Doctorate in Educational Psychology

Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

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Summary

This document is divided into three sections.

Part A is a detailed literature review which explores the relevant research into identifying ways that Educational Psychologists (EPs) could support schools working with children and young people (CYP) with Obsessive-Compulsive Disorder (OCD). This literature review starts by discussing recent legislation in relation to mental health in the UK. It then describes OCD and the key theories behind OCD. This is followed by a description of current treatment options for CYP with OCD and the current research available that looks at the different systems in the CYP's life in relation to OCD. Then a more in-depth critique is taken on the existing research that investigates the EP role with OCD. Finally, the rationale for the current study is explained and followed by the research questions.

Part B is the empirical study, which will explore the role of the EP working with schools to support CYP with OCD and how secondary school SENCos/ALNCos would like to be supported by EPs when working with these CYP. A summary of the relevant literature is discussed, followed by details of the methodology and procedure for the current study. Six EPs and six SENCos/ALNCos took part in virtual semi-structured interviews and the data was analysed using thematic analysis (TA). The main themes and subthemes from both participant groups are presented in the results section. The findings are then discussed in relation to the research questions in the discussion section along with the relevance to previous literature and psychological theory. Finally, the implications for EP practice and the strengths and weaknesses of the study are discussed.

Part C is the critical appraisal, which will provide an evaluation of the current study and will give a reflexive account of the research process and the decisions that were made. This section will consider the research position taken, methods, participants and recruitment, data analysis and the contribution to knowledge and the dissemination of the results.

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List of abbreviations

ACC	Anterior cingulate cortex
ADHD	Attention Deficit Hyperactivity Disorder
AEP	Association of Educational Psychologists
ALNCo	Additional Learning Needs Coordinator
ASC	Autism Spectrum Condition
BDD	Body Dysmorphic Disorder
BPS	British Psychological Society
CAMHS	Child and adolescent mental health service
CBT	Cognitive Behavioural Therapy
COMOIRA	Constructionist model of informed reasoned action
CPD	Continued professional development
CYP	Children and young people
DfE	Department for Education
DoH	Department of Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Eating Disorder
EHCP	Education Health and Care Plan
ELSA	Emotional Literacy Support Assistant
EP	Educational Psychologist
EPI	Education Policy Institute
EPS	Educational Psychology Service
ERP	Exposure and Response Prevention
GP	General Practitioner
ICD	International Classification of Diseases
IPA	Interpretive phenomenological analysis
IDEA	Individuals with Disabilities Education Act
LA	Local authority
LOC	Locus of control
MBCT	Mindfulness-Based Cognitive Therapy
MH	Mental health

NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OCD	Obsessive-Compulsive Disorder
PCP	Personal Construct Psychology
PEP	Principal Educational Psychologist
PPI	Psychophysiological Interactions
PRISMA	Preferred reporting items for systematic reviews and meta-analysis
SENCo	Special Educational Needs Coordinator
SLT	Senior leadership team
SP	School Psychologist
SSRI	Selective Serotonin Reuptake Inhibitor
TA	Thematic analysis
TEP	Trainee Educational Psychologist
TS	Tourette's Syndrome
UK	United Kingdom
USA	United States of America
VMPFC	Ventromedial prefrontal cortex
WHO	World Health Organisation

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Part A: Literature review

Word count: 10,425

1.0 Structure of the literature review

1.1 Introduction

This literature review will start by discussing recent legislation in relation to mental health in the UK. It will then describe Obsessive-Compulsive Disorder (OCD) and the key theories behind OCD. This will be followed by a description of current treatment options for children and young people (CYP) with OCD and the current research available that looks at the different systems in the CYP's life in relation to OCD. Then a more in-depth critique will be taken on the existing research that investigates the Educational Psychologist (EP) role with OCD. Finally, the rationale for the current study will be explained and followed by the research questions.

1.2 Search strategy

The original question that was explored in the literature review was "how do EPs support CYP with OCD?" This aimed to gain an overview of what the literature was saying about EP practice in this area and to explore if there was much research on the topic already. The literature included within this review was obtained from the following sources: PsycINFO, SCOPUS, ASSIA and British Education Index. The three search categories were Educational Psychologists, Obsessive-Compulsive Disorder, and schools. The following search terms were used "Educational Psychologist", "Educational Psychology", "School Psychologist", "School Psychology", "school", "educational setting", "secondary school", "high school", "Obsessive-Compulsive Disorder", "OCD", "Compulsive neuros". See Appendix 1 for the full search process.

The literature that arose from these searches was analysed by the researcher for relevance to the current study. Papers that related to CYP with OCD, OCD in the school setting, and educational or school psychologists working with OCD were included. Full inclusion/exclusion criteria can be found in Appendix 1. Other appropriate references were identified using the snowballing technique through references in the existing search papers and Google Scholar. Other literature was found by specifically searching

English and Welsh legislation, textbooks on OCD, Educational Psychology journals including 'Educational Psychology in Practice', and unpublished doctoral theses.

1.3 Structure

Due to the limited existing research that resulted from my searches that looked specifically into the EP role with OCD, a narrative literature review was decided as the most appropriate structure (Siddaway et al., 2019). Narrative reviews are considered appropriate to provide a historical account of the development of a research topic so a broader overview of the literature surrounding CYP with OCD could be encompassed (Siddaway et al., 2019).

2. Mental Health

Mind UK describes mental health (MH) as just like physical health (Mind UK, 2020). The Mind UK website (2020) states:

> Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with. This can feel just as bad as a physical illness, or even worse (Mind UK, 2020, "mental health problems- an introduction" section).

The most recent survey from the National Health Service (NHS) into the MH of children and young people (CYP) in England found that 12.5% of five to nineteen year olds had at least one MH disorder when assessed in 2017 (NHS, 2018). There has been a rise in the prevalence of MH disorders in five to fifteen year olds from 9.7% in 1999 to 11.2% in 2017 (NHS, 2018). It is important to note that this data is on diagnosable MH needs and there is currently no data on the number of CYP with MH difficulties that do not meet the diagnostic thresholds (Crenna-Jennings & Hutchinson, 2020). This therefore highlights not only the number of CYP in schools who have a diagnosable MH condition, but also raises the question about how many CYP are dealing with MH difficulties but are not meeting the threshold for help and support.

Despite the rising number of MH conditions (NHS, 2018) a report by the Education Policy Institute (EPI) (Crenna-Jennings & Hutchinson, 2020) found that a quarter of CYP referred to specialist MH services such as child and adolescent mental health services (CAMHS) were not accepted into treatment. This statistic has not changed since 2015 despite £1.4bn of reported government funding for CAMHS in England (Crenna-Jennings & Hutchinson, 2020). A majority of those rejected do not meet the eligibility criteria for the service (Crenna-Jennings & Hutchinson, 2020). The EPI also reported that CYP who do meet criteria for treatment, wait an average of two months to begin treatment but maximum waiting times can be up to a year in some local authority (LA) locations (Crenna-Jennings & Hutchinson, 2020). This raises the question of how CYP with lower-level MH needs that do not meet the criteria or those who are waiting for treatment are supported.

In recent years, there has been legislation released in England and Wales to try and address the need for MH and well-being support in schools, including the "Transforming Children and Young People's Mental Health Provision: a Green Paper" (Department for Education & Department of Health [DfE & DoH], 2017) in England and a "Draft framework guidance on embedding a whole-school approach to mental health and emotional well-being" (Welsh Government, 2020) in Wales. The need for more MH support in schools has been recognised, yet it is important to consider that MH encompasses a wide range of different conditions and more specific support for MH conditions such as OCD may need to be considered.

It has been reported that around 1% of the UK population has OCD (OCD-UK, 2020) and previous studies have shown that anywhere from 40-80% of OCD cases have a childhood onset (Chaturvedi et al., 2014). These figures indicate that OCD is an area of MH that needs to be supported.

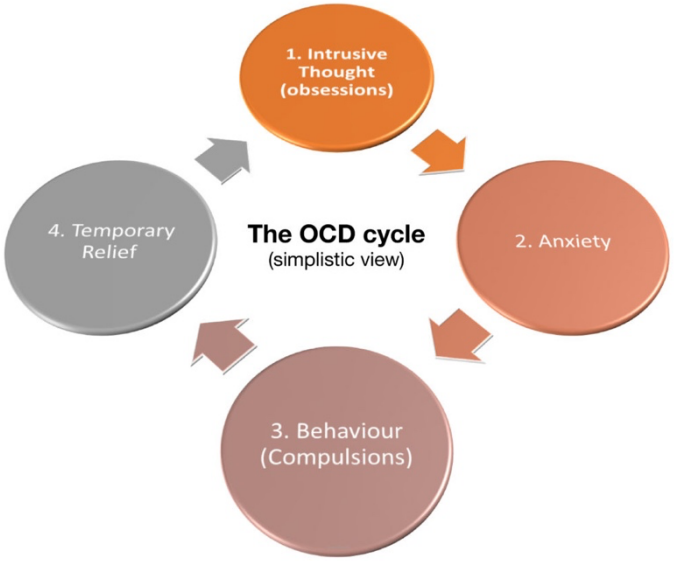
3.0 Obsessive-Compulsive Disorder

OCD is a MH disorder characterised by recurrent obsessions and compulsions that take over a person's life. Obsessions are described as frequent intrusive and unwanted

thoughts, images or impulses that are very distressing (Rachman & De Silva, 2013). Obsessions are not voluntarily produced, and the person interprets these thoughts as their own (Rachman & De Silva, 2013). These obsessions are very distressing and result in a person carrying out compulsions. Compulsions are purposeful, deliberate behaviours that a person feels driven to carry out repeatedly (Rachman & De Silva, 2013). The aim of compulsions is to prevent harm or misfortune occurring to oneself or others (Rachman & De Silva, 2013). OCD is considered to be made up of four components that feed into a cycle (see Figure 1) where the obsessions lead to anxiety and then a person carries out compulsions, which leads to temporary relief from the anxiety (OCD-UK, 2020). However, this relief may only last a few minutes before the next intrusive thought occurs and the cycle starts all over again (OCD-UK, 2020).

Figure 1

The OCD Cycle



Note Retrieved from OCD-UK (2020).

Obsessions and compulsions can take different forms and OCD typically goes undetected for many years before an accurate diagnosis is made (Krebs & Heyman, 2015). The condition is reported to be heterogeneous and two individuals with OCD may present with completely different profiles which can make the diagnostic process difficult (Krebs & Heyman, 2015). Tables 1 and 2 show some of the more common

obsessions and compulsions reported by the National Institute for Health and Clinical Excellence (NICE, 2005).

Table 1

List of obsessions

Obsession	Percentage
Contamination from dirt, germs, viruses (e.g. HIV), bodily fluids, chemicals, sticky substances, dangerous materials (e.g. asbestos)	37.8%
Fear of harm (e.g. door locks are not safe)	23.6%
Excessive concern with order or symmetry	10%
Obsessions with the body or physical symptoms	7.2%
Religious, sacrilegious or blasphemous thoughts	5.9%
Sexual thoughts (e.g. being a paedophile)	5.5%
Urge to hoard useless or worn-out possessions	4.8%
Thoughts of violence or aggression (e.g. stabbing someone)	4.3%

Table 2

List of compulsions

Compulsion	Percentage
Checking (e.g. gas taps)	28.8%
Cleaning, washing	26.5%
Repeating acts	11.1%
Mental compulsions (e.g. special words repeated in a set manner)	10.9%
Ordering, symmetry or exactness	5.9%
Hoarding/ collecting	3.5%
Counting	2.1%

OCD is currently considered a diagnosable MH disorder (OCD-UK, 2020). The two main diagnostic manuals that are used worldwide to categorise MH disorders are the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) and the World Health Organisation's (WHO, 2016) International Classification of Diseases (10 ed.; ICD-10). The current diagnostic criterion for OCD differs slightly between the two manuals so both will be discussed below.

3.1 DSM-5 diagnostic criteria

The DSM was revised for the sixth time in May 2013 for its 5th edition. Notably, the DSM-5 faced some controversy (British Psychological Society [BPS], 2011) as the decision was made to remove OCD from the "Anxiety Disorders" section to a new section called "Obsessive-Compulsive and Related Disorders". Prior to the publishing of the DSM-5, a paper surveyed authors of OCD publications internationally and asked if they supported the move to a different section (Stein et al., 2010). The argument for the move was due to obsessions and compulsions being the primary feature of OCD rather than anxiety (Stein et al., 2010). Others disagreed with the move as OCD and other anxiety disorders respond to similar treatment options (Stein et al., 2010). Table 3 shows the diagnostic criteria.

Table 3

DSM-5 diagnostic criteria for OCD

DSM-5 diagnostic criteria for OCD
A. Presence of obsessions, compulsions, or both: Obsessions are defined by **(1)** and **(2)**: 1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress. 2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralise them with some other thought or action (i.e., by performing a compulsion). Compulsions are defined by **(1)** and **(2)**: 1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven

to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behaviour, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

3.2 ICD-10 diagnostic criteria

The ICD is the international standard diagnostic classification for all recognised diseases and related health problems. The classifications are developed and monitored by the World Health Organisation (WHO) and it is currently in its tenth edition. The ICD-11 is due to be released for use in 2022. Table 4 shows the diagnostic criteria.

Table 4

ICD-10 diagnostic criteria for OCD

ICD-10 diagnostic criteria
For a definite diagnosis, obsessional symptoms or compulsive acts, or both, must be present on most days for at least two successive weeks and be a source of distress or interference with activities. The obsessional symptoms should have the following characteristics: • They must be recognized as the individual's own thoughts or impulses. • There must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resists. • The thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense). • The thoughts, images, or impulses must be unpleasantly repetitive. The compulsive acts or rituals should have the following characteristics: • Stereotyped behaviours that are repeating again and again. • Not inherently enjoyable, nor do they result in completion of inherently useful tasks.

- Performed to prevent some objectively unlikely event, often involving harm to, or caused by, the person, which he or she fears might otherwise occur.
- Usually recognised by the person as pointless or effectual and repeated attempts are made to resist them.

Anxiety is almost invariably present; if compulsive acts are resisted the anxiety gets worse.

3.3 Comorbidity

When two diagnoses occur in the same individual they are referred to as comorbid (van Oudheusden et al., 2020). OCD is often described as a heterogeneous disorder and several epidemiological studies into OCD comorbidity have shown that comorbidity rates in OCD are generally higher than what would be expected based on the base rates of comorbid disorders in the general population (van Oudheusden et al., 2020). People with OCD are often reported to differ distinctly from one another in the number and the sort of comorbid disorders that they have (van Oudheusden et al., 2020). Table 5 provides a summary of the comorbid diagnoses that resulted from the original literature search undertaken for this review including Autism Spectrum Condition (ASC), Attention Deficit Hyperactivity Disorder (ADHD), Tic Disorders and Eating Disorders (EDs). It is important to acknowledge that OCD comorbidity is not limited to these diagnoses (van Oudheusden et al., 2020) and that these were included because of the results from the search terms of the current review to give a broader picture of how OCD can present in CYP.

Table 5

Summary of several comorbid diagnoses with OCD

Disorder	Comorbidity	Any distinct differences	References
Autism Spectrum Condition (ASC)	• Estimated OCD is present in 10% CYP with ASC. • Repetitive or restrictive behaviours can present similarly in both OCD & ASC. • Need to be aware if any rituals for a CYP with ASC start to become stress inducing rather than stress relieving. • Cognitive Behaviour Therapy has been successfully adapted to treat CYP with ASC and OCD.	• In OCD, obsessions are thought to drive repetitive behaviours, in ASC it is theorised that this is driven by a sensory or reward need. In ASC engagement in these behaviours may feel pleasant or stress-relieving. • In ASC, some behaviours may be used to avoid demands or obtaining attention that can be misconstrued by parents as signs of anxiety or distress.	Postorino et al. (2017) Santore et al. (2020) Wolters et al. (2016)
Attention Deficit Hyperactivity Disorder (ADHD)	• There is a reported prevalence estimate of 19%. • Present as inattentive, restless and more likely to resist or disengage from treatment.	• Obsessive anxiety may cause inattention and executive dysfunction, rather than ADHD. • OCD is linked with frontostriatal hyperactivity, said to reflect high control and overplanning, whereas ADHD is linked with lower activity in	Abramovitch et al. (2013) Guzick et al. (2017)

		these regions, said to reflect lack of planning and inhibitory control.	
Tic Disorders	• It is estimated up to 60% of Patients with Tourette's Syndrome (TS) also have OCD and 15% of children with OCD also meet the criteria for TS. • Tics are commonly preceded by sensory phenomena and compulsions, which are commonly preceded by obsessions. • The repetitive behaviours are commonly linked to themes considered taboo or dangerous. • Slower, complex tics and compulsions can be very difficult to distinguish. • Sufferers of OCD and TS will present with a combination of involuntary tic movements and compulsions.	• Rituals in OCD are described as caused by intrusive, ruminative thoughts that cause anxiety. The repetitive behaviour in TS is often classified as a neurodevelopmental condition involving a movement disorder. • Before a tic happens, TS patients tend to feel physical or psychological tension or discomfort that causes them to act in order to remove this discomfort. Whereas the compulsions in OCD are in response to an intrusive thought and often an attempt to prevent a catastrophic event.	Eddy & Cavanna (2014)

Eating Disorders (EDs)	• Comorbidity rates are high with up to 41% occurrence of OCD in patients with EDs. • Restricting food and ritualised eating is often seen in both instances. • Thoughts and feelings of guilt and shame present in both instances. • The presence of obsessions and compulsions affects the individual's daily functioning potentially to the extent of being incapacitated. • Consistent cycles of obsessions and compulsions that never result in the patient feeling like they have reached their end goal (e.g. weight/image).	• Some patients with OCD may be restricting eating over certain fears such as being sick. The weight loss from this may lead professionals to diagnose an ED. • OCD compulsions around food hygiene and contamination may also cause individuals to restrict food or throw food out. • Professionals need to investigate the motives behind the behaviours to distinguish between the different disorders.	Jassi, Patel et al. (2016) Murphy et al. (2004)

3.4 Concerns with diagnostic labels

Despite there being an international consensus in favour of using diagnostic labels (BPS, 2011) such as OCD, it is important to acknowledge that not everyone agrees with the use of diagnostic labels and there can be some concerns around their use (Johnstone, 2018; Timimi, 2014). Timimi (2014) argued that the MH diagnoses listed in diagnostic manuals are not currently linked to any physical test or biological marker, so professionals do not have any pathophysiological correlates or independent data to support what is considered a subjective assessment of diagnosis. Another concern with the MH diagnostic process is the frequency at which patients are given more than one diagnosis, which further raises a concern about the specificity of diagnostic categories (Timimi, 2014).

The British Psychological Society (BPS) (2011) wrote a response to the DSM-5 and voiced concerns that potentially normal and natural responses to stress and trauma have been medicalised. Instead of seeing these responses as an illness, they argued it should be seen as normal individual variation to experiences (BPS, 2011). The paper argued that classifying these responses as illnesses misses the relational context of the problems and any potential social causation (BPS, 2011).

Johnstone (2018) also argued that diagnostic labels turn lifelong journeys of experience into simply an illness, which contributes to a loss of meaning around the life journey to the point at which the patient is diagnosed. Johnstone (2018) instead claimed that MH professionals should work with psychological formulations, a process that involves co-constructing a hypothesis about the origins of a person's difficulties in the context of relationships and life events and how they have made sense of these.

Although OCD has been discussed as having more empirical evidence to be classified as a medical illness than many of the other classifications within the DSM-5 (BPS, 2011), it may be important to consider that there is often a wider picture surrounding the presenting difficulties (Johnstone, 2018; Timimi, 2014).

3.4.1 The researcher's position

As discussed above, there is an argument for considering that diagnostic labels have limitations and need to be considered within a wider picture of need (Johnstone, 2018; Timimi, 2014). However, the current study acknowledges that diagnostic labels are being used and the label of "OCD" is given to CYP who present with particular diagnostic criteria (APA, 2013; WHO, 2016). The study has taken a critical realist ontological position which invokes that a real and authentic reality "sits behind the subjective and socially-located knowledge a researcher can access" (Braun & Clarke, 2013, p. 27). Therefore acknowledging that there is a considered truth to a diagnostic label of OCD and that treatment plans and support are offered based on this diagnosis (NICE, 2005). However, also acknowledging that diagnoses are subjective to an extent as there is not a biological marker to test for (Timini, 2014) and that it is important to consider the wider context that may be influencing the CYP as well as their diagnosis.

4.0 Theoretical explanations of OCD

4.1 History of OCD

OCD is said to be traceable throughout history and earlier records in the seventh century were often written in religious rather than medical literature where incidents of obsessive fears around religion and blasphemous thoughts were common (Fornaro et al., 2009). Until the 20th centrury, OCD was known as scrupolosity, which means an obsessive concern with one's own sins and is sometimes used now to describe a form of OCD involving religious or moral compulsions (OCD-UK, 2020). In the late 1800s and early 1900s, OCD started to become conceptualised as a stand-alone MH disorder that encompassed more than religious aspects. In the early 1900s, Freud described OCD as the patient's mind responding in a maladaptive manner to conflicts between unconscious sexual id impulses and the demands of conscious reality (Fornaro et al., 2009). Later in the 1950s and 1960s, learning theories linked OCD to work around phobias (Fornaro et al., 2009) and by the 1970s cognitive approaches suggested that it is the interpretation of normal unwanted thoughts that transforms them into

obsessive thoughts (Cougle & Lee, 2014). More recent work post the 1990s has focused on possible neurobiological factors and looked into comorbidity research with other diagnoses such as ADHD and Tic disorders (Fornaro et al., 2009).

Different theoretical explanations of OCD have been discussed throughout history including psychodynamic, cognitive and biological perspectives (Rachman & De Silva, 2013). These three perspectives will be discussed in more detail below.

4.2 Psychodynamic perspectives

The psychodynamic perspective describes obsessions and compulsions as symptoms of a deeper problem in a person's unconscious mind (Rachman & De Silva, 2013). These theories claim that memories, desires and conflicts are often repressed because they would otherwise cause anxiety (Rachman & De Silva, 2013). It is assumed that latent aggression plays a key role in OCD, which is hostility or aggression towards certain people that is not openly expressed but instead manifests in fantasies (Moritz et al., 2011). However, these repressed elements can later manifest themselves as neurotic symptoms and compulsions are seen as defensive reactions that suppress the anxieties (Rachman & De Silva, 2013). More specifically, psychodynamic theories posit that obsessions and compulsions arise due to a conflict between the impulsive id striving for aggressive and sexual impulses to be fulfilled and a rigid superego trying to get rid of these impulses from conscious awareness (Brauer et al., 2011). To mediate the conflict between the id and the superego, the ego develops defences such as doubting and indecision (Brauer et al., 2011).

Moritz et al. (2011) explored whether participants with OCD would score higher on measures of latent aggression and responsibility in comparison to control participants. They found that OCD patients exceeded control participants on scales of latent aggression and inflated responsibility and argue that these results suggest that anger experience but not anger expression is enhanced in OCD (Moritz et al., 2011). The study suggested that the translation of aggressive impulses into overt action is probably counter-acted by high moral standards as proposed by psychoanalytic theorists (Moritz et al., 2011). However, this study is not clear about whether the

latent aggression is a precursor of OCD as the theories suggest (Rachman & De Silva, 2013) or if it is a consequence of having OCD. The study acknowledged that the cross-sectional nature of the assessment scales is a limitation in this respect (Moritz et al., 2011).

4.3 Cognitive approaches

Cognitive approaches to OCD have been highly influential over the last few decades and have generated a wealth of research (Cougle & Lee, 2014). Cognitive approaches originated from Beck's (1976, as cited in Cougle & Lee, 2014) cognitive theory of emotional disorders that stipulates anxiety is caused by negative interpretations of stimuli. These approaches propose that it is the interpretation of the content and presence of intrusive thoughts that determines whether they become obsessions (Mantz & Abbott, 2017). A key assumption of cognitive approaches is that repugnant thoughts are a common occurrence for most of the population and that it is the pathological interpretation of non-pathological thoughts that cause the anxiety and distress that is witnessed in OCD (Cougle & Lee, 2014). Rachman (1997) explained that obsessions arise from a catastrophic misinterpretation of normal phenomena and people with OCD misinterpret intrusive thoughts as indicating they are immoral or dangerous people who will act on those thoughts.

Salkovskis' (1985) cognitive model asserted that inflated responsibility is central to OCD. This is where intrusive thoughts are interpreted to indicate personal responsibility for bringing about or preventing harm occurring to oneself or others. This causes discomfort and distress, which results in the individual attempting to neutralise the intrusion with compulsive behaviours (Mantz & Abbott, 2017). These compulsions are carried out in an attempt to minimise the likelihood of harm occurring and hence reduces the associated anxiety (Mantz & Abbott, 2017). Furthermore, Salkovskis (1985) suggested that treatment for OCD needs to proceed from an understanding of the meaning that OCD patients attach to their intrusive thoughts and needs to address the inflated responsibility attached to those thoughts.

Further research into the cognitive bias of OCD patients has found that these patients display thought-action-fusion (Cougle & Lee, 2014). This is when a person attaches great significance to an intrusive thought and believes this will increase the likelihood of this event happening. They hence feel a responsibility for potentially harming someone else as they put the same moral equivalence on the thought as if the action had taken place (Rachman & De Silva, 2013).

Since the publication of cognitive models of OCD (Rachman 1997; Salkovskis, 1985), numerous studies have supported the idea that how an individual interprets thoughts is part of OCD (Cougle & Lee, 2014). A literature review from Cougle and Lee (2014) described many studies that have found individuals with OCD display thought-action-fusion and that obsessive beliefs have predicted the development of OCD postpartum symptoms (Cougle & Lee, 2014). They also discussed that previous studies have shown that negative interpretations of intrusions led to greater frequency and distress and that cognitive interventions that target negative appraisals have been shown to be effective in treating OCD (Cougle & Lee, 2014).

However, there are also reports of contradictory findings. Several studies have reported that participants with OCD did not score higher on measures of obsessive-compulsive related beliefs and appraisals compared to control participants (Cougle & Lee, 2014). Also not all studies have found success when looking at cognitive-based treatments, which may suggest a need to expand on the current cognitive approaches (Cougle & Lee, 2014).

4.4 Biological approaches

Biological approaches to OCD claim that there are neurological, neurochemical and genetic causal factors and recommend treatment that targets these biological processes (Gershkovich et al., 2018).

Research into biomedical causes behind OCD have used brain imaging studies to show there are communication problems between the prefrontal cortex (the part of the brain involved with planning and control) and the amygdala (the part linked to

emotions and anxiety) (Paul et al., 2019; Simon et al., 2014). These studies found that an overactive frontostriatal pathway (part of executive functioning) had a role in mediating obsessions (Simon et al., 2014). Specifically, this involves the ventromedial prefrontal cortex (VMPFC), which plays a central role in the consolidation of fear extinction and the anterior cingulate cortex (ACC), which is said to be involved in the regulation of emotional and cognitive processes (Paul et al., 2019). Abnormalities in this circuit might relate to distress and dysfunctional appraisal in OCD (Paul et al., 2019).

One study sought to investigate amygdala connectivity with the ACC and VMPFC in three independent samples of unmedicated OCD patients obtained from previous studies (Paul et al., 2019). Paul et al. (2019) explored whether amygdala-prefrontal coupling was altered during active OCD symptom triggers as well as during passive viewing of triggers or even during resting state. They found that reductions in positive coupling between the amygdala and orbitofrontal cortex were observed in OCD patients relative to control participants during appraisal and passive viewing of OCD-relevant stimuli, whereas abnormally high amygdala–ventromedial prefrontal cortex coupling was found when appraisal was distracted by a secondary task (Paul et al., 2019). This could be argued to support the biological model that proposes the communication between the amygdala and the prefrontal cortex has a role to play in OCD symptomology (Paul et al., 2019).

However, it is important to note that this study used psychophysiological interactions (PPI) analysis, which includes an interaction term between a psychological variable (task design) and physiological variable (the time series of a brain region). Therefore, it may be possible that additional areas of the brain may be influencing the process that were not looked at.

4.5 Other approaches

It is important to acknowledge that the theories behind OCD are not limited to those discussed above (Rachman & De Silva, 2013). Other approaches have been summarised in table 6 below.

Table 6

Summary of other theories behind OCD

Theory	Description	References
Learning theory	• This theory claims that a person may learn through association with an upsetting experience to become extremely anxious over certain situations, objects or people. • That person may also learn that certain behaviour reduces this anxiety, which in turn strengthens this behaviour. • This theory is based on the hypothesis that obsessional thoughts have become associated with anxiety that has failed to extinguish. • Sufferers have developed avoidance behaviours which prevent the extinction of anxiety. • However, many patients with OCD do not recall initial painful experiences that started their problems. • This theory has been influential in the development of ERP and has led into the cognitive behavioural approaches.	OCD-UK (2020) Rachman & De Silva (2013)
Attachment theory	• Attachment anxiety and avoidance are said to be predictive of cognitive vulnerability factors for obsessional symptomology.	Boysan & Cam (2016) van Leeuwen et al. (2020)

	• Previous literature has found that attachment anxiety was a substantial predictor of threat overestimation and a ruminative response on distressing thoughts. • It is thus suggested that an insecure attachment style increases vulnerability to OCD. • However, most of the research that has explored this link has been correlational so cause and effect cannot be established.	

4.6 Summary

Psychodynamic, cognitive and biological explanations of OCD remain some of the most prominent theories behind OCD (Rachman & De Silva, 2013). These theories have influenced the development of different treatment options for OCD, with cognitive approaches and biological approaches being the most influential (Rachman & De Silva, 2013). Treatment options for OCD are discussed below.

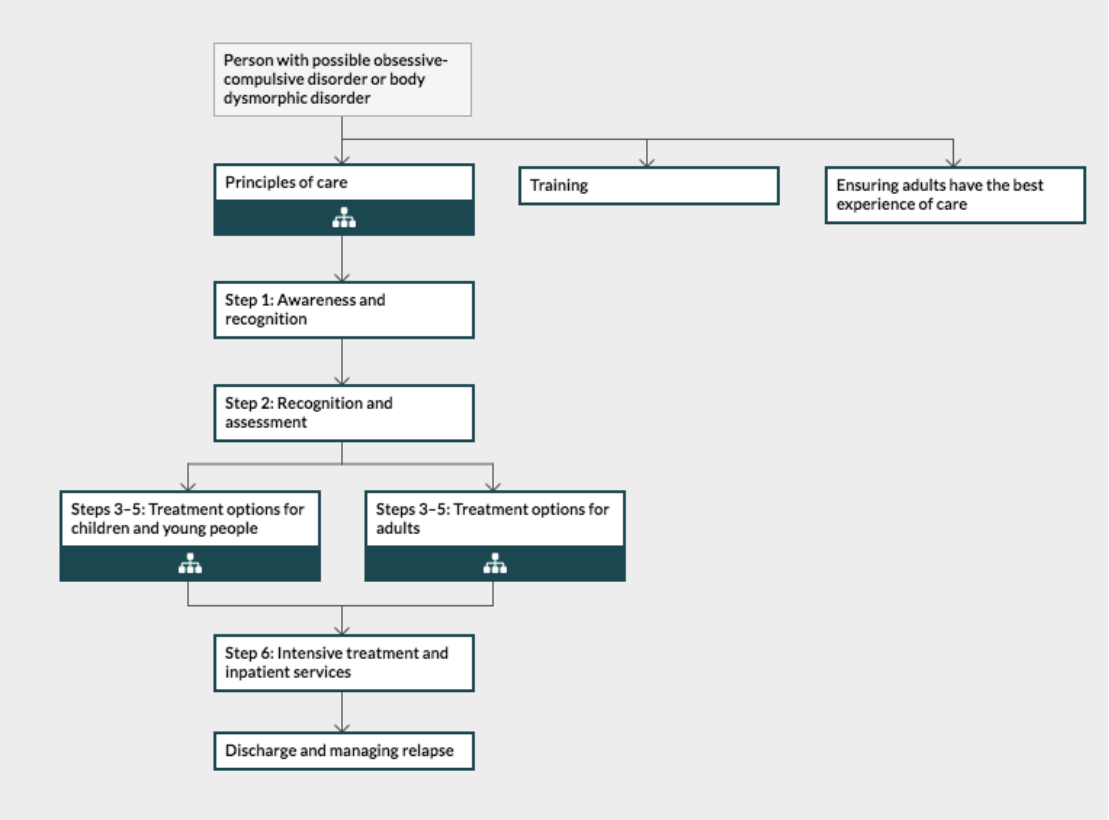
5.0 Treatment of OCD

5.1 NICE Guidelines

NICE is the organisation within the National Health Service (NHS) in England and Wales that is responsible for providing national guidance on treatments and care for people using the NHS. In 2005, NICE released guidance for the identification, treatment and management of OCD and Body Dysmorphic Disorder (BDD) for children and adults. Although OCD and BDD are distinct conditions, they are said to share a number of common features and there is a high degree of similarity between the treatments of the two conditions (NICE, 2005). NICE (2005) guidelines for CYP with OCD suggest a six-step pathway for diagnosis and treatment (see Figure 2).

Figure 2

NICE pathway for diagnosis and treatment of CYP with OCD or BDD



The treatment options suggested in steps 3-5 by NICE are shown in Table 7 (NICE, 2005).

Table 7

Treatment options recommended for OCD and BDD

Initial treatment options for children and young people with OCD and BDD
1.5.1.8 For children and young people with OCD with mild functional impairment, guided self-help may be considered in conjunction with support and information for the family or carers. **1.5.1.9** Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided

self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.

1.5.1.10 All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.

1.5.1.11 If psychological treatment is declined by children or young people with OCD or BDD and their families or carers, or they are unable to engage in treatment, an SSRI[a] may be considered with specific arrangements for careful monitoring for adverse events.

1.5.1.12 The co-existence of comorbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, or the presence of parental mental health problems, may be factors if the child or young person's OCD or BDD is not responding to any treatment. Additional or alternative interventions for these aspects should be considered. The child or young person will still require evidence-based treatments for his or her OCD or BDD.

[a] *Selective Serotonin Reuptake Inhibitor*

5.2 Specialist Services

There are currently two national and specialist OCD services for CYP in the UK, the Michael Rutter Centre and the Priory Hospital, both in London. To access these services, a CYP must have previously accessed the stepped care approach proposed by the NICE guidelines and have not responded to treatment or their OCD has returned worse than before (OCD-UK, 2020).

5.3 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is the main treatment option advised by NICE guidelines (2005) due to the large evidence base that supports it (Wu et al., 2016). CBT is based on the concept that a person's thoughts, feelings and actions are interconnected. The aim of CBT is to help a person with OCD to identify and challenge the patterns of thought that cause their anxiety, distress and compulsive behaviours (Rachman & De Silva, 2013). CBT for OCD involves psychoeducation, cognitive training, mapping of OCD and Exposure and Response Prevention (ERP) (Wu et al., 2016). CBT aims to weaken the association between obsessions and anxiety, and between compulsions and the relief from this anxiety (Wu et al., 2016).

Wu et al. (2016) carried out a meta-analysis of 13 studies to explore the efficacy of CBT as a treatment for OCD in CYP. The weighted mean difference from this meta-analysis showed that OCD symptoms decreased after CBT treatment, which suggests that CBT is successful with paediatric OCD (Wu et al., 2016). However, it is important to note that many of the studies involved in this meta-analysis were trials without control conditions for variables such as time, which may also contribute to the relief of OCD symptoms (Wu et al., 2016).

CBT has also shown to be an effective treatment option to use with CYP who have comorbid OCD and ASC (Kose et al., 2018). One literature review of previous studies found that significant and effective modifications such as visual aids, parental involvement and incorporation of the child's interests were made in various studies that investigated using CBT with CYP with ASC and OCD (Kose et al., 2018). Although all the CYP in these studies were reported to benefit from the CBT, it is important to note that they are considered high functioning ASC and that CBT may not be as effective across the whole spectrum of ASC need (Kose et al., 2018).

5.4 Exposure and Response Prevention

ERP is also one of the NICE recommended treatment options for OCD (NICE, 2005). ERP is usually a part of CBT that involves providing psychoeducation to the patient, helping

the patient confront fears related to their obsessional thoughts (exposure), and then having the patient resist performing compulsions (response prevention) (Law & Boisseau, 2019). Patients can be exposed to actual or imagined situations or to the physical sensations associated with the anxiety or discomfort that they feel (Law & Boisseau, 2019). The goal of ERP is to challenge how the patient responds to distress so they learn that the feared stimuli are actually safe (Law & Boisseau, 2019).

Riise et al. (2016) evaluated the effectiveness of ERP treatment for adolescents with OCD and found that after four days of therapist-assisted ERP and a three week follow up of self-administered ERP, the patients showed a significant reduction in OCD symptoms from pre to post treatment. These gains were maintained at the follow up (Riise et al., 2016). This study was replicated with forty-one new adolescents and again found significant reductions in OCD Symptoms (Riise et al., 2018).

However, Reid et al. (2017) found that ERP therapists reported that the length of the exposure times in ERP was the biggest barrier to treatment. Some therapists felt that the length of the session did not always provide enough time for the patients to habituate to the stimuli and therefore they felt it wasn't as effective (Reid et al., 2017). Therapists also felt that a lack of training was another barrier to effective ERP for adolescents as they felt newly qualified therapists may miss some of the more covert compulsions and avoidance behaviours and consequently implement habituation times for too long (Reid et al., 2017).

5.5 Pharmacotherapy

Selective Serotonin Reuptake Inhibitors (SSRIs) are currently only recommended for CYP as a last resort (NICE, 2005). SSRIs can help improve symptoms of OCD by increasing the level of the chemical serotonin in the brain (NICE, 2005). Serotonin is a neurotransmitter, which is a chemical that carries signals between nerve cells in the brain (NHS, 2020). After it has carried a message, the serotonin is usually reabsorbed by the nerve cells, which is known as reuptake (NHS, 2020). SSRIs work by inhibiting reuptake, meaning more serotonin is available to pass further messages between cells (NHS, 2020).

Kotapati et al. (2019) conducted a systematic review to evaluate the efficacy of SSRI for OCD in CYP. Their findings supported the NICE guidelines for choosing CBT as the first line of treatment and substituting it with SSRI depending on patient preference (Kotapati et al., 2019). Research found that adding CBT to SSRI treatment is effective for non-responders and partial responders, but adding SSRI to ongoing CBT does not prove to be beneficial (Kotapati et al., 2019).

