Firearms and Suicide: Lethal Means Safety Counseling in Dialectical Behavior Therapy Skills Training Manual and Teaching Notes

Lauren Lovato Jackson, Psy.D.

Lizbeth Gaona, Ph.D., LCSW

Meredith S. Sears, Ph.D.

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Acknowledgments

The material introduced in this manual has been created by the adaptation of the second edition Dialectical Behavior Therapy Skills Manual (2014) created by Dr. Marsha Linehan. Undoubtedly Dr. Linehan has been a pioneer in the mental health field and it is with a humble stance by which the authors of this manual have the privilege of adapting Dr. Linehan's good work for the purposes of streamlining firearm lethal means safety counseling into DBT.

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Introduction to Current Materials

Firearms are highly prevalent, with one out of every three U.S. households having at least one firearm in the home (Azrael, Cohen, Salhi & Miller, 2018). While Dialectical Behavior Therapy (DBT) clinicians are likely to know about the lethality of firearms, many are less aware about the nuanced relationship between firearm access, firearm experience, and even firearm storage practices as they relate to suicide. And while reducing access to lethal means is heavily emphasized in standard DBT (see pages 470-471, Suicidal Behavior Strategies Checklist outlined in Table 15.2 of Dr. Linehan's 1993 text), clinicians, even those working with suicidal individuals, are often not consistently asking about firearm access. Given the prevalence and lethality of firearms, the complex relationship between suicide and firearms, as well as the noted inconsistencies in targeting firearms in clinical settings, the current authors observed an opportunity to bridge the gap between lethal means safety counseling and routine DBT practice. What follows is a review of some of the most pertinent research to date providing a strong rationale for lethal means safety counseling, a discussion of how to do so from a DBT framework, and teaching notes for handouts and worksheets developed to assist clinicians with integrating assessment and intervention related to firearm access into routine DBT practice.

Background

The Lethality of Firearms

The lethality of a suicide attempt by firearm is staggeringly high. Death certificate data reveal that 85-90% of firearm suicide attempts prove to be fatal, whereas only 5% of all other methods combined result in fatality (CDC, 2016). It therefore follows that those that use a firearm to attempt suicide are more likely to die during their first attempt when compared to those that use alternative means (Anestis & Capron, 2018). These data become even more compelling when considering that approximately 90% of individuals who make a first-time suicide attempt do not go on to die by suicide, and 75-80% never make a second attempt (Owens, Horrocks, & House, 2002). The role of firearms in suicide is so significant that firearm ownership has proven to predict *overall* suicide rates, not simply firearm suicide rates (approximately 50% in the U.S.; Kegler, Dahlberg, & Mercy, 2018; Hyejin, Khazem, & Anestis, 2016).

Suicide is a major public health concern. It is the 10th leading cause of death (Kegler, Dahlberg, & Mercy, 2018) and the number one preventable cause of death in the United States. Current estimates suggest that over 20,000 people within the U.S. annually die by suicide using a firearm (Allchin & Chaplin, 2017). These data are clear: Efforts to reduce suicide rates, by necessity, have to include targeting firearms.

The Relationship Between Firearm Access and Suicide

Multiple studies have demonstrated that firearm ownership has been associated with suicide death above and beyond a number of potential confounding factors including demographics, religiosity, depression, antidepressant use, substance use, suicide ideation, and

even prior suicidal behavior (Anestis & Houtsma, 2018; Miller, Barber, White & Azrael, 2013; Miller, Lippman, Azrael, & Hemmenway, 2007; Miller, Swanson, & Azrael, 2016; Miller, Warren, Hemenway, & Azrael, 2015; Opoliner, Azrael, Barber, Fitzmaurice, & Miller, 2014). Firearm ownership rates largely determine variations in suicide mortality across the 50 states in the U.S. In fact, suicide is five times more common among firearm-owning households when compared to households where a firearm is not present (Simon, 2007). One particularly compelling study found that individuals who lawfully purchased a handgun died by suicide at more than double the rate of matched members of the general population. Furthermore, the risk of suicide increased immediately after the purchase of a firearm and remained elevated throughout the entire six-year study period (Wintemute, Parham, Beaumont, Write, & Drake, 1999).

Beyond simple access to firearms, research has observed several other firearm-related behaviors that appear to influence suicide outcomes. Experience with firearms (even just a history of firing one) appears to increase risk of suicide attempts, possibly due to increased comfort and aptitude with the weapon (Anestis & Capron, 2018; Klonsky & May, 2015). Even how an individual stores their weapon is significant when considering suicide potential. Khazem et al. (2016) demonstrated that those who store a firearm loaded and unsecured experience increased likelihood of future suicide attempts as well as a heightened fearlessness of death. This heightened fearlessness of death is particularly important when considering one's capability for suicide. According to the Interpersonal Theory of Suicide (Joiner, 2005; Van Orden et al., 2010), the capability for self-harm is a critical component for making a lethal or nearly lethal suicide attempt. Thus, the relationship between firearms and suicide appears to be multidimensional with factors like access, experience, and storage behaviors all influencing suicide outcomes.

The idea that access to firearms intersects with the impulsive, often mood-dependent nature of suicide will come as no surprise to the DBT community. In fact DBT, with its functions and modes, is structured specifically to address the issue of impulsivity and works to facilitate skill acquisition that will promote one's ability to resist the urge to engage in problematic mood-dependent behaviors.

Simon et al. (2001) note that 70% of individuals surviving a suicide attempt made the decision to attempt suicide within one hour of acting on a suicidal urge. Moreover, for some individuals, the window between urge to action appears to be even smaller, with 24-40% of suicide attempters making the decision to attempt suicide within 5 minutes of action (Simon et al., 2001; Williams, Davidson, & Montgomery, 1980). The issue of impulsivity is particularly important to consider when discussing firearm access. As previously noted, the chances of surviving an attempt by firearm is drastically low, with only a 10-15% survival rate (CDC, 2016). Given the extreme lethality of firearms and the highly impulsive nature of suicide, these data suggest that limiting firearm access before a suicidal crisis occurs is paramount to preventing suicide.

The Myth of Means Substitution

Clinicians and clients alike often suggest that targeting firearm access is unlikely to yield any significant benefit due to the belief that an individual with suicidal urges will inevitably resort to an alternative method for suicide if a firearm is made unavailable or difficult to access. Many communities have found, however, that reduced access to a commonly used suicide method at a population level (whether that be firearms, lethal pesticides, or carbon monoxide gas in ovens) lowers *overall* suicide rates, without substantial increases in attempts made with alternative means (e.g., Lubin et al., 2010; Daigle, 2005; Gunnell et al., 2007; Kreitman, 1976). One explanation for the absence of evidence for means substitution is that individuals tend to have a strong preference for a single method for suicide (Daigle, 2005). In addition, it should be reiterated that the probability of surviving a suicide attempt by firearm is overwhelmingly lower than survival rates for all other methods combined, so lethal means safety counseling targeting firearms is likely to increase the probability of survival even if a patient does consider or even attempt by alternative means (Barber & Miller, 2014).

The Decision to Focus on Firearms

The current authors deliberated over whether the proposed materials should singularly focus on firearms verses addressing a wider range of lethal means. Ultimately, the data presented above regarding the lethality of firearms when compared to all other lethal means as well as the unique relationship between firearms and the capability for suicide (e.g. access, experience with, storage practices) was sufficiently strong to warrant its own discussion. We also felt it was important to acknowledge the unique barriers clinicians face when discussing firearms including the lack of concrete guidance, lack of focused training, lack of knowledge and the special discomfort providers report experiencing when targeting firearms with their clients. Lastly, to the authors' knowledge, there are currently no other DBT skills worksheets targeted specifically at firearm suicide safety.

In addition, there are other unique concerns to targeting firearms in the clinical setting that do not present themselves with other lethal means. One such concern is that targeting firearm access with clients at risk for suicide may raise issues related to Second Amendment rights. The issue of firearms can often be an emotionally charged conversation as individuals often have strongly held beliefs when it comes to guns. It is to be expected that there will be situations in which a provider and client find themselves on opposite sides of the dialectic when discussing firearms. While DBT clinicians are specifically trained to acknowledge and work with dialectical tensions that may, and often do, occur in the therapy room, the current authors felt it was important to equip DBT clinicians with language that has been identified in the firearm lethal means counseling literature to help navigate this unique issue that is likely to arise when targeting firearm access with our clients.

While the authors of the current project decided to develop materials specifically designed to integrate firearm safety counseling into DBT due to the aforementioned reasons, it

should be noted that most worksheets can be adapted to address alternative methods of suicide should the therapist find a need to do so.

Barriers to Clinicians Targeting Firearm Access and Storage

As has already been emphasized, the data regarding the lethality of suicide by firearm is overwhelming. Despite these findings, healthcare providers are not consistently asking clients about firearm access and storage practices: In 2016 a systematic review summarizing 72 research articles regarding firearm injury prevention screening found that screening for firearms is infrequent among medical and mental health providers (Roszko et al., 2016). There are several barriers in medical and mental health fields that may account for the lack of streamlined, comprehensive assessment and clinical intervention when it comes to firearms.

One barrier is the lack of concrete guidance from organizations that provide oversight to medical and mental health disciplines. As an example, the American Psychiatric Association published a 117-page document in 2003 titled "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors." Only two pages in this document offer instruction on how to approach lethal means safety with their patients. Furthermore, this content is relatively vague, with the primary guidance suggesting that clinicians should initiate a conversation about lethal means and document their efforts in their clinical notes. Even leading researchers in the field of lethal means safety counseling suggest that suicide interventions that specifically address firearm access are "in their early stages" (Slovak et al., 2019).

An additional barrier noted in the literature is the lack of clinical training for providers. A 2016 systematic review found that only 25% of training programs met inclusion criteria for effective firearm lethal means safety training for healthcare providers and trainees (Puttagunta, Coverdale, & Coverdale, 2016). One study showed that over half of psychiatrists surveyed had not received any training related to firearm safety and of those who had, the most common sources of input were professional journals and meetings as opposed to content streamlined into their academic curriculum. Furthermore, only 25% of the sample had a routine system for identifying patients who owned firearms (Price et al., 2007). Another study found that 75% of social workers surveyed reported not receiving any training on firearm lethal means safety counseling. While a third of social workers assessed for firearm access with their clients on a regular basis, only one in six routinely provided counseling on reducing firearm access (Slovak, Brewer, & Carlson, 2008). Lastly, a study of clinical psychologists found that nearly half of those surveyed had not received any training on firearms and suicide, and only 25% reported having a routine system for identifying patients with access to firearms (Traylor, et al., 2010). With the lack of training, it is intuitive to suggest that providers who do not receive training in this area are going to be less inclined to engage their clients in firearm lethal means safety counseling. To this point, recent research has demonstrated that the likelihood of mental health providers conducting firearm safety counseling is highly unlikely among clinicians who have not received training in this area (Slovak, Brewer, & Carlson, 2008; Roszko et al., 2016).

