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DPsych Counselling Psychology

Portfolio for Professional Doctorate in Counselling Psychology

The impact of adverse childhood experiences:

A portfolio of work incorporating an empirical study on adverse childhood experiences in learning disability professionals.

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Preface

The doctoral portfolio represents my journey to become a Counselling Psychologist. It consists of three distinct pieces of work. The following portfolio aims to understand the impact of childhood adverse experiences from a critical realist and phenomenological perspective.

The research contains the thesis and a publishable paper summarising a segment of the critical research findings. Finally, a case study of a client with severe anxiety underpinned by a background of adverse childhood experiences is presented. The case study represents an example of my clinical work on my journey to become a Counselling Psychologist. Whilst I view myself as an integrative practitioner, adapting my approach to meet the needs of my client, the presented piece of therapy is from a client I worked with using a Cognitive Behavioural Therapy (CBT) framework.

1.1 Research

This section of the portfolio presents an original piece of research in the United Kingdom. It combines my personal research interests in the use of the Adverse Childhood Experiences measure with professional practice working in NHS Learning Disability Services with clients who have an Intellectual Disability and mental health difficulties.

The Adverse Childhood Experiences (ACE) research was begun by Feliiti et al. (1998) and my interest in this was ignited after attending a conference where it was presented, and the preventative work attached to this was discussed. The service level changes that had been made because of this excited me, especially when some of the preliminary outcomes were shared. After the conference, I continued to follow the ACE research base which began to rapidly develop. From my professional practice, I knew ACE research was lacking in Learning Disability Services. It also struck me how the research base was predominately quantitative in nature and the experiences behind the ACE measure were missing. These observations, therefore, motivated my research project to understand how adverse childhood experiences impact professionals working in learning disability services.

In line with the limitations of the current research base and my ontological assumptions, I chose a mixed-methods approach to the research. This allowed me to quantify how much adverse childhood experiences impact professionals working in Learning Disability services and hear the experiences behind this. The findings of the study were related to the existing literature base, with comparisons made to the sample from Hughes et al. (2020) study. A notable study which influenced the current research was by Keesler (2018). The research will be discussed in detail, including the relevant literature. The findings will be presented in full, the meaning of which will be discussed and linked to existing theory. The results include the ACE measurement, the frequency of professionals who listed a desire to help others as their career motivation and Thematic Analysis of the semi-structured interviews. The research was shaped by a Critical Realist standpoint with phenomenological underpinnings.

1.2 Publishable Paper

The publishable paper summarises the main findings of the research. The paper summarises the research study and outlines some of the key findings. The quantitative results are briefly outlined, and one of the three major themes found in the interviews is discussed. The theme of ‘my personal relationship with help’ will be discussed in detail. This theme was chosen for the paper as it was the most notable theme that emerged when analysing the data, and most strongly aligned with my research question 'Do Learning Disability professionals have a higher rate of Adverse Childhood Experiences than the general population and do they identify this as a factor influencing their career?'. The paper provides a deeper understanding of how adverse childhood experiences can impact healthcare professionals and what the impact of this is on their work in Learning Disability Services. This provides an important contribution to the ACE research and research for Learning

Disability Services in the United Kingdom. The paper has been written in the format of the Journal of Applied Research in Intellectual Disabilities (JARID). This journal was selected as it is a well-respected journal for research within Learning Disability Services. It has recently published several papers linked to trauma, trauma-informed care and ACE research.

1.3 Professional Practice

A combined client study and process report are presented as an example of my professional practice. This represents a piece of clinical work that took place in my final year placement with a Children and Adolescent Mental Health Service (CAMHS). The presented client had a background of adverse childhood experiences which had led to severe and enduring difficulties with anxiety. This case was chosen as I felt it represented my developmental journey as a final year trainee working towards qualification as a Counselling Psychologist. I also selected this case as I found it incredibly rewarding to be a part of the journey the client took in overcoming their past adversity. At the start of our work together the client felt unable to leave the house and had little confidence in themselves. The anxiety was severely restricting their quality of life. Using CBT, the client made significant process and was moving forwards with their life goals through therapy. They felt confident to leave the house, engaging with previously enjoyed activities and exploring new areas of life that interested them. This placement led to significant learning for me as it was a new client population for me to work therapeutically with. Professionally most of my clinical experience has been working in NHS or state Learning Disability Services.

The case study presents the assessment conducted with the client, the collaborative formulation we created and the agreed treatment plan. A segment of our work is then discussed in detail with a process report. The presented segment showcases the first time the client was able to share a distressing thought out loud in a therapeutic session. It was an emotive session, one that was challenging for me, but that led to significant developments in the therapeutic relationship. The segment is evaluated with the therapeutic relationship and use of supervision discussed. In summary, the professional work showcases an example of working with a young person using a CBT format, to overcome anxiety following a background of adverse childhood experiences.

1.4 Personal Reflections

Completing the doctorate has been a true journey of development and challenge. Shortly after commencing the programme, the Covid-19 pandemic hit the world. This changed the landscape of training and clinical practice, bringing many challenges and lessons. On a professional level, we were the first cohort of trainees to adapt to online therapy in such a short space of time. Prior to the pandemic, I had never considered offering therapy in this manner however I now truly believe it can offer value to my clinical work. For instance, some of the clients I have worked with in Learning Disability Services have acute physical health needs. This can impact their ability to attend appointments; therefore offering therapy remotely has been revolutionary for this group of clients. Equally working remotely for my research added the value that I could offer the research to people who worked in services across the United Kingdom.

A further significant contribution to my journey during training has been engaging with personal therapy, which is a requirement of the course. I learnt a lot about myself through this process, about who I am and how I want to be in relationships. This process has made me more in tune with my own thoughts and feelings, which has added benefit to my clinical practice. Through this, I have grown my ability to be truly present in the therapy room and more aware of the therapeutic process between the client and me.

Finally, the major thing I will take away from my time at City University is what the identity of a Counselling Psychologist means and helped me develop my own professional identity.
I hope that this thesis represents my development across the training, whom I am becoming as a Counselling Psychologist and that I have done justice to the narratives of my participants and client that I share in this portfolio.

Part 1.1 Doctoral Research

Do healthcare professionals have a higher rate of Adverse Childhood Experiences (ACE) than the general population & do they identify this as influencing their career? Experiences of Learning disability professionals.

Supervised by Dr Julianna Challenor & Dr Kathryn Emerson

Declaration

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Abstract

This study draws on the Adverse Childhood Experiences (ACE) research and Jung's concept of the wounded healer (1945). The current research aims to extend these concepts to understand the prevalence of adverse childhood experiences in healthcare professionals, along with if this influenced their career choice and experiences within the workplace. Specifically, healthcare professionals working in learning disability services were chosen for this study to extend the research begun by Keesler (2016; 2018). This current study takes a new direction by using a mixed methods approach to investigate the prevalence of adverse childhood experiences in professionals and their experiences working in learning disability services. The structured ACE questionnaire was administered online to professionals working in learning disability services. The score of healthcare professionals was compared to the ACE prevalence of the general population using statistics from Hughes et al. (2020) study. A significant difference between 0 ACE (U=114594, p=.000) and 4+ ACE was found between samples (U=249606, p=.000). A subset of professionals opted in to follow up semi-structured interviews to understand their experiences, analysed using reflexive Thematic Analysis. Major themes from interviews were experiences of help, communication in learning disability services and the journey of services and clients. The study provides evidence for the concept of the wounded healer attracting people to helping professions. Previous adversity interacted with the theme of help, and specific experiences working in learning disability services were explored in the remaining themes. The study provides valuable preliminary information, which could be applied to developing staff support, with the potential to improve staff wellbeing and client care.

Introduction Chapter

Aims of the study

The current research aims to expand the ACE research by Felitti et al. (1998) by applying this to the concept of the 'wounded healer' (Jung, 1945). The wounded healer is a professional who has experienced difficulty themselves, creating wounds. They use this in their pursuit to help others, but consequently, this relationship also benefits the helper's wounds through the act of helping. Research has linked 'wounded healers' as being more likely to choose helping professions, such as therapy, as the result of their difficult experiences, frequently this has been connected to adverse experiences during infant years. Furthermore, such experiences have been linked to the advantage of increased empathy in their work with clients, as long as the helper's wounds have been sufficiently healed or managed (Schonau, 2012; Wolgien & Coady, 1997). If the helper's wounds are unresolved, then the act of caring for others can become a burden to personal wellbeing (Gerada, 2015). The prevalence of 'wounded healers' in helping professionals, the underlying mechanisms shaping career choice and how this impacts the ability to help is still not fully understood. The concept of the wounded healer along with these unanswered matters shaped the current research objectives. The research aims to examine the prevalence of adverse childhood experiences in healthcare professionals, to understand how this has influenced their work and their experiences in the workplace. The study chose to use learning disability professionals, due to the association with high rates of re-traumatisation and burnout (Keesler, 2016), because of the requirement to manage complex needs and challenging behaviour at work. By inviting participation by professionals most at risk of re-traumatisation, it is hoped that the current study will inform further preventative measures. The study had a research question 'Do healthcare professionals have a higher rate of Adverse Childhood Experiences (ACE) than the general population and do they identify this as influencing their career? Experiences of learning disability professionals in the workplace.'

A mixed-methods approach has been used to meet the research aims, providing a holistic approach to the study as informed by my ontology. The quantitative strand of the study had two hypotheses. The hypothesis H1, 'Learning disability professionals will have a higher rate of Adverse Childhood Experiences than the general population’ was explored with the directional hypothesis that the sample will have a higher ACE score than the general population. The second directional hypothesis H2 investigated if 'professionals state a desire to help people as their career motivation'. The study aimed to complement the quantitative hypotheses through follow-up interviews. The qualitative aspect aimed to understand the research question 'How do healthcare professionals understand their work in learning disability services in relation to their experiences.' The qualitative aspect of the study aims to understand how professionals’ past experiences interact with their work, alongside hearing about their experiences within the workplace to understand what is meaningful to them in their role and what are the challenges they experience in learning disability services.

The literature review formed an essential part of designing the current research. Through reviewing the existing literature base, I the researcher, understood the developments made in the ACE research field. This included applications to the field of Learning Disabilities and trauma-informed care.

Search strategy and study selection

To inform the research question further a critical literature review was conducted. The search began by reviewing the literature that had inspired the research question. I reviewed the documents from the ACE awareness training that I had attended, and this directed me to the Felitti et al. (1998) article and the Centre for Disease Control and Prevention (CDC) website. I reviewed both, from which I became aware of the list of endorsed ACE research by the CDC. In total this resulted in sourcing 9 journal articles dated between 1998 and 2019. The initial reading from this informed the ongoing search strategy.

The search for further literature took place using the University of City library search function. The library is affiliated with the London University group, providing access to over 25,000 journal articles (City Library, 2022). The initial search used the term 'Adverse Childhood Experiences' refined from the date of the initial ACE study of 1998 to the present day. The only exclusion criterion was articles that were not available in English. A wide initial search was selected to understand the breadth of the literature. A total of 124,491 results were found, ordered by relevance. The results included journal articles and books. The results were reviewed for relevance by content. Any article that held relevance to the research question was included. Some irrelevant results had to be excluded as they were not in relation to the ACE research, including a series of medical journals about physical health illnesses in childhood that were not linked with experiences of adversity. In total, a further 13 articles were found through this search strategy. These articles were reviewed in detail, including their reference lists. A further 12 relevant articles were found by reviewing the reference lists. The literature found was predominately from America with popular journals, 'The Journal of Preventative Medicine' and 'Child Abuse and Neglect'.

The search strategy then became more refined, using the search terms' Adverse Childhood Experiences and Learning/Intellectual Disability'. The search continued through the university library, again filtered by availability in English. A total of 302 articles were found that again were reviewed for the relevance of content. A total of 8 journal articles were sourced through this search. All journal articles were reviewed in detail, including looking through the reference lists. A further 4 journal articles were found through reviewing the reference lists. From reviewing this literature, I became aware of the link between managing challenging behaviour in learning disability experiences and trauma responses (Rose & Rose, 2005). This prompted a new search term of 'impact of challenging behaviour, staff'. A single journal article was kept from this search, and this search term was not used again as the term generated largely irrelevant results.

Using the same parameters, outlined above, the further term 'Adverse Childhood Experiences' and 'staff/professionals' was added to the search. This new search yielded a total of 216 results, again reviewed for relevance. Only 3 articles were selected for their relevance from this search, however, reviewing the reference lists resulted in a further 4 articles being sourced.

The search strategy was repeated through direct journal article websites to ensure that no results had been missed. The terms 'Adverse Childhood Experiences', 'Learning/Intellectual disability' and 'staff/professionals' were also used with the criterion of results in English. This search was conducted in the American Psychological Association, Journal of Traumatic Stress Research, Counselling Psychology and Web Sciences Databases. A further 8 journal articles were found through this search, with no date criteria being used.

This initial search was conducted in 2019 and resulted in a total of 61 sources being found in relation to the research question. As the researcher, I signed up for alerts for any new articles that were published using the search terms across databases. Across a 2-year period, a further 15 journal articles were sourced from this. The total literature informing the review was 76, most of which were journal articles. The oldest piece of literature included was Jung's (1945) book as this was a classic piece of text relevant to the field. This was an exception, and most texts were from the last 20 years, with the most recent text included being from this year (2022). Most notably several articles were published in the Journal of Applied Research in Intellectual Disability, which is a well-respected publisher of research in the field of Learning Disabilities.

Introduction

Terminology

1.1 Adverse Childhood Experiences

The definition of Adverse Childhood Experiences is taken from Felitti et al. (1998). The 1998 study defines Adverse Childhood Experiences across seven categories of distressing events. The experiences include having physical, sexual or emotional abuse, witnessing domestic abuse, living in a house with mental health difficulties, use of illicit substances within the home or having a caregiver imprisoned. These experiences are listed on the Adverse Childhood Experiences questionnaire, where exposure to one of these events counts as a score of one on the questionnaire. The cumulative score from the questionnaire is referred to as their ACE score.

1.2 Childhood

Through this study, the term child or childhood refers to a person under eighteen years old. This is the definition used in the Felitti et al. (1998) study and informed the inclusion/exclusion criteria for administering the ACE measure. This is the definition used by the United Nations (1989) and is a well-recognised definition of childhood.

1.3 Healthcare professional

For the purpose of this study, any professional providing care to people with a Learning disability was classified as a healthcare professional. This included care/support workers, day service providers, care home managers, teaching assistants within a specialist education setting, nurses, and therapists.

1.4 Learning/Intellectual Disability

The British Psychological Society (BPS) (2000) defines an intellectual or learning disability as a significant impairment of intellectual and adaptive functioning. The impairment must be present before the age of eighteen years. The BPS specifies that all three criteria must be present for a diagnosis to be made. Specific guidance is provided on how assessments of intellectual and adaptive functioning can be tested. Whilst this document outlines what constitutes a learning disability, it recognises that this is an umbrella diagnosis and that the people with this diagnosis are unique. The term learning disability should not be confused with specific learning difficulties or neurodiversity, for instance, Dyslexia or Autistic Spectrum Conditions. These are specific conditions that do not equate to impaired intellectual and adaptive functioning.

1.5 Trauma-Informed Care

The ACES Aware Initiative (2022) defines Trauma-Informed Care as a framework used to understand and respond to Adverse Childhood Experiences. The framework is based upon understanding the impact of trauma, recognising the impact on wellbeing, training others to be trauma-informed, leading on care practices being trauma-informed and avoiding re-traumatising clients. Trauma-informed care is based on providing a safe place for all in services. For clients, this means that care is collaborative, person-centred and based on evidence-based practice.

1.6 Person-Centred Care

It is a values-based approach that puts understanding the individual at the heart of the practice. This includes building a good relationship with them and understanding their likes, dislikes, hopes, and wishes. By understanding this, good quality care can be provided, along with recognising when things are not going well (Jones, 2022).

1.7 Positive Behaviour Support

Positive Behaviour Support is based on behavioural science. It views most behaviour as a means to communicate needs. Positive Behaviour Support should be used alongside person-centred care to meet a person's needs. It endorses finding new ways to support a person and considering environmental changes. It views any approach based on punishment to be unethical (Jones, 2022).

1.8 Burnout

Sprang et al. (2007) define burnout as a state that involves several components. This has been said to involve negative symptoms of exhaustion, depersonalisation and not finding satisfaction in things. In addition, there will be impaired functioning, physical and mental distress, and a negative change in a person's attitude.

Literature review

The Adverse Childhood Experiences Research

The (1998) study by Felitti et al. was the first to examine the link between traumatic experiences during childhood to outcomes in later life. This is cited as a key time in a person's development (Zeanah, 2009). The ACE measure screens for traumatic events by looking at personal experiences of abuse and household malfunction. Specific questions were asked regarding experiences of abuse which were psychological, physical, or sexual. Respondents were asked if they had witnessed domestic violence or lived in a household where illicit substances were used. Other questions investigated if they had lived with someone experiencing mental health difficulties, who were actively suicidal, or had ever been imprisoned. In addition to this, the study asked respondents for detailed demographic and background information. This included the participant's highest level of education, employment status and relationship details. The respondents in the study were all patients at a private health clinic where they had attended a screening for physical health, with the sample consenting to their health information also being examined. The questionnaire was posted to a population of 13,494 adults who were patients and had attended their physical health screening between 1995 to 1996. A response rate of 70.5% was achieved with a final sample of 9,508. The respondents ranged in age from 19 to 92 years, with a gender split of 52% female and 48% male. Most respondents were white Americans (79%).

A graded relationship was found between experiencing a traumatic event and developing a disease or engaging with risk-related behaviours as an adult ($p<.001$). Logistic regression was used to adjust for confounding variables of age, sex, and education level. A significant correlation was found between the number of traumatic experiences encountered and developing health conditions, such as heart disease and cancer. A positive correlation was also found between trauma experiences and engagement with risk behaviours, such as smoking, which are associated with mortality and disease. The study concluded that there was a strong dose-response relationship between the number of traumatic events experienced with the leading causes of death (p,.001) and disease (p,.05). The study made the bold claim that exposure to trauma in childhood should be considered a cause of mortality in adulthood. Whilst prior studies have discussed the impact of a single traumatic event, the study by Felitti et al. (1998) was the first to examine the cumulative effect of trauma on health. Felitti et al. (1998) concluded their work by considering how this information could inform preventive healthcare.

The ACE study by Felitti et al. (1998) was revolutionary in the field. It has inspired further work to understand the health implications of trauma experienced in childhood. An example of this is Anda et al.'s (2006) study that examined the impact of childhood trauma on neurobiology, mental health difficulties and negative health behaviours. They surveyed 17,337 participants and found a strong dose relationship between the ACE score with negative health and behaviour outcomes (p<.001). The study linked the differences in health and behaviour to neurobiological changes in the brain due to trauma. Zeanah (2009) described how the brain has critical times in development through childhood, with key points linked to the development of neuro circuits and the brain's plasticity. Zeanah (2009) explained how adverse experiences during critical development phases can impact the brain's growth. Experiencing adversity in childhood can lead to 'toxic stress', where the stress responses in the body are persistently activated, including impacting the limbic-hypothalamic-pituitary adrenal axis, proinflammatory cytokines and catecholamines (Jones et al., 2020). This could explain why participants show differences in managing mental and physical health. Indeed, Chapman et al. (2004) found a strong graded relationship between exposure to ACEs and the risk of developing depression (p<.001).

Mersky et al. (2013) investigated ACE scores with social outcomes. Mersky et al.'s (2013) study consisted of 1,142 adults identified through the Chicago Longitudinal data. The study used multivariate analysis to understand the relationship between cumulative exposure to ACEs with life satisfaction scores and engagement with health risk behaviours; such as the use of tobacco, marijuana, and alcohol use. They concluded that participants who had experienced an ACE were more likely to have three or more poor outcomes on health or social data. The results from this study are like that of Campbell et al. (2016) study, which used secondary data from the Behavioural Risk Factor Surveillance System survey (2011). They analysed 48,526 cases and concluded that an ACE score of 4 or more was correlated with higher rates of binge drinking, obesity, and 'high-risk HIV behaviour'. These are typical examples in the field that have extended the original Felitti et al. (1998)

claims to health and social outcomes. Whilst only a handful of significant studies have been presented, it represents the scope of the ACE research field.

The ACE field has developed significantly recently and is now endorsed by several local governments, including in Wales, and the Centre for Disease Control and Prevention (CDC). A developing area from this is considering the long-term costs associated with adverse experiences and if preventative work mitigates this. Long-term effects of adverse childhood experiences include a graded relationship with sickness from work. Furthermore, associations were found with difficulties managing workplace stress and communication (Laditka & Laditka, 2019). Hughes et al. (2020) used the data from five other studies to examine a total of 15,285 cases from the United Kingdom. They aimed to understand the financial cost of work disability due to exposure to ACEs. They found a cumulative relationship between exposure to ACEs and health risks, where estimated costs of losses to productivity in the workforce due to health were calculated. Hughes et al. (2020) used a modified human capital approach to estimate the cost of ACE-related illness in workplaces. They estimated the highest ACE-related cost to be smoking, estimating a cost of £7.4 billion to the United Kingdom each year. The study recommended using this information in a preventative manner so that workplace adaptations reduce the likelihood of people having to be off sick. If this information were to be used proactively, then understanding trends in work-related sickness would be advantageous. The study had a good sample size in the United Kingdom, where census information was used to ensure participants' demographics were representative of the geographical locations being sampled.

The ACE measurement

The ACE questionnaire has ten questions, some questions include subsections, that measure three different forms of abuse and household dysfunction experienced before the age of eighteen. Felitti et al. (1998) constructed the questionnaire by reviewing other well-validated measures. This resulted in questions being taken from The Conflicts Tactics Scale (Straus, 1979), Wyatt and the National Health Interview Survey of 1988. Full methodological details are outlined in Felitti et al.'s (1998) article. From this, the ACE questionnaire was constructed and published for free use. Research has shown that the ACE measurement has good levels of ecological validity (Chapman et al., 2004; Anda et al., 2004) and test-retest reliability (Dube et al., 2004).