5.6 Mindfulness

Mindfulness is described as the practice of paying attention in the present moment, and doing so intentionally and without judgement (Black, 2011). Mindfulness meditation practices refer to deliberate acts of regulating attention through the observation of thoughts, emotions and body states (Black, 2011). Practicing in this way is considered to counter the effects of excessive orientation toward the future and is said to support patients to distance themselves from negative thoughts (Cludius et al., 2015). Previous studies have found that mindfulness reduces rumination and enhances emotional regulation (Goldin & Gross, 2010) and it has been suggested that it could be beneficial for improving OCD symptoms (Cludius et al., 2015).

However, Cludius et al. (2015) found no difference in OCD symptoms in a group after they received mindfulness training. Külz et al. (2019) researched the effects of Mindfulness-Based Cognitive Therapy (MBCT) on a group of patients with OCD who were still experiencing OCD after CBT treatment. No significant difference was found in clinician-rated OCD symptoms after an eight-week programme of MBCT.

Mindfulness is not currently under the NICE guidelines (NICE, 2005) for treatment for OCD for CYP or adults. It appears as though there is not yet a significant evidence base to recommend mindfulness treatments for OCD.

5.7 Summary

NICE guidance (2005) recommends a stepped-care treatment approach for CYP with OCD that begins with self-help materials and guidance provided by primary care

professionals, progressing if necessary, to CBT or ERP and then to medication such as SSRIs. There is an acknowledgment that treatment for CYP may also involve key adults in the CYP's life such as family members and school staff (Rachman & De Silva, 2013). The influence of key adults and the different systems in the CYP's life in relation to OCD will be discussed below.

6.0 Systems and OCD

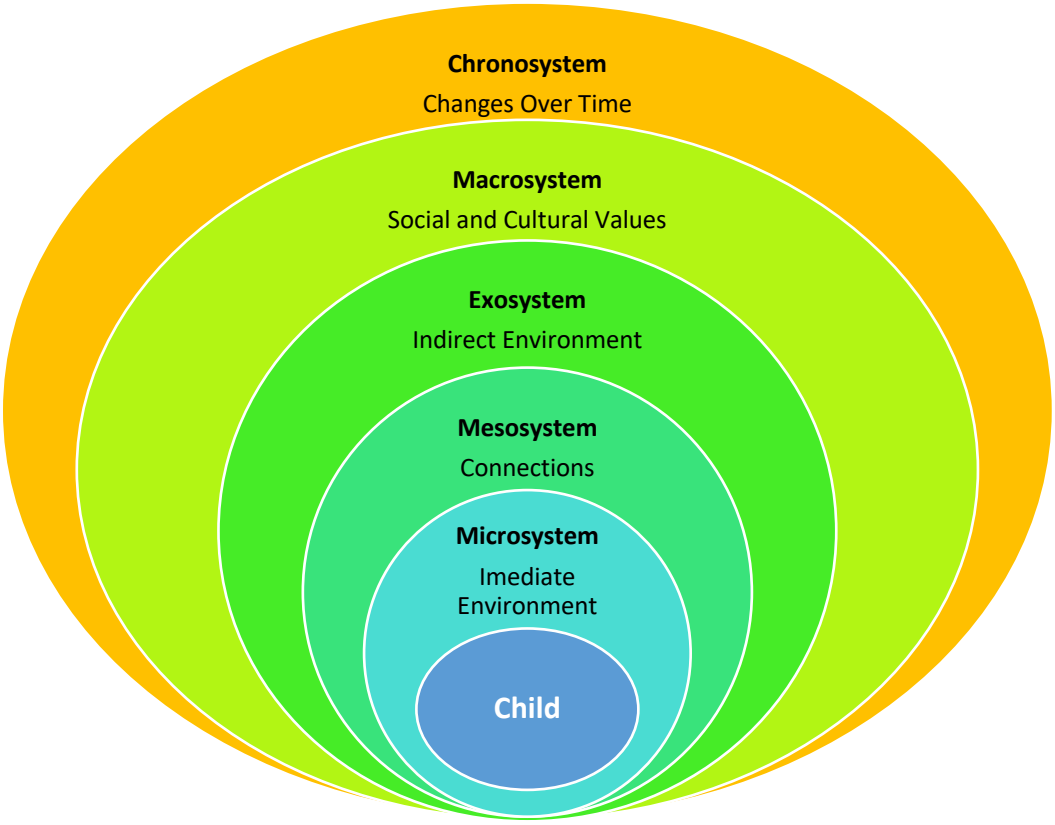
OCD is reported to be difficult to detect in CYP as they are often embarrassed about their experiences and may not be forthcoming about their symptoms, or they may struggle to articulate the obsessions that drive their behaviour (Fernández de la Cruz et al., 2015). Some CYP and their families have difficulties in seeking support so it is important that those around them can recognise the signs and symptoms of OCD and facilitate appropriate support (Jones et al., 2020).

Bronfenbrenner and Ceci (1994) claimed that interactions between a CYP and their environment has an effect on their development (see Figure 3). This development is influenced by changing micro contexts such as family, friends and communities that surround that child (Bronfenbrenner & Ceci, 1994). CYP spend a majority of their time in school or at home with their families, therefore these systems may be key in detection, support and intervention for OCD (Jassi, Kolvenback et al., 2016). Furthermore, there is an emphasis on the importance of the interconnections between two or more settings such as school and family in the mesosystem (Bronfenbrenner & Ceci, 1994). Previous literature into OCD in schools emphasises the need for the school and family systems to collaborate in order to support these CYP (Jassi, Kolvenback et al., 2016). CYP are also believed to be influenced by changes in macro contexts, which are the broader social and cultural contexts in which they are growing (Bronfenbrenner & Ceci, 1994). CYP and their families may therefore be influenced by social and cultural values and the opportunities and understanding within their communities when it comes to seeking support for OCD (Jones et al., 2020).

The different systems and how they interact have also been considered important for exploring potential support for CYP with different MH difficulties such as EDs (Elms, 2020). Therefore, it is important to consider the different systems around a CYP with OCD and how support can be offered and accessed at different levels.

Figure 3

Bronfenbrenner's Bioecological Systems Theory (1994)



6.1 The family system

6.1.1 Accommodation

Living with a CYP who has OCD can create a very distressing home environment for both the CYP and the other family members (Halldorsson et al., 2016). Previous research into the home environment has focused on the effects of family accommodation on CYP with OCD (Jassi, Kolvenback et al., 2016). Accommodation refers to the act by which someone else will help a person with OCD complete their

rituals by either direct action or answering any reassurance questions in the hope that this relieves distress for the person with OCD (Halldorsson et al., 2016). CYP with OCD are said to desire the involvement of others in their rituals as it temporarily transfers the responsibly of their obsession onto another person (Halldorsson et al., 2016). Temporary relief is also given to the family member as they are able to achieve some degree of normality such as being able to leave the house with the CYP (Monzani et al., 2020).

However, the reality of accommodation appears to be that it in fact leads to increased distress to both the CYP and other family members due to the increasing time and frequency of the rituals (Halldorsson et al., 2016) and that it can result in greater symptom severity and poorer treatment outcome responses (Kobori et al., 2012; Monzani et al., 2020).

6.1.2 Family involvement in treatment

As family factors such as accommodation have been found to contribute to treatment (Lebowitz, 2013) many treatment options for CYP with OCD will also aim to involve the family to help with the dynamics at home and ensure that treatment can run as smoothly as possible (Halldorsson et al., 2016). CBT treatment will often offer psychoeducation to parents to help them understand OCD and how best to support their CYP at home (Fischer-Terworth, 2013). Furthermore, CBT and ERP approaches can often ask parents to take the role as a coach in the family home to ensure that CYP follow the homework being set and that reassurance seeking is reduced (Lebowitz, 2013). ERP encourages independent coping and confrontation of avoided triggers so family accommodation is contrary to these goals (Lebowitz, 2013). Therefore some treatment options give an option for a parent only group that targets accommodation in parents and gives them support and strategies to help guide them through their child's treatment process (Lebowitz, 2013).

Therefore, it is important for professionals to consider the family microsystem when working with CYP with OCD and how they can work collaboratively to support the CYP (Lebowitz, 2013).

6.2 The school system

6.2.1 The experience of CYP with OCD at school

Living with OCD can have a detrimental effect on CYP in an educational setting and can lead to poorer academic achievement, social issues, depression and low attendance (Fischer-Terworth, 2013; Helbing & Ficca, 2009; Leininger et al., 2010; Pérez-Vigil et al., 2018).

In a nation wide study in Sweden, Pérez-Vigil et al. (2018) looked at the educational attainment of people born between 1976 and 1998 who were on the national register and examined how those with a lifetime diagnosis of OCD achieved in comparison to those in the sibling comparison sample without an OCD diognosis (or any other diagnosis). They found that those with a diagnosis of OCD were significantly less likely to pass core and additional courses at the end of compulsory school (Pérez-Vigil et al., 2018). Those with an OCD diagnosis were also significantly less likely to start or finish further education such as university degrees (Pérez-Vigil et al., 2018). Furthermore, individuals in the study who were diagnosed with OCD before 18 years of age showed worse educational attainment across all educational levels compared to those diagnosed at or after the age of 18 (Pérez-Vigil et al., 2018). The authors highlighted that OCD, particularly when diagnosed at school age, was associated with a profound decrease in educational attainment that spanned from school to postgraduate education (Pérez-Vigil et al., 2018).

However, this study only included participants who were diagnosed and receiving specialist care, not those supported by general practitioners (Pérez-Vigil et al., 2018). Therefore, this may not be representative of the true picture of the country. Plus the study did not look at measures of symptom severity, which may be a further indicator of the link to academic achievement.

CYP with OCD are reported to find social situations at school difficult due to their symptoms and may find more diffculty making friends, more victimisation from peers

and more shame about their behaviour in front of their peers (Borda et al., 2013; Kim et al., 2012). A study by Kim et al. (2012) found that parents reported their CYP with OCD had lower levels of social competence and more social problems than parents of CYP without OCD. They reported that their children had fewer friendships and a greater difficulty making friends (Kim et al., 2012). However, this viewpoint was not shared by the CYP themselves, who did not differ from the control sample in their views about being able to maintain friendships (Kim et al., 2012). This may suggest that although it appears these CYP have less friends than their peers, they may actually be satisfied with that. This is supported by Borda et al.'s (2013) study where CYP with OCD were significantly more likely to report preferring time alone compared to the control sample. The authors considered that these CYP may prefer being alone to avoid problematic social interactions such as rejection from their peers (Borda et al., 2013). Borda et al. (2013) also found the CYP with OCD were significantly more likely to report having fewer friends, having trouble making friends and wanting more friends.

Both of these studies have the limitation of using self-report measures as they are more susceptable to a social desirablity bias. Both the parents and the CYP may have wanted to portray themselves in a particular way to the researchers, which may have influenced how they answered the questionnaires.

6.2.2 Advice for school staff

Several position papers have been written to educational professionals to help them spot the signs of OCD in school and have provided advice on how to support these different aspects (Adams, 2004; Chaturvedi et al., 2014; Gaskins et al., 2020; Leininger et al., 2010; Sulkowski et al., 2018; Woolcock & Campbell, 2005). These have been summarised in Table 8.

Table 8

Advice for school staff recommended from position papers

Difficulty in school	Recommended support	References
<u>Concentration</u> • Students with OCD may have trouble focusing in class as their intrusive thoughts can be distracting and can take priority over what is being said in the classroom. • These children may be falsely assumed to be disruptive students who do not pay attention. • Students may be extremely tired after being up most of the night completing rituals.	• Break up tasks into smaller steps. • Teacher or supportive adult should be at close proximity to remind students of the task and re-engage them. • Breaks should be offered to students if they appear distressed or distracted.	Adams (2004) Chaturvedi et al. (2014) Leininger et al. (2010) Sulkowski et al. (2018) Woolcock & Campbell (2005)
<u>Task initiation and completion</u> • Students may have compulsions around certain tasks. For example, they may feel they have to read and re-read a certain phrase over and over.	• If there is an issue around writing, staff are recommended to offer alternatives such as audio recording or typing.	Adams (2004) Chaturvedi et al. (2014) Gaskins et al. (2020) Leininger et al. (2010)

• Students may also feel anxious over making mistakes or may feel that they need to make a piece of work perfect. • Staff may see children rubbing out the same word over and over or crossing out and frequently restarting work.	• For reading tasks, teachers are advised to offer shorter passages, simplified versions, or the option of someone else reading to the student. • Students should also be offered extra time for assignments and in exam conditions. • Give students a different task to complete or give alternative ways to complete the task if they appear stuck. • Keep a note of what lessons are more difficult for the student.	Woolcock & Campbell (2005)
<u>Reassurance seeking</u> • Students may constantly ask teachers questions or may ask them to check a piece of work over and over. • They may also repeatedly ask questions around the safety of a task and not appear satisfied with only one reply.	• Teachers should praise on task behaviour. • Teachers should try and ignore reassurance requests, instead they should bring the student's attention to the work they are currently doing and get them to determine why the worry is unnecessary.	Gaskins et al. (2020) Leininger et al. (2010)

<u>Social issues</u> • Students may avoid certain places and situations so they can hide their obsessions and compulsions. • Other students may comment that the CYP is strange or may ask the teacher why they are showing certain behaviours. • These students may have lower self-esteem and reduced confidence.	• It is recommended that teachers ensure they have a friendly and supportive classroom environment. • Other students can be educated on OCD, so they are aware of what it is and have a better understanding of the behaviours they are witnessing. However, staff need to make sure the student is happy with this. • Staff are recommended to focus on the student's strengths and areas where they feel confident. • Teachers may choose to assign a buddy to the student to help them with tasks in class and to also foster a friendship.	Adams (2004) Gaskins et al. (2020) Chaturvedi et al. (2014)
<u>Transitions</u> • Students may have particular rituals getting around the school such as avoiding certain	• It is recommended that students are not penalised for being late.	Adams (2004)

places, touching certain objects or doing repetitive movements. • Students may be late coming to the class or may take a long time leaving at the end of class.	• Teachers can leave handouts and instructions on a student's desk so they can join in when they arrive. This can be done for other members of the class too, so the student doesn't feel singled out. • Keep the school day as consistent and predictable as possible and give the student plenty of notice if there is any change.	Chaturvedi et al. (2014) Leininger et al. (2010)

Overall, there appears to be an overlap in the difficulties CYP with OCD experience in schools and the recommended strategies to support them in the different position papers (Adams, 2004; Chaturvedi et al., 2014; Gaskins et al., 2020; Leininger et al., 2010; Sulkowski et al., 2018; Woolcock & Campbell, 2005). However, it is important to note that as they are position papers, the recommendations and descriptions of difficulties are not a result of a research design (Adams, 2004; Chaturvedi et al., 2014; Gaskins et al., 2020; Leininger et al., 2010; Sulkowski et al., 2018; Woolcock & Campbell, 2005). Several of the papers use examples of case studies to illustrate their points but they do not specify if these are real case studies or not (Adams, 2004; Leininger et al., 2010). Therefore, there does not appear to be an exploration into whether these recommendations have been successful in a school setting. The papers also did not gather the views of school staff to see if they felt the recommendations were helpful and easily implementable in school. The views of school staff may be useful to explore in future research to see what they would like support with and if they are implementing similar strategies to those being suggested in the literature (Adams, 2004; Chaturvedi et al., 2014; Gaskins et al., 2020; Leininger et al., 2010; Sulkowski et al., 2018; Woolcock & Campbell, 2005).

6.3 The school-family system

6.3.1 The importance of collaboration

The school-family mesosystem (Bronfenbrenner & Ceci, 1994) is an important consideration for anyone who is involved with CYP with OCD as literature highlights the importance of collaboration and open communication between parents and school staff (Sabuncuoglu & Berkem, 2006). Children with OCD may be experiencing some symptoms at home and some of these symptoms may appear to decrease at school (Sabuncuoglu & Berkem, 2006). Fischer-Terworth (2013) argued that this could be due to the CYP repressing the compulsions at school rather than a reduction in the obsessions themselves. Furthermore, if CYP are repressing these compulsions at school, they could manifest more severely at home (Chaturvedi et al., 2014). Without input or help from parents, school staff may struggle to meet the needs of the CYP as they do not have all the information about the extent of the obsessions and

compulsions (Chaturvedi et al., 2014; Fischer-Terworth, 2013). Fischer-Terworth (2013) also argued that the onset of symptoms can sometimes link to critical life events and without information from the parents, school may be unaware of significant changes in a CYP's life.

6.3.2 Joint intervention

A collaborative research project between the Specialist OCD clinic at Maudsley hospital in London and the charity OCD Action evaluated two initiatives to raise awareness of OCD in schools and increase access to support for families (Jassi, Kolvenback et al., 2016). The study developed information packs for teachers, Special Educational Needs Coordinators (SENCos) and school nurses to increase awareness of OCD in secondary schools to help educational professionals identify pupils with OCD and provide advice on how to manage OCD in school and when to refer to professionals (Jassi, Kolvenback et al., 2016). The study also provided webinars for parents and carers to enhance their knowledge of OCD, provide advice on how to support treatment at home, and how to help with their needs at school (Jassi, Kolvenback et al., 2016). The research found that the educational professionals reported a significant increase in their knowledge about OCD from pre to post-intervention test questions (Jassi, Kolvenback et al., 2016). They also concluded that parents and carers found the webinar sessions helpful to developing their own understanding of OCD and having regular access to a professional helped to reassure them about what was happening with their child (Jassi, Kolvenback et al., 2016).

There are several limitations as to how the research findings are presented. It is unclear from the publication, which part of supporting OCD the educational professionals found the information packs most helpful with. The overall test scores were higher, but it is unclear how the packs were helpful within the classroom environment or which parts were useful for each professional. It was also not reported how helpful parents and carers found each webinar topic. The researchers gave rationale about the importance of reaching both school and home settings (Jassi, Kolvenback et al., 2016) but were not clear on how parents found the session about

schools. It would be helpful for future research to look specifically at the views of school staff to see what support they would find helpful.

6.4 The community system

Overall, research has found similar prevalence rates, symptom dimension and age of onset of OCD across cultures (Wu & Wyman, 2016). However, it appeared that ethnic minority groups were underrepresented in clinical service and clinical trials (Fernández de la Cruz et al., 2015). Fernández de la Cruz et al. (2015) reported that ethnic minority groups were underrepresented in clinical services in London relative to the ethnic composition of the corresponding catchment area.

As well as being underrepresented within the research, ethnic minority families have also been found to be less likely to access treatment than white families within the community (Fernández de la Cruz et al., 2016). Literature reported that different beliefs about MH, not knowing where to find help, and fears around stigma and discrimination can prevent parents seeking help for their CYP with MH needs (Jones et al., 2020). Jones et al. (2020) argued that to relieve stigma and increase knowledge about OCD amongst ethnic minority populations, support needed to be offered within the community. Information stalls and teaching workshops were offered to a range of organisations in a borough in South London such as schools, youth centres, libraries and religious centres. They found a significant increase in knowledge about OCD following the information stalls and the teaching events (Jones et al., 2020).

However, it is important to note that the study did not record the views of the attendees about how helpful they believed the stalls were. It would have also been useful to look at what they found accessible about the stalls and teaching settings, as although it appears the participant's knowledge about OCD increased, we do not know if they are now more likely to seek treatment or not based on this.

6.5 Summary

Research has discussed that the family, school and community system around a CYP with OCD can all contribute to the support and experience for that CYP (Jassi, Kolvenback et al., 2016; Jones et al., 2020). The EP is considered a professional that works with these three systems to support CYP (Association of Educational Psychologists [AEP], 2016) so it is worth considering that an EP is a professional who is potentially well placed to support CYP with OCD. Therefore, literature into the role of the EP with CYP with OCD will be discussed below.

7.0 The role of the EP with CYP with OCD

7.1 The EP role with Mental Health

The "Transforming Children and Young People's Mental Health Green Paper" (DfE & DoH, 2017) identified that schools have an important role in both helping to identify MH concerns in CYP at an early stage and helping to put in place support for these pupils. MH support teams who will provide schools with a link to specialist MH services are currently being piloted in England (Department of Health and Social Care & Department for Education, 2018) with the hope of reducing inappropriate referrals and waiting times. It is stipulated that these teams will work closely with the Educational Psychology Service (EPS) to create a collaborative approach to supporting CYP with MH difficulties such as anxiety (DfE & DoH, 2017).

In light of the increased prevalence of MH need (NHS, 2018) there has been a focus on EPs practicing in a more therapeutic manner (Greig et al., 2019). MacKay (2007) suggested that EPs have the opportunity within their role to make a significant contribution to MH and to include therapy in the range of services they routinely offer schools. Atkinson et al. (2011) argued that EPs have an understanding of the CYP's needs within an educational context, which places them in a better position than other branches of psychology to offer therapeutic interventions to schools. Furthermore, a survey undertaken by Sharpe et al. (2016) suggested that EPs are the key providers of

specialist MH support to schools when 577 school staff in England were asked which external professionals provided support.

A research study by Greig et al. (2019) investigated the EPS role in supporting MH in Scottish schools. Principal EPs (PEPs) from 19 LAs in Scotland completed a survey on behalf of their service and reported that EPs saw a role for themselves providing MH support in the form of training school staff, parent interventions and working directly with pupils (Greig et al., 2019). However, it is important to note that the PEPs were reporting on behalf on the EPS and individual EP views may not have been fully captured within the results. It may have highlighted what the PEPs believe as opposed to the rest of the EPS.

Zafeiriou and Gulliford (2020) conducted a constructivist grounded theory study that explored the EP role in MH case work in schools. They concluded that EPs used two distinct but interacting processes with MH casework (Zafeiriou & Gulliford, 2020). One process involved facilitating a secure base that offers emotional containment for overwhelmed adults such as staff and parents. The other process engaged adults in cognitively demanding problem-solving activities, leading to cognitive and behavioural change (Zafeiriou & Gulliford, 2020). The study found that EPs use a distinctive combination of specialist consultative skills and child development and organisational knowledge to support parents, school staff and the CYP themselves (Zafeiriou & Gulliford, 2020). A limitation of this research is that the EPs were from one LA in England so the results may be less relevant to other LAs that potentially practice in different ways.

An unpublished thesis by Price (2017) reported that when supporting schools with MH cases in Wales, EPs engaged in consultation, assessment, systemic intervention, 1:1 or group therapeutic intervention and multi-agency work. This suggested that EPs see a significant role for themselves in CYP MH intervention (Price, 2017). However, a limitation of this study is that it is unpublished and has therefore not been subject to peer review. Another limitation is the small sample size of only 17 EPs completing the online questionnaire and 6 EPs agreeing to be interviewed. The results from this small sample size in Wales may not be generalisable to the rest of the UK.

Although previous literature has described a role for the EP in MH (Greig et al., 2019; Price, 2017; Zafeiriou & Gulliford, 2020), research has also found that the role is not always clear. The SENCos interviewed in Price's (2017) thesis discussed that schools need better clarity about the role of the EP in CYP MH. Another unpublished thesis by Elms (2020) interviewed EPs about their role with EDs and found the EPs felt that as a profession they did not have enough knowledge about EDs. Furthermore, Greig et al. (2019) acknowledged that there is a gap between how the PEPs viewed the EPS role with MH and how the role was perceived by government departments in Scotland.

The Association of Educational Psychologists (AEP, 2016) described EPs as working in a range of situations and settings with CYP. They stated that the EP uses "a range of approaches with individuals, groups, schools and wider systems such as LAs and the community" (AEP, 2016, pg. 3). The document also specifically stated that EPs have a role in the community to "form joint working practices relating to attention deficit hyperactivity disorder (ADHD), communication disorders, autism spectrum disorder (ASD) and obsessive-compulsive disorder (OCD)" (AEP, 2016, p. 20). Therefore, it can be argued that EPs are well placed to support CYP with OCD as they work across the different systems that have been explored as important when it comes to support, assessment and treatment of OCD in CYP (AEP, 2016).

7.2 Critical appraisal of research into the role of the EP supporting CYP with OCD

The original systematic search found four papers that looked at School Psychologist (SP) involvement with OCD (see Appendix 2). These papers use the term SP as they were written in America. At the time of the search, no papers were found in the UK that looked at how EPs support OCD.

Two of the papers sought to gather the views of SPs about how they have worked with CYP with OCD (Adams et al., 2007; Gallant et al., 2007) and two papers sought to offer guidance to SPs on how to work with these CYP (Adams et al., 1994; Sloman et al., 2007). These four papers will be discussed in detail below.

7.2.1 Views of School Psychologists

A mixed methods study by Adams et al. (2007) asked SPs to complete a survey about how they assess and identify CYP with OCD. The survey got 123 responses. The study looked at how students with OCD were classified under the Individuals with Disabilities Education Act (IDEA) and found no significance between the severity level of the OCD reported by SPs and the level of support that they received. The SPs also disagreed over which category they would consider OCD to be a part of. Some saw OCD as a social/emotional disorder and others argued it was medical or clinical in nature. It is also important to note that only 10% of the students these SPs worked with were said to be in school full time (Adams et al., 2007). The authors argue that the results from this study suggest that there are difficulties encountered by SPs in the educational practices for classifying the students into support categories and supporting students with OCD (Adams et al., 2007).

In a study by Gallant et al. (2007), 227 registered SPs in a state in the USA answered questionnaires with the aim to gather their views on how to manage OCD within schools. Gallant et al. (2007) found that 89.8% of the participants had experienced at least one case of OCD, and 60% of the respondents identified the SP as the professional to take responsibility for these cases. The participants stated that they used cognitive-behavioural frameworks the most when it came to OCD cases (81%), followed by pharmacotherapy (80.5%) and then systemic/family-based approaches (34.5%). It was also reported that 63% of the participants did not see ERP used in practice. The majority of the participants stated that they need further training on OCD (89.2%) in both assessment and treatment of OCD.

7.2.2 Guidance on how School Psychologists should work

A position paper written by Adams et al. (1994) suggested that the best way to assess OCD in schools is to adapt a behavioural consultation model, which involves SPs and school staff working collaboratively to identify problem behaviours and formulate a hypothesis. Adams et al. (1994) also recommended gathering information from parents in order to get a home perspective. The paper highlighted the importance of

SPs developing a detailed description of a child's behaviour to determine the conditions under which the behaviours occur (Adams et al., 1994). SPs and school staff are advised to do this by using classroom observation, checklists, child interviews and family interviews (Adams et al., 1994).

A position paper from Sloman et al. (2007) looked at the different treatment options for OCD and then proposed a problem-solving model for SPs to use to assess and treat OCD in schools. Based on the review of previous treatment options, the authors proposed a five-step programme (Sloman et al., 2007). Step one was define the problem, two was develop an assessment plan, three was analyse assessment results and set goals, four was develop and implement the intervention plan and five was analyse the intervention plan. Sloman et al. (2007) discussed that teaching staff can implement exposure elements from CBT and ERP with the help and guidance of SPs, and that this could also be implemented as homework with the help of parents. These interventions should be monitored every week by the SP to evaluate their success.

7.2.3 Critique of the literature

It is important to consider that the role of the SPs may differ from EPs in the UK and hence the context may be different. SPs at the time of this research were discussed as often employed directly by a school rather than for a wider LA (Gallant et al., 2007), which may influence how the schools utilised them. Therefore, the views and experiences shared in these studies (Adams et al., 2007; Gallant et al., 2007) may not be generalisable to other countries such as the UK or the ways of working in the current time period. The advice given in the position papers from Adams et al. (1994) and Sloman et al. (2007) have also been suggested for SPs. The ongoing, therapeutic way of working suggested in these papers may be more viable in the American SP context at the time these papers were published but may not be realistic in a UK setting where EPs are hired by LAs and follow different allocation models (Marsh & Higgins, 2018).

Both position papers (Adams et al., 1994; Sloman et al., 2007) did not specify their inclusion and exclusion criteria or their methods of searching when reviewing previous

literature that helped position their argument. Therefore, it is unclear whether the authors gave an accurate scope of the research available or focused on papers to support their arguments. The authors were also assuming that SPs have certain levels of knowledge and skill to implement these programmes, however Gallant et al. (2007) found that most of the SPs claimed that they needed more training regarding OCD. There also needs to be a consideration of the school environment in which the advice has been written for. Sloman et al. (2007) recognised that there are limitations that may prevent the implementation of their five-step programme such as school resources, staff hours and the contracts of the SPs. None of these papers gained the views of school staff to find out how they would like to be supported with these CYP and what would be realistic within the school contexts in which they work.

Adams et al. (2007) used a mixed methods design in the form of a questionnaire, which gathered numerical, categorical and short descriptive responses from the SPs. The participants chose from the answers decided by the researchers and at times were asked to expand further on their answers. Gallant et al. (2007) used a quantitative design and used a questionnaire that was translated to English from Valderhaug et al's. (2004, as cited in Gallant et al., 2007) Norwegian study. The questionnaire was originally designed to gather information about how clinicians were working with CYP with OCD. There may have been a response bias to the questionnaires in both studies, where SPs who have more experience with OCD are more likely to respond. Gallant et al. (2007) acknowledged this and claimed there may be lots of views from those less experienced that have not been taken into consideration. Gallant et al. (2007) also discussed that their questionnaire did not ask if the SPs were directly responsible for managing these cases, so it is unclear if the feedback was related to their own decision points or part of a collaborative process. This may not fully capture how SPs are directly working. There was also a primary focus in the questions on interventions such as CBT and exposure work, which although evidence-based (NICE, 2005), limits the scope to explore the variety of ways the SP may have supported the CYP and the schools.

Both Adams et al. (2007) and Gallant et al. (2007) used descriptive statistics to analyse the data from the questionnaires, focusing on the percentage of respondents who

picked particular categories. Gallant et al. (2007) also used a chi-squared analysis to see if there was a difference between respondents of SPs with and without a Doctorate, in which they did not find any significant difference. Although both studies asked participants to give longer, descriptive answers to questions (Adams et al., 2007; Gallant et al., 2007), there was no qualitative analysis involved. Adams et al. (2007) chose to include some quotes, however there was not an in-depth look at any themes that may have occurred within the responses. Gallant et al. (2007) used a Likert scale to look at the longer responses within their questionnaire, for example scaling how successful a treatment had been. Again, this did not look in depth at how SPs have worked and their views on what they thought went well and what did not go so well when working with OCD.

7.2.4 Summary

Overall, these four papers have suggested that SPs have a role supporting CYP with OCD in schools and suggest that SPs should be involved in the identification, assessment and treatment of these CYP in schools (Adams et al., 1994; Adams et al., 2007; Gallant et al., 2007; Sloman et al., 2007). Two out of the four papers sought to get the views of SPs about how they work with CYP with OCD (Adams et al., 2007; Gallant et al., 2007). However, this was done in the form of questionnaires that involved close ended questions and Likert Scales, rather than seeking the wider opinions and detailed experiences of the SPs OCD (Adams et al., 2007; Gallant et al., 2007). The two position papers (Adams et al., 1994; Sloman et al., 2007) offered guidance for SPs and a potential framework to follow when exploring OCD cases in schools, however this assumed that SPs could work in an in-depth and continuing way.

The previous literature into the EP role is outdated and conducted in an American educational context. Therefore, this highlights a need for research to be conducted in the UK to explore the current role of the EP with CYP with OCD.

8.0 Rationale for the current study

There is currently significant pressure to provide earlier support for CYP with MH needs (Crenna-Jennings & Hutchinson, 2020; DfE & DoH, 2017; NHS, 2018) and due to pressure on waiting lists and the application of strict inclusion criteria in CAMHS (Crenna-Jennings & Hutchinson, 2020) there is an identified need to provide more support within schools (DfE & DoH, 2017). In light of the increased prevalence of MH need (NHS, 2018) there has been an increasing focus on EPs being more involved in MH support (Elms, 2020; Greig et al., 2019; Price, 2017; Zafeiriou & Gulliford, 2020).

Previous studies have shown that anywhere from 40-80% of OCD cases have a childhood onset (Chaturvedi et al., 2014) and paediatric OCD is said to be most prevalent at secondary school age (Heyman et al., 2003). CYP with OCD can experience significant impairment in the areas of social, emotional and academic functioning (Pérez-Vigil et al., 2018), and with the long waiting times to access CAMHS support on the NICE pathway (Crenna-Jennings & Hutchinson, 2020; NICE, 2005) it is important that these CYP with OCD are seen as a priority group within the suggested MH support within schools.

EPs are well placed to support CYP with OCD, as they work across different systems such as the family, school and community (AEP, 2016). Previous research into how EPs can help support CYP with OCD has been conducted with SPs in America and is outdated (Adams et al., 2007; Gallant et al., 2007). There is currently no research available that investigates how EPs can specifically support CYP with OCD within schools in the UK. Furthermore, previous position papers that have set out advice for how to support CYP with OCD in a school setting did not gather the views of school staff or evaluate whether the guidance was helpful (Adams, 2004; Chaturvedi et al., 2014; Gaskins et al., 2020; Leininger et al., 2010; Sulkowski et al., 2018; Woolcock & Campbell, 2005). Despite guidance existing for school staff, it is unclear what sort of support they would like to receive to help these CYP in the school setting.

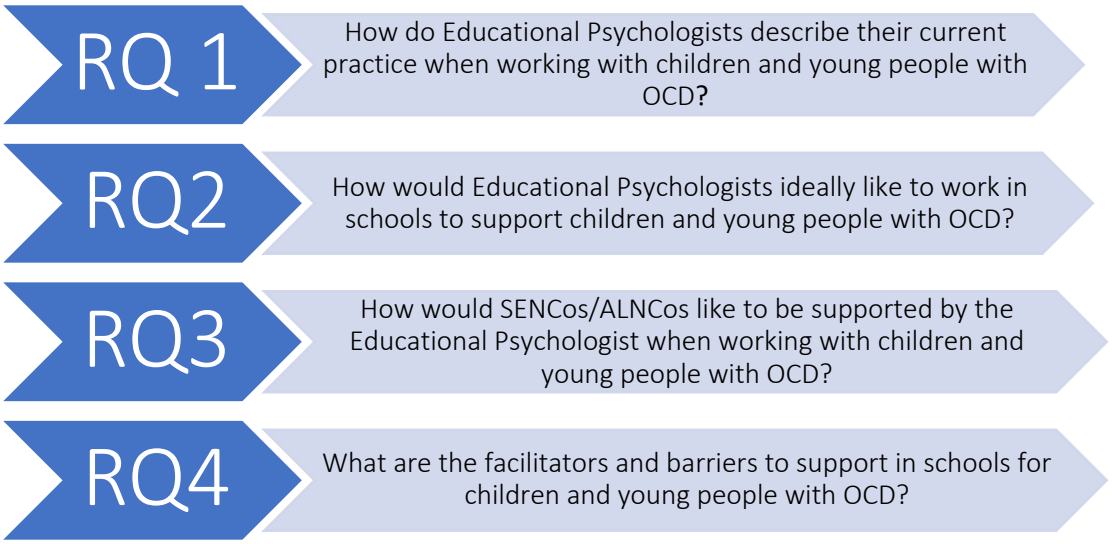
Therefore, the current study aims to investigate how practicing EPs in the UK view their role in supporting CYP with OCD. Furthermore, the study also aims to explore

how school staff would like to be supported by EPs with CYP with OCD as this has not been explored in previous literature relating to the school setting. The main contact for an EP in a school is usually the SENCo in England or the Additional Learning Needs Coordinator (ALNCo) in Wales (AEP, 2016). As paediatric OCD is most prevalent at secondary school age (Heyman et al., 2003), the current study will look to gather the views of practicing EPs and secondary school SENCos/ALNCos within England and Wales.

In response to identified gaps in previous research discussed in this literature review, the following four research questions will be explored.

Figure 4

Research questions for the current study



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Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

Part B: Major empirical study

Word count: 7789

1.0 Abstract

There is a growing emphasis on schools to support the mental health (MH) of children and young people (CYP). Obsessive-Compulsive Disorder (OCD) often has an onset age in adolescence and CYP with OCD can struggle with a range of difficulties at school such as academic expectations, social pressures, transitions and accessing equipment and rooms. This study explored the role of the Educational Psychologist (EP) working with schools to support CYP with OCD and how secondary school SENCos/ALNCos would like to be supported by EPs when working with these CYP. Six EPs and six SENCos/ALNCos took part in virtual semi-structured interviews and the data was analysed using thematic analysis (TA). The main themes that emerged from both groups included "importance of joined up working" "school environment" and "developing an understanding of OCD". The main themes of "gap in available support" and "EP skills" also emerged from the EP analysis and the main themes of "access to external services" and "understanding the EP role" also emerged from the SENCo/ALNCo analysis. Both the EPs and the SENCos/ALNCos saw a role for the EP in supporting schools with CYP with OCD through developing the understanding of others, working in a holistic, evidence-based way, and facilitating collaborative approaches with the school, family and health services. The findings are discussed in terms of implications for EP practice.

2.0 Introduction

2.1 Terminology

2.1.1 Obsessive-Compulsive Disorder (OCD*)*

The term "OCD*" has been adopted in the results and discussion sections in reference to:

- CYP who have received a diagnostic label of OCD.
- CYP who have been referred for further exploration of OCD traits on the respective pathways in their local authority (LA).

2.2 Mental Health in schools

There is a growing emphasis on schools to support the MH of CYP (DfE & DoH, 2017). A report in 2017 claimed that 1 in 8 children have a diagnosable MH disorder (NHS, 2018) which is roughly 3 children per average classroom size. The National Audit Office (NHS, 2018) reported that less than 1 in 3 CYP with a diagnosable MH condition get access to NHS care and treatment. With the number of CYP with recognised MH difficulties rising (Crenna-Jennings & Hutchinson, 2020) there is a suggestion that not enough is currently being done to support CYP, resulting in an increasing reliance on schools to identify problems and implement early intervention (DfE & DoH, 2017; Price, 2017).

2.3 Obsessive-Compulsive Disorder (OCD)

OCD is characterised by the presence of unwanted, intrusive obsessions (unpleasant thoughts, images or urges) and compulsions (repetitive behaviours which may be covert, e.g. mental counting) (Williams & Shafran, 2015). Obsessions lead to anxiety and then a person carries out compulsions, which leads to temporary relief from the anxiety (Williams & Shafran, 2015). However this relief may only last a few minutes before the next intrusive thought occurs and the cycle starts all over again (Williams & Shafran, 2015). It has been reported that around 1% of the UK population has OCD

(OCD-UK, 2020) and previous studies have shown that anywhere from 40-80% of OCD cases have a childhood onset (Chaturvedi et al., 2014). These figures indicate that OCD is an area of MH in CYP that potentially needs further supporting.