Clinicians also report discomfort in discussing firearm access with their clients. A lack of knowledge about how to operate firearms and how to promote safe and secure firearm storage has been identified by providers as a barrier to discussing safety measures with their clients (Price et al., 2013). Another provider worry is that engaging individuals in a discussion about firearm access may damage the patient relationship (Wintemute, Betz, & Ranney, 2016). Discomfort in discussing firearm access is also understandable given the tense political climate that exists within the United States regarding one's right to bear arms. To overcome these barriers, the Consortium for Risk-Based Firearm Policy (Allchin & Chaplin, 2017) published "Breaking Through Barriers: The Emerging Role of Healthcare Provider Training Programs in Firearm Suicide Prevention." This 51-page document provides recommended guidelines for furthering the advancement of effective firearm lethal means safety counseling in clinical settings. The authors make special note that providers have a unique opportunity to engage their clients in a productive conversation about the relationship between suicide, firearm access and storage behaviors. In order to address providers' lack of knowledge about firearms and firearm culture, the Consortium for Risk-Based Firearm Policy notes that there are many organizations that will work to help educate providers on firearms and relevant firearm safety enhancement options. While the materials developed for DBT Firearm Lethal Means Safety Counseling are meant to educate therapists about common firearm safe storage options, it is highly recommended that clinicians engage in some form of additional firearm safety orientation. Many such resources can be found locally as well as on the internet (see the additional resources section of this manual for suggestions).

Clinician attitudes related to firearm lethal means safety also serve as a barrier to engaging clients in effective counseling. According to Sullivan (2004), only 22% of surveyed psychologists reported believing that they *should* provide means-safety counseling to their patients (as cited by Bryan, Stone, & Rudd, 2011). Of those clinicians who do view firearm access as falling in a healthcare provider's purview, many believe that asking about firearm ownership once during the intake process is sufficient. This suggests that there is a lack of awareness among mental health providers regarding the importance of providing comprehensive firearm lethal means safety counseling to every patient that comes through their door as well as the importance of continued assessment for changes in firearm ownership and access. Many clinicians also report the problematic belief that engaging clients in firearm lethal means safety counseling will be unlikely to yield any significant benefit. Price et al. (2007) found that clinicians estimated that less than half of their firearm-owning patients would be inclined to take active steps to safely store their firearms if provided with safety-enhancement recommendations. In this same study, clinicians estimated that only a quarter of their firearm-owning patients would be willing to remove firearms from their homes when recommended to do so. Not surprisingly, clinicians who view means-safety counseling as ineffective are five times less likely to provide it to their patients (Price et al., 2007).

In light of these findings, it is important to emphasize that there is encouraging research to suggest that clients are more receptive to firearm lethal means safety counseling that we might anticipate. In a study conducted by Kruesi et al. (1999), 63% of counseling recipients reported

taking steps to secure their firearms when recommended to do so. Further, as Bonds et al. (2007) so aptly point out, the more we make firearm safety counseling the norm, as we do when we assess for other high-risk health behaviors such as alcohol or tobacco intake, the more it is likely to become an accepted part of routine health care.

Effectiveness of Interventions Promoting Firearm Lethal Means Safety

Although interventions aimed at promoting safer firearm storage are in their early stages, there are many examples that suggest that reducing access to firearms is a highly effective means of preventing suicide. One of the most powerful demonstrations of this is when evaluating the impact of a policy change made within the Israeli Defense Force in 2006. In response to tragic losses resulting from firearm-related suicide, the Israeli Defense Force changed its policy to require soldiers to leave their service weapons on base when they went home during weekend leave. This simple policy change resulted in a 40% reduction in suicide deaths among soldiers aged 18-21. It is notable that weekday firearm suicides did not substantially increase in response to this policy change, which is consistent with the evidence that suicidal crises are often very brief. This study also helped debunk the myth of means substitution in that findings revealed no subsequent increase in use of alternative suicide methods after weekend firearm access was restricted (Lubin et al., 2010).

Other studies highlight innovative ways in which reduction in access to means has been approached through legislature change. For example, state laws regulating access and exposure to handguns are associated with decreases in both firearm and overall suicide rates, even after accounting for important demographic and geographic factors such as race, education, and population density (Jin, Khazem, & Anestis, 2016). Examples of these legislation changes include requiring a license in order to own a handgun, universal background checks, mandatory waiting periods, and restriction of open carry laws.

Research even shows that safe storage moderates the relationship between suicidal ideation and self-reported likelihood of engaging in future suicide attempts. Khazem et al. (2016) recruited a large sample of firearm-owning military service members and discovered that the association between current suicidal ideation and the belief that suicide was likely in the future was significantly stronger among soldiers who stored their firearm loaded and unsecured. And as has already been reported, unsecured storage is also linked to increased fearlessness of death, which likely impacts the individual's capability to attempt suicide (Joiner, 2005; Van Orden et al., 2010).

Safe storage has recently been targeted through "gun shop projects" in which suicide prevention experts have teamed up with firearm retailors and other members of the firearm-owning community in order to promote the temporary removal of firearms from the home during times of crisis. Collaborations between the suicide prevention and firearm communities are growing and the impact of these efforts are still yet to be understood. Additional public resources are forthcoming, including state maps highlighting local firearm shops and law enforcement agencies that have expressed willingness to consider temporary firearm storage for

individuals during times of crisis. See the additional resources section for more information on these resources.

In addition to immediately increasing physical safety, there may be additional benefits that present themselves when working to incorporate firearm safety counseling into DBT. One such opportunity is to address many of the common misconceptions that the public may have regarding the relationship between firearms and suicide. According to Anestis, Butterworth, and Houtsma (2018), most firearm owners do not believe that firearm ownership and storage practices are significantly related to suicide. Furthermore, more than half of those sampled endorsed believing in the myth of means substitution. These findings suggest that many individuals do not believe that firearms play a significant role in the issue of suicide and thus may benefit from being addressed in a clinical setting as it may offer up opportunities to address inaccurate beliefs and highlight new learning. DBT-trained clinicians are well positioned to use DBT-based stylistic strategies to not only target firearm-keeping behaviors themselves, but also increase awareness regarding the relationship between firearms and suicide in a manner that may serve clients well into the future.

DBT Clinical Strategies for Firearm Lethal Means Safety Counseling

The general approach emphasized in effective lethal means safety counseling is very consistent with adherent DBT. Clinicians trained in DBT are thus well-suited to target change in firearm storage behavior as part of standard DBT.

The Dialectic of Acceptance and Change

One concept that both lethal means safety literature and DBT heavily emphasize is the importance of adopting a dialectical stance throughout the course of therapy. In her 1993 book, Dr. Linehan writes:

> The central dialectical tension in DBT is that between change and acceptance. The paradoxical notion here is that therapeutic change can only occur in the context of acceptance of what is; however "acceptance of what is" is itself change. DBT therefore requires that the therapist balance change and acceptance in each interaction with the patient. (p. 99)

This notion of finding the balance between acceptance and change is stressed in the firearm lethal means safety counseling literature. In an article discussing the application of Motivational Interviewing as it relates to suicide prevention, Brittan, Bryan and Valenstein (2016) write:

> 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 individuals' ambivalence often activates the opposite side of their ambivalence, eliciting behavior that is viewed as defensive or resistant… 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. (p. 53)

Both lethal means safety counseling and DBT are highly client-centered and the validation of the client's thoughts, beliefs and experiences are of paramount importance. In both modalities, the client's perspective is (of necessity) accepted and taken seriously. Acceptance of the client's freedom to choose, and the communication of this acceptance through the maintenance of a dialectical stance, is critical when working to promote changes in firearm-keeping behavior.

Validation

As is heavily emphasized throughout the model, the role of validation is essential in all adherent DBT. Dr. Linehan writes extensively on the importance of the six levels of validation in DBT. The current authors will not go in depth about how to validate given that it has been so comprehensively discussed in other works. However, we did want to make special mention of a few clinical situations where validation may be particularly important when targeting firearm access and storage practices.

As already described, discussing firearm ownership can be a polarizing topic that can elicit strong reactions from many people. Given how strongly some clients feel about their firearms, it is vital to understand a client's history with firearms and also explore what the client's firearm means to them. As an example, many firearm owners experience a strong sense of belonging and personal identity through being connected to the firearm community. Clients may derive a tremendous sense of tradition and connection through engaging in firearm-related recreational activities, such as hunting or organized shooting events. This sense of connectedness may also result in important social opportunities and behavioral activation. For clients who derive a sense of connectedness and community through firearm-related activities, or whose personal identity is closely tied to firearm ownership, the prospect of temporarily decreasing or

eliminating firearm access may be particularly alarming. In these situations it will be vital to explore the client's history related to their firearms and to validate any sense of threat or loss that may result from increasing distance between them and their firearm.

Opportunities to provide validation also present themselves when considering how lethal means safety counseling may activate client concerns regarding their constitutional rights. When beginning the conversation about firearm access and safety, therapists should be prepared for some clients to express concerns related to their Second Amendment rights. In particular, clinical efforts to decrease access may be perceived as infringing on clients' constitutional right to bear arms. In response to this, the therapist can reorient the conversation back to the client's goals for therapy and life worth living, emphasizing that the focus of DBT Lethal Means Safety Counseling is completely on that of enhancing the client's immediate safety, without the intent of infringing upon their constitutional rights. Values clarification and collaborative goal setting with an emphasis on safety (for the client and others around them) is a necessary step before taking further action to elicit change in firearm-keeping behavior. For this reason, the authors begin the current module content with the handout titled: *Introduction to DBT Firearm Lethal Means Safety Counseling: Exploring the Dialectic Between the Benefits of Firearm Ownership and Safety.* It may also be useful for the therapist to emphasize that some interventions, such as completely removing firearms from the home, can be used during heightened times of anticipated distress as a *temporary* measure. Collaboratively joining around the goal of helping the client realize their life worth living while also developing firearm safety plans that are flexible and take into account the client's perspective are key to navigating concerns related to Second Amendment rights.

Validation with Military Populations and Trauma Survivors

There are also specific populations for whom validation is likely to be especially important when working to promote safe firearm-keeping behaviors. For example, past and present military service members and individuals who have been exposed to trauma are likely to have unique and complex relationships with their firearm(s). Understanding these unique relationships is critical to providing effective validation.

The relationship between past and present service members and their firearms varies based on the nature of the individual's experience with the military, the nature of their experiences with firearms, and their military occupational specialty, among other factors. It is common for service members to report developing a very strong attachment to their weapon. This attachment is often overtly facilitated through military training. Active duty service members have strict rules with regard to when they are expected to have their firearm on them and how they attend to their firearm (with significant consequences if these rules are violated). The result is often a unique and personalized relationship with the firearm. This learning history ultimately reinforces the belief that their firearm is essential to safety, and that the storage and caretaking practices overlearned in the military must be maintained. Safety concerns may be particularly entrenched if the client has been exposed to combat situations, and are particularly vital for the clinician to explore and validate. Further, shame related to mental health concerns

may impact a Veteran or service member's willingness to reduce access to their firearm. For an active duty service member, embarrassment or ridicule by other unit members may even occur if others become aware of the individual's restricted firearm access. In sum, it is vital that DBT therapists explore and validate ways in which reducing firearm access with Veterans and military service members can be triggering.

