Mental Health: Meds and Communication

Psychotropic classes, serotonin syndrome vs NMS, therapeutic communication, suicide safety, restraints and alcohol withdrawal

ANTIDEPRESSANTS AND LITHIUM

CLASS	WATCH FOR	TEACH OR MONITOR
SSRIs, SNRIs	Serotonin syndrome, bleeding, low Na; SNRIs raise BP	4–8 weeks to work; taper
TCAs	Anticholinergic, orthostasis; overdose: wide QRS, seizures	Smallest supply; wide QRS: IV bicarbonate
MAOIs	Tyramine: hypertensive crisis, occipital headache, stiff neck	No aged cheese, cured meats, beer, wine, soy sauce
Lithium	Toxicity: dehydration, low Na, NSAIDs, ACEi/ARBs, diuretics	Normal salt; 2.5–3 L fluid at start; kidney, thyroid

- MAOIs: avoid decongestants, dextromethorphan, meperidine, other serotonergic drugs; limits last 2 weeks after stopping.
- Lithium target (label): 0.8–1.2 mEq/L acute, 0.8–1.0 maintenance (many texts 0.6–1.2); draw 12 h post-dose.
- Toxic ≥1.5 mEq/L (sometimes lower): vomiting, diarrhea, worsening tremor, ataxia, slurred speech, seizures. Hemodialysis if severe; charcoal does not bind.

ANTIPSYCHOTICS AND BENZODIAZEPINES

CLASS	WATCH FOR	TEACH OR MONITOR
Typical antipsychotics	Most EPS (haloperidol)	AIMS for tardive dyskinesia
Atypical antipsychotics	Weight, glucose, lipids (worst: clozapine, olanzapine)	Metabolic checks, baseline and ongoing
Benzodiazepines	Respiratory depression with opioids, alcohol	Taper; flumazenil may cause seizures

- All antipsychotics: NMS risk; boxed warning, more deaths in older adults with dementia.
- Clozapine ANC: ≥1,500/µL to start (≥1,000 if benign ethnic neutropenia); weekly to 6 months, every 2 weeks to 12, then monthly. REMS ended 2025.
- Clozapine plus fever or sore throat: urgent ANC. Also seizures, myocarditis (first 2 months), orthostasis, severe constipation.

EPS	ONSET	RESPONSE
Acute dystonia	Hours to days	IM/IV benztropine or diphenhydramine; airway
Akathisia	Within weeks	Lower dose; propranolol
Parkinsonism	Days to weeks	Lower dose; anticholinergic or amantadine
Tardive dyskinesia	Months to years	AIMS; VMAT2 inhibitor; may be permanent

SEROTONIN SYNDROME VS NMS

FEATURE	SEROTONIN SYNDROME	NMS
Cause	SSRI plus tramadol, MAOIs, triptans, linezolid	Antipsychotics, metoclopramide; levodopa withdrawal
Onset	Within 24 h, usually <6 h	Over days; often first 2 weeks
Muscles	Clonus, hyperreflexia, tremor	Lead-pipe rigidity; reflexes often reduced
Also	Agitation, dilated pupils, sweating, diarrhea	Fever often >40 °C, high CK, labile BP
Treat	Stop drugs; benzodiazepines, cooling; cyproheptadine	Stop drug; cooling; dantrolene, bromocriptine, benzodiazepines

EXAM TIP Clonus and fast onset: serotonin syndrome. Rigidity and slow onset: NMS. SSRI plus tramadol is a classic pairing.

THERAPEUTIC COMMUNICATION AND DEFENSES

USE	AVOID
Open-ended: "Tell me more."	"Why" questions
Reflecting feelings, restating	False reassurance: "It will be fine."
Clarifying: "Do you mean…?"	Advice or personal opinions
Presenting reality: "I don't hear voices."	Arguing with delusions
Silence; observations: "You look tense."	Approving, disapproving, sympathy, changing the subject

EXAM TIP The best answer usually names the client's feeling and invites more, unless safety is at risk.

- Denial: refusing a painful reality
- Projection: attributing one's own feelings to others
- Displacement: venting on a safer target
- Reaction formation: acting opposite to one's feelings
- Repression is unconscious; suppression is conscious

SUICIDE RISK AND SAFETY

- Screen with a validated tool (e.g., ASQ); Joint Commission: age 12 and up in behavioral health care.
- Ask directly: thoughts, plan, intent, means, past attempts. Asking does not raise risk.
- High risk: 1:1 observation; remove self-harm objects; check visitors' items; safe transport.
- Safety plan, not a no-suicide contract.
- Watch closely early in antidepressant therapy, especially ages 24 and younger.
- Discharge: follow-up and the 988 Suicide & Crisis Lifeline.
- LPN/LVN: collect data, keep observation, report changes to the RN.

SAFETY Plan plus access to means, goodbyes or giving away possessions: stay with the client and escalate.

RESTRAINTS AND SECLUSION

- Last resort; least restrictive; end as soon as possible.
- Physician or licensed practitioner order; never PRN or standing.
- Violent or self-destructive: orders last up to 4 h adults, 2 h ages 9–17, 1 h under 9; renew to 24 h, then provider sees client.
- Same group: face-to-face within 1 h by provider or trained RN (RN then consults provider).
- Chemical restraint: a drug to control behavior, beyond standard treatment or dose. Seclusion: violent or self-destructive behavior only.
- Monitor per policy: circulation, skin, breathing, fluids, toileting; document alternatives.

ALCOHOL WITHDRAWAL AND CIWA-AR

AFTER LAST DRINK	EXPECT
6–24 h	Tremor, anxiety, sweating, fast HR, high BP
12–24 h	Hallucinations; usually clear in 24–48 h
8–48 h (peak ~24 h)	Withdrawal seizures
48–96 h	DTs: confusion, fever, fast HR; usually last 2–3 days

- CIWA-Ar: 10 items, maximum 67; pulse and BP recorded, not scored.
- ASAM 2020: <10 mild, 10–18 moderate, ≥19 severe.
- Benzodiazepines first-line, symptom-triggered per your institution's protocol.
- CIWA-Ar needs the client's answers; not for delirium.
- Thiamine prevents Wernicke encephalopathy (confusion, ataxia, eye signs). Seizure precautions; check magnesium.
- Antipsychotics only as add-ons to benzodiazepines.

EXAM TIP Exams often key thiamine before glucose; ASAM 2020 allows either order or both together.

Sources (32) are listed with links at icubasics.com/sheets/mental-health-meds.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. ICU Basics is an independent study aid not affiliated with any certifying body.