The National Institute for Health and Care Excellence (NICE, 2005) guidance recommends a stepped-care treatment approach for CYP with OCD. This begins with self-help materials and guidance provided by primary care professionals, progressing if necessary, to Cognitive Behaviour Therapy (CBT) or Exposure and Response Prevention (ERP) and then to medication such as selective serotonin re-uptake inhibitors (SSRIs) (NICE, 2005). However, CYP may not always be accessing the pathway suggested in the NICE guidelines and a report by the Education Policy Institute (EPI) (Crenna-Jennings & Hutchinson, 2020) found that a quarter of CYP referred to specialist MH services such as the child and adolescent mental health services (CAMHS) were not accepted into treatment.

2.4 OCD in schools

Students with OCD may experience significant impairment in the areas of social, emotional and academic functioning (Chaturvedi et al., 2014; Pérez-Vigil et al., 2018). The school environment can be mentally and physically exhausting for CYP with OCD and they may be more likely to be socially excluded by their peers (Helbing & Ficca, 2009). This along with the involuntary and uncertain nature of the condition can leave students depressed and socially withdrawn (Chaturvedi et al., 2014). OCD typically goes undetected for many years before an accurate diagnosis is made (Krebs & Heyman, 2015). However, early identification and intervention is reported to increase the likelihood of positive social, emotional and academic outcomes for CYP with OCD (Cameron, 2007). So, it is important that these students receive the appropriate support whilst they are at school age in order to improve their future quality of life.

Research and advice to school staff has specified that to ensure that students with OCD succeed, it is imperative that teachers engage in continuous, constructive and positive collaborative processes with the multidisciplinary team involved in the education of these students (Chaturvedi et al., 2014; Gaskins et al., 2020; Sloman et al.,

2007; Woolcock & Campbell, 2005). This team may include the parent, the teacher, the EP and any external health professionals involved (Chaturvedi et al., 2014; Sulkoski et al., 2018).

2.5 EP role in supporting Children and Young People with OCD

Previous literature that refers to the role of the EP supporting CYP with OCD has been based in America and therefore the term School Psychologist (SP) was used (Adams et al., 1994; Adams et al., 2007; Gallant et al., 2007; Sloman et al., 2007).

It has been argued that SPs are uniquely positioned to help identify children with OCD and provide appropriate support as they have both knowledge of MH and the school environment (Gallant et al., 2007). Previous literature has highlighted that SPs have a role in the identification, assessment and treatment of OCD and some position papers have suggested that SPs should have ongoing involvement throughout the whole process (Adams et al., 1994; Sloman et al., 2007). It has also been suggested that the role of the SP is to share specialised knowledge and help reduce the stigma of OCD within a school so teachers will be better equipped to address the needs of these students (Chaturvedi et al., 2014).

However, whilst many papers recommend SP involvement, when Gallant et al. (2007) asked SPs how they managed OCD cases within schools, 86.8% of them felt that they needed further training in the area. Furthermore, research in the UK reported that EPs found time, resources and competency as barriers to supporting schools with MH intervention (Atkinson et al., 2014; Elms, 2020; Greig et al., 2019; Price, 2017).

2.6 Academic and Professional Rationale

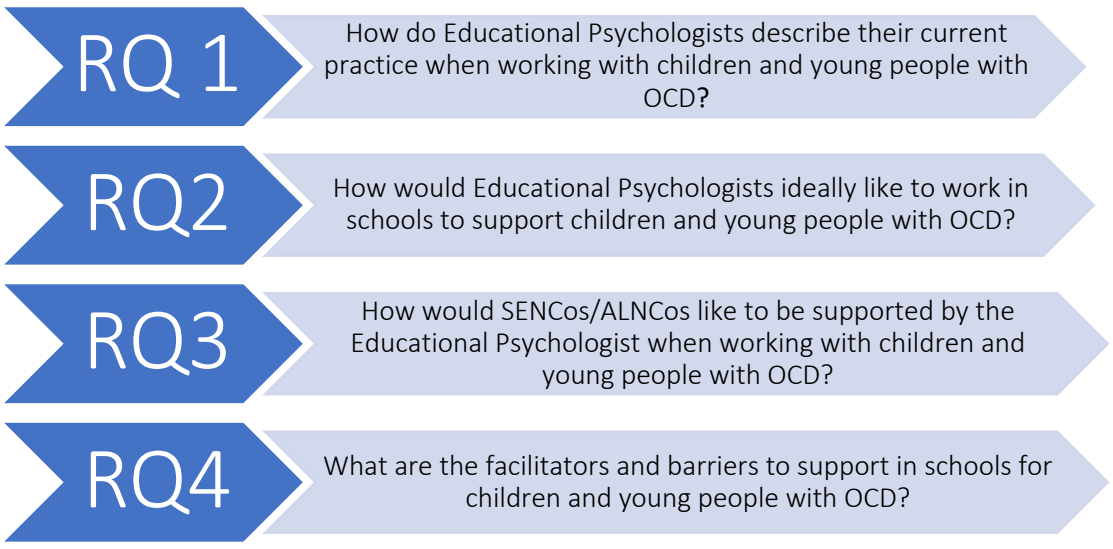
CYP with OCD are said to experience significant impairment in the areas of social, emotional and academic functioning (Pérez-Vigil et al., 2018), and with the long waiting times to access the NICE pathway (Crenna-Jennings & Hutchinson, 2020; NICE, 2005) it is important that these CYP are recognised as a key group within the suggested MH support in schools.

Previous research into how EPs can help support CYP with OCD has been conducted with SPs in America and is outdated (Adams et al., 2007; Gallant et al., 2007). Although there is research into how EPs support MH in schools in the UK (Greig et al., 2019; Price, 2017; Zafeiriou & Gulliford, 2020) there is limited research available that investigates how EPs can specifically support CYP with OCD within schools. There is also limited research on the views of school staff who receive support from professionals when working with CYP with OCD.

Therefore, the current study aims to investigate how practicing EPs in the UK view their role in supporting CYP with OCD. Furthermore, the study also explores how school staff would like to be supported by EPs with CYP with OCD as this has not been explored in previous literature relating to the school setting. The main contact for an EP in a school is usually the Special Educational Needs Coordinator (SENCo) in England or the Additional Learning Needs Coordinator (ALNCo) in Wales (AEP, 2016). As paediatric OCD is most prevalent at secondary school age (Heyman et al., 2003), the current study will look to gather the views of practicing EPs and secondary school SENCos/ALNCos within England and Wales to answer the research questions below.

Figure 5

Research questions for current study



3.0 Methods and Measurements

3.1 Ontological and Epistemological positions

The study has taken a critical realist ontological position. The critical realist position invokes that a real and authentic reality "sits behind the subjective and socially-located knowledge a researcher can access" (Braun & Clarke, 2013, p. 27). As knowledge is considered to be socially influenced, it is thought to be only partially accessible (Braun & Clarke, 2013). The study acknowledges that there is a reality to how schools and EPs support CYP with OCD, yet this is influenced by their experiences, knowledge and perceptions around working with these CYP.

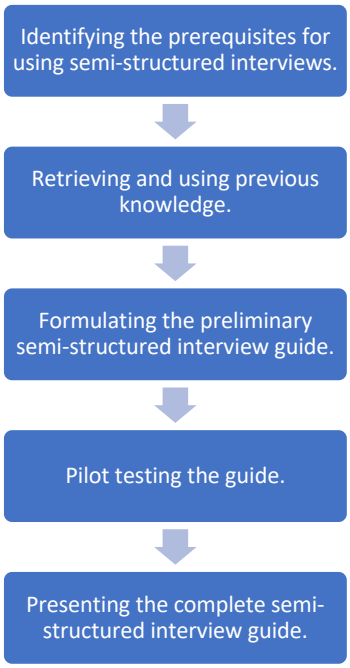
The study also adopted a contextualist epistemological lens. Contextualist epistemologies argue that "meaning is related to the context in which it is produced" (Braun & Clarke, 2013, p. 328). It suggests there is an underlying truth, yet the participants will have their own perceptions of this (Braun & Clarke, 2013). The participants will have developed their understanding of OCD from the different contexts in which they have worked in and supported these CYP. There is a recognition that the data collected reflects each individual's experience in these contexts.

3.2 Design

Qualitative designs are considered an appropriate method when a study is interested in exploring the views of participants (Robson & McCartan, 2016). Therefore, following the ontological and epistemological stance taken and the explorative nature of the research questions, the research used a qualitative design. Semi-structured interviews were conducted over video calls to gather the views and experiences of the participants. The creation of the interview schedule was based on the framework by Kallio et al. (2016; see Figure 6). The full interview schedule can be found in Appendix 3. A full explanation on the decision to conduct the interviews virtually can be found in part C.

Figure 6

Framework for developing a semi-structured interview



Note based on Kallio et al. (2016).

3.3 Recruitment and Inclusion Criteria

Table 9

Participant recruitment and inclusion criteria

EPs	SENCos/ALNCos
A gatekeeper letter was sent to Principal EPs (PEPs) in English and Welsh LAs (see Appendix 4). The PEPs gave permission for the researcher to email the EPs within the service with an information sheet (see Appendix 6). Those who wished to take part in the research contacted the researcher.	A gatekeeper letter was sent to Headteachers of secondary schools in English and Welsh LAs (see Appendix 5). The Headteachers gave permission for the researcher to email the SENCo/ALNCo an information sheet (see Appendix 6). Those who wished to take part contacted the researcher.

Inclusion criterion was that they must be currently practicing and had experience with at least one case where the CYP had either a diagnosis of OCD or had been referred for further exploration of OCD traits on the respective pathways in their LA.	Inclusion criterion was that they had to have been a SENCo/ALNCo for at least a year and had to work in a secondary school or a specialist provision that taught CYP who were secondary school age. They also needed experience in a school setting with at least one CYP who had either a diagnosis of OCD or had been referred for further exploration of OCD traits on the respective pathways in their LA.

Further explanation around recruitment decisions can be found in part C.

3.4 Participants

Table 10

Participant information

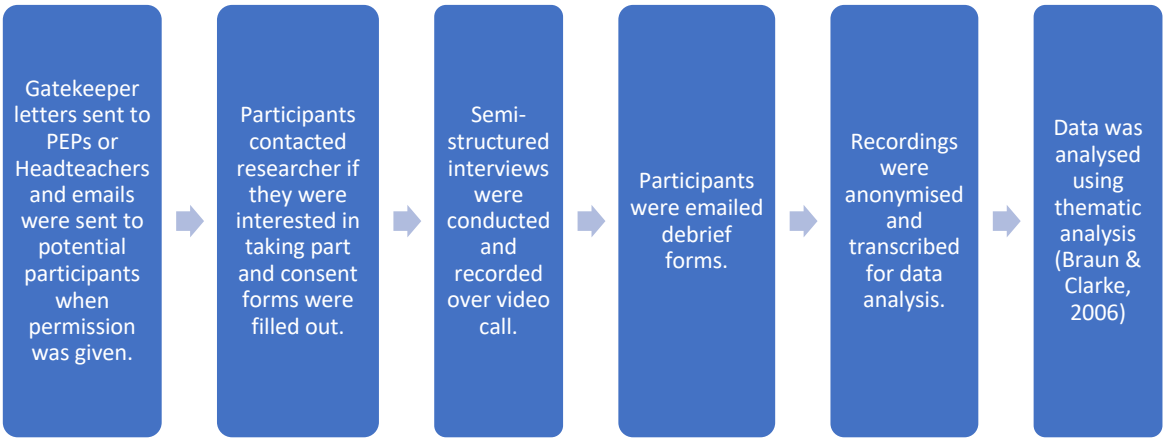
Job title	Number of participants	Roles	Location and workplace
EPs	Six EPs were recruited, which is the recommended number of interviews for analysis in a small project (Braun & Clarke, 2013).	Two senior EPs, three EPs and one newly qualified EP took part. All of them were currently practicing.	The EPs were from three LAs, two were traded services in England and one was a non-traded service in Wales.
SENCos/ALNCos	Six SENCos/ALNCos were recruited, which is the recommended number of	Four SENCos and two ALNCos took part. They had all been qualified for at least a year.	The SENCos/ALNCos were from three LAs, two were in England and one was in Wales. Three SENCos/ALNCos

	interviews for analysis in a small Project (Braun & Clarke, 2013).		worked in mainstream secondary schools and three SENCos/ALNCos had experience in both mainstream and specialist secondary provisions.

3.5 Procedure

Figure 7

Procedure for the current study



3.6 Pilot Interview

A pilot interview was conducted with a Trainee EP (TEP) to explore whether the interview questions felt appropriate and how they came across using video calling technology (Kallio et al., 2016). The participant fed back that the interview flowed well, that they understood the questions and that the interview helped them reflect on their own experiences working with a CYP with OCD. The participant was happy using the video call technology and did not feel that it affected the interview in a negative way. No amendments were made to the interview questions as both the participant and researcher felt that the quality and depth of the information obtained was good and

that the answers were relevant to the research questions (Kallio et al., 2016). As the participant agreed to take part in a pilot interview only, this interview was not included in the overall analysis.

3.7 Ethical considerations

Table 11

Ethical considerations taken in the current study

Ethical Consideration	Procedure
Confidentiality	Participants were told that the audio recording from their interview would be stored securely in password protected files. Video recording from the interview was deleted immediately. Audio recordings were then deleted immediately after they were transcribed.
Anonymity	Participants were encouraged before the interview to not name anything identifiable such as names of schools or local authorities. They were also reassured that any identifiable data would be made anonymous when transcribed.
Consent	Gatekeeper letters (see Appendices 4 & 5) were emailed to PEPs and Headteachers asking them for permission to contact the participants. Then the information sheet was sent to EPs or SENCos/ALNCos (see Appendix 6). The information sheet included the necessary information so participants could make an informed choice to partake in the research. Participants were also given the option to email the researcher to ask any questions. A consent form (see Appendix 7) was emailed to participants which they signed electronically to show that they understood their rights and were happy to participate.
Right to refuse to answer any question	Participants were informed that they were not expected to answer all the questions in the interview.

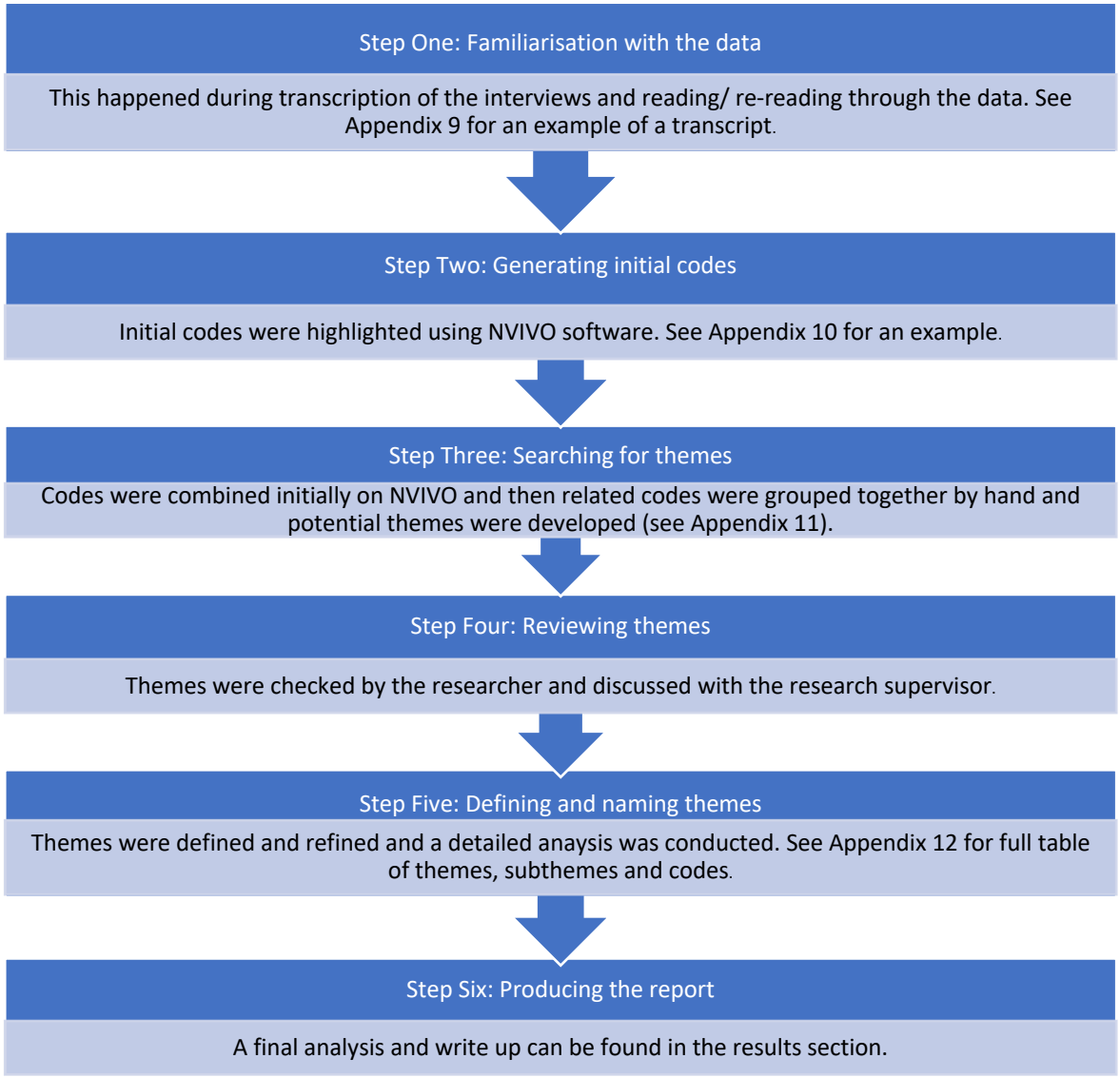
Right to withdraw	Participants were told that they had a right to withdraw their data at any point until the data was transcribed and anonymised (see Appendix 7).
Do no harm	Participants were reassured that if they felt distressed at any point in the interview it would be stopped immediately. The debrief sheet also provided participants with the researcher's details so they could be signposted to places they could receive support if they wished to do so (see Appendix 8).
Debrief	The debrief form was emailed to participants after the interview (see Appendix 8). This fully informed participants about the study and ensured that participants fully understood their right to withdraw and that their data would be transcribed anonymously. The researcher, supervisor and ethics board contact information was provided in case participants wished to contact them or ask any questions.

3.8 Data analysis

Two separate thematic analyses (TA) were conducted, one for the EP interviews and one for the SENCo/ALNCo interviews. Both TAs were done using the Braun and Clarke (2006) Six Steps (see Figure 8). Inductive coding was used to generate themes, which is described as a bottom up, data driven approach (Braun & Clarke, 2013; 2020).

Figure 8

Six Step process of Thematic Analysis



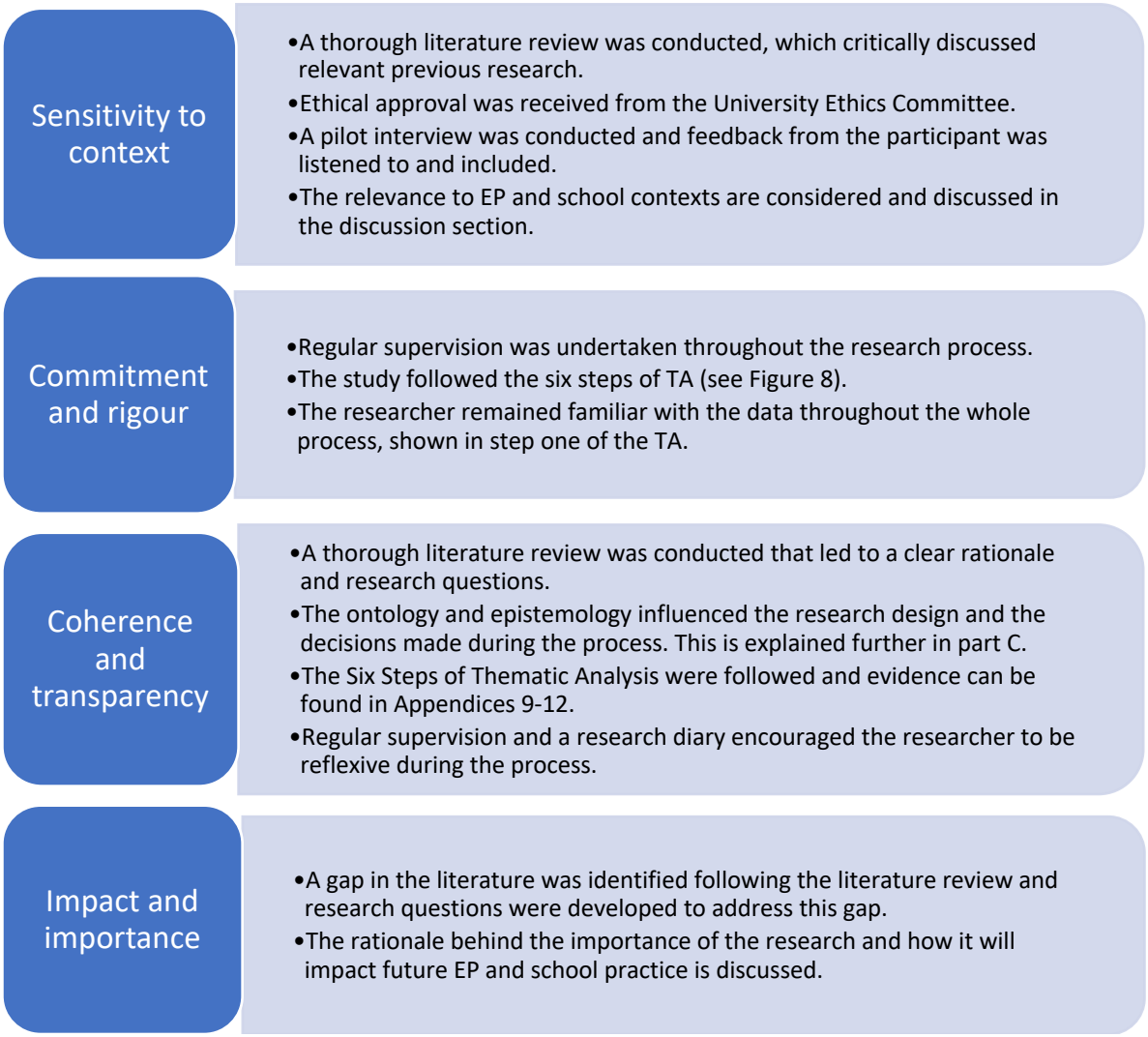
Note It is acknowledged that whilst the steps outlined suggest linearity, data analysis is a recursive process with movement back and forth between these phases (Braun & Clarke, 2013).

3.9 Trustworthiness

Yardley's (2008) framework was used to assess the trustworthiness of the research. This follows four core principles that are applicable to any qualitative research (Yardley, 2008). The core principles and the way in which the research has aimed to meet them are outlined in Figure 9 below.

Figure 9

Trustworthiness of the study



Note Trustworthiness of qualitative data based on Yardley's (2008) four core principles.

4.0 Results

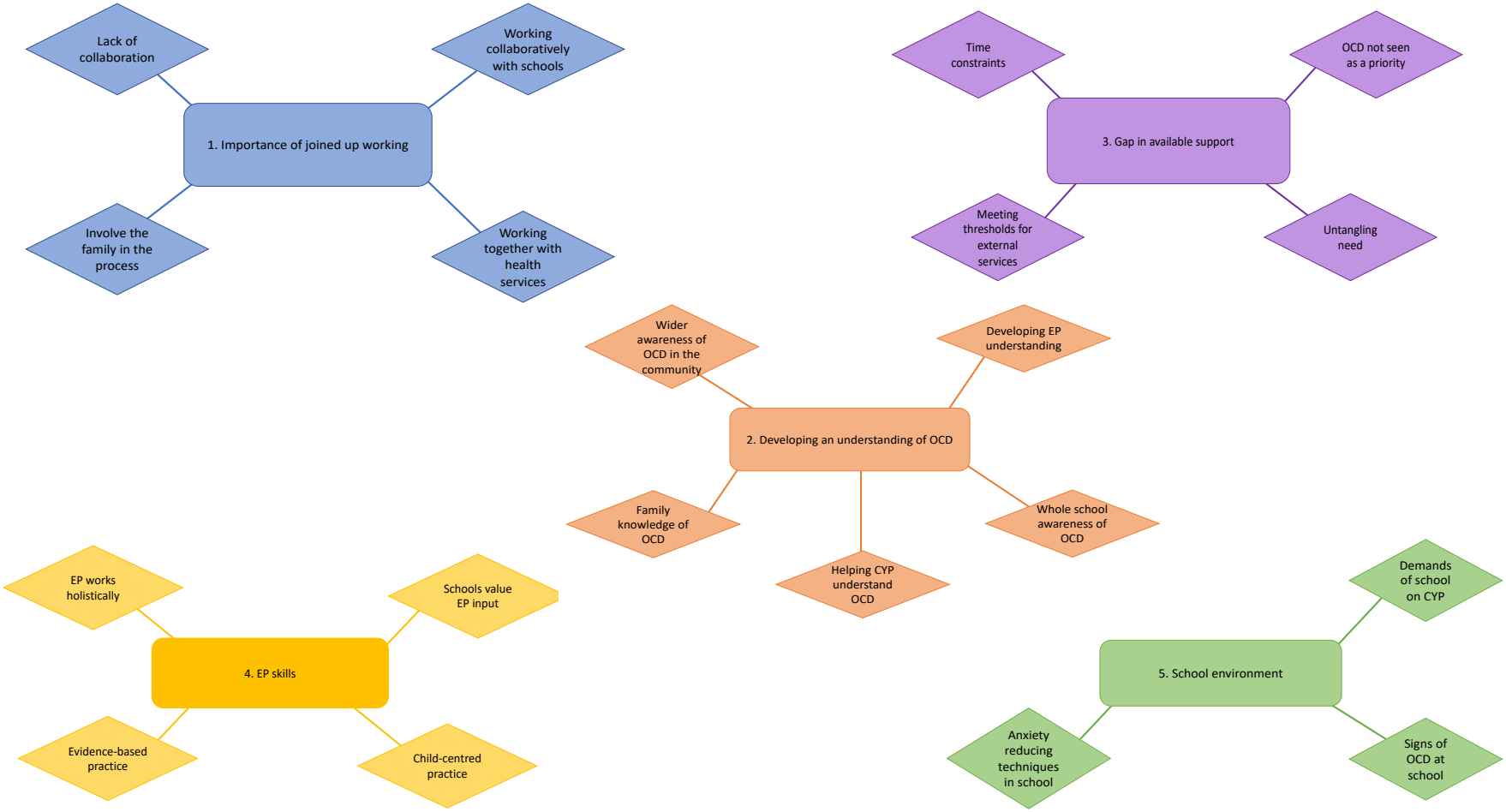
This section will discuss the main themes and subthemes that came out of both TAs, starting with the EP interviews and followed by the SENCo/ALNCo interviews.

4.1 EP Interviews

The six EPs discussed a variety of areas that contribute to their work supporting CYP with OCD*. Five main themes “Importance of joined up working”, “Developing an understanding of OCD”, “Gap in available support”, “EP skills”, and “School environment” were identified along with their own subthemes.

Figure 10

Thematic map for the EP analysis, highlighting five main themes and corresponding subthemes



4.1.1 Theme 1: Importance of joined up working

Figure 11

Main theme 1 Importance of joined up working and corresponding subthemes

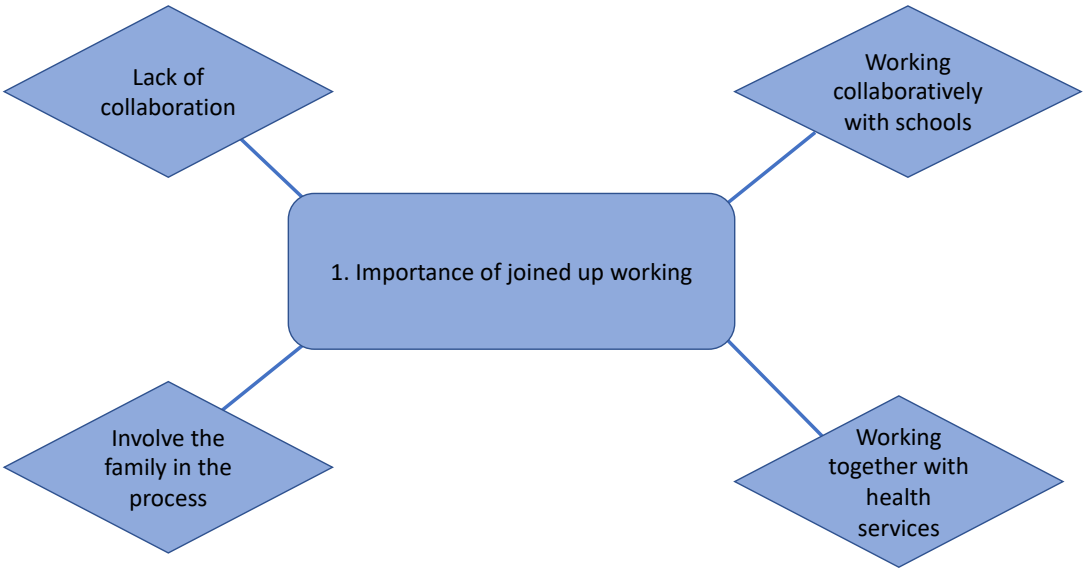


Table 12

Corresponding subthemes and participant quotes for main theme 1 Importance of joined up working

Theme 1: Importance of joined up working	
This theme highlighted the importance of EPs working with school staff, parents/carers and other professionals to enable joint decision making and the best outcomes for CYP with OCD*. Collaborative working was often described as a facilitator to successful support for these CYP. However, when collaboration and communication were not effective, this could be a barrier to working with these CYP.	
Subtheme	Participant Quotes
<u>Working collaboratively with schools</u> The EPs spoke about how important they felt collaborating with the school was to support CYP with OCD*. They felt that they had a role in building relationships between the CYP and school staff and working with school staff to develop interventions for the CYP. They also spoke about how being a facilitator for successful work is coming up with joint decisions with school staff and empowering them to take ownership of the outcomes. Consultation was considered an important approach to achieve this collaboration.	"I think that's where we have that unique role is that we support school and empower schools" **EP1** (line 498- 499) "it's really collaborative so actually we're thinking about the outcomes together we are thinking about the actions together" **EP 2** (line 201-202)

<u>Working together with health services</u> EPs discussed how they appreciated opportunities to collaborate with health services such as CAMHS, paediatricians and GPs. They spoke about how they appreciated the expertise when health professionals were involved and that agreeing ways forward with their help was a good way to work. It was also considered important to not duplicate work that other services were providing so dialogue between services was key for this.	"I worked really closely with the CAMHS worker with a specialist clinical nurse who um you know really understood the issue as much as I did so that was really really positive and we were able to both come with this similar converging message" **EP 1** (line 173- 175) "it's definitely not about duplicating it's definitely about you know being clear with other services" **EP 6** (line 82- 83)
<u>Involve the family in the process</u> The EPs mentioned that collaborating with parents was important as there can often be a difference in the presentation of OCD between home and school. They discussed that parents are often the experts and that their information was key to understanding the CYP's needs. They also spoke about how EPs can offer support for parents and advocate for them when other professionals are involved.	"I think perhaps the successful part of that was the mother feeling listened to and heard and being able to have a clear idea of going back to seek support" **EP 4** (line 225- 226) "I think what went well from an EP perspective um is working closely with parents because actually you know they've known the child for their whole life and so they are experts by experience" **EP 2** (line 83- 85)

<u>Lack of collaboration</u> The EPs discussed that a lack of collaboration and communication between different services was a barrier to providing support. Many of the EPs found that they could not get hold of other professionals and that they felt they were missing key information when this collaboration could not happen.	"he's had support from CAMHS but I wasn't able to link up with them" **EP 5** (line 105-106) "if we're not getting school other professionals and the family and child or young person to come together in a unified way then that's when things can go quite badly wrong quite quickly" **EP 1** (line 394-396)

4.1.2 Theme 2: Developing an understanding of OCD

Figure 12

Main theme 2 Developing an understanding of OCD and corresponding subthemes

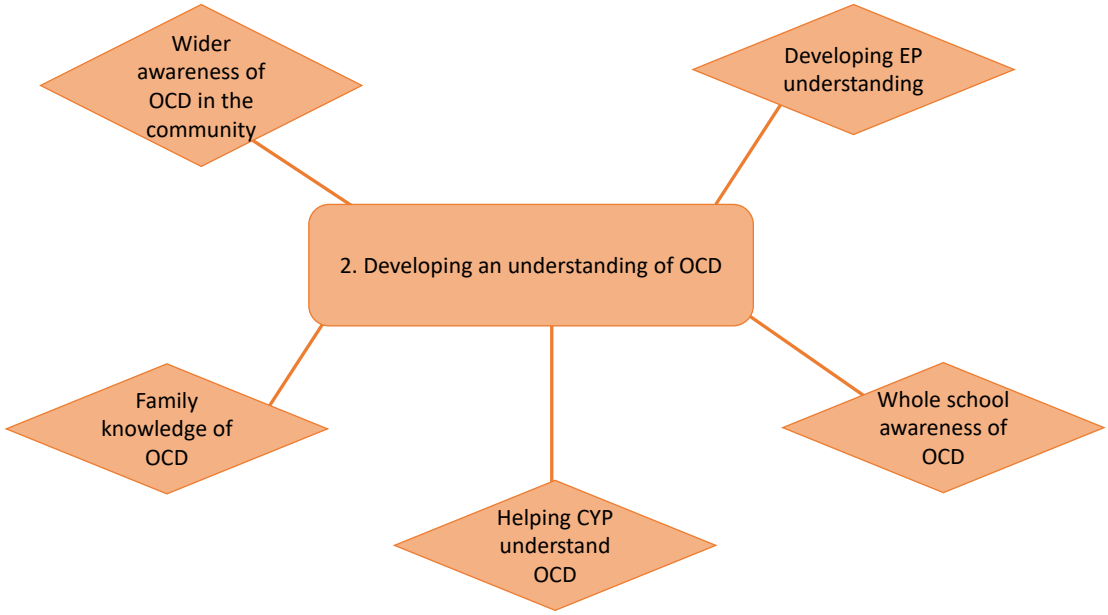


Table 13

Corresponding subthemes and participant quotes for main theme 2 Developing an understanding of OCD

Theme 2: Developing an understanding of OCD	
This theme highlighted the importance of everyone around the CYP, and the CYP themselves, developing an understanding of OCD. Having a good understanding and a positive attitude towards the CYP's needs was described as a facilitator to supporting the CYP and a lack of understanding and a judgemental attitude was seen as a barrier. EPs were seen as having an active role in developing the understanding of others, whilst being mindful of their own competence and understanding.	
Subtheme	Participant Quotes
<u>Developing EP understanding</u> The EPs differed in how much experience, knowledge and confidence they felt they had when working with CYP with OCD*. Some EPs spoke about this being a specialist interest of theirs and that they had developed their own understanding over the years with further reading. The other EPs said that they felt less confident and that they had not come across many OCD* cases before. The EPs mentioned that further training would be appreciated and that actually EPs are more qualified than they think they are at supporting OCD* cases. One EP	"I would definitely appreciate more specific guidance for the role of the EP" **EP 5** (line 275) "when things are outside our competence we either do extra research or speak to colleagues or we signpost and suggest other areas that might be helpful" **EP 2** (line 93- 94)

spoke about the importance of competent practice and the EPs all discussed that they sought to build their own knowledge from asking colleagues, asking health professionals, reading resources within the LA and searching MH charity websites.	
<u>Whole school awareness of OCD</u> EPs spoke about how it was important to develop the understanding school staff had about OCD. Some of the EPs mentioned that they had provided schools with training and that it was important that all staff attended the training. The EPs also mentioned that they felt EPs were well placed to deliver training for schools and that this could even be done alongside health professionals. They also spoke about how school staff can often misinterpret OCD behaviours as challenging and that the attitudes that staff have can become a barrier. They discussed that schools often lack confidence to work with MH needs and that they are more skilled than they believe, and that the EP can help them realise this.	"we did a whole school training on some of the issues that we were having so that was giving that full message to everyone so that everybody had that clear understanding that actually where these behaviours were coming from" **EP 1** (line 138-140) "staff's lack of confidence when actually they've got loads of brilliant skills to be able to support young people reduce anxieties and to work with other professionals that I think would really help" **EP 2** (line 238-240)

<u>Helping CYP understand OCD</u> The EPs discussed how they felt they have a role in developing the CYP's understanding of OCD and anxiety. Psychoeducation about the parts of the brain or strategies from CBT were both discussed as helpful approaches.	"the things that went well was the psychoeducation bit of it and supporting children and kind of having a narrative" **EP 3** (line 105-106) "I think helping young people if we can sort of understand that people do have some strange thoughts and um but that thoughts come and go" **EP 4** (line 290-291)
<u>Family knowledge of OCD</u> It was discussed that when parents lacked understanding about OCD, this could become a barrier to practice and that it is important to also develop the parents' understanding about the CYP's needs. The EPs also spoke about when parents had a good understanding and were using supportive strategies at home it was then important to use these in school.	"I mean thinking about things strategies that were in place at home and ways of bringing those sort of strategies into school in a safe way" **EP 6** (line 56-57) "maybe one of the barriers was that when I spoke to her mother... her mother had a huge amount of anxiety as well so it felt in a sense slightly limited because it was focused on the girl and the school whereas I think it was a slightly wider issue" **EP 4** (line 73-75)

<u>Wider awareness of OCD in the community</u> One EP spoke about how a lack of understanding within the wider community can become a barrier to supporting the CYP and their family. Ideally, there would also be opportunities to educate the wider community about OCD so there was more of an understanding.	"I think as well that barrier as well would be not being able to share that child's diagnosis with the wider community so that it becomes more accepting so again that's about educating the wider community" **EP 1** (line 414-416)

