

Identification and Diagnosis

Nazeer, *et al.* (2020) suggests that for a clinician to formally diagnose obsessive-compulsive disorder in early years a child must present symptoms of severe disruptive patterns of behaviours. Walitza, *et al.* (2011) maintains that when diagnosing children in the early years sector with any conditions it can be a long process, as when identifying OCD, it is considered a process of obsessiveness and compulsiveness which will tend to take over the life and mind of the child. Additionally, this could be by affecting and impacting the child's day-to-day function. For example, school, hygiene routines and social interaction (Walitza, *et al.*, 2011). Schachar, *et al.* (2022) highlights that OCD presents itself with symptoms over a long period of time with a continuous pattern of development, from glandular obsession to chronic obsession. Adams (2004) highlights that identifying OCD in early years can be a difficult task however, with children often there are common recognisable factors, which include the child having no interest in playing with other children or unfamiliar toys. Secondly, adding that children are wary or scared of germs from animals or objects outside including washing hands excessively. Lastly noticing that a child is collecting or sorting objects in high quantities (Adams, 2004). Mancebo, Eisen, Grant, and Rasmussen (2005) notes that the key aspect for practitioners to consider in early years when diagnosing OCD is that there are two main factors of OCD which includes obsessions and compulsions although they are very different, they are easily masked. Krebs and Heyman (2015) Agrees and believes that obsessions are undecisive, unwanted thoughts, or urges that trigger intense feelings for children. These obsessions are often discomforting for the child and cause a lot of worry for a child developing. However, Zandt, Prior and Kyrios (2007) adds that compulsions are defined differently as it effects the behaviours that the individual has chosen to carry out to meet the need of the obsessions or to decrease distress. It presents as though the child feels like he or she "must do", A child may also believe that engaging in the compulsions will in a way prevent anything bad happening in general. (Zandt, Prior and Kyrios, 2007).

Supporting children with additional learning needs

ECEY6006 (1,400) 2004452

Introduction

In Line with Curran (2020) summary, discussion and analytical points will be conveyed during this research to understand the research around obsessive-compulsive disorder in early years provision. The exploration of this topic is in conjunction with the Welsh Government (2022) new additional learning needs (ALN) system for supporting children and young people in Wales with ALN which has been put into practise by Additional Learning Needs and Education Tribunal (Wales) Act 2018 as children who manage ALN have the right to a full decent life where governments must do all that they can to support the individual child and their families (UNCRC, 2021).

Obsessive Compulsive Disorder (OCD)

Conclusion

To conclude all the analytical topics discussed consisting of diagnoses, barriers, strategies, and therapy of obsessive-compulsive disorder in early years, it is clear to see that there is sufficient evidence and research on OCD with children and how best to support and guide children within a provision to achieve the best quality of life and to reach their full potential. In accordance with Curran (2006) OCD presents itself in different forms and children display a vast variety of behaviours however, it is possible to manage and provide success with educational progress and understanding of the condition to others.

Barriers and Challenges

Peris and Piacentini (2014) claim that children who are diagnosed with OCD experience emotional barriers and struggle with difficulties as the condition often effects the way that they process their thoughts and their way of thinking, also each day can be different. Furthermore, when new challenges arise, often even if it is the same routine and environment, it can affect their wellbeing, self-esteem, cognitive function, and confidence, including developing anxiety disorders. Gadelkarim, *et al.* (2019) demonstrates that challenges can include the complication and discovery of the child having another condition such as autism, which can impact the way the child manages their OCD condition and how both are managed together to reach their full potential. Maguire, *et al.* (2016) advocates that children with OCD can experience barriers to education as they may struggle to concentrate, have a low attention span and struggle in educational environment. For example, where the child may have to ask the same question or ask for reassurance. Equally asking to erase, re-write, re-read material, or start over many times, this can also range to touching, feeling, and moving things within a classroom environment (Maguire, *et al.*, 2016). Huan, Rice and Storch (2008) highlights that children with OCD can struggle with social interaction which can cause barriers to maintaining friendships. In conjunction, Children with OCD may be too worn out from obsessions and compulsions to make friends, and their compulsion may leave them little time for social development (Huan, Rice and Storch, 2008). However, Lack, *et al.* (2009) presents that there may be possible physical barriers for example, having a germ obsession may include them wash their hands so much that the skin becomes red, raw, and painful. Furthermore, Chansky (2011) suggests that barriers to OCD in early years can present an impact on the family and the families homelife as a child who manages an OCD condition can be disruption to other's routines, home environment and to other members of the family unintentionally. This can cause emotional distress, difficulty in understanding and possible conflict in opinions on solutions (Chansky, 2011).



(Centre for mental wellness, 2019)

Strategies and Support

Tompkins (2020) discovers that Cognitive behavioural therapy (CBT) should be the main course of action in relation to a child being diagnosed. Valderhaug, *et al.* (2007) advocates that CBT therapy is defined as a learning technique that combines two separate types of therapies to help with the struggles of the diagnosed condition. For example, cognitive therapy which examines the things you think and behaviour therapy which examines the things you do. Skarphedinsson, *et al.* (2015) implies that CBT therapy is based on the way that a child thinks about situations and how actions are taken by themselves or others. For example, if the child interprets a situation negatively, the child will experience negative emotions and behaviours. According to Reynolds, *et al.* (2013) Cognitive behavioural therapy is the structure of managed strategies for the condition of a child for example, developing practical long-term support, concluding sustainable thinking and approaches, highlighting goals and aims to stay on track and developing problem solving skills. Lewin, *et al.* (2011) demonstrates that the goal of CBT therapy is to help an individual change their thinking patterns and behaviours in order to improve quality of life, this is done by not changing the circumstances that the child lives by day to day however, learning to feel comfortable. Bolton, *et al.* (2011) suggest that there is evidence to prove that the process helps children to take control of their own perception of circumstances from a young age especially children with OCD who struggle with obsessions and compulsions Franklin, *et al.* (2015) article presents that advantages of CBT include, that the process of the therapy can be completed for a short or long period of time depending on the needs of the child, Continuing that as it is structured it can be provided in different formats with group sessions, self – help books and individualised support. However, Funch, *et al.* (2020) advocates that it can also help the child to learn skills that are useful, practical, and present strategies that can be put into practise to manage long term. Additionally, it focuses on re-learning the child's thoughts and altering the behaviour in order to manage the child's outcomes. Funch, *et al.*, (2020). Furthermore, Turnerab, O'Gormanb, Nairc, and O'Kearneyc (2018) highlights that CBT is proven to be as effective as medication when treating obsessive compulsive disorder and may take priority when medication is not working on its own. Flancbaum, Rockmore, and Franklin, (2011) demonstrates that there can be disadvantages of CBT in relation to OCD as in early years there may be barriers for a child to commit themselves to the process including the understanding and the need for full cooperation on a regular basis. Weidle, *et al.* (2015) presents that there is difficulty with CBT when introducing it as it may not be fully effective due to the risk of promoting assumptions which are not fully manageable or possibly faulty for example, the concept that irrational thought patterns are responsible for all behaviours or conditions. However, Reid, *et al.* (2021) suggest that there is criticism around CBT when working with children as the approach is very dominant and it is argued that the approach is to structure and may not meet or address the concerns, behaviour, obsessions, and compulsions of the child as a whole.

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