NCLEX 2026 · PSYCHOSOCIAL INTEGRITY / MENTAL HEALTH NURSING / HIGH-YIELD

PRIORITY

Suicide Risk & Protective Factors

A clinical-judgment infographic for the nursing student. Assessment, prioritization, pharmacology, and the test-trap thinking that separates a safe nurse from a wrong answer.

SAFETY PRIORITY | SUICIDE ASSESSMENT | PSYCH PHARM

● EMERGENT / RED FLAG TOPIC

01

Definition & Overview

- **Suicidal ideation** — thoughts of ending one's life; ranges from passive (“I wish I weren't here”) to active (“I'm going to do it tonight”).
- **Suicide plan** — a specific method, time, or location identified by the patient. Presence of a plan dramatically escalates risk.
- **Suicide attempt** — non-fatal self-directed injurious behavior with *intent* to die. A prior attempt is the single strongest predictor of completed suicide.
- **Why it matters** — Suicide is a leading cause of death in adolescents and adults. The nurse is often the *first and last* person to assess for risk before discharge.

KEY VOCABULARY

Lethality — how likely a chosen method is to result in death.

Means — the object/method (firearm, medications, etc.).

Intent — patient's stated desire to die.

Parasuicide — non-lethal self-harm without clear intent to die.

02

Pathophysiology

Stress-Diathesis Model — biological vulnerability meets psychosocial stress.

01 **GENETIC PREDISPOSITION** + family history of suicide or mood disorder

▼

02 **NEUROTRANSMITTER DYSREGULATION** — ↓ serotonin (low CSF 5-HIAA); altered HPA axis

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03 **PSYCHIATRIC ILLNESS** — depression, bipolar, substance use, psychosis

▼

04 **ACUTE STRESSOR** — loss, humiliation, breakup, financial collapse, anniversary

▼

05 **HOPELESSNESS** + cognitive constriction → tunnel vision ("no other options")

▼

06 **SUICIDAL BEHAVIOR** emerges as a perceived escape from unbearable pain

03

Warning Signs & Symptoms

Early / Subtle

- Verbalizing hopelessness or worthlessness
- Talking about being a "burden" to others
- Social withdrawal, isolation
- Sleep disturbance — too much or too little
- Increased substance use
- Loss of interest in activities, work, hygiene
- Increased irritability, anxiety, agitation

Late / Imminent — RED FLAGS

- **Specific plan with means & timeframe**
- **Giving away prized possessions**
- **Saying goodbye, writing notes, putting affairs in order**
- **Sudden calm or improvement after deep depression — patient may have decided**
- **Acquiring lethal means (firearm, stockpiling pills)**
- **Statements of intent — "I won't be here next week"**
- **Rehearsal behavior (tying knots, sitting in garage)**

NCLEX PEARL

Sudden improvement is NOT recovery — it is a major warning sign. The patient has often resolved their ambivalence by deciding to act. **Increase** observation, do not decrease it.

Risk Factors vs. Protective Factors

Risk stratification is the foundation of suicide assessment. NCLEX expects you to recognize both columns and weigh them.

Risk Factors (escalate concern)

- **Previous suicide attempt** — strongest single predictor
- Psychiatric diagnosis — depression, bipolar, schizophrenia, BPD
- Substance use disorder (especially alcohol)
- Family history of suicide
- Hopelessness, anhedonia, chronic insomnia
- Chronic pain or terminal/serious illness
- Recent loss — job, relationship, status, loved one
- Access to lethal means (firearms in home)
- Male sex (higher completion), elderly white males highest rate
- LGBTQ+ youth, veterans, indigenous populations
- Recent discharge from psychiatric hospital (first 30 days)
- Social isolation, divorce, widowhood
- History of trauma, abuse, ACEs
- Impulsivity, aggression, recent humiliation

Protective Factors (reduce risk)

- **Strong social support** — family, friends, community
- Marriage / committed partnership; responsibility for children
- Religious or spiritual beliefs against suicide
- Cultural beliefs that discourage suicide
- Engagement in mental health treatment & therapeutic alliance
- Effective coping & problem-solving skills
- Reasons for living — future plans, goals, hope
- Restricted access to lethal means
- Pets / dependents that rely on the patient
- Adequate sleep & physical health
- Sense of purpose, employment, education
- History of positive treatment response
- Fear of disapproval from family
- Ability to articulate reasons not to act