4.1.3 Theme 3: Gap in available support

Figure 13

Main theme 3 Gap in available support and corresponding subthemes

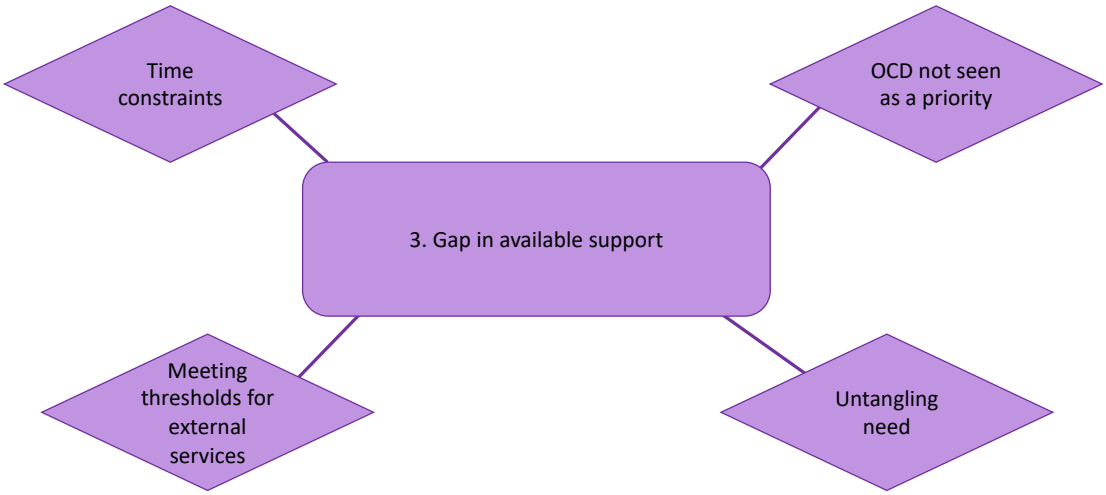


Table 14

Corresponding subthemes and participant quotes for main theme 3 Gap in available support

Theme 3: Gap in available support	
This theme highlighted that the EPs perceived that there was a gap in available support for CYP with OCD*. It was discussed that OCD was not always seen as a priority in schools, so they were unlikely to request whole school involvement. Another barrier was the difficulty of untangling the CYP's needs as OCD can present comorbidly with other disorders. The time constraints EPs work under was also seen as a barrier to the input an EP could offer with these CYP in school. It was also discussed that meeting thresholds for external services is a barrier as these CYP sometimes do not meet the criteria for referral to somewhere more specialist until the behaviour has escalated.	
Subtheme	Participant Quotes
<u>OCD not seen as a priority</u> The EPs spoke about how OCD is not always seen as a whole school priority and that their work tends to be on a case-by-case basis rather than allowing an opportunity for whole school training. They also discussed that the OCD behaviours may not actually be known in school as CYP can often hide their compulsions. Some of the EPs were involved in cases	"I think if you were to ask SENCos if you have to if you had to prioritise training I don't think they would say OCD that OCD is a significant need" **EP 3** (line 203-205)

where behaviours were prominent at home, but school were unaware.	"SENCos don't know about the children they don't know about because it can be quite hidden 'cause sometimes children can be quite skilled in hiding their routines and their compulsions" **EP 3** (line 232-234)
<u>Untangling need</u> The EPs discussed that it can be difficult to untangle the complex needs of some of these CYP. They mentioned that a lot of the CYP they have been involved with have comorbid diagnoses such as Tourette's or Autism. The EPs discussed how they felt the EP had a role in untangling some of these needs and helping school and home find a way forward. It was also mentioned that OCD behaviours may be misinterpreted as something else such as ADHD, especially when the compulsions are mental rather than physical.	"sometimes it can be hidden or not really well understood or kind of masked under behaviour or generalized anxiety or ADHD or sometimes autism... kind of being able to kind of um recognise what is and what's not" **EP 3** (line 166-168) "I think sometimes you know it can all feel very big and confusing and you know perhaps it's through having this sort of helpful conversation through consultation and that you know you can start to get a clearer sense about when things are happening" **EP 6** (line 32-34)
<u>Meeting thresholds for external services</u> The EPs discussed that often it can be difficult to refer a CYP on to more specialist services such as CAMHS as the referral	"I think the threshold for CAMHS is so high sometimes these cases end up with us because CAMHS aren't always able because of their own capacity issues to pick them up" **EP 3** (line 360-362)

threshold is too high. They spoke about how these CYP can fall into a gap as their behaviours may be too challenging for general support at school, yet not seen as challenging enough for external health services to become involved. The EPs mentioned that in some LAs, there is a difficulty finding the right service for these CYP.	"this massive gap in the middle where children just fall into this chasm and don't reach the criteria of CAMHS but are too challenging or too um that then that level of need is too high for other things" **EP 1** (line 253-255)
<u>Time constraints</u> The EPs discussed that often they do not get to do the intensive, on-going work that they would like with these CYP due to time constraints. This was spoken about in both a traded and nontraded capacity. They discussed that often their work is in a statutory or a one-off consultation structure and that they are unable to review the cases. One EP spoke about how they are fortunate that their school bought in a lot of hours, which is how the EP has been able to be involved with a CYP for years.	"I've been in an unusual position where I've been able to build up those relationships over a long period of time and the schools trust buying some additional time and not uh not many EPs are in that position" **EP 1** (line 376-378) "I mean ideally we'd be in a in a in a system where we could give a little bit more time to these children and work a little bit more closely with them and kind of develop that knowledge" **EP 5** (line 202-203)

4.1.4 Theme 4: EP skills

Figure 14

Main theme 4 EP skills and corresponding subthemes

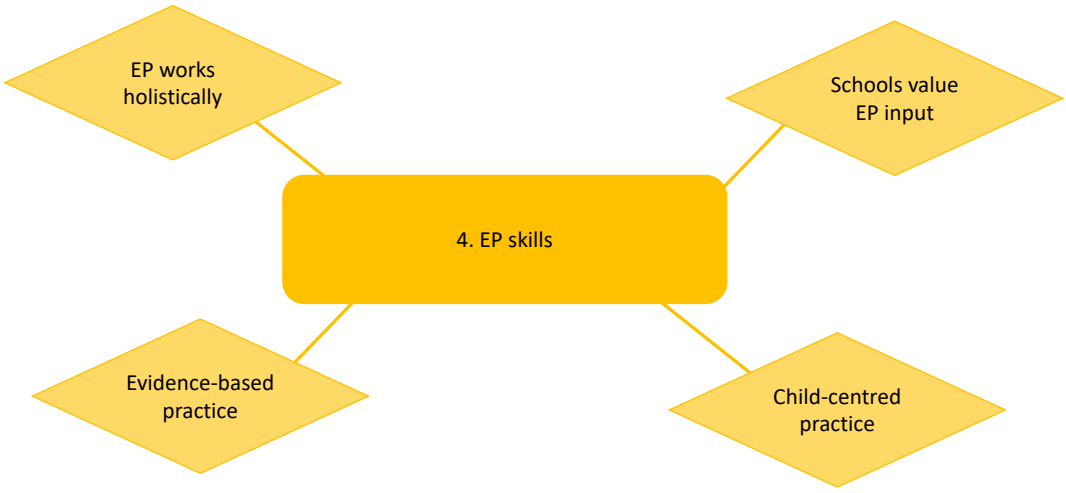


Table 15

Corresponding subthemes and participant quotes for main theme 4 EP skills

Theme 4: EP skills	
This theme focused on how EPs saw their role and their skills as unique in supporting these CYP. The EPs spoke about working holistically and looking at the wider needs of the CYP. The importance of using evidence-based practice underpinned by psychological theory and the NICE guidelines was also discussed. The EPs spoke about how schools have referred OCD* cases to EPs and that the EP input was often valued. The EPs also discussed how they saw their role as gathering the CYP's views and ensuring that the CYP had a voice in the process.	
Subthemes	Participant quotes
<u>Schools value EP input</u> EPs spoke about how schools often valued their input when they referred OCD* cases to EPs. One EP mentioned that having a long-standing relationship with schools potentially encourages them to refer to the EP for OCD* cases when they wouldn't usually. Another EP said that they would encourage schools to use EPs for these cases.	"I think that um for my experience has been they're really grateful for whatever support that we can give" **EP 1** (line 335-336) "I think I would encourage schools to talk to educational psychologists about their concerns for these children and young people definitely" **EP 6** (line 191-192)

Evidence-based practice The EPs spoke about how using an evidence base themselves and passing this on to schools was important to supporting these CYP. A few of the EPs spoke about using aspects from CBT and ERP in their own work or supporting school staff to use aspects from these approaches. The EPs discussed a range of different psychological approaches that underpinned their casework including consultation, cognitive theories, solution-focused approaches, Personal Construct Psychology (PCP) and neuropsychology.	"I know that we did a little bit of CBT approach if I think back to a couple of years ago and this seems to be a really proactive approach for this child or young person" **EP 1** (line 194-196) "I think we can help if we can get to a stage of helping a young person think of perhaps like in the first example of the specific situations that are difficult then we can help with some of that graduated exposure" **EP 4** (line 161-163)
EP works holistically The EPs discussed how they believed their role was to work in a holistic way using information gathering strategies such as consultations with key adults and classroom observations to get the bigger picture of the CYP's needs. One of the EPs spoke about how this is important when they write statutory advice for these CYP. The Interactive Factors Framework and Systems theories were discussed as helpful frameworks to	"I think the role of the EP is wanting to look at it holistically to bring together all these different we're not putting things in boxes we're bringing together everything kind of looking at the overarching picture for that young person" **EP 5** (line 124-127) "I think the framework that I'm most drawn to or that I use most often I guess is interactive factors framework and I particularly find it helpful

explore the wider needs of the CYP and bring information together.	when there are and potentially sort of um medical needs or um or we're not sure actually what the main need is and so actually it's helpful just to map those across the different areas" **EP 2** (line 278-282)
<u>Child-centred practice</u> The EPs discussed that gathering the CYP's views and giving them a voice in the process was key to supporting them. They discussed how they believed cases went well when the CYP was at the centre and that their views helped with the decision making and outcomes. The EPs spoke about how they have used PCP techniques such as the Ideal School or maps of the school to help gather the views of the CYP. They also discussed that it helps to have the CYP directly involved in the discussions and consultations.	"what did work really well for him was I sent him I sent mum he did it with mum instructions for the ideal school... and he was able to draw that and that gave us something to talk about" **EP 5** (lines 38-40) "I do think um it's about supporting young people because often they are the ones empowered to make a change" **EP 3** (line 307-308)

4.1.5 Theme 5: School environment

Figure 15

Main theme 5 school environment and corresponding subthemes

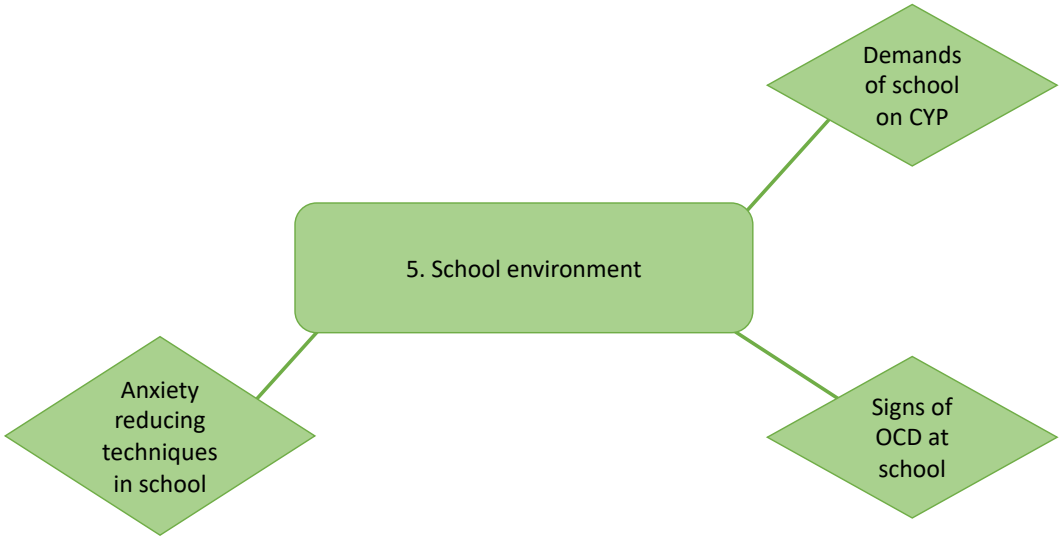


Table 16

Corresponding subthemes and participant quotes for main theme 5 School environment

Theme 5: School environment	
This theme focused on the impact of the school environment on CYP with OCD*. The EPs discussed how the demands of school can result in increased anxiety in these CYP. They also spoke about how OCD can present itself at school and anxiety reducing techniques that they have used or that school have used to support these CYP.	
Subthemes	Participant quotes
<u>Demands of school on CYP</u> The EPs discussed that the school environment can be very demanding for a CYP with OCD* as they must navigate the school, avoid certain lessons or equipment, and consider bathroom accessibility. The EPs also spoke about how this often results in the CYP missing school altogether. It was also discussed as difficult for these CYP to navigate their way around secondary schools if they have certain rituals around boundary crossing or routes. One EP also spoke about how this can be interpreted as challenging behaviours by staff who	"he just wasn't able to be comfortable in that environment so there was no way he could access learning or anything or even get himself into a classroom" **EP 5** (line 26-27) "you find it challenging coming into school and your behaviour's challenging and then you don't follow rules then you get excluded so then maybe then sometimes became risk of being excluded and then kinda in a habit of school refusal" **EP 3** (line 197-200)

do not understand it is the CYP's way of coping with the anxiety and the demand.	
<u>Signs of OCD at school</u> The EPs discussed many ways that they have seen OCD* present itself at school. A lot of what was discussed was around compulsions such as repetitive behaviours, counting, hygiene and routines around transition. They also spoke about mental compulsions and how this can be misinterpreted as daydreaming by staff. One EP also spoke about verbal tics and the comorbidity with Tourette's.	"I've worked with one young person that I think her routines were all internal in her mind so she didn't really act out yeah she was very distracted and she didn't pay lots of attention and she and the school would say that she kind of daydreams a lot and she doesn't focus" **EP 3** (line 79-82) "some of the behaviours that he did were um walking um sort of in one particular spot up and down up and down and he would um need to do that a certain number of times before for example going in from the playground or going out to the playground" **EP 2** (line 39-42)
<u>Anxiety reducing techniques</u> The EPs spoke about integrating general anxiety-reducing and relaxation techniques into the school day such as breathing	"we spoke about things like muscle progressive muscle relaxation and deep breathing and calming exercises so we knew that this young

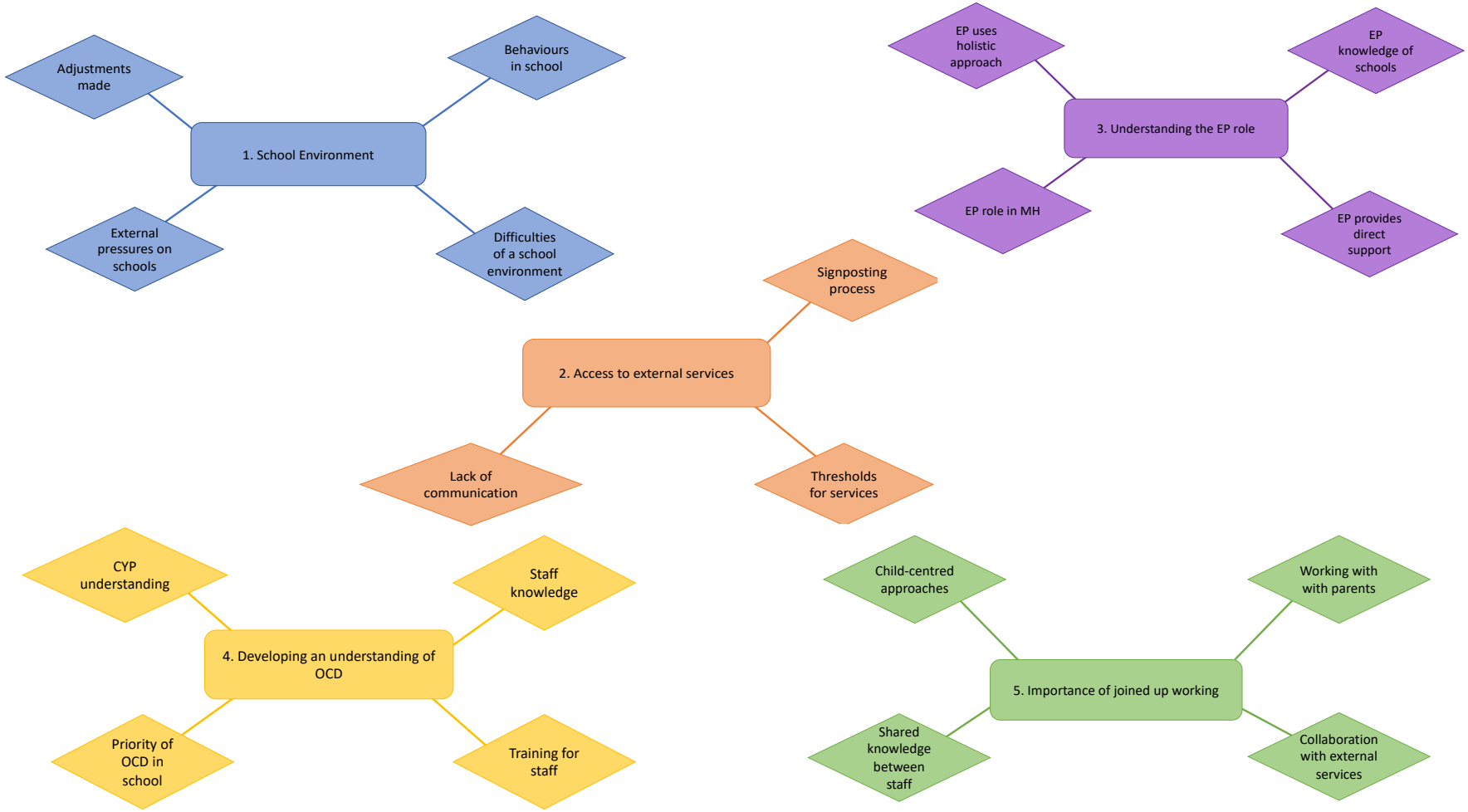
exercises. They also spoke about adapting the school day to relieve some of the demands and anxiety that these CYP were feeling by taking away certain lessons or adapting how the CYP used equipment. One EP also spoke about replacing the compulsions with other behaviours so the CYP could get the feedback that they wanted without it being considered violent.	person was anxious so before they showed us this is gonna be this is part of your timetable into school" **EP 3** (line 114-116) "replace unwanted behaviours with functionally equivalent behaviours that seems to have been really successful" **EP 1** (line 142-143)

4.2 SENCo/ALNCo Interviews

The six SENCos/ALNCos discussed a variety of areas that contribute to their work supporting CYP with OCD*. As the ALNCo job title can identify which participants worked in the Welsh LA, all participants will be referred to as SENCos for this section to keep participants anonymous. Five main themes of “School environment”, “Access to external services”, “Understanding the EP role”, “Developing an understanding of OCD” and “Importance of joined up working” were identified along with their own subthemes.

Figure 16

Thematic map for the SENCo/ALNCo analysis, highlighting five main themes and corresponding subthemes



4.2.1 Theme 1: School environment

Figure 17

Main theme 1 of School environment with corresponding subthemes

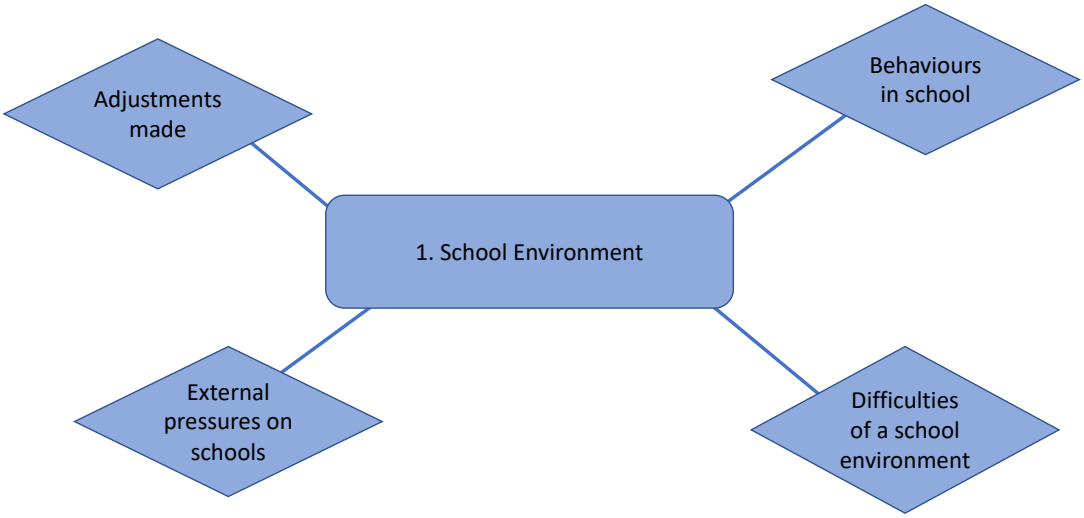


Table 17

Corresponding subthemes and participant quotes for main theme 1 School environment

Theme 1: School environment	
This theme highlighted the impact that the school environment can have on CYP with OCD* and the approaches that the SENCos have been able to make to support these CYP within the school environment. The SENCos also discussed that external pressures such as the COVID-19 pandemic, finances and time constraints can affect the ways schools provide support. It was discussed that secondary school pressures such as regular change, transition and social pressures can be seen as difficulties for these CYP.	
Subtheme	Participant Quotes
<u>Behaviours displayed in school</u> The SENCos discussed how they saw lots of repetitive behaviours in school around hygiene, crossing boundaries and equipment. They also spoke about how these CYP would often need to leave or miss lessons. It was discussed that sometimes this can feel quite challenging.	"so one of them was displaying symptoms where he couldn't move around the school and he couldn't get across boundaries and lines on the floor" **S1** (line 11-12) "it's that high anxiety all the time so trying to focus on something else like learning or listening to what the teacher is saying or some independent work or whatever it might be when you find it you've got that preoccupation" **S4** (line 24-26)

<u>Difficulties of a school environment</u> The SENCos discussed that the structure of a secondary school can be difficult for these CYP with multiple changes throughout the day and anxiety around not being able to access certain things easily such as toilets. It was also discussed that the social pressure from peers who don't understand can be difficult. The SENCos also mentioned that finding space within schools to provide interventions for these CYP can also be hard.	"just having those sort of areas where you can actually have that more sort of I guess therapeutic input that there just isn't that space in schools" **S5** (line 292- 294) "the environment of a large secondary school doesn't lend itself to supporting young people who have repetitive behaviours and you know the change in the classrooms all the time in the environments the different lighting different setup getting that pencil case out every time and managing that environment can almost seem impossible" **S2** (line 284-287)

<u>Adjustments made</u> The SENCos discussed that consistency, predictability and structure were key to supporting these CYP. Some SENCos mentioned that working in a specialist setting enables this to happen day to day compared to a secondary school. It was also discussed that getting to know the CYP and pre-empting their anxieties around certain equipment, seating arrangements and hygiene needs can help that CYP's experience. They spoke about modifying their language to avoid adding extra anxiety such as talking about germs or diseases in the classroom. One SENCo also mentioned that distraction or replacing the compulsive action with another action can be helpful to ensure the CYP does not need to leave the classroom.	"making sure that they're organised for using their own equipment as well and whether that means that they leave them in school with you or they take them home with them and bring them back in" **S6** (line 175-177) "I think just modifying what you teach so that you're not making it worse" **S5** (line 66-67) "I suppose that's where the CBT comes in a little bit... is what else can we do instead of that behaviour that we're seeing" **S4** (line 111-112)

External pressures on schools The SENCos discussed that the COVID-19 pandemic had affected the support they could provide to these CYP and that some of them progressed and some degressed over the first lockdown. It was also discussed that available time and money can affect intervention opportunities and the ability for external services like the EPS and CAMHS to become involved. It was also discussed that OCD is not a LA priority and that this may need to happen for more resources and training opportunities to become available. However, it was also mentioned that virtual working cuts down on time and may facilitate further support from the EPS. It was also discussed that drop-in style sessions with EPs and other professionals would be beneficial to school staff as often they need advice on a need and may not need the full referral.	"I think it's a shame that lockdown happened and therefore we've kind of almost taken a step back" **S1** (line 293-294) "are we training our SENCos to say what is my budget... I'm the professional here so you give me my budget and I'll spend it in the way that I see that is best" **S2** (line 241-243) "that would be quite a commitment of EP hours... and I don't know how effective that would be" **S4** (line 99-100)

4.2.2 Theme 2: Access to external services

Figure 18

Main theme 2 Access to external services and corresponding subthemes

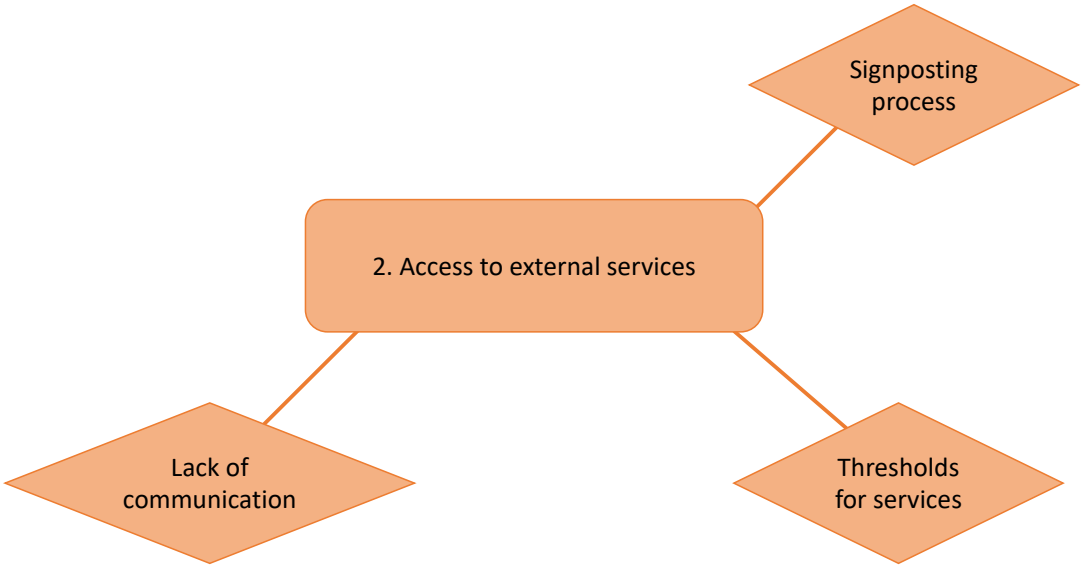


Table 18

Corresponding subthemes and participant quotes for main theme 2 Access to external services

Theme 2: Access to external services	
This theme highlighted the SENCos' experiences with accessing external services for support with these CYP with OCD*. It was discussed that the signposting process itself can be difficult as the SENCos do not always know where to refer to and once the CYP is on the diagnostic pathway or is being seen by external services, the school is not always informed about the CYP's progress. It was also highlighted that the thresholds for these external services mean that some CYP are not accepted and that if these CYP have other needs the school are advised to refer them elsewhere.	
Subtheme	Participant Quotes
<u>Signposting process</u> The SENCos discussed that it can be difficult to signpost when the CYP has another diagnosis such as autism as there can be a crossover in the presentation of behaviours. They discussed that the waiting lists for some services are long and that the CYP can often drop out during the process. The SENCos also mentioned that they sometimes felt unsure about where to	"if the young person says they don't need help and they don't want to go to the appointments they're immediately discharged from services" **S2** (line 53-54) "there should be some sort of directory of support... so you know I could look at it and think like I think this child's got this problem this is

signpost and that a directory of contacts or services would be helpful.	the best route to go down and these are the people that I can contact" **S5** (line 210- 212)
<u>Threshold for services</u> The SENCos discussed how it was hard to refer to services such as CAMHS when a CYP has a diagnosis of autism or has an EHCP/Statement as they have been told the CYP's needs will need to be met elsewhere. The SENCos also spoke about how high the thresholds are for CAMHs and that although the CYP are struggling, they are not seen as struggling enough and that the cut off points for these services can be a barrier to supporting the CYP.	"CAMHS are notoriously the threshold is notoriously difficult and high to be able to access them" **S3** (line 168- 169) "this is their EHCP need so therefore we're not meeting you on this we're not gonna help on this one because it's part of their ASD" **S1** (line 75-76)
<u>Lack of communication</u> The SENCos discussed how they often feel there is a lack of communication from external services such as CAMHS and Neurodevelopmental pathways once a referral has been sent and often they have to make a referral more than once. They also mentioned that there very little, if any feedback on	"conversations with CAMHS are often just about discharge to be honest and nothing else sometimes we refer over and over and over again" **S2** (line 143-144)

progress, they often only hear from them if a CYP is being discharged.	“families have this anticipation that if we've made a referral for them there will be some sort of answer and very often all they get is a piece of paper that says what's wrong but it doesn't necessarily set out how to help and I think you know more joined up approach to the how to help part would be really helpful” **S5** (line 227-230)

4.2.3 Theme 3: Understanding the EP role

Figure 19

Main theme 3 Understanding the EP role and corresponding subthemes

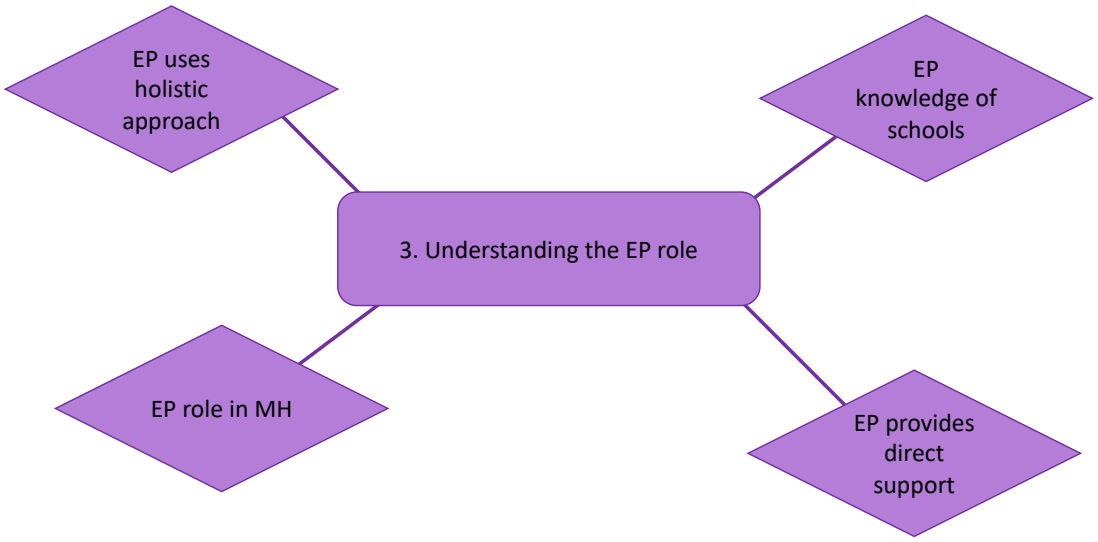


Table 19

Corresponding subthemes and participant quotes for main theme 3 Understanding the EP role

Theme 3: Understanding the EP role	
This theme highlighted how the SENCos understood the EP role and what they valued about EP involvement. The SENCos discussed that they were more likely to refer to an EP if there is a learning need and may not necessarily see the EP role as supporting medical diagnoses. It was also mentioned that the SENCos valued EP support when it was used, and they are more likely to refer after having previous support. The way that EPs work holistically was also discussed as a reason for using the EP and that the EP has more knowledge of the school environment than other professionals. It was discussed that direct support from the EP for CYP and for the school staff working with these CYP is appreciated. Furthermore, it was mentioned that the EP could have a supervision role with the SENCo for complex cases like OCD*.	
Subthemes	Participant Quotes
<u>EP knowledge of schools</u> The SENCos discussed that the benefit of using an EP is that they have the knowledge of a school setting, which other health professionals sometimes lack, so advice and outcomes were tailored to the school.	"educational psychologist would understand and be able to talk about strategies that we could actually apply to our setting" **S3** (line 140-141) "CAMHS or a psychiatrist is like it can feel like a list of demands that sometimes are unrealistic in the setting you're in" **S2** (line 180-182)

<u>EP provides direct support</u> The SENCos discussed that it was beneficial when the EP directly supported the staff who worked with a CYP with OCD* or directly supported the CYP themselves. They also spoke about how EPs could support school staff during consultations. It was also discussed that SENCos would benefit from direct supervision from an EP so they could discuss complex cases such as OCD* and see what school could implement without having to go through a lengthy referral process.	"they fed back then it was really helpful having somebody working with them to support just that one student 'cause it wasn't generic and it has helped him" **S1** (line 138-140) "I will say SENCo supervision you know that is something that I feel really strongly about" **S2** (line 195-196)
<u>EP uses holistic approach</u> The SENCos discussed that they valued the holistic approach that EPs use when working with the schools. They discussed that it was important to see the wider picture rather than simply the diagnosis of OCD and that the EP can bring together the home and school environments.	"you're looking at the holistic child rather than just a particular disorder and often those conversations are really useful" **S2** (line 131-133) "I think it needs to be a kind of whole not just looking at the student but the whole family and everybody that is helping provide for that student needs to be kind of brought together" **S1** (line 176-178)

<u>EP role with MH</u> It was discussed that OCD is often seen as a medical need and may need ongoing support that they do not see the EP being able to do. The SENCos spoke about referring to the EP if the OCD behaviours were affecting learning or had become an academic concern.	 "I see educational psychology is more helping a child to learn whereas the clinical and health team would be more about treating the child" **S5** (line 193-194) "I would consider OCD more medical and clinical than the EP" **S4** (line 124-125)

4.2.4 Theme 4: Developing an understanding of OCD

Figure 20

Main theme 4 Developing an understanding of OCD and corresponding subthemes

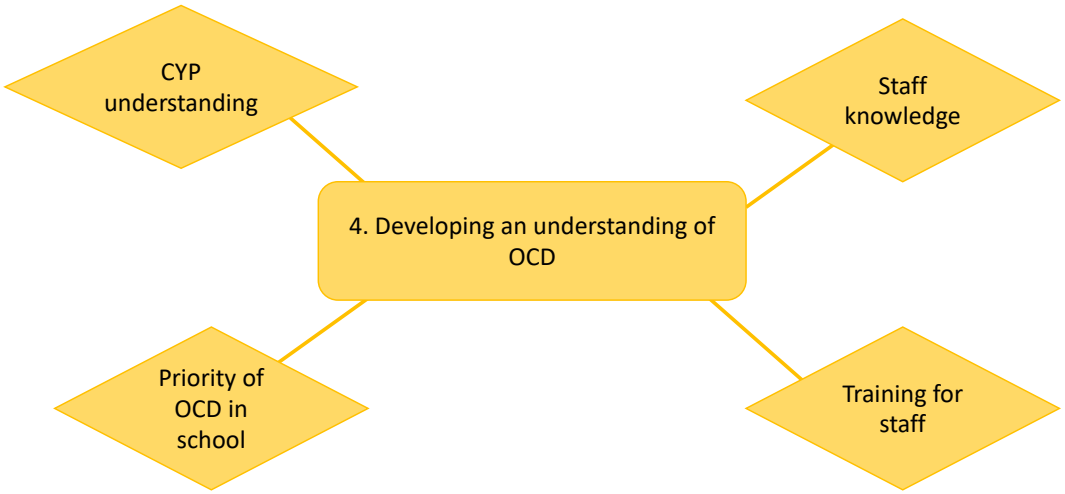


Table 20

Corresponding subthemes and participant quotes for main theme 4 Developing an understanding of OCD

Theme 4: Developing an understanding of OCD	
This theme highlighted the importance of the whole school developing an understanding of OCD. It was discussed that staff and CYP can lack knowledge and may not have positive or helpful attitudes towards these CYP. The SENCos varied in how much experience they had themselves and they also discussed that OCD* cases may not be prioritised in school or brought to their attention so there may be CYP they are unaware of in their schools. It was also discussed that training for school staff would be helpful and that the EP had a role in facilitating this training.	
Subtheme	Participant Quotes
<u>Staff knowledge</u> The SENCos varied in how much knowledge and experience that they perceived they had. Some of them spoke about building knowledge over the years, especially those linked to specialist settings. Others said that they felt they had hardly any experience at all. The SENCos also spoke about staff attitudes and misconceptions about what OCD is and believed that school staff do not always use the right language around the CYP. The SENCos also spoke about confidence of school staff, including the SENCos	"I haven't had a great deal of experience with OCD at all actually" **S3** (line 15) "it's in common language of saying you know if you're particular about something oh you're a bit OCD that kind of thing and just not having that understanding of what actual OCD is" **S2** (line 41-42)

themselves, and mentioned that it can be difficult to know if they are doing the right thing.	"that's what they found so hard is they didn't know if they were going to make things worse by saying certain things" **S1** (line 142-143)
<u>Training for staff</u> Some of the SENCos mentioned that it would be beneficial for information about OCD to be provided during teacher or SENCo training. One SENCo spoke about how beneficial whole school OCD training had been for their school. The SENCos discussed that the EP had a role in providing this training and that they would accept training from the EP if it was offered. One SENCo also spoke about how staff would benefit from more specific intervention training such as using aspects from CBT.	"(EP) has done a whole school couple of sessions and just on developing our whole school understanding of OCD" **S1** (line 129-130) "yeah absolutely… if an EP came to me and said I can offer support or training with OCD then definitely" **S3** (line 135-136)
<u>Priority of OCD in school</u> The SENCos discussed that in their role they may not actually be aware of a lot of these CYP with OCD* and that it may be supported by other staff within the school without their knowledge. The SENCos mentioned that it can become more of a	"we often hear that young people have these problems but we don't see it as very evident in school actually" **S2** (line 6-7)

priority when parents request involvement or there is a need for statutory assessment. The SENCos also discussed that OCD would need to be a priority for the leadership teams within the school for support to disseminate down to all staff.	"I guess I worry about there's gotta be a lot of students that we just don't know about" **S3** (line 201-202)
<u>CYP understanding</u> The SENCos spoke about how some pupils can be aware of their OCD and are able to talk about it and others are unaware or unwilling to discuss it. They also discussed that there can be a lack of understanding amongst the CYP's peers, which can make the school day difficult for them.	"I've never really come across a pupil that hasn't been aware that it's OCD and it's not just part of their life" **S5** (line 41-42) "scrutiny by peers wondering what's going on why are they doing it people thinking they're you know in their language they're a bit weird" **S2** (line 38-39)

