Care of Patient with Obsessive-compulsive disorder

Introduction

Obsessive-compulsive disorder (OCD) is categorized as an anxiety disorder. Obsessions are recurrent, intrusive thoughts or feelings, whereas compulsions involve ritualized behaviors. Although many people experience some type of obsessive-compulsive behavior while under stress, the intrusiveness of the obsessive thoughts and the amount of time that a patient spends performing the compulsive behaviors may lead to a diagnosis of OCD. Compulsive behaviors take the form of rituals, particular behaviors that are done (typically over and over again) to decrease the patient's anxiety. (See *Diagnostic criteria for obsessive-compulsive disorder*.)

DIAGNOSTIC CRITERIA FOR OBSESSIVE-COMPULSIVE DISORDER[2]

Criteria for obsessive compulsive disorder are:

A. Either obsessions or compulsions

Obsessions are defined as:

1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
2. the thoughts, impulses, or images are not simply excessive worries about real-life problems
3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.

Compulsions are defined as:

1. repetitive behaviors, such as hand washing, ordering and checking, or mental acts, such as praying, counting, and repeating words silently that the person feels driven to perform in response to an obsession or according to rules that must be rigidly applied
2. the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts aren't connected in a realistic way with what they're designed to neutralize or prevent or are clearly excessive.

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. (This criterion doesn't apply to children.)

C. The obsessions or compulsions cause marked distress, are time consuming (more than 1 hour per day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another disorder is present, the content of the obsessions or compulsions isn't restricted to it. For example, preoccupation with food in the presence of an eating disorder.

E. The disturbance isn't due to the direct physiological effects of a substance or a general medical condition.

About 75% of patients with OCD also experience depression. Thus, antidepressants are commonly used as first-line treatments.[1] Anti-anxiety medications (anxiolytics) may also be used, although these drugs create dependence (tolerance and discontinuation withdrawal), so should be used judiciously. When an antidepressant drug—usually a selective serotonin reuptake inhibitor (SSRI)—is prescribed for the patient, it's usually started at a low dose and then increased to a higher dose over time. There's a general consensus that high doses of SSRIs are needed to treat symptoms of anxiety.

Research has shown that OCD has a genetic component.[179] OCD and other anxiety disorders typically begin in childhood, and there's a growing belief that early treatment of such disorders may improve the course of the illness. Additional research suggests that children may develop OCD after an infection with group A beta-hemolytic streptococcal pharyngitis (strep throat).[5] There's a hypothesis that an antibody against the bacteria may mistakenly act like a brain enzyme, disrupting communication between neurons in the brain and triggering OCD.

Cognitive behavioral therapy (CBT) is the most effective psychotherapeutic treatment for OCD and should be used even if the patient is taking antidepressant medications.[1] CBT involves challenging distorted thoughts and replacing these thoughts with more functional, realistic ideas. It works to undo fears with neutralizing behaviors and involves:

- information (education), which breaks the anxiety experience into understandable elements and provides a model for change[1]
- exposure, which allows the patient to try something to see what happens.
- cognitive restructuring, which allows the patient to be aware of what he's thinking and then use his own experience to see if it's really true; thoughts are treated as hypotheses rather than truths; the patient monitors and evaluates the accuracy of his thoughts and substitutes more accurate thoughts.

Patients with OCD who don't receive treatment typically have a chronic course of fluctuating symptoms, which get worse at times of stress.

Nurses can anticipate that patients with OCD who are hospitalized will have increased symptoms because the hospital environment is anxiety-producing. Patients may be critical and demanding because of their heightened anxiety.

Equipment

- Medications as ordered
- Progress notes

Implementation

1. Review the patient's medical history, psychiatric diagnosis, and therapeutic regimen.

2. Confirm the patient's identity using two patient identifiers according to your facility's policy.[3]
3. Observe the patient for anxiety, depression, obsessions, ritualistic behaviors, and situation avoidance.
4. Assess the extent of the disorder and the range of behaviors presented.
5. Use a calm, reasonable approach when dealing with the patient.
6. Use simple, factual language to explain unit procedures and treatments; explain the rationale for these procedures but avoid arguing with the patient.
7. Avoid taking the patient's verbalizations and behaviors personally *because the patient is acting out of anxiety and isn't intentionally trying to be hurtful to the nurse.*
8. Help the patient to recognize the onset of anxiety and the stressors that may precipitate it.
9. Assist as needed with providing CBT.
10. Explore the meaning and purpose of the compulsive behaviors with the patient.
11. Encourage the patient to share his feelings and thoughts.
12. Help the patient to limit his ritualistic behaviors and learn alternative responses to stress.
13. When possible, allow the patient to have control of the schedule for such activities as bathing and eating.
14. Allow the patient to spend time with a significant other who helps decrease his anxiety.
15. Administer anxiolytic medication as needed and ordered *to help the patient gain some control over his anxiety.*
16. Ensure the patient's physical safety. If necessary, take the patient to his room or remove him from an environment that causes him stress.
17. Provide the patient and his family with information about community resources and reading material.
18. Encourage family participation in the patient's therapy program. *Behavioral interventions typically require a strong support system and close supervision of the patient.*[1]
19. Provide information to other staff members about decreasing the patient's behaviors.
20. Document the patient's behaviors and your interventions.[4]

Special Considerations

- Reasons for treatment failure include poor treatment compliance, cognitive impairment, and lack of understanding about the treatment plan.

Patient Teaching

Teach the patient how to decrease anxiety and stress to manageable levels and how to reduce ritualistic behaviors. Teach family members how they can help the patient attain his treatment goals. Place emphasis on involvement in support groups and community programs.[1]

Documentation

Record daily observations, interactions, therapeutic interventions, and responses to treatment in the patient's medical record. Describe your observations of the patient's behavior and use direct quotations to document the patient's verbalizations. Document nursing interventions performed based on the patient's behaviors and verbalizations. Note any teaching provided to the patient and his family members as well as areas of learning that require additional teaching.

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