Specific beliefs as they relate to firearm access are also important to be mindful of when working with individuals who have survived trauma. It should be noted that the co-occurrence of BPD and PTSD is estimated at 30% in community samples (Grant et al., 2008; Pagura at al., 2014) and 50% in clinical samples (Harned, Rizvi, & Linehan, 2010; Zanarini et al., 1998). These estimates do not account for individuals with BPD who have been exposed to trauma but do not meet full criteria for PTSD. As we know from an abundance of research, issues of safety, trust, power and control are often disrupted by trauma (Resick & Schnicke, 1993). As a result, many individuals engaged in DBT may come to therapy with fairly rigid and entrenched beliefs suggesting that having easy access to a firearm is vital to their overall safety. For this reason, the current authors developed *Worksheet 3: Check the Facts About Firearms and Self-Defense*. This worksheet prompts clients to consider their beliefs about firearms as a means of protecting themselves. And to assist with promoting change in these beliefs, the authors have provided clinicians with relevant research evaluating the effectiveness of firearms in acts of self-defense (see teaching notes for *Worksheet 3: Check the Facts About Firearms and Self-Defense* below). However, it should be emphasized that the role of validation is vital when engaging a trauma survivor in these discussions.

Evoking the Life Worth Living

DBT therapists regularly engage in dialogue around the client's "life worth living," and consistently root the change process in the client's goals throughout therapy. Similarly, the firearm lethal means safety counseling literature emphasizes the notion that critical elements of change exist within the client, and that it is the clinician's job to "evoke" or draw them out (Britton, Bryan and Valenstein, 2016). The client's personal reasons for change generate forward mobility well beyond any reasons for change that might be supplied by the therapist. The spirit of "evocation" hearkens back to the DBT life worth living in that the therapist's reasons for the client to change are typically far less meaningful to the client than are their own reasons. To aid in the evocation of the client's goals during lethal means safety counseling discussions, several of the DBT Firearm Lethal Means Safety Counseling Handouts and Worksheets prompt clients to consider their life worth living as they evaluate their firearm-keeping behaviors and consider ways in which they can increase safety from firearm-related injury.

Commitment Strategies

Specific commitment strategies emphasized in standard DBT are also useful when engaging a client in lethal means safety counseling. While all of the commitment strategies

emphasized in DBT are likely to be useful when targeting firearm storage, here we will specifically highlight "Foot-In-The-Door" and "Door-In-The-Face."

In the firearm lethal means safety counseling literature, the therapist's goal is typically complete removal of a firearm from a client's home. Unquestionably, complete removal of a firearm results in the greatest decrease in risk for a suicide by firearm. However, if complete removal is not likely to be an option that the client is willing to consider, increasing barriers to access has been shown to reduce the probability of death by firearm-related suicide (Conwell et al., 2002; Miller, Azrael, Hemenway, & Vriniotis, 2005; Shenassa, Rogers, Spalding, & Roberts, 2004). These kinds of negotiations between client and therapist are great opportunities to employ the commitment strategies of "Foot-in-the-door" and "Door-in-the-face." For example, stepped removal of an unloaded, unlocked firearm from a client's nightstand might be considered a graduated exposure exercise rooted in "Foot-in-the-door": The clinician might first encourage separating the ammunition from the firearm within the nightstand, then adding a lock, then removing the ammunition from the room, and so on. Similarly, a "Door-in-the-face" approach might start with an obviously unacceptable, seemingly outrageous recommendation by the clinician ("The safest option would be to surrender the firearm to the police for good!"), then a significantly scaled back request ("Well, what about just putting the ammunition in another room for a while?"). For more information regarding these strategies, see Chapter 9 "Core Strategies: Part II. Problem Solving" in Dr. Linehan's 1993 text.

Consultation to the Patient Versus Environmental Intervention

Support from friends and family when working to target firearm-keeping behaviors can be extremely important. For firearm lethal means safety counseling, this support may look like a trusted family member or friend temporarily taking possession of a firearm during times of crisis (although clinicians should note that state laws differ significantly when it comes to the temporary transfer of firearms). Support could also include a trusted collateral changing the code to the client's gun safe or temporarily holding onto a client's gun lock key. The DBT Firearm Lethal Means Safety Counseling Handouts and Worksheets prompt the client and clinician to consider ways in which trusted friends and/or family members can be brought into the change process.

When considering the role that the environment may have in enhancing firearm-related suicide safety, special consideration should be paid to situations where the client is at heighted risk for firearm-related suicide but is not the actual firearm owner (e.g., adolescents whose parents own firearms, or adults cohabiting with a spouse or roommate who owns firearms). In these situations, it will be vital to work collaboratively with the client in order to educate the firearm owner about the relationship between firearm access and suicide, and consider how best to alert the owner to the client's risk status if factors suggestive of suicide risk are present. Periodic family sessions may be useful, where the client is present and encouraged to use skills in order to participate effectively in the change process. As is stated in Dr. Linehan's 1993 text:

> During a meeting with family members or significant others, the therapist also helps the participants adopt a better understanding of and more validating attitude toward the patient. The DBT theory is advanced, and the need for validation and skill building is discussed. (p. 421)

As is already understood in adherent DBT, therapists should mindfully consider the dialectical tensions that exist between consultation to the patient and environmental intervention when targeting firearm access. The DBT therapist should also seek consultation from their DBT team when working to resolve these dialectical tensions. In the original DBT text, it is noted that "when the immediate outcome is very important and the patient is unable or unwilling to intervene effectively for herself, the therapist should move from the consultation strategies to the environmental intervention strategies (Linehan, 1993, p. 422)."

Dr. Linehan emphasizes chronic patterns in which clinicians over-fragilize their clients and as a result do too much on the client's behalf, which ultimately robs clients of the opportunity to practice using skills to intervene effectively on their environments (Linehan, 1993, p.422). When resolving the dialectical tension between consultation to the patient and environmental intervention as it relates to firearm access, it is useful to consider the position Dr. Linehan advises when working with clients who live in an unsafe environment:

> When an individual lives in an unsafe environment, how should a therapist target treatment? Should it focus on making the environment safer? Should the individual be taken out of the unsafe environment if it cannot be changed? Or should treatment focus on teaching the individual how to keep safe in an unsafe environment? Each approach has its merits; each is necessary at times. Within DBT, however, the philosophical emphasis is on the last of these—teaching the patient how to create safety for herself. (Linehan, 1993, p. 423)

Still, the clinical decision to intervene directly with the environment verses providing consultation to the patient is a complicated one. It goes without stating that an unsecured firearm in the home of a client represents a clinical situation in which the outcome is extremely important. Given the lethality of firearms and the importance of lethal means safety counseling occurring in the beginning stages of treatment when client skills are likely to be relatively low, there will likely be arguments for direct clinician environmental intervention. As with any

dialectical struggle experienced in the course of therapy, therapists are encouraged to consult with their team to find a wise mind dialectical synthesis.

A Note on Clinician Language

Research and discussion with the firearm community offer several important recommendations to healthcare providers when approaching firearm lethal means safety counseling. First, readers may notice that some researchers have historically used the term "lethal means *restriction*" in discussions of reducing access to a wide variety of lethal means. Recent research, however, indicates that the phrase "means *safety*" is deemed more acceptable, and generates greater intentions to adhere to clinician recommendations, when compared to the term "means restriction" (Stanley et al., 2017).

Second, the firearm community has indicated that the term "firearm safety"—while less cumbersome than "firearm lethal means safety" or just "lethal means safety"—traditionally refers to the first training a firearm owner receives in basic safety measures (which, for many individuals, means training they received as a child). These practices might include safe storage but also include not putting your finger on the trigger until you're ready to shoot, and never pointing a gun at another person, even if the gun is known to be unloaded. As such, the term "firearm safety" conjures up a different set of practices than the ones under discussion with a healthcare provider trying to address suicide risk. The authors thus recommend the somewhat more cumbersome "lethal means safety" over "firearm safety" in the suicide prevention context.

Lastly, research also suggests that clinicians may be able to increase willingness to secure firearms by highlighting the risk that unsecured firearms pose to others, as opposed to solely emphasizing the risk that firearms pose to the client themselves. Anestis, Butterworth, Houtsma (2018) found that 75% of firearm owners were at least moderately willing to consider improving safe storage practices in the service of preventing someone else's suicide. Similarly, 75% of the same sample reported being at least moderately willing to allow someone else to store their firearm in the service of preventing someone else's suicide.

Legal Issues Surrounding Clinician Counseling on Firearm Access

There is a significant legal history surrounding provider ability to assess for firearm access as well as relevant state laws for providers to be aware of when working to reduce suicide risk with their firearm-owning clients. It may be surprising for some to learn that recent state legislative proposals, known as "gag laws," have aimed to prohibit healthcare providers from asking their patients about firearm ownership (Allchin & Chaplin, 2017). Many organizations, including the American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association have publicly opposed such laws. And in fact, in 2017 the full U.S. Court of Appeals for the Eleventh Circuit struck down portions of a Florida law that prohibited physicians from asking patients about firearm ownership, stating that the law violated physicians' First Amendment rights to free speech (Parmet, Smith, & Miller, 2017). At

the time of this writing, *no state currently prohibits providers from assessing firearm access with their clients*. However, the Consortium for Risk-Based Firearm Policy (2017) suggests that other states are likely to pursue similar legislation and thus the issue of gag laws and free speech between providers and patients warrants ongoing monitoring.

Additional relevant legal issues include third-party transfer laws, temporary storage of firearms, and reporting requirements for the National Instant Criminal Background Check System (NICS). These laws vary by state and thus it is recommended that clinicians be aware of how these laws may influence a client's safe storage options. For example, third party transfer laws affect one's ability to temporarily or permanently transfer possession of a firearm to another individual or entity (e.g., family member, pawn shop or firearm dealer). Some states have more restrictive laws related to the transferring of a firearm. There are several online resources that can inform clinicians on relevant state laws. For convenience, authors have listed some of these resources below.

- *Law Center to Prevent Gun Violence*: http://smartgunlaws.org
- *Everytown for Gun Safety's Gun Law Navigator*: https://everytownresearch.org/navigator
- *The Giffords Law Center*: https://lawcenter.giffords.org/

Unresolved Dialectics

Which Clients?

With the proposal of incorporating firearm lethal means safety counseling into DBT, there are several issues to consider regarding how this content might fit into standard DBT. One such issue up for consideration is whether all DBT participants should be encouraged to complete DBT Firearm Lethal Means Safety Counseling, regardless of whether they endorse having access to a firearm at the outset of treatment. When originally setting out to create the proposed content, the current authors intended the DBT Firearm Lethal Means Safety Counseling Handouts and Worksheets to be used only with clients who endorse having access to a firearm. After all, it makes intuitive sense that for those clients that deny having a firearm; there is no need to encourage safe storage practices or restriction of a firearm during times of crisis.