04

Priority Nursing Interventions

*Safety always wins. ABCs apply, but in psych, **S = Safety** trumps almost everything else.*

IMMEDIATE & ONGOING

- **ASK directly** — “Are you thinking of killing yourself?” Direct questioning does NOT plant the idea.
- **Assess for plan, means, intent, timeframe** — the more specific, the higher the risk.
- **Initiate 1:1 (continuous) observation** for high-risk patients — within arm's reach, line of sight at all times.
- **Remove dangerous items** from environment — sharps, cords, belts, shoelaces, glass, plastic bags, medications.
- **Search belongings** on admission with patient present.
- **Restrict access to lethal means** — work with family to secure firearms and medications at home.
- **Document** precisely — quote the patient, note risk level, interventions, response.

THERAPEUTIC STANCE

- **Establish therapeutic alliance** — calm, non-judgmental, available.
- **Active listening** — reflect feelings; avoid “Why?” questions and false reassurance.
- **Collaboratively build a Safety Plan** (Stanley-Brown) — warning signs, coping strategies, supports, crisis line, means restriction.
- **Encourage verbalization** of feelings; instill realistic hope.
- **Coordinate care** — psychiatry consult, social work, family meeting, discharge planning.

PRIORITY ACTION

Patient states an active plan with available means → **do not leave the patient alone**. Stay with them, call for help, escalate to 1:1 observation, notify provider, document.

04b

Assessment Tools

Columbia Suicide Severity Rating Scale (C-SSRS)

Gold standard. Six screening questions about ideation, intensity, and behavior.

1. **1.** Wish to be dead?
2. **2.** Non-specific suicidal thoughts?
3. **3.** Thoughts with method (but no plan or intent)?
4. **4.** Some intent to act?
5. **5.** Specific plan and intent?
6. **6.** Behavior — attempt or preparatory acts?

SAD PERSONS Risk Scale

Quick 10-item screen. Each present item = 1 point. **≥ 6 = inpatient admission strongly considered.** Useful at the bedside; not a substitute for clinical judgment.

Safety Plan vs No-Suicide Contract

✓ **Safety Plan** — evidence-based, collaborative, specific steps.
✗ **No-suicide contract** — NOT effective, false sense of security. **Do not rely on this.**

Pharmacology — Suicide-Relevant Drugs

Some drugs reduce suicide risk. Others carry a black-box warning. Know the difference cold.

SSRIs
fluoxetine, sertraline, citalopram, escitalopram

BLACK BOX **Increased suicidality in patients < 25 years**, especially in the first 1–4 weeks before mood improves. Energy returns before mood lifts — the patient may now have the drive to act on plans. **Monitor closely during initiation and dose changes.**

SNRIs
venlafaxine, duloxetine

BLACK BOX Same age-related suicidality warning. Monitor BP (venlafaxine). Discontinuation syndrome with abrupt stop — taper slowly.

TCAs
amitriptyline, nortriptyline, imipramine

HIGH LETHALITY **Lethal in overdose** — cardiac arrhythmias, seizures. **Limit prescription quantity** in at-risk patients (1-week supply). Never give a 90-day supply to a suicidal patient.

Lithium
mood stabilizer

REDUCES RISK **Reduces suicide risk in bipolar disorder.** Narrow therapeutic index (0.6–1.2 mEq/L). Toxicity → tremor, confusion, ataxia, seizures. Lethal in overdose — limit supply for at-risk patients.

Clozapine
atypical antipsychotic

REDUCES RISK **Only antipsychotic FDA-approved to reduce suicide risk in schizophrenia.** Requires REMS enrollment due to agranulocytosis — weekly ANC monitoring initially.

Ketamine / Esketamine
Spravato® intranasal

RAPID ACTION FDA-approved for treatment-resistant depression with acute suicidal ideation. **Onset in hours-days** (vs weeks for SSRIs). Administered in REMS-certified clinic; 2-hour post-dose monitoring for dissociation, sedation, BP elevation.

Benzodiazepines
lorazepam, alprazolam

USE CAUTION May provide acute anxiolysis but **disinhibit impulsivity** and worsen depression long-term. Lethal in combination with alcohol or opioids. Short-term use only.

MAOIs
phenelzine, tranylcypromine

DIET RESTRICT Hypertensive crisis with tyramine (aged cheese, cured meats, wine). Lethal overdose potential. Reserved for refractory depression.

