**COLUMBIA-SUICIDE SEVERITY**

**RATING SCALE**

**(C-SSRS)**

Self Report

SINCE LAST VISIT
Version 6/30/10

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*Disclaimer:*

*This scale is intended for use by trained clinicians. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidality depends on clinical judgment.*

*Definitions of behavioral suicidal events in this scale are based on those used in* ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

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| ***IDEATION*****Check off “Yes” or “No” in the right-hand columns for each question** | **Since Last Visit** |
| 1. **Have you wished you were dead or wished you could go to sleep and not wake up?**
 | **Yes No****□ □** |
| 1. **Have you actually had any thoughts of killing yourself?**
 | **Yes No****□ □** |
| 1. **Have you thought about how you might do this?** *(For example, “I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.”)*
 | **Yes No****□ □** |
| 1. **Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them?** *(For example, “I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.”)*
 | **Yes No****□ □** |
| 1. **Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan?** *(For example, “I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.”)*
 | **Yes No****□ □** |

***If you answered “yes” to any of the questions above, answer the following questions 6-10 (INTENSITY OF IDEATION) with respect to the highest level you answered with a “yes” above (1-5).***

***If none of the above questions are “yes”, skip to the BEHAVIOR questions 11-18***

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| ***INTENSITY OF IDEATION*** |  | **Since Last Visit** |
| 1. **How many days a week did you have these thoughts?**
 | Less than one day a weekOne day a week2-3 days a week4-5 days a week6-7 days a week | **□****□****□****□****□** |
| 1. **How often did these thoughts usually last on the days you had them?**
 | Just a few seconds or minutesLess than 1 hour1-4 hours5-8 hoursMore than 8 hours | **□****□****□****□****□** |
| 1. **How easy was it for you to control these thoughts or push them out of your mind when you wanted to?**
 | EasyA little difficultSomewhat difficultVery difficultImpossible; unable to control the thoughtsDidn’t attempt to control thoughts | **□****□****□****□****□****□** |
| 1. **Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?**
 | Deterrents definitely stopped me from attempting suicideDeterrents probably stopped meUncertain that deterrents stopped meDeterrents most likely did not stop meDeterrents definitely did not stop meDoes not apply | **□****□****□****□****□****□** |
| 1. **What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?**
 | Completely to get attention, revenge or a reaction from others Mostly to get attention, revenge or a reaction from others Equally to get attention, revenge or a reaction from others and to end/stop the pain Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)Does not apply | **□****□****□****□****□****□** |

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| ***BEHAVIOR*****Check off “Yes” or “No” in the right-hand columns for each question** | **Since Last Visit** |
| 1. **Have you made a suicide attempt or done anything to harm yourself because you wanted to die (even if you were not totally sure you wanted to die or just wanted to die a little bit)?**

*How many times has this happened?* | **Yes No****□ □***Total # of times*\_\_\_\_\_\_ |
| 1. **Have you done anything to harm yourself purely for other reasons, without any intent to die (like to relieve stress, feel better, get sympathy, or get something else to happen)?**
 | **Yes No****□ □** |
| 1. **Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything (e.g., you had the pills in your hand but a friend stopped you from taking them)?**

*How many times has this happened?* | **Yes No****□ □***Total # of times*\_\_\_\_\_\_ |
| 1. **Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything (e.g., you took out pills but then changed your mind before you could swallow any of them)?**

*How many times has this happened?* | **Yes No****□ □***Total # of times*\_\_\_\_\_\_ |
| 1. **Have you taken any steps towards making a suicide attempt or preparing to kill yourself (e.g., collecting pills, getting a gun, giving valuables away or writing a suicide note**)**?**

*What have you done?* | **Yes No****□ □** |

If you answered **“yes” to question 11**, please fill out the below section (*MEDICAL DAMAGE*).

If you answered **“no” to question 11,** then you do not have any additional questions to answer.

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| ***MEDICAL DAMAGE*** |
| 1. **What was the date of your most lethal or potentially lethal attempt?**

**Date:\_\_\_\_\_\_\_\_\_\_\_** | **Describe what you did on that date:****On that date, please rate your medical damage from 0-4****□** 0. No physical damage or very minor physical damage (e.g., surface scratches).**□** 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).**□**2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).**□** 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).**□** 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). |