After thoroughly reviewing the literature around firearms and suicide, however, we have adopted the belief that a clinically appropriate degree of the DBT Firearm Lethal Means Safety Counseling content is likely to be beneficial for all DBT participants regardless of current ownership status. The Consortium for Risk-Based Firearm Policy states that, "Any patient at an elevated risk for suicide should receive counseling, especially if they disclose suicidal ideation or attempt, even if the individual does not have access to a firearm at the time of the clinical interaction" (Allchin & Chaplin, 2017). Given the portion of completed firearm-related suicides coupled with the aforenoted interactions between firearm access, firearm experience, and firearm storage practices, the current authors have come to believe that completing some degree of DBT

firearm safety counseling, even with participants who don't currently endorse having access to a firearm, can be a unique opportunity to educate individuals at risk for suicide about the relationship between firearms and suicide. We also believe that doing so will continue to foster a culture where providers discussing firearm access and storage practices with their clients becomes the standard for providing comprehensive outpatient care. Lastly, doing so may engender a culture in which providers are more motivated to seek out additional clinical training on lethal means safety counseling and become better equipped at addressing this important matter.

Which Modality?

An additional issue to consider with the proposed DBT Firearm Lethal Means Safety Counseling content is to determine what DBT mode this content should be incorporated into. In DBT, the group mode is where skills are overtly taught in a classroom-like structure. As is often said in the DBT community, "group therapy is where we push skills in and individual therapy is where we pull skills out." The advantages of streamlining lethal means safety counseling into the skills group would be that the topic would be taught in a manner consistent with other skills in DBT, and would also help ensure that the content is being administered in a systematic fashion to all DBT participants.

For several reasons, however, this topic is likely better suited for the individual therapy mode of DBT. One primary issue is the integral use of the word suicide when discussing firearm lethal means safety. As a rule of thumb, DBT clinicians avoid using potentially triggering words and graphic descriptions in group DBT (e.g., suicide, cutting, etc.). The authors ultimately felt that substituting the word "suicide" (e.g., to "target behavior") would result in a loss of causal learning. A primary aim of the DBT Firearm Lethal Means Safety Counseling Worksheets and Handouts is to educate clients about the direct relationship between firearms and suicide. To take out this word and substitute it for a more general term would undermine the very goal that these materials attempt to achieve.

Components such as the "Wise Mind Firearm Storage Plan" are also more practically completed in the individual therapy mode of DBT. As described earlier in these teaching notes, there are likely to be many opportunities for the individual therapist to use DBT stylistic and commitment strategies in order to further promote improved safe storage, particularly during times of crisis. Finally, although firearm lethal means safety counseling research is in its early stages, even less is known about addressing this topic in a group format. As is discussed in the limitations outlined below, the authors of the current project hope that these materials serve as a springboard for further consideration and discussion of how firearm lethal means safety counseling can be streamlined into DBT.

Future discussion, including direct feedback from the DBT community, will likely further exploration of these dialectics and ultimately work toward a synthesis that maintains the integrity of firearm lethal means safety counseling while also holding true to the theoretical principles and structure of DBT.

Limitations

There are several limitations to the proposed materials that are important for all DBT and DBT-informed clinicians to be aware of. The first limitation is that research on firearm lethal means safety counseling is in its infancy. While researchers and healthcare providers across disciplines have long known of the lethality of firearms, it is only within recent years that experts have begun to propose specific strategies and interventions to be used in clinical settings. With that, it should be emphasized that the DBT Firearm Lethal Means Safety Counseling materials are newly developed and have not been trialed or empirically evaluated as of yet. The authors saw an opportunity to bridge the gap between DBT and literature noting the importance of addressing firearm access and firearm-keeping behaviors in the name of suicide prevention. We expect that these materials will continue to evolve over time and through the direct feedback that we hope to receive from DBT clinician and client experiences. We would also love to see an empirical investigation of these materials and readily welcome any efforts to collaborate in this regard.

In addition to the experimental nature of these materials, another major limitation to these materials is to note that they have been developed predominantly with English-speaking adult populations in mind. We encourage clinicians working with adolescents as well as clinicians serving clients who do not endorse English as their primary language to consult the literature, remain mindful of the specific needs of their clients, and adapt these materials as needed. The authors also readily welcome efforts from the DBT community to expand the proposed materials in order to fit the unique needs of the diverse clients who engage in DBT around the world.

HANDOUTS

Introduction to DBT Firearm Lethal Means Safety Counseling: Exploring the dialectic between the benefits of firearm ownership and safety

Before working to facilitate change in firearm storage practices, it is important to first acknowledge all of the positive reasons why people may choose to own a firearm as well as validate the benefits that some experience from being a part of the firearm-owning community. These benefits may include competitive opportunities, ways of engaging in activities that promote pleasure and mastery, as well as increased social connection. As is highlighted throughout standard DBT, validation is the "grease to the wheels' ' in the change process and it is important to begin the DBT Firearm Lethal Means Safety Counseling module by exploring the ways in which some clients lives can be enhanced from the safe use of firearms.

After acknowledging the positive impacts that can be experienced from firearm ownership, this introductory handout works to engage the client in both values clarification and shared goal setting around firearm storage practices. Throughout the DBT Firearm Lethal Means Safety Counseling handouts and worksheets, it is emphasized that the primary goal of these materials is not to interfere with client's right to own a firearm; rather, it is to promote client safety as well as the safety of those around them. Working to align around the shared goal of safety can help the therapist and client effectively collaborate as they work to explore ways to potentially enhance safe storage practices.

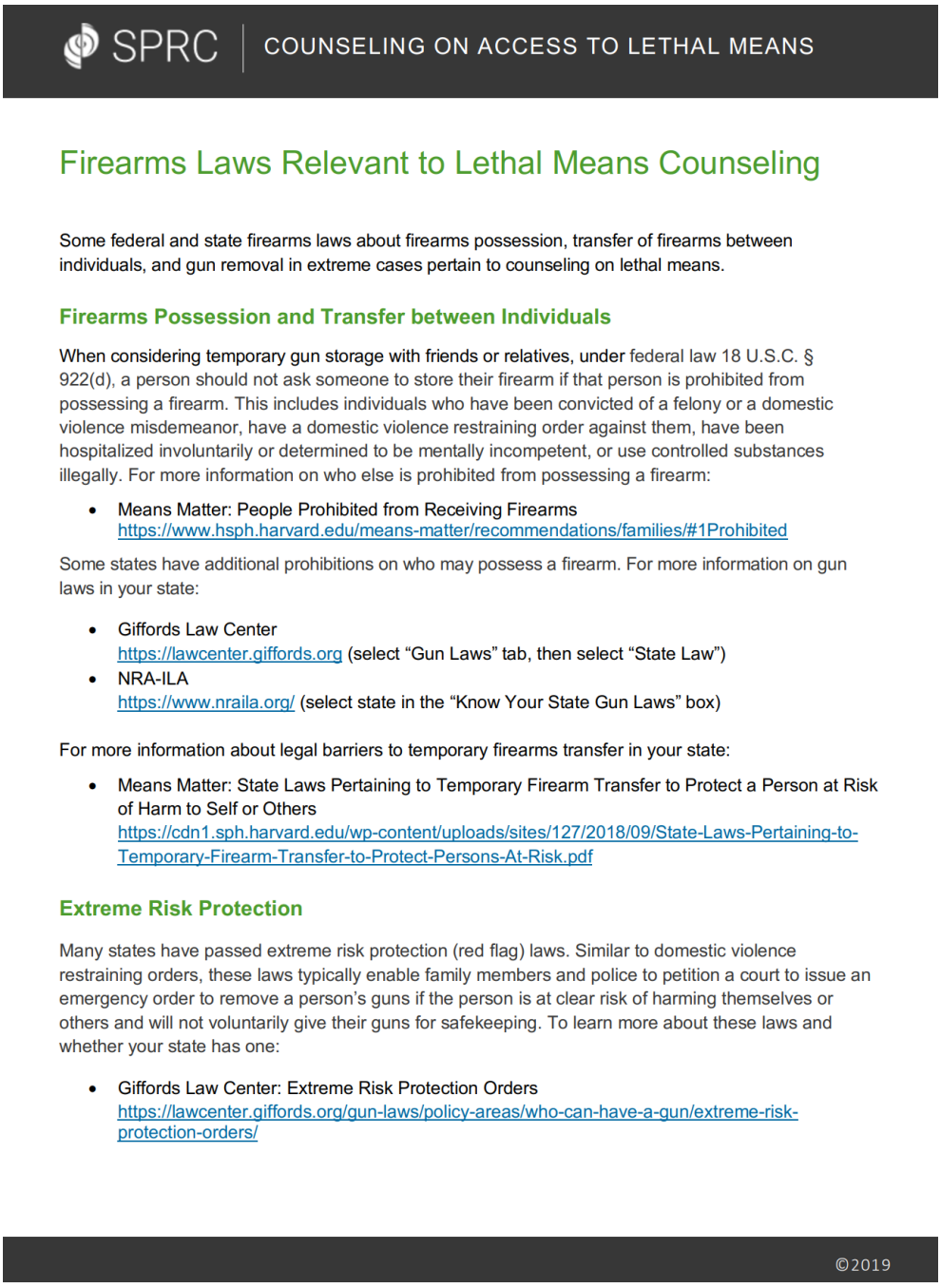
Handout 1: Increasing Your Immediate Safety Through Out-of-Home Firearm Storage

Handout 1 is intended to be reviewed by client and therapist in the service of exploring various out-of-home firearm storage options. Removing a firearm from the home is the preferred method of firearm storage, especially during periods of heightened acute risk and/or during the early stages of DBT while emotion regulation skills are still fairly new to a client. When introducing storage options, therapists are advised to utilize DBT commitment strategies of "Foot-In-The-Door" and "Door-In-The-Face." For more information regarding these strategies, see Chapter 9 "Core Strategies: Part II. Problem Solving" in Dr. Linehan's 1993 text. An application of foot-in-the door as applied to firearm safety might look like asking the client to remove the ammunition from their firearm; if the client agrees, this modest request may be followed by a request for a more significant change in storage practice, such as asking the client to move their firearm completely out of home. Conversely, door-in-the face as related to firearm storage might include beginning with a larger request than the therapist thinks would be granted, such as asking the client to store their firearm at a local firearm shop; if declined (as expected), the therapist can follow with a more modest recommendation, such as asking the client to allow their roommate to temporarily hold the key to their firearm lock.

Several DBT skills, including "wise mind" and "effectiveness," are particularly useful when reviewing firearm storage options. Clients may balk at various firearm storage options for many reasons, so drawing the client's attention back to the reason behind the change (e.g., an effective, wise mind response to signs of elevated acute suicide risk) can be a helpful strategy to addressing a client's stated reasons for maintaining their current storage status. In addition, the therapist can model effective problem-solving techniques in addressing barriers to preferred storage options.

