

Counsellors' experiences of working with learning disabled people who have been sexually abused: A thematic analysis

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Abstract

The study aimed to explore counsellors' experiences of working with clients who had learning-disabilities and had been sexually abused. This qualitative study assisted in identifying the issues raised for the participating counsellors when working with such people. Obtaining information from counsellors may further assist in identifying future social developments such as increasing awareness and minimising exclusion, discrimination and prejudice towards learning-disabled people who have been sexually abused.

This study used a qualitative descriptive design under the post-positivist paradigm. The participants were recruited within the Auckland region, through counselling and/or disability health services such as the Accident Compensation Corporation (ACC) that provide counselling and therapy for sexually abused learning-disabled people.

Counsellors or practitioners (which include psychologists, psychotherapists and therapists) who identified as having clients or learning-disabled persons who have been sexually abused, took part in a semi-structured interviews which explored their experiences of providing their services. The interviews were conducted face-to-face. Through the process, three participants (practitioners) who had previously or are currently working with sexually abused learning-disabled people, were interviewed.

The interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis. Through the analysis, a key theme of 'Applying practice' was developed with three sub-themes. These were: accessing therapy, using appropriate therapies and ensuring follow-ups. The findings identify how counselling practice and services may assist learning-disabled people who have been sexually abused. This included the recognition

of issues relating to learning-disabled individuals as being highly vulnerable, having limited educational support, particularly sexual education. Another issue was the identification of sexual abuse having occurred. Furthermore, there is a lack of prevention strategies in eliminating sexual abuse for learning-disabled people.

This research might help to influence New Zealand counsellors' and their practice methods when dealing with their clients who have a learning-disabilities. As mentioned earlier, this study might influence future development for learning-disabled people.

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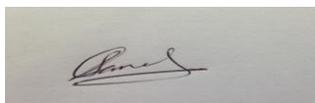
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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

A rectangular box containing a handwritten signature in black ink on a light-colored background.

Date: 16/03/17

Definition of terms

Learning Disability - Disabilities or disorders that affects individual's visual, intellectual, coping, understanding, cognitive functioning as well as reading and writing difficulties

Practitioner – includes counsellors, psychologists, psychotherapists, therapists

[...] – signifies that the following texts have been deleted from the original excerpts

Italics – signify participants' excerpts

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Chapter One - Introduction

This study aims to explore the counsellors' experiences of counselling clients who have learning disabilities and who have been sexually abused. A survey conducted in 2006 by Statistics New Zealand (2013), indicated that only 17% of children and 14% of adults with disabilities were able to access counselling services. Approximately 10,300 disabled individuals were unable to obtain counselling and social support services in the previous 12 month period (Statistics New Zealand, 2013). Hence, this qualitative study will assist in identifying the issues raised for New Zealand counsellors when working with such people. Obtaining information from this study population of counsellors may also further assist in identifying future social developments in relation to the incidence of sexual abuse experienced by people with learning disabilities.

1.1 Background

People with disabilities are targeted as sexual abuse victims (Sobsey & Doe, 1991). In many deprived nations, disabled children are 1.7 times more likely to be sexually abused than non-disabled individuals (Phasha, 2009)

The World Health Organization (2011) identified that discrimination and negative views of disabled people are the first steps in creating barriers and confusion. Experiencing such discriminatory and negative opinions easily restricts disabled people in how they live their lives. In addition, a lack of appropriate services, policies and appropriate knowledge can limit disabled people from living a productive life. Developing appropriate policies

relating to education and financial support, as well as protective services for disabled individuals can greatly assist them.

Learning disabilities are a broad definition of 'hidden disabilities' that influence people's capability to interpret and articulate information, either through speech, writing, reading, comprehension and communicative skills (Neuwirth, 1993, Atherton & Crickmore, 2011). In many cases, learning disabilities can be described as a number of learning disorders (Atherton & Crickmore, 2011, Neuwirth, 1993). Specific and diagnosed learning disorders such as autism or dyslexia can be defined as having particular visual, coping, understanding, cognitive functioning as well as reading, speech and writing difficulties (Neuwirth, 1993, Atherton & Crickmore, 2011). However, these learning disorders such as autism and dyslexia can also enhance and strengthen other abilities. For instance, people with autism may have a higher IQ, have long-term memory and are able to retain detailed facts (Happé, 1999), whereas people with dyslexia may have extraordinary artistic and musical abilities (Atherton & Crickmore, 2011).

There are different ways in which people who are identified as having a learning disability can be described or viewed in society. They can be viewed as an individual who has certain disadvantages or impairments when comprehending and interpreting information (Ministry of Health, 2001). They can be identified as people living with a learning disability who may have limited coping skills and mechanisms, which can have permanent future impacts on their day-to-day living. Furthermore, multiple terminologies reflect an attempt to describe the different kinds of ways in which a person may be learning-impaired which may include having a learning disorder. In some cases, rehabilitation, teaching and a supportive environment can be highly useful in maintaining a healthy lifestyle (Ministry of Health, 2001).

Given the many definitions of learning and intellectual disability and the slippage between the two, for the purpose of this thesis, the term learning-disability will be used instead of intellectual disability. This is the term that People First New Zealand has requested be used. People First NZ was established in the 1980's and is a self-advocacy organisation for people with a learning disability. Their definition includes individuals who have limited visual, coping, cognitive functioning as well as reading and writing skills (People First New Zealand, 2017).

Overseas studies have identified that significant numbers of people with learning disabilities experience sexual abuse. For example, Australian researchers Keilty and Connelly (2001) found that close to 50-99% of learning-disabled people are abused and/or more prone to sexual abuse than the non-disabled population. Martinet and Legry (2014) identified 209 cases of abuse in health care settings in France for learning-disabled clients and nearly half of those cases involved sexual violation and assault. This type of abuse they argued has led to physical, psychological and societal deficiencies within the daily lives of victims. Psychological deprivation and social isolation has the potential to lead to a higher vulnerability for learning-disabled individuals (Keilty & Connelly, 2001). Other outcomes that have been noted include over-attachment to carers, feeling powerless and having limited knowledge of sexuality (Keilty & Connelly, 2001).

Another issue for learning-disabled people who have experienced sexual abuse are the negative viewpoints they confront from health professionals/counsellors (Phasha, 2009). This is mainly due to the restricted education and knowledge-based resources available to counsellors regarding the increased susceptibility of learning-disabled people to sexual abuse (Phasha, 2009). Furthermore, sexually abused learning-disabled people are not provided with additional support services or care assistance. Due to the lack of information

and knowledge, academic research into the issue of sexual abuse for learning-disabled people has been limited (Phasha, 2009).

Sexual abuse also leads to long-term consequences for learning-disabled people (Peckham, Howlett, & Corbett, 2007), for instance, anger, frustration, low self-esteem as well as further mental and behavioural problems. In these cases, psychological therapy and counselling seem to be the best method of treatment for sexually abused learning-disabled people (Peckham, Howlett, & Corbett, 2007).

1.2 National approach

When addressing the issue of the sexual abuse of learning-disabled people, government and non-government based support as well as development of policies may help to acknowledge these acts and thereby work to prevent them. The New Zealand government created the New Zealand Disability Strategy ¹(Ministry of Health, 2001), with the key agenda to change what is seen as a disabling society to a more inclusive environment for disabled individuals (Ministry of Health, 2001). It was also to ensure that disabled people are valued, protected and not discriminated against.

Therefore, the Disability Strategy (Ministry of Health, 2001) addressed the significance of public/government services for disabled individuals to ensure that they are treated with respect and self-worth. The Strategy also asserts that people with disabilities should be informed of their individual rights, and that any forms of injustice or

¹ At the time of writing the Disability Strategy was being revised.

discrimination are intolerable. While not explicitly identified in the document, strategies addressing the issue of sexual abuse have the potential to be argued for and developed.

1.3 Global approach

Disabled individuals in particular, need as much support, if not more, accessing services and obtaining the resources and skills, they need to protect themselves from being harmed.

Likewise, double marginalization occurs for learning-disabled people as the World Health Organization (2011) emphasizes that they also experience more difficulties than other disabled individuals. On a global scale, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006) addresses the issues and rights of disabled people worldwide. They identify key elements under 50 different articles that describe the problems disabled people face on a daily basis. The UNCRPD also provides guidelines for eliminating these problems. The articles focus on the level of access for disabled people, provision of services, information and means of removing difficulties and barriers.

A particular UNCRPD article that relates to sexual abuse is Article 16, which focuses on eliminating any forms of abuse, neglect, exploitation and violence against disabled people. It identifies the importance of protecting disabled people from abuse and gender-related discrimination, as well as proposing government-based preventative approaches of creating programmes, interventions and appropriate assessments on services and support networks. This was to ensure a society which includes disabled people, where all society members have the right to be safe from abuse, neglect, exploitation and violence. The article also emphasizes the significance of policies relating to abuse, particularly the abuse of learning-disabled people. As New Zealand is party to the UNCRPD, a shadow

report was created in 2014 to ensure that the disability community of Auckland were able to identify issues and discuss ways in which the UNCRPD could be applied in New Zealand context (Committee on the Rights of Persons with Disabilities, 2014).

1.4 Gaps identified – New Zealand Disability Strategy and UNCRPD

When comparing the New Zealand-based and global-based approaches of recognizing the significance of sexual abuse for learning-disabled people, some limitations and gaps were identified. While the New Zealand Disability Strategy (2001) identified disabled people and their rights as well as their overall well-being, there is little or no evidence of support for better understanding of sexual abuse of disabled people. The strategy does emphasize support and services that are available for disabled people; however, they do not address services relating to sexual education or sexual abuse, e.g. Rape Crisis centres.

In comparison, the UNCRPD addresses the sexual abuse of disabled people. It also identifies ways in which these issues can be prevented and recognized within the global context.

In the beginning of 2014, a collaborative effort of New Zealand based non-government organisations produced a report to the UNCRPD. With the help of these several disability organisations, such as Auckland Disability Law Incorporated, CCS Disability Action and People First New Zealand, the report addressed the abuse of disabled individuals. The key purpose of these organizations was to identify and eliminate violence against disabled individuals (Domestic Violence and Disability Working Group, 2014). One of the main aims was to work with the UNCRPD and in particular, Article 16. The

report states that in New Zealand the recognition of any form of abuse towards disabled people is limited. It emphasizes that females with learning disabilities experience a higher rate of physical, sexual and emotional abuse than males. They also state that sexual abuse is strongly linked to psychological disorders, high suicide rates, pregnancies, social isolation and physical abuse within females with learning disabilities.

Some of the issues identified in the report, such as limited resources of retrieving support networks and assistance that could be easily provided for learning-disabled people, are relevant and relatable to the current topic. They proposed that further emphasis and collaboration with government and non-government organisations, drawing on the UNCRPD, can assist to eliminate the issues of sexual abuse on learning-disabled people. Continuous support recognizing and minimizing sexual abuse of learning-disabled people within New Zealand may assist to create similar programmes in a global scale.

1.5 A marginalized population: Critical examination of theories and models

There are two main theories regarding disability: the medical model and the social model. Hughes (2010) suggests that the medical model and the social model should be considered when addressing the issues of inequalities for disabled people within the community. The medical model recognizes a person's disability or impairment. The model identifies, categorizes and measures the disability, mainly to treat, support and assist people with disabilities. An example of this may include the use of the Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria, which assists in diagnosing and treating people with learning disabilities, or learning disorders (Hansell & Damour, 2008). The

medical model constructs disability as a deficit, which can make disabled people feel more different than and inferior to non-disabled people.

In contrast, the social model of disability focuses on the multiple obstacles faced by disabled people (Hughes, 2010). It proposes that mainly the negative views, aspects, attitudes and beliefs that people have towards disabled individuals create these obstacles. In other words, these are social barriers created by a wider disabling society (Barnes, Oliver, & Barton, 2002). These social barriers restrict disabled individuals from living a normal, productive life. Therefore, use of the term ‘disability’ can be described as social discrimination or disablism (Barnes, Oliver, & Barton, 2002).

When comparing the two models, it is evident that the medical model recognizes the physical, sensory, mental and intellectual disadvantages of disability or issues (Hughes, 2010). Whereas, the social model identifies the socially constructed nature of barriers and offers solutions to the disadvantages or issues that the disabled or differently-abled population face on a daily basis (Hughes, 2010). Therefore, it can be seen that the medical model attempts to change or modify the disabled person, whereas the social model attempts to change the views of society.

It can be easily identified that the New Zealand Disability Strategy (NZDS) and the UNCRPD, are mainly based on the social model of disability (Ministry of Health, 2001, United Nations Convention on the Rights of Persons with Disabilities, 2006, Hughes, 2010). The NZDS and the UNCRPD identify ways in which disabling obstacles can be prevented. These may include providing programmes and services for people with disabilities.

Furthermore, it is also apparent that the UNCRPD has a more primary health prevention aspect to addressing disability related issues and decision-making approaches (King, 2001). Primary health is the socially based, practical and culturally acceptable method of providing health access to people within New Zealand. It also addresses the importance of participation and community involvement to interact with the initial stages of health services. It is important to understand the ways that the social model of disability has shaped these policies as this has implications for health practitioners, including counsellors.

1.6 Rationale for the study

According to the Domestic Violence and Disability Working Group (2014), there are many reasons why people with learning disabilities are targeted and experience higher rates of sexual abuse than non-disabled people. The reasons proposed include when the person may have a lack of verbal and social skills, which may affect their capacity for judgement (Bruder & Kroese, 2005). Furthermore, when a high level of trust is placed on either people whom the person knows well or strangers, this may increase the potential for abuse to occur (Breen, 2014). In addition, some learning-disabled people who are also physically impaired, may be more at risk of being abused because they have more difficulty escaping from their attacker (Breen, 2014).

Another proposed reason for a higher level of vulnerability is when there is a lack of educational support, particularly sexual education and the ways that some victims may or may not be able to identify when they were being sexually abused (Bruder & Kroese, 2005). It is not uncommon for the perpetrators to ensure that sexual encounters are hidden by carrying out their abuse at times and in places where the incident cannot be seen or

heard by others (Breen, 2014). Furthermore, there is a lack of prevention strategies targeted to eliminating sexual abuse for learning-disabled people.

By educating learning-disabled individuals and the people around them about this issue, there is a possibility of preventing or avoiding the occurrence of these situations. As stated by Cambridge, Beadle-Brown, Milne, Mansell, and Whelton, (2011), developing policies and national guidelines can assist to inform, and prevent the sexual abuse of learning-disabled people.

Research indicates people with a learning disability experience a high rate of sexual abuse and for various reasons, they may not access counselling support (World Health Organisation, 2016). Also working with people who have a learning disability may call on counsellors to adopt different strategies (McGinnity, et al., 2004). However, little is known about counsellors' experiences of working with people who have learning disabilities. Thus, this research is focused on identifying and exploring the issues for counsellors when working with clients who have a learning disability and who have been sexually abused.