Although the measure has good levels of reliability and validity, it could be argued that the wording of the questions could be open to interpretation, with potential differences between cultures and generations. For instance, the meaning of divorce will vary across cultures (Finkelhor et al., 2013). It could also be argued that different types of adverse experiences will have different meanings depending on a person's culture. The ACE measure has been criticised for ignoring societal forms of adversity that impact wellbeing, such as coming from a poor socioeconomic background (Edwards et al., 2019).

A further limitation to the Adverse Childhood Experiences measure is that it relies on a self-report design. Recollecting traumatic experiences commonly results in people amplifying or minimising their experiences, affecting responses to questions (Thomson & Jaque, 2017). Retrospective questions are known to have limitations for reliability (Edwards et al., 2019). Then again, the ACE measure has been shown to have a good level of test-retest reliability despite the potential confounding variables, from memory and emotional intensity influencing answers (Dube et al., 2004).

Also, as the questions are measured in terms of frequency, it treats all the experiences as equal, when different types of experiences may be more emotive for respondents, resulting in different responses. LaNoue et al.'s (2020) study recognised this. It introduced a Likert scale for respondents alongside each ACE question to rate how much each type of adverse childhood experience is impacting their current life. Future research could benefit from this approach of exploring the meaning of experiences to individuals.

Evaluation of the ACE research field

As discussed, the Adverse Childhood Experiences literature has significantly contributed to understanding the impact of early trauma. However, the research has predominately involved white and well-educated people, with minority groups being forgotten, despite being more at risk for adverse experiences (Merksy, Topitzes & Reynolds, 2013; Vervoot-Schel et al., 2018). Differences have been found in the average ACE across socioeconomic groups. Participants from the most deprived socioeconomic area were more likely (12.7%) to score 4+ on the ACE measure than their counterparts from the most affluent areas (4.3%) (Bellis et al., 2014). Therefore, the ACE results from studies that are not representative of all societal groups may not be generalisable.

The ACE research could be criticised for not being person-centred or taking a representative societal view. For instance, two people may have the same ACE score, however, if the people are from different socioeconomic classes, then they will have access to different protective factors, which will affect their experiences (Liu et al., 2020). Indeed, the consideration of protective factors has not been considered enough in the ACE research to date. It could be argued that the ACE research has overlooked the role of resilience in the outcome of traumatic experiences, with the ACE measure treating adversity as predictive of negative outcomes. Variables relating to resilience that could be incorporated into future research include the duration of the trauma experience, personal temperament (Thomson & Jaque, 2017), social support, the availability of a safe adult and personal coping skills. Resilience can help trauma survivors avoid negative health outcomes and make positive changes in their lives because of their experiences (Crouch et al., 2018). Professionals caring for others are more at risk of burnout, so to maintain their resilience, practising self-care activities could be a crucial intervention (Mott & Martin, 2017).

Menschner & Maul (2016) highlight that there is no universal definition or consensus on what constitutes trauma. Therefore, they ask how one comprehensive ACE measure could be created that would include everything. ACEs are frequently discussed but without all discussions being based on competence and evidence-based practice. Menschner & Maul (2016) propose that going forwards, there needs to be more training on what an ACE measure is, and what this means.

It could be argued that asking people about adverse childhood experiences is unethical when it can cause a strong emotional reaction. Hardcastle and Bellis (2019) studied this in the United Kingdom to understand participants' experiences of being asked the ACE questionnaire. GP surgeries conducted a pilot where the ACE questionnaire was administered to clients. The GPs and a subset of participants agreed to a follow-up survey to understand their experiences. The study concluded that 85% of participants felt the questions were appropriate, and 81% felt it was an important area to be asked about. In addition, 60% of respondents said it was the first time a health care professional had asked them about trauma experiences, with comments such as it made participants feel it would be easier to discuss their experiences again in the future. Semi-structured interviews with 12 GPs found themes of it being a positive experience, with staff feeling it had the potential to enhance their patient's care. Specific comments were made about facilitating holistic care for patients and the knowledge allowing for referrals for further support (Hardcastle & Bellis, 2019). It, therefore, appears that whilst the questions can be emotive for respondents, they felt that it was ethical for the ACE measure to be administered.

The ACE measure was initially designed for epidemiological use by Felitti et al. (1998), however, it is now being applied clinically and to inform practice. This was not the purpose it had been designed for, and caution must be applied to using it in these new ways. In part because of how it influences the validity of the measure, but also for the risk of stigmatisation from people interpreting the measure who do fully understand it (Edwards et al., 2019). While applying the ACE measure to new groups is done to help, this information needs to be protected from misuse. To help with this, I would recommend that new applications of the ACE measure clearly state the study's rationale and hypotheses so that researchers keep this in mind to inform ethical practice.

The ACE measure has been criticised for its retrospective approach. It could be argued that this is only a weakness if the data collected from this is misused. A useful application is to use the ACE questionnaire as a screening measure to consider the short-term implications of adversity (Finkelhor et al., 2013). The ACE research could be criticised for implying a strong causation when the retrospective approach means no variables were controlled for. For instance, could there be another factor mediating the relationship between adverse experiences and negative outcomes that researchers have not accounted for, such as availability to support.

In summary, the ACE research has provided valuable contributions to understanding how adverse childhood experiences lead to negative health and social outcomes in later life. Despite the value the ACE measure has brought (Felitti, 1998), it is not without fault and has been critiqued for its limitations. The ACE research has grown substantially recently and is being applied to new fields. Future directions for the research will benefit from working with underrepresented groups and exploring individuals' experiences alongside administering the quantitative screening measure.

Implications for the workplace

In the United Kingdom, statistics are collected that monitor stress-related sickness from work by professional groups. The Health & Safety Executive (2021) outlined that healthcare professionals are consistently one of the top professional groups to suffer from workplace stress. This is consistent with Jung's (1945) concept of the wounded healer, which has been long discussed but has little research base (Hadjiosif, 2021). Furthermore, there has been an upward trend in sickness rates since Covid-19 (Health & Safety Executive, 2021). The ACE research has begun to be applied to healthcare settings using this information.

Mott & Martin (2017) looked at ACEs in professionals working in mental health services. They screened 371 mental health professionals for their level of ACE, self-care, and symptoms of burnout. They found that many professionals scored highly on the ACE measure (82.5%) and were more vulnerable to symptoms of burnout than those without adverse experiences. Furthermore, the article discussed the link between burnout symptomology and diminished quality of care to clients, such as poor care planning or misdiagnosis. Self-care behaviours were found as a protective factor against burnout. These results are consistent with similar studies in the field. Williams et al. (2012)

looked further at the relationship between childhood trauma experiences, personal wellbeing, workplace culture, feeling supported in supervision and experiencing vicarious trauma from the client's professionals supported. They found a correlation between professionals having their own trauma histories and difficulties with vicarious trauma, however, this was mediated by a good well-being status and having good quality supervision support. Indeed, this links as far back as Jung's (1945) concept of the wounded healer, which outlines how healthcare professionals are often drawn to this work area due to their own difficulties. Jung (1945), further discusses the need to be reflective on one's own experiences so that you can effectively help others. This idea fits well with Williams et al. (2012) notion that access to good supervision is essential, serving both as a protective factor to the professional's wellbeing and their practice with clients, enabling them to effectively help others without their own adversity polluting the relationship.

Services, where clients have high incidents of trauma experiences, place professionals more at risk of difficulties with vicarious trauma. Vervoot-Schel et al. (2018) documented how clients in learning disability services have a high rate of ACEs. This is linked to clients being from a vulnerable group who are faced with a higher rate of adversity. On average, they estimated that clients with a learning disability were 73% more likely to have an ACE score of 3+ than the general population. Truesdale et al. (2019) interviewed professionals working in learning disability services (N=25) and found that a high rate of clients referred to the services has a background of trauma experiences. Interviews highlighted several themes, including the barriers to working without appropriate support in the services. Suggestions included the use of trauma-informed care and multi-disciplinary working. Further work has been conducted to understand this area which offers promising insights, outlined further below.

Applications to learning disability services

Learning disability clients and services have been underrepresented in research, including the Adverse Childhood Experiences research field (Vervoot-Schel et al., 2018). Staff working in this field manage multiple needs, including challenging behaviour, with 25% of community service staff reporting violent behaviour incidents on most workdays. Episodes of challenging behaviour can be traumatic for the staff or trigger previous trauma (Keesler, 2018). Studies have shown that as challenging behaviour levels increase, so do the reported levels of carer stress (Lecavalier & Wiltz, 2006) and trauma experiences (Esaki & Larkin, 2013). Staff working in these services have been documented as highly vulnerable to burnout and stress-related sickness. This impacts the healthcare professional, the running of the service and the quality of client care (Baker & Osgood, 2019). It is documented that the risk of burnout increases with exposure to challenging behaviours. This is associated with staff leaving the service, sickness rates and reduced quality of care (Klaver et al., 2021). Staff can be impacted to the point of scoring within the clinical range for Post-Traumatic Stress Disorder on a screening measure (Impact of Events Scale-Revised) following episodes of challenging behaviour (Baker, 2017).

Staff wellbeing can impinge on managing challenging behaviour episodes and delivering positive behavioural support, the advised care approach within learning disability services (Baker, 2017; Rose & Rose, 2005). The degree to which staff feel supported in the workplace following incidents of challenging behaviour mediates how staff react and feel able to deliver care (Baker, Stafford & Hardiman, 2019). Employers have a duty to safeguard the wellbeing of staff in the workplace (Baker & Osgood, 2019).

Research has shown that providing good person-centred care that uses the principles of positive behaviour support depends on a healthy staff team who feel able to do their job (Baker, 2017). A staff team whose wellbeing has been compromised have been documented to feel overwhelmed when trying to meet the care needs of people with learning disabilities (Fernández-Ávalos et al., 2021). Therefore, the ACE research offers useful applications to learning disability services. This offers the potential to inform preventative interventions to support staff and enhance client care. Possible ways to support staff in this manner include a trauma-informed approach. This has been documented to build staff resilience by empowering them to manage their mental wellbeing whilst reducing the risk of mental distress from working in healthcare (Sprang, Clark & Whitt-Woosley, 2007). In learning disability services this should include using debriefing sessions following managing traumatic incidents (Tehrani, 2007) such as challenging behaviour. Therefore, the information gathered from the ACE research could be used to inform positive organisational change within workplaces, an application of the research which so far has been neglected.

Keesler (2014; 2016; 2018; 2020) has applied the ACE research to learning disability services. Most notably Keesler's 2018 study offers valuable insights. Keesler (2018) administered the ACE questionnaire to 386 learning disability support workers through an online link sent to learning disability services in New York and Alaska. Inclusion criteria for the study were that professionals had been working in services for at least one month, were adults and spent most of their working time providing care to people with learning disabilities. The sample was primarily made up of white females aged 20-39. Data were analysed in SPSS using descriptive statistics, T-tests, and ANOVAs. Keesler (2018) found that a high rate of staff working in these services had trauma histories, with the average ACE being 2.5. A total of 75% of staff in Keesler's sample scored at least one on the ACE measure, and 30% of staff had a high ACE score of 4+. Keesler (2018) found the highest incidence of ACE scores was in people who had worked in care services for the shortest duration (less than a year). The study provided valuable insight into how professionals working in learning disability services have high rates of trauma histories whilst working in services associated with the risk of re-traumatisation and burnout. As such, it was interesting that the highest rate of ACE scores was in those that had worked in services for shorter amounts of time; understanding this notion more would be helpful. From this research, Keesler (2018) concluded that further work to support staff in services was required, completing further notable work in the field regarding this.

Keesler (2016; 2020) has investigated how workplace culture can influence staff wellbeing and responses to incidents in the workplace. In these studies, Keesler discusses how important it is for services to recognise the potential for clients and people working in services to be re-traumatised. Keelser (2016; 2020) outlines how trauma-informed care is a cultural shift in care services. As an approach, it recognises the impact of trauma and how aspects of services can trigger trauma histories. A system-wide culture is created that aims to provide a safe environment for all clients and professionals. This is built on choice, equality, transparency, and empowerment principles.

Keesler (2016) piloted setting up learning disability services as trauma-informed organisations. The service was a day programme for 16 adults with learning disabilities in America. The service delivered training to all staff on trauma-informed care, reviewed care practices, facilitated daily meetings to improve communication, and made collaborative decision-making across the organisation. Semi-structured interviews were conducted with 17 staff 19 months after the programme opened. The results suggested that all staff were aware of trauma-informed care and its core principles, suggesting that a change to a culture committed to preventing re-traumatisation had been attained. Keesler (2014) indicated that trauma-informed care in learning disability services could lead to better wellbeing for staff/clients and a reduction in restrictive practices, such as using Pro Re Nata (PRN) medication.

The work of Keesler (2014; 2016; 2018; 2020) provides a valuable application of the ACE research to learning disability services. This has provided insights into the difficulties staff may have working in services with the risk of re-traumatisation and how a trauma-informed care approach offers a potential solution. Applying the ACE measurement to learning disability services has been limited to these studies, which, although useful are limited to a specific research team operating in the United

States of America. The potential implications this research could have for healthcare services, the wellbeing of professionals and the quality of client care is vast. It is this which has informed the research aims of the current study. The ACE measure and research field to date will be evaluated to help inform the direction of this research study.

Evaluation of Learning disability ACE research

The ACE research has promising applications to the field of health professionals, which brings an understanding of Jung's (1945) concept of the wounded healer and the high rates of stress-related sickness (Health & Safety Executive, 2021). This, however, is a very new area of study, and to date, only a handful of studies have investigated this (Keesler, 2014; 2016; 2018; 2020). Further understanding of how adverse childhood experiences can be applied to learning disability services is required.

More research is required to understand how to look after the wellbeing of staff working in learning disability services (Klaver et al., 2021). McNally et al. (2021) began investigating this and how trauma-informed care can enhance protective factors in learning disability services. The researchers outlined what the domains of trauma-informed care are and considered what factors lead to change in care services. Staff (n=32) working in learning disability services were interviewed for their understanding and experiences of implementing trauma-informed care into services. McNally et al.'s (2021) study provided valuable insights but concluded that this was a small-scale study in one geographical area, so further studies are required.

The research to date has had small sample sizes from one part of the world. Therefore, whilst the results are promising, further research is required. In addition, further research would benefit from understanding participants' experiences to identify the factors that mean adverse childhood experiences are leading to difficulties in the workplace.

New directions

The ACE research has grown substantially in recent years. It has provided valuable insights into understanding how trauma experiences during childhood can impact the brain's development, physical and mental health. Jones et al. (2020) proposed that the ACE information should be used to inform clinical practice, create community prevention policies, and shape the future of trauma-informed care. Menschner & Maul (2016) argue that future directions of ACE research should include appropriate training to ensure competence in using the measure.

The new applications of the ACE field include workplaces. A highly relevant application of workplaces is to healthcare, where rates of staff sickness and leaving the profession have raised during Covid-19 (Health & Safety Executive, 2021). This is needed most in services where professionals are working with high rates of trauma, severe distress (Mason-Roberts et al., 2018) and the risk of assault through managing challenging behaviour (Rose & Rose, 2005). The ACE research could provide valuable insights into this. Potential new areas of ACE research could be understanding how adverse childhood experiences interact with healthcare professionals' work, and how to prevent staff burnout. This could inform important preventative measures to look after staff wellbeing. Other potential areas to be explored further in line with this are how trauma-informed care, understanding resilience (Sprang, Clark & Whitt-Woosley, 2007) and the role of debriefing/supervision can support staff (Tehrani, 2007).

Summary

Overall, it appears that the benefits of conducting the ACE research outweigh any potential limitations. It would be important however for future research to expand the research to include more minority groups and additionally explore the role of resilience and the meaning of the adverse experiences to the individual. Future applications of the research to workplace environments would also be beneficial. Applying this knowledge to professionals working in health care feels important due to the risks of staff being re-traumatised or reaching burnout whilst working in care services (Keesler, 2018). As staff working in learning disability services have been documented to have high rates of burnout (Baker & Osgood, 2019), this feels like a valuable area to initially focus new research on.

Relevance to Counselling Psychology

My approach to the literature review was informed by my identity as a Counselling Psychologist. The British Psychological Society (2022) defines the ethos of Counselling Psychologists to be based on the principles of being a reflective scientific practitioner, working holistically and ethically. When reviewing the literature, I was aware of approaching this critically, and holistically, considering the clinical applications of what I was reading. My knowledge and practice as a Counselling Psychologist include working with trauma and in learning disability services, which aided my comprehension of the literature along with what is missing from the field. The expansion of the literature base will benefit from the approach of a Counselling Psychologist who understands the implications of trauma, the importance of personal meanings and the need for appropriate support to maintain fitness to practice (BACP, 2019). This view led me to my research question and methodology, where I have decided to focus on an under-researched area that could have implications for the services which clients use. Therefore, Counselling Psychologists can bring valuable contributions to this research field with their knowledge base, but as Counselling Psychologists also work in learning disability services and with trauma it remains highly relevant to their practice. Thus, the literature is highly relevant to Counselling Psychology practice.

Conclusion

A critical literature review was conducted to inform the research question 'Do healthcare professionals have a higher rate of Adverse Childhood Experiences (ACE) than the general population and do they identify this as influencing their career? Experiences of learning disability professionals.' To achieve this the breadth of the ACE research field was considered, starting from the original study by Felitti et al. (1998). From this, it became apparent that an exciting new application was to understand how ACEs relate to the workplace, and an identified vulnerable professional group was healthcare professionals. A new and promising application was to healthcare professionals working in learning disability services, although the research is still in its infancy at present. The research relating to professionals working in learning disability services was outlined. This was followed by a critical evaluation of the ACE research and the ACE measure.

The critical literature review highlighted the strengths and weaknesses of the research to date. This informed potential new directions for research. Some of which will be the focus of the current research study. The literature review shaped the research questions, with the quantitative strand having two directional hypotheses; H1, 'Learning disability professionals will have a higher rate of Adverse Childhood Experiences than the general population’and H2 'professionals will state a desire to help people as their career motivation'. The critical literature review was therefore followed by an outline of the aims of the current study. Time was also given to acknowledge how the literature review was conducted and key terminology identified through this.

The identified areas of focus from the literature review are how the ACE research can be used to shape clinical services and support staff, who have been suggested to be more vulnerable to having a background of adverse childhood experiences and having this re-triggered in the workplace. One of the limitations identified from the research field to date is that data has focussed on the frequency of experiences and not on meanings attached to this. As a result, the current study has opted to use a mixed-methods design, to understand the meanings and experiences of participants along with their ACE scores. The qualitative strand of the study was based on the research question 'How do healthcare professionals understand their work in learning disability services in relation to their experiences.'

Methodology Chapter

Outline

The previous chapter presented the literature relating to the Adverse Childhood Experiences (ACE) research (Felitti, 1998), how healthcare professionals can have their own histories of adverse experiences, and trauma-informed care approaches in response to this (Keelser, 2016). This critical review informed the rationale for this study and the methodological approach taken. This chapter will discuss the methodology in detail, describing the steps taken and why. It will also reflect on my process throughout conducting the research.

Aims

The research investigates the 'wounded healer' (Jung, 1945), suggesting people enter helping professions to heal the wounds of others that they cannot heal in themselves. It has long been discussed in the literature but has limited evidence for its prevalence. This study investigates this by expanding the ACE research by Felitti (1998), looking at healthcare professionals' experiences. The current research examines the prevalence of high ACE scores in healthcare professionals and explores how their experiences shaped their choice of profession and whether this influences them at work. A subset of healthcare professionals was selected for the sample, influenced by the literature and my professional experience in services. The literature suggested that levels of burnout are highest in the field of learning disabilities due to managing multiple needs, often with episodes of challenging behaviour (Keesler, 2018). This is also an area I have worked extensively in; therefore, the study selected a sample from this area of healthcare. The hypothesis H1, 'Learning disability professionals will have a higher rate of Adverse Childhood Experiences than the general population' was explored, with a directional hypothesis that the sample will have a higher ACE score than the general population. The study's quantitative aspect examined a second directional hypothesis (H2): ' Professionals will state a desire to help people as their career motivation'. The study aimed to complement the quantitative hypotheses through follow-up interviews. The qualitative aspect of the study sought to understand the following research question 'How do healthcare professionals understand their work in learning disability services in relation to their experiences'.

Rationale

The literature has long discussed the 'wounded healer' (Jung, 1945) with themes including career choice being shaped by a desire to help others in the way that the individual was not helped (Christine & Jones, 2014), increased empathy in their work and vulnerability to professional burnout. Despite these suggestions, there is little research exploring the prevalence of these experiences in professionals and how the meanings of these experiences could lead to factors such as increased empathy or burnout in healthcare professionals with a history of adversity (Fulford, 2017). In addition, due to the complex and demanding work in learning disability services, professionals in this sector are at higher risk of professional burnout and leaving the profession, but little is known about how this interacts with trauma histories (Keesler, 2016). Therefore, the current research addresses the identified gaps in the literature for investigating the 'wounded healer' and staff experiences in learning disability services. Developing our understanding in these areas could have real-world implications, allowing preventative actions to be taken within services to support professionals, preventing burnout and associated difficulties, which would indirectly improve client care (Laditka & Laditka, 2019). The ACE research has informed such promising preventive measures in social and health care, that it has been endorsed by the Centers for Disease and Control Prevention (2020) and several local governments (Hardcastle & Bellis, 2019). The expansion of this research will benefit from the approach of a Counselling Psychologist who understands the implications of trauma, the importance of personal meanings and the need for appropriate support to maintain fitness to practice (BACP, 2019).