4.2.5 Theme 5: Importance of joined up working

Figure 21

Main theme 5 Importance of joined up working with corresponding subthemes

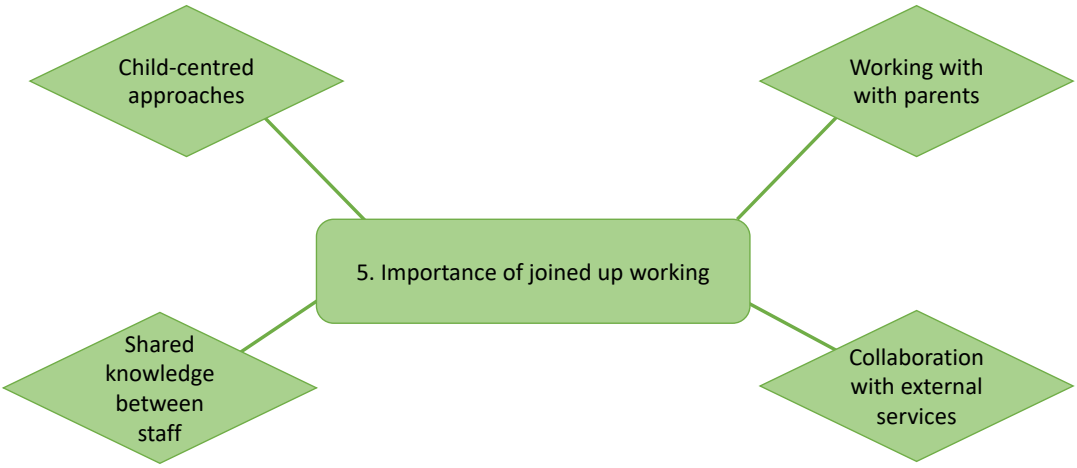


Table 21

Corresponding subthemes and participant quotes for main theme 5 Importance of joined up working

Theme 5: Importance of joined up working	
This theme focused on the importance of SENCos collaborating with parents, external services, school staff and the CYP themselves. It was discussed that although parents were key to providing information from home and other professional involvement, they may need support themselves and there can be a gap there if school cannot offer support. It was considered important for SENCos to collaborate with all key members of staff, especially adults such as the ELSAs who may be providing interventions. It was also discussed that it is important to keep the CYP at the centre of any decision making and ensure their views are heard throughout the process.	
Subtheme	Participant Quotes
<u>Working with the parents</u> The SENCos discussed that collaborating with parents was important to support the CYP. They spoke about how parents can provide important information about the home environment and pass on information from external services. The SENCos also spoke about how it is important for the school to support parents where possible and refer them on to other services where appropriate. One SENCo discussed that there is a gap in support for parents and	"again it's liaising with parents and guardians because they play a massive part in that process" **S6** (line 108-109) "knowing where to signpost parents for the accurate support and not good old Google search" **S4** (line 209-210) "I wish there was a service that could help at home as well as school I think that's been the difficulty that we've had" **S1** (line 150-151)

often the family are struggling and may not have the knowledge about OCD themselves. It was discussed that the EP could have a role in helping the parents develop this understanding.	
<u>Collaboration with external services</u> The SENCos spoke about how important it was to collaborate with external services such as CAMHS and the EPS to provide the best support for CYP in school. Regular meetings were discussed as helpful and the SENCos who were able to regularly meet with therapists and other professionals saw this as a facilitator for providing the right support. Some SENCos found the LAs they worked in more helpful than other SENCos.	"we meet as a therapy team so there would be myself and assistant SENCo and then parent support advisor art therapist our speech language therapist would all meet and our health care assistant" **S1** (line 92-94) "there's always opportunities where you can be signposted for somebody to support the relevant guidance I think that's a real strength of the authority that I work in" **S6** (line 240-242)
<u>Shared knowledge between staff</u> The SENCos discussed that communication and collaboration with everyone who works in the school was	"I think that's been my port of call is just using the expertise that's within teams and also within the support network of special schools or other school clusters and sharing of information" **S6** (line 67- 69)

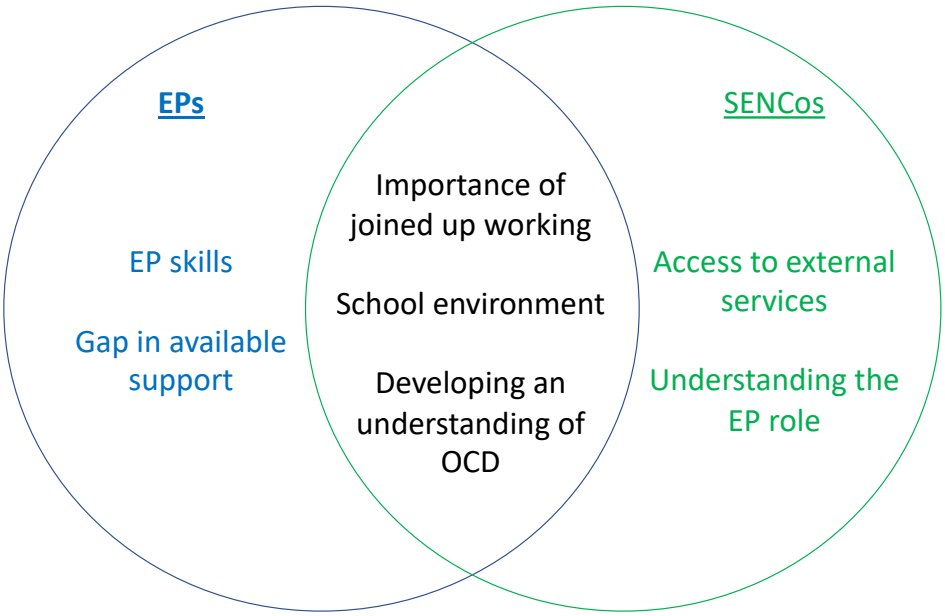
vital for CYP support. The SENCos spoke about how it was important to gather information from all key members of staff for annual reviews or consultations with professionals and parents. They also discussed the importance of allocating key members of staff for these CYP such as ELSAs who could liaise regularly. Some SENCos spoke about having MH professionals available in school such as counsellors and play therapists and that this was helpful to aid a decision process around support.	"we use ELSA in school so we probably look at some ELSA support" **S5** (line 109)
<u>Child-centred approaches</u> The SENCos discussed that being child-centred in their decision making was key and that it was important for the CYP's views to be central to any support that was offered. They also discussed that it can be difficult gathering these views if the CYP struggled with emotional literacy or did not have the capacity to describe what is happening.	"I think sometimes it's worth speaking to the young person as well and I think if the emotional literacy levels are in place then the young person can give you as much feedback as you need in order to best support" **S6** (line 119-121) "sometimes or very often actually pupils with OCD wouldn't necessarily communicate to us that it's better or worse" **S5** (line 138-139)

4.3 Summary

The themes produced by the two participant groups were generally in accordance, which suggests that EPs and SENCos agreed about ways to support CYP with OCD* and what the facilitators and barriers to support might be. No major disparities were noticed, the main differences were around specificities to the participant's job such as the signposting experience of schools, the gap in support acknowledged by the EPs, and the understanding of the EP role itself. The themes produced by both sets of participants will be discussed in relation to the research questions in the following discussion section.

Figure 22

Venn diagram of the main themes that were produced by both groups of participants



5.0 Discussion

This study explored the role of the EP supporting CYP with OCD* and how secondary school SENCos/ALNCos would like to be supported by EPs when working with these CYP. Six EPs and six SENCos/ALNCos took part in virtual semi-structured interviews and the main themes that emerged from the TA for both groups included “importance of joined up working” “school environment” and “development an understanding of OCD”. The main themes of “gap in support” and “EP skills” also emerged from the EP analysis and the main themes of “access to external services” and “understanding the EP role” also emerged from the SENCo/ALNCo analysis. The resulting themes from the TA will be discussed in relation to the four research questions and the literature. The links to psychological theory will then be discussed, followed by the implications for EP practice and finally the strengths and limitations of the research.

5.1 RQ 1) How do Educational Psychologists describe their current practice when working with children and young people with OCD?

Working collaboratively with school staff, families and external services was highlighted as important to the current practice of EPs. This was done via consultations or information gathering meetings with key adults around the CYP to create a wider picture of need and to facilitate joint decision making about outcomes. Previous literature has also highlighted the need for a collaborative approach between the SP and school staff in order to create successful outcomes (Adams et al., 1994; Sloman et al., 2007). Consultation has also been recommended as one of the steps for SPs to take with OCD cases (Sloman et al., 2007). The current study hence supported collaboration and consultation as a viable suggestion for ways for EPs to work in the UK as well as the USA. Previous research into how EPs see their role within MH also found that EPs saw their role as collaborative and that they would offer consultation (Elms, 2020; Greig et al., 2019; Price, 2017; Zafeiriou & Gulliford, 2020) which suggests that EPs practiced in a similar way with OCD* as they have done with MH in general.

The EPs described the work that they had done as holistic and that they did not directly deal with the diagnosis of OCD and that many of the CYP they worked with did not yet have an official diagnosis. The EPs gathered information about the wider picture through classroom observations and consultations and found the best way to support the CYP regardless of a diagnosis. Some of this work had been for statutory assessments where the focus was around consequences of having OCD such as school avoidance. They discussed the importance of their role bringing together information from everyone's perspectives whilst writing these assessments and looking at the wider impact of the school environment on these CYP. Previous research also found that a significant part of the SP role with OCD was around statutory work (Adams et al., 2007). However, unlike the SPs in Adams et al. (2007)'s study, these EPs did not see a role in categorising the need of OCD, nor were they doing it for treatment purposes (Adams et al., 2007). The previous research appeared far more diagnosis focused than the work described by the EPs in this study (Adams et al., 2007; Gallant et al., 2007).

The EPs explained that they try to remain child-focused and that they have ensured the CYP's views were central to the process, whether this was a one-off consultation, ongoing casework or statutory work. The EPs spoke about how they have used visual strategies such as maps of the school or the CBT triangle to help the CYP articulate their views. One EP spoke about the "Ideal School" approach and that this had been a helpful way to gain a CYP's perspective about the school environment. Previous position papers on the role of the SP also mentioned the importance of gathering the views of the CYP as part of the identification and treatment process (Adams et al., 1994; Sloman et al., 2007). However, this was done in an interview format rather than using PCP approaches, therefore it could be argued that the EPs chose a less formal way of gathering the views of CYP compared to the previous guidance for SPs.

The EPs spoke about evidence-based practice that they used whilst working with CYP with OCD*. Some of the EPs used aspects of CBT either directly with the CYP or with key adults that support the CYP in school. They spoke about using the CBT triangle as a visual aid and educating the CYP about their thoughts, feelings and actions and how they are linked. Some of the EPs also spoke about using aspects of ERP and doing simple exposure work and anxiety laddering to help the CYP face some of their fears in

school. The EPs also discussed the importance of using psychoeducation with the CYP, parents and school staff using aspects from CBT and neuropsychology. This helped everyone involved rationalise what OCD is and helped with creating ways forward. Some of the EPs also discussed that they had provided wider training for school staff and parents to develop their understanding of OCD and helped them support the CYP in school. The EPs have focused on approaches that are recommended by the NICE guidelines such as CBT and ERP (NICE, 2005) and one of the EPs even directly mentioned the NICE guidelines. Psychoeducation is considered one of the key elements of CBT and ERP and previous research has discussed this as being an effective approach to use with CYP with OCD (Riise et al., 2018; Wu et al., 2016). Previous position papers have suggested using CBT elements as part of the treatment for CYP in schools (Sloman et al., 2007). Hence, this suggests that EPs have had opportunities to implement some of the recommended approaches for SPs whilst working with OCD* in UK schools.

Overall, it appears that current practice described by the EPs in this study mirrors some of the suggested ways of working from the SP models by Adams et al. (1994) and Sloman et al. (2007) such as gathering information through consultation, collaborating with school staff, gaining the views of the CYP and using aspects of CBT and ERP with the CYP. However, the EPs in the current study considered their role more holistic in nature and there was less of a focus on the diagnostic aspect compared to the previous work done in America (Adams et al., 2007; Gallant et al., 2007).

5.2 RQ 2) How would Educational Psychologists ideally like to work in schools to support children and young people with OCD?

The EPs mentioned that they would like the opportunity for more collaboration with external services who are also involved with the CYP. The EPs had mixed experiences linking with MH services such as CAMHS, with some having regular contact and others not so much. They discussed that ideally, they would like to work jointly with MH services and learn from them. One EP also mentioned it would be helpful to create some joint training with MH services about OCD for schools. Previous literature has also stated a need for more collaboration between school settings and MH services to

support CYP with OCD and that a multidisciplinary approach is considered the most effective way to help these CYP (Sulkowski et al., 2018).

The EPs also discussed how they would ideally like more opportunities and time for ongoing work with CYP with OCD*. Some of the EPs were only able to do a one-off consultation and they would also like opportunities to review the cases or to do more work with the CYP or school staff. Many of these EPs felt that schools would be more satisfied with their involvement if they could work in this way. Also, if EPs did a statutory assessment in a school that they were not linked with, they did not hear about how the CYP was progressing after the assessment was written. The previous guidance written for SPs focused on an ongoing process and the authors considered that the ability for SPs to work in this way could pose as a limitation (Sloman et al., 2007). The current study supported this limitation and highlighted that although this was considered an ideal way of working, it was not always possible in the UK context.

The EPs also spoke about how they would like the opportunity to develop a wider understanding of OCD in schools and the wider community to ensure that misunderstandings and stereotypes could be avoided. The EPs believed that they could have a role in developing training about OCD and would like the opportunity to do this. Previous research has emphasised the importance of making OCD information available within community settings to develop understanding and attempt to destigmatise OCD (Fernández de la Cruz et al., 2016; Jones et al., 2020). The current study suggested that EPs also felt that this was important and that maybe there is a role for the EP in developing wider understanding.

Overall, it appears that EPs would like opportunities to work in ways that have been suggested in previous literature such as working collaboratively with health professionals (Sulkowski et al., 2018), working in an in-depth ongoing manner (Adams et al., 1994; Sloman et al., 2007) and developing a wider understanding of OCD within schools and communities (Fernández de la Cruz et al., 2016; Jones et al., 2020).

5.3 RQ 3) How would SENCos/ALNCos like to be supported by the Educational Psychologist when working with children and young people with OCD?

The SENCos/ALNCos saw the EPs as having a role in providing training to schools and upskilling parents and CYP. One SENCo had received OCD training from an EP and said that they felt it was successful in developing the knowledge of the school staff. They also felt that EPs could support school staff directly by building confidence and offering advice. This supports literature that has suggested that SPs have a role upskilling school staff to enable them to provide interventions and implement strategies suggested by professionals within the school environment (Sulkowski et al., 2018). The SENCos/ALNCos also wanted there to be more support available to parents and discussed the possibility of the EP providing some of this support by upskilling the parents and advising them on how to support the CYP at home. This further supports previous research that has highlighted a greater need for support and information being given to both the school and the family (Jassi, Kolvenback et al., 2016).

The SENCos/ALNCos also discussed that they would like to work collaboratively with EPs and health professionals to make decisions for these CYP. It was discussed that working virtually can be helpful as it saves time and means that more professionals are likely to attend meetings. The SENCos/ALNCos also felt that the EPs could support them accessing other services, either with the referrals themselves or by directing them to the most appropriate service. One SENCo mentioned that a directory within the LA would be helpful that included the best places to refer to for certain needs. This further supports literature that has emphasised the importance for collaboration between school staff and outside professionals to support the CYP (Chaturvedi et al., 2014; Gaskins et al., 2020; Leininger et al., 2010; Sulkowski et al., 2018).

The SENCos/ALNCos mentioned that they would appreciate opportunities for EPs and other professionals to hold drop-in type sessions where they could anonymously discuss CYP and needs such as OCD to get advice without having to go through a lengthy referral process. One SENCo also mentioned that is would be helpful to receive regular supervision sessions from an EP where they could talk through complex cases so support could be decided quicker and the SENCo could feel upskilled. This supports

previous research where EPs have seen a role for themselves in providing supervision for school staff for other MH difficulties such as EDs (Elms, 2020).

Overall, the views from the SENCos/ALNCos supported previous research that suggested school staff ideally need to work collaboratively with EPs and other professionals to support CYP with OCD (Chaturvedi et al., 2014; Leininger et al., 2010; Sulkowski et al., 2018). It also highlighted the need for the EP to upskill and support school staff and parents which supports literature that has highlighted the importance of a home and school approach to supporting OCD (Jassi, Kolvenback et al., 2016). They discussed that this could be done through training, consultations, or drop-in sessions which have been suggested as ways EPs support other areas of MH (Elms, 2020).

5.4 RQ 4) What are the facilitators and barriers to support in schools for children and young people with OCD?

5.4.1 Facilitators

Both the EPs and SENCos/ALNCos agreed that opportunities for collaboration and open and regular communication between services, key adults, families and the CYP was key to supporting CYP with OCD*. Both groups mentioned that this made the process easier, and they felt the right support could be offered as they had all the information and expertise within that extended group. This supports the previous literature that suggested collaborative and multi-disciplinary working is key to supporting these CYP as it promoted information sharing of different home and school behaviours and allowed an accurate description of response to treatment outcomes (Sulkowski et al., 2018).

Both groups of participants also discussed that working in a holistic manner facilitated good practice and the EP was a key professional to take this stance. It was considered beneficial to look at the whole picture for both the school and home environment and to keep the CYP's views at the centre of this process, rather than focusing on a diagnosis. Both groups also mentioned that this was particularly important when the

CYP had comorbidity with ASC, Tourette's or ADHD. Previous research has also discussed that there are high comorbidity rates in OCD and that this can make it difficult to unpick need and can create difficulty in the diagnostic process (van Oudheusden et al., 2020). Working in a holistic manner rather than focusing on diagnosis could also be argued to support the literature that favours formulation and the wider picture (Johnstone, 2018). Both groups seemed to perceive working holistically as helpful and spoke about how they supported the CYP regardless of whether they had a diagnosis or not.

The relationship between the school and the EP was considered a factor in the likelihood of schools referring cases to the EP. If the EP had worked in a school for a while, they felt the school was more likely to use them rather than referring to health services. Some SENCos/ALNCos discussed positive experiences of EP involvement with OCD* cases and felt that they would now use an EP in the future. The position papers written for SPs also agree that having time to work in an ongoing way with schools facilitates a successful process to supporting OCD (Sloman et al., 2007).

The SENCos/ALNCos mentioned that understanding the school environment and being aware of strategies that are implementable in schools is key for support and often CAMHS and other external services recommend strategies without being aware of the difficulties in school. On the other hand, the EPs were identified as having this knowledge and that SENCos/ALNCos appreciated their strategies and working methodologies as they were applicable to school staff. Previous literature also suggested that SPs are ideally placed to support CYP with OCD due to their knowledge of school psychology and the school environment and therefore served as a natural bridge between schools and MH support (Sulkowski et al., 2018).

Both the EPs and SENCos/ALNCos mentioned a variety of anxiety-reducing strategies that they found helpful for supporting these CYP. These included consistency, pre-empting situations that may make the CYP more anxious, exit cards, and making equipment and timetable allowances. They also discussed muscle relaxation and breathing exercises and replacing compulsive actions with other actions so CYP could

get the feedback they might desire. These strategies support the advice offered in previous position papers (Chaturvedi et al., 2014; Leininger et al., 2010).

Overall, the facilitators that were discussed support strategies and recommendations made from the previous literature that promoted collaborative approaches, anxiety-reducing strategies in the school environment and understanding the school environment itself to implement these strategies (Chaturvedi et al., 2018; Gaskins et al., 2020; Leininger et al., 2010; Sloman et al., 2007; Sulkowski et al, 2018).

5.4.2 Barriers

Many of the EPs felt that their own competency levels could be considered a barrier to offering support and mentioned that they would ideally like to have opportunities to develop their own understanding and be able to attend CPD on OCD within their services. Even the EPs who had more experience acknowledged that if they had not developed a special interest in this area then they would not have much confidence with OCD* cases. It was discussed that on the doctorate/masters courses that these EPs had attended, there was no input on OCD and that the LAs they are working in do not provide CPD for OCD, so any knowledge they have was developed independently through reading and experience of cases. This supports previous research into SPs knowledge of OCD that found 89.2% of the SPs in their study felt that they needed further training in OCD (Gallant et al., 2007). This suggests that there is a similar further training need in the UK.

This lack of knowledge was also mirrored by the SENCos/ALNCos who also appeared varied in their experience. The SENCOs/ALNCos acknowledged that understanding and confidence amongst school staff can be a barrier to supporting CYP as staff are often unsure if they are doing the right thing. They also spoke about how negative attitudes or stereotyping OCD can be a barrier, especially if this affects the language used by staff members around these CYP. Both the SENCos/ALNCos and EPs also mentioned that a lack of understanding from parents/carers and the wider community was a barrier as the CYP were sometimes seen as challenging. This supports previous research that highlighted the need to educate both school and home as behaviours

can often differ between the two environments and that both the school and home are crucial for successful treatment outcomes (Fischer-Terworth, 2013; Jassi, Kolvenback et al., 2016; Lebowitz, 2013).

Both the EPs and SENCos/ALNCos discussed that OCD needs were not always prioritised, which is consequently a barrier to support. The EPs felt that as OCD is not as widely recognised as other needs such as autism, that schools are less likely to request whole school training. The SENCos/ALNCos mentioned that OCD is not a current priority with Senior Leadership Teams (SLT) or within the wider LA so they are unaware of training out there and it can be difficult to access resources on OCD without extensive internet searches. The SENCos/ALNCos and EPs also discussed these CYP are not always brought to the SENCo/ALNCo's attention and that there may be many CYP within schools who are not getting support. Furthermore, previous literature into the presentation of OCD in schools has highlighted that CYP will often hide their compulsions in the school environment, which can make it difficult for school staff to identify and seek further support (Fernández de la Cruz et al., 2015).

The referral process and accessing external services was described by both the EPs and the SENCos/ALNCos as a barrier to support. The SENCos/ALNCos mentioned that they sometimes lacked knowledge about referral processes and what external services are available, so they are not always referring correctly. Also, both the EPs and SENCos/ALNCos commented on the difficulty of meeting the thresholds for services such as CAMHS and that unfortunately there can be a gap in external support available for CYP if they do not meet the criteria for CAMHS. The SENCos/ALNCos also mentioned that if a CYP has a diagnosis of autism or an Education Health Care Plan (EHCP) then they can be rejected from CAMHS as their OCD traits are seen as part of their autism presentation or they are expected to have their needs met as part of the EHCP. Furthermore, the SENCos/ALNCos discussed that even if CYP were accepted by CAMHS, the waiting lists were lengthy and sometimes the CYP would disengage and not attend appointments, which resulted in them being discharged without support. Also, schools were less likely to refer to the EPS as they saw the EP role as supporting learning needs and MH needs were separate and needed to be referred to health professionals. These difficulties all appear to support the recent reports on the

situation in CAMHS England, where waiting lists are long and lots of CYP do not meet the thresholds for the service (Crenna-Jennings & Hutchinson, 2020).

Just as collaboration was seen as a facilitator, the lack of collaboration was seen as a barrier by both groups. They mentioned that supporting CYP was more difficult when they were unable to meet with other professionals involved or if they did not have good relationships with the parents or key adults in school. The EPs discussed that it was difficult when behaviours were described at home, but school were not seeing them and hence disengaged from the process. The SENCos/ALNCos mentioned that they would often be unaware of a CYP's struggles at school until a parent brought it to their attention. The SENCos/ALNCOs also mentioned that they often relied on parents relaying information from CAMHS and that they would only hear from CAMHS if the service needed information from the school or if a pupil was being discharged. Again, this highlights the importance of collaboration that is emphasised in the literature (Sulkowski et al., 2018).

Finally, the demands of the school environment itself was considered a barrier. The SENCos/ALNCos discussed that a mainstream secondary school posed more difficulties than specialist settings and that regular changes in classroom, teachers, equipment, lunchtime set ups and distance to toilets can all cause difficulties. These difficulties all support previous position papers for schools (Chaturvedi et al., 2014; Leininger et al., 2010). They also spoke about how social demands and the CYP's need to hide compulsions can also be a barrier, which also supports what previous research has found about the social demands of OCD (Borda et al., 2013). The SENCos/ALNCos also spoke about external pressures such as a lack of time, finances, space and resources that can make it difficult to offer support in school. These pressures were also highlighted by Sloman et al. (2007) as potential difficulties to implementing an OCD treatment programme within a school environment. Furthermore, they mentioned the impact of the COVID-19 pandemic and that any support they had in place in school has stopped due to lockdowns and consequent bubble systems on the return to school.

Overall, the barriers that were discussed support the described difficulties of supporting OCD in the classroom from previous literature such as hidden compulsions,

social demands on the CYP, waiting lists and thresholds for specialist services, unpicking need, and a lack of confidence from professionals (Borda et al., 2013; Chaturvedi et al., 2014; Crenna-Jennings & Hutchinson, 2020; L. Fernández de la Cruz et al., 2015; Gallant et al., 2007; Leininger et al., 2010; Sulkowski et al., 2018).

5.5 Links to psychological theory

A psychological model that appeared pertinent to this research was the bioecological model (Bronfenbrenner & Ceci, 1994), which was introduced in part A and will be discussed in relation to the study findings below.

5.5.1 Bioecological model

Bronfenbrenner & Ceci (1994) claimed that interactions between a CYP and their environment influences their development. This development is influenced by changing micro contexts such as family, friends and communities that surround that child (Bronfenbrenner & Ceci, 1994). Furthermore, there is an emphasis on the importance of the interconnections between two or more settings such as school and family in the mesosystem (Bronfenbrenner & Ceci, 1994).

The participants in this study highlighted the different contexts and systems that influence the CYP's experience, from the school and family microsystems to the external services such as the EPS, CAMHS and the LA in the exosystem. The SENCos/ALNCos mentioned the importance of professionals in the exosystem having knowledge of the school context and that when strategies are suggested without this knowledge, they can be difficult to implement.

The study also highlighted the perceived boundaries between the different systems. It was discussed that there can be a lack of collaboration and communication with some external services such as CAMHS. These services appear to be separate from the educational context, especially if they are contextualised as health services. The thresholds to be accepted into these services appear to be a perceived boundary to accessing support and for some participants this appeared to further separate services

such as CAMHS from the school system. The logistics around referrals such as waiting lists and travel demands were also discussed as barriers to support and may be considered another boundary as this highlights these health services as separate and potentially difficult to access.

The mesosystem is described as the level of context that considers the interconnections between two or more settings and acknowledges their impact on the CYP (Bronfenbrenner & Ceci, 1994). This stipulates that the CYP is influenced by the relationships between key people within these settings (Bronfenbrenner & Ceci, 1994). The participants spoke about the importance of building relationships and collaboration when supporting CYP with OCD*. The participants acknowledged that sharing knowledge and supporting the home and school settings are important to supporting the CYP and that professionals such as the EP have a key role in facilitating these relationships and empowering everyone involved.

It may be argued that the role of the mesosystem may potentially shift the locus of control (LOC) (Rotter, 1954) for the school staff. The SENCos/ALNCos focussed on lots of external factors, which they believed contributed to barriers to supporting the CYP such as time, finances and accessing external services. This focus may be perceived as an external LOC where participants believed that events resulted from the influence of others rather than their own actions (Rotter, 1954). The SENCos/ALNCos described collaborative experiences as positive and an aid in decision making. The EPs felt that consultations and meetings with the school and family aimed to empower both parties and enabled them to take ownership of the outcomes from the meetings. Within the mesosystem it appears that the LOC can begin to shift from external to internal and hopefully result in school staff seeing an element of control with these cases.

The current study has highlighted the importance of increasing the permeability between the school microsystem and the external services such as CAMHS that sit within the exosystem. Creating opportunities for professionals from MH services to interact at the mesosystem level may empower the school staff and help them see OCD cases as within their control. If school staff and EPs feel they can collaborate and communicate easily with MH professionals, there may be a shift in narrative about

who has control over these OCD* cases. The current study highlighted the importance of a shared responsibility and control for successful support within schools, rather than referring out and not creating a support plan within schools.

5.6 Implications for Educational Psychology practice

The current study suggested that EPs do have a role in supporting schools with pupils with OCD*. The study highlighted the role of the EP in upskilling school staff, parents/carers and the CYP themselves through training and psychoeducation. It was discussed as important that EPs use evidence-based practice to gather the views of the CYP and support the CYP and the key members of staff working with these pupils such as the ELSAs. PCP, CBT and ERP were all described as approaches that the EPs found helpful to work directly with the CYP or to use with key adults who supported the CYP. The study therefore highlighted the importance of EPs continuing to use and share evidence-based practice with others including key adults and the CYP themselves.

Furthermore, the participants agreed that the EP had a key role in collaborative approaches to support the CYP. Both groups of participants saw the EP role as holistic in practice and that approaches such as consultation and systemic thinking, alongside the knowledge of the school setting, enabled them to help facilitate a joined-up approach to these cases. The study also highlighted the need for further communication and collaboration with external services such as CAMHS to further facilitate a way forward. The study hence suggested that EPs may need to find a way to increase opportunities for joined up working with other external services who are involved in these OCD* cases.

The current study highlighted the difference in EP experience and knowledge when it comes to OCD. The overall consensus from the EPs was that they would benefit from more training and CPD input around OCD as they often had to develop their own knowledge once they were referred a case. Although this may not be representative of all training courses, the EPs mentioned they had not received any input around OCD on the doctorate training or in previous teacher training. The study therefore highlighted

that there is a need for OCD to be covered either at the doctoral level or as a CPD package made available to EPSs.

Another implication for practice may be developing the SENCo/ALNCo understanding around the EP role. Some of the SENCos/ALNCos mentioned that they saw the EP as having a role in learning and education rather than with MH. However, after taking part in this research, they mentioned that the EP would be helpful in supporting these CYP and that they would consider using EPs. Therefore, the study highlighted that school staff do see EPs as having a role with OCD*, but some schools may need more information about how EPs could support MH needs like OCD. One way this could be done might be in initial planning meetings or information leaflets that are sent to the school to inform them of what sort of work EPs can do.

Finally, the study highlighted the barrier of time for EPs and that although many of the EPs would like to work in a more in-depth, ongoing way, this is not always possible. This was also discussed by the SENCos/ALNCos as a reason that they would not always consider referring OCD* cases to EPs. The SENCos/ALNCos spoke about potential ways forward to overcome the barrier of time such as EP drop-in sessions for staff or SENCo/ALNCo supervision from the EP. It was discussed that instead of a lengthy referral for individual cases, the EPs could provide support by discussing general issues like OCD anonymously with school staff. It was also considered that working virtually could also save time and will hopefully increase the likelihood for multi-disciplinary team meetings to happen. Consequently, the study suggested that EPs could have a role supporting SENCos/ALNCos directly as well as working therapeutically with the CYP.

Overall, the current study has highlighted the potential value for EPs to have a role in supporting CYP with OCD through collaborative approaches and developing the understanding of others. However, it also highlighted the need for EPs to develop a further understanding of OCD as a profession and find ways to overcome time constraints to create more opportunities to support these CYP and the schools.

5.7 Strengths and limitations

Some of the strengths and limitations of the current study are summarised in Table 22. A more comprehensive discussion can be found in part C.

Table 22

Strengths and limitations of the current study

Strengths	Limitations
The sample of participants was from English and Welsh LAs, which means a broader UK context was gathered.	The sample was only taken from three LAs, which limits the wider generalisability.
All the participants had experience with at least one CYP with OCD*, which enabled them to answer and expand on all of the interview questions.	The study only interviewed SENCos/ALNCos and no other school staff. Some of the SENCos/ALNCOs mentioned that cases may not always be known to them, so other staff members such as ELSAs may be appropriate to interview to get a wider view of different school staff who may support CYP with OCD*.
Using semi-structured interviews allowed an in-depth discussion to gather the views of the participants. Some participants commented that holding the interviews online encouraged them to take part as they perceived it as taking less time and effort than a face-to-face interview.	Using virtual interviews limited the interviewer's ability to respond to participants throughout the conversation as an overlap in sound can stop the participant being picked up on the video recording. Also, quality of broadband connections can limit how clear nonverbal cues such as nods or smiles are for the participant to see.
The sample was appropriate for a small-medium research project (Braun &	The researcher was less experienced at conducting interviews and thematic

Clarke, 2013), which increases the trustworthiness of the research.	analysis, as they were a first-time doctoral researcher.

6.0 Conclusions

The current study explored the role of the EP working with schools to support CYP with OCD*. The study investigated how EPs were currently practicing, how they would ideally like to work with these CYP and how secondary school SENCos/ ALNCos would like to be supported by EPs when working with these CYP. The study also explored potential facilitators and barriers to EP and school practice with CYP with OCD*. The main themes that emerged from both groups included “importance of joined up working” “school environment” and “developing an understanding of OCD”. The main themes of “gap in support” and “EP skills” also emerged from the EP analysis and the main themes of “access to external services” and “understanding the EP role” also emerged from the SENCo/ALNCo analysis. Both the EPs and the SENCos/ALNCos saw a role for the EP in supporting schools with CYP with OCD* through developing the understanding of others, working in a holistic, evidence-based way, and facilitating collaborative approaches with the school, family and health services. However, it also highlighted the need for EPs to develop a further understanding of OCD as a profession and to find ways to overcome barriers such as time limitations to create more opportunities to support these CYP and the schools. Furthermore, the study discussed the importance in collaboration between the different systems that interact to support CYP with OCD*, including the home, school and external services like the EPS or MH services. The study also highlighted that there are potential barriers in communication and access between the school microsystem and MH services in the exosystem (Bronfenbrenner & Ceci, 1994) and that the EP could have a role in making these boundaries more permeable.

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Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

Part C: Critical Appraisal

Word count: 6561

1.0 Overview

The critical appraisal will provide an evaluation of the current study and will give a reflexive account of the research process and the decisions that were made. The appraisal will discuss the rationale behind the research topic and the structure of the literature review. Then a critical account of the development of the research practitioner will be discussed which will include the development of the research paradigm, the research design, ethical considerations that were taken, decisions about participants and the data analysis process. Finally, the contribution to knowledge and the dissemination of the research will be considered alongside opportunities for further research. The limitations of the research will be considered throughout, as well as the rationale behind the decisions that were made, to give an opportunity to evaluate the trustworthiness of the research.

The appraisal will be written in the first person to ensure that it is a reflective and reflexive account of the process and that as the researcher I remain actively involved in the development of the research (Pellegrini, 2009).

2.0 Rationale

2.1 Developing the research topic

Mental health (MH) has always been a topic of interest of mine, and I found that during my experience as a Trainee Educational Psychologist (TEP) I was becoming involved in quite a few MH cases. It also appeared that Educational Psychologists (EPs) in the services that I worked for were becoming increasingly involved in MH and that this supported literature that highlighted that EPs have more of a role in MH (Elms, 2020; Greig et al., 2019; Price, 2017; Zafeiriou & Gulliford, 2020). There is also legislation in both England and Wales that aims to help schools support MH and wellbeing (DfE & DoH, 2017; Welsh Government, 2020). Therefore, I felt that MH was an important topic to be explored.

The idea of studying Obsessive-Compulsive Disorder (OCD) resulted from two cases I had in my second fieldwork placement. I became involved in two separate cases where the primary need was OCD, and the schools I worked with wanted help and advice supporting these children and young people (CYP). Although there is a drive for more MH and wellbeing support in schools, there still appears to be limited information on how to support specific MH difficulties such as OCD in an educational setting. During my supervision for these cases, I reflected that there did not appear to be clear guidance for EPs working with OCD when I did some initial searches. I therefore wanted to explore further how other EPs were working when they received referrals to support CYP with OCD.

2.2 Developing the rationale and research questions

In order to develop my rationale and research questions, I conducted a literature review. The original question that I wanted to answer in my literature review was “how are EPs supporting CYP with OCD?” as I wanted to gain a picture of what the literature was saying about EP practice in this area and if there was much available. I hoped this would then guide the direction of my research and help determine any gaps that I

could explore. To determine whether a systematic or narrative literature review structure would be appropriate, I used the preferred reporting items for systematic reviews and meta-analysis (PRISMA) model (see Appendix 2). However, it became apparent from my searches that there was very limited research into the role of the EP, even when I included studies that used the term School Psychologist (SP). I therefore made the decision to use a narrative review structure (Siddaway et al., 2019) as I became aware that I needed to broaden out my search to include health as well as education to gain a wider sense of how pupils with OCD were being supported. Narrative reviews are discussed as being appropriate to provide a historical account of the development of research on a topic (Siddaway et al., 2019). Due to the limited research into the EP or SP role with OCD, I felt it was needed to provide a broader historical account of OCD in relation to CYP and that the narrative structure allowed me to appraise the literature effectively. Furthermore, the original four papers that came out of the search were a mixture of two position papers and two mixed methods designs. As a narrative review structure is argued to be useful in linking together studies that have used diverse methodologies (Siddaway et al, 2019), I felt that this was the appropriate way to structure my literature review.

Narrative reviews have been argued to be subject to bias from the researcher in selecting research (Siddaway et al., 2019). Therefore, in order to reduce this bias, I used specific search terms and inclusion/exclusion criteria (see Appendix 1). In order to ensure I did not miss relevant papers that were not discovered in the databases, I also read grey literature such as government legislation, used reference chaining and searched relevant websites and journals. These techniques are suggested in order to identify relevant information that can be missed from initial systematic searches (Dixon-Woods et al., 2006).

My literature review identified an obvious gap in the research, and I felt that my original question “how are EPs supporting CYP with OCD?” needed to be addressed further in my research. This helped form my first research question “how do EPs describe their current practice with working with CYP with OCD?” as I felt I needed to gain a picture of how EPs in the UK were working as previous research and advice had focused on SPs. For my second question I wanted to explore a solution-focused

approach and ask, “how would EPs ideally like to work in schools to support CYP with OCD?” Whilst on placement, I often found that EPs may not always be working in the way they would ideally like due to different structures and commitments. I felt that it would be important to determine whether there are further ways they would like to work in addition to what they were able to do.

In addition to the EP views, I also felt that it was important to explore how the schools themselves would like to be supported by the EP as school staff views also appeared underrepresented in previous literature. EPs often liaise with the Special Educational Needs Coordinator (SENCo) in England or the Additional Learning Needs Coordinator (ALNCo) in Wales (AEP, 2016) and they can be in a situation where they negotiate with the EP what work will be undertaken with these CYP (Lee & Woods, 2017). Therefore, I felt that SENCo/ALNCo views were important to explore, to determine what sort of support they wanted from EPs if they came across CYP with OCD in their school setting. This therefore formed my third question: “how would SENCos/ALNCos like to be supported by the EP when working with CYP with OCD?” Finally, I decided that it was necessary to explore some of the facilitators and barriers that EPs and school staff had to supporting these CYP with OCD, which formed my last research question, “what are the facilitators and barriers to support in schools for CYP with OCD?” The answers to these questions should start to fill the gap in the current literature around how EPs support CYP with OCD.

