, recognition of the patient as a unique individual worthy of respect and trust. Clinicians working with patients who are thinking about suicide need to believe that patients' lives are worth living and their difficulties are real, despite potential challenges to empathy and acceptance due to interpersonal abrasiveness or crippling hopelessness. *Accurate empathy* is also a critical facet and includes not just trying to understand the patient's perspective, but also sharing that understanding so that patients feel heard. Patients who are thinking about suicide and own firearms need to feel that their reasons for thinking about suicide and their reluctance to restrict access are understood. Acceptance also requires *autonomy support*, the belief that patients must provide the reasons to change and means to do so. Essentially all suicidal patients eventually leave the clinician's office or hospital, so it is critical that patients identify their reasons to limit access to lethal means, develop and follow through with a plan, and avoid using alternative means. If these decisions are coerced it is unlikely that the patient will follow through. MI also requires *affirmation*, open acknowledgment of patients' strengths and efforts to encourage movement. Patients whose efforts are rewarded are more likely to engage in protective behavior than those who feel ineffective or unappreciated.

In addition to *acceptance*, the MI spirit also embodies a belief in *evocation*, that the critical elements of change are within an individual and it is the clinician's job to access them. The reasons and means for limiting access that patients generate are more personal and more likely to motivate behavior change than the reasons that clinicians come up with. MI clinicians believe in *collaboration*, that patients are experts and clinicians are a resource and that both cooperate to solve problems. It is the clinician's job to help patients explore reasons for limiting access and help them develop a concrete plan that they believe will work. MI clinicians also believe in *compassion*, a commitment to helping others for the other's well-being, rather than for their own gain. This quality differentiates MI from mere manipulation and ensures patients feel cared for rather than coerced.

In the context of a relationship embodying the MI spirit, MI clinicians guide patients towards change through the strategic use of specific techniques. The central technique of motivational interviewing is *reflective listening*, where a clinician shares his/her understanding of the patient's perspective to ensure that the patient hears that he/she has been heard and understood. Clinicians ask *open-ended questions* to encourage patient elaboration about reasons for limiting their access and ways to do so. When progress towards restriction is made, clinicians use *affirmations* to reinforce movement. During transitions, at the end of sessions, and when uncertain about what the client is saying, clinicians *summarize* to help both themselves and patients to integrate what was discussed and reinforce any movement that was made. From an MI perspective, explicitly directive techniques such as providing information and opinions and making recommendations are appropriate if patients give permission or the patient's autonomy is emphasized. Therapists can ask for permission to provide information or share past experiences, or respond to a request to do so, but should only do so after patients are provided the opportunity to explore their own thoughts and ideas.

Process outcome research on MI suggests that both the relational and technical pathways contribute to outcomes (Miller & Rose, 2009). Relationships can be healing and promote growth and development, but they can also be antagonistic, instilling resentment and resistance. Empathy and the MI spirit (i.e., evocation, collaboration, autonomy support) have been shown to increase patient engagement in treatment (Boardman, Catley, Grobe, Little, & Ahluwalia, 2006; Catley et al., 2006; Moyers, Miller, & Hendrickson, 2005), and empathy has been found to improve treatment outcome (Gaume, Gmel, & Daeppen, 2008). In the context of means restriction counseling, an MI approach provides patients with the opportunity to safely explore their reasons for and against limiting their access without being judged or derided. Exploring patients' own motivation, while acknowledging their right to make a decision, allows those who are uncertain about restriction to genuinely explore their thoughts and feelings about it.

MI's technical component is based on what clients say during therapy sessions, and suggests that their utterances are predictive of treatment outcome. Use of MI techniques increases the likelihood of change talk (Gaume, Gmel, Faouzi, & Daeppen, 2008; Moyers & Martin, 2006; Moyers et al., 2007; Vader, Walters, Prabhu, Houck, & Field, 2010) and decreases the likelihood of sustain talk, or resistance

(Moyers & Martin, 2006; Moyers et al., 2007). Conversely, use of MI-inconsistent techniques like confrontation, denial, and warning increase the likelihood of sustain talk (Moyers & Martin, 2006; Moyers et al., 2007) but decrease the likelihood of change talk (Gaume, Gmel and Daeppen, 2008, Gaume, Gmel, Faouzi and Daeppen, 2008). Change talk is predictive of positive treatment outcome (Gaume, Gmel and Daeppen, 2008, Gaume, Gmel, Faouzi and Daeppen, 2008; Hodgins, Ching, & McEwen, 2009; Martin, Christopher, Houck, & Moyers, 2011; Vader et al., 2010), whereas sustain talk is predictive of poorer outcomes (Miller, Benefield, & Tonigan, 1993; Vader et al., 2010), unless it transitions into change talk during the session (Bertholet, Faouzi, Gmel, Gaume, & Daeppen, 2010). In the context of providing a safe environment to explore pros and cons of means restriction, clinicians may be able to increase the likelihood of change if they selectively use MI techniques to contextualize clients' reasons for not limiting access to potentially lethal means, and elicit and reinforce talk about limiting access.