NCLEX Test Traps

The wrong answer that feels right — and why it isn't.

~~"Asking about suicide will plant the idea."~~

→ **Always ask directly.** Research is unequivocal: direct questioning does NOT increase suicidal thoughts; it gives the patient permission to talk.

~~"The patient signed a no-suicide contract — they're safe."~~

→ **Contracts are not evidence-based.** Use a collaborative *Safety Plan* instead. Contracts can give a false sense of security.

~~"Patient looks much better today — discharge planning can begin."~~

→ **Sudden improvement = RED FLAG.** The patient may have decided to act. Maintain or increase observation.

~~"Discuss it once on admission, then move on."~~

→ **Reassess every shift** — and after any change (visitors, news, medication change, transfer).

~~"Promise the patient I'll keep their suicidal thoughts confidential."~~

→ **Never promise confidentiality** about suicide. Safety supersedes privacy. Be honest upfront.

~~"Start the SSRI and the patient is safe."~~

→ Risk may **rise** in the first 1–4 weeks as energy improves before mood. Close monitoring is essential, especially under age 25.

~~"Patient has passive ideation — low priority compared to chest pain."~~

→ Suicidal patient with **plan and means** = priority equal to physical emergency.

~~"The 1:1 sitter can step away briefly for a break."~~

→ **1:1 means continuous, line-of-sight, arm's reach.** Never leave. Hand-off in person to

Patient & Family Education

For the Patient

→ Identify your personal warning signs

→ Practice coping skills before crisis

→ Carry safety plan + crisis numbers

→ Take medications as prescribed; never stop suddenly

→ Avoid alcohol and recreational drugs

→ Keep follow-up appointments

For the Family

→ Restrict access to firearms & lethal meds

→ Lock medications; use pill counts

→ Recognize warning signs — withdrawal, giving away items, sudden calm

→ Don't leave the person alone in crisis

→ Stay calm; listen without judgment

→ Call 988 or take to ED — don't wait

988 Suicide & Crisis Lifeline

Call · Text · Chat — 988

Post-Discharge

→ Follow-up within **7 days** of psych discharge — highest risk window

→ Caring contacts: brief calls/messages reduce re-attempt

Apply Maslow: safety is foundational.

another staff member.

→ Continue therapy (CBT-SP, DBT) & medication

Memory Boosters & Mnemonics

IS PATH WARM — Warning Signs

AMERICAN ASSOCIATION OF SUICIDOLOGY

- **I** deation — talking, writing about suicide
- **S** ubstance use — increased or new
- **P** urposelessness — "no reason to live"
- **A** nxiety, agitation, sleeplessness
- **T** rapped — "no way out"
- **H** opelessness
- **W** ithdrawal from people, activities
- **A** nger, rage, revenge-seeking
- **R** ecklessness — risk-taking
- **M** ood changes — dramatic shifts

SAD PERSONS — Risk Scale

10 ITEMS · ≥ 6 → CONSIDER ADMISSION

- **S** ex — male (more lethal completion)
- **A** ge — < 19 or > 45
- **D** epression or hopelessness
- **P** revious attempt or psych care
- **E** thanol / drug use
- **R** ational thinking loss (psychosis)
- **S** ocial support lacking
- **O** rganized plan
- **N** o spouse / single / widowed
- **S** ickness — chronic / terminal

PLAID — Suicide Assessment

WHAT TO ASK, EVERY TIME

- **P** lan — specific method?
- **L** ethality — how deadly?
- **A** vailability of means
- **I** ntent — desire to die?
- **D** uration — frequency, timing of thoughts

"5 S's" of Inpatient Safety

QUICK CHECKLIST ON ADMISSION

- **S** earch belongings
- **S** itter — 1:1 if high risk
- **S** harps / sharps-free environment
- **S** uicide assessment every shift
- **S** afety plan before discharge

Pattern-Recognition Pearls

- **Sudden calm** after depression = imminent risk, NOT improvement.
- **Highest-lethality population** = elderly white males with firearm access.
- **Highest attempt frequency** = young women; **highest completion** = older men.
- **First 30 days post-discharge** = peak risk window. Follow-up within 7 days.
- **Specificity of plan** = the single most important risk indicator on the exam.

- **Hopelessness** > sadness as a predictor of suicide.

"Safety first, every time. When in doubt, stay with the patient, escalate up the chain, and document precisely what they said — in their own words."

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