3.0 Critical account of development of the research practitioner

3.1 Development of research paradigm

The research paradigm represents a set of basic beliefs that define a world view held by the researcher (Guba & Lincoln, 1994). Therefore, it was important that I considered my epistemological and ontological position before I started my research. My previous experience with research before the doctorate took a positivist stance and used quantitative designs. A positivist stance assumes that there is a straightforward relationship between the world and our perception of it (Braun & Clarke, 2013) and my previous research looked for a cause and effect, assuming that this reflected the truth.

However, during my time on the doctorate, I have been exposed to a more constructionist way of thinking, particularly whilst working with the Constructionist Model of Informed Reasoned Action (COMOIRA) (Gameson & Rhydderch, 2008). Social constructionism (Burr, 2015) is at the centre of the COMOIRA framework, and it was one of the positions that I considered for my research. Social constructionism stipulates that "as a culture or society we construct our own versions of reality between us" (Burr, 2015, p. 9). Constructionist paradigms argue that what we consider to be the truth is constructed through our own views and experiences (Braun & Clarke, 2013).

However, once I decided on my research topic looking into OCD, I was aware that when working with a diagnosable MH condition there is a reality whereby CYP are getting diagnoses of OCD and that OCD is often treated according to the diagnostic label (Nice, 2005). Therefore, although the subject of diagnostic labels has been contended (Johnstone, 2018; Timini, 2014), there is a considered realist element to this subject. A critical realist ontological paradigm is described as a "theoretical approach that assumes an ultimate reality but claims that the way reality is experienced and interpreted is shaped by culture, language and political interests" (Braun & Clarke, 2013, p. 329). I felt that this paradigm was therefore a better fit for

my research than using social constructionism as it acknowledges that there is reality to how EPs and schools support CYP with OCD, however this reality is influenced by the experiences of the professionals.

I wanted to consider both the views of EPs and SENCos/ALNCos following my literature review and I was aware that these two groups of professionals would be working in different contexts depending on the school, country and Local Authority (LA) that they were in. Contextualist epistemologies argue that knowledge and meaning emerges from the context in which it has been produced (Braun & Clarke, 2013). Contextualism argues that whilst no single method can get to the truth, knowledge will still be true in certain contexts (Tebes, 2005). As this epistemological stance still retains the notion of a truth, I argue there is a fit for this to work alongside the critical realism ontology. The participants that were interviewed in this research will have developed their understanding of OCD from the different contexts in which they have had experience with OCD.

In summary, my critical realist ontological paradigm and my contextualist epistemological lens recognises that there is a reality to how EPs and SENCos/ALNCos support CYP with OCD and that there is a recognition that the data collected in this study reflects the participants' own individual experience based on the contexts where this knowledge has been developed. This therefore shapes the reality that the participants will reflect in their interviews (Fletcher, 2017).

3.2 Design

The research questions that I decided on were explorative in nature and I was interested in the views and experiences of the EPs and the SENCos/ALNCos. Qualitative designs are considered an appropriate method when a study is interested in exploring the views and experiences of participants (Robson & McCartan, 2016). Qualitative designs also recognise that researchers bring their own subjectivity into the research process (Robson & McCartan, 2016), which fits into my critical realist ontological position that recognises that reality is shaped by the experience of others (Fletcher,

2017). Therefore, following the ontological stance taken and the explorative nature of the research questions, I decided to use a qualitative design.

3.2.1 Interviews

Semi-structured interviews are described as being suited to exploring the understanding and perceptions of a topic in rich detail (Braun & Clarke, 2013). Semi-structured interviews were chosen for this research as I wanted to gather a rich picture of how EPs were working with CYP with OCD and the opportunity to explore further how they would like to ideally work with these CYP. I also wanted to explore in detail what support SENCos/ALNCos would like with CYP with OCD and what both EPs and SENCos/ALNCos considered to be facilitators and barriers to support in schools. Using a semi-structured interview schedule allowed me to be flexible and respond to what the participants were saying and gave me the ability to probe a bit deeper if participants did not respond with much detail (Braun & Clarke, 2013).

One of my choices when I was planning my research was whether to also create a structured questionnaire or survey to get a wider scope of how EPs were practicing around the UK. One of the considered limitations to my research was a potential lack of breadth by interviewing 12 participants. Including a wider questionnaire may have helped achieve this breadth. However, it was decided that with the size of my study, I felt interviewing SENCos/ALNCos and getting that school perspective was more important as this had not been represented in previous research. Also, previous research with SPs used a structured questionnaire format and I felt that this limited the responses of the SPs and that a more in-depth look at their experiences could have been obtained (Adams et al., 2007; Gallant et al., 2007). Furthermore, my epistemological position of contextualism formed my decision to ensure that I explored both the Educational Psychology Service (EPS) and the school context in detail.

Another consideration for my research design was whether to use focus groups or semi-structured interviews. One of the early concerns about conducting focus groups was that I wanted participants who had prior experience with OCD, and I was aware

that this may not be something lots of EPs have experience with, so logistically organising focus groups with participants geographically spread out may have been difficult (Braun & Clarke, 2013). I also wanted to explore and probe further what experience EPs and SENCos/ALNCos had, and I felt that in a focus group, the most experienced members may be the most vocal and I would not get the depth that I wanted from each participant and some participants may become overlooked (Braun & Clarke, 2013).

Overall, I felt satisfied that my semi structured interview schedule allowed my data to answer the research questions. However, on reflection I asked about what work the EPS and SENCos/ALNCos had done but I did not enquire in much depth about the CYP themselves and how involved they were in the process. On reflection, I believe that my themes may have been more child focused if this was the case. Future research in this area could explore this further and unpick in more detail.

3.2.2 Working virtually

After deciding to conduct my research using face-to-face semi-structured interviews, the COVID-19 pandemic happened, and I had to adapt my research to accommodate social distancing measures and lockdown procedures. Previously, the concept of virtual interviews was considered a poor alternative to face-to-face (Braun & Clarke, 2013), however the development of video call technology and the new normal of working online has meant that conducting interviews over video call has become an accepted method (Archibald et al., 2019; Gray et al., 2020). In order to explore whether my interview questions were accessible online, I conducted a pilot interview with a TEP to see if the technology worked and if the questions felt comfortable over zoom. The feedback was positive, and the participant felt that the technology was easily accessible and that they felt comfortable with the process.

Some of the participants in my main study also mentioned that knowing it would be over Zoom encouraged them to take part as they felt it was less time consuming and that it was easier to fit in around other commitments. This is considered one of the main advantages of using virtual interviews in research (Archibald et al., 2019; Gray et

al., 2020). I also believe that it helped me reach out to a LA that was a lot further for me geographically, which is considered another advantage of working virtually (Archibald et al., 2019; Gray et al., 2020).

One of the difficulties I faced when working virtually, was the quality of internet connection that the participants had. At times, when the connection was poorer, the sound quality was affected, which consequently made the transcription process difficult at times. These difficulties mirrored experiences in previous zoom studies (Archibald et al., 2019; Gray et al., 2020). Another difficulty I found was that the accessibility of the virtual interviews meant that many participants were at home for the interviews. Therefore a number of distractions such as doorbells going and children walking in meant that participants were distracted at times, which would normally be avoided in a face-to-face interview in a chosen location (Archibald et al., 2019).

3.3 Ethical considerations

As a TEP and a researcher, I have ensured that I follow the British Psychological Society (BPS) code of ethics throughout all aspects of my practice whilst on placement and conducting my own research (BPS, 2018). Table 10 in Part B gave an overview of how I managed the ethical considerations of consent, confidentiality, anonymity, right to refuse questions, right to withdraw, do no harm, and debriefing the participants. As I had to change and adapt my research to work online and during a time that added extra stress on my potential participants, it was important that I ensured my research could still be conducted in an ethical manner (BPS, 2020). In their guidance "Conducting research with human participants during COVID-19", the BPS (2020) state that the four primary ethical principles of research still needed to be adhered to: respect; scientific integrity; social responsibility; and maximising benefit and minimising harm.

3.3.1 Respect

Whilst I was conducting my research, I had to be mindful of the additional stress and pressures that both the EPs and SENCos/ALNCos may be experiencing in both a personal and professional capacity. Therefore, I ensured that the information letters and consent forms were clear in what was expected from them. I also arranged interviews at times that suited the participants, so they did not feel pressure to rearrange other commitments.

3.3.2 Scientific integrity

In line with the BPS (2020) stance on integrity, I resubmitted a proposal to the Ethics Committee that outlined my change to virtual interviews, and this was accepted before I proceeded. It was also important to consider the environmental conditions under which the participants were responding. For example, some participants were at home and had competing distractions. The pause function on Zoom helped with this as participants knew they could pause the interviews when they needed to. The ability to pause interviews was also considered a benefit of using Zoom in previous studies (Archibald et al., 2019).

3.3.3 Social responsibility

Zoom enabled me to store the recordings directly on my local device which is password and fingerprint ID protected, rather than storing the data on a cloud, which ensured that the recordings were as protected as an audio recording device face-to-face (Archibald et al., 2019). Prior conversations were had with participants via email to discuss whether the participants had access to Zoom or whether an alternative platform such as Microsoft Teams needed to be used. This happened on one occasion and the data was stored in the same way.

3.3.4 Maximising benefit and minimising harm

The current study focused on the participants' experiences with OCD in a professional capacity and did not seek to explore any personal experiences with OCD or MH, hence intending that participants were not exposed to greater harm than experienced in ordinary life (BPS, 2020). However, it was important to acknowledge in a particularly stressful time, MH may be more prominent for some participants. Therefore, participants were given the contact details of the researcher in the debrief form to contact to be signposted to further support if necessary.

3.5 Participants

When I first decided to explore OCD as a topic, I considered who I wanted as my participant groups to explore how CYP with OCD were being supported in school settings. As the role of the EP had not been explored in a UK setting before, I felt that this was an important avenue to explore and that I wanted the views of practicing EPs in the UK. However, I was conflicted over whether to also include the views of school staff, parents and the CYP themselves. All of these people are mentioned in the literature as key parts of the collaborative process to support CYP with OCD (Sulkowski et al., 2018). Previous literature has suggested that OCD can be extremely difficult for both the CYP and their families (Halldorsson et al., 2016). I was aware that asking questions may potentially be triggering and I did not wish to potentially cause harm to my participants (BPS, 2020). Furthermore, with the move to virtual interviews, this would have been even harder to manage (BPS, 2020).

Whilst looking at the literature into the school setting, there were studies that looked at how having OCD affected a CYP's experience at school and there were advice papers out there for school staff (Leininger et al., 2010) but there was limited literature that investigated the views or experiences of school staff. As this appeared to be the first study to explore the EP role in the UK with OCD, I felt it important to include the views of school staff as well to see what support they would actually like to receive.

3.5.1 Inclusion and exclusion criteria

The decision was made to recruit EPs and SENCos/ALNCos who had experience with at least one case of OCD as I felt they would struggle to answer some of my questions if they had not had this experience. Although I specified that the reason for involvement had to be around the OCD needs, I considered that the CYP did not need to have had an official diagnosis of OCD and that I would also include cases where the CYP had been referred for further exploration of OCD traits on the respective pathways in their LA. I felt that due to the difficulties and time that it can take to access a diagnostic pathway (Crenna-Jennings & Hutchinson, 2020), the EP may be involved earlier in the process and that how they worked with these children was important to explore regardless of a diagnostic label (Johnstone et al., 2018). Furthermore, a number of participants spoke about the difficulty of unpicking behaviours and referral processes when there appeared to be a comorbid need, which I believe was important to highlight.

I chose to recruit SENCos/ALNCos to gain the perspective of school staff as they are usually the link professional for the EP (AEP, 2016). Although the views and experiences of the SENCos/ALNCos were valuable, some of them mentioned that there may be lots of OCD cases that do not reach them in the secondary school and that other members of staff such as heads of year or ELSAs may have more experience and knowledge of these cases in the school. Future research may want to look at the perspectives of other school staff, especially those who work with these CYP daily. I also made the decision to recruit SENCos/ALNCos from secondary schools as the age of onset tends to be during secondary school age (Heyman et al., 2003). However, some of the EPs mentioned that some of their cases also had started in primary school, so this may be something that needs to be explored further in the future.

3.5.2 Generalisability

As I did not look at my research in regard to particular legislation, and I wanted to gain a picture over both England and Wales, I recruited participants from three different LAs: two in England and one in Wales. As this was the first study to my knowledge that

looked at EP practice with OCD in the UK, I wanted to create a broader insight to the UK context and not limit myself to one LA. Due to my research design, I have a small cross-sectional sample of 12 participants, which may be considered to have limited generalisability. It would be interesting for future research to explore more LAs within the UK to explore EP practice with OCD further.

I also did not fully consider the potential impact of recruiting from both traded and non-traded services. On reflection, the way that the EPs have worked with the schools and the way the SENCos/ALNCos use EP time may have been influenced by the EPS traded or allocation model (Lee & Woods, 2017; Marsh & Higgins, 2018). Although the participants' responses appeared to be in line regardless of the LA, future directions for research may want to investigate the difference between traded and nontraded services and how MH support is provided in these circumstances.

3.6 Data analysis

I chose to use thematic analysis (TA) to analyse my data as this analysis fits in with my ontological position of critical realism (Braun & Clarke, 2013; Fletcher, 2017). TA also acknowledges that social context influences the way participants make sense of experiences (Braun & Clarke, 2013; 2020) which fits with my epistemological position. Another analysis that I considered originally was interpretive phenomenological analysis (IPA), which focuses on how people make sense of their lived experience (Braun & Clarke, 2013). I considered the potential of using an IPA approach with EPs to look more in depth at how they made sense of their experiences working with OCD. However, once I decided to look at two groups and formed my ontological and epistemological perspective, I felt that IPA would not fit with my research. I could not guarantee that the participants would have had similar enough experiences to do an IPA justice (Braun & Clarke, 2013) and I wanted to recruit participants from a range of LAs and both in England and Wales to get a wider scope of experience. As well as TA being the most appropriate method based on my research paradigm and research design, I also felt the most confident using TA compared to other methods such as IPA as I had previously used TA on the doctorate with smaller scale research.

I decided to undertake a reflexive TA as this is considered to be suited to critical realist and contextualist positions (Braun & Clarke, 2020). Reflexive TA aims to generate an analysis from the data up that is not shaped by existing theory (Braun & Clarke, 2020). As there was very limited research that has looked at the role of the EP with OCD, I felt that it was important to use an inductive approach as this was the first research to my knowledge in the UK that explored this topic. Therefore, I did not approach my data with a preconceived theoretical perspective that is needed for a deductive or theoretical TA approach (Braun & Clarke, 2006). I conducted a separate TA for the EPs and the SENCos/ALNCos as this allowed me to become fully immersed with each participant group. I wanted to explore the perspectives from each role, which supports my contextualist epistemology that acknowledges that each group will be influenced by the contexts they work in such as their job role (Braun & Clarke, 2013). This in turn allowed me to compare the themes from each group.

I enjoyed the data analysis process as it was the stage that I started to establish my findings and I could see interesting themes and potential implications emerging from my data. However, as I did choose a reflexive approach, I found it difficult at times to remain fully data driven and avoid looking at my data through my research questions. Braun and Clarke (2020) highlight that a common mistake made whilst conducting TA is to simply use the questions posed to the participants as themes. Therefore, I was very mindful of this whilst I conducted my analysis, and this was something that I regularly reflected on during supervision. Reviewing the data set during stage four became very important during this process (Braun & Clarke, 2013) and I found it important to revise my codes and themes and accept that the process is recursive (Braun & Clarke, 2013).

The current study was a solo thesis project, and I was the only researcher involved. TA acknowledges that the analysis is always shaped to an extent by the researcher's standpoint, disciplinary knowledge and epistemology (Braun & Clarke, 2013). The process of TA is subjective and one's subjectivity cannot be necessarily considered to be correct and another's incorrect (Braun & Clarke, 2013; 2020). Braun and Clarke (2020) argue that reflexive TA embraces the subjective skills the researcher bring to the process and that a research team is not required or desirable for the quality of the

study. Reflexive TA is an interpretative process (Braun & Clarke, 2020) and I therefore did not use a second researcher to check my themes to see if they could be considered correct or incorrect. I did, however, use supervision as an opportunity to reflect on my coding and discuss any assumptions I had made or anything that may have been overlooked.

3.7 Reflection on the process

The overall process of developing my thesis research was both challenging and rewarding. As discussed, my previous experience prior to the doctorate had been using quantitative designs and I was new to qualitative research when I started the course. I felt that having opportunities to do smaller research projects earlier on in the course helped as I had been able to explore different research designs and methods and I was familiar with the research ethics procedures. Although starting a thesis felt daunting, I felt more confident in the research process than when I had started on the course. I acknowledge that this has been the biggest research project I have done and that it has been a learning process. Therefore, for the process to keep a sense of coherence and trustworthiness (Yardley, 2008), regular supervision was taken throughout to ensure that I remained reflexive about the process.

The most rewarding aspect of the process was producing my themes and then further looking into how this research contributed to EP practice, which I will go on to discuss further below.

4.0 Contribution to knowledge and dissemination

4.1 Contribution to knowledge

Throughout the research process, it became apparent that the topic explored in the current study was under-researched. At the time the literature review was conducted, there were no studies to my knowledge that investigated the EP role in supporting CYP with OCD in the UK and there was very limited research that explored the staff perspective into how they would like to be supported with these CYP with OCD. Therefore, the research questions addressed several gaps including how EPs are currently practicing, how EPs would like to practice, how SENCos/ALNCos would like to be supported and the facilitators and barriers to the support. It is hoped that the findings from this research will provide an increased understanding of how EPs can support schools with CYP with OCD.

4.1.1 Contribution to previous literature

The study has identified a UK context for practicing EPs working with OCD that was needed in a literature base that was previously limited to SP research in America (Adams et al., 2007; Adams et al., 1994; Gallant et al., 2007; Sloman et al., 2007). The current study supported previous literature that highlighted the importance of collaboration between schools, SPs, health services, parents and CYP (Sulkowski et al., 2018) and demonstrated that this is just as important in a UK context.

As well as adding a UK context to the literature base, the current study explored the views of the EPs in more depth than the previous research with SPs (Adams et al., 2007; Gallant et al., 2007). The previous studies that looked at the SP role used questionnaires and although there was a breadth of responses, I found that the responses themselves lacked the depth that the current study sought to secure. I believe that the responses from the participants in this study enabled the research questions to be considered in detail and that this was not limited to predetermined options from the researcher.

Furthermore, the current study explored the views of SENCos/ALNCos, which appeared to be underrepresented in the previous literature. The views of these participants gave an insight into the school context that has not been explored from the staff perspective before. Previous papers have offered advice and support models within school settings (Chaturvedi et al., 2014; Leininger et al., 2010) but did not consider whether these strategies were considered useful by the school staff themselves.

The current study also highlighted the need to acknowledge the importance of different systems around the CYP and how they interact. It was discussed how there are barriers between the systems identified as important for collaboration and the study used the Bronfenbrenner bioecological systems model to consider the boundaries between the school and family microsystems and the health services in the exosystem (Bronfenbrenner & Ceci, 1994). The study also highlighted the importance of the mesosystem (Bronfenbrenner & Ceci, 1994) and how the interactions within the mesosystem are key in establishing the right support for the CYP.

4.1.2 Contribution to practice

4.1.2.1 EP Practice

The study highlighted that EPs do currently have a role in supporting CYP with OCD with both the EPs and the SENCos/ALNCos discussing that they believe the EP has a valuable part to play and that there has been positive involvement experienced from both an EP and a school perspective. This was discussed in both English and Welsh LAs and from traded and non-traded services. The support that was offered by EPs included consultations, training, psychoeducation, statutory guidance, gathering the CYP's views and working collaboratively and holistically.

It is also important to consider how this research will contribute to my own practice as an EP. I originally developed my idea for this research topic whilst working on some OCD cases in my second-year placement and I sought to explore more about the EP

role in this area. I have enjoyed the process of learning what sort of work other EPs have done in this area and have reflected on how I can use the evidence-based practice described in this study in my own casework. I also found it helpful to consider the SENCo/ALNCo perspective and the sort of support they would like, and I will use this to shape my offer in the future to schools that I will be working with. Furthermore, I have developed my understanding about the different systems involved that contribute to the CYP's life. I found the Bronfenbrenner model (Bronfenbrenner & Ceci, 1994) particularly helpful to visualise these and understand the complexities in securing the collaboration that is described in both previous literature (Sulkowski et al., 2018) and in this current study as being important to ensure these CYP have the best outcomes. This increased understanding about the systems and the barriers to communication will hopefully shape my future practice and it has inspired me to ensure I aim for as much collaboration as possible in my casework.

4.1.2.2 School practitioners

Whilst specific implications for EP practice were considered in part B, I also reflected on how this study had implications for school staff and other professionals such as CAMHS who support these CYP. The current research also highlighted that the referral process to external services has implications for school practice in supporting CYP with OCD. The SENCos/ALNCos discussed that referral thresholds, a lack of communication from external services and their own lack of knowledge around where to refer to can be a barrier to supporting CYP with OCD. It is important to acknowledge that many schools may be having this difficulty and that there is scope for referral processes to be made more accessible. It was suggested that if SENCos/ALNCos had a directory of the services available in their LA that gave them a clear overview of when and how to refer to these services it would help make the referral process more accessible and easier to understand. Again, this further supports research that has reported that LAs across England have struggled to refer into CAMHS (Crenna-Jennings & Hutchinson, 2020).

Another implication for school practitioners to consider is that the EP does have a role with these cases and that EPs are not just to be considered for learning cases. The current research highlighted that some of the SENCos/ALNCos considered the EP role

as working with learning cases and saw MH cases as the responsibility of health professionals such as CAMHS workers. It is hoped that school practitioners can see the role for an EP with these cases and that they can support the school by working with individual consultation, work with the CYP, or supervision for staff. They can also provide systemic support in the form of training for school staff. Both the SENCos/ALNCos and the EPs in this study highlighted that training was considered a barrier to good practice.

Finally, it is important for school practitioners to seek opportunities for collaboration with the parents, the CYP themselves, the EP and any other professionals involved. The school may be the link setting where meetings can be organised, and information passed on. The current study highlighted that when there is effective collaboration, this facilitated good practice to support these CYP.

4.2 Dissemination

Disseminating the findings from this study and promoting opportunities for further research in this area may help to build overall EP understanding around how they can support CYP with OCD in schools. A way to do this would be by publishing my findings in an EP related journal in the hope that EPs will read it and realise that there is lots of potential scope for the profession to support CYP with OCD.

Both the EPs and SENCos/ALNCos highlighted the need for more knowledge and understanding around OCD in order to successfully support the CYP. One way that was suggested to develop this knowledge was for EPs and school staff to attend training on OCD. Both groups of participants also saw the role for the EP delivering training. As a consequence of doing my thesis, I have developed my own introduction to OCD training for school staff and delivered it to schools during my second year and third year placements (see Appendix 13). Also, two of the SENCos/ALNCos in the current study asked for training after their participant interviews. I received positive feedback from staff on the evaluation forms that I provided, and the feedback was that they felt that they would be more confident if they worked with a CYP with OCD. I believe that delivering training to schools is a good step to disseminating some of what I have

discovered from developing my thesis. Further research could be done into the training that I have developed to officially scale the understanding of the staff before and after the training. As well as developing training for schools, I am in the process of creating introduction to OCD training for EPs. My hope is to present this in the current EPS am on placement with as part of one of the EPS training development days and submit to future conferences. Again, it would be useful to officially evaluate this and research how effective it is.

4.3 Future research opportunities

Previous literature has described that in order to successfully support CYP with OCD at school, collaboration between school staff, parents and outside professionals involved is key (Sulkowski et al., 2018). Both the EPs and the SENCos/ALNCos in this study highlighted the importance of collaboration and mentioned the need for more joined up working with professionals such as CAMHS. Therefore, there is scope to develop further research that explores the views of CAMHS professionals. As collaboration is considered an important aspect to support, it would be interesting to gather the views CAMHS professionals and see what they consider to be the facilitators and barriers to support, and whether they have worked with EPs or consider the EP to have a role supporting CYP with OCD.

The participants also spoke about the importance of keeping the CYP at the centre of this process. Another way that this area could be researched further is by exploring the views of CYP with OCD in UK schools, their experiences and what they perceive as helpful or not so helpful support or intervention within schools. This could help to add to the picture of how to support these CYP whilst keeping them at the centre of the process.

Furthermore, the participants discussed the importance of involving the parents and how they felt it was vital to hear about the home experiences and work with the parents to create joint outcomes for the CYP at school. Further research could gather the views of parents and see what they consider to be the facilitators and barriers to support for their CYP in school settings.

5.0 Conclusion

In summary, the critical appraisal allowed me to analyse the process of my research and consider and reflect on the decisions that I made. I have discussed how my ontological and epistemological position influenced my decisions and I have discussed potential strengths and limitations of my research and how each decision impacted the outcomes of my research and my own knowledge as a researcher throughout the process. It was discussed that the current study added to the literature base by providing a UK context and an exploration into EP and SENCo/ALNCo views on supporting CYP with OCD. There is potential for the research to be disseminated by publishing or creating training opportunities for schools and EPs. It is hoped that this research will have created more opportunities for further research in this area, so more is known about supporting CYP with OCD in UK schools.

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Appendices

Appendix 1: Search terms for the literature review

The literature searches were conducted between July 2020 and November 2020. The table below shows the search terms used as a subject heading or a keyword. The titles and abstracts were then examined based on relevance to the study, so not all of the database returns were included. Duplicates were also removed using Endnote software. The three search categories were Educational Psychologists, Obsessive-Compulsive Disorder, and schools. The asterisk (*) was used in some of the searches to broaden the search on some of the words e.g. neuros*, neurosis. The following search terms were used “Educational Psychologist*”, “Educational Psychology”, “School Psychologist*”, “School Psychology”, “school*”, “educational setting”, “secondary school*”, “high school*”, “Obsessive Compulsive Disorder*”, “OCD”, “Compulsive neuros*”.

The following databases were chosen due to their access to psychology and education literature.

Database	Search terms	Results
Applied Social Sciences Index & Abstracts (ASSIA)	("obsessive compulsive disorder*" OR ocd OR "Compulsive neuros*" OR obsessive n/2 neuros*) AND ((school n/2 psycholog*) OR (education* n/2 psycholog*))	758
Scopus	((TITLE-ABS-KEY (school W/2 psycholog*)) OR (TITLE-ABS-KEY (education* W/2 psycholog*))) AND ((TITLE-ABS-KEY ("obsessive compulsive disorder*")) OR (TITLE-ABS-KEY (ocd)) OR (TITLE-ABS-KEY ("Compulsive neuros*")) OR (TITLE-ABS-KEY (obsessive W/2 neuros*)))	29

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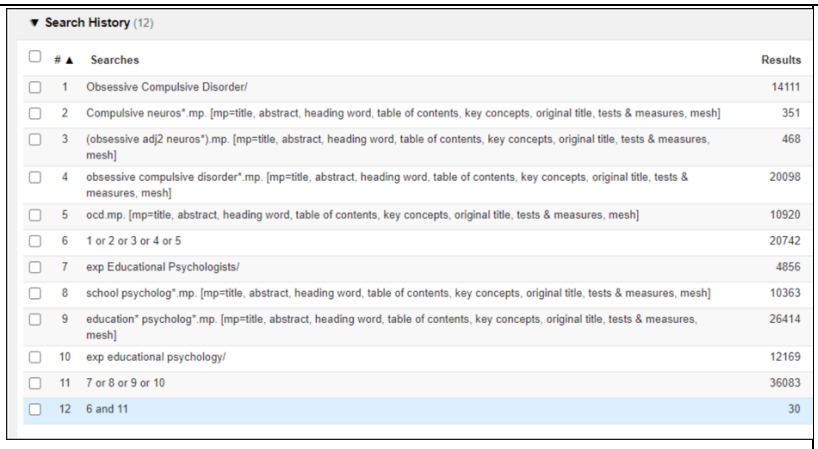
2020</td><td> 
</td><td>30</td></tr>
<tr><td>British
Education
Index
(BEI)
1952-
2020</td><td>("obsessive compulsive disorder*" OR ocd OR "Compulsive neuros*" OR obsessive n/2 neuros*) AND ((school n/2 psycholog*) OR (education* n/2 psycholog*))</td><td>14</td></tr>
</table>

In addition to the data base searches, general searches for grey literature were done using Google Scholar and the Cardiff Library book search. Other appropriate references were identified using the snowballing technique through references in the existing search papers and Google Scholar. Internet searches into relevant English and Welsh legislations and mental health and OCD charity websites were also conducted. Relevant journals such as 'Educational Psychology in Practice' and 'Journal of Obsessive-Compulsive and Related Disorders' were also explored for relevant articles.

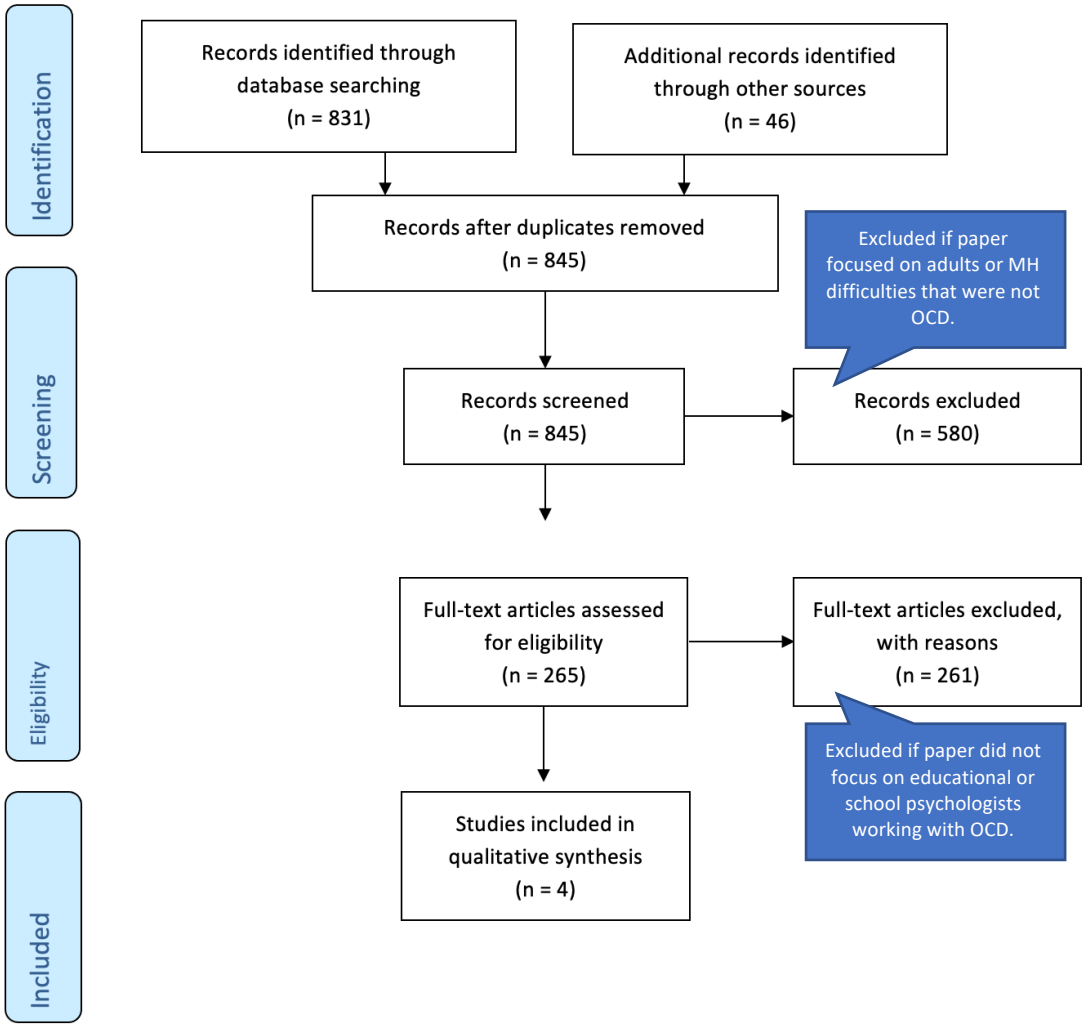
Inclusion/exclusion criteria

Papers that related to CYP with OCD, OCD in the school setting, and educational or school psychologists working with OCD were included. Papers from health as well as education were included to provide a wider context. As OCD is comorbid with other MH difficulties (van Oudheusden et al., 2020[1]) then studies on comorbidity were included. Recent research was used where possible however as there was limited

[1] van Oudheusden, L. J., van de Schoot, R., Hoogendoorn, A., van Oppen, P., Kaarsemaker, M., Meynen, G., & van Balkom, A. J. (2020). Classification of comorbidity in obsessive–compulsive disorder: A latent class analysis. *Brain and Behavior*, *10*(7), *e01641*. https://doi.org/10.1002/brb3.1641

research found, pre-2010 studies were included. Furthermore, due to limited research in this area conducted in the UK, research from other countries were included. Studies were excluded if they looked at adults with OCD or they were based on a different MH difficulty that was not OCD.

Appendix 2: PRISMA diagram



Appendix 3: Interview schedule for semi structured interviews

(Questions are subject to amendments as a result of responses, however any changes will not feature any sensitive information. It is likely that follow up questions will be added rather than alterations to the core questions.)

Key
Core questions
Potential follow up questions

Educational Psychologists:

Prior to starting, participants will be reminded about the aim of the study and their right to withdraw.

1. First of all I would like to hear more about the work you have done with children and young people with OCD. Can you please tell me about some of your cases?

How did the children and young people present with OCD at school?

How did it affect their day-to-day lives at school?

2. Can you please tell me about what went well with this/these case/cases?

What helped facilitate this?

3. What other services are there in your local authority for supporting children and young people with OCD?

How do you think the services available (or limited amount of services) in your local authority affect your role with working with children and young people with OCD?

Do you engage in multi-agency work in relation to children and young people with OCD?

4. What sort of support have schools requested from you to help them with OCD cases?

Does this tend to be whole school, group or individual?

Are the schools happy with the level of support you can offer?

How would you consider your role to be similar or different to another professional, such as a Clinical Psychologist or a mental health professional in CAMHS?

5. Can you describe any potential barriers to working with children and young people with OCD?

How do you think these barriers can be overcome?

6. Is there anything you would like to change about your opportunities to work with children and young people with OCD?

How do you think this could change?

Is there a particular way you would like to work with these children?

7. Which psychological theories or frameworks did you use to help with your work?

If they have mentioned any before, refer to these.

8. How did you develop your own experience?

9. Thank you for your discussion, is there anything else you would like to add that we have not discussed?

SENCo/ALNCo

Prior to starting, participants will be reminded about the aim of the study and their right to withdraw.

1. First of all I would like to hear about your experience of working with children and young people with OCD. Can you please tell me about how these children presented at school?

How does it affect their day-to-day lives at school?

2. Are you aware of any services that are available in your local authority to help support children and young people with OCD? If so could you tell me about them?

If you have a pupil with OCD, how do you decide on the appropriate support for them?

How much support do you put in place before referring to a service?

3. What kind of support have you had with children and young people with OCD?

What went well with this support?

Do you consider it the role of the EP to support you with OCD cases?

Do you perceive there to be a cut off point between what is considered to be the role of your EP, and what is considered to be the role of a different professional, such as a Clinical Psychologist or Psychiatrist working for CAMHS?

4. What kind of support would you ideally like to receive to help support these children and young people with OCD?

How could the EP provide support?

How do you think this could be achieved?

5. Are there any potential barriers to receiving support?

How do you think these barriers could be overcome?

6. Thank you for your discussion and time, is there anything else you would like to add that we have not discussed?

Appendix 4: Gatekeeper letter for Principal EPs

School of Psychology, Cardiff University

Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

I would like to request your permission to conduct a study to investigate the role of the Educational Psychologist (EP) when working with schools to support children and young people (CYP) with Obsessive Compulsive Disorder (OCD).

This study would involve scheduling semi-structured interviews with Educational Psychologists in your service that have been involved in at least one case with a child or young person with OCD. The interview will discuss how the EP believes that EPs can support the children and young people with OCD and what support they can offer schools.

I will arrange a location with the EP to meet; this would be face to face at one of the EPS bases within your local authority or via a video call.

Each interview would last for approximately one hour and the discussions would be recorded via a Dictaphone or via a video call that is password protected. The data collected would be kept confidentially before being transcribed and made anonymous, and then kept indefinitely by Cardiff University.

I would require your assistance in distributing the information sheets I have prepared for potential participants, as these contain all the information that participants would need in order to consent to partake. Participation in this study would be entirely voluntary, and they would sign a consent form before any data is collected.

Participants would also have the right to withdraw at any time before the data is anonymised when responses will be made untraceable.

This study has been reviewed and ethically approved by School of Psychology Research Ethics Committee.

Please tick the boxes when you have read and understood the following statements:

I understand this study will involve Educational Psychologists within this service taking part in an interview. I understand that these professionals will be asked questions by the researcher about their views on the EP role working with children and young people with OCD. ☐

I understand that the personal data will be processed in accordance with GDPR regulations (see privacy statement below). ☐

I understand that the data collected will be kept confidentially before being transcribed and made anonymous, and then kept indefinitely by Cardiff University. ☐

I, _____(NAME) consent to the proposed study being conducted by Rebecca Pearce School of Psychology, Cardiff University with the supervision of Dr Dale Bartle.

Signed: _____

Date: _____

If you have any questions or concerns, contacts are listed below.

Rebecca Pearce	Pearcerl3@cardiff.ac.uk
Dr Dale Bartle	BartleD@cardiff.ac.uk
School of Psychology Ethics Committee	psychethics@cardiff.ac.uk

Secretary of the Ethics Committee
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

029 2087 0360

Privacy Notice:

The information provided will be held in compliance with GDPR regulations. Cardiff University is the data controller and Matt Cooper is the data protection officer (inforequest@cardiff.ac.uk). The lawful basis for processing this information is public interest. This information is being collected by Rebecca Pearce.

The information on the consent form will be held securely and separately from the research information. Only the researcher will have access to this form and it will be destroyed after 7 years.

The research information you provide will be used for the purposes of research only and will be stored securely. Only the researcher will have access to this information. After a few months the data will be anonymised (any identifying elements removed) and this anonymous information may be kept indefinitely or published.