Motivational Interviewing for Means Restriction

The process of MI is comprised of four phases: (a) engaging, (b) focusing, (c) evoking, and (d) planning. Although the phases are conceived as linear, they are also recursive. Patient engagement improves efforts to focus on means restriction, which helps in evoking the patient's thoughts and feelings about means restriction, which logically leads to planning efforts. However, engagement is important throughout treatment, refocusing may be called for at any time, evoking can enhance engagement, and planning may be an exploratory process that includes evocation. Rather than functioning as a roadmap that must be followed to reach a specific location, the phases are similar to compass points to be used to guide patients through their journey, remaining aware that there may be forests to navigate and streams to cross. Indeed, strict adherence to a manual may interfere with clinicians' ability to uphold the spirit of MI (i.e., acceptance, evocation, collaboration, autonomy support, compassion). In a meta-analysis of 72 randomized controlled trials, MI was more effective in trials that did not use a treatment manual than in those that did use one (Hettema et al., 2005). Further supporting the importance of focusing on patients, a reanalysis of a trial in which MI did not significantly reduce drug use found that requiring patients to develop a plan before they were ready resulted in reduced motivation and poorer outcomes (Miller & Rose, 2009).

Engaging

At the start of the interaction, clinicians need to establish a collaborative working relationship with patients. Although most clinicians believe in the importance of the relationship, and most behavioral interventions tout its significance, there are many pressures that may interfere with the engagement process. In means restriction counseling there may be external pressures from administrators, colleagues, and protocols that push clinicians to take an authoritarian role. It is thus critical that clinicians avoid the "righting reflex" in an attempt to "fix" the problem. Such an approach may be ineffective with patients who have reasons for thinking about suicide or retaining access. In this phase, listening is of critical importance to ensure that the patient feels a connection with the clinician. It also provides the clinician with the opportunity to align with the patient against the problem.

Focusing

MI, like most empirically supported treatments, requires a target. Sometimes the focus is determined by the context. When a patient calls a suicide crisis line or meets with a suicide prevention specialist, both the patient and clinician understand that suicide-related topics may be the target of the discussion. However, in other settings, such as primary care offices or behavioral health clinics, patients may become suicidal as a result of multiple problems such as depression, substance dependence, and chronic pain and the focus may not be so clear. In these cases, clinicians can take a directive, following, or guiding approach if there is disagreement with the target. A directive approach where the clinician determines that means restriction is the target may inhibit patient engagement and interfere with any real change process. A following approach may lead the discussion away from means restriction, never to return. Guiding is halfway between a directive approach and a following approach, and is more collaborative than either. It requires clinicians to negotiate with the client and the demands of the setting. It also provides them with flexibility needed to keep clients engaged in the process of addressing important topics including means restriction. In some cases, patients may be willing to address means restriction after they are allowed to address a topic they feel is more critical.

Evoking

After patients agree to discuss means restriction, MI clinicians elicit patients' reasons for restricting their access. This approach is based on the premise that people often talk themselves into changing. If people are uncertain of what they want, they are unlikely to follow a plan of action unless they believe it is the best course. In MI for means restriction, clinicians elicit, listen for, and reinforce reasons for means restriction. Types of change talk identified in linguistic analysis of MI sessions include preparatory talk expressing the desire (e.g., I want to stay safe), ability (e.g., I can safely store my firearms), reasons (e.g., I need to store my firearms safely because I want to live), and need to change (e.g., I need to get rid of my guns). Such preparatory statements are believed to lead to talk indicating intent to engage in change behavior such as statements expressing

commitment (e.g., I am going to put my guns in a locked gun cabinet), activation (e.g., I am ready to store my guns safely), and taking steps (e.g., I have already talked to my brother-in-law about holding the keys to my gun cabinet). However, it is also important to acknowledge sustain talk or talk against means restriction. Patients may need to explore reasons *against* means restriction before they decide that means restriction is the desired outcome. When sustain talk is heard, clinicians' respectfully reflect it and integrate it into the larger context. Some patients may decide that they are not ready to take steps to restrict their access. In these cases, it is important to keep in mind that change is a process, most of which occurs outside the therapeutic setting. Sometimes the clinician's goal is to encourage the patient to begin thinking about means restriction, allowing them to decide for themselves after the session.