In general, it is recommended that DBT therapists be familiar with the options listed in *Handout 1: Increasing Your Immediate Safety Through Out-of-Home Firearm Storage*. Not all storage options listed on this handout may be available in all areas. Therefore, it is recommended that therapists research some of the out-of-home storage options that may be available in their area. In order to help increase awareness regarding out-of-home storage options, there are current efforts underway to develop state-specific firearm storage maps that will list out-of-home storage resources. Examples of such maps developed for Colorado and Washington can be respectively found online here:
https://coloradofirearmsafetycoalition.org/gun-storage-map/;
http://depts.washington.edu/hiprc/firearm-storage-wa/

In addition to local resources, it is also important to be aware of state laws surrounding out-of-home storage options such as transferring a firearm to a third party. Because laws vary greatly across all 50 states within the U.S., authors have included the following handout provided by the Suicide Prevention Resource Center titled "Firearms Laws Relevant to Lethal Means Counseling." This handout along with many other useful resources can also be found on the Suicide Prevention Resource Center website.



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Firearms Laws Relevant to Lethal Means Counseling

Some federal and state firearms laws about firearms possession, transfer of firearms between individuals, and gun removal in extreme cases pertain to counseling on lethal means.

Firearms Possession and Transfer between Individuals

When considering temporary gun storage with friends or relatives, under federal law 18 U.S.C. § 922(d), a person should not ask someone to store their firearm if that person is prohibited from possessing a firearm. This includes individuals who have been convicted of a felony or a domestic violence misdemeanor, have a domestic violence restraining order against them, have been hospitalized involuntarily or determined to be mentally incompetent, or use controlled substances illegally. For more information on who else is prohibited from possessing a firearm:

- Means Matter: People Prohibited from Receiving Firearms
  https://www.hsph.harvard.edu/means-matter/recommendations/families/#1Prohibited

Some states have additional prohibitions on who may possess a firearm. For more information on gun laws in your state:

- Giffords Law Center
  https://lawcenter.giffords.org (select "Gun Laws" tab, then select "State Law")
- NRA-ILA
  https://www.nraila.org/ (select state in the "Know Your State Gun Laws" box)

For more information about legal barriers to temporary firearms transfer in your state:

- Means Matter: State Laws Pertaining to Temporary Firearm Transfer to Protect a Person at Risk of Harm to Self or Others
  https://cdn1.sph.harvard.edu/wp-content/uploads/sites/127/2018/09/State-Laws-Pertaining-to-Temporary-Firearm-Transfer-to-Protect-Persons-At-Risk.pdf

Extreme Risk Protection

Many states have passed extreme risk protection (red flag) laws. Similar to domestic violence restraining orders, these laws typically enable family members and police to petition a court to issue an emergency order to remove a person's guns if the person is at clear risk of harming themselves or others and will not voluntarily give their guns for safekeeping. To learn more about these laws and whether your state has one:

- Giffords Law Center: Extreme Risk Protection Orders
  https://lawcenter.giffords.org/gun-laws/policy-areas/who-can-have-a-gun/extreme-risk-protection-orders/

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Figure 1. Firearm Laws Relevant to Lethal Means Counseling. Reprinted from *Counseling on Access to Lethal Means* by Suicide Prevention Resource Center, August 10, 2019, retrieved from http://www.sprc.org/sites/default/files/Handouts-FirearmsLaws.pdf

Handout 2: Increasing Your Immediate Safety Through Out-of-Home Firearm Storage

Out-of-home storage options may not be available to all clients for reasons of cost, access or a variety of other factors. For other clients, willfulness may be a barrier to considering out-of-home storage options. If the therapist suspects that willfulness is arising while targeting safe firearm storage, it is recommended that the therapist use DBT strategies to increase willingness as they would for any target behavior in standard DBT (e.g., identify the threat connected to the client's willfulness, validate the threat using the appropriate levels of validation, and then use clinically indicated acceptance and/or change-based strategies in order to prompt for willingness).

Handout 2: Increasing your Immediate Safety Through Out-of-Home Firearm Storage is intended to help the therapist and client review options for in-home safe storage. It is important to note that some of the devices listed on Handout 2 require instruction on how to operate the safety enhancement device. A good example of this is cable locks. Where indicated, it is recommended that therapists help their clients learn how to operate their in-home storage safety device by using DBT strategies (e.g., problem solving, commitment strategies, etc.) to prompt the client to reach out to appropriate individuals in the firearm community to teach them how to correctly operate their safety-enhancement device. This might include eliciting a commitment from the client to go to their local firearm shop to ask an employee to show them how to correctly install their firearm cable lock. Instructions on how to use safety enhancement devices can often be readily found at local firearm shops or other establishments that promote safe storage and usage of firearms.

Handout 3: How to Install a Cable Lock

Handout 3 is intended to be used in conjunction with *DBT Firearm Lethal Means Safety Counseling Worksheet 5: Wise Mind Firearm Storage Plan*. The instructions provided on this handout aim to promote correct installation of a firearm cable lock as incorrect installation is a primary reason why this safety enhancement device can fail. While these instructions do apply to many of the locks distributed to firearm owners, it is important to note that some cable locks may operate somewhat differently from the one noted on Handout 3. Therefore, it is recommended that therapists help their clients learn how to operate a cable lock by using DBT strategies (e.g. problem solving, commitment strategies, etc.) in order to prompt the client to reach out to appropriate individuals in the firearm community to teach them how to correctly operate their safety-enhancement device.

Handout 4: Factors Interfering with Improving Safe Firearm Storage

A number of barriers may arise that impact a client's willingness to engage in a lethal means safety discussion about their firearm storage. This handout is designed to assist the therapist and

client to collaboratively and explicitly addressing these barriers. If time is short in session, this handout can be reviewed fairly quickly by having the client note the specific interfering factors that relate to them with regard to improving safe firearm storage. If the client is able to identify one or multiple factors that appear relevant them, the therapist can then engage the client in a more lengthy discussion of those unique factors using the discussion points below.

1. *You don't know what safe storage options are available to you.* Handouts 1-3, in addition to the background section of these teaching notes, should provide ample information to help address a knowledge deficit that is acting as a barrier to improving the safety of the client's firearm storage practices.

2. *Your emotions are getting in the way.* Strong emotions may impede a client's wise mind decision-making and increase willfulness during lethal means safety counseling sessions. These emotions may include fear (e.g., in individuals with PTSD for whom ready access to firearms is an important safety signal against potential harm from others), anger (e.g., in individuals for whom concerns about Second Amendment rights are easily triggered by a healthcare provider bringing up the topic of firearm access), or shame or guilt (e.g., individuals for whom suicidality violates cultural or religious sanctions), among others. Fortunately, DBT is well-equipped to address mood dependence and strong emotions. Skills that the client can apply in these cases include Wise Mind, Opposite-to-Emotion Action, Willingness, and Radical Acceptance. Strategies that the therapist may apply to facilitate change could include validation (see the "Validation" subsection under the header "DBT Clinical Strategies for Firearm Lethal Means Safety Counseling," above), shaping and other exposure techniques, and Interpersonal Effectiveness skills such as broken record, turn the tables, and negotiation.

3. *You forget your long-term goals for short-term goals.* As is emphasized in the second edition DBT Skills Training Manual (Linehan, 2015) several factors can result in individuals giving priority to short-term goals over long-term goals. Two of these primary factors as they relate to safe firearm storage are low distress tolerance and underestimating the likelihood of negative consequences.

Low distress tolerance: Particularly for clients who associate quick firearm access with an increased sense of safety, the prospect of creating distance between themselves and their firearm (whether it be through increased physical distance or through the adoption of safety enhancement measures that increase time to access their firearm) can result in the experience of increased distress.

Underestimating the likelihood of negative consequences: As has been shown in recent research, the majority of firearm owners do not associate firearm ownership and storage practices with suicide (Anestis, Butterworth, & Houtsma, 2018). Given this, it is understandable that many people may not consider the potential consequences that an unsecured firearm may have for themselves and/or loved ones.

4. *You forget the consequences associated with unsafe firearm storage.* Many clients leave the therapy room committed to behavior change, only to return to their next session having either changed their mind or forgotten their decision. It may be useful for the therapist and client to cope ahead with this possibility during the lethal means safety counseling session (e.g., by engaging a collateral, such as a family member, to assist with the storage change; or by agreeing upon a scheduled phone coaching session to confirm the storage change has occurred). The client can also complete a "Pros and Cons" worksheet and take it home with them, to remind them of the negative consequences of inaction.

5. *Other people are getting in your way.* Some DBT clients may have access to firearms that they do not own (e.g., a parent's or spouse's firearms). This may limit their ability to directly intervene on their own risky environment—whether actually (if the owner refuses to change their storage practices and is more powerful than the client), or due to emotional barriers (for example, if the client is fearful of negative consequences of acknowledging suicidality to the firearm owner). In these cases, the therapist can consider the dialectic of consultation to the patient vs. environmental intervention (see the subsection with this title under the heading, "DBT Clinical Strategies for Firearm Lethal Means Safety Counseling" for additional discussion of this topic), as well as coaching the client on making a wise mind decision about the emotions that may be getting in the way of action towards suicide risk mitigation (and, subsequently, the client's life worth living).

6. *Your thoughts and beliefs are getting in the way.* We review several common beliefs that impede change in firearm storage practices below:

Belief 1: "I have the right to own a gun, and you have no right to take it from me." DBT therapists will be familiar with the idea that setting oneself on the opposite side of a dialectic (e.g., suicide risk mitigation vs. freedom to choose) typically increases the client's resistance to taking the therapist's point of view. Consultation to the patient and validation are important therapist interventions if this belief is a barrier to change in firearm storage practices. And ultimately, with the exception of very rare legal situations, the client—not the clinician—does indeed have the power to make the final decision about whether or not to reduce their access to their firearms. Validation of the client's rights can loosen the stranglehold of opposing stances on firearm access, and pave the way for a dialectical synthesis: The client has the right to maintain access to their firearm, and the provider may also have information that could impact the client's decision-making process, especially if they are in a period of acutely elevated suicide risk.

The therapist can also reorient the conversation towards the client's goals by balancing validation of the client's rights with validation of the client's own concerns for their safety and desire to achieve a life worth living. We recommend ending such a reflective statement with the latter concern to orient the discussion towards change. In this way, an argument about rights can be sidestepped and the conversation re-focused on suicide prevention.

Belief 2: "Firearms are an integral part of my life and my culture. I can't be myself or part of my community without my firearm." Given how strongly some clients may feel about

their firearms, it is vital to understand a client's history with firearms and also explore what the client's firearm means to them, and to validate any sense of threat or loss that may result from working to promote increased distance between them and their firearm. It is also often useful to emphasize that more extreme interventions, such as completely removing the firearm from the home, can be used selectively and temporarily during heightened times of anticipated distress. This can be a major incentive for a client to practice self-monitoring, such as through a diary card: When they are able to more effectively self-identify increased acute risk in early stages, they can more safely utilize a wider variety of flexible, risk-responsive safety measures. Conversely, when the client experiences mood-dependent action as occurring without warning, and is not practiced at self-monitoring, more long-term and less flexible approaches to safe firearm storage would be warranted. Chain analyses are a critical tool to help the client build awareness of early cues that their acute risk is elevating.