Appendix 5: Gatekeeper letter for Head Teachers

School of Psychology, Cardiff University

Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

I would like to request your permission to conduct a study to investigate the role of the Educational Psychologist (EP) when working with secondary schools to support children and young people with Obsessive-Compulsive Disorder (OCD).

This study would involve conducting a semi-structured interview with the SENCo/ALNCo in your school. The interview will discuss how schools would like to be supported by EPs in regards to children and young people with OCD.

I will meet with the SENCo/ALNCo via a video call.

Each interview would last for approximately 45 minutes and the discussions would be recorded via video call recording technology, which is password protected. The data collected would be kept confidentially before being transcribed and made anonymous, and then kept indefinitely by Cardiff University.

I would require your assistance in distributing the information sheets I have prepared for potential participants, as these contain all the information that participants would need in order to consent to partake. Participation in this study would be entirely voluntary, and they would sign a consent form before any data is collected. Participants would also have the right to withdraw at any time before the data is anonymised when responses will be made untraceable.

This study has been reviewed and ethically approved by School of Psychology Research Ethics Committee.

Please tick the boxes when you have read and understood the following statements:

I understand this study will involve the SENCo/ALNCo from this school taking part in an interview. I understand that this professional will be asked questions by the researcher about their views on the EP role working with children and young people with OCD. ☐

I understand that the personal data will be processed in accordance with GDPR regulations (see privacy statement below). ☐

I understand that the data collected will be kept confidentially before being transcribed and made anonymous, and then kept indefinitely by Cardiff University. ☐

I, _____(NAME) consent to the proposed study being conducted by Rebecca Pearce School of Psychology, Cardiff University with the supervision of Dr Dale Bartle.

Signed: _____

Date: _____

If you have any questions or concerns, contacts are listed below.

Rebecca Pearce — Pearcerl3@cardiff.ac.uk

Dr Dale Bartle — BartleD@cardiff.ac.uk

School of Psychology Ethics Committee — psychethics@cardiff.ac.uk

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The information on the consent form will be held securely and separately from the research information. Only the researcher will have access to this form and it will be destroyed after 7 years.

The research information you provide will be used for the purposes of research only and will be stored securely. Only the researcher will have access to this information. After a few months the data will be anonymised (any identifying elements removed) and this anonymous information may be kept indefinitely or published.

Appendix 6: Information sheet

School of Psychology, Cardiff University

Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

Dear …,

You are invited to take part in a study to investigate the role of the Educational Psychologist (EP) when working with schools to support children and young people (CYP) with Obsessive-Compulsive Disorder (OCD). The study aims to investigate how EPs work with CYP with OCD, how school staff would like to be supported with these CYP and what the facilitators and barriers are for EPs and schools working with CYP with OCD.

This study will involve discussing how EPs see their role in supporting CYP with OCD and how secondary school SENCos/ ALNCos would want to be supported by EPs when working with these CYP.

This will happen in semi-structured interviews that will last for approximately 30-45 minutes and will either be conducted face to face or via a video call.

Your discussion will be recorded via a Dictaphone or via video call recording technology. Recordings will be treated as confidential and will be protected by password security and will be transcribed within 2 weeks. The recordings will be destroyed after transcription. You will be asked to avoid using names or other identifying information and any identifiable information will be removed from the transcript.

There are no known concerns or dangers about participation in this study. The risk of harm in this research is not considered to be greater than that encountered in your everyday life (BPS, 2014), however, if any feelings of concern are evoked from the interview, you will have the opportunity to speak to the researcher afterwards to discuss any potential support that you feel you may need.

Your participation is voluntary, and information will be held confidentially until the point of transcription. Once data has been transcribed, all identifying features will be removed so that the data will be made anonymous and no information will be traceable to any individual or place. You have the right to withdraw your data at any time before the data is anonymised when responses will be made untraceable.

This study has been reviewed and ethically approved by School of Psychology Research Ethics Committee.

If you have any questions or concerns, contacts are listed below.

Rebecca Pearce (Researcher)	Pearcerl3@cardiff.ac.uk
Dr Dale Bartle (Supervisor)	BartleD@cardiff.ac.uk
School of Psychology Ethics Committee	psychethics@cardiff.ac.uk

Appendix 7: Consent form

School of Psychology, Cardiff University

Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

Participant Consent Form – Confidential data

Please tick the boxes when you have read and understood the following statements:

I understand that taking part in this study will involve being part of a semi-structured interview. I understand that we will be asked a few questions by the researcher about my views on how EPs and can support children and young people with OCD and the schools those children attend. This will require up to one hour of my time. ☐

I understand that taking part in the interview is entirely voluntary and that I can withdraw from the interview at any time without giving a reason. ☐

I also understand that I can withdraw my data from the study up until the point the data is made anonymous. I can do this by contacting the researcher. ☐

I understand that I am free to ask any questions at any time. I am free to withdraw or discuss my concerns with the researcher, Rebecca Pearce or the supervisor, Dr Dale Bartle. ☐

I understand that the personal data will be processed in accordance with GDPR regulations (see privacy statement below). ☐

I understand that at the end of the study I will be provided with additional information about the study. ☐

I, _____(NAME) consent to take part in the study conducted by Rebecca Pearce School of Psychology, Cardiff University with the supervision of Dr Dale Bartle.

Signed: _____

Date: _____

If you have any questions or concerns, contacts are listed below.

Rebecca Pearce (Researcher)	Pearcerl3@cardiff.ac.uk
Dr Dale Bartle (Supervisor)	BartleD@cardiff.ac.uk
School of Psychology Ethics Committee	psychethics@cardiff.ac.uk

Privacy Notice:

The information provided will be held in compliance with GDPR regulations. Cardiff University is the data controller and Matt Cooper is the data protection officer (inforequest@cardiff.ac.uk). The lawful basis for processing this information is public interest. This information is being collected by Rebecca Pearce.

The information on the consent form will be held securely and separately from the research information. Only the researcher will have access to this form and it will be destroyed after 7 years.

The research information you provide will be used for the purposes of research only and will be stored securely. Only the researcher will have access to this information. After a few months the data will be anonymised (any identifying elements removed) and this anonymous information may be kept indefinitely or published.

Appendix 8: Debrief form

School of Psychology, Cardiff University

Supporting children and young people with Obsessive-Compulsive Disorder in schools: the role of the Educational Psychologist

Debrief Form

Thank you for taking part in the interview for the study. The aim of the current study is to investigate the role of the Educational Psychologist (EP) when working with schools to support children and young people (CYP) with Obsessive-Compulsive Disorder (OCD). The project aims to explore how EPs see their role in supporting CYP with OCD and how secondary school SENCos/ ALNCos would want to be supported by EPs when working with these CYP.

The findings will be written up and submitted to Cardiff University as part of my doctorate studies and may be used in presentations and published in a journal. Please be assured that the information will only be used in an entirely anonymous format. If you would like a summary of the findings this can be made available for you.

You can withdraw your data from the study up until the point the data is made anonymous. You can do this by contacting the researcher. You are free to withdraw or discuss your concerns with the researcher, Rebecca Pearce or the supervisor, Dr Dale Bartle.

There were no known concerns or dangers about participation in this study. The risk of harm in this research was not considered to be greater than that encountered in your everyday life (BPS, 2014), however, if any feelings of concern have been evoked from the interview, you have the opportunity to speak to the researcher to discuss any potential support that you feel you may need.

If you have any further questions, please do not hesitate to contact myself or my research supervisor (contact details below).

The personal data will be processed in accordance with GDPR regulations (see privacy statement below).

Name of Researcher: **Name of Supervisor**

Rebecca Pearce Dr Dale Bartle

School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

Email: pearcerl3@cardiff.ac.uk Email: BartleD@cardiff.ac.uk

If you have any concerns or complaints please contact the Ethics Committee:

Secretary of the Ethics Committee
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

Tel: 029 2087 0360

Email: psychethics@cardiff.ac.uk

Privacy Notice:

The information provided will be held in compliance with GDPR regulations. Cardiff University is the data controller and Matt Cooper is the data protection officer

(inforequest@cardiff.ac.uk). The lawful basis for processing this information is public interest. This information is being collected by Rebecca Pearce.

The information on the consent form will be held securely and separately from the research information. Only the researcher will have access to this form and it will be destroyed after 7 years.

The research information you provide will be used for the purposes of research only and will be stored securely. Only the researcher will have access to this information. After a few months the data will be anonymised (any identifying elements removed) and this anonymous information may be kept indefinitely or published.

Appendix 9: Example of transcript

The transcriptions were completed with guidance for orthographic transcription provided by Braun and Clarke (2013)[2]. All transcripts were anonymised, with names, places or organisations or any other material that could possibly identify participants removed and/or replaced with brackets with a reference provided to retain the meaning of the sentence. For example (local authority). An example of part of a transcript is provided below. Full interview transcripts can be made available on request.

Transcription key	
Notation used	**Meaning**
…	Pause
(dash) -	Cut off speech
(laughs)	Speaker laughing
(laughter)	Participant and researcher laughing
(coughs)	Speaker coughs

EP 3: lines 48-127

Interviewer: Brilliant and thinking about the children and young people I know you said that one of them wasn't attending school but what sort of behaviours were they presenting at school? With the ones that you worked with in school.

EP Three: So the ones that I've worked with in school the vast majority if they weren't... if they were in school their attendance was shockingly poor um and I guess... um the behaviours that that school were seeing where I guess would would kind of fit under that umbrella of of challenging behaviour so some children were potentially if their compulsion was to shout out that's what they were doing or not wanting to sit in a particular chair in particular way and so kind of these you almost got a list about their behaviour but actually their

[2] Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: a practical guide for beginners.* London: Sage Publications.

behaviours around their their compulsion or not want to do something with that would trigger them having to do something and so children I think so for a child who was coming into school so that attendance is really low but then was missing lots of classes because the compulsion um was happening among the bathroom and getting in and out of it and so they're spending lots of time to being on school compound but not where they should be... um so those types of... um... usually it was around school attendance and it it it most of them were part of it with school refusers even if they were in school for some some time but then the challenging behaviour was more around not following adults not following requests from staff but actually they're not following the request was part and parts of their of their compulsive behaviour routine that they had to follow so they would explain that I have to do this I have to walk the long way around that I have to do it this many times and not being where they should be.

Interviewer: So I guess it's um so how did it affect their day to day lives? So you said that obviously affected at school so obviously affected their movement and where they felt comfortable going...

EP Three: I think it affected every part of their lives like there was not a part of their life and I think that's what... I guess when you kind of think oh is this anxiety is this OCD? What is this? It's almost like the impact on that child and young person's life and for children and young people where where you think we're we're kind of working with that possibly is this OCD it impacts every part of their life and it completely cripples friendships engagement with learning peer relationships as I said family relationships... so it feels as though... so that's when you think actually is it is so it is so big in their world that impacts it completely... impacts every part of their functionality in the world so their engagement with learning their attention and focus because they're kind of preoccupied with the routine... I've I've worked with one young person that I think her routines were all internal in her mind so she didn't really act out yeah she was very distracted and she didn't pay lots of attention and she and the school would say that she kind of daydreams a lot and she doesn't focus and

you could see how you almost start to go down that path of schools almost you know for whatever reason needing a label to kind of support them better understanding this child or young person thinking is this a girl with ADHD 'cause that looks quite different in girls and actually recognising the comorbidity between these things and actually she could be making sense and playing out the routine internally and so it impacts every area of their schooling their ability to engage in learning and friendships and relationships with family.

Interviewer: Yeah so thinking about some of these cases could you tell me about what things you considered that went well with these cases?

EP Three: I think... I think if I'm kind of reflecting on on what went well or if I'd have done anything differently... I think for me it was the awareness raising around the key adults because I think for things to change for children and young people adults' understanding the key adults around their understanding has to go up and so initially that kind of the behaviour because they in terms of the behaviour differently how they responded to that child was then different so the things that went well was if you if you kind of raise the awareness of the empathy in adults um that how they respond to that child and young person is different and it gives them a different environment so then the things they put in place in school become different so I think once you explain what the what the behaviour is likely to be communicating then the things that need to be put in place to support children's anxiety or managing their compulsions um... adults are better able to support that so I guess um school's understanding that went really well in terms of understanding that this young person is not trying to be difficult... you know they don't wake up this morning thinking 'how how can I make SENCo's and the key adult's life difficult?' but actually this compulsion supported them in feeling calm and so then schools and then school's own reading and and the child and young person kind of thinking about their own levels of anxiety and why so I think those things those things went well... the things that went well was the psychoeducation bit of it and supporting children and kind of having a narrative about about potentially and not diagnosing but wondering whether this makes sense you know there's

things that you do when you do this it is helpful to feel calm and why that might be.

Interviewer: And you mentioned about that school put some things in place could you tell me a bit more about what those sort of things were?

EP Three: For school put a key adult in place for a young person and but also their school started to refer to other services... yeah so the things that were put in place were particular key adult almost almost under recognising that children this young person was anxious and as part and part of their day in school we spoke about things like muscle progressive muscle relaxation and deep breathing and calming exercises so we knew that this young person was anxious so before they showed us this is gonna be this is part of your timetable into school... but then then we refer on to other services in terms of and and to be fair schools can schools don't do CBT but they use CBT type approaches don't they so they have those things like feel good books and and I thought it was really useful for for the for the young people that I worked with they really hated using the worksheets but they but so I almost supported the TAs to kind of think about not having a piece of paper but kind of talking to them around your thoughts your feelings and your behaviours and kind of understanding how they're all linked... so kind of my piece of work was more around the teaching assistant and the key adults that were going to support this young person rather than direct work with them and I think some young people see a piece of paper coming in and they kind of want to throw it but at least it's a kind of support that is around those programmes and those techniques which draw on CBT was was helpful but actually we knew a bigger piece of work needed to come from potentially outside of school.

Appendix 10: Example of initial codes

Example of EP interview 3	Codes
Interviewer: Great so I guess and just to start off um I'd just like to hear a bit more about some of the work that you've done with the children and young people with OCD... so if you could just start off by telling me about some of your cases and that you've had and the kind of work that you've done with these children.	
EP Three: Um I think the cases that spring to mind I think I've started as part of statutory assessment and so um going in and reading the pack it was quite apparent that the young person was highly anxious and as a result had stopped going to school so was about particularly started as a statutory assessment and the child was school refusing and when I then went to the home 'cause that's where I had to kind of do my work because he was not coming into school and speaking to mom it was quite apparent that his anxiety was um had become had completely taken over his life and the amount of time that he spent on obsessive and compulsive behaviour made me start to think does a working diagnosis of OCD fit in with this young person's primary need... and so I guess my report for that you know is with education health with App Ds you often don't see where that report ends up I mean you might probably see the draft but actually the provision that you put in there then fits in in terms of supporting to manage his anxiety and OCD type techniques speaking about going to um get um that kind of EPT like therapy which we wouldn't do as EPs but actually knowing that that was best practice in terms of supporting with one person and kind of seeking out that diagnosis via um CAMHS and paediatricians... I've also worked with children who had a diagnosis of OCD and thinking about schools schools understanding of how to support their needs and recognise their needs.	Statutory assessment Emotion-based school avoidance Recognising OCD behaviours Statutory assessment Signposting School staff understanding

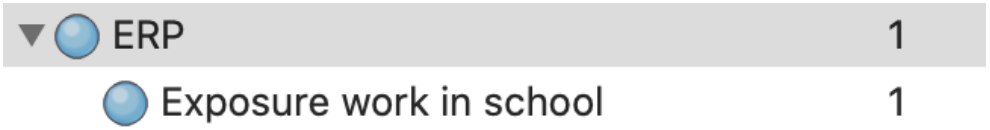
Example of EP interview 6	**Codes**
Interviewer: Brilliant and and with this case that you know that you were speaking about or any others can you tell me a bit more about what went well so either with your involvement or with school's involvement or if anyone else became involved?	
EP 6: So there's there's already some external mental health type support in place when I became involved in one particular case which is positive... I think what what probably went went well from my point of view was having the opportunity to meet with home and people from school who knew the child well in in order to sort of think creatively about what was happening in the situation and to be able to focus not just on where there were concerns but where do the concerns not happen not happen there's sort of solution focused approaches and questioning and and so... I think sometimes you know it can all feel very big and confusing and you know perhaps it's through having this sort of helpful conversation through consultation and that you know you can start to get a clearer sense about when things are happening and when things are not happening and what's going well and building on those positives and having a plan I suppose that the sense of a joint um people on same page finds a support for the child yes so that that is I think a good... it's one outcome is a good outcome it's not obviously the end 'cause at the end of the day you want the child to be you know freer much freer from those anxieties.	Mental health services involved Collaboration between home and school Solution-focused approaches Getting a clearer picture of need Everyone on the same page
Example of SENCo interview 1	**Codes**
Interviewer: It's fine so are you aware of many services within the local authority that can help you with these children and young people with OCD?	

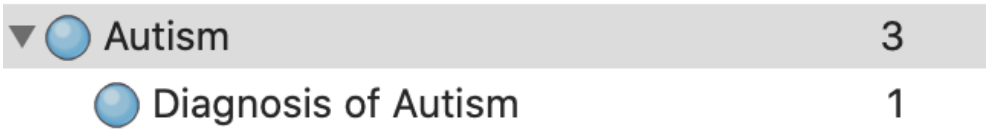
SENCo One: There aren't many for us if I'm honest with you and or there are we as a school we're not aware of them we we've got the disabled children's team who will support some of our students but some of them don't meet the criteria... CAMHS support some of our students but lots of don't meet the criteria um and some of the other kind of support services that are out there aren't really enough for some of our students... they kind of fall in a little gap where they don't meet the criteria for some like CAMHS and other things and then or they don't meet or they they're too... too special they need too specialist a service you know we've got on site we've got therapists and we buy in a play therapist as well once a week and so we we've got two parent support advisors who do a lot of the liaising with the parents and that and the services and that they often find that our referrals are sent back to us because they again don't meet criteria or are too specialist a problem.	Not aware of many services Disabled children's team Don't meet threshold for external services Service not specialised enough Specialists work on school site
Example of SENCo interview 2	**Codes**
Interviewer: Yeah brilliant so um what kind of support have you had um with the children and young people with OCD? SENCo Two: Um... I've had conversations with (EP) around in relation to a young person with autism and they were really useful and started the conversation around crossovers there and how you what strategies we might be able to use for that particular young person... I'm well and although it was decided by CAMHS it wasn't OCD that young person had and it was still those strategies were still very relevant even though the you know the reason for these behaviours might be different and we could agree or disagree with that and so but other than that other than conversations with our EPs that's the only support we haven't had any training or anything and and spent a lot of time trying to look online to see if there is anything... um there's general mental health training	Difference between autism and OCD Autism diagnosis stops referral Only had support from EPs No training in school

	which does like it will list OCD but what you don't have that I can find is... I mean if you if you Google dyslexia strategies for the classroom you'll get books and sheets of prompts and all that kind of thing... nobody seems to have that I can find anyway there doesn't seem to be a go to resource for it... often often there is a book isn't there there's a book that everybody would say you know read this book to start and but yeah nothing's been recommended to me or that I can find beyond the conversations that I've had with the EP yeah.	General mental health training Lack of online resources

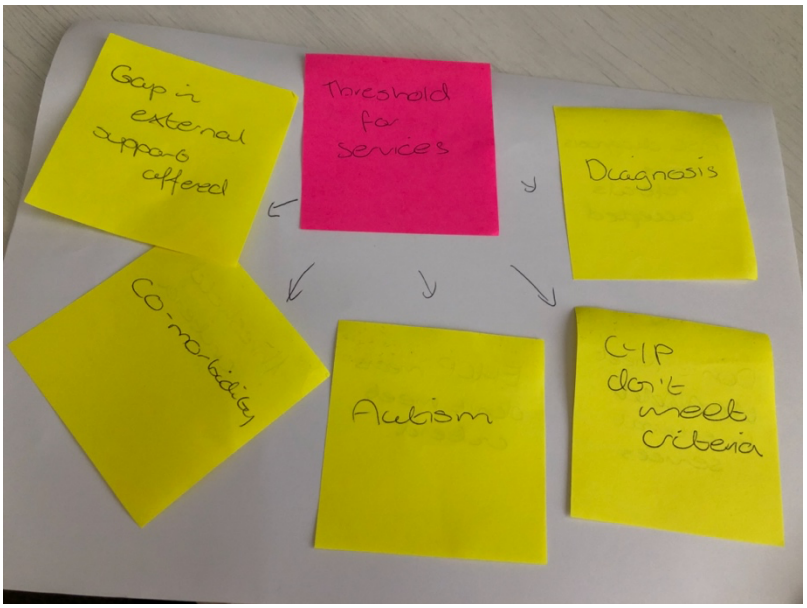
Appendix 11: Example of codes combining

As part of step three of the TA process, I combined my initial codes into final codes and began to search for patterns in the data to form themes (Braun & Clarke, 2013[3]). Below are screenshots of examples of my initial codes combining to form the final codes that went on to create my subthemes and main themes.





Once I felt happy with the names of the codes, I began grouping the codes into potential subthemes by hand (Braun & Clarke, 2013[5]).



[3] Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: a practical guide for beginners.* London: Sage Publications.

Appendix 12: Table of themes, subthemes, codes and supporting quotes

The tables below show an example of three main themes, the corresponding subthemes, codes, and supporting quotes that formed the analysis.

Main theme (EP group)	Subthemes	Codes	Supporting quotes
Importance of joined up working	Working collaboratively with schools	Information gathering	"seek advice from somebody who might be more sure of what's going on for that child or young person as well I think that that can be really really proactive" EP 1 "I did all the things I would normally do I spoke to school and I spoke to mum" EP 5 "I talked to staff in his current school about what some of the issues are and mum about what some of the things are he's finding difficult" EP 5
		Advisory Teachers	"the advisory service or learning support service I think was involved with one just in terms of strategies for cognition and learning but... but not to a huge extent because neither of them had particular cognition and learning needs it was more their emotional wellbeing that was acting as a barrier" EP 5
		Working with the SENCo	"I think that the SENCo is obviously the person that you have the most direct contact with certainly the SENCo would be involved" EP 1
		Develop programmes with schools	"I do think there is um something really useful and powerful about if we could be part of sitting with

			schools to kind of create programmes which are going to support children feeling less anxious and manage their anxiety and be able to kind of talk about it and recognise how their body responds and those types of programmes" EP 3
		Working with school staff	"I would I would love to work more and I think it would... just kind of having someone to tie that whole process together someone who's got an overview of how the staff feel about it how you know what their anxieties might be how the parent is feeling about it what their anxieties are you know that that for me is is that EP role that holistic bringing everyone together making sure that everyone is kind of on the same page that the child feels included and in control of that I think there is that that would be a lovely use of our time to kind of help manage that transition progress but that's just not an option sadly yeah" EP 5 "building on those positives and having a plan I suppose that the sense of a joint um people on same page finds a support for the child yes so that that is I think a good... it's one outcome is a good outcome it's not obviously the end 'cause at the end of the day you want the child to be you know freer much freer from those anxieties" EP 6 "they are doing that piece of work so they come up with some ideas so I think that's where we have that unique role is that we support school and empower schools and parents as well and I'm a great believer in that whether we're dealing with somebody with OCD or

			other conditions is that's where the power of our EP work lies is is in actually creating you know adults have the power to change adults have that ability to to create change for a child or young person" EP 1 "that's the power and I think by supporting the adults that that that work with that child in in seeing their own power within that and empowering them that's where I think we have the most unique role" EP 1 "I see my my role about is giving away that psychology in order to empower others to support children young people" EP 1 "I think the working together bit is really key so it's actually bringing everybody together in the same room" EP 2 "they were concerned that he did have autism and it wasn't identified and it wasn't something that was specifically explicitly mentioned and to parents and so that's something that we had quite an open... we were able to then have that open conversation in the consultation which um I think was helpful and it and it would it was that parents had thought that that was something that might fit with him but that one of the parents um wasn't didn't want to sort of have the specific labels and so it's very person centred in some ways and but I think the unique role of the EP there as well was almost creating that open space in dialogue which sometimes schools aren't able to or they don't feel confident in kind of creating that and almost when

			appropriate mentioning those things that actually might need to explore a bit further" EP 2 "it's really collaborative so actually we're thinking about the outcomes together we are thinking about the actions together and we're thinking exactly about who's going to do that and by when and this particular so and it worked really well" EP 2 "that was collaborative based on what parents were saying what school were saying they do and they'd like to change and then just a little bit of sort of what I was bringing in terms of that psychology and specific sort of programmes so it worked quite well in that sense whereas I think if I'd um if we hadn't discussed actions and I just listed like you know random kind of strategies that might be helpful then we know that's not gonna be put in place 'cause yeah as well as other" EP 2
		Build relationships in school	"I think it's about relationship building isn't it as well so it's just normal EP good practice isn't it so some of that is really really helpful so that you're actually coming at it from an informed position" EP 1 "I think we're really well placed because we are in schools we do have relationships with our SENCos we do form really positive images of families and children and we bring them along with us" EP 3 "I think we have unique relationship and access to school and to staff and and that kind of trusting

			relationship with you know which is really really helpful to change" EP 6
		Working with key adults in school	"he had a like a key member of staff to try and support him and he had a lot of support getting to and from lessons and that kind of thing because he found that really overwhelming... support at lunch and break time things like that he could go to the base he had support to go and get his lunch and then bring it back to the base" EP 5 "my piece of work was more around the teaching assistant and the key adults that were going to support this young person rather than direct work with them" EP 3 "they were happy in terms of the TA felt supported and being able to do pieces of work" EP 3 "I would see it as being really useful to work with people like the ELSA in school and to work with people with staff class teachers teaching assistants generally um around um areas like supporting children with anxieties" EP 6 "we did super basic CBT that could be done by the ELSA so the ELSA in school ELSA did this with this child regularly" EP 1 "that was facilitated by an ELSA that I worked with because she was there on the ground and was able to do that with him either after a um a time when he

			become dysregulated or a time when he seemed to be highly anxious she could use that way a way of kind of focusing his thinking around what was happening for him in that moment so that was quite useful" EP 1
	Working together with Health services	CAMHS input	"it would be the CAMHS link workers as they were then so that's that kind of triage CAMHS almost really it's not um it wouldn't be a clinical CAMHS I've been working with... although I have done at later stages so thinking about the young person we've talked about he's definitely got CAMHS involvement" EP 1 "my kind of a go to at the time and I guess now I would have been CAMHS and I think I looked on the website at the time and did make a suggestion" EP 2 "she had already had CAMHS support which I think made it a lot easier because her awareness of what was happening was much much higher and I think she had a good level of awareness and she'd already been through um considering the things that made it easier and better for her" EP 4 "I think my understanding is that sort of CAMHS work and CBT is is kind of um I think that's NICE guidelines isn't it that that's what works for OCD" EP 4 "one of them is known to CAMHS so he's had support from CAMHS" EP 5

			“there's already some external mental health type support in place when I became involved in one particular case which is positive” EP 6 “CAMHS offers CBT the the difficulty with CAMHS is that the exposure work with children and young people need to do is often assigned as homework and I'm not... well well... that that that was my understanding when I was kind of supporting this case and the difficulty in that is that that exposure work if you are anxious for example about holding something blue until you avoid all things blue by avoiding all things do you feel calm you are unlikely to then touch something blue without a key adult there who can support you because your anxiety is gonna go up the first time you touch something blue but of course when you finally touch something blue and nothing bad happens your brain has to give you a new message in a new story” EP 3 “it's called ERP exposure therapy... in terms of um approaches but I again I wouldn't see us as doing that work” EP 3 “the emotion the mental health link workers that have been been trained up on the IAPT training again IAPT training is very much based on a CBT approach and they they um they would be picking up low level OCD cases so for somebody was picking it was showing early signs of OCD type behaviours they might take on a 6 to 8 week course of CBT support In order to um try and re address some of those behaviours and that some of those intrusive thoughts and try and see if that they

			cannot support that child or young person to find more positive ways of displaying some of the anxieties that they've got so it's around that kind of understanding that this is an anxiety based" EP 1 "so CAMHS do CBT work and I'm not sure if they've moved it but my last understanding is that the exposure work is done as homework" EP 3 "I suppose the first thing would be GP and CAMHS... um and uh on the basis of generally CBT is considered to be the way forward for young people so that would that would be a first thing" EP 4 "I think my understanding is that sort of CAMHS work and CBT is is kind of um I think that's NICE guidelines isn't it that that's what works for OCD" EP 4
		MDT agreement	"I literally had a um a kind of safeguarding meeting about last week with multi professionals from everywhere right right up to um Great Ormond Street so there's been a huge amount of medical involvement as well with this child" EP 1 "so that's why there's this massive collective... you know group of people pulling around this family to try and see if we can provide the level of support that is necessary to maybe reduce some of those levels anxiety so that he can maybe start to reengage with education at the right level at the right support" EP 1

			“having this uh multi agency safeguarding meeting which drew there must be twenty five people in the chat room you know it's amazing and it was a really proactive meeting really proactive um look at the entire family and what is happening for that family so for for that case I think that is the only way forward and it may well be because the the family is resistant and we've been trying to put in kind of level two and level three support and the family’s been resistant to that and so we've seen this escalation in in a number of the behaviours of a number of the children within the family is that actually now need to look at level four support” EP 1 “when agencies do work together collectively that's when it works really really well as well so that avoids those barriers so that's the you know I said one of the barriers can be not doing that but when that does work well that definitely avoids those barriers” EP 1 “kind of jointly working in a multi professional way... that would be ideal” EP 3 “I guess it's thinking about how we can do it in a multidisciplinary way so that it's not only the EP but potentially EPs and I guess CAMHS professionals as well as you know home so it it it's kind of that joint working within a school system to kind of hold the young person at I guess the centre of what it is that um... is happening for them” EP 3

			“I think um while it's really useful to kind of do statutory report actually uh a kind of continue review of them would need to be in a multi professional multidisciplinary way I think and if and I think it's about yeah so I think it's kind of working in that multi agency way to support children and young people who have a diagnosis of OCD or we suspect to be have to to have a diagnosis of of OCD” EP 3 “trying to work in a more multi agency way if possible” EP 4 “I don't know it depends on your definition of multi agency work I guess at the moment it feels a bit different I did have a communication with have a conversation with the communication and autism team for both of them to kind of get a feeling of the support that's been in place so far and what that looks like and what their feelings were as professionals.. that's probably the extent of it” EP 5 “then it would be about in addition linking up with any other services who would be involved... whether there’s specialist CAMHS involved or whether there's you know external therapies or or perhaps therapies going into school you know linking up with those those professionals as well and then coming up with agreed ways forward” EP 6 “getting agreement between professionals can sometimes be a challenge as well so kind of really unpicking that” EP 1

			“actually sometimes bringing professionals together in order so that you've got a unified voice is can be quite challenging so you know and sometimes um you can have a different professionals giving a different viewpoint which can either support or undermine what other people have been doing so so that can be a challenge from time to time” EP 1 “as I said Great Ormond Street have been involved as well really heavily so actually when it gets to a certain point then actually it's amazing when you look at the list of people who were at the meeting last week” EP 1 “when the needs becomes so high then actually we we are seeing paediatricians becoming involved we're seeing clinical psychologists becoming involved with perhaps even with referrals to Great Ormond Street for highly specialized support to become involved between specialist OCD and Tourette's paediatricians so so that's been involved” EP 1 “if there was the opportunity for more multi agency work um I think that would be really beneficial” EP 5
		External services involved	“I do know that there are private therapists who will work with children and do that exposure work with them because they found that um clients well they call them clients are unlikely to do that exposure work initially on their own because actually that's a significant source of stress and anxiety” EP 3

			“CAMHS do CBT work and I'm not sure if they've moved it but my last understanding is that the exposure work is done as homework... whereas some private therapists do that with you together” EP 3 “I've worked in a previous authority where there was a it was the hospital reintegration service but their remit was much wider than that and they probably would have been the ones I would have gone to with cases like this where they kind of specialize in helping support children with specific issues like this or or health needs back into school” EP 5 “I think they had had some health care involvement in terms of the GP but in terms of wider sort of assessment of his profile of needs that hadn't been looked at” EP 2
		Collaboration with CAMHS	“I think that that's then something that you know and again it's about sometimes working alongside CAMHS so that's been really successful I would say is when I've had um joint meetings with CAMHS” EP 1 “I can think of this particular case and another case that I worked really closely with the CAMHS worker with a specialist clinical nurse who um you know really understood the issue as much as I did so that was really really positive and we were able to both come with this similar converging message which actually was really really helpful because it's sort of added weight to what we were trying to say” EP 1

			“CAMHS might be coming in from a different perspective and I might be working much more with the school and parent and trying to to come to a way forward which is going to work within the classroom and obviously CAMHS might be looking a bit more holistically about what's going on for that child but together we can usually work quite positively” EP 1 “I've been lucky enough to have um or in the past I'm not sure how lucky that's going to be in the future to have worked really really closely with those with people that working in CAMHS” EP 1 “the first one only multi agency in the sense that I contacted the CAMHS practitioner and we spoke on the phone she'd already closed the case I did try to sort of you know push it to rethink it and it was the liaison between her and home and school then that that happened so only multi agency in that way” EP 4 “it's all about having links with other services like Specialist CAMHS the clinical psychology team and primary mental health” EP 6 “I've linked with um CAMHS services in a range of different ways and so... through those links there will have been the opportunity for discussions to take place and that's the most important thing really it's um it's having those links knowing those people being able to make contact” EP 6

			“over the years I’ve had various opportunities to have conversations with people from specialist CAMHS and um conversations with primary mental health and so yes it’s been something that I’ve had an awareness of” EP 6 “it's definitely not about duplicating it's definitely about you know being clear with other services you know what what they're doing what they're aiming to achieve how they're working and what I could potentially add into that and just making sure that we are working together on you know shared goals and so the family are happy with and signed up to and understand” EP 6 “this might just be the local authority that I'm in we're not particularly good at multi agency working so I would I would really benefit the no that's not the word I'm trying to say appreciate the ability to to work closer with CAMHS... um and kind of understand what's happening for from their perspective and how we can kind of tie that in with our knowledge of educational settings um and the fact that we're just we are getting these one off pieces of work where we don't have the chance to kind of look at things more holistically in terms of more systemically rather in terms of schools and what can be changed” EP 5 “I also want to say sort of access to health care professionals as a barrier even though that's out of our control um I guess the systems in this area are changing and hopefully improving in terms of these systems and I would hope that that would lead to a greater working

			together because actually um we can be very work much working in our schools then I guess it's easy for me to say that the health care professionals were a barrier but in a sense actually if we were all able to get together and discuss those um I think that would create better yeah better outcomes for children and young people" EP 2 "I mean there is some a clinical psychology advice line which operates in this area... it's once a week so there's a possibility of ringing um that advice line to try to sort of talk through with a clinical psychologist but you know if if I have concerns if you're working on a similar... issue" EP 6
		Develop training with health	"potentially we have a role in um like training but along alongside like health care professionals so those working in mental health um sectors around actually how can we support these needs in education is something that um probably we don't have scope to do but it would be quite interesting I think I would be quite well placed to kind of do that" EP 2
	Involve the family in the process	Advocate for the family	"I think like most things we are really skilled at ensuring that the the views of the child and the family are really central and kind of highlighting and advocating for them" EP 3
		Referrals from parents	"pressure had come from parents rather than school identifying either of those young people as having needs that needed an EP... which I think particularly it was it you know interesting say for me to reflect because I think both of them came in that way so it was

			sort of a case of could you go off and do that... as opposed to a sort of commitment of a consultation approach um of what could school do differently" EP 4 "the child was school refusing and when I then went to the home 'cause that's where I had to kind of do my work because he was not coming into school and speaking to mom it was quite apparent that his anxiety was um had become had completely taken over his life and the amount of time that he spent on obsessive and compulsive behaviour made me start to think does a working diagnosis of OCD fit in with this young person's primary need" EP 3 "I suppose traditionally clinical psychology roles have been much less based in the community and much more based in you know settings or clinic settings um so you know the EP role being primarily in school also we can make home visits which it would sometimes be appropriate you know I think it's a really important place to be really to make a difference" EP 6 "I think perhaps it was effective in the sense that some of the strange behaviours that mum was seeing... it enabled us to sort of think about some of those and and sort of it was it was about providing a bit of a narrative for that I think yeah so that she so I think in in doing that it was... yeah I guess it was about providing that kind of narrative really about how things were and how things had got that far and that some of those behaviours were typical of what you might see with somebody with OCD and um and I think perhaps the

			successful part of that was the mother feeling listened to and heard and being able to have a clear idea of going back to seek support yeah" EP 4
		Support for parents	"if you kind of do lots of reading on OCD it impacts your entire family and so lots of the treatment around it or the it's about kind of bringing the family together" EP 3 "um again young minds um I'd recommended that sort of within the consultation around um I think if that's the different that's the website that I'm thinking of um where I thought it was quite helpful and I think if I'm right in thinking 'cause it was a while ago so I'm just trying to think there is some information on there about young people" EP2 "I pointed school in the direction and Mum in the direction of various um... sort of websites and I think that that was probably about my involvement really with her" EP4 "I think signposting to websites like young minds... um is it OCD action I think yeah... the other one um so yeah signposting to those" EP4 "it's been through reading websites" EP4 "so what I talked to Mum about a little bit was the sort of resilience factors as well that were there and again helping her think about the things that um make things easier for her" EP4

		Collaboration with parents	“I think as well working with the parent is been really vitally important so as I mentioned that there there are questions around one's mental health and and actually the way that I have approached it I've learned on how to approach it with this particular parent is actually just to take on board all of her concerns” EP 1 “I think what went well from an EP perspective um is is working closely with parents because actually you know they've known the child for their whole life and so they are experts by experience and so that's most important because actually and and alongside that getting parents together” EP 2 “you know my experience has been with parents who've been quite willing to talk and wanting to support and open to conversation which is really positive” EP 6 “there was the voice of the parents there was some input from CAMHS there was the voice of the young person there was a commitment from school to take some of those ideas forward to actually listen to her to work with her on supporting her challenge some of those fears I think that was a much more rounded piece of work and I think they were happy because it did move things forward quite a lot and it gave teachers an opportunity to actually think about how they were supporting her as well” EP 4