Theoretical Assumptions

Ontology

My worldview is that whilst reality does exist, social-cultural meanings continually shape the perception of reality and how we interact with it. Therefore, people’s accounts of events act as valuable information, providing insight into their perception of reality. This would fall within the realist worldview (Clarke, Braun & Hayfield, 2015). I can see this within my clinical practice, where I view my clients as their own experts and focus on the meanings they bring to sessions, whilst also considering the views of the systems around them, even though these may be different to the clients. I feel that this outlook is well suited to that of a Counselling Psychologist, where it has been defined that the underpinnings of Counselling Psychology are based on the client's subjective experience, viewing people as unique, overcoming power differences, and encouraging personal growth (Kasket, 2012). These values also align with a trauma-informed approach that considers a holistic view of individuals and the systems around them. It additionally respects the individual meanings of a person's trauma experience aiming to work toward post-traumatic growth (Menschner & Maul, 2016).

Epistemology

Willig (2022) discusses how a researcher needs to consider what knowledge they would like to produce with their research. My approach to knowledge falls within the critical realist theory as I do not believe there is one definite truth. People can only describe their version of reality. For instance, I believe that two people can have the same situation happen to them; however, they will have different experiences and meanings to report. Therefore, there is no one single truth, and it is possible to approach the same data via multiple approaches to gain a comprehensive view of meanings (Clarke, Braun & Hayfield, 2015).

My epistemology takes a phenomenological base to thematic analysis, focusing on lived experience in the world and the meaning that individuals place on this. The descriptive phenomenology-based thematic analysis searches for meaning across the experiences of a group, keeping the analysis based within the participant's words (Sundler et al., 2019). The themes are more than simply pairing together similar concepts, as a theme understands shared meanings. Specifically, I took a reflexive approach as the researcher. As such, I have been open about the philosophical underpinnings of my approach to this research project and acknowledged the meanings I have made through my engagement with the research and the data set. As I acknowledge that we all have our own meanings of an experience, I view the thematic analysis of this project resulting from the data, my interpretation of the data and the research skills applied to this project. I have been committed to careful engagement with the data set and I have tried to be aware of my process and how I approach the data. As such a reflexive approach was taken.

Reflexivity comprises disciplinary reflexivity, functional reflexivity, and personal reflexivity. A true reflexive approach considers how knowledge is approached, how this aligns with the chosen methods, how I engage with the data as the researcher and how the research impacts me (Braun & Clarke, 2019). I believe that this epistemology is also in line with a Counselling Psychology philosophy, as this approach to knowledge and data incorporates holistic and person-centred principles (Kasket, 2012).

Axiology

Within the critical paradigm, my axiology is that my own values and belief systems impact how I interact with the research, as there is no pure objective reality to study. Critical axiology believes that if the researcher is open about how they approach the research, this can be used productively in the research process (Ponterotto & Grieger, 2007). True to this position, I will briefly outline the experiences that led me to this area of research.

As my clinical background has involved working in the field of learning disabilities, Positive Behaviour Support and trauma clients in mental health settings, I was naturally drawn to this research area. I have been attracted to the question of what influenced my career choice and found the concept of the 'wounded healer' (Jung, 1945) fascinating. My curiosity was then ignited when attending a conference on ACE research and hearing about the predicted adverse life outcomes and the excellent work that was taking place to install preventative measures in society (Felitti, 1998). I am passionate about the model of trauma-informed care, which is a growing theory, and its clinical applications (Menschner & Maul, 2016). I can see the benefit of working in this way. Consequently, I have volunteered my time to support the implementation of trauma care in services.

I kept a reflective diary throughout the research to manage my processes. I regularly engaged with my research supervisors to discuss my process and the practicalities of conducting research (Dallos, 2006). I also had access to a peer supervision group at university for research methods. I accessed personal therapy during the study to provide a safe place to take any difficult emotions that arose during the research process.

Methodological approach

My epistemological and ontological assumptions shaped my approach to the data. As such, I chose to use a mixed-method approach to capture the different views and meanings of my research topic. My methodology was informed by pragmatism, a tool closely aligned with mixed methods research that focuses on solutions (Tashakkori & Teddlie, 2010). This is based on the belief that all types of knowledge are valuable and that the employed methods must be chosen for their suitability to analyse your data set and explore the meanings this contains. This is different from other methodologies that align with certain types of methods. Whilst there has been contention in mixing qualitative and quantitative approaches, the pragmatist approach suggests that the two approaches can be used to complement each other in research. While some will still argue that combining approaches confuses epistemological and ontological assumptions, the pragmatist highlights that mixed methods are only a method. Therefore, how you approach the design of your methods will be shaped by your methodology and epistemology (Hanson et al., 2005).

Felitti's (1998) research on the use of ACE measures and subsequent studies on ACE (Keesler, 2018) have only used quantitative methods to administer the structured ACE questionnaire. This appeared lacked depth in exploration as personal meanings had not been explored. My realist epistemological and ontological framework supports the extension of ACE research through the use of a mixed-methods approach. The mixed-methods approach offers the benefit of extending the ACE research through the questionnaire whilst allowing personal stories to be explored through semi-structured interviews. Creswell and Clarke (2007) discuss how mixed methods offer a better understanding of research than using either approach in isolation. From administering the structured ACE questionnaire to a large sample of professionals working within the field of learning disabilities, I hoped to understand if there is a relationship (Sturgis, 2006) with the concept of the wounded healer (Jung, 1945). I expected the semi-structured interviews to allow personal views and meanings around a professional's career to be explored further (Breakwell, 2006). This approach allows for triangulation of my data to produce a holistic data set encompassing the different perspectives produced by quantitative and qualitative methods (Rawson, 2006).

Sequential data collection with concurrent data triangulation was employed; with participants completing the questionnaire first and then opting in for a subsequent interview. The quantitative and qualitative methods complimented each other, allowing for different parts of the research questions to be explored (Creswell & Clark, 2007). Equal weight was given to the quantitative and qualitative methods, with the data then being mixed at the analysis stage. The data was given equal value (Hanson et al., 2005), as the quantitative results address the hypothesis regarding the frequency of ACE scores compared to the general population. The qualitative results provided information on participants’ experiences at work to understand the relationship with past adverse experiences.

The results from the questionnaire were analysed using statistical analysis with IBM SPSS Statistics for Windows, version 27.0. The semi-structured interviews were transcribed and then analysed using Thematic Analysis, with the theoretical underpinning of a 'Big Q' paradigm, being that the researcher takes the active role in data collection and analysis, and as such researcher subjectivity needs to be considered. A 'Big Q' approach is grounded within the researcher's epistemological underpinnings, as opposed to a 'Small Q' approach which is aligned more with a set of procedures only (Braun & Clarke, 2019). Whilst a 'Small Q' approach is interested in finding one objective truth, a ‘Big Q' approach wants to understand the nuances of answers whilst understanding there are likely multiple truths. This fits within the paradigm of reflexive thematic analysis, where the researcher is viewed as shaping the data through analysis, and the data requires analysis (Braun & Clarke, 2022). The analysis took a Semantic Thematic Analysis approach that focuses on the explicit meanings of themes across interviews (Clarke, Braun & Hayfield, 2015). This approach fits my epistemology, as it values what the individual has to say and respects their choice of words without implying latent meanings.

Thematic Analysis was approached using Braun and Clarke's (2006) model, which outlines six stages of analysis. Stage one of analysis starts with familiarisation with the data, listening to the interviews, and transcribing the data myself. I immersed myself in the data by listening to the interviews multiple times whilst checking for transcription accuracy. I also began making initial notes on the meanings identified through the interviews. I did this within the Microsoft Word document where the transcript was, using the comment function to make notes in the margin alongside the transcript. This prepared for stage two of coding the data, where patterns were initially identified and explored. Stage three is when searching for themes began, with codes grouped together to create a map of significant patterns that had shared meanings regarding participants' experiences. Stage four involved reviewing the themes to check that clear, coherent themes were established before stage five, where the themes are defined and labelled. The final stage of my analysis was to write up the analysis. This was initially written as a draft chapter for a university assignment to present my results. Writing this draft proved to be a valuable exercise that initiated many reflections and questions, an example of which is documented in the diary entry (Appendix I). Following this, I returned to stage five to define the themes further and then to the final write-up. Braun and Clarke (2022) reflect on this being a normal part of writing up thematic analysis, where you often return to earlier stages to grapple with theme development.

Supervision was used throughout the research process; this is in line with my epistemology and axiology and important to my reflexivity during the research. Supervision helped me consider different viewpoints, fitting with my view that there is no one objective truth. I found that supervision helped me become aware of my own 'blind spots', helping me to consider different aspects when planning the research to ensure that I had a well-grounded research design that was in line with my epistemology. In addition, supervision helped guide me when I believed I was lost in my analysis. An area that was considered extensively in supervision at the start of the research was ethics and ensuring that the research design treated participants ethically, not to cause undue distress. An example of using supervision for this purpose was when designing the interview schedule or creating the debriefing resources for participants. As my study was conducted using the

'Big Q' approach, I designed the research, administered the data collection, completed the interview transcription, and analysed all the data, whilst being open to multiple truths/themes that emerged. Therefore, supervision was used to consider subjectivity and ethical issues (Smith, 2015).

Procedures

Sampling

An opportunity sample was taken from the population of professionals working in the field of learning disabilities within the United Kingdom. As outlined in my rationale, this subset of professionals was purposively selected as informed by my professional background and the literature review. The inclusion criteria for the sample were any professionals currently working in learning disability services who were over eighteen years old, could access the internet and had been directly involved with providing care to a person with a learning disability for at least one month. As the research involves self-completion of a questionnaire, this also requires a sample with a basic English reading level. It is a disadvantage that the research potentially excludes people who do not have access to the internet or have a poor reading level in English. This was an area of contention for the research project values when fair representation across all cultures and socioeconomic backgrounds is important to my work as a Counselling Psychologist. The sample selection was limited to online means only due to the research being conducted during Covid-19, where non-essential travel was prohibited. This stopped me, the researcher, from being able to visit any learning disability services in-person to distribute the questionnaire and offer reasonable adjustments in the completion of the questionnaire if someone required support with reading or could not access the internet. As the research had to follow government guidelines I had to sit with this unease and used supervision to help manage this.

In addition, I also acknowledge that using Qualtrics to distribute the questionnaire has allowed for the research to be shared across the United Kingdom, allowing for a more representative sample of geographical regions than in-person distribution of the research would have allowed. As a result, a more diverse sample of socioeconomic backgrounds could be gathered. As there is no one list of professionals currently employed within this field of work, it was not possible to approach all professionals who would fall within the sampling frame or establish specific characteristics of the population, such as gender or age splits across the profession. As a result, only an opportunity sample could be obtained instead of other sampling types which offer more representation to the population, such as Quota Sampling (Coolican, 2004).

Recruitment

The questionnaire was hosted online using Qualtrics, with an email being sent to learning disability services asking them to distribute the link to their staff (Appendix A.1, B.1, C.1). Learning disability services were found using a Google Search for services within the United Kingdom using key search terms of 'learning disability' followed by; 'service', 'supported living', 'day service', 'care home' and 'education'. It was anticipated that the services approached were privately owned or affiliated with the government or charities. The services involved direct support for people with a learning disability, and the websites were checked for this. The information sheet also outlined the requirements to take part in the study. As the research targets professionals involved with the day-to-day care of people with learning disabilities, NHS services were not explicitly targeted as the nature of NHS services does not routinely provide day-to-day care to clients but specific interventions. Websites found via Google were explored for contact details. If found, then an email was sent (Appendix A.1), including an attached version of the participant recruitment poster (Appendix B.1) and participant information sheet (Appendix C.1).

Recruitment relied on learning disability care services distributing the research study information to their staff and participants opting in to complete the research, first with the questionnaire and then an online interview. To help motivate participants to opt into completing the advertised study, the potential benefits of taking part were advertised on the recruitment poster. Specifically, the addition of literature to an under-researched area was specified, along with the potential to win a gift card. For the quantitative aspect of the study, the chance to win one £20 Amazon gift card was offered and electronically sent to the winner. As the qualitative aspect of the study is a longer time commitment, a £30 gift card was provided for participation in this study section. The recruitment poster also listed the potential disadvantages of participating, with the potential for emotional distress greater than experienced in everyday life by recalling potentially distressing memories. The study was approved by the City University Psychology department's medium ethics committee. The reference for the ethics application was also been listed on the recruitment sheet. All recruited participants were provided with a thorough debriefing, including access to further mental well-being support.

Inclusion criteria

Participants were required to be over 18 years to participate due to the ACE questionnaire by Felitti (1998) asking about adverse experiences up to 18 years. Participants needed to currently be working in the field of learning disabilities and were asked to click to confirm this with one of the opening questions on Qualtrics. Participants were from an opportunity sample of services approached via email regarding the research (Appendix A.1). The study aimed to recruit a minimum N=68 for the quantitative aspect of the study to meet power assumptions calculated through G-Power (2020). This calculation was based on a one-tailed test's power level of 80% with a significance level of 0.05. The initial aim was to recruit eight participants for the semi-structured interviews to ensure themes could be adequately captured across interviews. Whilst no set number is required for thematic analysis, most texts recommend a minimum of five interviews and then reviewing transcripts to understand when you have reached saturation for fully developed themes. Upon reviewing the transcripts, I knew that saturation was reached at seven interviews, so recruitment stopped at this point. This decision was reached when no new codes or experiences relating to the research questions were found in the seventh interview (Vasileiou et al., 2018).

Participant demographics

The study aimed to achieve a good representation of participants from across the United Kingdom, with a good representation of genders and a range of ages; however, as the participants were self-selecting, there is no way to control for participant variables. Indeed, the final sample was overrepresented by female respondents. The final sample comprised 72 participants (10 male, 61 female, and 1 identified as other). Demographics were asked regarding age range, time working in services and location of where they worked. A summary of the results is shown in Table 1 below. Only demographic details relating to the research questions were asked, as it is unethical to gather unnecessary personal data.

Table 1, *Quantitative sample demographics*

Demographic	N	Percentage (%)
Gender		
Male	10	14
Female	61	85
Identify as other	1	1
Age range		
18-24 years	6	9
25-34 years	24	33
35-44 years	21	29
45-54 years	16	22
55-64 years	5	7

65+ years	0	0
Location		
Southeast England	43	59
East England	3	4.2
Southwest England	10	14
West Midlands	3	4.2
Yorkshire	2	3
North England	2	3
Midlands	6	8.3
Declined to answer	3	4.2
Time working in services		
Less than 1 year	4	5.5
More than 1 year, less than 2	6	8.3
More than 2 years, less than 5	20	27.7
More than 5 years, less than 10	15	20.9
More than 10 years, less than 15	10	13.9
More than 15 years, less than 20	10	13.9
More than 20 years	7	9.8

Data collection

Data collection was comprised of two parts across the quantitative and qualitative aspects of the study. The quantitative aspect of the study was hosted online using the website Qualtrics, which presented the participant information sheet, consent form and some demographic questions before hosting the official ACE questionnaire by Felitti (1998). At the end of the questionnaire, participants were presented with a debrief sheet, the option to enter their email address for the prize draw and the opportunity to opt into the follow-up interview.

The ACE questionnaire has ten main questions, with some subsections within this, that measure three different forms of abuse and household dysfunction experienced before age 18. The questionnaire has been made available to use freely. Research has shown that the ACE measurement has good levels of ecological validity (Chapman et al., 2004, Anda et al., 2004) and test-retest reliability (Dube et al., 2004). This was arguably a valid measure to explore if professionals working in the field of learning disabilities have a higher rate of adverse experiences than the general population. The results were compared to the 'general population' using the dataset from

Hughes et al., (2020). This sample was selected because it was a large-scale research project in the United Kingdom (n=15285). The dataset used stratified random sampling to achieve a fair representation of genders, age ranges and different socioeconomic backgrounds. It published the entire dataset for free, allowing easy comparisons to be made. In addition, I spoke to the lead author (Hughes), who consented to the data being used for this purpose. Compared to the 'general population', only 25% of people would have an ACE of two or more.

The second part of the study collected data through semi-structured interviews. The interview questions were derived through reviewing the literature and my, the researchers, experience working in the field. The participants from the quantitative aspect of the study were asked at the end of the questionnaire if they wished to be contacted regarding a follow-up interview. I, the researcher, then emailed the information sheet to those that opted in, asking the participants to email back if they wished to arrange an interview. The plan was that if more than eight participants opted in, then the first to reply would have been selected; however, only seven responded to the initial email. As saturation was also reached at this point, interview recruitment stopped. The demographics of the participants who opted in are shown below, with participant pseudonyms used to protect participant identity and maintain ethicality.

Table 2, *Qualitative sample demographics*

Participant	Gender	Age range	Occupation	Time in services	Pseudonym
1	Male	45-54 years	Nurse	Over 20 years	James
2	Male	35-44	Manager of home	Between 10-15 years	Derek
3	Female	35-44	Support worker	Between 5-10 years	Lilly
4	Female	25-34	Therapist	Under 5 years	Sarah
5	Female	55-64	Therapist	Over 20 years	Chloe
6	Female	35-44	Therapist	Between 5-10 years	Kathryn
7	Female	45-54	Support worker	Between 5-10 years	Kayleigh

As shown in Table 2, a combination of professional backgrounds was in the sample. Females were however over-represented in the sample, as were 35 to 44-year-olds, relative to the general population. The quantitative data of participants were purposively not reviewed before the interviews. This decision was made as I did not want to influence my process during interviews.

The qualitative interviews aimed to explore the research question, 'How do healthcare professionals understand their work in Learning Disability Services in relation to their experiences'. The interviews to understand this was conducted via a Microsoft Teams video call. This method of interviews was necessitated by the Covid-19 pandemic and restrictions on non-essential travel. The online interviews consisted of a semi-structured interview composed of seven questions and a full interview schedule (Appendix E.2). The interview schedule was informed by the literature review and researchers experience working in the field. The following questions formed the base of the interview:

1. How long have you worked in the job role for, and what key experiences (positive or negative) have impacted you professionally?
2. What influenced you entering work in the field of learning disabilities?
3. Do you feel that your childhood had any influence on this?
4. Do you feel that your childhood impacts you currently?
5. Does this cause you any difficulties in the workplace?
6. What gives you meaning in your job?
7. Do you feel supported in your job role?

Therefore, the data collection involved the use of a structured questionnaire followed by semi-structured interviews. The data collection was fully completed online, with participants accessing the questionnaire and interview in their own environment. Guidance was given to participants in the participant information sheet about ensuring the study was completed in a private and quiet area. For the interviews, participants were advised to use headphones if other people were in the house, and the option of blurring their backgrounds via Microsoft Teams was recommended (Appendix C.1; C.2).

Analysis

The analysis of the quantitative and qualitative data took place after all data had been collected. This was chosen as the data is being managed with the 'Big Q' approach (Smith, 2015). As I conducted, transcribed, and analysed the data, I did not want to enter the interviews with preconceived ideas about the data.

The questionnaire was structured, gathering demographic data and using the official ACE questionnaire (Felitti, 1998). This resulted in continuous and discrete data, analysed using SPSS 27.0. The data set was explored to test the null hypothesis for H1, that the difference between the mean ACE score in the sample of learning disability professionals and the general population is due to chance, using a significance level of 0.05. To test if there is a significant difference between the mean score of the current study and the general population, this was compared with the average score from Hughes's (2020) study. This was chosen because it was recently conducted in United Kingdom, whilst most ACE research was conducted in the United States, making comparisons less representative. Firstly, the dataset was tested to ensure that the assumptions were met for the use of a parametric test. If assumptions had been met, then the intention was to use an independent T-test to compare the means. The data set was visually explored using bar charts and the Kolmogorov-Smirnov test. It was clear from this analysis that the data sets from the current study were not normally distributed and the scores were a different distribution shape to the Hughes (2020) dataset. That homogeneity of variances was not achieved, so a Mann-Whitney U test was used to compare the means instead. The four critical assumptions were met for using the Mann-Whitney test, as the sample had used two independent groups with independent results, and the ACE scores were a continuous dependent variable. As the two groups had different distribution shapes, the Mann-Whitney U test was used to determine if the distributions between groups were significantly different, using the mean instead of the median (Dancey & Reidy, 2002).

The data were analysed in SPSS 27.0 to determine the evidence and reject the null hypothesis for H2, that people will state a desire to help people as the motivation for their career choice. The data was explored visually to ensure that it was normally distributed but was found to be negatively skewed. As the data was a single categorical variable, tests for homogeneity of variances could not be performed. A non-parametric test was chosen, and a Chi-Square test was used to analyse. Again, the significance level of 0.05 was used and met, meaning that the null hypothesis was rejected for H2, and the experimental hypothesis was accepted.

The interviews were transcribed by the researcher using Trint software to assist with the process of transcription. The transcripts were then converted into a Microsoft Word document and analysed using the six stages of Thematic Analysis outlined in Braun and Clarke's (2006) work. I read over the interviews several times within the word document and considered the participant's worldview during the interview, whilst being aware of my own assumptions. I recorded my initial thoughts during this in my journal (Appendix I) and discussed this with my research supervisor before moving on to stage two of coding. Fereday (2006) describes the act of coding as recognising a valuable moment during the interview. Whilst I understood that software is available to complete the coding, this was not a suitable format for me. So, I used the comment function within the Word document to make comments directly alongside the transcript as I found this an easier way to interact with the data. I also feel that this supported me with the third stage of analysis, where I moved to the thematic mapping of themes across the interview data. The themes were reviewed again in stage four before being defined and named in stage five. I utilised Mindview 8.0 software to depict my thematic map (appendix H) visually. I believe this aided with defining themes and moving beyond codes to ensure that coherent themes were created. I took this to supervision, where we discussed the process of naming themes, which I found more challenging than anticipated. This approach recommends that stage six of the write-up be conducted shortly after stage five, as there is no distinction between analysis and writing as a process (Braun & Clarke, 2022). Therefore, I began writing my draft chapters shortly after completing the analysis.

