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Suicidal Man With Gun

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The Case

The patient is a 36-year-old man who came to a psychiatry clinic for outpatient evaluation of severe depression that had persisted for nearly 2 years. On initial interview, the patient reported chronic thoughts of suicide, stating "If I had a good way [to kill myself], I'd have done it already." On screening for suicide risk factors, the patient admitted to possessing a handgun. He denied active plans for suicide, including using the gun, because "A friend or family member would have to clean up the mess."

The attending physician and resident performing the evaluation assessed the patient as at chronic risk for suicide, but not acute risk, and noted that prompt removal of gun from the patient's possession was paramount to his safety. Both also agreed that building a treatment alliance would be a critical factor in accomplishing that goal. For the patient's depression, the treatment plan included starting an antidepressant (citalopram) as well as psychotherapy.

The patient resisted plans to remove the handgun and refused multiple disposition plans proposed by the resident and the resident's supervisor (who was not the evaluating attending physician during the initial assessment). Suicidal ideation continued and, as time passed in treatment, the supervisor viewed him as a significantly higher risk to complete suicide than the resident did. Discussions with other faculty and the clinic's risk manager ensued in an effort to delineate the resident's legal options to remove the gun from the patient's possession. Unfortunately, they were not able to develop a clear pathway to removing the handgun. The resident felt that forcing the issue legally would cause the patient to feel abandoned and unsafe, with a strong possibility of either suicide or termination of treatment (with concomitant increased risk of suicide). The supervisor felt that the institution's primary responsibility was to keep the patient safe, and the longer it took to remove the gun, the more at risk the patient was for an adverse outcome. Both resident and supervisor agreed that prior to exploring any emotionally sensitive issues in treatment, the gun had to be removed.

The gun was eventually removed from the patient's residence, but it required nearly 3 months to achieve this goal. Though no harm occurred, this case was a "near miss," given the prolonged exposure of a potentially suicidal patient to such an obvious hazard.

The Commentary

This case describes a severely depressed patient, who admits to possessing a handgun. The attending physician and resident determine that he is at chronic risk for suicide and note that “prompt removal” of the gun is a top priority. Although they correctly identify gun possession as the central management issue, the gun was not removed from the home until after nearly 3 months of psychotherapy.

One can easily sympathize with clinicians struggling with multifaceted issues in cases like this one. Since these situations are so challenging, charged, and nuanced, it is difficult to offer precise guidelines. However, some general rules of thumb may help clinicians balance these issues.

Clinicians must set reasonable treatment terms and boundaries. Metaphorically, clinicians in situations like this can feel like they themselves are operating “under the gun.” It is vital that they work with the patient to diffuse the tension and create a safe environment in which therapy can proceed.

The creation of this safe environment (for both patient and clinician) often requires an initial period of evaluation before outpatient therapy commences. A diagnostic impression and the suitability of the patient for outpatient treatment also can be determined from the initial evaluation. Patients at significant risk for suicide usually have a combination of Axis I and Axis II disorders.(1) Much of the difficulty in managing this patient may have arisen from an unrecognized personality disorder. In assessing suicidal patients, it is important to ask whether the problem is a manifestation of a single or recurrent episode of major depression, a bipolar condition, or dysthymia. It is also vital to review the psychiatric history and current life information to develop a systematic suicide risk assessment, and from there a comprehensive treatment plan. Even with the truncated information presented in this case, I believe that the therapeutic impasse and the danger to the patient were foreseeable.

A suicide prevention contract might have been useful in this case. After the patient was determined to be at risk, an oral or written contract could have been proposed, requiring that the patient safely dispose of his gun. After all, the patient admitted possessing a gun at the initial interview. A clinician hearing such an admission should wonder whether this was “a cry for help” to test the therapeutic alliance. The clinician might have taken this opportunity to say, “Can we work out a plan together to dispose of the gun?”

Although the suicide prevention contract has achieved wide acceptance, no studies demonstrate that it is effective in preventing suicide.(2) Suicide prevention contracts should never take the place of adequate suicide risk assessment. Moreover, it is important to recognize that the suicide prevention contract is a clinical, not a legal, contract; it provides no immunity against a malpractice suit.(3) The patient is free to accept, modify, or reject a suicide prevention contract. However, when a severely depressed, suicidal patient rejects a contract, the patient is unlikely to develop a therapeutic alliance and may not be a suitable candidate for therapy. Therefore, although the resident and the attending agreed “that building a treatment alliance would be a critical factor” in removing the patient’s gun, in my view the opposite is likely true. Removing the gun before initiating treatment might have allowed the therapeutic alliance to develop.