1.6.1 Potential Benefits

As the current study uses a qualitative approach, no generalisation towards all counsellors/therapists/psychologists can be made. By having counsellors as participants this study might assist identifying how counselling practice and services may be used to assist learning-disabled people who have been sexually abused. Further, this research might help to influence specific counsellors and their practice methods when dealing with these clients.

The study findings, which will be provided to participants and their professional organisations, may offer useful information about what strategies the participating counsellors have found helpful or unhelpful and identify any other issues they may

experience. This information may also be useful to learning disability advocacy organisations such as People First, and facilitate their access to counsellors.

1.6.2 Research Question

In this regard, the research question of this study is: what are counsellors' perspectives towards providing therapy for learning-disabled people who have been sexually abused?

Being a disabled person myself, my interest in this study is based on my motivation to develop an encouraging and promising outcome for all counsellors and learning-disabled clients alike. I want to know about the therapeutic treatments that are used for learning-disabled clients, the processes that are required when clients are referred for counselling as well as identifying what these areas are lacking.

My disability was sustained when I was 15 years old through a spontaneous intracranial haemorrhage on the 21st of April, 2005. The haemorrhage has caused physical and neurological damages. I have right homonymous hemianopia, where I am unable to see anything on the right visual field of both eyes, right-sided numbness and constant headaches which affect my ability to write. I also experience cognitive fatigue, limiting the amount of time I remain focussed on my studies. I also experience limited verbal reasoning skills, memory, information-processing abilities and concentration. Therefore, I require constant repetition and additional time to learn and remember new information.

From my personal experience of disability, I have realized that without verbal interaction, learning-disabled people can become isolated and socially excluded which may result in an environment for social ignorance. This then affects people's views of learning-disabled individuals.

1.6.2.1 Assumptions

After developing the research question and personal reflection, I was able to identify my underlying assumptions about the study.

They included:

- The participants (counsellors/psychologists/therapists/psychotherapists) may have a formal checklist they follow when working with and treating their clients. (For example, the DSM criteria).
- They may have worked with or are currently working with clients who experience different levels of impairment.
- They may have adapted a checklist e.g. DSM criteria
- Different practitioners may work differently. For example, some may carry out assessments, others may screen for safety.
- Others may express empathy and a level of understanding,
- People with learning disabilities may take time to express their thoughts and feelings to the counsellors/psychologists/therapists/psychotherapists.

Through acknowledging these assumptions, I hope to obtain sufficient information and understanding of counsellors' experiences of working with sexually abused learning-disabled people. To better understand this study, I will provide a structured outline of this thesis.

1.7 Structure of the thesis

In this first chapter I have introduced the thesis with an explanation of the purpose of the study.

Chapter Two provides information for developing a theoretical framework with an exploration and explanation of existing research on this thesis topic. This chapter examines the relevant history, laws, theories and models. It then examines articles and studies that relate to sexual abuse, learning disability and counsellors. An examination of the key themes that are developed from the analysed articles follows.

Chapter Three describes how I collected and analysed the data. It also provided information on the types of methodology, method and data analysis approach used in this study. This chapter also focuses on the ethical considerations, methods of obtaining consent and confidentiality in the study as well as describing how rigour was ensured throughout the study process.

Chapter Four provides an in-depth description of the findings from the transcripts of the participants. Short descriptions of the participants are described, followed by the themes created from the data analysed. These themes follow the three stages of applying practice and include accessing therapy, using therapy and ensuring follow-up.

Chapter Five assists to link the findings, what they mean to me and reflects on the existing knowledge on the topic of counsellors' experiences of working with sexually abused learning-disabled people. The chapter addresses the implications, limitations and recommendations of the study with a concluding section.

Chapter Two - Literature Review

The World Health Organisation (2011) has recognised that there is double marginalisation within the disabled population. There is a realisation that disabled people are a marginalised group with increased inequalities. In addition, research shows that learning-disabled individuals are more at risk of exploitation than individuals with physical disabilities (World Health Organisation, 2011). This would make them more vulnerable and in danger of being sexually abused.

This chapter reviews the literature on sexual abuse and counselling about learning disability. First, I will outline the terms and databases I employed to locate relevant literature. Next, I will address the history of disability; examine theories and models, relevant law and legislations, as well as therapeutic approaches relating to disability. I will then discuss literature related to counsellors' experiences, sexual abuse and learning-disabled people. My goal was to find out what is known and not known about this current topic.

2.1 Locating literature

To locate literature on the current topic of counsellors' experiences of working with sexually abused learning-disabled people, I used the terms: "counsellors' experiences," "sexual abuse" and "learning-disabled people." The databases I used were: PsychINFO, Scopus, PubMed, the AUT online library search engine as well as the Google Scholar web-engine. When using the PsychINFO, PubMed, Scopus and the AUT online library search engines, I specifically concentrated on publications that dated back 15 to 20 years.

Altogether, 11 articles were found, with two articles focused on therapeutic models and approaches based on sexual abuse (Hays, Murphy, Langdon, Rose, & Reed, 2007, Becker, 2015). The next two studies were found under the references used by these 11 articles and were closely related to my research topic of counsellors' experiences with sexually abused learning-disabled people (Faccini & Saide, 2011, McConkey & Ryan, 2001). However, due to limited information on this topic, I had to broaden my search and find other literature that addressed either: sexual abuse and learning-disabled people, or practitioners' and learning-disabled people, or practitioners and sexual abuse. By following this pathway, four articles were found that focused on learning-disabled people and the justice system (Niehaus, Kruger, & Schmitz, 2013), the involvement of family/carers (Eastgate, Scheermeyer, van Driel, & Lennox, 2010), treatment (Nijnatten & Heestermans, 2010) as well as the availability of therapy (Hollins & Sinason, 2000). While three articles were found focusing on counsellors' experiences as participants in studies (Doran, 2015, Etherington, 2009) and as victims of sexual abuse (Little & Hamby, 1999).

2.2 Essential context

The essential context in this section of the chapter is dedicated to New Zealand's history, laws, legislations, theories and models relating to disability and learning-disabled people. While I was able to obtain literature on the above topics, there was very limited information and knowledge about New Zealand's influence on the history and laws affecting disability as most of the articles were based in the United Kingdom (U.K.) and the United States of America (U.S.A.).

2.2.1 History of disability and learning-disabled people in New Zealand

History had always been the absent portion of the disability jigsaw puzzle (Barnes, Oliver, & Barton, 2002).

The history of disability has not been widely studied. This has been seen as a limitation of disciplines such as sociology in Britain during the 19th century, which mainly viewed disabled individuals as dependent individuals (Barnes, Oliver, & Barton, 2002). When considering disability and learning disability within the New Zealand context, there have been continuous changes within the last 150 years (Smith, 2015). Under this section, I will show how constructions of learning disability and policies have changed over time: from dependency to institutionalisation, to social inclusion.

During the 1850s, learning-disabled people in New Zealand were made dependent on their family members and considered a liability in society. Smith (2015) stated that the New Zealand government's immigration processes involved high levels of restrictions on learning-disabled individuals, as they were perceived to be an inconvenient burden. The New Zealand government passed two laws that assisted in the restriction process. First, they passed an 'Imbecile Passengers Act' in 1882 and then an 'Immigration Restriction Act' in 1899 (Stace, 2007). These Acts were developed to limit non-European groups or disabled people from coming into New Zealand.

In the late 19th and the beginning of the 20th century, modern industrial capitalism started to emerge. With modern medicine, learning-disabled individuals were assessed, diagnosed and kept in controlled environments where they were marginalised and institutionalised (Smith, 2015). Finkelstein (1980) has identified phases in the treatment of disabled individuals, which recognized the effects of the changing world and how it could

affect disabled people in general. In the first phase, disabled people were assembled as a collective group who were mostly ignored or paid less, existing at a lower level of the socioeconomic system. In the second phase, disabled individuals were segregated, excluded and kept in institutionalized environments. The New Zealand government developed the 'Education Act' in 1914, which included education departments, and police as well as parents. It involved the removal of children identified as having learning disabilities from their home environments.

People identified as having a learning disability in New Zealand were labelled as unwanted and dangerous. In 1924 the government established a "Committee of Inquiry into Mental Defectives and Sexual Offenders" and included learning-disabled people who were considered by default to be perpetrators of sexual abuse (Smith, 2015). By 1969, the Mental Health Act was developed where learning-disabled people were controlled and monitored by health professionals in institutionalized environments (Smith, 2015). Disabled individuals were understood through a medical model (Smith, 2015). They were seen as people who needed to be fixed because there was something wrong with them (Smith, 2015).

By 1985, global and national influences had encouraged community-based residential support services for learning-disabled people in New Zealand. The change was part of a move from the medical model of disability to the social model of disability. Learning-disabled individuals were given more rights and the power to become independent in society. In many ways, the views of the social model of disability seemed to influence the government, its public health policies and systems. Smith (2015) explained that there had been a shift in the social environment as disabled individuals were less restricted and were becoming more included in society. The government adopted the

Scandinavian academics' concept of "normalising" learning-disabled people by treating them equally to other non-disabled individuals (Smith, 2015). These normalising principles subsequently influenced governmental policy relating to deinstitutionalisation. However, 'normalisation' as 'one size fits all' was also assessed critically as every learning-disabled person had different needs (Smith, 2015). If everyone is treated the same, some people's needs may not be met.

One of the purposes of identifying the history of disability is that it may assist disability communities in the future. Barnes, Oliver and Barton (2002) stated that due to the lack of historical knowledge of learning-disabled people, there has been limited education and lack of involvement with disability studies and methodologies in academic contexts. Therefore, by conducting this current study, others might gain information and knowledge about the significance of therapeutic support given to learning-disabled people who have been sexually abused.

2.2.2 Law, legislation and the criminal justice system

A counsellor needs to understand the justice system in relation to sexual abuse to help their clients. This section will discuss how the laws, legislations and the justice system influence the lives of disabled people. These laws and legislation should assist preventing abuse as well as ensuring the rights and safety of all disabled individuals.

When considering the law and the justice system, it can be acknowledged that learning-disabled people have experienced discrimination when pursuing social amendments (Johnstone, 2001). Where sexual abuse is concerned, I have found limited literature about New Zealand's legislation affecting disabled people. Legislation such as the New Zealand Crimes Act 1961 provides the recognition and accountability through

imprisonment for the types of sexual crimes committed on disabled individuals. For instance, sexual mistreatment or sexual interaction when the disabled individual is unaware of the indecent act conducted or knowingly committing sexual abuse of a disabled individual without their consent (Parliamentary Counsel Office, 2015).

Nevertheless, in New Zealand, there is inadequate information about the steps taken to obtain justice after the act of sexual abuse. In comparison, other international legal systems, such as in the U.K., have developed changes to their legislation on the rights of disabled people (Johnstone, 2001). This may indicate that there is a need for more appropriate methods of attaining justice for sexually abused learning-disabled people in New Zealand.

In the U.K. during the 1990s, it was identified that the framing guideline and structure of the legislation had many gaps that had been overlooked and maintaining equality had become less of a priority than in recent years (Johnstone, 2001). Developing an efficient representation and appropriate policy guideline was needed. The U.K. government created the Disability Discrimination Act (DDA) in 1995, which included disabled individuals who had limited physical and psychological abilities and were unable to do daily tasks (Johnstone, 2001). This Act addressed key issues that specifically identified means of reducing discrimination and isolation towards disabled people. The legislation ensured that disabled people were not discriminated against in any environment or workplace and that they should have access to public transportations, provision for facilities, appropriate information as well as all services such as counselling and therapy.

However, the DDA did not have a tangible implementation system to support disabled people (Johnstone, 2001). Therefore, a commission was created to support

disabled people whenever they faced racial or sexual discrimination. This was the “National Disability Council” (Johnstone, 2001). Under the Council, the term disability was re-defined to signify social barriers and attitudes that restricted disabled people from living a normal daily lifestyle as well as describing physical and psychological disadvantages (Johnstone, 2001).

Laws in the U.S.A. had similar limitations to the U.K. As a result; the U.S.A. developed the American with Disability Act (ADA) in 1990. When comparing the ADA (U.S.) with the DDA (U.K.), the ADA was a more robust and inclusive civil rights law where sexual discrimination or abuse was concerned (Johnstone, 2001). The ADA has also been used as a paradigm for disability-related guidelines or methodology in many other countries, including Australia and New Zealand (Johnstone, 2001). When considering these laws and legislations, it can be evident that the aims were to ensure that the disabled individuals were protected from harm and abuse. The aims of the laws do acknowledge the issue of sexual abuse and discrimination of disabled individuals. However, they propose that a stronger emphasis on sexual abuse prevention and protection may be needed to ensure the safety of all people. The DDA and the ADA can create conditions for disabled individuals to be more informed about support services and access to better opportunities. The ADA and the DDA both aim to ensure that every disabled individual has access to a better life (Johnstone, 2001).

While recognising that New Zealand may have some supports for disabled individuals, there have been issues for learning-disabled people relating to laws and the criminal justice system (Mirfin-Veitch, Gates, Diesfeld, & Henaghan, 2014). It can be acknowledged that the UNCRPD and the NZDS recognise the legal, human rights of learning-disabled people in New Zealand (Human Rights Act 1993, 1993). However, they

continue to face problems and are confronted with barriers when the justice system is concerned (Mirfin-Veitch, Gates, Diesfeld, & Henaghan, 2014). Mirfin-Veitch, Gates, Diesfeld, and Henaghan, (2014) conducted a qualitative study in New Zealand to explore the legal challenges that learning-disabled people, as well as the judges and the lawyers, faced. Their study found that learning-disabled participants needed lawyers and judges to spend time and attend to their statements. That is, the lawyers and judges found grievances regarding learning-disabled clients were more time-consuming involving more communication and extra attention.

It can be concluded that there is a need for counsellors and the justice system to work together to support the needs of sexually abused learning-disabled people. The next step would involve providing further therapeutic methods of practice for sexually abused learning-disabled people.

2.2.3 Therapeutic models and approaches to sexual abuse

There is evidence that sexual abuse is an issue for both people with and without learning disabilities. Previous research in an article written by Doran (2015) has indicated that 473,000 non-disabled adults reported being sexually abused from 2008 and onwards in England and Wales. Furthermore, only 40% of adults and 33% of children were able to testify the abuse (Doran, 2015). It was also revealed that 25% of women and 16% of men were sexually abused before the age of 18 (Becker, 2015).

An article written by Hays, Murphy, Langdon, Rose and Reed (2007) recognise the importance of cognitive behaviour therapy (CBT). Cognitive behaviour therapy (CBT) is widely considered useful for learning-disabled clients. This interview-based therapeutic method involves encouraging the clients to understand their feelings and how they can

affect their ideas and actions. CBT can be supplemented with alternative approaches such as art therapy (Becker, 2015). Art therapy is also used as a non-verbal means of communication (McGinnity et al., 2004). The two studies that my search criteria revealed are discussed below.