Thematic analysis was considered the most appropriate method for analysing the qualitative data. I thought the search for themes in meaning fit well with my epistemology, allowing for multiple truths to be explored using themes. This is concordant with my realist ontology and critical realist axiology, where I believe there is no single truth as our reality is shaped through our socio-cultural meanings. Interpretative Phenomenological Analysis (IPA) was considered as an alternative approach as that also explores the meanings people make and concentrates on life experiences. This was, however, not chosen due to its ideographic underpinnings with the emphasis on personal experience and the use of targeted sampling to facilitate this. I considered that IPA would not complement this study because my methods aimed to get a large representative sample to complete the questionnaire before the interviews and focussed on patterns across personal experiences.

Data storage

All data was stored on the secure City University's One Drive account. Data from the quantitative aspect of the study was stored using separate Microsoft Excel sheets for each section of the study. Therefore, the quantitative aspect of the study was de-identified and saved on one database, with the contact details being stored in a separate Microsoft Excel sheet. As part of the anonymisation of data, the list of people who have opted into interviews was also saved on a separate Microsoft Excel sheet, ensuring that there is no way for participants' data to be identified across the different parts of the study. Contact details that are not required following the recruitment process were deleted, unless participants opted in to receive the study results.

The qualitative data was also de-identified. The qualitative data comprised the original transcripts saved as a Word document. A saved version of each transcript was edited using the comment function within Word. The thematic mapping was completed using Mindview software. All de-identified data was stored on the university's One Drive account. This is a secure encrypted service and password protected using a two-stage verification process to sign in.

The data has been stored on the University One Drive to ensure that Data Protection Act (2018) principles are met. As per City University's guidance on storing and destroying data, all data will be stored and deleted. The recommendation currently states that data needs to be stored for ten years following the completion of the research. The university asks that electronic personal data records be destroyed by contacting City University's Service Desk. They have a contract for data to be securely destroyed, including audit trails with certification of destruction provided. Data storage and destruction follow City University guidance and GDPR legislation, and I carefully considered how to ethically manage data within Psychology research (BPS, 2014).

Evaluation

Reflexivity

As previously discussed, my approach to this research has been shaped by my ontology and epistemology. As I do not believe there is one single truth to knowledge, and I am using the ‘Big Q’ approach to data (Smith, 2015); keeping a diary, and engaging with supervision are vital for the research. I know that my clinical background of working within learning disability services and with trauma shaped my approach to the research and how I engage with the data. I am also mindful of my personal experiences and my ACE score, asking myself how that attracted me to the concept of the wounded healer (Jung, 1945) and ACE research in the first place. Therefore, in addition to supervision, I continued to use personal therapy during the research to ensure that I reflected on my own process in reaction to the data. I feel that this was incredibly important to safeguard the data by being able to separate what is my worldview compared to the participants. I took this seriously as I am aware that my reflexivity level impacts the data's validity and ethics. I feel this is important as I asked people about their experiences, including difficult events.

Ethical considerations

Ethical considerations are essential to the research study and must begin at the start of the research planning. Ethical decisions align with the BPS (2014) code of human research ethics. The sensitive nature of administering the ACE questionnaire, which asks about adverse childhood experiences, was considered when designing the study. This involved considering if recalling memories would cause distress greater than the levels experienced in daily life. However, a study by Hardcastle and Bellis (2019) demonstrated that the administration of the ACE measure might not be associated with distress. They asked for feedback on how people had found completing the ACE questionnaire, seeing that most people described this to be a positive experience and appreciated being able to discuss their experiences. However, the sensitive nature of the questions was kept in mind throughout the study. As a result, it was suggested that participants engaged with the research in a private space, using headphones if required to maintain their privacy whilst discussing their experiences.

A thorough debriefing sheet was also constructed, incorporating access to further support and suggestions for apps that help manage well-being. The option of having one telephone call with the researcher to get help with signposting to services for additional support was also offered, although no one used this. The nature of the study and the potential for recalling difficult experiences was explicitly stated so that participants could give informed consent before engaging with the study. The interview schedule (Appendix E.2) included prompts to be vigilant for signs of distress and ensure that participants understand they can withdraw from the study or skip a question they do not feel comfortable with. The interview schedule listed prompts to check on a participant's well-being if they appeared distressed and to check if they felt okay to continue.

Informed consent was carefully considered with thorough information included on the recruitment poster (Appendix B.1; B.2) and participant information sheets (Appendix C.1; C.2). Participants were made aware of the aims of the study, the time commitment, and the potential benefits or disadvantages of taking part. The participants ' information sheet stated the right to withdraw from the study but was also reiterated to interview participants before beginning the interview. It was made clear that this would not impact their entry into the prize draw to win a gift card. The limitations of withdrawing were outlined to ensure that the participants understand what they are consenting to. For the quantitative aspect of the study, this was at the point of data analysis where only de-identified data was used. For the qualitative aspect of the study, this was at the point that interview transcripts were anonymised. How participant information is stored and managed was also outlined to participants. Participants were made aware of the information sheet, consent form and how the research will be written up for a doctoral thesis, including the potential for further publication. Participants completing the interview online were shown the participant information sheet and consent form before accessing the study. Still, they were given the researcher's contact details if they wanted hard copies of this to be sent to them. All interview participants were sent a copy of the participant information sheet, consent form and debriefing sheet.

All participant data is managed following GDPR guidance and City University's protocols for data management. The specific data management and storage details were outlined earlier in this document. An essential ethical principle to uphold during the research process is maintaining participant confidentiality. This is a part of data management and a part of the researcher's responsibility to the participant. As the research was conducted remotely from my home, I ensured I was in a private space where no one else could see the screen or overhear discussions, in addition to using headphones. When reflecting on my process in personal therapy, I made sure to uphold these principles and only discussed my process without mentioning any identifiable participant details.

Further ethical considerations I ensured were upheld through the research process was to be aware of the power differences in the researcher-participant relationship. I had hoped that making sure participants were fully informed of the research process and their rights before entering the study, this may have helped, but as a Counselling Psychologist, I understand that there are elements of the power differentials that are hard to eliminate. I equally was aware of cultural considerations and equality/diversity issues. This is part of why I was saddened not to be able to offer reasonable adjustments to potential participants by going and meeting them in person. This would remove barriers of having to be able to read English and access the internet. Unfortunately, the government restrictions at the time due to Covid-19 prevented this. I was mindful that further ethical issues may have arisen during the research process, although I am glad to report this did not occur. If there had been unexpected ethical dilemmas, I would have taken them to my research supervisor. Being transparent about my ethical decision-making considerations is part of a reflexive qualitative approach (Braun & Clarke, 2022). The research study received approval from the Medium Risk Ethics committee of the university.

Research integrity

An extension of ethical considerations in my writing is the endeavour to achieve integrity in my writing. It has been suggested that applying scientific principles to a mixed-methods approach, alongside clearly writing up how each step of the study was completed achieves the integrity of the write-up. Specifically, rigour can be achieved in thematic analysis through systematic reading and re-

reading of the data (Fereday, 2006). I have been mindful of these recommendations during the research analysis and write-up.

I have been committed to critical engagement with the research process throughout the project and have reviewed quality frameworks to reflect on my work. I found the questions posed by Yardley (2000) resonated with my epistemology and role as a Counselling Psychologist researcher. I valued Yardley's (2000) inquiry on considering the role of power differences in the research process, as this made me reflect on conducting research ethically. Specifically, I was mindful of making sure participants were informed of what they were consenting to, monitoring for signs of distress during the interviews and the concept of transparency throughout my work to ensure that my methods and reflexivity were documented accurately. This also assisted with the quality issue of replicability by documenting how I have engaged with my data, making it possible for others to replicate the study and add to the research literature.

Furthermore, fundamental principles in producing research with integrity were incorporated into the study. Part of this was making sure I had sensitivity to the context that the research was investigating. As a professional working in learning disability services with experience in trauma-informed care, I believed that I approached the subject with a good understanding; however, my knowledge was extended through the literature review process. I was also aware that my knowledge may result in me making assumptions or being clouded during data analysis, so I regularly used supervision to check in regarding this, both individual and peer group supervision through university research groups. I have considered the potential impact of the research. I believe that the study contributes to the theory and literature and that it could have real-world applications (Yardley, 2015).

I conducted research in an under-researched area as I feel passionate about the potential difference this could make to professionals, clients, and services that this could have. Adding to the research literature could implement preventative measures, as shown in Keesler's work (2016; 2018). As a critical realist, I do not believe it is possible to be objective throughout the research process. Still, I have been committed to being transparent and reflexive in my work to manage this whilst engaging with the data. The ACE measure by Felitti (1998) has been investigated and suggested to have good ecological validity (Chapman et al., 2004; Anda et al.; 2004) and test-retest reliability (Dube et al., 2004). As I used a validated measure, it was not considered necessary to use a pilot group before conducting the research.

As there is no definitive list of professionals working in learning disability services, establishing the population's demographics has not been possible. Consequently, it is impossible to comment on the representativeness and generalisability of the sample to the population. As a convenience sample was used, participant variables could not be controlled for.

Summary

The research study aimed to produce high-quality work to add to the literature base for learning disabilities and trauma-informed care. Two quantitative research questions were explored concerning this; H1 proposed that healthcare professionals working in learning disability services will have a higher ACE score than the general population, and H2 suggested that professionals will state a desire to help people as their career motivation. A mixed-methods approach was taken to the research, underpinned by a critical realist epistemology. The quantitative portion of the study administered the ACE questionnaire to healthcare professionals working in learning disability services. The results were compared to the general population from Hughes et al.’s (2020) study. Follow-up interviews were then conducted with a subset of participants to explore their views on if prior experiences had influenced their work. This allowed the qualitative research question 'How do healthcare professionals understand their work in Learning Disability Services in relation to their experiences' to be explored. There were limitations to the study, which have been critically reflected on. Quality frameworks and ethical guidelines were used throughout the research and supervision.

Results and Analysis Chapter

Outline

As outlined in the previous chapter, the quantitative data was collected first, and then a subset of participants opted into the qualitative aspect of the study. The data was analysed concurrently to allow for data integration to commence. The quantitative data was collected through a structured questionnaire hosted by Qualtrics. This website hosted the participant information sheet, consent form, demographic details, structured questions regarding their work and the official ACE questionnaire (Felitti, 1998). Nominal and ordinal data were collected and imported into SPSS 27.0 for analysis. The interviews were recorded, allowing for qualitative data to be transcribed (Appendix G); this was predominately analysed in Microsoft Word 16.0.

Aims

The research aimed to expand the Adverse Childhood Experiences research by Felitti et al. (1998) by applying it to Jung's (1945) notion of the wounded healer. Therefore, the directional hypothesis is that 'Professionals working in learning disability services will have higher levels of Adverse Childhood Experiences (ACE) than the general population and identify this as a factor influencing their career' was explored, along with seeking to understand their workplace experiences further through interviews.

Research questions

The quantitative aspect of the study had two directional experimental hypotheses, tested using a significance level of 0.05. To test hypothesis H1: 'Professionals working in learning disability services will have higher levels of Adverse Childhood Experiences', the score gathered in the current study of professionals was compared to Hughes et al. (2020) study of the 'general population'. The hypothesis H2, ' Professionals will discuss a desire to help others as motivating their career choice,' was assessed using structured questions about the participant's work. The literature (Barnett, 2007) regarding the desire to work in caring professions informed H2. It shaped the five options to the question, 'What was the primary reason you chose to work in the field of learning disabilities?'. The qualitative aspect of the study was investigated using Thematic Analysis; themes discovered through the data set will be presented and explored to understand the research questions 'How do healthcare professionals understand their work in learning disability services in relation to their past experiences' and 'What experiences in the learning disability services are meaningful for professionals and what experiences feel challenging at work'.

Quantitative responses

A structured questionnaire was hosted via Qualtrics to gather demographic data and host the ACE questionnaire (Felitti, 1998). Data was imported into SPSS, where nominal and ordinal data were analysed. Data was analysed relating to respondent demographics and the ACE measure (n=72). As the ACE questionnaire was a compulsory field, a complete dataset was collected.

Demographics

Demographic data relating to the research hypotheses were collected according to the Data Protection Act (2018), where only necessary data should be collected and stored. The data set was split 85% female, 14% male, and 1% other. The sample had an age range of 18-64 years. There was a higher response rate from professionals working in Southeast England. Length of service ranged from 1-20 years; the mode length of service was the category of 2-5 years' service (28%).

Hypothesis 1

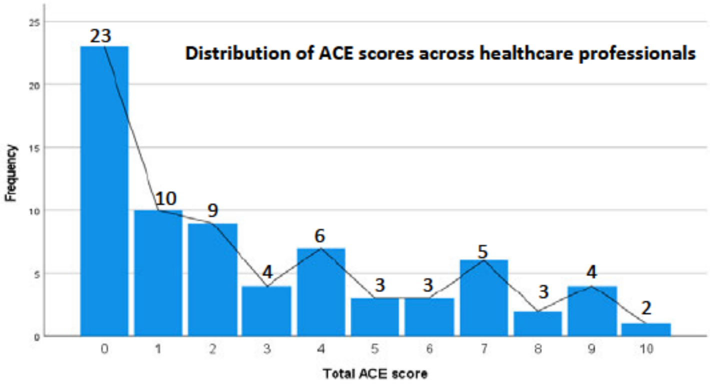
H1 explores if 'Professionals working in learning disability services will have higher levels of Adverse Childhood Experiences' by comparing the score gathered in the current study of professionals to Hughes et al. (2020) study of the 'general population'.

The adapted ACE questionnaire from the Centre for Disease Control and Prevention was used (accessed 2019), as the comparison study had. The questionnaire has ten main questions, with subsections to questions included, but result in a score of one only per question item. The measure looks at adverse experiences across the categories of experiencing abuse (physical, sexual, verbal), witnessing domestic violence, parents separating, and exposure to difficulties with mental health problems, alcohol/substance misuse or incarceration. The data were grouped into the categories of 0, 1, 2-3, or 4+ for the ACE scores, as these are the categories established within the ACE literature and research paradigm (Felitti, 1998; Hughes et al., 2020).

Normality

The data were explored to ensure that the assumptions were met for using a parametric test. The data set was visually explored using bar charts to check that the data was normally distributed, as shown in Figure 1.

Figure 1, *Distribution of ACE scores across healthcare professionals*



The distribution of ACE scores across the sample was negatively skewed. As the data did not appear to meet the assumptions required for parametric tests, the Kolmogorov-Smirnov test was used to check if the data set was normally distributed. This test was selected as it is appropriate for use with discrete variables. K-S was significant, $p < .01$; therefore, the data set was not normally distributed, or homogeneity of variance achieved. As such, a non-parametric test was chosen for analysis.

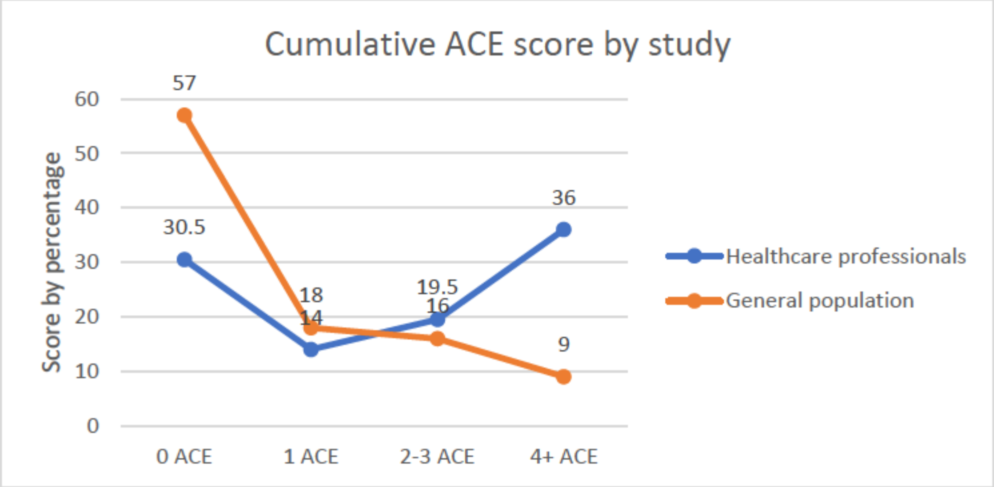
Analysis

If assumptions had been met, then the intention was to use an independent T-test to compare the means from the current sample of healthcare professionals with the 'general population' sample taken from Hughes et al. (2020). As the data did not meet the required assumptions, the non-parametric Mann-Whitney U test was used to compare the means. The four critical assumptions were met for use of a Mann-Whitney U test, and the distribution of scores informed the choice to use the mean instead of median scores (Dancey & Reidy, 2002).

Results

The sample had a mean ACE score of 3 across healthcare professionals (n=72). The data set was analysed to determine if there was a significant difference in ACE scores between the healthcare professionals and the 'general population' compared to the Hughes et al. (2020) study. Specifically, the difference between a score of 0, 1, 2-3 and 4+ on the ACE measure was investigated. Figure 2 below illustrates the relationship between the samples and the ACE scores.

Figure 2, *Cumulative ACE score by study*



As shown in Figure 2, there was an inverse relationship between the samples and the distribution of scores across the ACE measure. The frequency of ACE scores per sample was explored further and a significant difference found in the distribution of results for a score of 0 ACE and 4+ ACE across the samples. This difference was analysed further using a Mann-Whitney U test to determine if the level of difference was significant. The 'general population' scored significantly higher for having 0 on the ACE questionnaire than professionals (U=114594, p=.000). There was no significant difference between the scores for variables 1 and 2-3 on the ACE measure. Healthcare professionals scored significantly higher than the 'general population' with a score of 4+ on the ACE measure (U=249606, p=.000). Therefore, the Mann-Whitney U test showed the 'general population' (Hughes et al., 2020) was more likely to score zero for adverse childhood experiences. Healthcare professionals were more likely to score highly (4+) for adverse childhood experiences. From this, the null hypothesis was rejected, and the experimental hypothesis was accepted for H1.

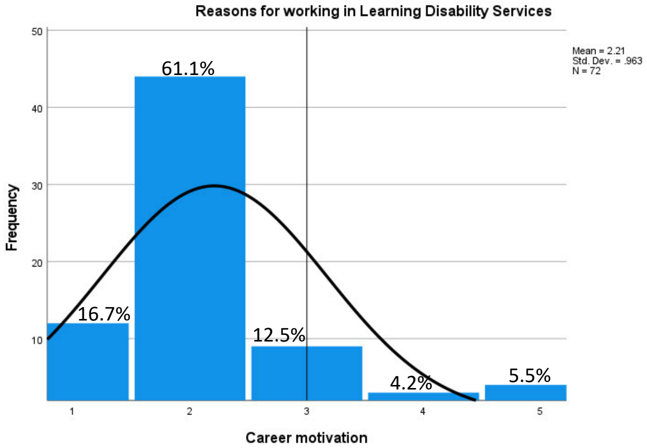
Hypothesis 2

To explore H2 'People will state a desire to help people as the motivation for their choice of career', the question 'What was the primary reason you chose to work in the field of Learning Disabilities'? was presented to participants. Participants could select from the following five options; 1. good career opportunity, 2. desire to help people, 3. convenient job for personal circumstances, 4. someone in my life has a learning disability, 5. other (please specify). Participants were only able to select one option. The experimental hypothesis was that people would choose the second option to express a desire to help others.

Normality

As the data were a single categorical variable, tests for homogeneity of variances were inappropriate. Therefore, the data was visually explored to check it was normally distributed.

Figure 3, *Reasons for working in Learning Disability Services*



1. Good career opportunity, 2. Desire to help people. 3. Someone know has a learning disability. 4. Convenient job. 5. Other

As shown in Figure 3, the data distribution supported use of a non-parametric test, therefore a Chi-Square test was chosen for further analysis.

Analysis

There were five potential options for participants to select the primary reason they entered the field of learning disabilities. Most participants (61.1%) selected a desire to help people as the reason they entered their profession. To understand if this answer was significantly different to the other variables, a Chi-Square test was performed using a significance level of 0.05.

Results

A Chi-Square test of independence was performed to examine the relationship between variables that indicate career motivation. The relationship between the variables was significant, *x2* (4, *N*=72)= 79.8, p<.01. The null hypothesis was rejected, and the experimental hypothesis H2 was accepted; most participants stated a desire to help people as the primary reason they entered the profession. No significant correlations were found between career choice and demographics of gender, age range or length working in services.

Summary of quantitative results

In summary, there were two experimental hypotheses for the study, that healthcare professionals would have a higher rate of ACE than the general population and that they would list a desire to help people shape their choice of career. Evidence was found to accept both hypotheses, and the null hypotheses were rejected. A subset of respondents opted for a further interview to understand their personal experiences, so there was an additional opportunity to understand the stories behind these results and their experiences working in learning disability services.

Qualitative analysis

Stages of thematic analysis

There was an option for respondents to opt for a further interview on the questionnaire. All 18 people who opted in were emailed an invitation to participate, with 7 professionals accepting, giving a response rate of 39%. All the interviews were with professionals working in the field of learning disabilities. Professions varied from support workers to nurses and therapists. The gender split was 71% female and 29% male. The interview participant demographics are shown below; client pseudonyms have been used.

Figure 4, *Qualitative demographics*

Participant	Gender	Age range	Occupation	Time in services	Pseudonym	Code
1	Male	45-54	Nurse	Over 20 years	James	A
2	Male	35-44	Manager of supported living	Under 15 years	Derek	B
3	Female	35-44	Support worker	Under 10	Lilly	C
4	Female	25-34	Therapist	Under 5 years	Sarah	D
5	Female	55-64	Therapist	Over 20 years	Chloe	E
6	Female	35-44	Therapist	Under 10	Kathryn	F
7	Female	45-54	Support worker	Under 10	Kayleigh	G

The mean interview time was 38 minutes. The interviews were analysed using the framework of reflexive Thematic Analysis. Interviews were transcribed and analysed in the order the data was collected. The analysis only began after all data collection was complete using Microsoft Word, with de-identified data stored on the University One Drive.