Planning

When patients begin to talk about change with conviction or verbalize taking steps towards change, it may be time to begin to introduce the possibility of making a plan. Such an inquiry should follow the natural flow of a conversation from preparatory talk (e.g., I have reasons to be more safe with my firearms) to commitment talk (e.g., I am going to do something to safely store my firearms) to planning. It is sometimes helpful to assess readiness to change by summarizing the patient's preparatory and commitment talk and asking a nonthreatening question such as "Where does this leave you?" or "What do you think you might want to do about that?" The process of planning may require a variety of strategies. Sometimes patients have no ideas and a plan needs to be developed, other patients come up with a number of options, and still others know exactly what they need to do. Thus, planning may require different activities, including the identification of options, weighing the pros and cons of different options, troubleshooting any concerns or barriers, specifying the steps that must be taken, or eliciting and reinforcing the patient's intent. Once a plan is agreed upon, the clinician may ask the patient if they think putting the final plan in writing would be helpful, as it provides them with a resource they can return to after they leave the office. The clinician may also want to inquire about the patient's thoughts about enlisting the help of others, so that the patient has some assistance in following through.

Case Example

For the past few years, I have been working closely with psychiatrically hospitalized veterans, many of whom own firearms. The following case example illustrates a few discussions I've had with veterans. It is important to note that it is a simplified example to illustrate the principles and phases, and most discussions are more tangential and challenging.

Engagement

CLINICIAN: Mr. Smith, it's good to see you. I heard about your stay on the inpatient unit. Sounds like things have been difficult. How are you feeling now?

VETERAN: I've been thinking about Vietnam recently, happens every October. That's when it was really bad. I was thinking about suicide, told my wife that I was thinking about it and she called 911. I spent a week on the inpatient unit and left with a tackle box of medication and a bunch of appointments. I'm not happy with this, you know.

CLINICIAN: You must have been feeling terrible, but you're home now. (*affirmation, reflection*)

VETERAN: They let me go because I told them I don't want to kill myself, and I don't. I'm angry with my wife, but I know that she was scared. I got her, my kids and grandkids. I don't want them to think that granddad's finally done it. I want to watch them grow up.

CLINICIAN: You probably don't want to hurt them either. (*reflection*)

VETERAN: No, I don't. So I have to learn how to live with all this. I've been living with it a long time, but it's hard.

CLINICIAN: It's hard, but you really do want to live. (*reflection*)

VETERAN: Yeah. Sometimes the pain is so strong that I don't think about my family, but they are why I'm still alive.

CLINICIAN: Your family is really important to you and you want to stay around for them. It reminds me of something I'd like to talk with you about. Would now be a good time? (*reflection, asking permission*)

VETERAN: Sure, what is it?

Focusing

CLINICIAN: We've been talking about your suicidal thoughts and I know that you like to hunt and have guns around the house. One thing we know is that individuals who have access to firearms are at greater risk for suicide than individuals who don't have access, particularly if they've been thinking about using a gun. You've said that you want to live and I'm wondering what you think about taking gun safety precautions? (*giving information, open question*)

VETERAN: I don't think about it and I don't want to talk about it. People have been bringing it up and pissing me off.

CLINICIAN: You're pretty angry. (*reflection*)

VETERAN: On the inpatient unit they talked to me about it and told me that I had to give my gun to somebody to hold, but I told them no. Then they told my wife that she should do it, but I got angry and told her that nobody had any right to take my guns away from me. They can put me in the hospital, but they can't take my guns away.

CLINICIAN: You felt they went behind your back trying to get your wife to take your guns. I can see why you are angry. (*affirmation*)

VETERAN: I'm a grown man, I said no, and they went and asked my wife. Do you think that's right?

CLINICIAN: Well, I know that you don't feel respected and it makes sense that you don't want to talk about it. It's really your choice and nobody can make you do it. (*affirmation*)

VETERAN: I know that you want me to get rid of the guns too.

CLINICIAN: What I really would like is to help you explore what you think about possibly taking gun safety precautions like using

locking cabinets or gunlocks, things like that. What do you think about that? (*giving information, affirmation, open question*)

Evoking

VETERAN: Well I already have some gun cases and I try to keep my guns away from the grandkids.

CLINICIAN: So you've already taken some steps to protect yourself and your grandkids. What made you do that? (*reflection, question*)

VETERAN: They're my grandkids. If there's something I can do to keep them safe I'm going to do it. It's not safe to have guns sitting around loaded with kids running around.

CLINICIAN: You need to protect your grandkids. (*reflection*)

VETERAN: What kind of grandfather would I be if I put them in danger? If the stove is on I tell them to stay away or they might burn themselves, why wouldn't I keep the guns away?

CLINICIAN: And you're a person who protects the ones you love. (*reflection*)

VETERAN: That's why I joined the army. My grandfather served, my father served, I've been taught to protect my whole life.

CLINICIAN: What do you think about protecting yourself? (*open question*)

VETERAN: Well... I see what you're saying. If I kill myself I can't protect my wife, kids, and grandkids.

CLINICIAN: It's almost as if you have to protect yourself to protect them. (*reflection*)

VETERAN: I'm not giving up my guns but I do want to be around to protect my family.

CLINICIAN: And that's worth taking some steps to protect yourself and your family. (*reflection*)

VETERAN: I also don't want those doctors who tried to use my wife to take my guns away feel like they did the right thing.