Hays, Murphy, Langdon, Rose, and Reed's (2007) qualitative study was conducted in the U.K. and looked at effective ways to treat learning-disabled men who had sexually abusive behaviours. In this study, the researchers used a Service User semi-structured interview method where 16 male learning-disabled individuals with sexually abusive tendencies towards staff or other learning-disabled clients were interviewed. This included their understanding of appropriate and inappropriate behaviours or types of sexual conduct, and their significance for learning-disabled people. The participants were aged between 18 to 65 years and treated through CBT over a one-year period.

The results of Hays, Murphy, Langdon, Rose, and Reed's, (2007) study found CBT to be valuable. The learning-disabled males were able to gain knowledge about issues such as sexual education, inappropriate sexual acts that are illegal, as well as the possible outcomes of assaulting others. In relation to this current research, this study does indicate the potential usefulness of CBT in working with learning-disabled people.

Becker, (2015) conducted a pilot study with sexually abused non-learning-disabled clients using alternative therapy techniques. Similar to the Hays et al. (2007) study, Becker (2015) used CBT in addition to art therapy approaches with clients sexually abused during childhood and demonstrating Post Traumatic Stress Disorder (PTSD). Becker proposes that art therapy would be more useful as it would involve a non-verbal method of therapeutic treatment and could help to decrease PTSD levels in clients (Becker, 2015).

The main purpose of Becker's (2015) study was to investigate the practicality of group treatment that combined art therapy and the exposure-based treatment method of CBT. The five participants comprised one male and four females aged between 39 to 58 years and based in California. The participants' abuse accounts included sexual abuse by a parent, multiple abuses by family or unfamiliar individuals as well as psychological and physical abuse. The participants attended a two-hour group session for nine weeks. Three measuring tools, which included the PTSD Checklist – Civilian Version (PCL-C), Trauma Symptom Inventory (TSI) and the Beck Depression Inventory-II (BDI-II) were used to assess the psychological progression of the participants. A PCL-C, which is a self-reported measure drawn from the DSM-IV-TR criteria, was used to assess the seriousness of participants' PTSD symptoms during the treatment process. The TSI was a self-reporting, valid method of identifying serious and prolonged indicators of PTSD. The BDI-II is a self-reporting method of identifying depression. These measuring tools were used before the treatment of the participants, then on the ninth week of the treatment and again a month after the treatment. The treatment session included art activities such as painting, drawing using pastels, crayons and markers, and were combined with psychoeducation, exposure, grounding cognitive restructuring and narrative therapy. The results from this study found that the use of art therapy, CBT and involvement in group activities, evidenced a decrease in PTSD symptom levels and depression. This indicated the potential use of new and innovative methods of treatment for sexually abused individuals.

2.3 Counsellors' experiences and sexually abused learning-disabled people

When searching the literature on sexual abuse counselling in relation to people with learning disability, I found very little evidence of counsellors' experiences of working with sexually abused, learning-disabled people. Only one article by Faccini and Saide (2011) was highly relevant to the key aspects of sexual abuse, learning-disabled people and counsellors' experiences. A previous article written by McConkey and Ryan (2001) looked at the lived experiences of staff/health professional members who volunteered at disability centres. These two papers are discussed below.

The main purpose of Faccini and Saide's (2011) quantitative study was to explore the manner in which psychologists train, supervise and process learning-disabled people's allegations of physical, emotional and sexual abuse. There was little-documented evidence or research of approaches used by psychologists when working with this group of people. Health professionals demonstrated an inability to use accepted and consistent approaches towards interviewing and analysing sexual abuse cases when investigating them. The authors noted that there were no formal, valid and reliable sets of assessment processes regarding the sexual abuse of learning-disabled people. Due to high number of cases of sexually abused learning-disabled people, Faccini and Saide argue that it is necessary that assessments and evaluation of these cases be done correctly after their confirmation. Abuse can be considered as physical, emotional or sexual injury. Such abuse may be carried out by another learning-disabled person or client or by staff members working in a disability institution (Faccini & Saide, 2011).

Faccini and Saide's (2011) study recruited as participants 32 psychologists who worked with learning-disabled people within New York and Long Island. These participants were recruited through their working environments, which ranged from small community-based programmes for disabled people and other disability units. Their work experience in the area ranged from one to 35 years.

Thirty one initial survey questionnaires were completed with an attempt to find out how practitioners/psychologists interview and analyse cases where learning-disabled people make allegations of abuse. These questionnaires were asked before the participants received any further training on specific interviewing tools to use with learning-disabled clients. Examples of the questionnaires included "When you conduct an alleged abuse interview, what is the format of the interview?" or "What percent of the time did you have to testify in court regarding your interview findings and analysis results?" (Faccini & Saide, 2011, p. 294). Next, the researchers introduced two interviewing tools that may assist psychologists working with sexually abused learning-disabled clients.

Faccini and Saide's (2011) study found that of the 31 psychologists, 87% routinely carried out interviews and analyses. When asked about the training and supervision they received, only 21% of the participating psychologists thought that they required and would pursue further training outside of work, either through workshops or through conferences. The majority of psychologists did not receive consistent supervision of their analysis and interviewing skills. Almost 51% of the participants were unclear about how they analysed their clients and identified their needs.

It was evident that most of the participants had limited knowledge of interviewing and analytic skills when working with disabled people who allege that they have been

abused. Instead, these participants normally were guided by psychological criterion listings. Faccini and Saide (2011) suggest that specific guidelines that focus on learning-disabled people and the issues that they face would make it easier and more effective for practitioners to treat their clients.

Furthermore, only 3% of the participants used audiotapes and 9% used videotapes to record their interviews. Faccini and Saide (2011) suggest that the use of audiotapes, videotapes and other technological approaches for treating clients would again make the treatment process more effective and all information maintained for the betterment of the client and the counsellor. Researchers found that there was no method of analysis or interview process specifically designed for psychologists to work with sexually abused learning-disabled people.

A previous research article written by McConkey and Ryan (2001) looked at the lived experiences of staff/health professional members who volunteered at disability centres as well as private services providing support and assistance to learning-disabled clients. One hundred and fifty staff and health professionals from Northern Ireland answered the written, self-completed questionnaires that involved identifying seven particular scenarios of sexual activities or abuse perpetrated by learning-disabled clients and how confident these health professionals felt in their ability to manage such incidents.

McConkey and Ryan's (2001) findings showed that two-thirds of the health professionals had worked with at least one of the seven scenarios. The study found that health professionals with more experience of the particular incidents were able to deal with these behaviours. However, half of the health professionals stated that they required more

training, supervision and guidelines when working with learning-disabled individuals as this would then better prepare them to treat their clients and increase their well-being.

2.3.1 Discussion of the literature

When examining these articles about counsellors' experiences of providing therapy to sexually abused learning-disabled people, it was evident that Faccini and Saide (2011) were able to recognize and explore the limitations of current forensic interviewing and analytical approaches towards learning-disabled people's allegations of abuse. However, when comparing this particular article to my research study, there was very little evidence of the psychologists' experiences or their personal viewpoints about working with sexually abused learning-disabled people. Faccini and Saide (2011) identified the limited knowledge on the forensic methods and techniques of learning-disabled people in general. Therefore, the authors recommend that implementation of better guidelines would help counsellors. They also recommended that future research into appropriate interviewing and analysis techniques may help to provide clear outcomes for accounts of sexual abuse of learning-disabled people.

McConkey and Ryan's (2001) research took a different approach to addressing learning-disabled clients. This study explored what therapists, staff and other health professionals' face when treating their patients/clients. When comparing this article to my study, the therapists/health professionals did provide their experiences of working with learning-disabled clients.

McConkey and Ryan proposed that staff health professionals need appropriate knowledge about guidelines and processes to implement when they work with clients who engage in inappropriate sexual behaviour.

2.4 Learning-disabled people as victims of abuse

As mentioned above, individuals with learning disabilities have a high probability of experiencing sexual abuse (Niehaus, Kruger, & Schmitz, 2013). Higher rates of sexual abuse occur towards learning-disabled people than other people (Hollins & Sinason, 2000). Furthermore, one consequence of being sexually abused is that these victims may be more likely to become abuse perpetrators (Hollins & Sinason, 2000). But more importantly, learning-disabled people who have been subjected to sexual abuse may also experience further psychological harm (Hollins & Sinason, 2000).

In this section, I discuss four papers that explore general aspects of sexual abuse and the sexuality of learning-disabled people. Five themes were identified when reading these papers and so this section is divided into five short sub-sections: learning-disabled people and the justice system, the low conviction rates of perpetrators, the involvement of family/carers, working with learning-disabled people and providing means of therapeutic treatment.

2.4.1 Learning-disabled people and the justice system

The lack of socialisation in the wider community for some learning-disabled people has the potential to create more harm within the environments that they inhabit (Niehaus, Kruger, & Schmitz, 2013). For some, this may limit their knowledge and “increases their probability of becoming victims of sexual abuse” (Niehaus, Kruger, & Schmitz, 2013, p. 374). Some learning-disabled individuals may not be able to identify dangers and may have difficulties differentiating between what is and is not sexual abuse. Some may also be dependent on carers and family members to attend to their needs. If these relationships are

abusive, it may be more difficult and complicated for them to identify perpetrators (Niehaus, Kruger, & Schmitz, 2013). Due to a lack of information, learning-disabled individuals may be unable to defend themselves when facing the justice system process (Niehaus, Kruger, & Schmitz, 2013).

Another issue is that learning-disabled people may have difficulties reporting sexual abuse. The justice system can be complicated, making it harder for learning-disabled people to understand their own rights (Niehaus, Kruger & Schmitz, 2013). Niehaus, Kruger and Schmitz (2013) further identify the lack of support for learning-disabled people, as the justice system is not willing to change to meet their needs. An additional issue they identified was the possible myths, adverse attitudes and assumptions about learning-disabled people who have been sexually abused. For instance, the assumption that learning-disabled people do not know what is happening when the abuse occurs, or that learning-disabled people are protected from abuse as they are seen as unattractive or less appealing. Nijnatten and Heestermans (2010) further stated that those learning-disabled people who have more limited cognitive abilities may be unable to deal with traumatising events such as sexual abuse, particularly when individuals in their surroundings do not encourage them to deal with or address the issue.

Niehaus, Kruger and Schmitz (2013) conducted a mixed methods study to gain knowledge about certain circumstances learning-disabled abuse victims face in the justice system. They concentrated on different methods for identifying sexually abused learning-disabled people using health professionals as well as the justice system, to gain knowledge of processes that are required within Austria, Germany and Switzerland. They used both quantitative and qualitative approaches and developed five research questions that were linked to their study. The first research question aimed to identify the type of health

professionals involved in criminal processes experienced by learning-disabled people who have been sexually abused and what they are taught about learning disability. The second research question involved analysing the literature based on the topic of sexually abused learning-disabled people and the criminal justice systems. The literature reviewed was either that recommended by lecturers or that used in the curricula. The third research question involved a written survey to develop quasi-experimental study. The survey questionnaire was given to a convenience sample of health professionals and professionals who work under the justice system. This was to identify their views, attitudes and personal assumptions towards learning-disabled people and sexual abuse. Nine hundred and forty-six (out of three thousand and fifty-nine) participants responded and included social workers, police as well as lawyers, forensic psychologists and anyone who have been involved in a case with learning-disabled people and sexual abuse.

The fourth research question involved using qualitative and quantitative research methodologies to analyse criminal processes that have been recorded. The last research question looked at the experiences of learning-disabled people who had been sexually abused. For this question, the researchers used a content analysis approach to interview learning-disabled participants who had been abused. To better analyse and understand the last two research questions, the researchers developed many scales, such as “Rape myths acceptance scale” or the “Acceptance of Modern Myths about Sexual Aggression Scale”, to help recognise the severity of the issue at hand.

Research questions one and two revealed that there was less literature and knowledge about the sexual abuse of learning-disabled people when questioning health professionals such as psychologists and psychiatrists as well as professionals working with the justice system. Research question three revealed high levels of reluctance amongst the

participants towards helping learning-disabled people. The myths and assumptions about learning-disabled people held by health professionals and the judicial system were less evident mainly due to the factual and empirically-based criminal records kept.

Nevertheless, the questionnaires made certain myths and assumptions evident.

2.4.2 Low conviction rates of perpetrators

While the sexual abuse of learning-disabled people occurs frequently, there is a lack of perpetrator convictions (Niehaus, Kruger, & Schmitz, 2013). One of the limitations in Niehaus, Kruger, and Schmitz's (2013) study was related to the recorded convictions. The researchers found that most convictions were not carried to completion. This, they suggested, may be because the justice system, police and other health professionals working in these cases do not take learning-disabled people and their accusations seriously.

Another reason would be the limited experiences of health professionals such as social workers, forensic psychologists and psychiatrists when working with learning-disabled people. After listening and treating their clients, health professionals might alter their statements after a period.

2.4.3 Learning-disabled people and their families/carers

As time changes, society is becoming more aware of disability-related issues (Eastgate, Scheermeyer, van Driel, & Lennox, 2010). Previously, learning-disabled individuals were seen as asexual or naïve when sex and sexual abuse was concerned (Eastgate, Scheermeyer, van Driel, & Lennox, 2010). However, they are now recognized as holistic individuals who need support to experience fulfilling relationships (Eastgate, Scheermeyer, van Driel, & Lennox, 2010).

Eastgate, Scheermeyer, van Driel, and Lennox (2010) stated that more learning-disabled individuals are living in community-based housing and are integrating into the wider society. They conducted a qualitative study to identify the views of family, friends and carers of learning-disabled people. This approach aimed to obtain information about the methods of informing learning-disabled people about sexuality and the prevention of sexual abuse. They used semi-structured interviews for individuals as well as focus groups with twenty-eight family members and paid support workers. The study was based in Australia and was conducted over three months.

There were 28 participants altogether, with 18 participants involved in three focus groups and ten participants who chose to take part in individual interviews. Within the individual interviews, seven were family members and three were carers. There were altogether 23 female and five male participants. The family members/participants were aged 18 years or older who provided evidence of being a family member or carer of the learning-disabled individual. The interviews and focus group sessions were 40 to 75 minutes long, digitally recorded and transcribed. The researchers then coded the transcriptions using content analysis.

After conducting the interviews and coding the findings, key themes were developed in Eastgate, Scheermeyer, van Driel, and Lennox's, (2010) study. This included "Views on sexuality" where participants shared similar opinions about learning-disabled individuals having the right to safe, consensual relationships. Another theme was based on "Disempowerment" as one of the main difficulties that learning-disabled people faced when building relationships and communicating with others. "The sex industry" was also a theme that identified participants' distress about learning-disabled people obtaining sexual interaction through bars and prostitutes. Furthermore, the researchers developed an

“Exploitation and sexual abuse” theme where participants discussed the inappropriateness of sexual abuse. They found that participants were adamant about the need to develop strategies to help learning-disabled people and their families. An additional theme was “Parenting” where the participants discussed learning-disabled people having the right to become parents with additional support where appropriate. The findings showed that learning-disabled people are considered isolated, discouraged from building relationships and prone to sexual abuse. Moreover, as the world changes through technology, communication through the Internet has developed new means of harm towards learning-disabled people.

2.4.4 Working with learning-disabled people

If a person with a learning disability has been abused, it is important that appropriate methods of interviewing take place. However, as discussed below, research in this area is limited. Nijnatten and Heestermans, (2010) qualitatively explored and analysed different methods of interviewing sexually abused learning-disabled people. Their aim was to identify issues that health professionals face when interviewing. They used a post-event clinical analysis of a single case study involving five encounters a 32-year-old female participant with autism and a learning disability and her female health professional. The interview processes were videotaped and transcribed in Dutch, then translated into English.

The authors identified three different interviewing methods with the participant. These included the general assessment interview, appraisal interview and the trauma-related interview (Nijnatten & Heestermans, 2010, p. 393). The general assessment interview included intelligence testing, and personality assessments as well as direct interviewing. Appraisal interviewing involved legal procedures and criminal investigations where strict empirical evidence and detailed descriptions would be required from the

learning-disabled accuser. Lastly, the trauma-related interview involved the assessment of possible outcomes of sexual abuse on learning-disabled clients. This would include psycho-educational assessments, therapy and coping mechanisms.

Nijnatten and Heestermans (2010) found that the three different approaches to interviewing assisted identifying the client's sexual abuse encounters with another learning-disabled client. The general assessment interview section assisted the client to deal with sexual abuse. The appraisal interview elicited either detailed descriptions or identified signs of sexual abuse. For example, the participant used the word 'hurt' which indicated that she was being abused. The participant also identified the locations of where, on the body, she was being hurt. The trauma related interviews with the participant had assisted her to cope with the event of abuse.

2.4.5 Availability of therapeutic treatment

One way that learning-disabled people may be able to manage their day-to-day living or overcome traumatic experiences, would be through approaches to therapeutic treatment.

An article written by Hollins and Sinason (2000), considered therapeutic treatment a means of helping learning-disabled people in their daily lives. They identified that there was a lack of availability of psychological therapies for individuals with learning disabilities. They identified that people with learning disabilities tend to have some difficulties, such as expressing anger, frustration or fear, which affect their daily lives. This paper has indicated that counsellors or practitioners need to take these traits and emotional difficulties into consideration when treating learning-disabled clients. That said, there is a lack of psychotherapeutic methods specially designed for use with individuals that have learning disabilities.

Limited research on learning disabilities has led to inappropriate therapeutic treatment for learning disability individuals. This, in turn, fosters psychological problems. Hollins and Sinason (2000) further identified in their study that only 12 out of 596 individuals received appropriate psychological treatment, most of which was CBT. This may indicate that, at the time of the study being carried out, new approaches to treatment and therapy were not recognised or widely used within the field of therapy for learning-disabled people

After reviewing the different aspects of this study, it was evident that there were psychotherapeutic approaches that could be used for attending to the specific needs of learning-disabled individuals.

2.4.6 Discussion of the literature

The literature on learning-disabled people as victims of abuse reviewed in this section has provided useful insights into the challenges faced by learning-disabled people who have suffered abuse.

The strength of Niehaus, Kruger, and Schmitz's (2013) study was the use of mixed methodologies to obtain knowledge and understanding of the issues faced by learning-disabled people who had been sexually abused. On the one hand, Niehaus, Kruger, and Schmitz, (2013) analysed the work of forensic psychologists and psychiatrists, which correlate with my research. However, they focused on the experiences of sexually abused learning-disabled individuals instead of the psychologists/psychiatrist and social workers. It may be helpful to understand the experiences of the health professionals and how they interact with learning-disabled clients on a daily basis.

The Eastgate, Scheermeyer, van Driel, and Lennox, (2010) study also revealed that researchers focused more on learning-disabled individuals and their knowledge and expression of sexuality, rather than sexual abuse. In addition, they highlighted changing social views about learning-disabled people and their needs as human beings. However, the views and opinions of learning-disabled peoples' were not identified or addressed. In addition, the small sample size may restrict the generalizability of the study.

One of the main limitations of the Nijnatten and Heestermans, (2010) study was that the interviews were transcribed in Dutch and translated into English, which may have altered the interpretations of participants' actual views.

Hollins & Sinason's, (2000) study was based on reviewing and exploring psychotherapeutic aspects of working with learning-disabled people. It was mainly based on issues that related to learning disability and how these issues were identified from psychotherapists' viewpoints. This particular study did address approaches to therapeutic treatments for learning-disabled people, contributing some knowledge about the different types of therapeutic treatments that may be used by counsellors when providing therapy for sexually abused learning-disabled clients.

Nevertheless, Hollins and Sinason (2000) did not explore any forms of abuse, which more commonly affected learning-disabled individuals. It is evident that this study was not specifically related to sexual abuse, but sexuality in general. In addition, this was the only study that focused on psychotherapists and people with learning disabilities.

These four articles emphasise the importance of limited knowledge, support, collaboration and strategic methods for helping learning-disabled people. These similarities can be useful when creating and assisting the current study. Although these articles

recognise the significance of sexual abuse on learning-disabled individuals, it can be also acknowledged that their abuse may not always be due to their cognitive impairments. Many non-disabled people who have experienced sexual abuse may be able to communicate and cognitively comprehend information, but still be powerless to stop a committed perpetrator. Similarly, learning-disabled sexual abuse victims may be portrayed as vulnerable, unable to differentiate danger nor understand abuse, yet in reality, many have the ability to do so.

Another critical aspect that could be recognised is that learning-disabled people are not always dependent on carers or family members. In many cases, learning-disabled may require differing levels of support which may include family members or support workers. However, not all learning-disabled people are reliant on others. For instance, a study conducted by Wehmeyer and Bolding (2001) identified that through deinstitutionalisation and normalisation of learning-disabled people, they are more likely to have higher levels of self-determination, broader range of opportunities and develop decision-making abilities. They had higher positive outcomes and quality of life in general, as they interacted and intergrated into a community-based environment (Wehmeyer & Bolding, 2001). It can be useful to consider these views when understanding, interacting and working with learning-disabled people.

2.5 Counsellors as participants

Research has found that it is common for sexually abused individuals to seek help and counselling. However, it is often a long and painful process for victims to feel comfortable enough to open up to health professionals (Doran, 2015). Further to this, research has shown that expressing their feelings and disclosing these to practitioners could lead to victims committing suicide (Doran, 2015). This also highlights the importance of ensuring

that appropriate practitioner services and support are provided for sexually abused clients. This section will focus on literature that discusses counsellors and their need for supervision as well as recognising that some counsellors may also be victims of sexual abuse.

Doran (2015) focused on exploring four counsellors' experiences of working with sexually abused clients. She used a qualitative phenomenological interpretive approach to the study. The four counsellors worked in Sexual Assault Referral Centres (SARC) and specialist voluntary agencies within England and Wales. Her study aimed to generate future ideas and conversations about the sensitive topic of sexual abuse with therapists.

The recruitment process involved sending letters to therapists who were identified through telephone as well as International Society of Traumatic Stress Studies directories. Twelve female therapists working in social services or rape crisis centres were involved in the study. All the participants were qualified in fields of psychology, social work and counselling, as well as having six to forty years of work experience. Their experiences of interaction with sexually abused victims ranged from three to more than a hundred. The researcher conducted a face-to-face interview at every participant's workplace. Each interview was between 41 to 90 minutes long. Before the interview started, participants signed a consent form and filled in a form to describe their work experience, level of education, and training as well as the types of treatments they used.

Doran's (2015) findings generated four main themes: influential rewards, demands of integrity, coping mechanisms as well as the psychological and physical outcomes for counsellors. The first theme identified the "powerful rewards of purposeful compassion" (Doran, 2015, p. 13). This involved therapists and counsellors who had similar goals

creating an environment where motivation and positivity are generated to ensure that sexually abused individuals are supported.

The second theme, “the demands of integrity are challenging and absolute” (Doran, 2015, p. 13), identified that it could be highly demanding for counsellors and therapists when working with sexually abused individuals. The challenges may include having appropriate conversations that ensure beneficial outcomes for the client and the therapist or working with clients who have suicidal tendencies.

The third theme identified “the important quality of depth when choosing a safety net” (Doran, 2015, p. 13) while working with sexually abused individuals. Under this theme, the supervision of practitioners seemed to be a key guideline.

The fourth and final theme of “sometimes it hurts” (Doran, 2015, p. 13), involved the psychological outcomes of working with sexually abused clients. Doran (2015) identified that working with these clients and the overwhelming, negative environment that can be created have the potential to affect counsellors.

Another article addressing the issue of counsellors working with victims of sexual abuse was written by Etherington (2009). This paper was more of an interactive discussion than a research article. The purpose of this paper was to acknowledge a supervisor’s duties to teach and support counsellors and therapists who treat sexually abused individuals. Etherington (2009) used the terms ‘helper’, which represented therapists and counsellors and used the term ‘helping relationship’, which represented the therapeutic relationship. She stated that there is a rising recognition of the need for supervision of helpers or counsellors and therapists who specifically work with sexually abused individuals.

As a supervisor, Etherington worked with counsellors who treat sexually abused people. She also mentioned that most of the counsellors and therapists work with disabled individuals who experience recent and/or continuous abuse. Other therapists and counsellors worked with children and students at school and even work-related issues such as bullying and discrimination. One of the main benefits of having a supervisor would be to limit the chances of therapists or counsellors: misinterpreting the information provided by their clients, portraying embarrassment towards their clients, showing aggression or anger towards the client, as well as practitioners minimising the effects of their clients' sexual abuse accounts.

One of the key issues Etherington's (2009) identified was the potential for vicarious traumatization of counsellors. Vicarious traumatization occurs when the therapist or counsellor becomes less compassionate towards their client and is subjected to the hurtful or stressful experiences that occurred to their clients. Etherington (2009) further mentions her own experiences of being subjected to vicarious traumatization. She stated that her clients were psychologically, physically and sexually abused males. She described that she felt helpless and powerless, and had upsetting dreams and thoughts. She even became socially reserved as people around her avoided conversations about her discussion paper.

Etherington (2009) described another issue that psychologists and counsellors face when working with sexually abused victims: "empathic strain" (Etherington, 2009, p. 184). This occurs when psychologists and counsellors find it harder to empathise with their clients' traumatic situation. Four possible issues may affect the psychologists and counsellors experiencing empathic strain. These include "empathic withdrawal," "empathic repression," "empathic enmeshment" and "empathic disequilibrium" (Etherington, 2009, p. 184). Empathic withdrawal occurs when the psychologist or counsellor is naïve and has not

had any negative personal experiences of trauma. In these situations, the counsellor or psychologist mostly use theoretical guidelines to treat their clients and avoid emotional interactions with them. In these scenarios, supervisors would assist to guide and educate the practitioners to find better ways of dealing with these issues. Next is empathic repression where a practitioners' raw or untreated trauma is triggered while working with their clients. This can be identified when the counsellors or psychologists avoid the specific topic that triggered the conversation with their clients or forget the topic altogether. Empathic enmeshment occurs to practitioners who have experienced excessive personal trauma such as emotional, physical or sexual abuse. In these situations, the practitioners interact well with their clients. However, they may become overprotective towards their clients and exceed their limits as health professionals. Lastly, there was empathic disequilibrium where practitioners experience instability and have difficulties working with traumatised clients. Similar to vicarious traumatization, in these situations, the practitioners may have difficulties dealing with their feelings towards their client's issues and may experience helplessness and doubt. The practitioners may also experience exhaustion and even depression. In these scenarios, supervisors are expected to ensure that the practitioners' limit their involvement with their clients or that they take breaks in between to de-stress.

2.5.1 Counsellors as victims

The daily stressors faced by counsellors when working with sexually abused learning-disabled people can be challenging. It is possible that counsellors will experience sexual abuse from their clients or re-live experiences of past abuse.

As such, studies have found that many health professionals have experienced sexual abuse as children (Little & Hamby, 1999). It was identified that of their 1,251 mental health professional respondents, 26% of female and 16% male had experienced sexual abuse as

children. The authors suggest that these experiences have the potential to affect practitioners' professional ethical and moral codes when treating their clients, as their own experience of abuse might create biases and limit the efficiency of the treatment process. In contrast, sexually abused practitioners may have developed healing and coping mechanisms to treat themselves which could be highly beneficial for their clients (Little & Hamby, 1999).

2.5.2 Gender differences

Male and female therapists deal with sexual abuse in various ways. When addressing gender differences, research has indicated that women are more comfortable talking with health professionals about sexual abuse than men (Little & Hamby, 1999). This may be due to the stereotypical view that men are seen as the perpetrators and not the victims of sexual abuse. This restricts the scope of support services, which are mostly structured for females (Little & Hamby, 1999).

The main purpose of Little and Hamby's (1999) study was to understand the gender differences between male and female therapists who had been sexually abused as children, how they coped with the abuse and how they were able to effectively treat others with similar experiences. The researchers used a mixed-method approach where survey questionnaires and open-ended questions were given to practitioners in Vermont, U.S.A. 131 sexually abused practitioners responded, with 71% of females and 29% males aged between 31 to 50 years. The questionnaires involved Likert scales in obtaining information such as type of sexual encounters, relationships with perpetrators, relationships with family, other forms of abuse, as well as the type of healing approaches they used to deal with the trauma of abuse. Lastly, participants had a chance to comment at the end of the

questionnaire. This gave the researchers an in-depth assessment of the differences between male and female viewpoints.

In regards to the practitioners' experiences of being sexually abused as children, Little & Hamby's (1999) study found that there was no substantial evidence of gender difference. Female participants commented on the overall impact of the abuse and how the experience had made them more empathetic towards their clients. Male participants took a descriptive approach towards the abuse that took place and how it affected their lives. However, results indicated that female practitioners experienced more harmful impacts from abuse than male therapists. For instance, women therapists had more attachment, self-respect, sexual intimacy and trust issues than men. Then again, it was found that women had more recovery and healing capabilities such as recording thoughts, writing about their abuse experiences or talking about the incident. The researchers had stated that practitioners are more likely to underreport and less likely to assess the sexual abuse of men than women.

2.5.3 Discussion of the literature

Doran's (2015) study did relate well to the current study of practitioners' experiences of working with sexually abused individuals. However, it did not include learning-disabled clients. She explored key issues that arose from therapists and counsellors, which could be highly beneficial for future research into the field of sexual abuse counselling. As sexual abuse is a sensitive topic, developing and sharing knowledge seems to be a key message of the research study. On the other hand, the researcher could only find four participants for the study, which may be due to the limited number of counsellors with experiences of working with sexual abuse individuals.

One of the main strengths of Etherington's (2009) study was its reflection on the literature and personal experiences of the author. The study described her own personal accounts of the issues that she had to deal with when working with sexually abused men. She also helped identify particular issues such as empathic strains, which counsellors and psychologists experience when working with traumatized clients. This has assisted me to identify possible issues that my participants may experience when working with sexually abused learning-disabled people.

When dealing with therapist's experiences, one of the main limitations identified by Little and Hamby (1999) was that there were restricted healing and therapeutic techniques for male therapists. This may create more difficulties when recovering from the abuse. The researchers did identify guidelines and key ideas for ways that therapists can treat themselves and their clients, however, there were no gender-related therapeutic techniques for men.

It can be identified that all three articles addressed counsellors' views on sexual abuse. Two articles focused on counsellor's workings with sexually abused clients whereas one addressed the issue of abused counsellors. Some similarities include counsellors' treatment approaches and methods, personal viewpoints and the challenges that they face. There were also differences when comparing the articles. For instance, Little and Hamby (1999) focusing on gender differences and Etherington (2009) identified personal experiences of vicarious traumatization and empathic strain. This indicated the level of personal consent when writing and publishing an article.

2.6 Key findings

From the eleven articles reviewed, four key findings will be discussed below. The first relates to methodologies that researchers chose to use when conducting their studies.

Further, three key findings recognize issues such as limited education, knowledge, lack of training, supervision as well as additional recommendations about collaborating and modifying therapies for learning-disabled people.

2.6.1 Methodologies

Firstly, it was acknowledged that five of the 11 research studies were qualitative, one was quantitative and three were mixed-method (McInyre, 2005) (See Appendix I). The mixed-method approach to research combines qualitative and quantitative research methodologies to gain specific outcomes from research (Greene, Caracelli, & Graham, 1989). When comparing these methodologies with the current study, none of the articles used thematic analysis or a qualitative descriptive research methodology.

2.6.2 Limited knowledge

There is limited knowledge about working with and treating learning-disabled people. This may be due to the level of unreliability that health professionals and the justice system attribute to learning-disabled people and their accounts of traumatic sexual abuse. The literature suggests that claims of sexual abuse from learning-disabled people are ignored due to the lack of experience and knowledge from health professionals such as psychologists and counsellors, as well as the police when working with learning-disabled individuals. Therefore, limited knowledge may be another theme that arises from the reviewed articles. There are limited resources from counsellors/psychologists as there is

very little therapeutic treatment of clients. Moreover, the literature accessed was from overseas contexts, and no local research was identified

There is also limited knowledge from learning-disabled people's perspectives as they are not educated about different types of physical, sexual and emotional abuse. It was evident in McConkey and Ryan's (2001) research that training and policy guidelines are necessary to ensure the well-being of learning-disabled individuals.

2.6.3 Limited training and supervision

Three studies recognised the issue of limited training and supervision. Faccini and Saide's (2011) quantitative study looked at psychologists' ability to analyse and process learning-disabled sexual abuse allegations through interviewing techniques. Due to a lack of appropriate interviewing and analysis methods of assessing the abuse cases, more training and supervision of psychologists might be needed. When looking at the published dates of the 13 studies, it may be recognised that most of the articles were conducted after the year 2000.

Overall, it was evident that there has been much research about counsellors/therapists and their work with sexually abused people. However, when considering Hollins & Sinason's, (2000) study, as well as the research of Doran (2015), Etherington (2009) and Little and Hamby (1999), there is very little work done with learning-disabled people and counsellors/therapists/psychologists. Most of the research carried out with learning-disabled people cannot be replicated due to their level or types of disabilities. After reviewing and analysing the articles, I was able to synthesise and create key themes and issues to assist me with my current study.

2.6.4 Collaborative and modified treatment

Hays' et al. (2007) qualitative study used CBT to treat 16 learning-disabled men with sexually abusive behaviours. However, due to their cognitive and communicative difficulties, one of the limitations was interviewing these learning-disabled clients.

Therefore, further education and knowledge as well as collaboration and modification of different treatment approaches maybe recommended for future research. One of the main issues of qualitative research may be that the studies and their results are subjective and analysed from the researcher's point of view. These researchers' different points of views may affect the outcomes of a research study.

2.7 Conclusion

Overall, the articles have provided information to assist this study. Though none of the articles specifically focus on counsellors' experiences of working with sexually abused learning-disabled people, they did relate to aspects of this study. This information helped me to identify my participants, the method of data collection and analysis. It assisted a comparison of the literature with the findings of this study. Having explored the literature relevant to this study, I now turn to describing the methods used, how rigour was ensured and the consideration given to ethical issues.

Chapter Three - Methods

The purpose of this chapter is to describe the procedures conducted in this study.

3.1 Methodology

This study applied a qualitative research approach, under the post-positivistic paradigm and employed a qualitative descriptive methodology.

3.1.1 Qualitative research

Qualitative research involves understanding objective behaviours as well as their subjective significance (McInyre, 2005). While quantitative research uses numbers and empirical data as a means of attaining information, qualitative research mainly focuses on collecting data that is harder to quantify. Qualitative research focuses on individuals' experiences, their views, behaviours and attitudes towards certain things. There is much describing and interpreting of data of individual experiences of particular actions without using statistical methods (Jackson, 2009). This research methodology is usually conducted in the field where participants are in their natural environment taking part in daily routines. This is called field research (Jackson, 2009). Research in this field includes observational and unstructured interviewing where the interviews are expected to be open-ended (Jackson, 2009). With this type of research, there is less structure and control of the study environment and the participants. This can be seen as more of a strength than weakness as it gives participants the opportunity to express their unique viewpoints (Jackson, 2009).

Qualitative research is different from quantitative research as it is developed through a particular socially related issue or circumstance and is not formed through theory. After identifying the social issue, researchers address questions such as ‘what is happening here’ (Grant & Giddings, 2002) and ‘what are these people doing and why’ (McInyre, 2005).

3.1.1.1 Defining the post-positivist paradigm

This study is positioned in the post-positivist paradigm, structuring the study’s methodology guidelines used in this study. Paradigms are seen as structures for creating order in society. Paradigms focus on addressing current issues and implementing problem-solving skills to ensure that research is conducted accordingly for the betterment of the participants and the population. Grant and Giddings (2002) explain that paradigms are developed to either solve or identify the issue more effectively.

The post-positivist paradigm is derived from the objective and empirically based paradigm of positivism (Grant & Giddings, 2002). The positivistic paradigm mirrors reality and identifies the objective truth of participants (Ryan, 2006). Post-positivism, on the other hand, creates a learning environment by conducting research ‘with others’ rather than ‘on others’ through the aim of seeking multiple truths or interpretations of science (Ryan, 2006, Grant & Giddings, 2002). In this case, I aimed to gain knowledge with the assistance of practitioners.

Post-positivism involves the researcher/s recognising their epistemologies and identifying how they affect them (Ryan, 2006). In other words, instead of applying an epistemological approach to examining how individuals know things and how they consider they know things (Ryan, 2006); I might examine my assumptions, ideas and

beliefs of the practitioners' experiences. Furthermore, the post positivist paradigm takes a different perspective to recognising and examining a problem instead of solving it (Ryan, 2006). That is, this paradigm identifies the importance of the issue/s and helps develop the right questions that may assist future research (Ryan, 2006).

3.1.1.2 Qualitative descriptive methodology

Within the post positivist paradigm, one qualitative methodology used is qualitative-descriptive (Grant & Giddings, 2002), which I apply to this study. Methodologies are regarded as theoretical beliefs that underpin a research approach (Grant & Giddings, 2002). Methodologies are ways of expressing views and opinions about humans and reality, as well as finding out about what we know and what we want to gain more knowledge of working with research methods (Grant & Giddings, 2002). In summary, methodology describes why we use particular methods in our research.

Qualitative descriptive methodology involves a broad summary of experiences portrayed in the participants' day-to-day lives. An article written by Sandelowski (2000), described qualitative description in three ways. Unlike interpretive descriptive methodology, qualitative description is more categorical, less interpretive and is less committed to a theoretical representation of the data.

Although this methodology is widely used in research, there are no detailed maps for qualitative description, and in many cases, it is considered an insignificant kind of study (Sandelowski, 2000). She further mentioned that qualitative description could also have indications of other methodologies. For instance, adding grounded theory where findings are compared without developing any philosophical interpretations (Sandelowski, 2000).

Nevertheless, by using this methodology, researchers can create a stronger connection with the data, its descriptions or terminologies, as well as participant's lived experiences.

Overall, by applying the paradigm of post-positivism and qualitative descriptive methodology, there is a possibility of varied findings, which may generate a broad and subjective overview of the study (Ryan, 2006, Sandelowski, 2000, Grant & Giddings, 2002). When this happens, the researcher and the researched study might connect to influence each other with the aim of developing knowledge.

One of the main reasons why I chose to use qualitative descriptive methodology is mainly because it was generated by researchers, such as health professionals or practitioners (Sandelowski, 2000, Grant & Giddings, 2002). Using a similar methodology to that used by practitioner-participants would assist me to better understand them. In turn, they would have an improved understanding of my situation as a first-time qualitative researcher.

3.2 Recruitment

The participants (practitioners) were recruited through counselling services offered on the Internet for people seeking sexual abuse counselling. This included the ACC registered counsellors' list on the "ACC" website, a "FindSupport" web page from the 'ACC – Help after sexual abuse or assault' section as well as the "Auckland Therapy: Counselling and Psychotherapy" website. Additional organisations included the Rape Crisis Centre's website, New Zealand Psychological Society website; and HELP support services, which provide counselling and therapy for sexually abused individuals (HELP, 2012). The

websites assisted me to identify counsellors, psychologists and psychotherapists based in Auckland and who had experience with sexually abused people.

The recruitment process involved several stages. To determine the participants' interest in taking part in the study, an initial e-mail was sent to all practitioners publically listed on the above websites using the email addresses on their webpages (see Appendix II). Allowing two weeks for the email recipients to consider participating in the study, I then contacted them all by telephone (listed on the websites) to ask whether they were interested in taking part. As I had no desire to harass the counselling/psychological communities, unless interest was signalled, no further phone calls or email contact was made with potential participants in this database. Those practitioners who were interested in the study responded to the invitation via mobile phone and/or email. At that point, I collected the interested practitioners' further contact details to confirm an interview.

3.2.1 Inclusion criteria

The inclusion criterion was incorporated in the Participant Information Sheet (see Appendix III), which was emailed to potential participants when they contacted me for further information. The inclusion criterion was for practitioners who had worked or were currently working with, sexually abused learning-disabled people. The purpose of this criterion was that such participants would be able to provide rich experiential data.

The aim was to recruit a minimum of six participants into the study. However, I experienced considerable difficulty recruiting participants. Thus, the recruiting process was extended to five months, from September 2015 to February 2016. Over this time only three practitioners chose to participate. Due to low participation, the exclusion criteria of not

including any practitioners who approached me after the extended cut-off date was not invoked.

In consultation with my supervisors, a decision was made to not spend any further time and effort on recruiting. This was necessary, as further recruiting time would have delayed my completion of the thesis. I already had adequate information from the three practitioners about their experiences and the issues they faced. There are many advantages of having a smaller sample size (Hackshaw, 2008). Furthermore, working with a small sample when conducting an exploratory study limited the excessive use of resources (Hackshaw, 2008). In the end, I did not refuse anyone who had only limited experience of counselling learning disabled people for sexual abuse.

3.3 Participants

In this study, a purposive sampling method was used to identify specific practitioners who had experiences of counselling sexually abused learning-disabled people. From the 46 potential participants, only three practitioners chose to participate in the study. These practitioners were identified as working with learning-disabled clients who had been sexually abused (McIntyre, 2005, Roulston, 2011).

3.4 Data collection

This study included a semi-structured interview process (McIntyre, 2005, Roulston, 2011, Britten, 1995) A Researcher Safety Protocol was followed (see Appendix IV) during all three interviews. The protocol included an arranged travel plan about where and when an

interview was conducted, the participants' contact details, and the time and duration of the interview. To ensure my safety as a researcher, a confirmation process with my supervisors occurred before and after the interviews.

3.4.1 Interview process and protocols

The interview process explored the practitioner's experiences of providing counselling/therapy for learning-disabled clients who had been sexually abused. They were asked to recall such experiences and the issues that were raised to ensure that the learning-disabled person's needs were met.

To create some level of trust and rapport between the participants and myself, I informed them about my disabilities and the main reason why I was conducting this particular study. Clifford, (2016) stated that developing trust between the interviewer and the interviewee ensures that the data collected is highly robust. By opening up about my own experiences, the participants were able to share theirs. Another method of developing trust between interviewer and interviewee is by conducting a face-to-face interview (Clifford, 2016). As all three interviews were conducted face-to-face, there was more potential for collecting in-depth, quality data (Knox & Burkard, 2009). Alternatively, Knox and Burkard (2009) argue that issues such as response bias are decreased when phone interviews are used instead; phone interviews also help to eliminate any discomfort or uneasiness between the researcher and the participant. Nevertheless, face-to-face interviews provide both verbal and non-verbal data that increases the quality of the research study.

The three interviews were each approximately an hour long, audio recorded and transcribed verbatim. All handwritten notes/resources from each participant/counsellor were kept as a record of the study. The handwritten notes mainly included additional

information that was addressed during the interview process such as names of particular researchers, articles or specific terminologies. Due to the delays finding enough potential participants, I chose to use a professional transcriber for all three interviews. The transcriber was required to sign a Confidentiality Agreement (see Appendix V) to ensure the information shared by the participants was not disclosed to any persons other than my first supervisor and myself.

As the topic of sexual abuse of learning-disabled clients is highly sensitive, and the possibility that the interview might cause distress, the participants were offered confidential counselling support with three free counselling sessions through the AUT Health Counselling and Wellbeing department (see Appendix VI). However, no participants required counselling support. Practitioners also had the opportunity to ask for the transcript of their interview, which none have requested.

The process of qualitative interviewing involves gathering valuable and comprehensive data from participants' experiences of how they understand certain facets of their lives (Clifford, 2016). The current study opened with the question 'Tell me about your experiences of working with people with learning disability?' and was followed by a list of potential focal questions, contingent on the response of the participant (Clifford, 2016).

3.4.1.1 Questions

As a semi-structured interview process was used, all of the open-ended questions that initiated the interview were similar, making it easier for answers to be compared. Thus, the research study was more trustworthy. Knox & Burkard, (2009) identified that open-ended questions provide varied and in-depth responses that can assist to generate theories and assumptions.

Additional follow-up and probing questions were used, which assisted developing the main topic of conversation. Follow-up and probing questions were generated through the participant's previous answers (Knox & Burkard, 2009). An example of an indicative question was: 'What challenges do you face when working with learning-disabled people who have experienced sexual abuse?' A follow-up to the indicative question was: 'How do you deal with these challenges?' Probes or probing questions included 'Can you give me an example?' (Clifford, 2016).

3.4.1.2 Interview techniques

To gain self-confidence when interviewing the practitioners, I had to understand how they interviewed their own clients and how these techniques could assist me. I had to develop techniques such as attentive listening, identifying verbal and non-verbal behaviours as well as connecting with the potential participants to ensure that I could interpret and analyse the findings. However, by identifying the qualitative interviewing techniques that could be used in research, I was also interested in understanding the methods and techniques that practitioners used when and interviewing their learning-disabled clients during therapy sessions. Egan (2014), provided information about the skills that practitioners use when attending to clients and their issues. Egan (2014) emphasised the importance of communication for practitioners when working with and helping their clients. Through these techniques and skills learnt, I conducted a trial interview with a friend to get a feel of such a process which assisted me with the interviews. Practitioners usually focus on clients' personal issues, helping them to overcome problems and generate new ways of thinking. It is essential that these practitioners help their clients to create healthier, interactive relationships that can be maintained through proper communication (Egan, 2014). While I

had a different, non-therapeutic purpose, I developed and aimed to maintain these communicative skills during the interview process.

One approach was the “Dialogue-focused interaction” (Egan, 2014) technique. This involved communication skills that correlated or merged with the arrangement of a conversation or dialogue and focused on four specific areas that included turn-taking, connecting, mutual influencing and co-creating outcomes. I drew on the first two in my research interviews. Turn-taking involved maintaining a constant dialogue and mutual interaction between myself and the counsellor. Connecting is one of the main ways to prevent or resolve issues that arise. In this research study, I was able to engage with participants on the topic of disability and how it affects my daily living. This, in turn, enabled a connection between the practitioners and myself to develop.

Furthermore, there are physical attributes or non-verbal behaviours that are equally important when conducting an interview (Egan, 2014). By conducting the interviews at their workplace, the practitioners’ would have felt comfortable enough to open up and share their experiences. Small features such as body posture, eye contact, smiling, pitch and tone of voice, as well as the way people dress and their physical behaviour portray their level of interest during an interview. Therefore, I positioned myself opposite to the interviewees. During this process, I ensured that I made appropriate eye contact, as well as nodding and smiling to emphasise agreement. I placed the recorder closer to the participant to ensure that recordings were clearly received.

3.5 Data analysis

Data was qualitatively analysed using a thematic analysis approach to explore the practitioners' experiences when dealing with learning-disabled people who had been sexually abused.

Qualitative data analysis is described as going through a transformation (Gibbs, 2007). Many researchers and academics describe analysis in terms of collecting and categorising data or information. Others describe the process as interpreting and retelling experiences. After collecting the first set of data, I started the analysis. This can assist future changes with the questions that I asked previous participant (Gibbs, 2007).

However, there are issues with qualitative data analysis apart from the time-consuming work of data collection and analysis. More specifically the possibility of researcher bias, the generalisability and credibility of the findings (Gibbs, 2007).

3.5.1 Thematic analysis

Thematic analysis (TA) involves the interpretation of words and phrases from interviews and the development of key themes from raw data (Guest, Kathleen, & Emily, 2012, Clarke & Braun, 2013). These themes should reflect the variety of the data and a comprehensive understanding of the theoretical perspectives and conceptual factors within the findings (Clarke & Braun, 2013).

This method of analysis is widely used notwithstanding the debates that occur about its use. Thematic analysis can be adopted as an analytical or a methodological approach (Braun & Clarke, 2006). Because thematic analysis can be highly flexible, it can be harder to identify its level of reliability. Therefore, it is important that the analytical process be clearly defined. Unlike a focus on developing theory shared by phenomenology and

grounded theory, thematic analysis aims to explore the initial stages of developing theoretical concepts or perspectives (Braun & Clarke, 2006).

There are six steps to thematic analysis:-

3.5.1.1 Phase 1: “Familiarising yourself with your data” (Braun & Clarke, 2006)

I began by familiarising myself with the raw data collected by repeatedly reading the data, listening to the recorded interviews and assessing the transcribed information. Although this process was time-consuming, it was a reliable means of data analysis. Important phrases or words (excerpts) were identified and described to understand what they meant to me. This information assisted the creation of codes and themes.

3.5.1.2 Phase 2: “Generate the initial codes “ (Braun & Clarke, 2006)

Coding involved sifting through the data collected and also identifying the patterns and developing themes, ideas, words or phrases (Gibbs, 2007). These codes can be single words, sentences or paragraphs and were used to retrieve and develop themes based on the main ideas evolving from the research. ‘Challenges’ is an example of a code that I first developed from an excerpt “people with learning disabilities it’s quite often quite complex because it often depends on what age they, they’re functioning at um whether they’re verbal or not um whether they’re able to give a case history or not.” This code assisted me to identify the specific difficulties that practitioners face.

Three types of coding stages can be used in qualitative research: descriptive, categorisation and analytic (Gibbs, 2007). Descriptive coding involves identifying activities or behaviours that participants do or say. For example, practitioners treating sexually abused learning-disabled clients is a basic level of activity. Then, these activities can be compared with other participants or with other different behaviours.

Second, is categorisation coding where the researcher has to jump from describing the activity or behaviour, to a categorical or conceptual stage (Gibbs, 2007). For instance, changing from practitioners treating sexually abused learning-disabled clients to a more categorical stage of therapeutic approaches or challenges. At this stage, particular labels or groupings were made within the coding frame. Lastly, the analytic coding process, which involves intellectual thinking from the researcher and more interpretation of the codes or themes developed. For example, my interpretations that the practitioners developed connections with their clients to better understand them. The coding process included reading and identifying reoccurring patterns in the initial codes across three data sets.

3.5.1.3 Phase 3: “Searching for themes” (Braun & Clarke, 2006)

During phase three, reoccurring patterns of the codes were grouped and labelled.

Sometimes codes were combined because similarities were identified across the three data sets, which assisted analysis of the codes.

First, the labels were described, and the grouped, codes were then interpreted to identify the key ideas or concepts. While interpreting the coded excerpts, three questions were constantly reiterated. They include ‘What is happening here?’, ‘What did I learn from the codes?’ and ‘Why did I choose these codes?’ These questions assisted recognising the reliability of the three data sets and the interpretations of codes.

Next, the similarities of responses were identified as participants were asked similar interview questions (See Appendix VII). At this stage, it was important to recognise the interconnections within the three data sets and finding similarities and differences between the codes to show comparisons and developing themes.

Subsequently, I recorded my reflections on the interpreted codes through analytic memo entries. Under every interpreted code, a possible theme was created. To do this, I used a software programme “Inspiration Mind-Map,” which assisted me to keep track of the theme-building process. These themes were then either merged or grouped.

3.5.1.4 Phase 4: “Reviewing themes” (Braun & Clarke, 2006)

Themes are highly meaningful or significant patterns developed from the codes and data sets relating to the research question (Clarke & Braun, 2013, Braun & Clarke, 2006). It is not necessary that a large quantity of data or coding represent a theme as even a small amount of data or coding can signify a vital part of the thesis itself (Braun & Clarke, 2006). In the interests of validity, it is essential to ensure that the generation of codes and their interpretation relate to the research question. The candidate themes were reviewed, defined and named to reflect the current study (Clarke & Braun, 2013). Altogether, 16 themes were identified from which 11 were considered as key points to address in the Findings chapter. The 11 themes were merged and condensed into three main themes, which related to the different stages of counselling practice with sexually abused learning-disabled clients.

3.5.1.5 Phase 5: “Defining and naming themes” (Braun & Clarke, 2006)

During this phase, the researcher has drafted a structured map of the data, which is followed by a clearer and more defined layout of the three themes and any sub-themes. According to Braun and Clarke (2006), it was important during this phase to reflect on the overarching theme, reassess the themes and sub-themes, as well as evaluate the overall thesis. In the current study, the three themes were derived from the experiences of the three practitioners who were interviewed.

Theme	Sub-theme	
Applying Practice	Stage 1 – Accessing Therapy	Recognizing the experience of abuse
		Recognition by caregivers
		Referrals for ACC funded counselling
	Assessments	
	Lodging a sensitive claim for additional therapy sessions	
	Stage 2 - Using Appropriate Therapies	Modified and combined therapies
	Art therapy	
	Stage 3 – Ensuring Follow-Up	Collaboration and building partnerships
	Lack of education in practitioner training	
Supervision		

Table 1: Theme and sub-themes developed during data analysis

3.5.1.6 Phase 6: “Producing the report” (Braun & Clarke, 2006)

The sixth and final phase involved well-structured themes, concluding analysis, and the written report (Braun & Clarke, 2006). This process includes detailed explanations of the data excerpts and demonstrated elements of the themes arising from the thesis research.

With the support of the data excerpts, the theme, sub-themes and its processes (See Table 1 above) assisted in formatting a report. Using this format proved very useful as it developed three main stages of accessing support. This ensured that the themes clearly signified the chosen data and told a well-structured story fitting with the research.

3.6 Ethical considerations

Ethical approval was gained from the Auckland University of Technology Ethics

Committee (AUTEK) application 15/233 (See Appendix VIII). After which, I was able to start the recruitment and interview processes. The interviews occurred at a time and place

convenient to the practitioner. They had the choice of participating at their home, workplace or AUT.

When considering the three main principles of partnership, protection and participation under Te Tiriti O Waitangi, there was emphasis on the connections and information that was shared between the practitioners and myself. Maori consultation was made where I contacted a Maori counsellor at AUT. As Auckland is a highly diverse city, I aimed to find practitioners with diverse cultural and ethical backgrounds. However, due to the limited participants and time constraints, less focus was on finding culturally diverse practitioners. The research protocols, values and ethical behaviours aimed to respect the participants' beliefs, viewpoints and to ensure that I as the researcher, conducted myself according to the ethos of Treaty obligations (Ministry for Culture and Heritage, 2014). Therefore, an effective level of engagement or participation, as well as the assurance of safety and protection of the participants, was ensured.

3.7 Obtaining consent

The practitioners gave written consent through the AUTEK Consent Form (See Appendix IX), which was completed and signed by practitioners before commencing with the interview. Practitioners had the right to withdraw from the study or stop the interview process at any time. A 'Thank You' card to acknowledge their time and efforts participating in the study was sent as part of AUTEK's ethical requirement.

3.8 Maintaining confidentiality

The Participant Information Sheet also ensured that the practitioners' employers would not be informed of their involvement in this research study.

Any information provided by participants was discussed in strict confidentiality. That is, the participant's name was not used during the interview process or on the transcripts. Any identifying information was removed from the transcripts and instead of pseudonyms, the participants were assigned numerals. The names and contact details of participants' clients were not required as data. In addition, the transcriber employed to transcribe the interview was required to sign a Confidentiality Form (see Appendix V).

3.9 Rigour

During research, rigour involves ensuring and demonstrating validity and reliability during data collection and analysis (Giddings & Grant, 2009). The reader is then able to recognise that the research had been legitimately and consistently monitored, with findings that have authentic outcomes (Beck, 1993). Rigour also recognises the issues of generalisation, bias and preconceptions that are common in the research of social experiences (Lincoln & Guba, 1986; Mays & Pope, 1995).

While comparing qualitative and quantitative research, there are apparent differences in approaches to rigour. As explained by Krefting, (1991), reliability and validity are more suited for quantitative research where phenomena are tested through empirically based evidence. Qualitative research, on the other hand, takes a subjective approach, with the purpose of learning and gaining insight into the phenomena.

Therefore, to satisfy reliability alongside external and internal validity, different guidelines were developed for qualitative research to retain rigour and understand the overall study (Lincoln & Guba, 1986; Beck, 1993). This is to ensure that the quality of data collection, analysis and the outcomes of a study demonstrate trustworthiness (Krefting, 1991). To validate trustworthiness and achieve robustness of a qualitative research method, strategies such as tests for credibility, fittingness, auditability along with reflexivity assist to sustain rigour (Krefting, 1991; Beck, 1993; Mays & Pope, 1995; Giddings & Grant, 2009).

Quantitative researchers use internal validity to examine the results of a study, while qualitative researchers use credibility or truth-value strategies to ensure that study findings are valuable, authentic and believable to readers (Lincoln & Guba, 1986; Beck, 1993; Krefting, 1991; Mays & Pope, 1995). The strategies carried out in this study included the description or interpretation of the phenomena or lived experiences of participants while identifying repetitive themes in the study (Krefting, 1991). The themes or patterns would then assist a deeper connection with the data, enhancing this and the overall research. In the current study, I was able to recognise recurring themes across the three practitioner interviews, which assisted with the initial findings.

The concept of fittingness is similar to external validity in quantitative research (Beck, 1993). Fittingness involves the researcher's findings, their generalisations, values, and preconceptions made towards their study, as well as how the research fits next to the wider body of research in the field (Beck, 1993). In this current study, particular assumptions informed the questions that were developed around practitioners' experiences of working with sexually abused learning-disabled clients.

In quantitative studies, researchers attain reliability when they aim to replicate a study (Beck, 1993). Similarly, qualitative researchers use consistent or dependable methods to attain auditability (Beck, 1993). With this strategy, the researcher can develop a similar methodological pathway for other researchers to replicate. These pathways can be followed through audit trails or results concluded by the researcher. To enable auditability in the current study, I have described the research processes I followed to ensure that other researchers can replicate it.

Another method of maintaining rigour during the process is reflexivity. Reflective views are essential when conducting qualitative research as it enables the researcher to evaluate their own perspectives, opinions and experience of benefits from the overall research. When looking at the current research, I kept an audit trail of all the necessary steps I took when I started my thesis journey. After developing research questions, I considered asking a friend to assist in trial interviews at an early stage of the process to identify the 'assumptions' brought in to the research. I was also able to provide an analytic and reflective view during the data analysis stage where I wrote down my views of the useful transcripts. This study enabled me to develop a deeper understanding and respect for this topic, the practitioners (counsellors/psychologists/therapists) as well as learning-disabled people. Experiencing disability firsthand, I believe that learning-disabled individuals understand, feel and express things in different ways and at a different pace. I believe it is important that society needs to take a few moments' of their time to patiently listen, comprehend and gain awareness of their needs.

Lastly, it was also vital that I recruit participants who had acquired knowledge of a specific lived experience (Mays & Pope, 1995). Therefore, it was important that I recruit practitioners who had worked with sexually abused learning-disabled clients. All of these

strategies assisted maintaining rigour in my study and in-turn assisted in developing integrity and trustworthiness within the research.

3.10 Conclusion

In this chapter, I outlined the processes and methods I used to conduct this research. I identified the detailed approaches taken to ensure that the study was robust, credible and reliable enough to be a useful resource for further research.

Chapter Four- Findings

This chapter identifies and describes research findings. Although only three practitioners were interviewed, the results obtained might indicate useful information about the counselling/therapy process. This chapter describes the three participants or practitioners. This background introduction is followed by the overarching theme of ‘Applying Practice’ identified through thematic analysis of the transcripts. This overarching theme was underpinned by three sub-themes: accessing therapy, using appropriate therapy and ensuring follow-ups.

4.1 Practitioners

All three practitioners were females; two were clinical psychologists, and one was a practitioner who specialised in art therapy. The work experience of the three practitioners varied. The most experienced practitioner working with learning disabled clients had worked with such clients for ten years, whereas the least experienced had worked with a limited number of clients. The most experienced practitioner had worked with approximately 20 learning-disabled clients, most of whom were female. Her average treatment length was between two to three months. The least experienced practitioner had worked with two males and one female client who had a higher level of disability. All the clients’ treatment/therapy was paid for by ACC.

4.2 Themes

The main theme of ‘Applying Practice’ emphasises the importance of therapeutic processes and the functioning of sexually abused learning-disabled clients. The sub-themes are organised chronologically, highlighting when a learning-disabled person was first recognised as abused, access to initial counselling (and ACC funding), receiving appropriate counselling/therapy and lastly, continuing therapeutic strategies at home or in a specialised therapy setting. The first sub-theme or stage towards treatment was accessing therapy and support services. This stage involved identifying the procedures that a learning-disabled client could follow to receive treatment and support from services. The second stage involved the different types of therapeutic treatments that practitioners employed to meet better the needs of learning-disabled clients who had been sexually abused. This included therapeutic treatments that were modified or combined with other treatments, as well as methods that catered more specifically for learning-disabled people; for instance, art or dance therapy. The third sub-theme looked at strategies for continuing with specialised therapy or assistance for learning-disabled clients and the people around them. This involved issues such as limited education within the therapy profession, and collaborating with the community to generate a better everyday home environment for learning-disabled clients.

4.3 Applying Practice

The key findings of this study show the current system of accessing therapy and how its practices are geared towards people who can recall and verbally articulate their experiences

of abuse. The findings also show the practitioners' experiences of having to find and apply ways of counselling their clients.

4.3.1 Stage 1 – Accessing Therapy

4.3.1.1 Recognising the experience of abuse

One issue identified by the practitioners was recognising that the client had been sexually abused. This was partly due to some learning-disabled clients who had difficulty recalling, verbalising or otherwise articulating information and case histories, as well as recognising the event of the traumatic abuse that they have experienced. For example:

Practitioner One: “But to do an assessment is really, really difficult because they can't give you a case history, they can't, they are completely reliant on other people reporting.”

Practitioner Two: “I think other challenges, of course, are that people with neurological disorders often find it difficult to recall information so um they process information um, particularly verbal information differently or you know some, some people might be the vulnerable ones but different um profiles but some people find it much harder to process information particularly abstract concepts.[...] I often don't talk directly about the abuse; I don't think it's particularly helpful for people unless they really want to. A lot of people don't have the emotional regulation skills to deal with that.”

The ACC process requires information from the client to the counsellor (practitioner) about the sexual abuse incident the client has experienced. Therefore, the client needs to recognise the incident as one that is sexual abuse, and then s/he needs to be able to recall the event(s) and communicate it to the practitioner. Practitioners One and Two explained that due to their cognitive functioning abilities, learning-disabled clients have a harder task

processing, recalling and verbally articulating the experience of abuse, which makes it a challenge to access and receive therapeutic treatment. The practitioners also showed that they did not want to create more stress and tension for their clients by recalling the abuse.

4.3.1.2 Recognition by caregivers

The assessment process for accessing counselling requires a learning-disabled person to be recognised as abused and needing therapy. It was common for others to access support on behalf of the learning-disabled clients, rather than clients acting independently. The referral process was in most instances made by the family or carer of the learning-disabled person. One practitioner highlighted the issue of self-referral and her views of how caregivers request support. Practitioner Two stated:

“One challenge is that a lot of people don’t self-refer [...] often they’re being referred for problems that they aren’t themselves identifying as being the issue. So sometimes, what you get is a mismatch between what other people expect to see as an outcome and what the person, themselves, wants to look at and think about. [...] what often happens is people, other people identify the behaviour as being problematic which I think is an enormous challenge in itself.”

These words indicate that learning-disabled people who have experienced sexual abuse are not always the ones who are seeking help. It is mostly the people who are around them or people who look after them or live with them, who seek assistance. This referral by others creates the potential for there to be a difference between what the carers/family/society think the ‘abnormal’ behaviours are of the learning-disabled person, what behavioural changes the practitioners propose to bring about through therapy and what the learning-disabled person wants. It indicates that the caregivers who interact with the learning-disabled people are able to recognise the ‘out of norm’ behaviours that could be an issue for

them. The caregivers may be able to recognise the issues that they face, rather than the issues that learning-disabled people face. In this regard, these issues might affect the therapeutic treatment process for the clients and the implications for the caregivers.

4.3.1.3 Referrals for ACC funded counselling

After the experience of abuse had been recognised, the next issue was acquiring funded counselling for learning-disabled clients. By locating a practitioner who is ACC certified, funded referrals could provide the initial stages of therapeutic treatment for learning-disabled clients. It also assists to activate different levels of support services that might be available for learning-disabled clients (Accident Compensation Corporation, 2016).

Practitioners spoke about the referral processes, assessments and criteria listings of learning-disabled clients. For the three practitioners, ACC was the main source of funding for learning-disabled clients who had been sexually abused.

Practitioner One stated:

“If you’ve got a recognised claim for sexual assault and that’s what you’re talking about mostly isn’t it? Sexual abuse. Um then ACC is your primary source of contact [...] Um or WINZ I believe will fund part, you know, \$50 towards counselling sessions for a number of sessions um but yeah your best bet is ACC really in terms of getting it funded.”

To have access to ACC funding for counselling, clients, whether or not they have a learning disability, have to provide evidence that they have a mental injury from the sexual abuse. To provide counselling to sexual abuse victims, practitioners must be registered by ACC.

All three practitioners talked about the process of accessing ACC funding as highly structured when working with sexually abused clients. For example, Practitioner One mentioned the structured guidelines that ACC requires them to follow:

“Yeah the ACC process is quite structured um”. [...] So yeah it’s quite good in that it focuses the work and it gives me some direction as the counsellor as to what, what the clients want to do. And it’s a good chance then to sort of have a think about is that within my scope um or is there someone that could better do that bit of work that I could refer them to or um, you know? What else might they need? Do they need a social worker? Um do I need to talk to um their key worker or anything like that?”

The ACC procedure clearly outlines the process that practitioners need to follow. It begins with an assessment phase that allowed this practitioner to determine whether she was the best therapist to work with the client and what other agencies might also be needed.

4.3.1.4 Assessments

Here, Practitioner One talked of the assessment procedures that took place before the counselling process began:

“I’ve done a few assessments for people with learning disabilities through ACC. [...] what ACC needs to do to cover long term cover for sexual abuse to prove that there’s a mental injury as a result of the sexual abuse. [...] So to diagnose a, another mental health injury as a result of the sexual abuse. Um over and above whatever their pre-existing diagnoses or disabilities were.”

An assessment is made for an ACC client who has suffered mental injury due to sexual abuse. This process is called a ‘Mental Injury Assessment’ (Accident Compensation Corporation, 2016), where the mental health injury must be identified. After the

assessment, the ACC would provide ‘Integrated Service for Sensitive Claims (ISSC) and an ACC registered practitioner for the client (Accident Compensation Corporation, 2016).

Practitioner Three explained that the learning-disabled clients’ have to be assessed and identified under specific diagnostic criteria as psychologically injured individuals, to obtain appropriate therapeutic treatment:

“So with my ACC contract um the person needs to have a mental injury so, an Axis I um. So it might be depression, anxiety or it might be a PTSD, often it’s PTSD and it’s complex PTSD. [...] Sometimes they have an Axis II, might have some borderline personality traits as well um and they have to have meet criteria for what ACC call as schedule three of their, which is um, itemised what is schedule three so any sexual abuse um during childhood or, or throughout their lifespan actually um. Yeah. So it has to meet those two criteria to be able to come under ACC services.”

Here, Practitioner Three described how the ‘Mental Injury Assessment’ had a list of criteria that could be used to obtain counselling services under ACC. She refers to the Diagnostic and Statistical Manual of Mental Disorders’ (DSM) system of classifying dimensions of psychological disorders under the categories of axes. Under Axis I from the “Mental Injury from Sexual Abuse Assessment Report” (Accident Compensation Corporation, 2009), the sexually abused person would have had a psychological injury to acquire therapy. Axis I would include clinical disorders such as Post Traumatic Stress Disorder (PTSD), which could occur to a person who experienced traumatic events such as sexual abuse. Axis II includes personality disorders.

Before commencing with the counselling/therapy, the practitioner and client sign an ‘Individual Rehabilitation Plan’ (IRP) agreement (Accident Compensation Corporation,

2016). The IRP outlines a client's goals and assesses their therapeutic processes, which can be observed, measured and in some cases, altered.

Practitioner Three spoke about the guided and required procedures that are needed to complete appropriate ACC funded counselling:

“So these clients have been assessed already by a psychiatrist or psychologist, I'm just working with them therapeutically. [...] Then it is up to developing a therapy plan that is going to suit that individual given the assessment information. [...] so what ACC does is they ask us who's working with learning disability and we have to indicate that and then they will refer people to us specifically if you're working in that area.”

Practitioner Three showed how her clients are first assessed by a psychologist or psychiatrist using the DSM (Hansell & Damour, 2008) criteria listing, then, referred for therapeutic treatment by a practitioner, such as herself, who works with learning-disabled clients. A psychologist, or psychiatrist or any other health professional with a standard qualification can conduct a Mental Injury Assessment when lodging an ACC sensitive claim (Accident Compensation Corporation, 2016). The psychologist or psychiatrist or health professional would be required to have a New Zealand Association of Psychotherapists Advanced Clinical Practice qualification or a post-graduate level course in abnormal psychology, assessing and identifying formulations, knowledge of psychometric tools and therapeutic intervention models (Accident Compensation Corporation, 2016).

4.3.1.5 Lodging a sensitive claim for additional therapy sessions

After the assessment, practitioners identify key issues relating to the client's daily problems or struggles due to the abuse. After recognising these daily issues, the practitioners lodge a sensitive claim.

Sensitive claims come under psychological injuries that may occur following criminal offences listed in Schedule 3 of the Accident Compensation Act 2001 (Accident Compensation Corporation, 2016). Examples of Schedule 3 offences include acts such as sexual violation, assault or incest. The ACC sensitive claim Schedule 3 also covers any exploitative or attempted exploitative sexual connection with an individual with considerable impairment (Accident Compensation Corporation, 2016). That is any sexual assault or abuse of people with a disability.

When looking at the ACC sensitive claims guidelines and support sessions, different criteria models could be used to diagnose the clients (Accident Compensation Corporation, 2016). These models may include the “Psychodynamic Diagnostic Manual (PDM), Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), International Classification of Disorders (ICD) and Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3R) (Accident Compensation Corporation, 2016). These models can assist diagnosing and therapeutically treating learning-disabled clients to ensure that they live a healthy and productive lifestyle. After lodging a sensitive claim, a learning-disabled client can get immediate support therapy sessions with an ACC registered practitioner (Accident Compensation Corporation, 2016). As the claim is assessed, the client can get four sessions over an eight-week period. All sexually abused clients are eligible for support sessions and entitled to 16 sessions overall.

Practitioner One explained:

“They give two sessions that they call Getting Started which is a chance to sit down, get to know each other, just talk. Then assuming the client is happy to carry on um, they get four sessions of what ACC calls Early Planning and that

is around working out what the client wants. [...] if it's a short piece of work and we can do it in another eight sessions then we just carry straight on and do it. In addition, ACC will pay eight sessions to do that, that specific bit of work. If they want longer-term cover, then they have to go through a Supported Assessment and get a mental health diagnosis. Proving that there is a mental injury that is directly attributable to the sexual abuse and not to everything else, that has happened in life. Therefore, you get 10 sessions to do that assessment and then assuming that ACC accepts it, then you get up to 48 sessions. Which is like a year basically."

There was a step where practitioner and client worked together to plan what the client wanted to gain from the counselling sessions. ACC allows for eight sessions of therapy but further sessions would be medically assessed to prove that more sessions are required to treat the client. Practitioners indicated that most of the learning-disabled clients referred, who are sensitive claim issues, do require longer period of treatment by ACC practitioners. If ACC assessments indicate that the sexual abuse has not caused any long-term mental injuries, a shorter period of therapeutic sessions is provided and a sensitive claim is not issued.

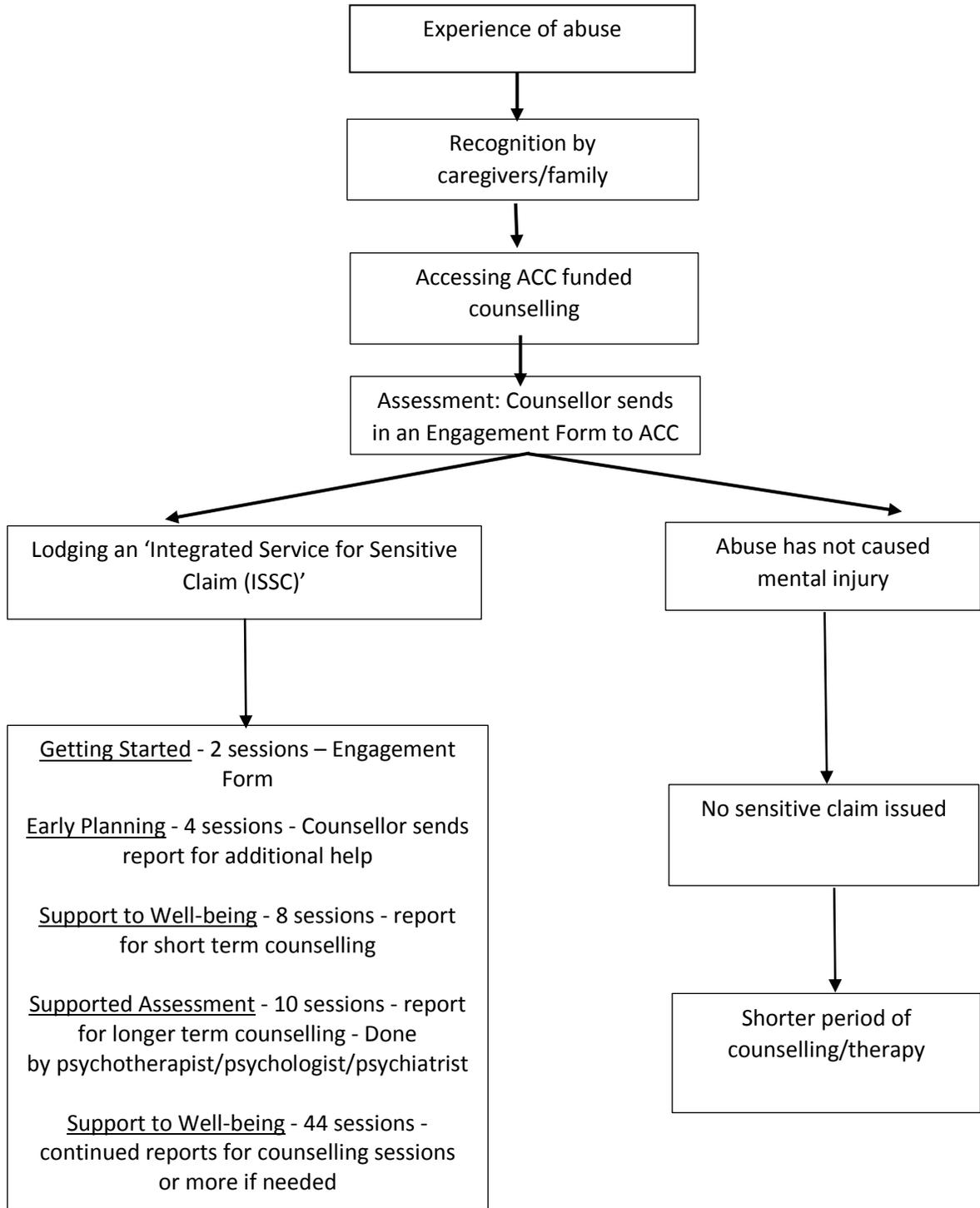


Fig 1: Diagram showing the ACC funding and referral process involved in the first stage of accessing therapeutic treatment.