An inductive analysis was used, which takes the themes from the interviews instead of trying to make the data fit pre-existing theoretical contexts. Semantic coding was employed where participants' meanings were taken from the language, and assumptions were not made about what may be underneath the spoken language with hidden meanings (Braun & Clarke, 2022). The six stages of analysis included distinct and progressive steps of data analysis. As I completed semantic coding, only surface-level codes were taken from what the respondents directly said regarding their experiences. Whilst I took the codes directly from the data, I did have my research questions from the quantitative strand of the study in my mind. This helped ensure that relevant codes were identified, but I was also aware this may influence how I engage with the data. I took my themes and data to supervision to evaluate and ensure I had not been unduly biased when interacting with the data. At no point were assumptions made about meanings or data taken to fit into the literature.

In total, 68 codes were identified across the 7 interviews. Some of the codes identified were expected, such as a desire to help others; however, there were some unexpected codes, such as external barriers to providing care and money.

Presentation of themes

The qualitative analysis aimed to answer the research questions 'How do healthcare professionals understand their work in learning disability services in relation to their past experiences' and 'What experiences in learning disability services are meaningful for professionals and what experiences feel challenging at work'.

The inductive analysis from a reflexive framework established a total of three themes. The first theme established was the personal experience of helping. This theme concerned how participants' adverse experiences had shaped their relationship with receiving help and providing help to others. Participants discussed positive and negative experiences of the help they had received. Similarly, providing care to others had areas of personal gain and cost associated with the experience.

The second theme looked at participants' communication experience in learning disability services. This theme offered valuable insights into working within the setting of learning disability care, where participants reflected on the importance of communication. This theme extended across services with client care, communication within the team for effective service delivery and managing communication with outside people concerned with the client's care, such as family or outside professionals.

The final theme was the developing journey of clients and services in learning disability care. This theme looks at clients' journey through their care pathway, the developing journey of professionals working in services and the journey of services developing care models. A key concept found within this theme was the experience of change. This theme helped to provide insight into meaningful and challenging work areas to professionals working in learning disability care. A summary of the themes is shown in Figure 6, key theme concepts.

Figure 5, *Key theme concepts*

Theme	Key theme concepts
My personal experience of help	My experience of receiving help; my adverse experiences shaped me into someone who naturally cares for others; my experiences taught me how I want to help others; my experiences mean I understand how to help others better than other people can; making a difference to others is fulfilling; always being the person to care is tiring
My lived experience of communication in learning disability services	I have always been an effective communicator; past experiences of communication shape how I am at work'; communication is vital to my job; need to adapt communication to fit clients; there can be barriers with communication; how to understand clients who are non-verbal; communication within the team is important; communication can be supportive; difficulties in communicating through different systems; need to communicate to other people who are involved with the client; what is unspoken in care services
The journey of clients and the service through learning disability care	How I have developed as a professional and person working in learning disability care; how clients have developed; clients learning new skills; learning disability services progressing; new legislation; new challenges in learning disability care; areas of work in learning disability services that are meaningful or motivate me as a professional

The themes shown in Figure 5 will now be discussed in turn, along with my reflexive experience of analysing them.

Theme one, my personal experience of help:

Theme one was a dominant theme across all seven interviews. Participants discussed how their experiences shaped them into people who wanted to help others in this theme. Participants reflected on their experiences of receiving help through childhood up to their current professional roles where they are helpers. The experiences included positive and negative aspects that led them to a helping profession. In addition, participants were found to reflect on their unique experience of helping those with a learning disability. This theme was linked with the first qualitative research question, which aimed to understand how participants' past experiences interact with their work.

Through the theme, participants reflected on how their experiences of adversity had shaped their personalities. Two participants discussed childhood experiences of living with and caring for a parent with mental illness. Experiences included a parent with mood difficulties and alcohol dependence. It appears that because of these experiences, participants had to adapt to their changing environment and the needs of others from a young age. Participant E described how she "learnt" to respond to her parents’ mental health by adapting her behaviour to fit their mood. As summarised by participant A below, this skill of adapting to others' needs appears to continue throughout his career.

Participant A, line 205: It made me a good listener, all the listening and understanding, I guess, because I had to do it when I was little. And then it just it just becomes you. You become defined…. But it, it does define you, definitely looking back as a child and things I went through and being so conscientious. It does make me a good nurse and caring person.

Other adverse childhood experiences from the three participants were linked directly with relationship difficulties. These included parents divorcing, being separated from their parents, and having complicated relationships with their primary caregivers. Participants reflected on how these experiences had impacted them.

Participant G, line 66: I think when my mum and dad split up and that had a massive impact on how I viewed the world, I think and, and, it led me, drive me into the caring profession.

Participants described this as more than just a learned skill, often linking the impact to their personality characteristics. Across interviews, the characteristics of being caring and a good listener were shared. One participant (D) discussed this as; "something internal within me, and I think I've got this big drive to want to care". The characteristics developed through childhood appear stable as the participants continue to reference them in their current professions. Participants discussed this in a manner which made traits such as being a good listener and caring seem advantageous to their role in helping others. Through the interviews, I was aware of my reactions as the researcher and how it felt very natural for traits of caring and listening to be discussed in this context with healthcare professionals. However, I was not anticipating several references to a "lack of confidence" from participants. I noted that a different tone was used in connection with experiences liked with this trait.

In contrast to the previous traits, which were framed as beneficial to their career in helping, a lack of confidence was linked as a barrier in their role to help others. Through the interviews, it appeared that this "challenge" had to be overcome for them to effectively help others and represent the client's needs in learning disability services. An example of this is shown in an extract from participant E. In this extract, the participant reflected on how her adverse childhood experiences had led to personal traits that she described as a benefit or disadvantage to her work across a long career as a helping professional in learning disability services.

Participant E, line 124: I learnt very quickly how to navigate his anger and my mother's unhappiness….. That's kind of built into me I guess…Erm… But I think the disadvantages are a lack of confidence. Something I've never possessed in bucketloads and I think that's just part of it was that kind of destabilising, you know? And it's not the same for lack of sort of personal inner confidence is it's been the biggest…. Disadvantage I think…… So all through this time and I've sort of been adding to to it and doing other things. So all the things that I've done. I've.. have made me. I've I've taken on things that have made me develop confidence. I've taken on things that have been scary for me personally, and sort of conquered them. So I guess each time I. Build a bit more. Um? So yes, I mean I've found ways of dealing with it.

The Oxford Dictionary (2022) defines self-confidence as a noun concerning belief in your abilities. Therefore, when analysing the data sets, I was struck by the juxtaposition of hearing how naturally adept the professionals were in helping others but equally without the confidence in themselves whilst doing this.

Other adverse childhood experiences shared regarded participants' struggles with their mental health and their experiences of help with this. Three participants reflected on their experiences of mental health difficulties beginning in childhood. Participants discussed challenges with mental health and their experiences of trying to access help for this. Participants' experiences of receiving support were mixed, with some noting how a positive relationship had impacted them, subsequently shaping how they wanted to be a helping professional. Participant F reflected on her experience of being in therapy as a teenager "as I kind of sought therapy myself had an experience of recovery, and I suppose that influenced me and wanting to explore therapy more". She shared how she initially had a negative experience that worsened her mental health. However, the participant then went on to work with a different health professional, which was a positive experience. They noted that this experience taught her both how she wanted to be when with clients and what she wanted to avoid in interactions with clients.

Participant G, line 37: that is what led me into the to what I'm doing because I didn't get the support from anybody and all the way along. It was me trying to push until I worked in a school, but I didn't get support from anybody particularly, and I felt that that was something I wanted to do.

Participants identified key experiences from the help they received that they wanted to incorporate into their own work. These were feeling listened to, supported, and a holistic approach being taken. As summarised in the account above, others felt compelled to help others in a way they weren't.

There was one negative case study where the participant described having a "rosy" upbringing with no adverse childhood events. The participant (C) however, explained that she had a traumatic event happen in later life and was then attracted to a profession helping others. Participant C had a son with a learning disability who sadly died following problems accessing the care provision he required. She felt deeply impacted by her experience and decided to re-train in a profession where she felt she could help others in a way she had not been helped. Participant C referenced how she saw traits in her clients that she associated with her child. She spoke passionately about how she was involved in projects trying to improve services so that people would not fall through gaps in service provision and miss out on receiving the help they need. Sadly, this was the negative experience participant C faced when trying to get help for her son.

Participants reflected on their relationship as being the helper in learning disability services. Participants across the seven interviews reflected on a desire to understand others and the work satisfaction felt when this is accomplished. As the nature of having a learning disability impacts communication, participants discussed the need to understand their clients to help them effectively. This added layer to the 'helper role' was referenced as being "fascinating". Participants linked their ability to do this back to their personality traits of a "natural ability" to be a good listener and caring. Participants shared their experiences of wanting to help and care for others. References were made to this desire being enhanced in learning disability services due to the vulnerable client group, who often have multiple needs.

Participants discussed the complexity of client's needs and how this impacts the client and their families. The desire to help appeared strong for this client group, with the help extended to family members. Working with clients with multiple needs and involving family members appears to be central in learning disability services. Participants shared that they felt their clients could often not advocate for themselves, making their desire to help stronger. Participant D described this process as activating the "rescuer" in her. All participants reflected on the satisfaction felt when their help resulted in positive change for clients, as shown in the account below.

Participant B, line 56: To support them so I always find it extremely fascinating that the whole process, and then when you get it right. I mean you do feel this sense of fulfilment of being there. As you know, if it works and that the person is calmer? Now you know it's good, they have quality of life.

The participant's desire to help is linked with making a difference to someone else, but the helper also appears to gain from this relationship. Participants discussed their pride and enjoyment in making a difference to others. Participants talk about work as most rewarding when an observable change has been made, for instance, when distress has been alleviated or their families are seen to be coping better. Not all clients with learning disabilities can verbalise their thanks or explain the difference made, but behavioural change was referenced the most. Listening to participants' accounts, the sense of satisfaction appeared permanent, as demonstrated in the extract below.

Participant A, line 153: If I if my career ends today, I've done… Good for thousands of people, maybe because I wouldn't be one that would blow your own trumpet, because I'll be very humble about it, but it is a nice feeling to look back and go, well, I've helped people. Nobody I can ever take that away from me.

Participants discussed the importance of helping others as a longstanding positive, explaining that this helps them cope with more challenging days. Participants frequently discussed the sense of satisfaction they feel when helping others, seeing a difference in clients or when they receive a thank you for their efforts. This appears to be an anchor to cope when work is stressful or emotionally demanding, such as when clients may present with challenging behaviour. Whilst this appeared to be an unintended benefit to the role of helping others, it struck me listening to the interviews that this was an important aspect of the experience of helping. Furthermore, this positive experience is a lasting feeling that the participants reflect on.

A downside to the role of helping is when there are perceived barriers to this. Participants discussed how feeling unable to fulfil their role as a helper was a source of stress. This was linked with perceived barriers to the role of helping, such as "too much" paperwork or organisational systems that take them away from their direct helping role. Participant B discussed his difficulty when organisational systems, such as funding, prevent him from being able to help the client and provide them with what they need, such as specialist equipment. Participants appear to find not being able to help in the manner they wish to as a source of stress. Listening to this response made me consider how this was connected to their passion for helping others. This enthusiasm appears to bring a great sense of fulfilment to participants in their work, but this passion can also cause difficulties. Several participants discussed being a carer and helping others as part of who they are and that you cannot switch off from this. The toll of caring was reflected on with participants discussing elements of burnout and feeling tired.

Participant A, line 444: "we get burnt out, we get tired, we don't lose the care, you lose the energy, and you get the burn out at different times".

It appears that the relationship with helping others can come at a personal cost. It should be contextualised that the research interviews were conducted during the Covid-19 lockdown when self-reported stress levels were generally high. During this period, there were additional pressures on staff working in services. Participants discussed the additional barriers they faced in their pursuit to help during this time, from fearing they would bring the coronavirus home to their families to managing client care when services were short-staffed due to people's self-isolating.

In summary, the theme of participants' personal relationships with help has been discussed. Most participants felt they wanted to care for others after experiencing adverse childhood experiences, making them want to influence how care is delivered to others. Participants reflected on how helping others is a part of who they are, bringing great benefits to their work whilst carrying some personal costs. Specifically, barriers to professionals being able to fulfil their role of helping others appear to be the central source of stress. Participants described working in learning disability services with vulnerable clients as a rewarding experience. Most participants shared their passion and pride for their work and their relationship to helping others. This theme helped provide insights into the research interest of understanding how participants' past experiences shape their relationship with work and helping others.

Theme two, my lived experience of communication in learning disability services:

Theme two regarding participants' communication experiences was present in all seven interviews. This theme further explains how professionals experience communication in learning disability services, with links to past experiences of communication during childhood. The theme of communication seemed to underpin helping professionals work in services, revealing useful information for the second qualitative research question regarding what experiences in learning disability services are meaningful or challenging for the professional. The theme looked at how professionals try to adapt their communication to fit the needs of their clients with communication difficulties. The importance of effective communication within the services participants work in, and the broader systems around the client were considered. This was linked to positive and negative experiences with communication. The theme will be explored in detail, along with my reflections on analysing the data as the researcher.

During all interviews, participants discussed their experience with communication. The level of complexity with communication was considered where participants outlined the diversity of communication needs. Participants reflected on how 'one size does not fit all' as clients will have varying levels of abilities to process information and express their needs. Participants reflected on how some of the people they support are non-verbal, bringing an added complexity. Two clients referenced this complexity as the analogy of a puzzle that needs to be solved.

Participant F, line 46: I also liked the, the, added complexities on having learning disabilities because it's just like another, another ingredient, you know that I love puzzles and so trying to figure out somebody's story or what's going on that might be leading to this distress. And you've got to think about that as well. Uh is interesting. And, and also think about how you communicate with and adapt how you communicate. I find interesting as well. So that people feel understood.

The challenge of understanding the communication of clients appeared to be an enjoyable task linked to the skill set of learning disability professionals. Participants used words such as 'fascinating' and 'intriguing process' to share their experience of understanding the client's communication. This appeared to be an ongoing and renewed challenge in their work, the variety of which is enjoyable to participants. Participants explained their experiences of trying to understand clients' communication. Participants discussed how clients may have difficulty expressing themselves or the need to have the information communicated to them in adapted ways. One participant described how they think about the words they will be using before saying them to consider the appropriateness for their client. Although framed positively, the level of consideration given to how you communicate appeared to be a cognitive demand for participants.

All participants reflected on their enjoyment of working with communication; however, one participant shared how their interest in communication began in childhood and influenced his choice to work in learning disability services. Participant B reflected on how this interest had led him to complete training to support his interest.

Participant B, line 69: I've been trained from a very young age to sign language and Braille. Um, just because I had this interest, even though I had no one to converse with, I just found it extremely interesting as a field.

As demonstrated in the extract above, communication can form a specialist interest or skill for people from childhood. Furthermore, this skill set was often linked to developing through direct experiences of adverse childhood experiences. Participant E shared how, because of her adverse childhood experiences, living with two parents who had mental health difficulties, she learnt to 'read people's personal languages'. She saw this as a skill developed from a young age to navigate how to meet her parents' needs and described how this skill had become advantageous in understanding communication in the workplace. Further examples of specialist training in communication were referred to for non-verbal clients who use their behaviour to communicate their needs. The high level of communication skills held by professionals and their ability to adapt stood out to me through hearing their experiences. Participant A summarised his experience of this in the below extract.

Participant A, line 126: In the severe disability world, you really put yourself in the shoes of somebody who can't communicate their needs and your head's going to the dozen trying to work out what it is, it's they can't tell you themselves or you're trying to communicate a different way, that makes a special person.

A further dimension to client communication was "advocating" on their behalf. Multiple participants described how important this element of communication felt to them. They shared the experience of being the voice for clients when they cannot communicate their needs in specific domains. Participant B described the power of being the voice for a client when they needed this.

Participant B, line 158: Advocate for people with severe disability that are the lost hidden generation, I guess, where they can't, I was there to speak out. And there's not the support and there's not people that can speak up. They can't speak up themselves.

In addition, through the interviews, I noted how the importance of communication extended beyond collaborating with clients. The need for excellent communication was also linked to working with the client's families and external professionals involved with the client. Participants discussed how because of the nature of a learning disability, people require support to manage their daily life, or their multiple healthcare needs necessitate several professionals being involved at a time. The need for a systemic approach to communicating with clients was reflected on. Participants shared their experience establishing essential information for their work with a client. This would often require taking accounts from the client and someone in their support network; then, they would try to maintain effective communication channels with these people to support their client. Therefore, the role of communication is complex and expansive in learning disability services, with several stakeholders involved. Participant A’s thoughts on this are shown in the extract below.

Participant A, line 141: it is all about having the good communication skills and listening skills and all those things close to the case applies to families and to your colleagues and all the others as well, you know.

The complexity of communicating with so many different stakeholders seemed hard to maintain at times and was referenced as being a less enjoyable communication dynamic. Participants shared how different organisations have their own policies for communication and manners of doing things, which was listed as a potential source of delays or breakdowns in communication. Furthermore, participants referenced how different stakeholders (family members or professionals) may have different views about the client's needs, leading to strained communication between them. An example was participant F reflecting on how a person's family wanted her client to continue living at home, but this was not in the client's best interests. Participant F shared her experience of communicating this to the family and having explicit discussions about this. This is a case example of how communication in learning disability services is inherently complex and systemic in nature.

The need for joined-up and thorough communication within the services participants work in was also discussed. Most participants reflected on their experience of communication within the team being a positive experience; some stated this as an area they are proud of.

Participant F, line 127: Without that, with the people you help, the team you have around you can, can help you have, turn how you feel around to help you and able to support the children better? So at the end of each day, we talk. We have a debrief every evening.

Professionals shared their experience working closely with colleagues, where informal communication routes were frequent and supportive. Teams also referenced formal structures to support communication. This included reflecting teams, complex case discussions, morning check-in meetings and debriefing sessions if an incident has occurred. Participants referenced the mix of informal and formal communication with their team as a source of support and that it helped their work. Overall, this felt like a positive experience through the interviews, contrasting with the mixed experiences reported with outside agencies. On listening to participants' stories, it appeared that there were not the same barriers when communicating with colleagues that other areas of communication can be impacted by.

There was also a different side to communication shared. Several participants discussed the challenging experience of navigating communication with non-verbal clients. One participant (E) shared her reflections on what is also not discussed within teams.

Participant E, line 43: When you're doing that kind of caring work you have to create the boundary, but find out where the boundary is to set it and articulate it in every gesture in every every communication, every, everything, everything you're doing that for you and the other person in the hope that you're getting some of it right, really? Because most of the time you just don't know. Um? And the people who. I met doing that then. We're quite a mixed bag, but that we never talked about that….. I think I think the fact that you can't talk to the to your colleagues. Um creates some very interesting dynamics. But also, um, it's not talked about. It's not talked about now, not really.

Such unspoken communication elements in learning disability services were essential to participants' experiences working in learning disability services. These experiences contrasted with the other communication experiences involving open, honest and holistic communication. Whilst participant E was the only participant to discuss it extensively, this dynamic was referenced in three other interviews. As the interviewer hearing these experiences, it appeared that this dynamic was the challenging side of communication which was harder to share. As the researcher, I am grateful for participant E sharing this.

In summary, the theme of lived experience communicating in learning disability services was explored. This helped to understand what provided meaning or challenge to professionals in their work through learning disability services. The importance of communication has been highlighted in these services, with the need for dynamic and holistic communication. The complexity of communication was reflected on through adapting communication to fit individual needs and the complexity of managing communication systems. Finally, the unspoken elements of communication in learning disability services were shared. Whilst communication experiences were focused on within the workplace, several participants reflected on their communication experiences from childhood and how the skills developed from this continue to aid their communication as professionals.

Theme 3, being part of the journey of clients and services through learning disability care:
The final theme was present across all seven interviews, although to varying extents. The theme explores how participants experience the journey of clients and services through learning disability care. The professional's journey was also reflected as they progressed through the services. The roots of where the journeys began are included, but this theme concerns change and development through learning disability services. The path to development includes challenges which will be acknowledged. This theme is again linked to the second qualitative research question to understand what key experiences professionals have whilst working in learning disability services to understand what gives professionals value in their role in helping others and what stressors there may be.

The pertinent journey reflected on through interviews was the journey experienced whilst working with clients. Professionals shared their experiences witnessing clients' progress, learning new skills and reaching new milestones. Professionals appeared to feel pride in participating in the client's development. An example of this process is shown with participant G's account.

Participant G, line 153: You think wow, look how far you've come. Also, some of the kids that can just stand hold a conversation with that, don't you think they could have done that five years ago?

The journey of professionals supporting clients was signified by personal development and change. Hearing participants' reflections on being a part of the changes made it apparent how person-centred this process was. Participants discussed areas of change such as clients having a conversation, learning to cook something, or coping with daily difficulties. The client's journey was unique to them regarding the goal accomplished and the period the change takes over. No comparisons were made to other people's changes or expectations noted on the changes that should be produced. I was humbled as the researcher to hear how impacted the participants were by witnessing this journey.

Participant D, line 238: I guess makes me really excited for how things will continue to develop in the future, and I guess just being able to be a part of someone's journey towards change. And I guess is what motivated me.

As shown above, participant D’s reflection connects the important client journey with that of services. The journey of services was another significant experience present through the interviews. Unlike witnessing clients' journey, which was presented as a distinct journey, the journey of services was ongoing. Several references were made to the journey's beginnings, with services as institutions and then into hospitals before the community model we know today was introduced. Whilst participants reflected on this as a necessary and positive journey for clients, associated challenges were noted. The biggest challenge was the unaccounted-for barriers in the journey to community care. A lack of funding, difficulty accessing services or activities and social isolation were referenced. Participant E's account below reflects on the contention between wanting to move away from institutions but not being satisfied with the destination the journey has reached with community care.

Participant E, line 251: Although we don't think necessarily fondly of hospitals and big institutions, there was aspects to them that that, erm have been lost …. something around the provision of community… the provision of appropriate occupation, meaningful, appropriate occupation and activity that has been lost.