CLINICIAN: Using your gun to kill yourself would show them that they really did know what you needed and you don't want that. (*reflection*)

VETERAN: I want to make sure that nobody uses my guns to hurt themselves or another person. But I'm not getting rid of them.

CLINICIAN: So you're not willing to get rid of your guns. What other options do you think you have? (*reflection, open question*)

VETERAN: Well, I don't know. What do you think?

CLINICIAN: It sounds like you really want to live and continue to protect your family, and even see your grandkids grow up. If you shoot yourself, you can't be there with them or protect them. You also don't want to shoot yourself because then they were right and they should have taken your guns away. Although you are not willing to surrender you guns, you are willing to discuss other options. What do you think about keeping your guns but taking some safety precautions? (*summary, open question*)

Planning

VETERAN: I don't know. I want to be able to protect my family.

CLINICIAN: So you want to have some access but you don't want to have so much access that you can shoot yourself as soon as you have a thought. (*reflection*)

VETERAN: Well, it's probably not a good idea to keep a loaded gun in our bedroom. I usually go back to bed when I'm feeling depressed and it wouldn't be a good idea to have a loaded gun there.

CLINICIAN: That makes sense. Keeping your guns somewhere other than your bedroom and keeping it unloaded is one solution. Where would you keep it? (*affirmation, open question*)

VETERAN: Well, I have gun cases for most of my guns, but not my handgun. So, I can keep the guns in their gun cases and keep them in the basement where I keep my deer stand and my other hunting gear. I can keep my handgun there too up on a shelf.

CLINICIAN: Good idea. You use them for hunting so keep them with your hunting equipment. What about your ammunition? (*affirmation, open question*)

VETERAN: Well, I can keep that in the back of my garage. I have a storage locker back there, and it's pretty flimsy, but I have the only key. I lost the other one.

CLINICIAN: Would it be ok for me to share a little bit about what I know about gun safety? (*asking for permission*)

VETERAN: Sure, go ahead.

CLINICIAN: Basically, the greater number of barriers you have in the way, the safer you are. Suicidal thoughts and desires can be extremely intense, but they are often intense for short periods of time. The more barriers you have, the more likely it is that you start thinking about your family, your grandkids, and proving that the people who tried to take your guns away were wrong. So putting barriers in the way makes a lot of sense. What do you think about that? (*giving information, open question*)

VETERAN: I think I can do that. What do you suggest?

CLINICIAN: What do you think about gunlocks or locking gun cabinets? (*open question*)

VETERAN: Well, I would be willing to use them, but I don't really have the money right now. I know that gun cabinets can be expensive.

CLINICIAN: We have some gunlocks here in the VA that I can look into getting for you. How does that sound? (*giving information, open question*)

VETERAN: That sounds good, I'll use them.

CLINICIAN: How many will you need? And where will you keep the keys? (*open question*)

VETERAN: I have three guns, so I'll need three locks. I'll keep the keys in my nightstand, maybe that'll help me feel safe. Sometimes I have nightmares and I like to have something close to me that makes me feel safe.

CLINICIAN: That's a really good idea. If it's OK with you, I'd like to summarize your plan, write it down, and make a copy of it so that we can both remember it. How does that sound? (*affirmation, asking permission*)

VETERAN: Sounds good.

CLINICIAN: So, if I remember correctly, you are going to keep your guns unloaded in the basement with your hunting equipment: two guns in their cases and your handgun on the shelf. You'll have locks for each gun and will keep them locked. Your ammunition will be kept in the storage locker in the garage that you will also keep locked. And you'll keep all the keys in your bed stand so you feel safe. (*summary*)

VETERAN: I think that'll work.

CLINICIAN: That way you'll feel safe and be able to keep your family safe. Would it be all right for me to ask you how the plan is working during the next session? (*affirmation, closed*

question preparing for follow-up)
VETERAN: Sure.
CLINICIAN: Great, I am going to make a copy of this plan and give you the original so that we each have a copy of it. What are your thoughts about getting someone to help you, like your wife or another family member? (*giving information, open question*)
VETERAN: I'd rather not; I can handle it on my own.
CLINICIAN: Sounds like you're pretty confident. OK, I'll see you next week. (*affirmation*)

Additional Phase for Motivational Interviewing for Means Restriction

Follow-Through

MI was developed as a brief intervention to be completed in one or two sessions and most MI-based approaches do not address the maintenance phase of treatment, or what happens after a patient agrees to means restriction. Maintenance is critical in means restriction counseling as a patient may not restrict access after leaving the session or may regain access while they are still at risk. Clinicians should ask patients permission to follow up with them about their activities to provide the clinician an additional opportunity to collaborate with patients on overcoming unexpected barriers or reconsidering their need for continued restriction. If the patient's motivation is waning, the clinician can also return to any earlier phase in MI. Clinicians should detail any reasons for and agreements concerning means restriction in progress notes to ensure that they remember the plan.

