Suicide Risk Assessment
Confidential Report

Name: Mrs. Elizabeth Smith (an example)
Age: 38 **Sex :** Female
Date of Birth: 01/30/1977
Ethnicity/Race: Other

Last 4 Digits of SSN: 1234
Education: High School
Marital Status: Married
Date Scored: 07/28/2016

Suicide Risk Assessment (SRA) results are confidential and should be considered working hypotheses. No decision should be based solely upon SRA results.

SUICIDE RISK

Mrs. Smith's Suicide Risk Assessment (SRA) Suicide Risk Scale classification is in the **problem risk category**, which is characterized by the emergence of observable suicide-related acts like putting *her* affairs in order. In accordance with *her* problem risk classification *Mrs. Smith* has a serious suicidal problem but has not discussed *her* suicidal intentions with another (Q: 24-T; 56-T; 58-T; 60-T; 78-T; 86-4; 98-4; 100-3; 104-4; 105-4; 112-4; 113-4; 114-1, 2, 3, 4; 115-1, 2, 3, 4; 117-1, 2; 118-4). *Mrs. Smith's* suicide risk classification is in the problem risk range.

CHRONIC SUICIDALITY

Mrs.Smith admits to multiple (2+) suicide attempts (Q: 99-2, 3, 4; answer sheet item #6), which meets the **chronic suicide risk** criterion. Even when *Mrs. Smith's* acute suicide crisis has been ameliorated (which may be the case), *her* chronic and enduring suicide risk continues. Chronic suicide symptoms are similar to recalcitrant and enduring personality traits, in that they require long term therapy before they improve or are resolved. ***Mrs. Smith's*** **chronic suicide risk requires continuing, long term care**. Chronically suicidal patients can be safely treated in outpatient settings, **as long as there are no expressed (verbal or written) intentions to die.**

ANSWER SHEET SELF-REPORT

1. Alcohol-related problem:…..Y
2. Drug-related problem:……..N
3. Anxiety problem:……Y
4. I am depressed:……Y
5. I am suicidal:……Y
6. Suicide attempts:….2

INTRODUCTION

Each Suicide Risk Assessment (SRA) scale (disorder, symptom cluster or domain) is represented and discussed in SRA reports. SRA scales (domains) include: Truthfulness, Suicide Risk, Depression, Anxiety, Alcohol, Drug, Substance Use and Stress Management. Excluding the Truthfulness Scale, each of the remaining seven scales (disorders) are symptomatic of suicidal pathology when their scale scores are elevated in the problem or severe problem range. ***Mrs. Smith*** **has *five (5)* elevated scale (Suicide Risk, Depression, Anxiety, Alcohol, Drugs) scores**. A general rule of thumb is the higher the scale score, the more malignant the prognosis. Similarly, the more elevated scale scores there are the more heightened the suicide risk.

TRUTHFULNESS

Sometimes patients deny, minimize or even lie about their suicidal history and intentions. To help suicidal patients, clinicians must know if their patients self-report can be relied on. "An accurate risk assessment is only possible if accurate patient information is available" (Rudd, 2006). **A Suicide Risk Assessment (SRA) Truthfulness Scale score below the Severe Risk range means that the SRA and all scales (domains) contained therein are accurate.**

Mrs. Smith's Truthfulness Scale score is in the **Problem range**, which means all of *her* SRA scale (or domain) scores were truth-corrected to insure accuracy. Problem risk scorers are defensive and guarded regarding self-disclosure. Although denial and problem minimization are present, truth-corrected scale scores are accurate. For background, when an SRA Truthfulness Scale score is in the problem range, all SRA scale scores are automatically truth-corrected with a procedure that is similar to that used in the MMPI, the most widely used personality test in the U.S. **SRA truth-correction only takes place when the Truthfulness Scale score is in the problem range.**

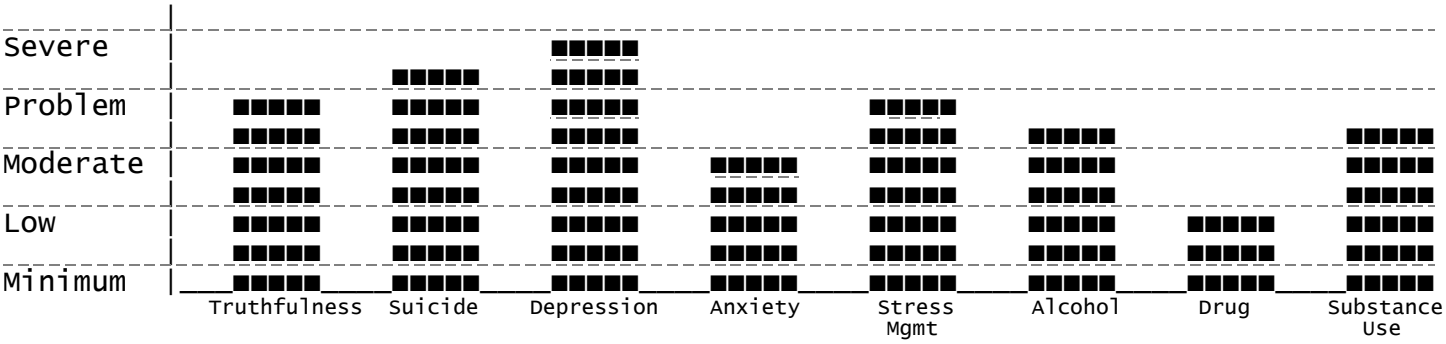
DEPRESSION SCALE

Mrs. Elizabeth Smith's DSM-5 Depression Scale score is in the **Problem or established depression range**. *Mrs. Smith* is depressed and untreated depression usually worsens. Problem depressions are characterized by a depression mood along with a progressive lost of interest and pleasure in activities that were once enjoyed. On its own merits *Mrs. Smith's* depression warrants outpatient counseling or treatment. There are several successful psychotherapies to choose from. Cognitive behavior therapy is well researched, effective and popular. Mutual-help groups might augment, but should not replace, the patient's treatment. In summary, *Mrs. Smith* is depressed and outpatient counseling should be considered.

ANXIETY SCALE

Mrs. Smith's Anxiety Scale answers meet the DSM-5 **Low anxiety** criterion. Although some anxiety is present, it is not problematic. For background, anxiety affects one's body, emotions, mind and spirit. More specifically, research has shown that anxiety disorders are independent risk factors for suicidal behavior. And anxiety disorders with co-occurring mood (depression) disorders increase the likelihood of suicide. There are many good books available in libraries on anxiety reduction techniques and strategies. The way one manages anxiety is, essentially, how one manages stress. Check the SRA's Stress Management Scale score.

SRA PROFILE



STRESS MANAGEMENT SCALE

Mrs. Elizabeth Smith's Stress Management Scale score is in the **Problem risk range**. Stress or more specifically *Mrs. Smith's* stress management skills are problematic and could heighten suicide risk. *Mrs. Smith* would benefit from stress management classes, counseling or training. Lack of stress management skills (techniques and strategies) is apparent. Stress management, or coping skills are sometimes integrated into inpatient or outpatient treatment. *Mrs. Smith* has a stress management **problem** and would benefit from attending stress management classes.

Historically, good stress management or stress coping abilities have been considered protective factors. Yet, their impact on DSM-5 disorders (symptoms clusters) like anxiety, depression, substance (alcohol/drug) use, etc., emphasizes its role in assessing suicide risk. The SRA Stress Management Scale goes beyond identifying stress**.** Indeed, it identifies and quantifies how well the patient manages, or copes with stress.

ALCOHOL SCALE

Mrs. Smith's Suicide Risk Assessment (SRA) Alcohol Scale score is in the **Problem risk range**. *Her* Alcohol Scale score answers indicate *she* is a "heavy drinker" or a "recovering" (alcohol problem but has stopped drinking) alcoholic. If recovering, how long? Consider individually or in combination, outpatient chemical dependency treatment (cognitive behavior therapy) and/or Alcoholic Anonymous (AA) meetings. That said, alcoholism and heavy drinking have consistently been demonstrated to be a suicide risk factor. On its own merits *Mrs. Smith's* alcohol use is problematic and warrants intervention or treatment. Without treatment *Mrs. Smith's* alcohol (drinking) problem will likely worsen.

DRUG SCALE

Mrs. Smith's Suicide Risk Assessment (SRA) Drug Scale score is in the minimum or **Low risk range**. Few, if any, significant indicators of nonprescription or prescription drug abuse are evident. Alcohol use, if present, would likely be minimal, historical, or experimental. For background, prior research demonstrates a strong link between drug use and suicidal behavior. Drugs and alcohol are second only to depression in terms of increasing the likelihood of suicide. For clarity, the term "drugs" refers to both prescription and nonprescription drug use and abuse. That said, *Mrs. Smith* does not have a drug problem. *Her* Drug Scale score is in the minimum or low drug use range.

DSM-5 SUBSTANCE USE DISORDER

The Suicide Risk Assessment (SRA) Substance Use Disorder is based entirely on DSM-5 classification criteria. The presence of this disorder is determined by how many of the eleven (11) DSM-5 Substance Use Disorder symptoms are endorsed. The DSM-5 Substance Use Disorder incorporates both alcohol and drugs, making no obvious distinction between the two. Therefore, the SRA also includes a separate (independent) and well-defined Alcohol Scale and Drug Scale. *Mrs. Smith* endorsed "**three or four**" of the eleven DSM-5 Substance Use Disorder symptoms/criteria, which means *she* **meets the moderate risk Substance Use Disorder criterion.**

PREDICTING SUICIDE

"There is considerable research that demonstrates low base-rate problems like suicide cannot be meaningfully predicted on an individual basis" (Rudd, 2006). Rudd (2006) continues, "although we can not predict individual suicides, we can determine periods of heightened suicide risk." Identifying heightened periods of suicide risk is similar to "foreseeability," which is an important component in the "standards of practice" in suicidality.