Further challenges noted through the participant's journey across services included an increase in managing paperwork and "red tape". This was cited as a challenging and ongoing experience in services.

My interpretation of what was shared regarding this is that services have increased accountability with increased legislation. Whilst this was linked to many benefits listed by participants that improved standards of care, it is accompanied by increased administration. This challenge was viewed as taking healthcare professionals away from the frontline and being a part of the direct journey. A further interesting challenge was noted by participant A, who was reflecting on his career of over twenty years in learning disability services. He noted that as services are improving and clients are living for longer, new challenges are emerging. Participant A framed this as a positive challenge, as shown in the extract below, but a challenge that will require further work. This reinforced the sense that the service journey had only just begun.

Participant A, line 53: People with intellectual disabilities are living longer, as well as people with Down's syndrome, all with the health in the early intervention stuff. There's whole new challenges ahead. You've got people with Down's syndrome now developing dementia, which 15, 20 years ago…they wouldn't be here. So, it's it's throwing out more challenges, which from a professional point of view is good because it's keeping you on your toes and you're keeping new skills and learning new ways.

The desire for continual progress accompanied the dissatisfaction with the lack of resources. Participants spoke with passion about trying to improve services continually. The initiative of progress shared involved national strategic policies and services creating their own cycle of progress. Participants referenced their experience working in services during the introduction of such initiatives. Specific national policies that were referenced included The National Health Service and Community Care Act (1990), Valuing People (Department of Health, 2001) and STOMP (NHS England, 2016). It appears that such national policies impacted the landscape of learning disability services, and participants experienced how this prompted further developments in services. Participant F below outlines her experience of being a part of shaping service developments in response to changing national policies.

Participant F, line 265: we offer these positive behaviour support clinics where carers or family members will come in for an adult with an LD…. And then we'll write summaries and recommendations…….It was on the back of CQC with a push from CQC and more nationally to work more integratively rather than have people sitting caseloads and to get away from these extend long *assessments with long reports… because it means the person actually isn't going to get help for months… and actually in line with STOMP initiative to reduce medication use in people.*

Participant F spoke enthusiastically about her experience of seeing services change, it appears she viewed this as being for the better. She used words such as "fantastic" to express her view of witnessing this journey.

A total of five interviews reflected on the progression they have been a part of in services and the change they have observed. Three of the participants used the word "journey" as part of these discussions, which shaped the name of this theme. Participants discussed with pride their role in initiating service improvements, including setting up different services for clients, developing staff training and writing new policies. It was clear through the interviews that participants were not satisfied with where the journey was and will continue to work towards change for the better. Participant C’s extract shows that the client's needs appear to be at the heart of all the service developments.

Participant C, line 57: We've been able to do some wonderful pieces of joint work and we've been able to go on a journey together to see how it can really benefit the person with an LD.

This part of the analysis made me stop and reflect myself on what I had experienced working in learning disability services as a professional at the time initiatives such as STOMP were introduced. I recall discussions at work about this; this was an optimistic time, although one accompanied by significant change. I believe such matters impacted the workplace culture, opening up new considerations for people working in the services at the time. I had not considered this until I engaged with the data set and noted how my experience felt in line with the participants. As a researcher, I feel that my lived experience of working in learning disability services and understanding the initiatives mentioned helped with this research element. A researcher without this lived experience would have likely not understood what references such as STOMP or valuing people were and how significant these changes felt when working on the front line in services. This could have resulted in missing important elements of the journey services have been through or would have required stopping the interview flow to ask for clarification, which could impact data collection.

In summary, participants' journey in learning disability services and working with the clients who access these services has been explored, providing important information as to what experiences are significant to the professionals working in these services. This theme links to the second qualitative research question. This was a theme characterized by change and progression, with largely positive connotations attached to this. Whilst witnessing the clients' journey appeared to be discrete, the services journey appeared as if it had only just begun. Unexpected challenges were linked with the journey of services and the professionals trying to manage these new obstacles. Participants, however, shared a true passion for their part in continuing this journey to fulfil the required changes. This theme resonated with me as the researcher, so I have tried to be open about my process through the analysis. By sharing this, I hope to be transparent about how I have engaged with the data and note how my understanding aided the analysis.

Summary of qualitative analysis

The interviews provided rich information about people's experiences and journeys. Across the seven interviews, themes concerning the experience of help, communication and the journeys through learning disability services have been discussed. The themes related to participants' experiences; theme one strongly linked with participants' adverse childhood experiences and how this shaped their present experience as a professional supporting individuals with an Intellectual Disability. This theme was the most frequently noted and present across all seven interviews, which helped to understand the first qualitative research question and linked to the quantitative research questions. The second theme explored participants' communication experience from childhood to the present, where a developed skill set to manage communication was noted. The second theme was also present across all seven interviews. This helped to answer the second qualitative research question regarding professionals' experiences in learning disability services. Similarly, the third theme is linked to this research question. Theme three provided the experience of professionals through working in services; whilst this theme had historical roots in services, this was less connected to the history of participants. The third theme felt significant to include as it is pertinent to the experience of working in learning disability care. This theme helped to understand what is meaningful or challenging to professionals working in services, important concepts linked to managing well-being and vulnerability to burnout. The third theme was present in six of the interviews. I noted how this theme resonated with me as an inside researcher who works in learning disability care.

The interviews provided rich data on the experiences of professionals working in learning disability care. The themes provided information on what gave participants value in their work and the challenges that could be linked to stress. This information is valuable in understanding what shapes the role of caring in learning disability services, which aids the understanding of the quantitative aspect of the study. Theme one notably provided in-depth information related to the quantitative hypotheses, understanding how adverse childhood experiences shaped their career choice and how they engage with helping others. The interviews also highlighted a negative case study where someone did enter this career following an adverse event; however, they would have scored very low for the ACE measure, as their experience happened in later life. Themes two and three provided an understanding of the experiences of professionals working in services, which is crucial for understanding how to retain staff and what challenges need to be supported. In summary, the interviews provided rich information regarding participants' experiences, some of which aided the understanding of the quantitative aspect of the study.

Overview of analysis

A mixed-method design was used because the quantitative and qualitative analysis provided information for the research questions. Data triangulation allowed for a deeper understanding of healthcare professionals' experiences relating to ACE. The quantitative and qualitative data are therefore treated with equal value. The data were collected concurrently and integrated from the analysis stage to consider how each data set complements the other. This will be explored further in the discussion chapter. This data triangulation is consistent with my belief in pragmatism and epistemology. I believe there is no single truth or no single method that can gather meanings (Hanson et al., 2005).

From the analysis, we could see that the quantitative data suggested a higher prevalence of healthcare professionals with adverse childhood experiences. However, the interviews provided richer information, as some respondents did not have adverse childhood experiences but had significant adverse experiences in adulthood, which prompted a career change. For instance, participant C, an interview participant, described how her grief prompted a desire to help others. Without integrating quantitative and qualitative data, this information would have been lost. This is an important example as it highlights the impact of adverse experiences in the workplace. Such experiences could have the same influence on entering the profession, and without the proper support in place could impact the nature of their work and vulnerability to burnout. The mixed-methods approach for this study allowed for different parts of the hypothesis to be explored, and richer information gathered. The approaches help offset each approach's weaknesses alone, with the data gathered on each side of the study complementing the other. As the researcher, I have enjoyed being able to explore the two sides of the research. I feel that this unique extension to the ACE research field offers exciting ecological validity.

Discussion Chapter

Introduction

This chapter aims to consolidate the previous chapters and discuss the findings. A detailed discussion of findings from the quantitative and qualitative research will take place, where the results from each strand of the study will be integrated and linked to existing literature. The discussion will stay true to the methodological approaches by explaining how the sample compares to other groups and bring life to themes in participants' experiences. This will aim to understand how the findings link to the research questions. The research study will then be evaluated to consider its strengths and limitations, which will inform recommendations for future studies. My realist worldview and phenomenological epistemology will shape how I engage in sharing the findings.

Purpose of thesis

The thesis aimed to extend the Adverse Childhood Experiences (ACE) data by applying this to Jung's (1945) concept of the wounded healer. A subset of healthcare professionals was chosen for the focus of this study. As rates of sickness and professionals leaving the field are highly documented in learning disability services (Baker & Osgood, 2019), a sample of professionals from this field was selected as this felt like the most pertinent staff group to begin with this application of research. The research aimed to provide valuable insights into how trauma histories and past experiences can interact with healthcare professionals' work. It is hoped that the information gathered in this study can be developed further to inform interventions in healthcare services that may impact staff retention and sickness rates.

The research investigated the question 'Do learning disability professionals have a higher rate of Adverse Childhood Experiences than the general population and do they identify this as a factor influencing their career?'. This was achieved with two directional hypotheses investigated through the quantitative strand of the study. H1 was that 'Healthcare professionals would have a higher ACE score than the general population' and H2 'Professionals will state a desire to help people as their career motivation'. This was complemented by the qualitative research question 'How do healthcare professionals understand their work in learning disability services in relation to their experiences'. The qualitative and quantitative research questions were given equal weighting.

Overview of research

The ACE research was pioneered by Felitti et al. (1998). It provided a revolutionary understanding of trauma and how it can cause negative health or social care outcomes. The study showed a significant relationship between the number of traumatic events experienced and negative health or social consequences in adulthood, such as the increased risk of depression, obesity, and diabetes. The study by Felitti et al. (1998) developed the ACE measurement, which asks about different forms of traumatic experiences. This measure has now been used in thousands of studies with increasing applications to new areas. A recent application has been to the world of work with good ecological validity from the findings (Hughes et al., 2020).

The most notable application of the ACE research to an area of work has been by Keesler (2014; 2016; 2018; 2020). Keesler (2018) applied the ACE measure to professionals working in learning disability services. The study found that professionals had a high score on the ACE measure, meaning that they had extensive trauma histories from childhood. The Keesler (2018) study outlined the vulnerability of professionals working in learning disability services to the risk of re-traumatisation through managing challenging behaviour in the workplace. There is extensive literature outlining that professionals who work in learning disability services have a high risk of sickness or leaving the profession (Esaki & Larkin, 2013.; Baker & Osgood, 2019).

The current research extends the ACE research (Felitti et al., 1998) and Keesler's (2018) study. It applied the ACE measurement to learning disability professionals in the United Kingdom. The measurement was hosted online, with the link being shared via email to services that offer care to people with learning disabilities. Care services were found through an internet search and emailed the recruitment poster and participant information sheet, asking for this to be shared with employees. The questionnaire had a response rate of 72 professionals who completed the ACE questionnaire, along with questions regarding career motivation and demographic details. A subset of seven professionals opted into follow-up interviews to hear about how their past experiences may interact with their work. The results from the questionnaire and interviews were then analysed separately and compared to better understand each aspect of the study.

Quantitative results

The quantitative aspect of the study aimed to understand two hypotheses, which will be discussed in turn. A questionnaire was hosted online via Qualtrics to investigate the hypotheses. The questionnaire was made up of questions relating to background information, the ACE measurement and work questions, including why professionals chose to work in learning disability services.

To investigate H1, the ACE measurement was administered to healthcare professionals, and the results were analysed. This showed that most healthcare professionals scored high on the ACE measurement, falling into the category of 4+ scores. A score of 4+ indicates a high level of childhood trauma and is linked with negative health outcomes (Felitti et al., 1998). The results were compared to the general population to understand if the high score was noteworthy. To do this, secondary data was used from Hughes et al. (2020) study, where the ACE measure was administered to a sample of the general population in the United Kingdom. The score from this sample was compared to that of Hughes et al. (2020) study to understand if the professionals' score was higher than the average person's score. From this, we can conclude that the score of healthcare professionals on the ACE measurement was significantly higher than the score of the general population. This meant that hypothesis H1 was supported. Therefore, professionals working in learning disability services in the United Kingdom were found to have high rates of adverse childhood experiences.

The results from this study support the findings from Keesler's 2018 study, which found that professionals working in learning disability services had a high score on the ACE measurement. Remarkably, Keesler (2018) found the highest ACE scores were in professionals who had worked in services for the shortest duration. This was an interesting finding, which may link to the literature on burnout. However, the current study did not find any significant relationships between the ACE scores and duration of employment. However, both studies support the concept that professionals working in learning disability services have histories of trauma and adverse childhood experiences, which has been recorded at a higher rate than non-healthcare professionals.

The findings in support of H1 relate to the existing literature. The literature suggests that people with higher ACE scores experience more work difficulties. This is important because the literature outlined the risk of traumatic experiences being re-triggered when working in learning disability services, caring for people with complex needs, challenging behaviour, and their trauma histories (Lecavalier & Wiltz, 2006.; Esaki & Larkin, 2013). The Hughes et al. (2020) study discussed the increased risk of workplace sickness with adverse childhood experiences, linking this to loss of workplace productivity with financial implications. Furthermore, Mott and Martin (2017) examined the increased risk of professional burnout when people with high ACE scores worked in mental health services.

Additionally, Williams et al. (2012) found an increased risk of vicarious trauma at work for professionals with their own trauma histories. Williams et al. (2012) linked the negative well-being of professionals to reduced efficiency and quality of client care at work. Therefore, the literature supports the importance of understanding if professionals have trauma histories, as it can have implications for the workplace.

Notably, the literature suggests that preventative measures can be taken by understanding the link between professionals' trauma history and their work (Sprang, Clark & Whitt-Woosley, 2007). For instance, the importance of access to formal debriefing after incidents, good quality supervision and supportive work culture have been discussed (Tehrani, 2007). Trauma-informed care has shown promising results in positively impacting professionals in healthcare services and the quality of care provided to clients who access the services (McNally et al., 2021). Trauma-informed care involves the principles of understanding how trauma impacts people, how to support this in a safe environment and a commitment to avoiding re-traumatising people (ACEs Aware Initiative, 2022). The current study highlights the importance of moving forwards with how services can consider supporting professionals at work, given the emerging data to suggest professionals are more likely to have trauma histories.

To understand H2, professionals answering the Qualtrics survey were asked their primary motivation for their career choice. Participants could select from five options, including the option of 'other' where free text could be entered. Most respondents selected a desire to help people as the reason they entered the field of working with learning disabilities. The number of people who selected a desire to help others was statistically significant compared to other options. Therefore, the hypothesis was supported, suggesting professionals enter work in learning disability services due to a desire to help others.

The findings from the study link with the literature, most notably Jung's (1945) concept of the wounded healer, which has been extensively discussed in the literature. The literature suggests professionals enter healthcare services to help others with what has not healed in themselves (Jung, 1945). Some have discussed how this unconscious process drives the desire to help others, often arising from significant personal adversity (Barnett, 2007). Salvilla (2021) reviewed the literature and concluded that there is a significant link between professionals entering work because of their trauma histories and being re-traumatised whilst caring for others. The study also reported how under-researched this area has been, despite the essential ecological applications. The current study supports this under-researched area, with H2 providing evidence that professionals state their career motivation is due to a desire to help others.

Overall, support was found for the two hypotheses, indicating that professionals do have a high rate of ACE and that they demonstrate a desire to help others. Therefore, bringing the two hypotheses together provides essential applications for the workplace, suggesting professionals are more likely to have trauma histories and be attracted to working in healthcare to help others. The literature discussed the likelihood of professionals having their traumatic histories re-triggered in the workplace, noted especially prevalently within the learning disabilities sector. This has been linked to the clients having high rates of adversity themselves and staff managing incidents of challenging behaviour (Klaver et al., 2021). Unfortunately, the limited research to date has focussed mainly on quantifying the prevalence of trauma histories in professionals and has not given voice to what professionals have experienced. To overcome this limitation in the research field, the current study conducted follow-up interviews with a subset of staff. The results from this will be discussed below.

Qualitative results

To fully understand the impact of ACE on learning disability professionals in the workplace, seven follow-up interviews were conducted to hear about participants' experiences. The interviews aimed to understand the qualitative research question 'How do healthcare professionals understand their work in Learning Disability Services in relation to their past experiences'. All participants had taken part in the quantitative study and opted into the interviews following this. Interviews were conducted online (via Microsoft Teams video calls) using a semi-structured interview format. The interview consisted of seven questions about participants' experiences at work and whether they felt that their childhood had influenced their career choice.

Participants were asked how their past experiences may influence them at work. Questions were kept open, with participants being asked if they were aware of the positive or negative impacts of their past experiences on their work. The interviews were then analysed using Thematic Analysis (Braun & Clarke, 2022) to understand the uniting experiences across participants. In total, three major themes were found.

The first theme was 'my personal experience of help'. This theme discussed how professionals experienced help, often associated with their own adverse childhood experiences. The theme highlighted the impact of help received and the impact of an absence of help. Either way, these experiences appeared to influence participants' relationships with help, being linked to how they wanted to be in the helping relationship with their clients. This theme helped to understand the qualitative research question by providing insights into how participants understand their past experiences interacting with their work, both in their career choice and how they want to behave with clients. Therefore, the experiences shared also link to hypotheses 1 and 2 in the quantitative part of the study. This provided valuable insights into the experiences underpinning career choice and how adverse childhood experiences had shaped this. Participants shared complex personal histories that had led them to need help and how this had shaped them. The experiences of help outlined were mixed, with professionals stating positive qualities that they had carried into their work and negative experiences of help that had taught them how 'not to be' when helping their clients. Whilst previous literature has alluded to healthcare professionals being more likely to have adverse experiences; there is little understanding of the mechanisms underpinning the link between ACE and entering this field of work. The interviews provide valuable insight into how professionals were influenced into helping roles after having their own difficulties.

Furthermore, we understood through the theme that professionals' experiences influenced their work. Professionals discussed how they did not receive support or did not receive helpful support, leading them to want to make sure others were afforded a more positive experience. Alternatively, some participants had received valuable support at a time when they were greatly struggling, and this positive experience of help inspired them into a helping profession. Whilst the experience of help was individual, there was a common theme that participants had required help in response to their difficulties, and these experiences had influenced their work as healthcare professionals. Participants shared encounters that had motivated them specifically to the field of learning disability, including two participants having their own children with a learning disability. This was a noteworthy finding as it meant that whilst ACE had shaped their desire to work in a helping profession, it had not led to the field of learning disabilities. Indeed, experiences in later life (having their own family) influenced this field of work. This critical finding adds value to the study and would not have been captured by the quantitative aspect alone.

The second theme present across all interviews was participants' lived experience of communication. This theme heavily focussed on participants' experience of communication in the workplace, presently and across their past years working in services. The theme was also significant for a subset of professionals' experiences growing up, where communication first became important to them. The theme, therefore, provided further insights into the research question by understanding how participants' past and current communication experiences interact with their work in learning disability services.

Participants discussed both the importance and complexity of communication in their work. They reflected on how they must adapt their communication to fit the diverse needs of their clients but also communicate with the broader systems around clients. Professionals shared the need to communicate with family members and wider professionals involved with the client's care. The role of communication appeared extensive and present across all avenues of their work. For participants, it appeared this could be a positive or negative experience. Some reflected with pride on successful examples of communication, such as daily handover meetings with their team or reflective spaces, which left them feeling supported in their work.

On the other hand, communication experiences also included difficulties, with participants naming barriers in communication systems as a source of stress. It appeared that such barriers in communication were perceived as preventing them from doing their job at times. My reflection listening to this was how it linked back to the passion I heard in theme one of wanting to help others and how difficult it appeared for participants when there were barriers to achieving this. The literature extensively discusses the risk of burnout and professionals leaving the profession of working in learning disability services (Baker & Osgood, 2019); however, there is little explanation as to why. Whilst this is just one instance of stressors experienced in the workplace, it still provides additional insights into what professionals find difficult working in learning disability services.

Some participants reflected on how their childhood experiences had shaped their relationship with communication. This included adverse experiences such as navigating communication with parents with mental health difficulties. This provided a further understanding of the ACE literature, first discussed by Felitti et al. (1998), as to how living with a parent with mental health difficulties may affect a child's development. One participant shared a different childhood experience where an interest in communication was supported, so he learnt sign language at a young age. These childhood experiences were reflected as having the same outcome of making them effective communicators. This was seen as a strength of their work, making them adept at modifying their communication to the complex needs of their clients. The shared experiences appeared to have led to the development of being a skilled person at understanding others' communication and responding accordingly. The complexity of communicating with clients with a learning disability, including with some clients who are non-verbal, was reflected on. Participants frequently discussed this as being a 'fascinating' and 'enjoyable' aspect of their work, and they shared the feeling that their past experiences with communication aided this.

The third and final theme was professionals' involvement in the journey clients and services go through. This theme was characterised by change, personal growth and unexpected challenges as new journeys are navigated. The theme supplied an understanding of how professionals' journeys had influenced them at work, allowing them then to become involved in the journey of others. The strongest element of this theme was the personal satisfaction from being a part of the journey of services and clients in their role as a helping professional. Seeing the progress made appeared to be a source of job satisfaction for participants. Specific developments in learning disability services were reflected on through discussions of local and national initiatives, such as Valuing People (2001). The history of services and how this influenced client care across developing services appeared vital to understanding participants' experiences at work. This theme was necessary to include to fully comprehend the research question's aim in understanding the experiences of professionals in learning disability services. These experiences link to the literature on learning disability services, where delivering care to clients in line with best practice guidance is discussed (Baker, 2017). This also connects with the literature discussing the importance of the culture in learning disability services to effectively deliver care to complex clients (Keesler, 2014).

Integration of results

A mixed-methods approach provided valuable knowledge towards the overarching research question 'Do Learning Disability professionals have a higher rate of Adverse Childhood Experiences than the general population, and do they identify this as a factor influencing their career?'. The quantitative aspect of the study established that professionals from this sample did have a higher rate of ACE than the 'general population'. The quantitative division provided some insights into career motivations but did not fully answer the research question. The qualitative aspect of the study provided valuable information on factors influencing professionals' work and their experiences in the workplace. Through integrating the results, valuable additions to the research field have been found, which qualify and extend the current literature whilst answering the research questions.

Integration of the quantitative and qualitative strands led to richer data. For instance, the quantitative aspect added further evidence to professionals having their own history of adversities and a desire to help others; however, the reasons behind this remained unclear. The interviews helped me understand the concept of the wounded healer (Jung, 1945) and how their experiences of receiving help in response to adverse experiences motivated their desire to help others. The interviews provided information that would have been missed with the administration of the ACE measure alone. For instance, there was a negative case study where a participant scored very little on the ACE measurement but sadly went on to have traumatic experiences in adulthood. They reflected on how a career change in adulthood was prompted by the adversity experienced in adulthood after they had a "rosy" upbringing. Therefore, the concept of the 'wounded healer' (Jung, 1945) remains valid, although it would not have been reflected in the ACE measurement. Furthermore, whilst the ACE measure and career motivation to help others could be partially explained by the study's quantitative aspect, this did not explain a motivation to work in learning disability services. The interviews provided information on why participants precisely wished to help people with learning disabilities. Two participants had children with learning disabilities, which attracted them to this area of work. Other interviews reflected on the enjoyment of working with complexity, such as communication needs, or the fulfilment of collaborating with a client group perceived to be vulnerable. In summary, the integration of interviews with the ACE measure led to a deeper understanding of why professionals with trauma histories were attracted to helping roles in learning disability services.

The literature discusses how professionals working in learning disability services are notoriously at risk of work-related sickness or burnout (Keesler, 2016). However, the only causative factor given is a history of trauma. The interviews provide beneficial information on further stressors experienced in the workplace that help to explain why professionals may reach burnout or work-related stress. Therefore, this information used in conjunction with the prevalence of ACE scores found in professionals helps to understand associated risk factors. These results are preliminary and further investigation into what professionals perceive as barriers to their role in helping others and the discussed difficulties with communication are required. When risk factors for re-traumatisation and workplace stress are understood, preventative measures can be explored to support professionals.

In summary, the research on adverse childhood experiences in healthcare professionals is small to date. Whilst the emerging data suggests healthcare professionals have a higher rate of adverse childhood experiences, including professionals in the sector of learning disabilities, the reasons why professionals have entered this work sector have largely been unknown. The integration of data in the current study provides some insights into why and begins the discussions on why professionals in this sector are at risk of burnout.

Strengths and limitations

The current research offered the benefit of providing research in a developing area, which importantly represented learning disability services in the United Kingdom. The approach offered the strength of mixing quantitative and qualitative methods, which offered new insights into why healthcare professionals might be more likely to enter helping professions. Further strengths of the study were that it offered insights into the experiences of professionals working in learning disability services, which have had little research before. The study has strong ecological validity to healthcare services with implications for professionals and the care of clients.

The quantitative and qualitative aspects of the study had satisfactory sample sizes. The research was conducted online, which offered the benefit of a diverse sample across the United Kingdom. The disadvantage of an online study was that it potentially excluded participants who cannot easily access the internet or have difficulties reading English, either because English is their second language or because of neurodiversity or educational needs. As a Counselling Psychologist, inclusivity in research is important to me and an ethical consideration. I would have liked to offer the services approached the option of online or in-person participation; however, as the research took place during Covid-19 lockdowns, this was not possible to offer. This is a consideration I would recommend for future research. A further disadvantage of the sample is that it is not possible to generalise the population of healthcare professionals working in learning disability services as there is no sampling frame to compare with. As healthcare professionals working in learning disability services include carers and support workers that are not regulated professions, no records could be publicly accessed of who is working in the field within the United Kingdom. A possible way to overcome this downfall would be for future research to have a large enough sample to ensure fair representation across services. This would also improve the power of the sample. In addition, this would reduce the likelihood of a type 1 error.

The qualitative research offered powerful insights into healthcare professionals' experiences through Thematic Analysis. The strength of Thematic Analysis was that it provided insights into this group of professionals. However, a critique of Thematic Analysis is that it does not offer in-depth interpretations of the individual's experience. This method suited the research question and aims of the study. In addition, the methods were shaped by the ontology underpinning the study, that there is no one truth available and so hearing the overarching experiences of a group felt most important. A further strength of the qualitative analysis was that it represented the dominant experiences of the group and did not simply pick stories that fit the research aims. To ensure this, a reflexive approach was taken to Thematic Analysis so that the decisions made and my reasons for this were shared with the reader. This also supports the reliability of future studies.

The quantitative aspect of the study used the ACE measurement, which research suggests has good internal consistency (Chapman et al., 2004; Anda et al., 2004) and test-retest reliability (Dube et al., 2004). A criticism of the measurement is that it may not apply to all cultures and trauma experiences (Finkelhor et al., 2013). However, I understand these are areas being considered in the field currently with studies in development. Still, the ongoing weakness of the research is that it is asking about retrospective experiences meaning true causation cannot be established (Edwards et al., 2019), although it is arguable if such a matter exists.

Overall, the research has many strengths to the addition of the ACE research field, particularly to understanding the impact of childhood adversity on healthcare professionals working in learning disability services. Data triangulation offered significant developments to the field, where combining methods offset the limitations of one method. The study provides a helpful start to understanding professionals in the United Kingdom, although future studies will be required to strengthen the findings. Although there are weaknesses to the current study, quality standards were used to ensure the research was valid and ethical. The research established two significant findings from the quantitative aspect of the study and valuable accounts of participants' experiences from the qualitative aspect of the study.

Quality evaluation

Quality frameworks were used during the research study to ensure vigour through the research process. Different frameworks were used to support the distinct stages the research took. This included the CASP checklist (2018) when conducting the critical literature review and Yardley's (2000) work on ensuring quality in research.

The CASP criterion (2018) outlines ten areas to consider when conducting a literature review. This shaped how I engaged with the literature search and helped determine what studies I included in my literature review. When engaging with the literature, considerations included how clearly the research aims were outlined for the study and how the study was informed by existing literature in the field. Such criterion helps to consider if the study was conducted ethically and was representative of the wider research field. Furthermore, the study results were considered for their significance and validity. Underpinning engagement with any literature were ethical considerations, making sure the research had considered potential causes of harm and that the research was conducted ethically. I have continued to incorporate these considerations in my work to ensure that my research is conducted ethically, reliably and with valid applications to healthcare services.

Furthermore, a framework which had great significance to how I conducted my research was Yardley's (2000) work. In particular, it made me review how I could conduct my research ethically, including considering power dynamics between researcher and participants, influencing the design of the study and wording of questions. Yardley's (2000) work also helped ensure validity across my study, including how this can be reached in qualitative work when sample sizes are smaller. I used the saturation test to determine the sample size in response to this. In addition, the framework strengthened my commitment to being transparent through my work, so I chose to use reflexive Thematic Analysis.

The research was informed by best practices in the field, with relevant texts referenced for my statistical tests and Thematic Analysis. In summary, quality frameworks were used throughout the research process, designing the project, engaging with the literature, and conducting all aspects of my research. Relevant governing bodies' guidance was followed by the BACP (2019) and BPS (2014). In addition, the City University of London's guidance on conducting research was followed at all times, including receiving ethical approval from the moderate ethics committee. The university's guidance continues to be followed as I hold the data set at this time and will follow their guidance on the management and destruction of this. A commitment to high-quality rigour and ethical working was present through the research.

Theoretical applications

Since Felitti et al.'s (1998) initial study on adverse childhood experiences, ACE research has grown into its own research field. There are now thousands of studies, literature and conferences based on this. Most notably, organisations such as The Centre for Disease Control and Prevention endorse this research. The theoretical basis of the adverse childhood experiences research is considering the impact of disruptions to childhood attachment and the consequences of trauma experienced during childhood. Developments in the field include neuropsychological and immunological understandings of the impact of childhood trauma. The impact of trauma has been mapped onto long-term consequences in adulthood, with health, social and behavioural considerations explored (Jones et al., 2020). Whilst these theoretical applications provide the foundations upon which recent ACE research has been built, the current study does not explore this in detail. The current research has focused on the clinical implications of trauma in learning disability services and exploring the impact of adverse childhood experiences on healthcare professionals. The aim had been to establish a deeper understanding of the prevalence of adverse childhood experiences in professionals and their experiences of how this impacts their work. The hope is that this information can inform future research directions, understanding the vulnerability of trauma being re-triggered and burnout. Future directions of research will be discussed in detail below, but the essential theoretical considerations are considering trauma and burnout in professionals further, along with how this can impact healthcare services and the care provided to clients.

Relevance to Counselling Psychology

The current study is highly relevant to the field of Counselling Psychology. The research offers insights into learning disability services, with implications for the delivery of services, support of professionals working in the field and, consequently, the care of clients. Counselling Psychologists work in learning disability services, often holding senior positions that involve responsibilities for the delivery of client care and working as part of a multi-disciplinary team. In addition, as professionals working in these services, psychologists are not immune from the findings of this research, meaning we may come with our own trauma histories and be at the same risk of re-traumatisation and burnout. Of course, this could have implications for fitness to practice, so managing the well-being of professionals at work can have a personal stake for psychologists. The research also benefits from a Counselling Psychology approach where this professional group understands the clinical applications of trauma, works with clients with a learning disability, and holds leadership positions in healthcare teams, often supervising other professionals. In summary, the research offers a two-way relationship with Counselling Psychology as it offers ecological validity to the services in which Counselling Psychologists work whilst also benefitting from their expertise.

Suggestions for further research

The research offered a valuable contribution to the ACE research and to professionals working in learning disability services. It, however, should only be the beginning of this work in the United Kingdom. As outlined when considering the strengths and limitations of the current study, the sample used was not ideal. Future research would firstly benefit from replicating the current study but using a larger sample which could offer both in-person and online means to engage with the research. This would be a step towards the research being more accessible and inclusive. A more extensive and diverse sample would allow for a better representation of professionals working in learning disability services.

Future research needs to extend the findings from this initial research. This includes considering if professionals working in learning disability services do have a higher rate of adverse experiences; then how does this lead to re-traumatisation, burnout, and work-related sickness? We understand that these difficulties occur but not the mechanisms underlying this phenomenon. Through better understanding of this, work on supporting services professionals could begin. Such preventative measures would help overcome the current difficulties in services with staff sickness, a high staff turnover and continuity in service delivery to clients. Some work has begun on this by discussing the impact of trauma-informed care in learning disability services, however, this research is currently lacking outside of the United States of America. Furthermore investigating the role of resilience in professionals would be beneficial to incorporate into preventative work against burnout. This research has however highlighted the importance of practical measures such as staff having regular supervision, access to debriefing after incidents (Williams et al., 2012) and services working collaboratively with all stakeholders in the organisation, staff and service users (Sprang, Clark & Whitt-Woosley, 2007).

The key findings from this study pave the way forward for future studies. For instance, the first major theme from the interviews discussed participants experiences of help. Participants indicated that their experiences shaped how they wanted to behave when with clients. The interviews however did not have the space to explore this further. Future interviews however could ask about this concept in more depth as the findings could inform clinical practice. Furthermore, the above recommendations regarding implementing trauma informed care could be implemented in clinical practice. This is something that to date has only been executed in selective services, however if policy makers could support with implementing this then this would be advantageous. For instance I am aware that most services have incorporated person-centred care into core training for staff; if this approach could be taken for trauma-informed care then it would enhance understanding in the care industry and promote services adapting this approach.

Further areas of investigation would be to understand the relationship between this and length of time working in services, as the current findings do not corroborate Keesler's (2018) findings of an inverse relationship between the score on the ACE measure and length of time working in services. The ACE research would benefit from cultural and socio-economic considerations to ensure it is representative of all in society. To achieve this work needs to take place on reviewing the questions on the ACE measure.

Reflections

Completing this research has been a personal and professional experience that has been both enjoyable and challenging. Reflecting on this takes me back to my critical realist epistemology, which I feel even more certain about completing this research. As I believe there is no single truth and we can only describe our versions of reality, this led me to the methods chosen to explore the research questions. A mixed-methods approach using different data sources provides several angles of information to try and capture as many versions as possible of reality. This also aligns with my interest in phenomenology to understand the lived experience people report driving my interest in Thematic Analysis to analyse the interview data set. Staying true to this, I do not advocate that this research is truly objective, as it has been shaped by my interest in this topic and how I engaged with the data set. To try and manage this bias, I have been committed to a reflective approach, where I have tried to share my rationale for decision-making and note when specific topics caused personal reactions.

An instance of this was when the theme regarding the journey services and clients was found across interviews. This resonated with me as a professional who has worked in learning disability services for many years. I feel it is an ethical duty to ensure that my world views and experiences did not cloud my engagement with the data set. To safeguard against this, I used supervision regularly, kept a diary, and engaged in personal therapy. Going through these measures made me more attuned to when I was having personal reactions and thoughts about the data. Some of these were beneficial, such as not needing to ask participants to clarify acronyms used during interviews, but I am aware this carries the risk of making assumptions. I was also mindful that my not asking for clarification on acronyms may have revealed to participants that I am an inside researcher, which increases the risk of social desirability in answers. This could have made it more difficult for participants to open up about the impact of adverse childhood experiences on their professional experiences.

I am also aware that overseeing and conducting this research has led to a level of introspection. I have considered what led me to this topic and how my own past experiences shape the professional I am at work and with clients. I am leaving this more mindful of this and under no illusion that, as a psychologist, I am exempt from the risk of burnout that I have discussed. I leave this project with a commitment to continue my reflective journey as a Counselling Psychologist, with a commitment to maintaining my own well-being to ensure that I am fit to practice as a professional.

Conclusion

In conclusion, the discussion chapter has encapsulated the previous chapters' findings to discuss the findings from the research and consider what this means. Links have been made to the literature and theoretical underpinnings of the research from the current study and in considering future directions for research. The strengths and limitations of the study have been outlined, along with my reflections on conducting the study. Importantly insights have been gained on applying the ACE research to healthcare professionals in learning disability services. This current research has therefore extended the ACE research begun by Felitti et al. (1998), with Jung's (1945) concept of the wounded healer. Most notably, the applications to learning disability services have been led by Keesler (2014; 2016; 2018; 2020). The current study has extended this research to professionals working in the United Kingdom and extended the scope of the research's aims to include the experiences of professionals working in services and what attracted them to this work.

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Appendix

Appendices

Appendices

Appendix A.1 Recruitment email

To whom it may concern,

I am a doctoral researcher from City University who is conducting research into the experiences of Learning Disability Support Workers/paid carers. The field of Learning Disabilities is often under researched and so I am hoping you can assist me with adding to the research literature by sharing this email with your staff.

I am asking if your staff who support individuals with Learning Disabilities would be willing to take an online questionnaire. The questionnaire will take up to 15 minutes to complete. The questionnaire can be accessed on a mobile device or computer. All questionnaire results are stored anonymously, and the data is kept confidentially. I would be unable to share with you if your staff have taken part in the study or not.

Please ensure that the voice of people working in Learning Disabilities is heard by sharing this email with your staff. I attach a poster about the study and an information sheet.

The questionnaire can be accessed by clicking on this link:
https://cityunilondon.eu.qualtrics.com/jfe/form/SV_cusCgNNI6Z4AMSh

If appropriate, I would be happy for this information to be shared on any social media pages that you may run.

Many thanks for your time and cooperation with the study.

Kind regards

Natalie Keeling

Appendix B.1 Recruitment poster for quantitative study

Department of *Psychology* City, University of London

PARTICIPANTS NEEDED FOR
RESEARCH IN *THE EXPERIENCES OF LEARNING DISABILITY SUPPORT WORKERS. WE ARE INVESTIGATING IF SUPPORT WORKERS HAVE HAD ADVERSE CHILDHOOD EXPERIENCES & IF THIS HAS IMPACTED THEIR CAREER.*

As a participant in this study, you would be asked to take part in an online questionnaire about adverse childhood experiences and your choice of career. The topic does cover difficult and adverse childhood experiences.

Your participation would involve 1 online questionnaire which can take up to 15 minutes to complete.

In appreciation for your time, you will receive
the chance to enter a prize draw where one person will win a £20 gift card

For more information about this study and to take part please click on this link:https://cityunilondon.eu.qualtrics.com/jfe/form/SV_cusCgNNI6Z4AMSh

Or contact *Natalie Keeling at Natalie.keeling@city.ac.uk*

This study has been reviewed by, and received ethics clearance
through the (*insert name of committee here*), City, University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix B.2 Recruitment poster for qualitative interviews

Department of *Psychology* City, University of London

PARTICIPANTS NEEDED FOR
RESEARCH IN *THE EXPERIENCES OF LEARNING DISABILITY SUPPORT WORKERS. WE ARE INVESTIGATING IF SUPPORT WORKERS HAVE HAD ADVERSE CHILDHOOD EXPERIENCES & IF THIS HAS IMPACTED THEIR CAREER.*

As a participant in this study, you would be asked to take part in an online interview to be asked about adverse childhood experiences, your choice of career and if you feel that this has influenced your work. The topic does cover difficult and adverse childhood experiences.

Your participation would involve 1 online interview lasting up to 1 hour.

In appreciation for your time, you will receive
the chance to enter a prize draw where one person will win a £30 gift card

For more information about this study, or to volunteer for this study,
please contact:
Natalie Keeling at Natalie.keeling@city.ac.uk

This study has been reviewed by, and received ethics clearance
through the (*insert name of committee here*), City, University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk
City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix C.1 Information sheet for quantitative study

Participant information sheet

REC reference number:

Study Title: 'Do people working in the helping profession have a higher rate of Adverse Childhood Experiences than the general population, and do they identify this as a factor influencing their career? A study into the experiences of Learning Disability Support Workers.'

Researcher: Natalie Keeling, Trainee Counselling Psychologist & doctoral research student. Email: natalie.keeling@city.ac.uk.

We would like to invite you to take part in a research study, which is a doctoral research project for the school of psychology at City University of London. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. This study has passed ethical approval from the City University of London.

Aims: The study aims to find out more about the experiences of staff working in the Learning Disability Services, and if these experiences have influenced your career. You are being invited to take part as you are a paid member of staff working in this field. You do not have to take part in this study.

What will happen if I take part? The study would involve asking you for demographic details and to complete The Adverse Childhood Experiences Questionnaire, which asks you about events which may have happened during your childhood. This includes adverse and difficult experiences during your childhood, including experiences of physical, sexual, or emotional abuse. There is a total of 25 questions to complete and we believe this will take up to 15 minutes. You can complete the questionnaire online at your own convenience. We would recommend that you complete the questionnaire in a private place due to the sensitivity of some of the questions. For this stage of the study it only required this one online questionnaire, but you may opt in to take part in an interview about your experiences.

Do I have to take part? Participation in the project is voluntary, and you can choose not to participate in part or all the project. Participation is voluntary and no one will know if you have taken part in the research. You can withdraw at any stage of the online questionnaire without being penalised or disadvantaged in any way, this will not affect your chances of being entered into the prize draw. It is up to you to decide whether to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time whilst completing the questionnaire and without giving a reason.
The data will be anonymised at the point of you submitting your online questionnaire. For this reason, it will not be possible to withdraw your data after this point. All data will be stored anonymously on the University's secure One Drive.

Appendix C.2 Participant Information Sheet for qualitative interviews

Participant information sheet for interview

What are the potential advantages of taking part? You will be contributing to the knowledge of experiences for staff working in Learning Disability Services. You will be entered into a prize draw to win a gift card. The winner will be randomly selected to win a £20 gift card. For the researcher to be able to contact the winner an email address will have to be provided. The email address will not be used for any other purpose.

Researcher conflicts of interest: The research is part of a University project, and the researcher is not receiving any funding for this project. There are no known conflicts of interest for the researcher conducting the research.

If you want to take part in this study, then please use the survey link: https://cityunilondon.eu.qualtrics.com/jfe/form/SV_cusCgNNI6Z4AMSh

If you have any difficulties with accessing this link please email the researcher. You can also email the researcher to request a copy of this information sheet, the debrief sheet or the results of the study.

If you have any concerns over the study, please contact the researcher or supervisor. The research is being supervised by Kathryn Emerson (kathryn.emerson@city.ac.uk).

Data privacy statement : City, University of London is the sponsor and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).
The only people at City who will have access to your identifiable information will be Natalie Keeling, and researcher supervisors. City will keep identifiable information about you from this study until the study has finished. Data will be destroyed in line with City's policy on the destruction of research data.
You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

What will happen to the results? The results are going to form a part of a Doctoral Research Project and will be written up for this purpose. There is the chance that this information may be used for publication within psychology journals at a later date.

Who has reviewed the study? This study has been approved by City, University of London Medium Risk Research Ethics Committee.

What if there is a problem? If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *'Do people working in the helping profession have a higher rate of Adverse Childhood Experiences than the general population, and do they identify this as a factor influencing their career? A study into the experiences of Learning Disability Support Workers.'*

You can also write to the Secretary at:

Anna Ramberg
Research Integrity Manager

City, University of London, Northampton Square
London, EC1V 0HB

Email: Anna.Ramberg.1@city.ac.uk

Insurance: City University London holds insurance policies which apply to this study, subject to the terms and conditions of the policy. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information available by contacting the researchers:

Researcher- Natalie Keeling, Natalie.keeling@city.ac.uk

Researcher supervisor- Kathryn Emerson, Kathryn.emerson@city.ac.uk

Thank you for taking the time to read this information sheet.

Appendix D.1 Quantitative online questionnaire, including confirmation of consent (copied from Qualtrics)

1. Have you read the participant information sheet and consent to taking part in the study?

● Yes

○ No

2. Are you currently working as a paid member of staff for people with Intellectual Disabilities?

○ Yes

○ No

3. How long have you worked in the field of Learning Disabilities?

○ 0-6 months

○ 7-12 months

○ 1-2 years

○ 2-3 years

○ 3-4 years

○ 4-5 years

○ 5-10 years

○ 10-15 years

○ 15-20 years

○ Over 20 years

4. What was the primary reason you chose to work in the field of Learning Disabilities?

☐ Good career opportunities

☐ Desire to help people

☐ Convenient job for personal circumstances

☐ Someone in my personal life has a Learning Disability

☐ Other: please specify in next question.