Follow-Through
CLINICIAN: The last session we discussed gun safety and I was wondering what happened after you left the session. (*structuring*)
VETERAN: When I went home I looked at the plan and used the gunlocks and separated the guns from the ammunition, which I put in the garage.
CLINICIAN: Protecting yourself was important enough to follow through with your plan. (*affirmation*)
VETERAN: I didn't do everything though; I kept my gun in the nightstand… I just don't feel safe at night.
CLINICIAN: You feel too scared to keep the gun somewhere else. (*reflection*)
VETERAN: What if something happens and I can't get to it when I need it?
CLINICIAN: That's a struggle for you. On one hand you want to protect your family from potential danger, on the other you want to keep yourself around so that you can protect them. You're not sure which is more likely to happen, your needing the gun in an emergency, or you being a risk to yourself. (*reflection*)
VETERAN: When you put it that way it sounds kind of silly to keep it around, but I'm still not sure.
CLINICIAN: It sounds like you're not ready to take it out of your nightstand. What, if anything, do you think you're ready to do? (*reflection, open question*)
VETERAN: Well I am keeping it locked and I keep the clip in my bureau across the room.
CLINICIAN: And you feel like that will keep you safe. (*reflection*)
VETERAN: It's good enough for now. I haven't been thinking about using it.
CLINICIAN: How would you know it's not good enough? (*open question*)
VETERAN: If I start thinking about suicide again, I'll follow through with the original plan.
CLINICIAN: Is it OK if I continue to follow up on this in the future? (*asking permission*)
VETERAN: Sure.

Empirical Support

Despite the compelling argument for the importance of means restriction counseling, the paucity of alternative empirically supported approaches, and anecdotal evidence supporting this counseling approach, we note that there is currently no empirical support for the use of MI for means restriction. This lack of empirical evidence must be considered when deciding if and when to utilize MI for means restriction counseling in clinical practice. Empirically supported treatments such as cognitive therapy for suicide prevention, brief cognitive therapy for suicide prevention, and dialectical behavior therapy should be considered whenever possible, and each includes a means restriction component. When it is not possible to use one of these interventions, clinicians can still engage in means restriction counseling and will find that most patients will be willing to discuss means restriction and many will take precautions after hearing their clinicians' concerns (Bryan et al., 2011). An MI approach to means restriction counseling may be particularly appropriate and ethically defensible when patients are ambivalent or rejecting of means restriction and empirically supported or practical approaches need to be supplemented. In these cases, it provides clinicians with a tool they can use to help patients identify and explore their motivation for engaging in means restriction, think about the conditions that would compel them to take action if they are not ready, and develop a plan if they become ready. Whenever using MI, but especially when using it for target behaviors for which empirical support has yet to be developed, clinicians should keep the rule of thumb "let your clients be your guide" in mind. If the intervention seems to be increasing patients' defensiveness rather than allowing for a more open and genuine discussion about engaging in means restriction, clinicians should consider other strategies, making sure that they do not increase client resistance to future efforts to address access their access to lethal means.

Limitations

There are additional limitations that must also be considered. MI was not developed for people in the midst

of a suicidal crisis and extra care must be taken when working with such patients. Sometimes immediate intervention is needed for individuals at imminent risk, means need to be immediately removed, and patients need to be hospitalized. However, it may be beneficial to explore means restriction with patients before they are discharged, as they will have to keep themselves safe and likely to continue to limit access after they return home. In these cases, an MI approach can be used and may be particularly helpful as patients may be angry about being hospitalized and MI has been found to work well with angry patients (Karno & Longabaugh, 2004; Project MATCH Research Group, 1997). Additionally, MI is an approach that is easy to understand but difficult to do well, and substantial training is often required before clinicians master the skills (Martino, Canning-Ball, Carroll, & Rounsaville, 2011; Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). The most recent MI text (Miller & Rollnick, 2012) and the MI Network of Trainers (MINT) website (http://motivationalinterviewing.org/) are resources that clinicians can use to learn more about MI and obtain invaluable training. A brief version of MI, distilling the elements of the MI spirit and techniques that are most applicable to means restriction counseling, may improve dissemination efforts. Although there is a great need for efficacious strategies for addressing means restriction, there is a paucity of research examining this or any approach to means restriction. Thus, efficacy and effectiveness studies are sorely needed.

Conclusions

The suicide prevention literature provides little guidance on clinical approaches to means restriction with ambivalent or challenging patients. MI, a clinical approach developed for clinicians to help patients resolve their ambivalence about hazardous drinking habits, may also help patients resolve their ambivalence about restricting access to potentially lethal means. The approach requires clinicians to engage patients, establish a focus on means restriction, evoke reasons for means restriction, and collaboratively develop a plan. It is hypothesized to work by eliciting and reinforcing patients' reasons for means restriction, essentially by helping them convince themselves that means restriction is in their best interests, and collaboratively developing a plan that patients believe will work and are willing to enact. There are currently no studies testing the efficacy of an MI-based approach to means restriction and such research is needed.

