NCLEX 2026 · PSYCHIATRIC–MENTAL HEALTH

Obsessive-Compulsive Disorder

Clinical judgment · Prioritization · Safety · Pharmacology

DSM-5-TR | Anxiety-Related | SSRIs 1st line | >1 hr/day

1 DEFINITION · OVERVIEW
What is OCD & Why It Matters

Obsessions

Recurrent, intrusive, unwanted thoughts, images, or urges that cause marked anxiety or distress. Patient recognizes them as irrational (ego-dystonic) but **cannot stop them.**

Compulsions

Repetitive behaviors or mental acts the person feels driven to perform to neutralize the obsession or prevent a dreaded event. Brings **only temporary relief.**

NCLEX Criteria: Consumes **>1 hour/day**, causes significant distress, and impairs social/occupational function. Often co-occurs with depression, anxiety, and tic disorders. **Onset:** adolescence–early adulthood.

2 PATHOPHYSIOLOGY · SIMPLIFIED
The OCD Cycle

1. **Trigger** — Internal or external cue (dirt, doubt, fear)
2. **Obsession** — Intrusive thought spikes anxiety
3. **Anxiety ↑** — Distress becomes intolerable
4. **Compulsion** — Ritual performed for relief
5. **Relief (brief)** — Cycle reinforces & repeats ♻

Neurobiology — Know This

Serotonin (5-HT) dysregulation → hyperactivity of the **cortico-striato-thalamo-cortical (CSTC) circuit** (orbitofrontal cortex ↔ basal ganglia ↔ thalamus). Result: faulty "error-detection" loop — brain can't signal that the action is *done*. **Genetic + environmental contributors** (PANDAS in kids post-strep).

3 CLINICAL MANIFESTATIONS
Signs & Symptoms

Early / Mild — RECOGNIZE

- Excessive hand-washing / cleaning

Late / Severe — ACT FAST

- Skin breakdown, dermatitis from washing

- Repeated checking (locks, stove, doors)
- Counting, ordering, arranging objects
- Need for symmetry or "just right" feeling
- Intrusive blasphemous / aggressive thoughts
- Hoarding items with no real value
- Mild anxiety when rituals interrupted

- Rituals consume **many hours** daily
- Social isolation & withdrawal
- Unable to maintain job / school
- Severe sleep & nutritional deficits
- Co-morbid major depression
- Panic if ritual is blocked

RED FLAGS — Escalate Immediately

- Suicidal ideation or plan
- Refusal to eat / drink / sleep due to rituals
- Infection from skin breakdown
- Self-injury from ritual (chemical burns, bleeding)
- Psychotic features or loss of reality testing
- Severe dehydration or electrolyte imbalance

PRIORITY NURSING INTERVENTIONS

4 What the Nurse Does — ABCs → Safety → Prioritize

PRIORITY ORDER: ABCs / Physiologic needs → Safety (self-harm, skin integrity) → Anxiety reduction → Ritual limitation (gradual) → Insight building

Assess safety FIRST
Screen for suicidal ideation & self-harm from rituals each shift. Inspect skin.

Allow rituals initially
Do *not* interrupt abruptly — causes panic. Build time for rituals into the schedule.

Set gradual limits
Collaborate on *small* reductions in ritual time/frequency as trust & coping grow.

Therapeutic communication
Use open-ended questions. *Do not* argue the logic of the obsession.

Skin & self-care
Monitor skin integrity; apply emollients; assist with ADLs around rituals.

Structured schedule
Predictable routine reduces decisional anxiety & ritual triggers.

Teach relaxation
Deep breathing, progressive muscle relaxation, grounding — *before* anxiety peaks.

Administer SSRI as ordered
Monitor for therapeutic effect (4–6 wks) & worsening suicidal ideation, esp. young adults.

✓ DO
- ✓ Acknowledge feelings without judgment
- ✓ Allow rituals during high anxiety
- ✓ Involve patient in goal-setting
- ✓ Reinforce non-ritualistic behavior
- ✓ Offer alternative coping skills

✕ DON'T
- ✕ Stop rituals abruptly — triggers panic
- ✕ Argue the thought is irrational
- ✕ Shame or hurry the patient
- ✕ Reinforce by doing the ritual *for* them
- ✕ Skip safety checks for SI / skin

PHARMACOLOGY

5 Medications — SSRIs First Line

SSRIs — Selective Serotonin Reuptake Inhibitors
1ST LINE · FDA-APPROVED

Fluoxetine · Sertraline · Fluvoxamine · Paroxetine *Prozac · Zoloft · Luvox · Paxil*

MOA Block serotonin reuptake → ↑ 5-HT available in synapse → normalizes CSTC circuit.

SIDE FX GI upset, headache, insomnia, sexual dysfunction, weight change, **serotonin syndrome** (HTN, hyperthermia, clonus, agitation).

NURSING Takes **4–6 weeks** for effect. OCD often needs **higher doses** than depression. Monitor for **↑ SI in patients <25**. Never stop abruptly — taper.

Clomipramine (Anafranil) — TCA
2ND LINE · EFFECTIVE

MOA Blocks serotonin & norepinephrine reuptake (stronger 5-HT action than most TCAs).