5. If you selected 'Other' reason in Q3 then please specify your reason here. If not, then please skip to the next question.

6. While you were growing up, during the first 18 years of life, did a parent or adult in your household often swear at you, insult you, put you down or humiliate you?

○ Yes

○ No

7. Did a parent or other adult in your household often act in a way that made you afraid that you might be physically hurt?

○ Yes

○ No

8. Did a parent or other adult in your household often push, grab, slap or throw something at you?

○ Yes

○ No

9. Did a parent or other adult in your household ever hit you so hard that you had marks or were injured?

○ Yes

○ No

10. Did an adult or person at least 5 years older than you ever touch or fondle you, or have you touch their body in a sexual way?

○ Yes

○ No

11. Did an adult or person at least 5 years older than you ever try to or actually have oral, anal or vaginal sex with you?

○ Yes

○ No

12. . Did you often feel that no one in your family loved you or thought you were important or special?

○ Yes

○ No

13. Did you often feel that your family didn't look out for each other, feel close to each other or support each other?

○ Yes

○ No

14. . Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

○ Yes

○ No

15. Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

○ Yes

○ No

16. Were your parents ever separated or divorced?

○ Yes

○ No

17. Was your mother or stepmother; often pushed, grabbed, slapped or had something thrown at her?
OR
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
OR
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

○ Yes

○ No

18. Did you live with anyone who was a problem drinker or alcoholic or used street drugs?

○ Yes

○ No

19. Was a household member depressed or mentally ill or did a household member attempt suicide?

○ Yes

○ No

20. Did a household member go to prison?

○ Yes

○ No

21. Please select your gender:

○ Male

○ Female

○ Transgender

○ Decline to answer

22. Please indicate your age range?

○ 18-24

○ 25-34

○ 35-44

○ 45-54

○ 55-64

○ 65+

23. What county did you grow up in?

24. If you would like to be entered into the prize draw to win a £20 gift card for participating in this online questionnaire then please enter your email address below:

25. Would you be happy to take part in 1 further interview to hear about your thoughts on what influenced your choice of career?

The interview can take place via an online video call at a time convenient to you. There will be the chance to win a further gift card if you participate in the interview too.

If you mark yes to this question the researcher will email over further information about the interview.

○ Yes

○ No

26. If you selected yes to receiving information about the interview then please enter your contact details below:

Appendix E.1 Consent for interview

INFORMED CONSENT SHEET FOR THE INTERVIEW

'Do people working in the helping profession have a higher rate of Adverse Childhood Experiences than the general population, and do they identify this as a factor influencing their career? A study into the experiences of Learning Disability professionals.'

Researcher: Natalie Keeling

A copy of the signed information sheet will be provided to you, and a copy will be kept by the researcher.

Please tick or

initial box

1	I confirm that I have read and understood the participant information dated July 2020 (Version 1) for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to the time of transcription, which will begin in February 2021	
4.	I agree to the interview being recorded and understand I have the option of audio recording only or video recording	
5.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	*I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.*	
7.	*I understand that my interview data will be used for writing up a research study and this may include using (anonymised) direct quotes from the interview. The research project may be published elsewhere for research purposes.*	
8.	I agree to take part in the above study.	

_____________________ _____________________________ _____________

Name of Participant Signature Date

_____________________ _____________________________ _____________

Name of Researcher Signature Date

Appendix E.2 Qualitative interview schedule

1. How long have you worked in the job role for, and what key experiences (positive or negative) have impacted you professionally?
2. What influenced you entering work in the field of learning disabilities?
3. Do you feel that your childhood had any influence on this?
4. Do you feel that your childhood impacts you currently?
5. Does this cause you any difficulties in the workplace?
6. What gives you meaning in your job?
7. Do you feel supported in your job role?

Notes for interviewer:

- *Check participant information sheet and consent form have been given prior to the interview starting*
- *After each question, the interviewer is to ask the participant 'are you feeling okay and wish to proceed to the next question'?*
- *The interviewer is to be vigilant for signs of distress during the interview. The interviewee is to be given the option to pause the interview, skip a question or terminate the interview.*
- *At the end of the interview the interviewee is to ask if the participant is feeling okay.*
- *The end of the interview will be followed by discussing the debrief sheet and a copy of this will be emailed to the interviewee.*
- *At the end of the interview and after the debrief information has been sent over, participant contact details will be deleted. If the interviewee wishes to be contacted with the results of the study, then this will be stored on a separate database.*
- *Once the interview is completed then the recording will have the transcript downloaded and checked for accuracy. At the point this is done the video recording will be deleted in line with City's destruction of data policy. The transcripts are to be stored on City One Drive.*

Appendix E.3 Debriefing sheet for quantitative questionnaire

DEBRIEF INFORMATION for the online study:

'Do people working in the helping profession have a higher rate of Adverse Childhood Experiences than the general population, and do they identify this as a factor influencing their career? A study into the experiences of Learning Disability professionals.'

Thank you for taking part in this online study. Now that it's finished we'd like to tell you a bit more about it.

The current study is investigating if certain life experiences will influence your choice of career. The questionnaire you completed was the Adverse Childhood Experiences Questionnaire by Felitti et al (1998) to help us understand what experiences you may have had when you were growing up.

If answering the questionnaire has brought up any difficult feelings, then please email the researcher (natalie.keeling@city.ac uk) and 1 phone call can be arranged to talk through how you can access further help. The next page will also provide links to some helpful resources and contacts.

We hope you found the study interesting If you have any other questions please do not hesitate to contact us at the following Researcher, Natalie.keeling@city.ac.uk or researcher supervisor (kathryn.emerson@city.ac.uk).

If you would like a copy of any of the resources emailed to you or further information on the study, then please email the researcher and this can be arranged.

Helpful resources

Support lines:

- Samaritans, free phone number 24/7, 116 123

- SANE, phone support 4.30-10:30pm on 0300 304 7000. Text based support can be found at www.sane.org.uk/textcare or an online forum is available at www sane org uk/supportforum

Websites:

- www mind org.uk
- https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/
- http://www.mentalhealth.org.uk/
- https://www.nhs.uk/conditions/stress-anxiety-depression/mental health-helplines/

Apps that you can downloaded onto smart phones:

- CALM
- Head Space

Appendix E.4 Debriefing sheet for qualitative interviews

DEBRIEF INFORMATION following an interview:

'Do people working in the helping profession have a higher rate of Adverse Childhood Experiences than the general population, and do they identify this as a factor influencing their career? A study into the experiences of Learning Disability professionals.'

Thank you for taking part in the interview. Now that it's finished it may help you to know more about it.

The current study is investigating if certain life experiences will influence your choice of career. There is a suggestion that people who have had difficult upbringings are more likely to enter the helping profession, as they want to help care for others. The questionnaire you completed was the Adverse Childhood Experiences Questionnaire by Felitti et al (1998) to help us understand this in more detail.

If anything from the interview has brought up any difficult feelings, then please email the researcher (natalie.keeling@city.ac.uk) and 1 phone call can be arranged to talk through how you can access further help. The next page will also provide links to some helpful resources and contacts.

Please use the telephone support on offer if you are feeling distressed.

We hope you found that taking part in both parts of the study was interesting. If you have any other questions please do not hesitate to contact us at the following: Researcher, Natalie.keeling@city.ac.uk or researcher supervisor (kathryn.emerson@city.ac.uk).

If you would like a copy of any of the resources emailed to you or further information on the study, then please email the researcher and this can be arranged.

Ethics approval code: ETH1920-1929

Helpful resources

Telephone support- ***please use the support if you need to talk to someone now:***

- Samaritans, free phone number 24/7, 116 123
- SANE, phone support 4.30-10:30pm on 0300 304 7000. Text based support can be found at www.sane.org.uk/textcare or an online forum is available at www.sane.org.uk/supportforum

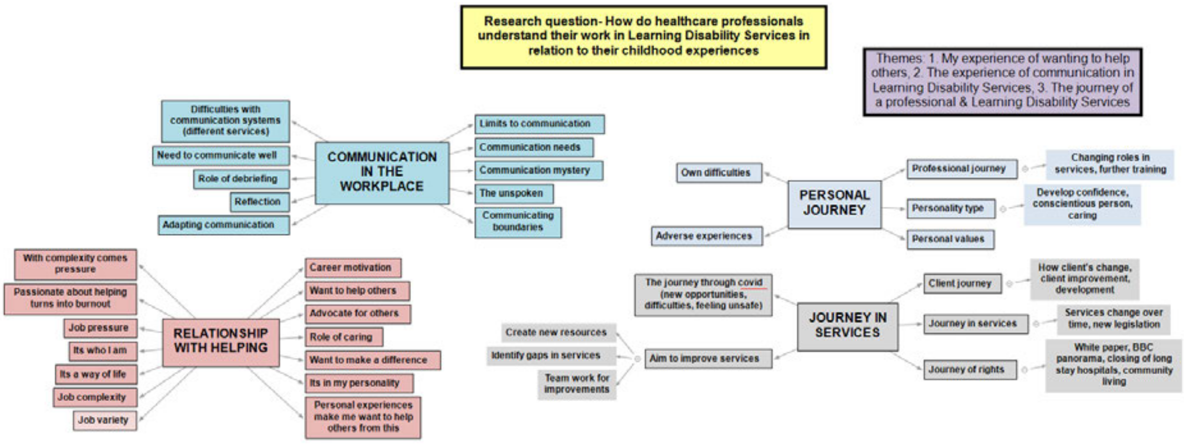
Websites:

- www.mind.org.uk
- https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/
- http://www.mentalhealth.org.uk/
- https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

Apps that you can downloaded onto smart phones:

- CALM
- Head Space

Appendix F Map of themes



Appendix G Sample transcript of interview 1

R: Thank you for agreeing to talk with me today and the first question I was interested in asking you about is how long you've worked in your job for and what you think are the key experiences you've had as a professional, either positive or negative. Some of those key experiences that really come to your mind over your profession?

P1: OK, so, yeah, I've been working as an intellectual disability nurse since 1996, but actually started working in the area of the field since 1990. So when I was 19, 19… 19 and yeah, it's been an experience of being the most important part is the adult or children I work with. I tend to enjoy working more with adults with severe intellectual disabilities so that I'm more nursing and I'm more able to find the complexity... It works for my brain. If that makes sense, it makes me think, well, you really have to put yourself in their shoes. And it's challenging. It's still challenging. Now, at the minute we work in a house, we've moved to cover, which is a new challenge and I've never had before, which is different…

But the challenges, I think it's given me so many different opportunities. When I started, I worked in a secure hospital with sex offenders and rapists, some with very mild intellectual disability and dual diagnosis and health in London. And then kind of used my qualification and then a lot of the time for my work I was in Australia, in sort of in social care field as a manager through the services. And then also it help me brought into mental health quite a lot as well. Kind of… It's given me the chance to travel to Australia and do different things. So it's had lots of different things, but it's always been about the people. Now I think after 10 years, whatever is it, I probably wouldn't try and rest now because it's not nursing anymore. I think it's very much ticking boxes and very admin work. My, my manager now is probably a demonstrator rather than a manager, and that's going to help them manage some paperwork. And it's also the other way we have healthcare over here, which is our inspection authority, and everyone's run scared of them. And it takes a while, what it does is, it takes place in the courts and like the children, the service or like updating and the kids are very complex and they come in and all that, but under pressure because of where they're from it… and having school. So I feel so sorry for them because they're complex young people and their families struggle with it big time. And I think that's probably well spread. So the…. I think it is I love I still enjoy nursing much now, I love the kids I'm working with.. I'm working with three different men because of what's going on. And they're very different, very loud and very challenging. You think on your feet and every day is different. And that's what I like about it. It's it's the individuals in the families that you work with are amazing, amazing people. I never I think the funny thing is I've never looked at the children as the disability. It's me, it's the child. And that's just another something. When we have students visit with them, look at the books because you get a diagnosis. And that's not just children in front of you. You get to know them and their personalities and them as people before you start reading into their background. You can, you can read stuff… And it doesn't give a good first impression, sometimes as well. This and that's not right. So, yeah. Is that kind of…

R: Yeah, that's really helpful. And it's really interesting to hear how kind of in your profession, you've obviously had different types of roles, worked in different types of places. But the theme that sounds like coming out is really the value of working with the individuals, but also their families and their support systems around them, which is, from my experience, one of the huge things working in learning disabilities, isn't it?.

P1: Yeah, it's my first experience as a student was working in a big institution. They taught in institutions, very old people from the community. And actually it was actually the building that was used for a TV series and it was a horrible place. But actually, I realised some of the things, the practices were not good, but that's the way it was at that time. It was different 12 years ago and how much services have developed since then and how in the. I think people… People with intellectual disabilities are living longer, as well as people with Down syndrome, all with the health in the early intervention stuff. There's whole new challenges ahead. You've got people with Down syndrome now developing dementia, which 15, 20 years ago…they wouldn't be here. So it's it's throwing out more challenges, which from a professional point of view is good because its keeping you on your toes and you're keeping new skills and learning new ways. But I think for families, it's also like we're I mean, your children service now, whereas as a manager in our service, when the children are 18 here, there is nothing for respite because of their intellectual disabilities. It's nothing. And it's like the kids don't get any easier as they get older, they get harder and the parents are getting tired and everything else is just wrong. I know I've been in England for a long time, but now in Australia money was put in and things have developed kind of Australia's jumped ahead of Ireland and England. So I can't really comment because I've not been there for a long time working. But here it's it's drowning in red tape and you find a way not to do things rather than trying to be creative. And there's always budgets and there was money. There's ways that you can develop things and be smart. And here you find it very frustrating that looking at models of care, like in Australia, you've got self directed living, which is huge over there and very much…But the culture is different, whereas here it's very much you look after my son, my daughter, your service. Over there, it's like, OK, here, it's kind of like you've got one service or another take or leave, you lucky to have that over there. It's like, well, 50 grand for you that's how much you're worth. Go shopping. Get what you this is a bit of this, you know, so it's a it's a mindset thing.

R: Yeah. It sounds more person centred your experiences in Australia, which kind of fits with your ethos on, you know, wanting to get to know the individual and why you do. the work?

P1: I think what I think it's also a mindset that in 2004 when I was there, first of all, the service is way behind because I worked in a sort of institution where the House had been condemned three times and there was rats and two young adults with disabilities living there. But then the government of New South Wales government poured millions into mental health and disability and very much intelligence services. And everything's gone. But you have to have money. That's that's the thing. And his money isn't spent on those services, especially like you know with who I support. With each physio who needs the hoist, who needs all that is, you know, for them, it's a thousand for service for you, for one of the individuals who is very able, independent, but doesn't make it right that they shouldn't have it. That's what needs to be there. But money is just not prioritised here by the government. And your story and families are in crisis even more now because of parents. Services were locked down from March to September, the schools and then now they've been closed again since it began in January. And I'm sure the same special needs schools in England. I think some are open, aren't they? Or maybe.

R: Yeah, there's a couple that are open for particularly high needs. But yeah, I know a lot of them are close to offering online session.

P1: Not everyone can engage. No ?

R: No, no.

P1: Everyone's got the technology and all that kind of stuff to be able to do online and everything else. Yeah, it's I guess it's a new challenge for me. It's a different challenge. I just got weekly covid test results back and that's a negative. Thank goodness we're not working under these pressures now, like the last month I've been in this house. It's not my choice to be there. You're working with positive kids and you're trying to keep yourself safe and safe... Your families are juggling all these kind of goals while still trying at the same time, still providing a good service. So it's nice you still get that sense of satisfaction now. But I've always got a reason why I went into it was I think because of my career as a footballer didn't work out. Then I went to Australia when I was eighteen. Then I came back because I need to get a job. I couldn't do mechanics and things like that, but I was good. I just get with people because it happened when I was younger and I just got people. And I think the the interest of working in disability saw it on a Sunday magazine back in those days. And I applied and thought, well, this is something that and I was. It suited me as a person, as a personality, and then I had to give up

Appendix H Sample of coded list for interview 1

Coding list

Interview one:

1. Job satisfaction (people work with, enjoy role)
2. Client preference (severity of disability)
3. Complexity of work (understanding clients, enjoyment, clients have multiple needs)
4. Challenges/pressure of caring for others (understand complex clients, challenging work lead to new opportunities, upcoming challenges, new challenges in different services)
5. Empathy/sympathy- put self in client shoes, personal experiences mean have empathy for others,
6. Opportunity to have different experiences
7. Diagnoses -different clients work with, see the person not the diagnosis- own diagnosis,
8. Locations- different places worked
9. People- working with clients and colleagues
10. Role change- more administration, change over time
11. External services-
12. Job variety
13. Tired- caring for others leads to feeling tired,
14. External barrier/system- money impacting care,
15. Money- budgets for care, cost of equipment,
16. Service types
17. Covid related challenge- testing, remote working, worry about bringing virus home,
18. Safety
19. Service quality
20. Career motivation- other career avenues failed, saw job advertised,
21. Good with people/personality compliments job- natural ability with people, job suits personality, being good with people more important than training, get others,
22. Communication
23. Stigma
24. Personal experiences- mental health problem, eating disorder, ACE lead to listening to others, ACE lead to caring for others, look back on experiences,
25. Role of caring- job to care
26. Helping others- attitudes towards care, aim for best to help and listen
27. Role of advocating- speaking for those that can’t, mental health advocacy
28. Communication needs
29. Role of disability
30. Adverse childhood experiences- father drinks alcohol, divorce,
31. Energy/burnout- less energy with age, more tired over time, politics, burnout over time, loss of energy
32. Understanding others- innate ability to understand,
33. Disability world
34. Job frustration- “overkill paperwork”,
35. Leaving profession
36. Barriers at work
37. Making a difference to others
38. Personality- shy, conscientious, caring, sensitive

Appendix I Extract from reflexive diary

Diary entry after interview [redacted]

I enjoyed listening to the participants experiences today and am excited to progress with data analysis, although I know this will be a lengthily process. My initial reflection listening to today’s interviews was how their experiences related to helping others began at such an early age. The other area which stood out of me is how passionate the participant sounded as they spoke about their work, and I personally found this to be really inspiring to listen to. I wanted to try and be with the participant and their experiences so my focus was on this which means I am not sure how the data will yet link to my research questions, but certainly the participants discussed the impact of their childhood experiences influencing who they are and their career so I am hoping there will be some rich data to work with. The comment made about how certain types *of people are drawn to work in certain areas made me stop and reflect on what this may mean for me as a professional working in healthcare. This is something that I am aware of and need to consider taking to supervision or I have personal therapy on Sunday. Once all the interviews are finished, I will start the transcription process and I wonder if any other reactions like this will arise?*

Part 1.2 Publishable Paper

Do healthcare professionals have a higher rate of Adverse Childhood Experiences (ACE) than the general population & do they identify this as influencing their career?

Natalie Keeling, Natalie.keeling@city.ac.uk

Supervised by Dr Julianna Channelor

City, University of London

Formatted according to the guidelines of:

The Journal of Applied Research in Intellectual Disabilities (JARID).

Original article

Do healthcare professionals have a higher rate of Adverse Childhood Experiences (ACE) than the general population & do they identify this as influencing their career?

Natalie Keeling 1, Dr Julianna Challenor 2, Dr Kathyrn Emerson 3 -City University of London

1. Natalie.keeling@city.ac.uk 2. Julianna.Challenor.2@city.ac.uk 3. Kathryn.Emerson@city.ac.uk

Abstract

Background: The Adverse Childhood Experiences research pioneered by Feliiti et al. (1998) provided a deeper understanding of childhood adversity's impact in later life. This includes applications to work and healthcare. High staff sickness rates in learning disability services and reports of trauma in response to managing challenging behaviour informed the decision to apply ACE research to learning disability services.

Aims: The research aimed to understand if staff working in learning disability services have a higher rate of adverse childhood experiences and the extent to which this impacted their work in learning disability services. The research aimed to extend the existing ACE research field whilst exploring the concept of the wounded healer (Jung, 1945).

Methods: A mixed-methods approach was taken. Seventy-two participants completed the quantitative aspect of the study, completing the ACE measure, questions about their work and demographic details. Follow-up semi-structured interviews were completed with seven participants. The quantitative data was analysed using SPSS with a Mann-Whitney U tests. The interviews were analysed using Thematic Analysis.

Findings: Significant results were found for the quantitative investigations. The ACE score of professionals in the study was compared to the 'general population' (taken from Hughes et al., 2020 study). The 'general population' scored significantly higher for 0 on the ACE measure (U=114594, p=.000) whilst healthcare professionals scored significantly higher for a score of 4+ (U=249606, p=.000). Furthermore, a significant number of professionals listed their career motivation to work in learning disability services to be due to a desire to help others, x2 (4, N=72)= 79.8, p<.01. The Thematic Analysis yielded revealed a dominant theme of the participant's relationship with help.

Conclusions: Healthcare professionals in learning disability services reported significant levels of adverse childhood experiences, suggesting a risk of re-traumatisation working in services when they want to help their clients. Thematic analysis revealed participants had a complex relationship with help; as the helped and helper. These results begin the evidence to consider preventative measures to support professionals, services, and client care in Learning Disability Services.

Keywords: Adverse Childhood Experiences, Healthcare Professionals, Intellectual Disability, Learning Disability Services, Trauma, Trauma-Informed Care, Wounded Healers

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Part 1.3 Clinical Case Study

The following part of the thesis will be redacted for data protection reasons.
This report has used de-identifying information with client pseudonyms. The client and their parent consented to audio recording; all sessions were recorded for professional development and ethical reasons.

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Relevant childhood data	[redacted]
Core beliefs(s)	[redacted]
Conditional assumptions/beliefs/rules	[redacted]
Compensatory strategies	[redacted]
	↓
Situation	[redacted]
Automatic Thought	[redacted]
Meaning of Automatic Thought	[redacted]
Emotion	[redacted]
Behaviour	[redacted]

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Figure 2

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