References

Beautrais, A. L., Fergusson, D. M., & Horwood, L. J. (2006). Firearms legislation and reductions in firearm-related suicide deaths in New Zealand. *Australian & New Zealand Journal of Psychiatry, 40*, 253–259.

Bertholet, N., Faouzi, M., Gmel, G., Gaume, J., & Daeppen, J. B. (2010). Change talk sequence during brief motivational intervention, towards or away from drinking. *Addiction, 105*, 2106–2112.

Betz, M. E., Miller, M., Barber, C., Miller, I., Sullivan, A. F., Camargo, C. A., & Boudreaux, E. D. (2013). Lethal means restriction for suicide prevention: Beliefs and behaviors of emergency department providers. *Depression and Anxiety*, http://dx.doi.org/10.1002/da.22075.

Betz, M. E., Barber, C. W., & Miller, M. (2010). Firearm restriction as suicide prevention: Variation in belief and practice among providers in an urban emergency department. *Injury Prevention, 16*, 278–281.

Boardman, T., Catley, D., Grobe, J. E., Little, T. D., & Ahluwalia, J. S. (2006). Using motivational interviewing with smokers: Do therapist behaviors relate to engagement and therapeutic alliance? *Journal of Substance Abuse Treatment, 31*, 329–339.

Brehm, S. S., & Brehm, J. W. (1981). *Psychological reactance: A theory of freedom and control*. New York, NY: Academic Press.

Brent, D. A., Perper, J., Moritz, G., Baugher, M., & Allman, C. (1993). Suicide in adolescents with no apparent psychopathology. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*, 494–500.

Bridges, F. S. (2004). Gun control law (bill C-17), suicide, and homicide in Canada. *Psychological Reports, 94*, 819–826.

Britton, P. C., Patrick, H., & Williams, G. C. (2011). Motivational interviewing, self-determination theory, and cognitive behavioral therapy to prevent suicidal behavior. *Journal of Cognitive Behavioral Practice, 18*, 16–27.

Britton, P. C., Conner, K. R., & Maisto, S. A. (2012). An open trial of motivational interviewing to address suicidal ideation with hospitalized veterans. *Journal of Clinical Psychology, 68*, 961–971.

Britton, P. C., Williams, G. C., & Conner, K. R. (2008). Self-determination theory, motivational interviewing, and the treatment of clients with acute suicidal ideation. *Journal of Clinical Psychology, 64*, 52–66.

Brown, G. K., Have, T. T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *Journal of the American Medical Association, 294*(5), 563–570.

Brown, G. K., Steer, R. A., Henriques, G. R., & Beck, A. T. (2005). The internal struggle between the wish to die and the wish to live: A risk factor for suicide. *The American Journal of Psychiatry, 162*, 1977–1979, http://dx.doi.org/10.1176/appi.ajp.162.10.1977.

Bryan, C. J., Stone, S. L., & Rudd, M. D. (2011). A practical, evidence-based approach for means-restriction counseling with suicidal patients. *Professional Psychology: Research and Practice, 42*, 339–346.

Carrington, P. J., & Moyer, S. (1994). Gun control and suicide in Ontario. *American Journal of Psychiatry, 151*, 606–608.

Catley, D., Harris, K. J., Mayo, M. S., Hall, S., Okuyemi, K. S., Boardman, T., & Ahluwalia, J. S. (2006). Adherence to principles of motivational interviewing and client within-session behavior. *Behavioural and Cognitive Psychotherapy, 34*, 43–56.

Centers for Disease Control and Prevention. (2012). Wisqars injury mortality reports 1999–2009. Retrieved April/12, 2012, from http://www.cdc.gov.ezpminer.urmc.rochester.edu/ncipc/wisqars/

Chapdelaine, A., Samson, E., Kimberley, M. D., & Viau, L. (1991). Firearm-related injuries in Canada: Issues for prevention. *Canadian Medical Association Journal, 145*, 1217–1223.

Conwell, Y., Duberstein, P. R., Connor, K., Eberly, S., Cox, C., & Caine, E. D. (2002). Access to firearms and risk for suicide in middle-aged and older adults. *American Journal of Geriatric Psychiatry, 10*, 407–416.

Daigle, M. S. (2005). Suicide prevention through means restriction: Assessing the risk of substitution. A critical review and synthesis. *Accident Analysis & Prevention, 37*, 625–632.

Eddleston, M., & Phillips, M. R. (2004). Self poisoning with pesticides. *British Medical Journal, 328*, 42–44.

Gaume, J., Gmel, G., & Daeppen, J. (2008). Brief alcohol interventions: Do counsellors' and patients' communication characteristics predict change? *Alcohol and Alcoholism, 43*, 62–69.

Gaume, J., Gmel, G., Faouzi, M., & Daeppen, J. B. (2008). Counsellor behaviours and patient language during brief motivational interventions: A sequential analysis of speech. *Addiction, 103*, 1793–1800.

Glatt, K. M. (1987). Helpline: Suicide prevention at a suicide site. *Suicide & Life-Threatening Behavior, 17*, 299–309.

Grossman, J., Dontes, A., Kruesi, M. J. P., Pennington, J., & Fendrich, M. (2003). Emergency nurses' responses to a survey about means

restriction: An adolescent suicide prevention strategy. *Journal of the American Psychiatric Nurses Association, 9*, 77–85.
Gunnell, D., Eddleston, M., Phillips, M. R., & Konradsen, F. (2007). The global distribution of fatal pesticide self-poisoning: Systematic review. *BMC Public Health, 7*, 357.
Gunnell, D., Fernando, R., Hewagama, M., Priyangika, W. D., Konradsen, F., & Eddleston, M. (2007). The impact of pesticide regulations on suicide in Sri Lanka. *International Journal of Epidemiology, 36*, 1235–1242.
Hawton, K. (2002). United Kingdom legislation on pack sizes of analgesics: Background, rationale, and effects on suicide and deliberate self-harm. *Suicide & Life-Threatening Behavior, 32*, 223–229.
Hawton, K., Simkin, S., Deeks, J., Cooper, J., Johnston, A., Waters, K., ... Simpson, K. (2004). UK legislation on analgesic packs: Before and after study of long term effect on poisonings. *British Medical Journal, 329*, 1076.
Hawton, K., Townsend, E., Deeks, J., Appleby, L., Gunnell, D., Bennewith, O., & Cooper, J. (2001). Effects of legislation restricting pack sizes of paracetamol and salicylate on self poisoning in the United Kingdom: Before and after study. *British Medical Journal, 322*, 1203–1207.
Hemenway, D., & Miller, M. (2002). Association of rates of household handgun ownership, lifetime major depression, and serious suicidal thoughts with rates of suicide across US census regions. *Injury Prevention, 8*, 313–316.
Henriques, G., Wenzel, A., Brown, G. K., & Beck, A. T. (2005). Suicide attempters' reaction to survival as a risk factor for eventual suicide. *American Journal of Psychiatry, 162*, 2180–2182.
Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91–111.
Hodgins, D. C., Ching, L. E., & McEwen, J. (2009). Strength of commitment language in motivational interviewing and gambling outcomes. *Psychology of Addictive Behaviors, 23*, 122–130.
Jobes, D. A., & Mann, R. E. (1999). Reasons for living versus reasons for dying: Examining the internal debate of suicide. *Suicide and Life-Threatening Behavior, 29*, 97–104.
Karno, M. P., & Longabaugh, R. (2004). What do we know? Process analysis and the search for a better understanding of project MATCH's anger-by-treatment matching effect. *Journal of Studies on Alcohol, 65*, 501–512.
Kovacs, M., & Beck, A. T. (1977). The wish to die and the wish to live in attempted suicides. *Journal of Clinical Psychology, 33*, 361–365.
Kreitman, N. (1976). The coal gas story. United Kingdom suicide rates, 1960-71. *British Journal of Preventive & Social Medicine, 30*, 86–93.
Leenaars, A. A., Moksony, F., Lester, D., & Wenckstern, S. (2003). The impact of gun control (bill C-51) on suicide in Canada. *Death Studies, 27*, 103–124.
Lester, D. (1990). The effects of detoxification of domestic gas on suicide in the United States. *American Journal of Public Health, 80*, 80–81.
Lester, D. (1993). Suicide from bridges in Washington, DC. *Perceptual & Motor Skills, 77*, 534.
Lester, D., & Abe, K. (1989). The effect of restricting access to lethal methods for suicide: A study of suicide by domestic gas in Japan. *Acta Psychiatrica Scandinavica, 80*, 180–182.
Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., ... Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*(7), 757–766.
Loftin, C., McDowall, D., Wiersema, B., & Cottey, T. J. (1991). Effects of restrictive licensing of handguns on homicide and suicide in the District of Columbia. *New England Journal of Medicine, 325*, 1615–1620.
Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... Hendin, H. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association, 294*, 2064–2074.
Martin, T., Christopher, P. J., Houck, J. M., & Moyers, T. B. (2011). The structure of client language and drinking outcomes in project match. *Psychology of Addictive Behaviors, 25*, 439–445, http://dx.doi.org/10.1037/a0023129.
Martino, S., Canning-Ball, M., Carroll, K. M., & Rounsaville, B. J. (2011). A criterion-based stepwise approach for training counselors in motivational interviewing. *Journal of Substance Abuse Treatment, 40*, 357–365.
Miller, M., Azrael, D., & Hemenway, D. (2002). Household firearm ownership and suicide rates in the United States. *Epidemiology, 13*, 517–524.
Miller, M., Azrael, D., Hemenway, D., & Vriniotis, M. (2005). Firearm storage practices and rates of unintentional firearm deaths in the United States. *Accident Analysis & Prevention, 37*, 661–667.
Miller, M., & Hemenway, D. (1999). The relationship between firearms and suicide: A review of the literature. *Aggression and Violent Behavior, 4*, 59–75.
Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*, 455–461.
Miller, W. R., & Mount, K. A. (2001). A small study of training in motivational interviewing: Does one workshop change clinician and client behavior? *Behavioural and Cognitive Psychotherapy, 29*, 457–471.
Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.
Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.
Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*, 527–537, http://dx.doi.org/10.1037/a0016830.
Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology, 72*, 1050–1062.
Moyers, T. B., & Martin, T. (2006). Therapist influence on client language during motivational interviewing sessions. *Journal of Substance Abuse Treatment, 30*, 245–251.
Moyers, T. B., Martin, T., Christopher, P. J., Houck, J. M., Tonigan, J. S., & Amrhein, P. C. (2007). Client language as a mediator of motivational interviewing efficacy: Where is the evidence? *Alcoholism: Clinical and Experimental Research, 31*, 40S–47S.
Moyers, T. B., Miller, W. R., & Hendrickson, S. M. L. (2005). How does motivational interviewing work? Therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology, 73*, 590–598.
O'Donnell, I., Arthur, A. J., & Farmer, R. D. (1994). A follow-up study of attempted railway suicides. *Social Science & Medicine, 38*, 437–442.
Oliver, R. G., & Hetzel, B. S. (1972). Rise and fall of suicide rates in Australia: Relation to sedative availability. *Medical Journal of Australia, 2*, 919–923.
Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm. Systematic review. *British Journal of Psychiatry, 181*, 193–199.
Peterson, L. G., Peterson, M., O'Shanick, G. J., & Swann, A. (1985). Self-inflicted gunshot wounds: Lethality of method versus intent. *American Journal of Psychiatry, 142*, 228–231.
Phillips, M. R., Yang, G., Zhang, Y., Wang, L., Ji, H., & Zhou, M. (2002). Risk factors for suicide in China: A national case-control psychological autopsy study. *Lancet, 360*, 1728–1736.
Price, J. H., Kinnison, A., Dake, J. A., Thompson, A. J., & Price, J. A. (2007). Psychiatrists' practices and perceptions regarding anticipatory guidance on firearms. *American Journal of Preventive Medicine, 33*, 370–373.
Project MATCH Research Group. (1997). Project MATCH secondary a priori hypotheses. *Addiction, 92*, 1671–1698.
Rodriguez Andres, A., & Hempstead, K. (2011). Gun control and suicide: The impact of state firearm regulations in the United States, 1995-2004. *Health Policy, 101*, 95–103.
Rudd, M. D., Bryan, C. J., Wertenberger, E., Delano, K., Wilkinson, E., Breitbach, J., ... Peterson, A. L. (2014, November). *Brief cognitive behavioral therapy for suicidal military personnel: Results of a two-year randomized controlled trial*. In C. J. Bryan (Chair), Brief cognitive