			“I think what what probably went went well from my point of view was having the opportunity to meet with home and people from school who knew the child well in in order to sort of think creatively about what was happening in the situation and to be able to focus not just on where there were concerns but where do the concerns not happen not happen there's sort of solution focused approaches and questioning” EP 6 “I think the relationship between home and school and just... it's reinforcing the importance of that's um facilitating conversation and and in a particular way... um in a way that tries to reduce anxiety about what's happening” EP 6
	Lack of collaboration	School are a closed system	“the second time I didn't have as much success at getting involved in the school situation it seemed a more kind of closed thing and we just want you to go and work with the parent or just go and listen to the parent because that's what a parent wants it wasn't kind of commitment in a sense from school to be thinking about what they might do” EP 4 “another barrier is actually when a school and parents won't work together... so if you're not seeing the schools and parents working together” EP 1 “in both situations I think it was pretty much seen as a sort of quite an in person... view” EP 4 “I think one um one of the barriers is um perhaps I I mentioned you know just now in that answer about the

			the reason why though that that piece of work is being requested and I think... perhaps a tendency to locate that issue within person and so not kind of see the role that there might be for school" EP 4 "I found it very difficult to get the school then to engage with what we could do in school to support her" EP 4 "I think school were happy that I had met the parents and mapped out what the problems were and that the parents felt supported in that they knew where to go with it... from a professional point of view I'm not sure that... I'm not sure it was as effective because the school were not as engaged" EP 4 "mum was very much of the opinion that he needs to be in a specialist setting" EP5
		No communication from CAMHS	"we've lost that kind of um CAMHS link worker that that role is almost completely gone from the entire county so you know I'd be really clear about sort of like trying to fill that role" EP 1 "I think earlier intervention would have made that a lot better and the school recognizing the issue rather than leaving it too long... I think you know had say the you know as an EP being involved earlier while CAMHS were involved I think would have made that much better and much easier for that that young person" EP 4

			“I think what could have made it a lot better was... much more involvement from CAMHS as well... so sort of a joint piece of work because as it was I did contact the CAMHS practitioner but she'd already finished the work so she wasn't particularly forthcoming about how that could have been supported in school” EP 4 “if CAMHS were involved and much more multi agency way of working really because I think I think that is poor I think things are happening in tandem and I think perhaps it would be nice to see I don't mean it again I'm not blaming another service but it would be really nice to see what's happening in clinic situations having a little bit more application to how could a school support that as well” EP 4 “he's had support from CAMHS but I wasn't able to link up with them so that that's a bit of a that's something that's not working so well” EP 5
		No MDT opportunity	“sadly not specifically with with OCD but I'd love to be able to say to you that that yes it you know that that's the case” EP 6 “I'm not aware of any one mechanism in particular that is specific for children with possible OCD” EP 6
		Not working together	“so if we were not getting a um if if we're not getting school school other professionals and the family and child or young person to come together in a unified way then that's when things can go quite badly wrong quite quickly” EP 1

Main theme (EP group)	Subtheme	Code	Supporting quotes
Gap in available support	OCD as a priority	Competing SEN need	“they have less young people with SEN so they can potentially have a bit of extra space” EP 2
		OCD not prioritised	“Cases like this it wasn't whole school level at all because I think if you were to ask SENCos if you have to if you had to prioritize training I don't think they would say OCD that OCD is a significant need... prioritise um minor attachment difficulties or perhaps generalized anxiety so you could potentially fit it in a slide or two but it wouldn't be particularly around OCD training or recognising and supporting children for OCD” EP 3 “I think it's individual um because I think it's mostly because it's it's quite rare I think for schools they don't tend to have like a cohort of children with OCD or um it's usually just one or two and actually once you you do start thinking about it though they do tend to think of this other children that would benefit from that but we could shift that I don't know that's more the autism side of things um... but they yeah no one's never come to me and said kind of we have a whole school issue with OCD how do we how do we manage this” EP 5 “I mean I don't know I don't know how how much of an issue it is I don't know how well it's picked up either” EP 5

			“work collaboratively over a period of time with the family and school but that opportunity isn't always available because of as a pressing issues and priorities and needs that schools have and want to support with” EP 6 “basically we go into school to support children that SENCos are concerned about and we don't know what the children we don't know about... and SENCos don't know what the children they don't know about because it can it can be quite hidden 'cause sometimes children can be quite skilled in hiding their routines and their compulsions and not being aware that that it's not that this is not a typical way” EP 3
	Untangling need	Co-morbidity	“he has got a confirmed diagnosis of OCD he's got ADHD he's got tics and they're actually looking into ASD as well because as you know there's a huge level of comorbidity with those conditions” EP 1 “he it it's it's been quite complex but I really think that this is kind of um is a is a complex mix of his different conditions that he's dealing with” EP 1 “um and again is about unpicking what what is OCD and what is Tourette's... and I and actually I think that's really been challenging to do... um and 'cause it's looking so different what it did a few years ago but he does have the co- co-diagnosis of both” EP 1 “it's a very complicated yeah it's not strictly just OCD that's the thing” EP 1

			“I also wondered around that link between autism and OCD as well um and research that’s sort of being being done around that” EP 2 “you could see how you almost start to go down that path of schools almost you know for whatever reason needing a label to kind of support them better understanding this child or young person thinking is this a girl with ADHD 'cause that looks quite different in girls and actually recognising the comorbidity between these things and actually she could be making sense and playing out the routine internally” EP 3 “sometimes it can be hidden or not really well understood or kind of masked under behaviour or generalized anxiety or ADHD or sometimes autism... kind of being able to kind of um recognise what is and what's not” EP 3 “I took a special interest in Tourette’s when I was um when I was actually studying my doctorate so I did uh one of one of my papers one of the choice papers that you had early on in my training I chose to do Tourette’s and through doing that I had to explore all the comorbid um difficulties that go alongside that” EP 1 “from looking at really in depth Tourette’s actually and intrusive thoughts and how they work and then exploring the OCD through that and some of the other comorbid um features of of that so that's where it came from” EP 1

		Autism	“I think it's it's something that we need to be really clear about is is it's a difficulty for a lot more children than have got a diagnosis for and I think that you know um and it's very easy for us to be kind of quite narrow minded in it and saying all that this is you know only for children who have got are on the spectrum it’s not the case and in fact what if I think back to some of the girls that I've worked with who have maybe got a diagnosis in their mid to late teens of autism and then quite often it was the OCD kind of stuff that was the earliest indication of stuff that was happening for that child or young person that young girl 'cause as we know girls presenting a different way and so that you know is about kind of sometimes unpicking those kind of things in a in a different way” EP 1 “I probably say that um other than that case which is totally confirmed as having OCD traits and is is that other cases I've dealt with quite often been children young people who have been on the autistic spectrum so they've had that comorbidity with the OCD traits as well” EP 1 “when I became involved there were some questions around whether he had autism social communication type difficulties and so that was kind of the um I guess why school wants to um involve wanted me to become involved” EP 2 “I guess the conversations in consultation so it was relatively short piece of work um and in conversations

			with the family um mostly I think those were around to focus on potential autism social communication needs and then the OCD as a uh a separate but also like linked issue" EP 2 "I think I've had a few where there's been kind of OCD tendencies and that overlap with autism" EP 5 "I've had a similar case with a young man who takes forever to pack up at the end of the lesson because he has to do it in a certain order and no one else can touch anything but he hasn't got a diagnosis he's just got an autism diagnosis but tendencies yeah" EP 5 "obviously there's the overlap with autism for him as well so it being kind of really low sensory quiet calm" EP 5 "both of the ones that I've worked with so far that I've been talking about have diagnosis of autism and they've both been involved with the communication and autism team which have helped give strategies on things like sensory environment and that kind of thing" EP 5
		No diagnosis	"I don't recall having any involvement with young people who already have a diagnosis... um but I do recall having involvement where... a child is showing symptoms anxiety driven behaviours where there hasn't been any diagnosis so I've been involved probably at an earlier stage rather than later on once the diagnosis is being given" EP 6

			“so there's there's been several cases that I've been involved with… not all children have got a confirmed diagnosis of OCD” EP 1
		Untangling needs	“he had and I guess for me it's really difficult to kind of pull out for him… what bits were um his attention needs? What bits were his um I you know his um OCD? And therefore the tics as well so that the there is difficult to kind of um pull apart those different aspects of what was going on for that particular young person” EP 1 “So as I said for this young person it was in he's incredibly complex probably one of the most complex children and young people that I I've worked with” EP 1 “so I guess for him it was really about I'm trying to unpick those kind of different um what what was OCD and what was tics and and you know and and some of it what was um anxiety and and so you know” EP 1 “it's you know that can quite often go either way can’t it depending on the child or young person... it could be learning need it could be a social emotional need it could actually be something that's very trauma based... so so there seems to be... I I haven't... and you can probably you may have asked me this... actually I haven't seen any uh a single trigger that I would say produces those kind of obsessive behaviours” EP 1 “I think sometimes you know it can all feel very big and confusing and you know perhaps it's it's through having

			this sort of helpful conversation through consultation and that you know you can start to get a clearer sense about when things are happening and when things are not happening and what's going well" EP 6
		Concern at home not school	"the first one the school asked me to be involved.... but basically because of parental concerns rather than a concern particularly arising at school" EP 4 "they asked me to see the parents which I did and the mum spent a long long long time just talking about the whole history of difficulties that happened since primary school and that it had now got to a point where... some of the behaviours that she was seeing out of school in in the sense of the compulsions were getting very prominent and um Mum wasn't really feeling that she knew how to support her at all and was starting to feel very worried" EP 4 "I think school was seeing things in a kind of minor way whereas the things that were being seen at home were much more pronounced and the rituals about kind of zigzagging in roads and lots of things to do with symmetry that were happening where they go out for a walk and she'd have to touch the hedge this side touch the head this side" EP 4 "I don't think I've been involved with um a young person at secondary school and I think that's really interesting um... I I wonder why that is but I wonder whether in primary school with a children with anxiety driven behaviours and you know 'cause they're spending all

			that time with usually one member of staff or possibly two members of staff you know that there's quite close relationship the staff member is noticing and and you know perhaps perhaps all of that concern is invested in one or two people um whereas in secondary school there's such a vast array of staff who are interacting with with the young person I wonder whether I wonder whether the educational psychologist might be less likely to be involved" EP 6
	Meeting thresholds for external services	Thresholds	"the difficulty with lots of different services is the kind of high thresholds um in terms of the impact that it is having on him but also in terms of the type the young people and the needs that they see which is yeah which is a frustration" EP 2 "I think they were a bit more frustrated when with the with the sign posting and what we could and couldn't do" EP 3 "the SENCo felt they had understanding but actually the larger pieces of work from outside agencies I think they felt frustrated in in terms of that wait or or the responses coming back" EP 3 "I think the threshold for CAMHS is so high sometimes these cases end up with us because CAMHS aren't always able because of their own capacity issues to pick them up so then we are often the ones picking them up because they don't meet threshold and so actually we are really well placed to deal with them because they are coming our way" EP 3

			“I've had a few with OCD tendencies mentioned by the family and whether that's um I've recently had one that's actually quite it sounds quite severe but that CAMHS have felt that it's not worth pursuing the diagnosis obviously the medical experts but kind of to what extent do you focus on those tendencies and think about that was the young man with the compulsion where you know he had to put everything away um in a certain order which was actually making him miss the beginning of lessons and it had quite a big impact on his education but from medical perspective it wasn't um it wasn't that important I guess so it wasn't that severe so I guess it's it's kind of what we should be looking for in our role” EP 5
		Gap in support	“we've got that there isn't this massive gap in the middle where children just fall into this chasm and don't reach the criteria of CAMHS but are too challenging or too um that that then at level of need is too high for other things and there is currently this massive gap and that would definitely include children and young people who are displaying OCD behaviours” EP 1 “Yeah there's the low level support staff and the low level supports there for that initial first bit but then you know you you don't quite meet the criteria but for CAMHS so you sort of kind of fall off the cliff when things start to and and then of course if you're not getting that support they're going to exacerbate and two years time you'll be getting CAMHS support when you’ve got to that point where things are becoming

			detrimental to your daily life um and maybe prevent you going to school for example thinking of the young person I'm working with currently so yeah it's um yeah this is quite complex things going on there so yeah" EP 1 "so they're not falling off that big massive cliff between what is available in schools which is to support children with low level needs and low level OCD in particular and what is available at CAMHS level where their needs have become so overt they're impacting on their daily life so so it's kind of like trying to see if we can get back to bridging that gap ourselves a little bit really so I think that's what I'd like to see happen" EP 1 "unfortunately at that time in the local area the referral systems for paediatricians in terms of assessing social communication needs had changed and so that young person didn't unfortunately fit into that category which I think is um is a real gap in in the services being provided under know that there are some discussions about how that can be improved for those young people so I guess that was disappointing because actually it would be quite helpful just have that explored in a bit further detail" EP 2
		Signpost externally	"I think sign posting is a key role and knowledge of local services even though you know I admit my own kind of lack of knowledge in that area" EP 2 "speaking about going to um get um that kind of EPT like therapy which we wouldn't do as EPs but actually knowing that that was best practice in terms of

			supporting with one person and kind of seeking out that diagnosis via um CAMHS and paediatricians" EP 3 "also their school started to refer to other services" EP 3 "but actually we knew a bigger piece of work needed to come from potentially outside of school" EP 3 "I think initially because my cases initially started as statutory and then some like going into a TAC (Team Around Child) meeting initially it was about inviting those other services in or referring to them" EP 3 "I've never been sitting in a meeting with... maybe one meeting in my seven years of working with um a link CAMHS professional but usually it's it's kind of getting the referrals in and are supporting schools I think maybe a referral would be appropriate" EP 3
	Time constraints	Limited time in schools	"the barrier I guess is is actually that's not common now I think that I I've been in an unusual position where I've been able to build up those relationships over a long period of time and the schools trust buying some additional time and not uh not many EPs are in that position so uh a lot of EPs are trying to work with these complex cases based on purely a really small part of community time within their school and it's about trying to address those needs and do that early intervention work to prevent those cases coming up to that next level of support" EP 1

			“actually I'm thinking about you know how often do we do PDR pieces of work if we're not traded so I'm really lucky as I said I've got a huge traded package with my schools but actually we don't do very many PDR pieces of work anymore” EP 1 “when I was a TEP you had time I had time to kind of put programmes in school and kind of develop them with TAs and do pre and post stuff and kind of drop in on these kind of CBT type groups for children who are anxious” EP 3
		Lack of EP time	“you know as EPs we are rarely kind of hands on for extended periods of time in a way that that these children and young people would have needed” EP 3 “I think potentially one of the barriers might also be the amount of time that we get to spend in school and work on cases that come up to us and then actually we need a... basically we go into school to support children that SENCos are concerned about and we don't know what the children we don't know about” EP 3 “I think more and more... we we rarely work in that way sometimes we do get to I guess depending on the school and their trading get to do that creative pieces of working in school” “um so the second one... didn't go as well um... and I it didn't go as well because it wasn't such a complete piece of work” EP 4

			“I don't think I foresee a sort of role in the current political climate that we would be involved in doing that sort of intense it you know work with and with a young person” EP 4 “I think yes more more time to work with the young person” EP 4 “more time to work with the young person” EP 4 “it's not even like I feel comfortable that the school EP would be able to do quite an extensive piece of work with that young person I think it was probably that they would be able to offer a bit more advice in consultation but other than that... unless the school buys them time which yeah” EP 5 “I feel that the support that I could offer was limited by the time that that I was able to give a to give the school” EP 6 “I think you know time time was a barrier definitely” EP 6 “I perceive the only barrier to have been um time and availability and that sort of thing really” EP 6
		Fire fighting	“I think that's a major barrier and and over the last eight years or so I've seen a massive change in how we work as an EP... I've seen us being called further and further away from those preventative pieces of work that would have ordinarily have done a few years ago into their sort

			of much more firefighting work that we're doing now" EP 1
		Preventative work	"several years ago we would have been involved in a much lower level if that makes sense... yeah that's that's definitely a barrier" EP 1 "it is at that point where the schools are just going I'm not sure what's going on here something's not quite right something isn't working all the things we're doing or not you know we want a little bit more understanding and I think that's where our unique role is quite often we are the first people to go 'could it be...' lets think about how we gain the evidence in order to either refer further on or or what support can we do through our own actions you know through our own plan do review and get any actions in place to support that child um so as I've said I've run through quite a few thing that are put in place for a potential thing" EP 1 "I'm hoping that we're going to see more of focus on that preventative type of work and more of a kind of uh of us regaining some of that kind of skill set that were almost kind of losing really" EP 1 "thinking about actually what does that look like what does that consultation process look like when we're talking to um and how do we regain some of that early intervention work so that we can do that early work so that we're not seeing children escalate up to that much higher levels" EP 1

		Plan-do-review	“for most children that their level of support would be perhaps us coming into school offering that PDR support” EP 1 “lets monitor this lets think lets start recording what’s going on lets start doing some ABC charts and see what’s happening for that child or young person and asking that through the plan do review process asking them to kind of come up with more information so that we’re information gathering I think that’s where we are in a unique position is quite often these things are brought to us” EP 1 “I then went back and reviewed things that we put in place for that young person in terms of the shorter term within school it was things like um how to reduce anxiety how to gain like a wider picture of understanding of his needs” EP 2 “it would be interesting to to go back um... and see after a significant period of time how things are going and perhaps that would be you know the next thing to do” EP 6 “I suspect that you know in an ideal world I would have been able to spend more time you know going back and reviewing and working on you know other ways of adapting perhaps adapting the environment and other strategies but you know I think it was very time constrained unfortunately” EP 6

			“in an ideal world I think there needs to be new good opportunities to sort of review and and plan” EP 6 “then you know having a cycle of review really” EP 6
		Ongoing work	“for the case that I've been most recently involved in I've known the child and young person for about five years which has been really really interesting to see the kind of change in his presentation of his OCD type behaviours and how they kind of manifested for him” EP 1 “my experience the schools that I've worked with certainly the the last five years I've been working with the same schools which is unheard of for an EP you know to have that luxury of getting to know a group of schools and SENCos that well is fantastic and to have that continuity of cases as well it has been really really helpful” EP 1 “I mean in a perfect world it would be lovely wouldn't it for us to do individual work with children and young people that is ongoing over weeks and weeks and weeks that's not gonna happen that isn't gonna happen and I’m a realist you know” EP 1 “I mean ideally we'd be in a in a in a system where we could give a little bit more time to these children and work a little bit more closely with them and kind of develop that knowledge” EP 5

			“I would like to have more time um I would like to see it through as a process I think because I guess thinking about that psychology and I think for me that the biggest point is that these children experts in their own lives and trying to follow that through the whole process and kind of particularly the one that's transitioning back into school or to a new setting kind of that I would like to be a part of that process to kind of follow that make sure that that thread is continued because I think for a lot of and this is just just my thoughts I don't know whether it's correct or not a lot of it comes down to control and feeling like things are within control and that I think that process has the ability to shift how in control they feel” EP 5 “I suspect that you know in an ideal world I would have been able to spend more time you know going back and reviewing and working on you know other ways of adapting perhaps adapting the environment and other strategies but you know I think it was very time constrained unfortunately” EP 6

Main theme (SENCo group)	Subtheme	Code	Supporting quotes
Developing an understanding of OCD	Staff knowledge	School staff experience	“We've probably got quite a few children who have OCD in our school” S1 “it's a lot about experience as well I think isn't it you know in a way and an awareness of I think you know I've been you know I've been doing this 30 years so I think I

			think it helps when you have so much what's the word... you just so much experience and I think you sometimes you know you can put strategies into place because you can clearly see it" S6 "So I don't have much experience of working with students with OCD" S3 "I haven't had a great deal of experience with OCD at all actually" S3 "it's difficult to say 'cause I as I said I haven't had haven't had a lot of experience" S3 "I don't really have much experience of OCD" S3 "if I had a parent come to me and say I think my child's got OCD I don't know whether I'd be confident to know how to deal with that you know where to you know where to refer them or what what to do from there" S4
		School staff confidence	"that's what they found so hard is they didn't know if they were going to make things worse by saying certain things and they really worried about making things worse and worried about him but of course we don't have those answers either so I think it helped them to have somebody else support them through that" S1 "I think training the staff in school um is the and supporting the student in school and knowing... and just giving staff that confidence that they are not going to make things worse if they make a mistake if they say

			things wrong and giving them the knowledge and the... and the skills really to to kind of be confident in what they're doing and to support in a confident way" S1 "as a school I often feel like I don't know what advice to be giving" S2 "really conscious that I'm not um... trained to be giving advice on on OCD but absolutely happy to signpost" S6 "new for us at school that we've never had that extreme and we didn't know how to handle it with the kind of softly come on you can do it encouraging approach or whether but that no you are doing this kind of this more stern approach" S1
		School staff knowledge	"I don't know enough about OCD and I'd probably say it's definitely I need something I need to know more about" S3 "there's so many stereotypes and misconceptions about OCD um... I think that's unhelpful as well you know that it's in common language of saying you know if you're particular about something oh you're a bit OCD that kind of thing and just not having that understanding of what actual OCD is and it's tricky yeah" S2
		Attitudes	"I mean it's um it could come back to the staff training again but you will have some staff you just think it's a bit ridiculous you know it can seem a bit ridiculous a kid doing the same thing over and over again that sort of snap out of it sort of attitude that could be quite tricky

			um... and difficult to manage in schools... but you would hope with the correct training these people could get over that" S2 "staff's attitudes and understanding so particularly I hate to say in Primary so you know they they come to the classroom they've got skills to learn they can sit and listen... that understanding of of behaviours like obsessive compulsive you know why can't I just like I just get over it why can't they just you know carry on... so for me it could be around kind of staff attitudes to some of the behaviours children like display... or or they're in control of it they're just being naughty you know it's choice behaviour... I hate that phrase choice behaviour... so I think that can be it that can be a barrier to to support" S4 "I think sometimes it's finding the right staff I you know we've I've plenty of people have asked me about becoming ELSAs and I just think you would be terrible you know with their best will in the world it's not it's not something anybody can just I don't think I would be particularly good you know" S5
	Training need for school staff	OCD module in teacher training	"I think sometimes I think when when when new people come into the profession I think it's it there there is perhaps a training need for staff to be aware of all of the various issues young people can um experience that can cause anxiety in their learning environment so that's a really good point I think probably and you you've opened my eyes up to it in that sense in that is probably on the teacher training program there may be an

			opportunity for this um unit or module to be shared with you know young teachers coming into the profession about things to lookout for and then if this is if if they do experience them who do we signpost to so I think perhaps you know out of this could come perhaps a unit to go into the PGCE course really" S6 "I suppose in terms of this it could be shared with the wider with an array of people so as I mentioned the PGCE course could be a good one but again it could be an opportunity where um wider training module on it" S6 "I also wonder whether it's something that needs to kind of come into SENCo training... so I've done my National Award and and and... it focused on the big hitters you focused on your ADHD and your ASD and dyslexia and and that got I don't you know OCD didn't really come in into that so again that's looking strategically as to how you can raise awareness and and make a difference" S4
		Training on strategies	"I suppose the ideal would be some training that a member of staff could attend... I'm I'm I'm a huge advocate for... so it doesn't have to if you've got to go externally all the time um... then you're always reaching that threshold before you can necessarily support effectively... so if there was some training that a member of staff could go on to um recognize or you know or a few stuff and maybe and whether that is right is within those pastoral teams or head of year and your student welfare staff who see the kids first and

			foremost in that graduated response... for them to recognise the signs and symptoms of OCD and know basic strategies" S4 "online resources... would be great you know hints tips etc you know sounds basic but you know if there was a a website around supporting young people with OCD in the classroom well even if it was just references to books or something would be really helpful it would give you somewhere to start you know when you're that entry level of assess plan do review... and you just want to start trying strategies 'cause you don't know that could be fine if you just put a couple of things in place that would be really useful" S2 "really working with the teaching teams to try and skill those upskill them to understand and know better" S1 "I'm thinking that of the two we've got so some it needs to be a kind of mix of some support in school for some strategies and training the staff" S1 "there's general mental health training which does like it will list OCD" S2
		EP to train staff	"(EP) did training with our teaching teams and so with two particular students (EP) worked with the teams and (EP) done a whole school couple of sessions and just on developing our whole school understanding of OCD and those needs of those of general OCD needs but also those particular students as well" S1

			“I think training the staff in school um is the and supporting the student in school and knowing... and just giving staff that confidence that they are not going to make things worse if they make a mistake if they say things wrong and giving them the knowledge and the... and the skills really to to kind of be confident in what they're doing and to support in a confident way” S1 “yeah absolutely… if an EP came to me and said I can offer support or training with OCD then definitely” S3 “in this model for OCD I'd probably see them within wave two and supporting me in terms of the provision and training you know providing some training and support for me and my team” S4 “whether that's something that EP service could help you know whether they can deliver that training or or provide the advice or signpost towards it I guess that that's where I'd see their role then again” S4 “I think in terms of my you know dealing with the EP was looking for support and guidance and and look for implementation and I think for me then what I would do is that if then I look at strategies that that was then identified and I put into place” S6 “working with the teaching teams to try and skill those upskill them to understand and know better and and that actually initially might involve you (Educational Psychology Service)” S1

			"definitely sharing that information with ALNCos and also perhaps um with the ALNCo regional meet where the EP could do a short recap presentation with the clusters you know across the place" S6 "coming in and listening to particular situations and case studies that we have got... sharing case studies that you know experiences that the EP is had from working across other schools" S3
		CBT training	"then some training for the TAs within my team to provide something like cognitive behavior therapy... or you know something or lower level... you know where they could do some individual or small group work because then we can repeat it over multiple children rather than have to refer out all the time" S4
		Need for more training	"Access to training... um would be really so helpful for staff and I think that that would solve an awful lot of the difficulties that we have" S2 "I definitely I think training is probably the main thing" S2 "we haven't had any training or anything" S2 "I think that there are possibly some training needs... definitely for myself and within within the team... yeah to understand how... how we can support it better" S3

			“delivering that... you know via training kind of practical training where possible would be would be really good” S3 “I think that's around it that comes back to training again and and their understanding” S4 “I meet with my additional learning team every fortnight for one hour CPD so I think what would be really useful is for us to have a session around OCD so we could um we could develop the knowledge around it in the team and if we feel then that we could share that with the wider school community whether it be via a presentation or in terms of just ensuring the young person’s person centered planning was up to date um to capture it and I think there’s a definitely training session from an EP in relation to our school would be very useful” S6
		SENCo to upskill staff	“usually it's (assistant SENCo) advisory teacher but just to make sure that they are up to date in confident in what they're doing” S1 “the teaching teams will kind of lead on that but if they you know will make sure that they have the knowledge and training to do that and assistant SENCo will work with them” S1 “I guess at first it depends on what the OCD is actually about whether it's to do with you know keeping up with work or whether it's to do with kind of hygiene and cleanliness which in this particular situation it is so... in

			terms of you know again I'm I am not aware that he has any rituals in school to do with walking a particular way around the school or having to wash his hands or you know etc but um... we we just we just prep staff to make sure that they if they notice anything well they are concerned to make allowances for that and obviously to get back to us" S3
		Lack of online resources for schools	"I've really struggled to find adequate resources there's resources online about OCD but not that I've been able to find it really talk about the classroom... and the education setting and they speak more to the individual or the family I would say rather than than teachers and SENCos" S2 "spent a lot of time trying to look online to see if there is anything" S2 "I mean if you if you Google dyslexia strategies for the classroom you'll get books and sheets of prompts and all that kind of thing... nobody seems to have that I can find anyway there doesn't seem to be a go to resource for it... often often there is a book isn't there there's a book that everybody would say you know read this book to start and but yeah nothing's been recommended to me" S2
	Priority of OCD in school	SLT priority	"a strategic position from the SLT... actually that that's not OK to have that approach or that thing and that has to kind of be that again that will take time to filter through but it's got to come from the top" S4

			“it’s helpful I think if you have a really understanding leadership team in school that will provide space and provide time um then that’s helpful and one’s that can see the worth in what you’re doing” S5 “I can only speak from a secondary point of view and I appreciate that SENCos in a primary school would be in a very different position and I think it's quite different role given how much time you teach etc when you're in primary and obviously they’re a much smaller setting that you've got but speaking from a secondary SENCo point of view I think... there is something about how SENCos are trained there's something about and this might be in the new code of practice that SENCos are on an SLT... and you know you can barge your way in there you don't have to wait to be invited that's what I did... and it may you need to turn up for that meeting you know when is the SLT meeting I want to come to that kind of attitude rather than waiting to be invited but I get that that’s difficult and time consuming” S2
		CYP are unknown to SENCos	“I might dip in particular for something like OCD because if they've got I can see if we had a child with a diagnosis... the head of year would turn around and go don't know it's but actually if their strategies and their provision is within wave one it would sit under our pastoral team then we've got the wave two provision which is where we might be trying something that's additional to or different from that's where my team over sees it” S4

			“some of it probably doesn't reach me... because if we have a you know well being team... so some of it probably doesn't reach the level of SENCo” S3 “I guess I worry about there's gotta be a lot of students that we just don't know about and they’re the ones they’re the ones we've gotta worry about really” S3 “probably gets to me when when it gets to me when you know there’s school refusal or um you know if parents want to apply for funding or an EHCP or I guess feel that they're not getting the support that they need” S3 “sometimes the behaviours are not really intrusive um at school but you do know there's a problem and you you want to provide early support rather than escalating to become a crisis situation” S2 “giving into parental pressures school pressures but ultimately SENCos... need to give themselves permission to take those things” S2

Appendix 13: Introduction to OCD training

An Introduction to Obsessive Compulsive Disorder in Schools

Becky Pearce
Trainee Educational Psychologist

Overview:

- What is OCD?
- How can it present in school?
- How can I help?

- **Statistics:**
  - Estimated around 1% of the UK population has OCD (OCD-UK, 2020)
  - Anywhere between 40-80% cases start in childhood (Chaturvedi et al. 2014)
  - Consistent in different countries, cultures and ethnicities.

OCD Myths:

- I'm a bit OCD..." "It's my OCD!"
- OCD is the same as obsessions with football or shopping.
- People with OCD love keeping things neat and organised.
- OCD is just about keeping clean and avoiding germs.
- It's obvious when a person has OCD.

What is OCD?

- Obsessive-compulsive disorder (OCD) has two main parts: **obsessions and compulsions.**
- **Obsessions** are unwelcome thoughts, images, urges, worries or doubts that repeatedly appear in your mind. They can make you feel very anxious (although some people describe it as 'mental discomfort' rather than anxiety).
- **Compulsions** are repetitive activities that you do to reduce the anxiety caused by the obsession. It could be something like repeatedly checking a door is locked, repeating a specific phrase in your head or checking how your body feels.

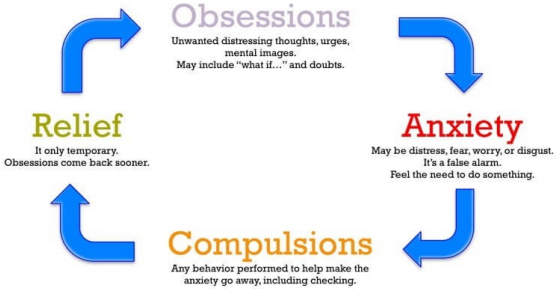
Obsessions

Type of obsession	Example
Fear of causing or failing to prevent harm	• **Already harmed someone** by not being careful enough. E.g. knocked someone over in your car. • **Going to harm someone** because you will lose control. For example, that you will push someone in front of a train or stab them.
Intrusive thoughts, images and impulses	• **Violent intrusive thoughts or images** of yourself doing something violent or abusive. These thoughts might make you worry that you are a dangerous person. • Thoughts can also be sexual, blasphemous, or doubts over relationships.
Fear of contamination	• **Contamination (for example by dirt, germs or faeces)**. You might worry that you have been contaminated and that you - or other people - are spreading the contamination. You might worry that you have or might get a disease. • This can also be **mental contamination** - experience feelings of dirtiness triggered by your own thoughts, images or memories.
Fears and worries related to order or symmetry	You might have a **fear that something bad will happen if everything isn't 'right'** - for example if things are not clean, in order or symmetrical.

Compulsions

Compulsion	Example
Rituals	• washing your hands, body or things around you a lot • touching things in a particular order or at a certain time • arranging objects in a particular way
Checking	• checking doors and windows to make sure they are locked • checking your body or clothes for contamination • checking your body to see how it responds to intrusive thoughts • checking your memory to make sure an intrusive thought didn't actually happen • checking your route to work to make sure you didn't cause an accident
Correcting thoughts	• repeating a word, name or phrase in your head or out loud • counting to a certain number • replacing an intrusive thought with a different image
Reassurance	• repeatedly asking other people to tell you that everything is alright.

The OCD Cycle



Subtle ways OCD can present in the classroom:

- Distraction
- Needing extra time
- Avoidance
- Tapping or touching symmetrically
- Repeating questions
- Fatigue
- Late to lesson
- Long or frequent trips to the bathroom
- Low attendance

Listening/Participating: not concentrating on what a teacher says; misunderstanding key points; not giving prompt answers; avoiding topics/class activities
Work Completion: getting "stuck" on a question; inability to skip items; overly thinking about questions or doubting one's answer; need to complete tasks perfectly
Exams/quizzes: not able to prepare enough; challenges with multiple choice items and timed tests; uncertainty about "right way" or "right answer"
Reading: being distracted from words due to focus on worries (e.g., highlighted red = blood) or rituals (e.g., counting letters); need to re-read to fully understand meaning
Maths: avoiding to complete problems that contain certain numbers; redoing/re-checking problems; difficulty with rote memorization due to focus on obsessions/compulsions
Writing: putting ideas on paper (e.g., perfectionism); tendency to excessively erase or re-write things; taking too long to write sentences (until it feels "just right"); handwriting difficulty (too rushed or too perfect)

Consequences of having OCD:

- Poorer academic achievement
- Struggles with social life
- Depression
- Low attendance
- Stigma within the community

Top Tips

1 **Good communication between home and school is important.**

A 'diary' or 'concerns book' can help to monitor and share progress. A child with OCD may be a target for bullying. If the child and family are in agreement, it can help to have a classroom discussion about OCD so that classmates understand it better.

2 **Don't be impatient or criticise/punish a child for behaviour they can't control.**

But it's important that children with OCD, like other children, are helped to learn good behaviour and obey rules. It's also important they miss out on opportunities so help them to 'face their fears'. Help them to focus on their strengths and on areas where they feel confident.

3 **If a child becomes anxious in the classroom, it can help to recognise this.**

Options are to help them 'sit out' their anxiety, discuss it, or take a short break. Be aware that some subjects may be more difficult depending on a child's worries, e.g. maths might be tricky for a child who worries about numbers.

https://www.mentallyhealthyschools.org.uk/mental-health-needs/obsessive-compulsive-behaviour/

How can I help?

Concentration

- Break up tasks into smaller steps.
- Teacher or supportive adult should be at close proximity to remind students of the task and re-engage them.
- Breaks should be offered to students if they appear distressed or distracted.

- Task Completion
  - If there is an issue around writing, staff are recommended to offer alternatives such as audio recording or typing.
  - For reading tasks, teachers are advised to offer shorter passages, simplified versions, or the option of someone else reading to the student.
  - Students should also be offered extra time for assignments and in exam conditions.
  - Give students a different task to complete or give alternative ways to complete the task if they appear stuck.
  - Keep a note of what lessons are more difficult for the student

How can I help?

Reassurance seeking

- Teachers should praise on task behaviour.
- Teachers should try and ignore reassurance requests, instead they should bring the student's attention to the work they are currently doing
- On some occasions a nonverbal symbol may be agreed between staff and young person to show this is an OCD question

Transitions

- It is recommended that students are not penalised for being late.
- Teachers can leave handouts and instructions on a student's desk so they can join in when they arrive. This can be done for other members of the class too, so the student doesn't feel singled out.
- Keep the school day as consistent and predictable as possible and give the student plenty of notice if there is any change.

Collaboration is key!

Useful Links:

- https://www.mind.org.uk/information-support/types-of-mental-health-problems/obsessive-compulsive-disorder-ocd/#.XcmGand2vIU
- https://www.nice.org.uk/guidance/cg31
- https://www.researchgate.net/publication/249832670_Teaching_Students_With_Obsessive-Compulsive_Disorder
- https://www.ocduk.org/
- https://ocdaction.org.uk/resource/ocd-school-personnel-guide

Appendix 14: GDPR form

Personal data research form

Researcher responsible for the data: Rebecca Pearce

Research project name or SREC code: EC.20.03.10.5981RA

Description of personal data held or processed. Provide a narrative description of what the data are.	Participants will be interviewed via video call technology and this will be recorded and stored on an encrypted memory stick and will only be accessible to the researcher.
Information that is being held or processed. Indicate the nature of the data: how could the person be identified and what information is stored alongside that identity.	This electronic recording could be identifiable to the participant through the sound of their voice. Participants will be reminded not to mention individual names during the interviews, however if this does occur then names will be replaced with a pseudonym at the point of transcription.
When is data collection likely to begin and be completed?	May- October 2020.
Number of individuals for whom information will be held.	8-12 participants.
Lawful basis for processing. This will probably be 'Public Interest' or 'Consent'.	Consent
Does the data include special category data (or Criminal offence data)? Special categories include: race, ethnicity, politics, religion, trade union membership, genetics, biometrics, health, sex life or sexual orientation. If yes then is specific consent used to process this information?	No
Length of time personal data will be kept. Personal data should only be kept for as long as necessary. Research data should be anonymised as soon as possible and the length of time before this happens should be communicated to the participant.	The interview recording will be transcribed within 2 weeks of each individual interview, after which time the participant's data will become anonymous. Participants will be made aware that after this time they will no longer be able to withdraw their data from the research. Each individual interview recording will then be deleted

	and the transcriptions of the interviews will be kept by Cardiff University indefinitely.
What are the data security procedures? Ensure all personal data is kept secure.	Recording will be transferred to an and stored on an encrypted memory stick straight after the interview. Memory stick will only be accessible to the researcher.
List CU (Cardiff University) staff who have access to the personal data.	Dr Dale Bartle
Indicate whether all people listed above have completed their mandatory information security training. Available here: https://intranet.cardiff.ac.uk/staff/news/view/211993-information-security-training-when-will-you-complete-yours	Yes
List CU students who have access to the personal data.	Rebecca Pearce
What guidance or training have/will the students receive concerning data security?	I have completed the Research Integrity and Information Security modules provided by the university. I also have training and supervision throughout my Doctorate.
List people external to CU who have access to the personal data. Provide their affiliation	None
What agreements are in place for data security outside of CU?	N/A
Justification for not anonymising these data. Explain why the data are not or cannot be anonymised.	Interviews cannot be considered confidential from the researcher, however will be anonymised within 2 weeks of the interview taking place.