SIDE FX **Anticholinergic** (dry mouth, constipation, blurred vision, urinary retention), **orthostatic hypotension, sedation, cardiac arrhythmia, lowered seizure threshold**.

NURSING Baseline & routine **ECG**; monitor BP (orthostatic); **fatal in overdose** — limit supply. Avoid with MAOIs (wait 14 days).

Serotonin Syndrome Alert: Triad → **mental status changes + autonomic instability + neuromuscular hyperactivity** (clonus, hyperreflexia). Hold drug, supportive care, consider cyproheptadine. Risk ↑ with combining SSRIs + TCAs + MAOIs + triptans + St. John's Wort.

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NCLEX TEST TRAPS

⚠️ What Students Miss — Priority vs Non-Priority

1	~~Immediately stop the patient's hand-washing ritual.~~	→ Allow the ritual & set gradual limits — abrupt interruption triggers panic.
2	~~"Your hands are clean — stop washing, it's irrational."~~	→ Acknowledge anxiety without debating the obsession's logic.
3	~~Expect SSRI to work in a few days.~~	→ Therapeutic effect takes **4–6 weeks**; OCD often needs higher SSRI doses.
4	~~Prioritize ritual reduction over safety.~~	→ **Safety first** — suicide risk, skin integrity, nutrition & hydration.
5	~~OCD = OCPD (Obsessive-Compulsive Personality Disorder).~~	→ OCD = ego-dystonic (distressing). OCPD = ego-syntonic (rigid, no distress).
6	~~Complete the ritual *for* the patient to save time.~~	→ Never reinforce the behavior — it strengthens the compulsion cycle.
7	~~ERP means flooding the patient with triggers right away.~~	→ **Exposure & Response Prevention** is gradual, hierarchy-based, with therapist guidance.
8	~~Abruptly discontinue SSRI once symptoms improve.~~	→ Always taper — abrupt stop → discontinuation syndrome (flu-like, mood changes).

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PATIENT & FAMILY EDUCATION

Teach-Back Ready Points

Medication patience

SSRI takes **4–6 weeks**. Don't stop early. Never quit abruptly — taper under provider guidance.

ERP is gold standard

Exposure & Response Prevention + CBT. Gradual exposure; resist ritual. Skill, not weakness.

Identify triggers

Keep a thought-record. Track triggers, anxiety level (0–10), ritual performed, outcome.

Support network

Family psychoeducation: don't accommodate rituals. Support groups (IOCDF) & therapy.

Avoid alcohol & self-med

Alcohol & recreational drugs worsen anxiety, interact with SSRIs, raise bleeding risk.

Report warning signs

Call provider: new/worsening suicidal thoughts, rash, fever + rigidity, bleeding, severe agitation.

Stress reduction

Sleep hygiene, regular exercise, mindfulness, caffeine limit (caffeine ↑ anxiety).

Follow-up is mandatory

Regular appointments to monitor response, SI, skin integrity, and adjust therapy.

MEMORY BOOSTERS

8 Mnemonics & Pattern Recognition

Mnemonic: "WASHERS"

The classic OCD symptom cluster — memorize this and you've memorized the clinical picture.

W	A	S	H	E	R	S
Washing rituals	Arranging / symmetry	Safety checking	Hoarding	Ego-dystonic thoughts	Repetitive behaviors	SSRI first-line

Treatment Mnemonic: "ERP" — Gold Standard Therapy

Combined with SSRIs, this is the evidence-based OCD treatment.

E	R	P
Exposure — face the trigger gradually	**Response** — resist ritual urge	**Prevention** — build new pathway

Pattern Recognition — Quick Recall

- ★ **OCD vs OCPD:** OC**D** = **D**istress (ego-dystonic). OCP**D** = **D**isorder of personality (rigid, syntonic, no insight).
- ★ **SSRIs > depression dose** for OCD. Wait 4–6 wks.
- ★ **Allow ritual → limit gradually** (never abrupt).
- ★ **Young adults on SSRI →** black-box warning: monitor SI.
- ★ **Clomipramine = TCA →** anticholinergic + cardiac risk.
- ★ **PANDAS** = pediatric OCD post-Strep infection.
- ★ **Time criterion**: rituals > **1 hr/day**.

NCLEX Rapid-Fire Recall

- ★ **Priority? →** Safety (self-harm, skin, nutrition).
- ★ **Best response? →** Reflect feelings, don't debate thoughts.
- ★ **Best therapy? →** CBT + ERP.
- ★ **1st-line drug? →** SSRI (fluoxetine, sertraline).
- ★ **Teach? →** "Medication takes **4–6 weeks** to work."
- ★ **Nursing diagnosis? →** Ineffective coping, anxiety, risk for impaired skin integrity.
- ★ **Evaluation? →** ↓ ritual time, improved function, reports less anxiety.

Gold Standard Therapeutic Response (OCD)

When the question asks "What is the best nurse response?" — pick the one that:

① Acknowledges	② Avoids	③ Accepts
the feeling / anxiety	arguing the logic	patient & allows time for ritual