behavioral interventions to reduce suicide attempts in military personnel. Paper presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Philadelphia, PA.

Seiden, R. H. (1978). Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. *Suicide & Life-Threatening Behavior, 8,* 203–216.

Shenassa, E. D., Rogers, M. L., Spalding, K. L., & Roberts, M. B. (2004). Safer storage of firearms at home and risk of suicide: A study of protective factors in a nationally representative sample. *Journal of Epidemiology & Community Health, 58,* 841–848.

Simon, O. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M. J., & O'Carroll, P. W. (2001). Characteristics of impulsive suicide attempts and attempters. *Suicide & Life-Threatening Behavior, 32,* 49–59.

Slovak, K., Brewer, T. W., & Carlson, K. (2008). Client firearm assessment and safety counseling: The role of social workers. *Social Work, 53,* 358–366.

Vader, A. M., Walters, S. T., Prabhu, G. C., Houck, J. M., & Field, C. A. (2010). The language of motivational interviewing and feedback: Counselor language, client language, and client drinking outcomes. *Psychology of Addictive Behaviors, 24,* 190–197.

Wenzel, A., Brown, G. K., & Beck, A. T. (2009). Cognitive therapy for suicidal patients with substance dependence disorders. 283–310.

Whitlock, F. A. (1975). Suicide in Brisbane, 1956 to 1973: The drug-death epidemic. *Medical Journal of Australia, 1,* 737–743.

Yamasawa, K., Nishimukai, H., Ohbora, Y., & Inoue, K. (1980). A statistical study of suicides through intoxication. *Acta Medicinae Legalis Et Socialis, 30,* 187–192.

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