Problem-solving is also a useful tool to address concerns about reducing social connection through reducing access to firearms. For example, the client may be able to develop new or less frequently used hobbies that connect them with their communities and identities (e.g., fishing, mountain biking, and so on).

Belief 3: "A locked firearm is an expensive paperweight. That won't protect my family." Beliefs about safety may lead clients' fears about harm from others to far outweigh their fears about harm from themselves—even if their risk of suicide is likely far greater in actuality. Functionally, maintaining easy access to firearms for personal safety is negatively reinforced through a reduction in anxiety about harm from others. Shaping and graduated exposure can be integrated into treatment to address both anxiety symptoms (by reducing safety signals and facilitating exposure to fear that does not "fit the facts") and suicide risk. For example, the therapist may encourage the client to slowly decrease access to loaded, unlocked firearms in a stepwise fashion and test out hypotheses related to anxiety or personal safety.

Irreverent communication can also be a useful tool in responding to a client's concerns about harm from others. For example, a therapist might say, "I'm so glad to hear you're so worried about your safety! I am too!" An unexpected and surprising alignment of goals may, again, sidestep a power struggle, and pave the way for the therapist to provide psychoeducation about access to lethal means and suicide risk or employ some of the tactics described above.

Belief 4: "I'll just get rid of my gun if I start feeling suicidal." Clients may feel high levels of motivation and commitment to safety and a life worth living during a counseling session, and still experience unexpected crises in their environments that abruptly increase suicidality in the moment. As described under *Belief 2* (see above), self-monitoring and mindfulness are extremely important skills for clients who tend to be unaware of their own tendency towards mood dependence and swift mood changes. The therapist can gently challenge this belief by investigating past experiences the client may have had with mood dependence and impulsivity. In addition, it is worth mentioning to the client that handling their weapon when feeling acutely suicidal—even in the service of a temporary transfer of the firearm to a collateral or reducing access in some other way—may be even more dangerous at that moment than

leaving the firearm stored as-is. It would be akin to planning to drive one's car keys to a friend's house in an acute state of intoxication, in an effort to reduce access to the car when at elevated risk of an accident.

WORKSHEETS

Worksheet 1: Beginning the Conversation about Firearm Lethal Means Safety

It is important to understand a client's relationship with their firearm(s) as well as their current storage practices and history of handling firearms. *Worksheet 1: Beginning the Conversation about Firearm Lethal Means Safety* prompts therapist and client to explore these issues through a series of questions taken from leading research highlighting specific risk factors associated with firearm-related suicide. As has already been noted, recent research identifies the importance of language used during firearm lethal means safety counseling sessions. For additional details, please reference the "Stylistic Strategies for DBT Firearm Safety Counseling" section in this provider manual. As a brief summary regarding language-related tips when beginning the conversation about firearm safety, see below.

- Be direct when discussing issues related to suicide safety and firearm access.

- Therapists are advised to avoid using the word "restriction." Research shows that this word tends to elicit a negative reaction from firearm-owners when attempting to discuss safety enhancement strategies (e.g., Stanley et al., 2017). Rather, use alternative words such as "safety."

- When beginning the conversation about lethal means safety, it is important to orient clients to the reasons why they are being asked to consider a change in firearm storage practices. Emphasize that all clients are asked to engage in firearm lethal means safety counseling even if they don't currently have access to a firearm. Firearms, especially when stored in an unsecured manner, can be a significant safety risk. So for clients that own a firearm, an early lethal means safety counseling session may increase their safety as well as the safety of those around them in a very important way. For clients who don't currently have access to a firearm, the counseling session is an opportunity to learn content that may serve them in the future.

- When beginning the conversation about firearm access and safety, therapists should be prepared for some clients to express concerns related to their Second Amendment rights. In response to this, the therapist should emphasize that the focus of these handouts and worksheets are not in any way meant to obstruct their constitutional right to bear arms. Rather, the focus here is 100% on safety. It may also be helpful to emphasize that these interventions are meant to be done collaboratively with their

therapist and can often be constructed in a flexible manner. For example, it is common for clients to develop a firearm safety storage plan for times of non-crisis as a separate firearm storage plan for when patterns or risks associated with increasing acuity reveal themselves.

- *Worksheet 1: Beginning the Conversation about Firearm Lethal Means Safety* will provide multiple opportunities for the therapist to validate reluctance to change firearm-related behaviors. For many firearm owners, their firearms are connected with an increased sense of safety, which may be particularly important especially for individuals who may have been exposed to one or more traumatic events. For more content regarding the importance of validation when completing *Worksheet 1: Beginning the Conversation about Firearm Lethal Means Safety*, see the "Role of Validation When Discussing Firearm Safety" section above.

Worksheet 2: Myths in the Way of Practicing Firearm Safety

When it comes to firearms, there are many myths that are likely to lead to unsafe firearm-keeping practices. On *Worksheet 2: Challenging Myths in the Way of Practicing Firearm Safety*, we have listed several myths that participants may endorse when beginning to consider issues related to their firearm-keeping behaviors. As is often done with other challenging myths worksheets in DBT, we recommend that therapists have participants review each firearm-related myth and circle the ones that they believe are true when they are in emotion mind, and put a checkmark by the ones they agree with when they are in wise mind. As when reviewing myths covered in similar worksheets in DBT, the therapist can then collaborate with the client in order to offer challenges. To assist the therapist in providing psychoeducation where needed, below are relevant research findings for each myth noted on *Worksheet 2*: *Challenging Myths in the Way of Practicing Firearm Safety*.

1. Myth: *Firearm access is not related to suicide.*

- Challenge: Anestis, Butterworth, and Houtsma (2018) discovered that most firearm owners believe that there is no relationship between firearm access, storage, and suicide. Furthermore, confidence in these beliefs was highest among participants who took a more extreme stance. As described in detail in the background section of the teaching notes, however, firearm access is associated with suicide death above and beyond demographics, religiosity, depression, antidepressant use, substance use, suicide ideation, and even prior suicidal behavior (Anestis & Houtsma, 2018; Miller, Barber, White & Azrael, 2013; Miller, Lippman, Azrael, & Hemmenway, 2007; Miller, Swanson, & Azrael, 2016; Miller, Warren, Hemenway, & Azrael, 2015; Opoliner, Azrael, Barber, Fitzmaurice, & Miller, 2014).

2. Myth: *I need a firearm for self-defense.*

- Challenge: Owning a firearm has been linked to higher risks of homicide, suicide, and accidental death by firearm.
  - It may be surprising for clients to learn that the number of incidents where someone actually protects themselves with a firearm is rare. The National Crime Victimization Survey found that firearms are used in self-defense in less than 1% of crimes (Hemenway & Solnick, 2015).
  - Carrying a firearm may actually escalate danger in the event of an assault: One study found that the odds of an assault victim being shot were 4.5 times greater, and the odds of being killed 4.2 times greater, if the victim carried a firearm (Branas et al., 2009).

3. Myth: *Having a firearm in my home makes me and others in the home safer*.
   - Challenge: There is a large body of research showing that having a firearm in the home significantly raises overall risk for everyone in the home.
     - Owning a firearm has been linked to higher risks of homicide, suicide, and accidental death by firearm. To illustrate this, research shows that for every one time a firearm is used in self-defense in the home, there are 4 unintentional shootings, 7 criminal assaults or homicides, and 11 attempted or completed suicides, assaults or murders involving firearms in or around a home (Kellermann et al., 1998).
     - Firearms in the home pose a significant risk, especially to children. Many parents are inclined to keep a firearm in the home in order to protect their families. However, research shows that 43% of firearm owners with children in the home keep at least one firearm unlocked.
     - States with the highest prevalence of firearms had seven times the rate of accidental firearm deaths as states with the lowest prevalence of firearms (Miller, Azrael, & Hemenway, 2001).
     - A disproportionately high number of women and children ages 5 to 14 die from unintentional firearm deaths in states with higher firearm prevalence (Miller, 2002a; Miller, 2002b).
     - Firearms are more likely to be used to threaten a family member at home than to protect a family member against an intruder (Azrael & Hemenway, 2000).

4. Myth: *Others in the home aren't at risk if I do a good job of hiding my firearm where others won't find it.*
   - Challenge: Children are curious. They also often have a knack for finding things that we don't intend them to find.
     - A significant percentage of firearm-related deaths in the United States are what are called "accidental deaths." These kinds of deaths can occur in situations where a minor finds a firearm that an adult thought was well hidden or out of reach.

- One study showed that one third of 8-to-12-year-old boys who found an unsecured handgun in their home pulled the trigger (Jackman, Farah, Kellermann, & Simon, 2001).
- Each year thousands of children die or are treated for firearm-related injuries.
- Firearm-owning parents substantially underestimate their children's knowledge about firearms stored in the home. In a 2006 study, 75% of children knew the location of the firearms stored in their household and more than a third had handled a household firearm. Furthermore, their parents incorrectly reported whether their children knew the location of the household firearm 39% of the time, and whether their child had handled the firearm 22% of the time (Baxley & Miller, 2006).
- Unintentional firearm fatalities are more likely to occur in states where firearm owners are more likely to store firearms loaded. The highest rates of unintentional firearm fatalities occurred in states where loaded firearms were more likely to be stored unlocked (Miller, Azrael, Hemenway, & Vriniotis, 2005).

5. Myth: *I'll have enough time to secure my firearm(s) if I ever find myself in a crisis or start to see that my safety is at risk.*
   - Challenge: Crises are hard to predict and often can be triggered by unexpected life events or stressors that you don't see coming. We also know that most crises are brief and that the most likely time for people to engage in a target behavior is shortly after the crisis arises.

Worksheet 3: Check the Facts About Firearms and Self-Defense

As is emphasized with other DBT Check the Facts worksheets, changing beliefs and assumptions about firearm safety in order to fit the facts can help change emotional reactions and thus facilitate behavioral change when prompting safe firearm-keeping behaviors. Validation with regard to history (validation level 4) and assessment of potential for current threat are important to when completing this worksheet. Important topics to discuss include:

1. Ask: *Why does this belief make sense? Where did you learn that having a firearm makes you safer?*
   - Explain to participants that beliefs about firearms and self-defense may come from many places including but not limited to direct experience where they were threatened or where violence was perpetrated upon them, cultural or familial beliefs that were directly or indirectly communicated to them, models that they have observed through direct experience or society at large, etc. It will be important for the therapist to validate the origins of their beliefs in the context of their prior experiences (validation level 4) and current circumstances (validation level 5).

2. Ask: *What are your thoughts and assumptions regarding having a firearm and its ability to increase your overall sense of safety?*

● Elicit from participants assumptions they may be making regarding a firearm's ability to actually enhance their safety.

3. Ask: *Are you assuming threat? If so, is this threat based on fact or feeling?*

● Engage clients in guided discovery using basic cognitive therapy strategies. Examples can include asking clients to consider evidence for this belief as well as evidence against the belief. Can also ask if they are jumping to conclusions or confusing a low probability event with a likely event.

4. Ask: *If this threat were to arise, what other ways could you keep yourself and loved ones safe?*

● Discuss the specific threats that are a concern for the client. Find out what other means of protection they would consider, such as self-defense sprays (if legal in the client's state), flood lights, an alarm system, taser, a dog, etc.

5. Ask: *Do your beliefs regarding firearms and self-defense fit the facts*?

- There is a large body of research showing that having a firearm in the home significantly raises overall risk for everyone in the home. Owning a firearm has been linked to higher risks of homicide, suicide, and accidental death by firearm

6. Ask: *What are the probabilities of a suicide attempt versus risk of home invasion or out-of-home attack in the near term*?

- Again, the risk of a violent home invasion is very small for most people and is dwarfed by the far greater risk of suicide if a person prone to mood-dependent behavior has a firearm close at hand). Evidence suggests that the number of incidents where someone actually protects themselves with a firearm is rare.
- Furthermore, research suggests that firearms are used to threaten at least as often, if not more, than they are actually used in self-defense. (Azrael & Hemenway, 2000).

7. Ask: *What are you willing to do to keep yourself safe from suicide*?

- While dangers in the world do exist, the risk of suicide is significantly higher for an individual with a history of self-harm and/or suicidal ideation and access to a firearm. At this point in the worksheet, it is recommended that the therapist illustrate how efforts to keep themselves safe through carrying an unsecured firearm raises their level of danger exponentially. Begin to explore steps they are willing to take to keep themselves safe.

- If the client endorses a high probability of danger that appears factually supported (e.g. in a relationship where domestic violence is occurring or high frequencies of community violence have been experienced) the clinician should emphasize collaboratively developing a safety plan (e.g. packing a "go bag," gathering resources, keeping a list of emergency services and contacts).

8. Ask: *If you live with family, friends or loved ones, what are you willing to do to keep them safe from firearm related injury, suicide attempt, or death*?

- Among households with children and firearms, only 3 in 10 firearm owners store all firearms in the safest manner which is locked and unloaded (Azrael, Cohen, Salhi, & Miller, 2018).
- Firearm-owning parents substantially underestimate their children's knowledge about firearms stored in the home. In a 2006 study, 75% of children knew the location of the firearms stored in their household and more than a third had handled a household firearm. Furthermore, their parents incorrectly reported whether their children knew the location of the household firearm 39% of the time and whether their child had handled the firearm 22% of the time (Baxley & Miller, 2006).
- Unintentional firearm fatalities are more likely to occur in states where firearm owners are more likely to store firearms loaded. The highest rates of unintentional firearm fatalities occurred in states where loaded firearms were more likely to be stored unlocked (Miller, Azrael, Hemenway, & Vriniotis, 2005).

Worksheet 4: Pros and Cons for Increasing Firearm Safety

Part I: Values

- Inspired by Emotion Regulation worksheets seven and eight in the second edition of Marsha Linehan's DBT Skills Training Manual (2015), the first goal of this worksheet is to help clients identify their values. As Linehan (2015) describes, the goals of values clarification is to help clients first identify their values so that they can then make choices in which they live lives that are aligned with their values.
- Clients are first asked to identify what some of their values are and/or what they envision in a life worth living. These questions are aimed at helping clients elicit who or what they value and then examine how increasing safe firearm storage may be associated with their values.

For example:

I value	*family*	How is increasing firearm safety associated with my value?	*Securing my firearm may mean my children are less at risk for seriously hurting themselves or someone else.*

- In the above example, the client shares how securing a firearm may mean their children are less at risk for serious injury. The aim is to help clients consider how their choices/behaviors related to firearm storage may affect their values.
- It is important to support clients and assist them in identifying their values by encouraging them to exercise wise mind and a nonjudgmental stance while they attempt to identify their values. For example, encouraging clients to identify values whether their values are associated with characteristics such as honesty or hard work or even future goals, objects, people, or pets. The section is open ended in hopes to be inclusive to diverse values.

Part II: Pros and Cons

- This second part of the worksheet asks clients to make a pros and cons list of both working to reduce access to firearms and not working to reduce access to firearms. After completing Part I, the hope is that clients will be mindful of their values and life worth living while creating these pros and cons lists.
- A "check the facts" section with a few questions to support clients in being mindful of their values was inserted in this section. If needed, go back to Part I and review the values they have identified.
- Part II also contains a short assessment of whether the client was willing to practice firearm safety. Ask the client whether they are willing improving their firearm safe storage practices both before and after completing their pros cons list.

Part III: Checking with Wise Mind

- The final section of the Pros and Cons worksheet entails a series of assessment questions beginning with asking clients to note what they decided to do given their pros and cons analysis. Based on what they decided to do, the worksheet then prompts them to evaluate what state of mind this decision corresponds with (e.g. Emotion, Reasonable or Wise Mind).
- Lastly, if clients identify that their decision ultimately aligns with their Wise Mind, they are asked to describe how their decision aligns with their wise mind values. Clients can use Part I of this worksheet to assist them in completing this last question.

Worksheet 5: Wise Mind Firearm Storage Plan

Part I: Wise Mind

- The goal of this worksheet is to give the therapist and client an opportunity to collaboratively develop a concrete safety plan that emphasizes safe firearm storage practices. First, it is important to help clients identify how the three states of mind may influence their decisions regarding firearm storage behaviors. In Part I clients are asked to identify what their reasonable mind, emotion mind, and wise mind may say when they consider taking steps to improve their firearm storage behaviors. In this section, if needed, you may refer back to previous module content in order to

explore how their 3 states of mind are impacted by decisions regarding firearm storage.

Part II: Life Worth Living and Wise Mind

- It is also important for clients to recall their life worth living and to draw upon their values in an effort to move towards a wise mind firearm storage plan. Further, this section prompts clients to be mindful of their life worth living- and to consider their goals and interpersonal relationships in an effort to help them commit to safe firearm storage behaviors.
    - Aid clients in identifying goals associated with their life worth living followed by people associated with their life worth living. Next, aid them in identifying what values are tied to these goals and people.
- Next, ask clients to consider how leaving your firearm(s) unsecured may compromise their life worth living goals. If they are having difficulty completing this section, help them to mindfully review *DBT Firearm Lethal Means Safety Counseling Worksheet 4: Pros and Cons for Increasing Firearm Safety*, then return to this section.

- Lastly, ask clients to consider how leaving your firearm(s) unsecured may compromise the important relationships in their life. If they are having difficulty completing this section, help them to mindfully review *DBT Firearm Lethal Means Safety Counseling Worksheet 4: Pros and Cons for Increasing Firearm Safety*, then return to this section.

Part III: Wise Mind Firearm Storage Plan

Refer to *DBT Firearm Lethal Means Safety Counseling Handouts 1 & 2* to help the client complete the section titled, "Wise Mind Firearm Storage Plan"

- In this section, aid clients in mindfully exploring the following questions. Encourage the clients to take a willing stance as these questions are explored:
    - What steps are you willing to take in order to immediately increase your safety and/or the safety of those around you?
    - What support people can you DEAR MAN to help with your wise mind firearm storage plan?
    - What cues can you use to serve as a reminder of your values and the people that are important to you noted in Part I and how can these cues be implemented in your wise mind firearm storage plan (e.g., taping a picture of a beloved pet on your gun safe)?

- Next, ask the clients to write down a wise mind firearm storage plan they are willing to commit to. Ask the client to indicate a specific date by when they are willing to engage in this plan.

Coping Ahead

- Next, help the client use the strategy of cope ahead by identifying what barriers may get in the way of following through with their wise mind firearm storage plan. Assess for any potential emotions, thoughts, urges or behaviors that could result in the client finding themselves becoming derailed from their commitment.
- Finally, help the client identify what specific DBT skills they can use in order to follow through with their wise mind firearm storage plan. It is likely that a number of DBT skills (e.g. wise mind, willingness, radical acceptance, opposite to emotion action, DEAR MAN, just to name a few) could be applicable to helping the client enact their wise mind firearm storage plan. If clinically indicated, in session rehearsal of some of these skills as they might apply to carrying out their wise mind firearm storage plan may be beneficial.

Additional Resources

- **The Consortium for Risk-Based Firearm Policy:** https://efsgv.org/consortium-risk-based-firearm-policy/about/
- **Rocky Mountain MIRECC:** www.mirecc.va.gov/lethalmeanssafety
- **Means Matter:** www.meansmatter.org
- **CALM-Online:** training.sprc.org
- **UC Davis Health**: https://health.ucdavis.edu/what-you-can-do/
- **Lock to Live**: http://lock2live.org/
- **The National Center for Veterans Studies**: https://www.youtube.com/watch?v=-GSo1np_LUY&t=3s
- **The Educational Fund to Stop Gun Violence**: https://efsgv.org/
- **The Giffords Law Center**: https://lawcenter.giffords.org/
- **Educational Fund to Stop Gun Violence:** https://preventfirearmsuicide.efsg.org
- **American Foundation for Suicide Prevention (AFSP) "Project 2025: Firearms":** https://project2025.afsp.org/

In addition to the online resources noted above, firearm retailers are beginning to partner with suicide prevention programs nationally in order to promote lethal means safety among at-risk customers. Also, some states are beginning to provide firearm storage maps to alert the public to safe options for temporary, voluntary storage. To learn more about these developments, you can visit:

- **New Hampshire Firearm Safety Coalition's Gun Shop Project:** www.nhfsc.org

- **The Colorado Firearm Safety Coalition:** https://coloradofirearmsafetycoalition.org/

- **Harborview Injury Prevention & Research Center:** http://depts.washington.edu/hiprc/firearm-storage-wa/

References

Allchin A. & Chaplin, V. (2017). *Breaking through barriers: The emerging role of healthcare provider training programs in firearm suicide prevention.* Consortium for Risk-Based Firearm Policy.

American Psychiatric Association. (2003). *Practice guidelines for the assessment and treatment of patients with suicidal behaviors*. Washington, DC: Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf

Anestis, M.D., Butterworth, S.E., & Houtsma, C. (2018). Perceptions of firearms and suicide: The role of misinformation in storage practices and openness to means safety measures. *Journal of Affective Disorders, 227,* 530-535.

Anestis, M. D. & Capron, D. W. (2018), Deadly Experience: The Association Between Firing a Gun and Various Aspects of Suicide Risk. *Suicide Life Threat Behav, 48,* 699-708. doi:10.1111/sltb.12381

Anestis, M. D. & Houtsma, C. (2018), The Association Between Gun Ownership and Statewide Overall Suicide Rates. *Suicide Life Threat Behav, 48*, 204-217. doi:10.1111/sltb.12346

Azrael, D., Cohen, J., Salhi, C., & Miller, M. (2018). Firearm storage in gun-owning households with Children: Results of a 2015 national survey. J Urban Health, 95(3), 295-304.

