哥伦比亚自杀严重程度评定量表(C-SSRS)– 成人/青少年 (≥12 岁) 速筛

——由哥伦比亚大学，宾夕法尼亚大学和匹兹堡大学联合为（美国）国家精神卫生研究院开发的筛查工具

询问每一个问题, 如果患者没有提供相应信息的话，则询问病人是否在过去的一个月内有过这些想法或行为。

自杀意念			
问题	**过去的 1 个月中**		**肯定的回复表明了什么？**
询问问题1 和问题2			
1. 你有希望自己死掉或者希望自己能够睡着后再也醒不过来吗？	是 ☐	否 ☐	**想要死去。**病人承认有想要死去或者不再生存的想法，或者想要睡着后不再醒来。 例子:“我希望自己不再活着。”
2. 你事实上有过想要自杀的念头吗？	是 ☐	否 ☐	**不明确的活跃的自杀想法.** 一般的不明确的想要结束生命或付诸自杀的想法例子: “我有想过自杀.”
如果问题 2 的回答为“是”，则询问问题 3,4,5,6； 回答为“否”，则直接询问问题 6			
3. 你有想过你可能会怎样自杀吗？	是 ☐	否 ☐	**活跃的自杀意念并想到过一些自杀方式（不是计划），但无付诸行动的意图。** 患者承认有自杀想法，以及想过至少一种自杀的方式。 例子:“我想过服药过量（来自杀），但我从没有一个关于何时何地以及何种形式来执行的具体计划...我绝没有想要实行它。”
4. 你有这些想法以及有一些想要将之付诸行动的意愿吗？	是 ☐	否 ☐	**活跃的自杀意念并有付诸行动的意愿。**活跃的自杀想法，父母报告其有一 些将这些想法付诸行动的意图。 例子:“我有这些想法，而且我想过实行它们。” 反例:“我有这些想法，但我肯定不会实行它们。”
5. 你有否开始制定出如何自杀的细节？你有想要执行这个计划吗？	是 ☐	否 ☐	**活跃的自杀意念，并有具体的计划。**有自杀的想法，且制定出了整个或部分的详细计划，而且患者有一些执行计划的意愿。 例子:“我知道下周四老公会晚下班，我打算将保存在楼上医药箱中的安眠药吞下。”

自杀行为			
6. 你曾经有为结束自己生命做过什么事情，或者开始要做什么事情，或者准备做什么事情吗？	是 ☐	否 ☐	**真实的企图。**一个潜在的有些想要自杀的自我伤害行为。行为在某种程度上被看作是一种自杀的方式。 不一定是100%的意图。假如有任何关联行动的自杀意图/渴望，则这就可以被当作一个真实的自杀企图。不一定要已经受了伤害，而只要有受伤的潜在可能。譬如， 一个人把枪口塞到嘴里且扣动了扳机，但因为枪是坏掉的，所以没有受伤的 结果，但这依然是（自杀）企图。 **夭折或自我中止的尝试。** 患者采取了自杀尝试，但又在自我毁灭的行为发生前，自己阻止了自己。 **被打断的尝试。** 患者在开始可能的自我伤害行动后被打断（被一个外在环境因素打断，且如果没被打断的话，真实的自我伤害就会发生。） **准备的行动或行为。**朝向紧迫自杀意图的行动或准备。
在过去的三个月中？	是 ☐	否 ☐	
在过去的 4 周中？ 例子: 收集药片，获取一把枪，放弃财物，写遗嘱或遗书， 取出了药片但没有吞下， 举起了枪但改变了主意或者枪被人夺下，去了房顶但没有跳下；或者真的吞下了药丸，尝试去射杀自 己，割伤自己，尝试上吊, 等等。	是 ☐	否 ☐	

C-SSRS 筛查的响应规程

条目 1 出院时，转诊到行为健康服务（Behavioral Health）

条目 2 出院时，转诊到行为健康服务

条目 3 行为健康咨询（精神科护士/社工），考虑病人安全干预措施（Patient Safety Precautions）

条目 4 立刻通知医生或者行为健康服务和病人安全干预措施

条目 5 立刻通知医生或者行为健康服务和病人安全干预措施

条目 6 三个月之前：行为健康咨询（精神科护士/社工），考虑病人安全干预措施

条目 6 三个月之内：立刻通知医生或者行为健康服务和病人安全干预措施

证道 正心 诚意 共 成 长

证道心理近期精彩课程

扫描二维码了解详情

关系创伤的动力学治疗
临床全过程及操作技术指导

Janet Bachant

创伤治疗顶尖专家

纽约精神分析中心督导师

纽约灾难咨询联合会主席

主体间性心理治疗
理论与个案演示十二讲

Peter Buirski

主体间学派临床大家

45年心理治疗与教学经验

丹佛大学心理学研究生院荣誉院长

《主体间性心理治疗》作者

Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years) Quick Screen

Ask each question, then ask whether the patient has had these thoughts or behaviors in the past month if he or she doesn't provide that information.

Suicidal Ideation

Questions	Past month	What a positive response indicates
Ask questions 1 and 2.		
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Yes ☐ No ☐	**Wish to be dead.** Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: "I've wished I wasn't alive anymore."
2. Have you actually had any thoughts of killing yourself?	Yes ☐ No ☐	**Non-specific active suicidal thoughts.** General non-specific thoughts of wanting to end one's life/commit suicide. Example: "I've thought about killing myself."
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3. Have you been thinking about how you might kill yourself?	Yes ☐ No ☐	**Active suicidal ideation with any methods (not plan) without intent to act.** Person endorses thoughts of suicide and has thought of at least one method. Example: "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it…and I would never go through with it."
4. Have you had these thoughts and had some intention of acting on them?	Yes ☐ No ☐	**Active suicidal ideation with some intent to act.** Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: "I have had the thoughts, and I have considered acting on them." Not: "I have the thoughts but I definitely will not do anything about them."
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Yes ☐ No ☐	**Active suicidal ideation with specific plan.** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Example: "Next Thursday when I know my husband will be at the office late, I am going to take the sleeping pills I keep in the upstairs medicine cabinet."

Suicidal Behavior

Questions	Past month	What a positive response indicates
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	Yes ☐ No ☐	**Actual attempt.** A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt. **Aborted or self-interrupted attempt.** When person takes steps toward making a suicide attempt, but stops him/herself before he/she actually has engaged in any self-destructive behavior. **Interrupted attempt.** When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. (If not for that, an actual attempt would have occurred.) **Preparatory acts or behavior.** Acts or preparation toward imminently making a suicide attempt.
In the past 3 months?	Yes ☐ No ☐	
In the past 4 weeks? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Yes ☐ No ☐	

Clinician Signature:______________________________ **Date:**__________ **Time:** __________

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Screen50043

C-SSRS Adult/Adolescent Quick Screen

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Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions