A Patient-Centered Approach for Assessing Suicidal Risk

David A. Jobes, PhD; W. Isaiah Chambers, MA; Anna Maclellan, MSc

ABSTRACT

The Suicide Status Form (SSF) is a theory-based and empirically supported suicide assessment instrument that has evolved over decades to become a highly effective therapeutic tool. Developed to address the limitations of clinical judgement and problems with existing suicide risk tools, the SSF employs both quantitative ratings and qualitative prompts to assess suicide risk based on extensive theory and research. Beyond quantitative aspects, qualitative assessments provide insights into a patient's lived experience and the factors that drive patient suicidality. The SSF is the central tool within the Collaborative Assessment and Management of Suicidality (CAMS) framework, facilitating reliable and therapeutic assessment and collaborative engagement in treatment. The SSF thus weaves together a comprehensive and psychometrically sound clinical assessment experience that also incorporates the patient's voice, prompting a dynamic and empathetic dialogue between patient and clinician. In turn, this dialogue can enhance a patient-centered assessment experience that can facilitate effective suicide-focused clinical care.

Research shows that clinicians highly value their clinical judgement,[1] despite clinical judgement being less psychometrically sound than actuarial assessments.[2] Clinicians may overestimate their capacity to detect suicidal risk and misperceive patients' internal experiences and motivations.[3,4] Such research directly inspired the development of the Suicide Status Form (SSF) as a novel approach that relies on both quantitative[5] and qualitative[6] assessments to supplement clinical judgment. The SSF has evolved over 30 years into a multipurpose tool used in the effective suicide-focused treatment called the Collaborative Assessment and Management of Suicidality (CAMS).[6] This article highlights quantitative, qualitative, and related SSF research and its use within CAMS.

From The Catholic University of America, Department of Psychology, Washington, DC.

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Address correspondence to David A. Jobes, PhD, The Catholic University of America, Department of Psychology, 314 O'Boyle Hall, Washington, DC 20064; email: jobes@cua.edu.

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SSF CONSTRUCTION AND PSYCHOMETRIC STUDIES

Initial SSF Test-Construction Research

The original SSF was a six-item self-report tool derived from prominent theories of suicide. The first three items—psychological pain, stress, and agitation—were based on Shneidman's Cubic Model, wherein acute suicidal risk is a convergence of unbearable psychological pain, stressors that impinge on one's psychological world, and intense emotional upset prompting behavior.[7] The fourth item, hopelessness, was derived from the work of Beck and colleagues on suicidal hopelessness.[8] The fifth item, self-hate, was based on Baumeister's idea that suicide can be a means of escape from unbearable self-hatred.[9] The sixth SSF item was an overall rating of behavioral risk for suicide. These six items, collectively known as the SSF Core Assessment, are each rated on a 5-point scale, ranging from low to high for the first five items, and from extremely low risk to extremely high risk for the overall risk of suicide on the sixth item.

Early psychometric evaluation of the SSF showed strong convergent and criterion-prediction validity, and moderate test-retest reliability with 106 treatment-seeking college students who were suicidal.[10] The SSF items exhibited low communality/collinearity, suggesting quasi-independence. The SSF variables

significantly distinguished clinical from non-suicidal samples. Importantly, in contrast to assessment tools constructed using reductionistic multivariate analyses, the SSF was built using theory from the "ground up."

SSF Replication Study

Although the initial 1997 psychometric study[10] demonstrated the SSF's validity, reliability, and clinical utility, concerns were raised regarding its generalizability beyond college students and its ability to assess high-risk patients. A replication study[11] was thus conducted with a more diverse sample of 108 psychiatric inpatients who presented with suicidal ideation within 48 hours of admission. The quasi-independence of SSF variables was replicated, along with concurrent and criterion-prediction validity, demonstrating solid test-retest reliability. The study also showed the SSF's ability to distinguish between *acute-resolvers* who met resolution criteria (three consecutive sessions where suicidal thoughts and behaviors were low and effectively managed) within the course of treatment, and *chronic non-resolvers*, who did not meet resolution criteria during treatment and remained preoccupied with suicidal thoughts and behaviors.

Adolescent Psychometric Study

Brausch and colleagues studied the psychometrics of the SSF with 100 inpatient youth who were suicidal (ages 12 to 17 years old).[12] The results supported using the SSF with teens; convergent validity was significant for all SSF Core Assessment variables, except for Item 2, stress. This may be due to discrepancies in the type of stress being measured, as the SSF stress item measures current stress and the comparative stress measure captures overall life stress. The Implicit Association Test (IAT) provided behavioral validation of the overall risk rating, and the SSF Core Assessment demonstrated good internal consistency. Support of the use of the SSF with teens was important because suicide is a leading cause of death among youth, and identifying suicidal risk in youth early may improve long-term prognosis.

SSF QUALITATIVE ASSESSMENT

The use of quantitative and qualitative methods for assessing suicide has been debated for years. Although nomothetic and quantitative suicide risk assessments have undeniable virtues, they tend to miss the idiographic and qualitative nature of what it means for a person to be suicidal.

SSF Core Assessment Qualitative Prompts

To better capture the idiographic nature of suicidality, later SSF iterations added qualitative prompts to improve risk assessment.[13] These open-ended prompts describe the first five SSF ratings. For example, beneath the patient's rating of psychological pain, there is a prompt, "What I find most painful is___" enabling the patient to write out their answer. A reliable coding system was developed to categorize the range of written responses using 636 written SSF responses from individuals who were actively suicidal. Two-thirds of the responses were reliably captured by four primary coding content themes: relational, role responsibilities, self, and unpleasant internal states. Extant research supports each theme as a factor in suicidality. Importantly, eliciting patients' responses to such prompts validates their experience, builds rapport, and enhances clinical care.

SSF Reasons for Living versus Reasons for Dying

The SSF next asks a patient to list up to five reasons for living (RFL) and five reasons for dying (RFD). Using a college student sample of 49 treatment-seekers who were suicidal led to identifying eight coding categories, with the top RFL content areas being: family, future, and plans and goals.[14] Nine reliable coding categories of RFD responses were identified, mainly focusing on escape, hopelessness, and pain. Gysin-Maillart and collaborators found that more baseline RFDs correlated with increased suicidal attempts over 2 years.[15] However, RFLs did not predict future suicidal behaviors and may not be "protective." Considering these results, the authors argued that early focus on RFLs may stem from a clinician's need to hastily focus on reassuring the patient that "you [patient] have so much to live for." This can shame or invalidate suicidal patients. Studies show the clinical usefulness of RFL/RFD queries, especially for suicide treatment.[6]

SSF One-Thing Prompt

The final SSF qualitative query prompt is: "The one thing that would help me no longer feel suicidal would be___." This query encourages the patient to summarize their suicidal experience into a single reductionist focus, revealing aspirations, wishes, fantasies, and practical considerations that often have treatment utility. Reliable coding categories have centered on Orientation, Reality Testing, and Clinical Utility.[5] Orientation refers to the patient's response and its relation to the self or relationships with others. Reality Testing concerns the objective viability of their response (eg, "winning the lottery" vs "getting my meds right"). Clinical Utility can provide new information that may better inform clinical interventions. The "one-thing response" illustrates how written content can become clinically meaningful within a qualitative framework, which many suicide treatment approaches fail to consider.

SSF Macro-Coding

The preceding qualitative SSF research is generally referred to as *micro-coding* (ie, the reliable categorization of

patients' written responses into distinct and meaningful categories). There is also a *macro-coding* approach that considers the gestalt of all the SSF qualitative responses taken together.[6] For example, Hamedi and colleagues examined perseveration in SSF qualitative prompt written responses.[16] Across two studies of 73 Soldiers and 73 college students seeking treatment, it was found that patients who repeated the same qualitative content three or more times across their SSF written responses had significantly more frequent and severe suicidal ideation. For example, both a Soldier who noted "my wife" seven times across his SSF and a student who referred to being "bullied" five times on her SSF had significantly more severe and frequent suicidal ideation compared to patients who do not repeat content. These results identify a behavioral form of rumination, which may be more valid than studies on suicide rumination relying on subjective self-report.[16]

OTHER SSF-RELATED STUDIES

Beyond test construction, quantitative psychometric validity and reliability, and qualitative aspects of the SSF, several investigations have utilized the SSF in other assessment studies with diverse clinical populations.

Wish to Live versus Wish to Die Ratings

A series of studies has been conducted using the SSF's two 9-point rating scales, which pertain to a patient's relative "wish to live" (WTL) versus their "wish to die" (WTD). These ratings can be used to render a Suicide Index Score that can meaningfully divide patients who are suicidal into three types: 1) those who mostly wish to live; 2) those who are ambivalent about living versus dying; and 3) those who mostly wish to die. Research has shown that organizing patients using these typologies can be clinically meaningful in terms of cross-sectional assessment differences[17] and for predicting linear reductions in suicidal ideation, hopelessness, and depression throughout inpatient care.[18] Moreover, Brown and colleagues found that high WTD ratings were significantly associated with future suicidal behaviors.[19]

SSF and Linear Analyses

The SSF was used to investigate predictors and moderators of clinical care with a sample of 92 treatment-seeking undergraduate college students who were suicidal.[20] Using hierarchical linear modeling (HLM), an initial Level 1 linear analysis determined that patient ratings of "overall risk" from the SSF Core Assessment could significantly predict four different linear reductions in suicidal ideation based on the number of clinical sessions (from a low of four to a high of 17 sessions). In a Level 2 HLM analysis, this initial prediction model was significantly moderated by patient SSF ratings of "self-hate" and "hopelessness." This study thus offers insights with implications for treatment planning, particularly regarding the necessary "dose" of care that is required to reduce suicidal ideation across different types of patients reliably.

SSF as a Therapeutic Assessment

Within assessment research, *therapeutic assessment* refers to tools that enhance patient well-being through personalized, collaborative processes that engage the patient in testing feedback.[21] Poston and Hazen conducted a meta-analytic study of 17 assessments across various psychological conditions, finding that the SSF meets therapeutic criteria with a moderate effect on well-being.[22] In a direct study of the SSF assessment experience, Oakey-Frost and colleagues[23] used multilevel modeling with 57 suicidal inpatients, showing significant distress reductions pre- and post-SSF.[23] Empirical support confirms the SSF assessment's therapeutic essence, likely aiding CAMS' positive treatment outcomes.

SSF Word Count

Another line of research using the SSF has focused on simply counting the number of words written by the patient on the first page of the SSF. Peterson-Fleming conducted a study of 152 help-seeking suicidal college students (Peterson-Fleming E. Unpublished doctoral dissertation, 2004).[13] Counting the words written on the first page of their SSF qualitative prompts at the first session revealed a range of 0 to 226 words/patient, with an average of 75 words. In this study, overall suicidal risk resolved significantly more quickly for patients with the lowest word counts compared to patients with higher word counts. Indeed, those with the highest word counts tended to be chronically suicidal and had a significant history of suicide attempts.

Corona and colleagues studied the SSF word count for 38 inpatients.[24] They found that higher word counts were significantly associated with initially higher suicide ideation scores that steadily declined throughout treatment. In contrast, lower word counts were significantly associated with lower initial hopelessness.

Although the SSF word count findings are mixed, these studies reveal something about the complexity and elaboration of suicidal thinking reflected in the production of written words by patients who are suicidal, with distinct implications for assessment and treatment.

SSF Invariance

Oakey-Frost et al sought to replicate previous SSF factor analyses and used measurement invariance to identify differences in the SSF Core Assessment variables.[25] Confirmatory factor analyses indicated a good fit for both one- and two-factor solutions, and the SSF works equally well across genders and ethnic racial groups. Ordinal logistic regression

models indicated that neither race nor gender significantly moderated the relationship between the SSF Core Assessment total score and clinical outcomes, demonstrating the relative stability of the SSF Core Assessment.

SSF WITHIN CAMS FRAMEWORK FOR TREATING SUICIDAL RISK

Years of SSF-based assessment research have led to several revisions of the tool and the development of a novel suicide-focused intervention called the Collaborative Assessment and Management of Suicidality[5,6] (CAMS). Its philosophy rests on four pillars: empathy, collaboration, honesty, and a suicide-focused approach, defining what CAMS-guided entails. The SSF is validated for both adolescents and adults for patient-centered suicide risk assessment and treatment. Therefore, rather than a prescribed treatment length, CAMS concludes when the patient has three consecutive sessions meeting all three SSF criteria: 1) patient rates their suicide risk as very low (1 or 2 out of 5); 2) patient can manage their suicidal thoughts and feelings in the past week; and 3) patient reports no suicidal behaviors in the past week. CAMS uses a multipurpose version of the SSF throughout the course of suicide-focused care, employing a collaborative side-by-side seating arrangement as patient and clinician complete their respective sections of the SSF. Notably, the SSF-5 includes three distinct versions of the SSF: 1) a lengthier first session version; 2) a shorter version that is used repeatedly for all interim sessions; and 3) an outcome/disposition version.[6] Beyond merely assessing suicide risk using the SSF Core Assessment at the start of every CAMS session, the three versions of the SSF also include sections on risk variables. This treatment plan includes the CAMS Stabilization Plan (CSP), which, like other safety plans, helps acutely suicidal patients by reducing access to lethal means, listing coping strategies and resources, and lowering isolation.[26] Each SSF version includes medical record documentation related to mental status, a judgement about relative stability, case notes, and *Diagnostic and Statistical Manual of Mental Disorders* and International Classification of Diseases ICD (ICD) diagnoses. As a suicide-focused treatment, CAMS focuses on patient-identified "drivers" of suicide (what makes them suicidal) and the subsequent targeted treatment of drivers using indicated interventions (eg, cognitive-behavioral therapy for self-hatred, values clarification to develop purpose, vocational counseling for employment issues, and insight-oriented psychotherapy or exposure therapy for trauma).

To date, CAMS is supported by two meta-analyses, eleven open clinical trials, and seven randomized controlled trials (reviewed by Jobes and Rizvi[27]). When compared to control care, CAMS significantly reduces suicidal ideation, symptom distress, and hopelessness,[28] and can also significantly reduce suicide attempts among adults.[29] CAMS is a well-studied suicide-focused treatment, and the SSF-5 functions as a clinical roadmap guiding the dyad through the full course of CAMS: assessment, treatment planning, interim care, and outcome disposition.[6]

SUMMARY AND CONCLUSION

Clinicians vary in their use of structured suicide risk assessment tools, with most opting not to use such instruments. In the absence of a tool, clinical assessment of suicidal risk may lack a reliable approach with multiple, even random, influences on the clinical assessment process and an overreliance on potentially fallible clinical judgment. Critically, such an approach may fail to reliably and accurately capture the lived experience of the patient's suicidal struggle. As a remedy, we propose using the SSF. Backed by 30 years of clinical research, the SSF is a patient-centered, theory-grounded, valid, and reliable assessment tool with diagnostic utility to identify suicidality and support clinical judgment. It offers both quantitative and qualitative rigor. In the CAMS framework, the SSF-5 is used not only for assessment at each CAMS session's start but also to inform and shape suicide-focused treatment.

In this article, we have endeavored to describe both the quantitative and qualitative aspects of the SSF and related SSF assessment research, along with a brief review of its use within CAMS. The effectiveness of CAMS highlights key therapeutic principles like empathy, shared decision-making, and planning, which strengthen the therapeutic alliance and improve assessment and treatment outcomes. Clinicians without formal CAMS training can still adopt these principles by engaging patients as partners in understanding their suicidal struggles and collaboratively developing treatment plans. We thus assert that using a valid, reliable, and therapeutic assessment approach can provide crucial information about a patient's suicidality that can be used to directly inform a potentially life-saving form of suicide-focused clinical care.

REFERENCES

1. Jobes DA, Eyman JR, Yufit RI. How clinicians assess suicide risk in adolescents and adults. *Crisis Interv Time-ltd Treat*. 1995;2:1-12. https://psycnet.apa.org/record/1997-02907-001
2. Grove WM. Clinical versus statistical prediction: the contribution of Paul E. Meehl. *J Clin Psychol*. 2005;61(10):1233-1243. https://doi.org/10.1002/jclp.20179
3. Hawton K, Cole D, O'Grady J, Osborn M. Motivational aspects of deliberate self-poisoning in adolescents. *Br J Psychiatry*. 1982;141(3):286-291. https://doi.org/10.1192/bjp.141.3.286
4. Coombs DW, Miller HL, Alarcon R, Herlihy C, Lee JM, Morrison DP. Presuicide attempt communications between parasuicides and consulted caregivers. *Suicide Life Threat Behav*. 1992;22(3):289-302. https://doi.

org/10.1111/j.1943-278X.1992.tb00734.x
5. Jobes DA. *Managing Suicidal Risk: A Collaborative Approach*. Guilford Press; 2006.
6. Jobes DA. *Managing Suicidal Risk: A Collaborative Approach*. 3rd ed. Guilford Publications; 2023.
7. Shneidman ES. *Definition of Suicide*. Wiley; 1985.
8. Beck AT, Brown G, Berchick RJ, Stewart BL, Steer RA. Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *Am J Psychiatry*. 1990;147(2):190-195. https://doi.org/10.1176/ajp.147.2.190
9. Baumeister RF. Suicide as escape from self. *Psychol Rev*. 1990;97(1):90-113. https://doi.org/10.1037/0033-295X.97.1.90
10. Jobes DA, Jacoby AM, Cimbolic P, Hustead LAT. Assessment and treatment of suicidal clients in a university counseling center. *J Couns Psychol*. 1997;44(4):368-377. https://doi.org/10.1037/0022-0167.44.4.368
11. Conrad AK, Jacoby AM, Jobes DA, et al. A psychometric investigation of the Suicide Status Form II with a psychiatric inpatient sample. *Suicide Life Threat Behav*. 2009;39(3):307-320. https://doi.org/10.1521/suli.2009.39.3.307
12. Brausch AM, O'Connor SS, Powers JT, McClay MM, Gregory JA, Jobes DA. Validating the suicide status form for the collaborative assessment and management of suicidality in a psychiatric adolescent sample. *Suicide Life Threat Behav*. 2020;50(1):263-276. https://doi.org/10.1111/sltb.12587
13. Jobes DA, Nelson KN, Peterson EM, et al. Describing suicidality: an investigation of qualitative SSF responses. *Suicide Life Threat Behav*. 2004;34(2):99-112. https://doi.org/10.1521/suli.34.2.99.32788
14. Jobes DA, Mann RE. Reasons for living versus reasons for dying: examining the internal debate of suicide. *Suicide Life Threat Behav*. 1999;29(2):97-104. https://doi.org/10.1111/j.1943-278X.1999.tb01048.x
15. Gysin-Maillart AC, Jansen R, Walther S, Jobes DA, Brodbeck J, Marmet S. Longitudinal development of reasons for living and dying with suicide attempters: a 2-year follow-up study. *Front Psychiatry*. 2022;13:865831. https://doi.org/10.3389/fpsyt.2022.865831
16. Hamedi A, Colborn VA, Bell M, Chalker SA, Jobes DA. Attentional bias and the suicide status form: behavioral perseveration of written responses. *Behav Res Ther*. 2019;120:103403. https://doi.org/10.1016/j.brat.2019.04.011
17. O'Connor SS, Jobes DA, Yeargin MK, et al. A cross-sectional investigation of the suicidal spectrum: typologies of suicidality based on ambivalence about living and dying. *Compr Psychiatry*. 2012;53(5):461-467. https://doi.org/10.1016/j.comppsych.2011.09.007
18. Lento RM, Ellis TE, Hinnant BJ, Jobes DA. Using the suicide index score to predict treatment outcomes among psychiatric inpatients. *Suicide Life Threat Behav*. 2013;43(5):547-561. https://doi.org/10.1111/sltb.12038
19. Brown GK, Steer RA, Henriques GR, Beck AT. The internal struggle between the wish to die and the wish to live: a risk factor for suicide. *Am J Psychiatry*. 2005;162(10):1977-1979. https://doi.org/10.1176/appi.ajp.162.10.1977
20. Jobes DA, Kahn-Greene E, Greene JA, Goeke-Morey M. Clinical improvements of suicidal outpatients: examining suicide status form responses as predictors and moderators. *Arch Suicide Res*. 2009;13(2):147-159. https://doi.org/10.1080/13811110902835080
21. Finn SE. *In Our Clients' Shoes: Theory and Techniques of Therapeutic Assessment*. Routledge; 2020. https://doi.org/10.4324/9781003064459
22. Poston JM, Hanson WE. Meta-analysis of psychological assessment as a therapeutic intervention. *Psychol Assess*. 2010;22(2):203-212. https://doi.org/10.1037/a0018679
23. Oakey-Frost N, Moscardini EH, Cowan T, et al. The suicide status form-4 (SSF-IV) as a potentially therapeutic suicide risk assessment tool. *Suicide Life Threat Behav*. 2025;55(1):e13128. https://doi.org/10.1111/sltb.13128 PMID:39291637
24. Corona CD, Ellis TE, Jobes DA. Word count as an indicator of suicide risk in an inpatient setting. *Bull Menninger Clin*. 2018;82(2):115-135. https://doi.org/10.1521/bumc.2018.82.2.115
25. Oakey-Frost N, Divers R, Moscardini EH, et al. Factor structure and measurement invariance of the Suicide Status Form-IV. *Assessment*. 2024;31(3):574-587. https://doi.org/10.1177/10731911231170150
26. Tyndal T, Zhang I, Jobes DA. The collaborative assessment and management of suicidality (CAMS) stabilization plan for working with patients with suicide risk. *Psychotherapy (Chic)*. 2022;59(2):143-149. https://doi.org/10.1037/pst0000378 PMID:34410761
27. Jobes DA, Rizvi SL. The use of CAMS and DBT to effectively treat patients who are suicidal. *Front Psychiatry*. 2024;15:1354430. https://doi.org/10.3389/fpsyt.2024.1354430 PMID:39100852
28. Swift JK, Trusty WT, Penix EA. The effectiveness of the collaborative assessment and management of suicidality (CAMS) compared to alternative treatment conditions: a meta-analysis. *Suicide Life Threat Behav*. 2021;51(5):882-896. https://doi.org/10.1111/sltb.12765 PMID:33998028
29. Santel M, Neuner F, Berg M, et al. The collaborative assessment and management of suicidality compared to enhanced treatment as usual for inpatients who are suicidal: a randomized controlled trial. *Front. Psychiatry*. 2023;14. https://doi.org/10.3389/fpsyt.2023.1038302