PROTECTIVE FACTORS

The term "protective factor" refers to any tangible or intangible element (or factor) that is statistically associated with **a decreased likelihood of suicide**. *Mrs. Smith* endorsed the following protective factors: Q: 10-T; 31-T; 80-t; 86-1; 87-1, 5; 89-1, 2, 3, 4; 91-1; 93-5; 95-5; 96-1; 97-5; 98-1; 99-5; 101-1; 104-1; 105-1, 2; 109-1, 2, 3, 4; 110-1; 113-1, 2; 116-5; 118-1; 120-3, 4; 122-3, 4; 123-1; 125-3, 4; 126-1; 128-3/4; 129-3, 4; 130-3, 4; 131-3, 4; 134-3, 4.

RISK FACTORS

The term "risk factor' refers to any tangible or intangible element (or factor) that is statistically associated with **an increased likelihood of suicide**. *Mrs. Smith* endorsed the following risk factors: Q: 3-T; 6-T; 17-T; 20-T; 22-T; 23-F; 26-T; 27-T; 29-T; 31-F; 32-T; 33-T; 40-T; 43-T; 47-T; 50-T; 55-T; 63-T; 65-T; 73-T; 74-T; 81-T; 85-T; 87-3, 4; 95-1; 99-1, 2, 3, 4; 104-5, 4; 105-5; 110-4, 5; 113-4, 5; 118-4, 5.

ESCALATING SUICIDE RISK

A critical variable when distinguishing between a suicide attempt, accidental death or attention getting behavior are the patient's **suicidal intentions**. The following **escalating suicide intentions** were endorsed by *Mrs. Smith*: Q: #63-t; 73-t; 78-t; 85-t; 87-3, 4. When present, escalating (increasing) suicidal intentions are very important for optimum suicide risk assessment accuracy and treatment decision making. Symptoms (anxiety, depression, substance use, etc.) often move in conjunction with escalating suicide risk.

SUMMARY

Mrs. Smith's Suicide Risk Assessment (SRA) answers place *her* in the **Problem Suicide Risk** category, which is characterized by the emergence of **suicidal intentions**. Subjective suicidal intentions are written or verbalized, whereas objective suicidal intentions (e.g., attempts to prevent discovery or rescue) may be observed. *Mrs. Smith* has engaged in multiple (2+) suicide attempts (Q: 99-2, 3, 4; answer sheet item #6), which meets the **chronic suicide risk** criterion. Even when *her* acute crisis subsides, ***Mrs. Smith* will still be at chronic suicide risk.**

OBSERVATIONS/RECOMMENDATIONS:_____

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STAFF MEMBER SIGNATURE DATE

Fluid Vulnerability Theory

Rudd (2006) applied Fluid Vulnerability Theory (FVT) to suicidality, which provides a conceptual model for understanding suicide risk over time. At the risk of over-simplification, patients who have not attempted suicide, or attempted once, are classified **acutely** suicidal, as they have limited periods (crises) of heightened suicide risk. In contrast, **chronically** suicidal patients have attempted suicide two or more (2+) times and their suicide symptoms are treated over long periods of time. When working with chronically suicidal patients it is important to clearly state in the patient's record (progress notes) **that the patient is at chronic risk for suicide**.

When an acutely suicidal patient's symptoms have abated or subsided, that patient is no longer a significant suicide risk. In contrast, when a chronically suicidal patient's acute suicide symptoms have been resolved, their susceptibility to future suicidal crises has not. They are still at risk and this should be noted in their chart or progress notes.

Rudd, M. D. (2006). *The assessment and management of suicidality*. Sarasota, FL: Professional Resource Press.

Rudd, M.D. (2006). Fluid vulnerability theory: A cognitive approach to understanding the process of acute and chronic suicide risk. *Cognition and Suicide: Theory, Research, and Therapy.* Washington, DC: American Psychological Association: 355–368.

Additional research citations are available at www.suicide-risk-assessment.com.

SRA RESPONSES

1- 50 FTTFTTTFFF FFFFFFTFFF FFTTTTFTTF FTTFFTFTFF FTTFFFTFTF
51-100 FFFFFTFFFT TFFTTFFTFF FFFTFTFFTT TFTF311232 1213322131
101-142 3211313233 4424424444 2123243141 14