Azrael, D. & Hemenway, D. (2000). 'In the safety of your home': results from a national survey on gun use at the home. *Social Science & Medicine, 50(2),* 285-291.

Barber, C.A. & Miller, M.J. (2014). Reducing a suicidal person's access to lethal means of suicide. *Am J Prev Med, 47*, 265.

Baxley, F. & Miller, M.D. (2006). Parental misperceptions about children and firearms. *Arch Pediatr Adolesc Med,160(5),* 542-547. doi:10.1001/archpedi.160.5.542

Branas, C.C., Richmond, T.S., Culhane, Ten Have, T.R., & Wiebe, D.J. (2009). Investigating the Link Between Gun Possession and Gun Assault. *American Journal of Public Health 99,* 2034-2040. Retrieved from https://doi.org/10.2105/AJPH.2008.143099

Britton, P.C., Bryan, C.J., & Valenstein, M. (2016). Motivational Interviewing for Means Restriction Counseling with Patients at Risk for Suicide. *Cognitive and Behavioral Practice, 23*, 51-61.

Bonds, D. E., Ellis, S.D., Weeks, E., Lichstein, P., Burke, K., & Posey, C. (2007). Patient attitudes toward screening. *NC Med J, 68(1),* 23-29.

Butterworth, S.E., Daruwala, S.E., & Anestis, M.D. (2018). Firearm storage and shooting experience: Factors relevant to the practical capability for suicide. *Journal of Psychiatric Research, 102*, 52-56.

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(5),* 339-346.

Centers for Disease Control and Prevention. (2016). Web-based inquiry statistics query and reporting system (WISQARS). Retrieved August 10, 2019, from http://www.cdc.gov/injury/wisqars/index.html.

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(4),* 625-632.

Grant, B.F., Chou, S.P., Goldstein, R.B., Huang, B, Stinson, F.S., Saha, T.D… Ruan, J.W. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the wave 2 National Epidemiologic Survey on Alcohol and Related *Conditions. J Clin Psychiatry, 69(4),* 533–45.

Gun Storage Map. (2019, August 29). Retrieved from https://coloradofirearmsafetycoalition.org/gun-storage-map/.

Gunnell, D., Fernando, R., Hewagama, M., Priyangika, W.D.D., Konradsen, F., & Eddleston, M. (2007). The impact of pesticide regulations on suicide in Sri Lanka. *International Journal of Epidemiology, 36*(6), 1235-1242.

Harned, M.S., Rizvi, S.L., & Linehan, M.M. (2010). The impact of co-occurring posttraumatic stress disorder on suicidal women with borderline personality disorder. *Am J Psychiatry, 167(10),* 1210–1217.

Hemenway, D. & Solnick, S.J. (2015). Children and unintentional firearm death. *Injury Epidemiology, 26, 2(1)*. doi:10.1186/s40621-015-0057-0. http://dx.doi.org/10.1186/ s40621-015-0057-0.

Jackman, G.A., Farah, M.M., Kellermann, A.L., & Simon, H.K. (2001). Seeing is believing: what do boys do when they find a real gun? *Pediatrics, 107(6),* 1247–1250.

Jin, H.M., Khazem, L.R., & Anestis, M.D., (2016). Recent Advances in Means Safety as a Suicide Prevention Strategy, *Current Psychiatry Reports,18,* 10.1007/s11920-016-0731-0.

Joiner, T.E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.

Kegler, S.R., Dahlberg, L.L., & Mercy, J.A. (2018). Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2012–2013 and 2015–2016. *MMWR Morb Mortal Wkly Rep;67,* 1233–1237. DOI: http://dx.doi.org/10.15585/mmwr.mm6744a3

Khazem, L.R., Houtsma, C., Gratz, K.L., Tull, M.T., Green, B.A., & Anestis, M.D. (2016). Firearms matter: The moderating role of firearm storage in the association between current suicidal ideation and likelihood of future suicide attempts among United States military personnel. *Military Psychology, 28*, 25-33.

Klonsky, E.D. & May, A.M. (2015). The Three-Step Theory (3ST): a new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy*, 8, 114–29.

Kreitman, N. (1976). The coal gas story. United Kingdom suicide rates, 1960-71. *Journal of Epidemiology & Community Health, 30,* 86-93.

Kruesi, M. J., Grossman, J., Pennington, J. M., Woodward, P.J., Duda, D., & Hirsch, J.G. (1999). Suicide and violence prevention: Parent education in the emergency department. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 250-255.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York : Guilford Press.

Linehan, M. (2015). *DBT Skills training manual*. Guilford Publications.

Lubin, G. , Werbeloff, N. , Halperin, D., Shmushkevitch, M. , Weiser, M. and Knobler, H. Y. (2010), Decrease in Suicide Rates After a Change of Policy Reducing Access to Firearms in Adolescents: A Naturalistic Epidemiological Study. *Suicide and Life-Threatening Behavior, 40,* 421-424. doi:10.1521/suli.2010.40.5.421

Matarazzo, B. (2019, January 16). Lethal Means Safety: How PTSD Clinicians Can Have the Conversation [Webinar]. In *Rocky Mountain MIRECC Webinar Series.* Retrieved from https://www.ptsd.va.gov/professional/consult/2019lecture_archive/01162019_lecture_slides.pdf.

Miller, M., Azrael, D., & Hemenway, D. (2001). Firearm availability and unintentional firearm deaths. *Accid Anal Prev, 33,* 447–484.

Miller, M., Azrael, D., & Hemenway, D. (2002a). Firearm availability and suicide, homicide, and unintentional firearm deaths among women. *J Urban Health,79(1),* 26–38.

Miller, M., Azrael, D., & Hemenway, D. (2002b). Firearm availability and unintentional firearm deaths, suicide, and homicide among 5-14 year olds. *J Trauma, 52(2),* 267–275.

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., Barber, C., White, R.A., & Azrael, D. (2013). Firearms and suicide in the United States: Is risk independent of underlying suicidal behaviors? *American Journal of Epidemiology, 178,* 946-955.

Miller, M., Lippmann, S.J., Azrael, D., & Hemenway, D. (2007). Household firearm ownership and rates of suicide across the 50 United States. *Journal of Trauma, 62,* 1029-1034.

Miller, M., Swanson, S.A., & Azrael, D. (2016). Are we missing something pertinent? A bias analysis of unmeasured confounding in the firearm-suicide literature. *Epidemiologic Reviews, 38,* 62-69.

Miller, M., Warren, M., Hemenway, D., & Azrael, D. (2015). Firearms and suicide in US cities. *Injury Prevention, 21,* e116-e119.

Opoliner, A., Azrael, D., Barber, C., Fitzmaurice, G., & Miller, M. (2014). Explaining geographic patterns of suicide in the US: the role of firearms and antidepressants. *Injury Epidemiology 1*(6). http:// dx.doi.org/10.1186/2197-1714-1-6.

Owens, D., Horrocks J., House A. (2002). Fatal and non-fatal repetition of self-harm. Systematic review. *British Journal of Psychiatry, 181*, 193-9.

Pagura J., Stein, M.B., Bolton, J.M., Cox, B.J., Grant, B., & Sareen, J. Comorbidity of borderline personality disorder and posttraumatic stress disorder in the U.S. population. (2014). *J Psychiatr Res. 2010;44(16),* 1190–1198.

Parmet, W.E., Smith, J.A., & Miller, M. (2017). Physicians, firearms, and free speech-Overturning Florida's firearm-safety gag rule. *New England Journal of Medicine, 376(20),* 1901-1993.

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 Preventative Medicine, 33(5),* 370-373.

Price, J.H., Thompson, A., Khubchandani, J., Wiblishauser, M., Dowling, J., & Teeple, K. (2013). Perceived roles of emergency department physicians regarding anticipatory guidance on firearm safety. *The Journal of Emergency Medicine, 44(5),* 1007-1016.

Puttagunta, R., Coverdale, T.R. & Coverdale, J. (2016). *Academic Psychiatry, 40(5),* 821-824. https://doi.org/10.1007/s40596-016-0490-6

Resick PA, Schnicke MK. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Thousand Oaks, CA: Sage Publications.

Roszko, P.J., Ameli, J., Carter, P.M., Cunningham, R.M., & Ranney, M.L. (2016). Clinician attitudes, screening practices, and interventions to reduce firearm-related injury. *Epidemiologic Reviews, 38(1),* 87-110.

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, R. I. (2007). Gun safety management with patients at risk for suicide. *Suicide and Life-Threatening Behavior, 37*, 518 –526. http://dx.doi.org/10.1521/suli.2007.37.5.518

Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M., & O'Carroll, P. W. (2001). Characteristics of impulsive suicide attempts and attempters. *Suicide and Life-Threatening Behavior, 32(1) (Supplement),* 49–59.

Slovak, K., Brewer, T.W., & Carlson, K. (2008). Client firearm assessment and safety counseling: The role of social workers. *Social Work, 53(4),* 358-366.

Slovak, K., Pope, N., Ginger, J., & Kheibari, A. (2019). An evaluation of the counseling on access to lethal means (CALM) training with an area agency on aging. *Journal of Gerontological Social Work, 62(1),* 48-66.

Stanley, I.H., Hom, M.A., Rogers, M.L., Anestis, M.D., & Joiner, T.E. (2017). Discussing Firearm Ownership and access as a part of suicide risk assessment and prevention: "means safety" versus "means restriction." *Archives of Suicide Research, 21*, 237-253.

Suicide Prevention Resource Center. (2019). Firearm Laws Relevant to Lethal Means Counseling. Reprinted from *Counseling on Access to Lethal Means* by Suicide Prevention Resource Center, August 10, 2019, retrieved from http://www.sprc.org/sites/default/files/Handouts-FirearmsLaws.pdf

Traylor, A., Price, J.H., Telljohann, S. K., King, K, & Thompson, A. (2010). Clinical psychologist' firearm risk management perceptions and practices. *Journal of Community Health, 35(1),* 60-67.

Van Orden, K.A., Witte, T.K., Cukrowicz, K.C., Braithwaite, S., Selby, E.A., & Joiner, T.E. Jr (2010). The interpersonal theory of suicide. *Psychological Review, 117(2),* 575-600.

Williams C.L., Davidson, J.A., Montgomery I. (1980). Impulsive suicidal behavior. *Journal of Clinical Psychology, 36(1):*90–94.

Wintemute, G.J., Betz, M.E., & Ranney, M.L. (2016). Yes, You Can: Physicians, Patients, and Firearms. Annals of Internal Medicine, 165(3), 205–213.

Wintemute, G.J., Parham., C.A., Beaumont, J.J., Wright., M., Drake., C. (1999). Mortality among recent purchasers of handguns. *N Engl J Med, 341*: 1583-1589. DOI: 10.1056/NEJM199911183412106

Zanarini, M.C., Frankenburg, F.R., Dubo, E.D., Sickel, A.E., Trikha, A., Levin, A., & Reynolds, V. (1998). Axis I comorbidity of borderline personality disorder. *Am J Psychiatry; 155(12),* 1733–9.