Psychiatrists have deemed patients like this one, who are at once calling for help and turning their back on it, “help-seeking, help-rejecting” patients.(4) When these patients present at suicide risk, they create countertransference reactions in the therapist that can make treatment extremely difficult if not impossible.(

5,6) It is reasonable to ask if the clinician's defense of reaction formation (7) to frustration with this uncooperative patient played a role in perpetuating the patient's gun possession. Another countertransference trap occurs when the therapist assumes the role of "rescuer." Inevitably, this approach ends in futility for the therapist, dooming the therapy. Clinicians must try to identify and manage their own feelings to remain effective in caring for patients like this.

Clinicians, when brought to an impasse, may seek "legal options" because the clinical issues presented by a non-adherent, thwarting patient are so difficult. Unfortunately, there are no viable legal solutions. Involuntary hospitalization, an emergency clinical intervention, was rejected as an option. Voluntary hospitalization, partly aimed at separating the patient from his gun, is not mentioned in the case example, but is clearly indicated. Intensive psychotherapeutic work could examine the psychological meaning of the gun, which is likely a resistance to treatment. Continued rejection of treatment recommendations by the patient is an indication for appropriate termination and referral.

Although residents must learn to care for patients within the entire spectrum of psychiatric illness, this case would be difficult to manage even for an experienced psychiatrist. Residents should not be assigned patients whose treatment and management is beyond their competence, training, and experience. In this case, the resident and supervisor disagree on how to manage the continued presence of the patient's gun. Based on his or her greater knowledge, experience, and clinical responsibility for the patient, the supervisor should instruct the resident that the patient's life is in serious jeopardy, treatment is at an impasse, and temporizing is not appropriate (ie, the patient needs to make a decision between continuing treatment or keeping the gun). Although respecting the resident's autonomy is often laudable, the supervisor's first priority must be the patient's safety.

Unfortunately, it is not possible to predict which patients will commit suicide.(8,9) Suicide risk factors (Table) are highly sensitive in identifying at-risk patients, but have low specificity. In other words, many depressed patients possess risk factors for suicide, but few go on to attempt it. Suicide is a multi-determined act—the result of a complex interplay of many factors. Although no guideline exists for predicting suicide, the standard of care requires that adequate suicide risk assessment be conducted.(10) Systematic suicide risk assessment allows the clinician to weigh risk and protective factors that inform treatment and safety management.(11) For example, risk factors such as anxiety, agitation, and sleep dysfunction can be treated and modified. The clinician must take reasonable steps to prevent the patient's access to lethal weapons, such as guns. Guns in the home have been shown to substantially increase the risk of suicide in psychiatric patients, as does the recent purchase of a firearm.(12,13) Easy accessibility and the lethality of guns make them a "weapon of choice" for committing suicide.

Halfway measures such as locking up or hiding a gun at home are often inadequate. Guns *should be removed* from the home by a *responsible* person and secured in a safe place. Also, the gun should be safely disarmed and the bullets stored in another secure place. Unfortunately, there may be no guarantee that the person asked to remove a gun is less disturbed or more responsible than the patient. If the patient agrees, the therapist can (and should) meet with both the patient and the designated person who accepts responsibility for removing the gun. Specific instructions for gun removal should be documented in the patient's record (ie, calling the therapist after the gun is removed, disarmed, and safely secured). Under no circumstances should clinicians allow patients to bring guns to their office for safekeeping.

Take-Home Points

- Begin by creating a safe environment for therapy and making an accurate psychiatric diagnosis.
- It is vital to perform an adequate suicide risk assessment in all suicidal patients. Such assessments serve to inform subsequent treatment and management decisions.
- The usefulness of suicide prevention contracts is case specific. However, there is no evidence that such contracts prevent suicide.
- Suicide prevention contracts should not take the place of adequate suicide risk assessment.
- Clinicians should make every effort to remove lethal means, particularly firearms, from patients at risk for suicide.
- Suicide cannot be predicted. However, the standard of care requires that patients at risk for suicide be adequately assessed.

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Table

Table. Major Risk Factors for Suicide*

Major Risk Factors for Suicide*
Severity of mental illness
Depression
Schizophrenia
Borderline personality
Suicide ideation, intent, plan
Substance abuse
Prior suicide attempts
Comorbidity
Loss (eg, relationships, employment, health)
Short-term risk factors†
Impulsivity
Hopelessness

Recent discharge from a psychiatric hospital

* Single risk factors cannot be relied upon to assess suicide risk (eg, suicidal ideation). †Statistically significant within 1 year of assessment (eg, panic attacks, anxiety, depressive turmoil, loss of interest and pleasure, alcohol abuse, diminished concentration, global insomnia).

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