4.3.2 Stage 2 - Using Appropriate Therapies

All three practitioners spoke of how they applied counselling practice to meet the needs of the learning-disabled clients. They each spoke about how they modified therapies or used different types of counselling/therapy techniques, such as art, to facilitate the effectiveness of therapy sessions.

4.3.2.1 Modified and combined therapies

Under this theme, two out of the three practitioners, who identified as psychologists, spoke about modifying or tailoring the different therapeutic techniques that they use when working with sexually abused learning-disabled clients. This involved combining therapies such as Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy (CBT), mindfulness therapy, breathing and coping skills to assist their learning-disabled clients in dealing with the trauma that they had experienced. For instance, Practitioner Two used a combination of CBT and mindfulness therapies for these clients. These therapeutic techniques helped clients to learn about their thinking and articulating processes:

“[...] for many people I do, I will use if someone is able to use Cognitive Behavioural Therapy um which requires a lot higher level of cognitive skill because of course you have to reflect on your thinking, be aware of your thinking. You have to be, noticing your thinking; you have to be able to shift the thinking thoughts stuff. [...] Mindfulness is one that people seem to be able to access. I do a lot of psycho-education, so looking at what’s happening to their body and why they’re experiencing the things that they’re experiencing.”

Practitioner Two used this method of therapy with her clients who were able to know and make sense of their thoughts and feelings. She teaches them how to understand and manage them. She pointed out that the cognitive skills required by the client when using CBT are

higher cognitive skills and therefore this method of therapy would only be useful to clients who have the cognitive ability to do such work. Therefore, it might not work for someone with lower levels of cognitive capacity and other methods would need to be used.

Practitioner Two also used psycho-education and mindfulness therapy to teach her clients to understand their own physical and psychological behaviours. This excerpt indicated that assessing learning-disabled clients' cognitive abilities might be an important component of her practice to ensure that she can provide appropriate therapy.

Practitioner Three talked about combining CBT and DBT for individual clients and providing the most suitable means of treatment:

"I use mainly use CBT trauma and with my current client, DBT. So Dialectical Behavioural Therapy. And I, use a modified package because they cannot access it like a usual adult, you know, it is difficult for them cognitively to access the information. [...] I use adaptive processes as well and I try and develop a treatment plan unique for that individual so I'm not using manualised approach, I use some of the trauma based CBT and I, but I use some of DBT as well. So depending on the client's needs during assessment I, I'll use things that are going to, that I think are going to be really suitable for them."

This excerpt describes the modification or combination of two therapeutic approaches, CBT and DBT, to treat learning-disabled clients. Here Practitioner Three shows how she caters to the individual learning-disabled client and aims to provide the most suitable means of treatment. For instance, she uses a technique of adaptive processing. The adaptive process is a method that can change and evolve through gaining knowledge to suit a condition, behaviour or situation for someone or something (Munakata, McClelland, Johnson, & Siegler, 1997).

Practitioner Three elaborated further on the purpose of how she applies these therapeutic treatments to her clients. She also mentions using additional mindfulness, visual material, symbols, drawing (art), emotions, words and sensory functioning to help learning-disabled clients with their treatment process.

“[...] so really focus on gently opening with a mindfulness practice to get relaxed in the session. Then doing some therapeutic work and then ending for the rewarding task like colouring or some other activity that they like [...] So I’m talking about stage one, trauma therapy which is skills building. [...] I use a lot of visual information, visual aids, and present things to people visually in terms of the psycho-education. [...] using many visual aids as I said you know I think is helpful to get. With my client that I am working with, she has got really good in giving me feeling words. So I’ve started with visual and then getting her to draw and then getting her to point where she’s at on a scale and then she knows what the words are now so she’s really good at giving me words and, and therefore telling staff she’s feeling a little anxious or whatever. [...] As well as non-verbal drawing, that sort of expression”. [...] I use sensory modulation quite a bit too. [...] Sensory modulation is using your senses to calm down. Um when people get to manage their emotions. See over there I have got some squeeze, some soft balls. So I might, if they’re talking about something, in that basket I’ve just got some stuff in there like the squeeze ball, and I’ve got some little things that smell, as well. I use those quite a bit as part of mindfulness practice in managing emotions. [...] The client’s got some tools at home, she’s got a little box, a soothing box so she can take something out of there that’s got something in it that she can smell or touch or, or look at that helps soothe her and that’s unique to her. We’ve developed that ourselves with her.”

This practitioner starts with creating a comfortable environment for the client, does therapeutic work and finishes off with a fun activity that the client enjoys. Practitioner Three uses a systematic technique that slowly develops the learning-disabled clients' self-recognition. It involves working past the abuse and gaining new skills that might help clients in their daily lives. Similarly, she uses different non-verbal, pictorial or physical methods of helping learning-disabled clients to learn and get treatment. She indicated that she had found visual/pictorial/non-verbal learning very useful as a means for learning-disabled clients to understand themselves. Practitioner Three used a systematic approach of visualising and illustrating a particular feeling, and then picking a word to describe those feelings on a scale. Thus, Practitioner Three's client uses affective or feeling words to describe certain scenarios.

Another therapy technique that Practitioner Three mentioned was sensory modulation, which involved controlling emotions and the sensory function to achieve comfort or relaxation. This practitioner uses techniques to decrease the learning-disabled client's stress and tension. It is a means of learning to control one's emotions and feelings by using the senses of smell and touch to understand different types of emotions or thought processes.

She explained the therapeutic techniques that her supervisor had developed:

“So she calls it Coping Skills and it's very good. I use her package. It is very solid. It follows some, process that a DBT programme would and with a lot of visual material, and getting teaching skills that is encouraging them to practice outside of sessions so it might be a mindfulness or a breathing technique or relaxation, etc.”

The technique involves coping skills and mechanisms such as breathing, teaching self-awareness and mindfulness. These methods continue as homework for the clients. This may assist with self-building techniques used for the clients where they can slowly trying to recognise themselves and understand their wider environment.

Practitioner Three also explained the issues of modifying therapeutic treatment approaches:

“So yes so the client that I’m working with at the moment, her disabilities are more severe than what I’ve worked with previously so, I can’t assume, I can’t just use a manualised approach.”

Here the practitioner talks of how she has to alter specific treatment approaches and techniques as her client has a different level of impairment: a strictly structured therapy plan would be less suitable. Another practitioner also spoke of the different therapies she used with her learning-disabled clients that were not so reliant on the use of words.

4.3.2.2 Art therapy

Of the three practitioners, only Practitioner One uses art therapy as a non-verbal means of communication when working with sexually abused learning-disabled clients:

“But I did my training as an arts therapist so I don’t need to talk [...] she’s completely nonverbal um she loves to dance. So we danced! Um and it works fine, it is great. [...] And some through other counsellors that have just kind of said talk therapy is not working, try art therapy! So yeah all sorts of ways.”

Practitioner One develops a different connection with her clients through non-verbal communication. She also explained that there might be other alternative art therapy options. Here she speaks about how she uses dance as a form of therapy with her verbally restricted client. This form of therapy had assisted the client to overcome trauma.

There are additional forms of therapy that this practitioner used that did not require verbal communication:

“Body casting works for a lot of people. Um which like create, taking a part of your body, taking a cast, I’ll show you one, taking a cast of it and recreating it, designing it as something different. [Here the practitioner showed me a Plaster of Paris cast of a person’s fist.] So this is a lady who is making her fist. And inside she’s lined it with fur and I don’t really know what that means yet but she might tell me one day. So that’s body casting and that’s her actual fist. And it’s just plaster like the hospital use when you break your arm and you just mold it and then dry it and yeah. So that works. [...] I use arts therapy but my training is multimodal so I use art, I use drama, I use music, drumming. Drumming works really well with men because it can calm them right down. So that is like African drums sort of thing. Dance, movement, storytelling with soft toys, talk therapy or even sand therapy. For instance, underneath this lid here, there is a box and you recreate the world or whatever it is that you want to work in the sand. You can re-enact it or change the ending or you just pick things off the shelf to represent different things, and so it is a way of telling your story without having to put words to it. You can just re-enact it or change it or do something different with it or beat up your perpetrator.”

Practitioner One uses body casting as well as other forms of art therapy to help her clients. She takes time to understand her clients and works with them at their pace. By using artistic and other non-verbal methods as a means of expression, art therapy seems to assist the clients to express themselves and gain therapeutic treatment. These forms of art can represent different things for different clients, which may help when interpreting their thoughts and feelings. Practitioner One can draw on multiple approaches to ensure that her

client is able to process his/her emotions and thoughts. One example that she gives is the use of drumming as a means of releasing and physically expressing the anger that may be an outcome of their abusive experience.

4.3.3 Stage 3 – Ensuring Follow-Up

All three practitioners identified methods of continuing with useful therapeutic strategies for learning-disabled clients who require specialised or individualised care. All three identified ways whereby learning-disabled clients' self-worth and self-esteem could increase. They spoke about how educating the learning-disabled clients and their caregivers about treatment techniques and support services can be highly useful and how establishing relationships with these people was an important part of their work

4.3.3.1 Collaboration and building partnerships

Social expectations are high for practitioners working with learning-disabled clients. This may be due to the expectations of the practitioners themselves about helping their clients and learning-disabled people to be part of a social norm (Pfeiffer et al., 2003). All three practitioners mentioned the idea of cooperation between themselves and key support services to get involved and work together to develop a better environment for learning-disabled people. Practitioner One explained:

“Have they got family members that would benefit from some psycho-education around sexual abuse and what’s normal and what’s not, and all that sort of thing so that we can build all of that in as well so that they can get a complete wrap around package from ACC which is cool, yeah”.

This showed that obtaining caregiver support is essential for the treatment of learning-disabled people. By educating family, friends or carers, learning-disabled people could get appropriate support.

Practitioner Two points out her views about informing the society about the challenges that are faced and developing new strategies to overcome them. She stated:

“[...] it’s always the person that’s coming to see you, that you’re working with your relationship is with, but it’s a bit more of a complexity when somebody else is funding it and they’re expecting outcomes that’s different for the person you’re working with. So that, that’s always a challenge”. [...] difficulty actually being able to use the information to change emotions or behaviours we might go to schools and talk to um, teachers about what sort of emotion regulation stuff we might be doing with that person so they can prompt them to do it as well.”

This practitioner ensures that carers and support workers are involved during the therapeutic sessions. It also showed that Practitioner Two tries to reach the wider communities involved with the learning-disabled client to create an awareness with them about how to deal with the distress that the client is experiencing and how to deal with the behaviours that the client might manifest.

Practitioner Three focused on clients teaching caregivers about the therapy process that helps empower them.

“I think it’s also really good to spend quite a bit of time in developing rapport and in taking things really slowly so um, and getting, making it quite collaborative, so they (carers/staff) are on board with the process. So sometimes, if a new staff member comes on board I encourage my client to teach that staff member or share what they know so they feel empowered in the process. [...] Okay, so I’d have to be really careful in having someone to support them in the work they’re doing so I always ask a staff member or a parent to be present when I’m doing the work [...] I’ve done staff training like

training with staff so I'll go and spend a couple of sessions going in and letting them know what my formulation is and what I'm doing to get their buy in. Moreover, how to manage some of the behaviours in terms of DBT focus therapy. Therefore, they will be consistent in, how they are dealing with that client. [...] Again getting staff on board that is a big thing. You know that is a big thing. If I can get staff on board then that's, that is really, helpful. Or even one member, staff member, be it a keyworker on board, then that seems to make a big difference I think".

This excerpt shows that the client, support staff and psychologist work together to assist the client, which includes developing a collaborative work environment fostering mutual understanding and rapport. The client is encouraged to teach the support worker and caregivers about the work they and the psychologist do. It also indicates that Practitioner Three and the caregivers are working together to ensure that the learning-disabled person is supported and that the caregiver is able to understand the client's treatment process. The practitioner has found that sharing the knowledge or therapeutic treatment goals with the support worker or caregiver, may develop some continuity between the therapeutic treatment and the clients' daily life and help their treatment process.

Practitioner Three has found that while involving the staff is important they may not always support her work: She stated:

"[...] main difficulties I have, have had is not dealing with the clients but dealing with staff or the people around them! Yeah so um. Getting staff on board if they are in residential care or getting parents on board. [...] and because I can teach the client skills and work therapeutically with them but

sometimes the staff don't support that coaching or the, that those skills that they might be learning."

This indicates that practitioners' work with staff and caregivers can be an additional challenge. It shows that the support from staff and caregivers can be highly significant during the therapeutic treatment of learning-disabled clients.

4.3.3.2 Lack of education in practitioner training

All three practitioners highlighted the issue of limited knowledge and education amongst practitioners with the needs of learning-disabled clients. Practitioner One stated:

"[...] the first time someone walked in the door and said 'I've got an learning disability', it was like I don't know how to work with you' and I went and did some research and I couldn't find anything. [...] learning disability is not contagious, just work with them! It's like you're not going to catch it. They're not going to hurt you! You might have some fun! You need some fun. Um but yeah it impacts in as much as I take on far too many clients and like I haven't had a holiday all year."

As indicated in this excerpt, when referred to her first learning-disabled client, this practitioner recognised that she had not been taught how to provide appropriate therapeutic treatment for learning-disabled clients. Although Practitioner One has now worked with many learning-disabled clients, she believes that this is a result of other practitioners preferring not to do so. She proposes that there is a perception amongst practitioners that it is difficult to work with learning-disabled clients.

Practitioner Two also acknowledged the issue of insufficient training or therapy-related courses within the counselling community in New Zealand:

“A lot of people struggle in getting that support and there’s not a lot of avenues to get into that work in this country [...] In New Zealand, there is such a limited way of getting that experience. [...] I do not see the university, clinical psychology courses reaching out to services that support people with learning disabilities to give their interns that experience. Whereas in the UK you had to have that learning disability experience to become a clinical psychologist. It was one of your five core areas that you had to have experience in. In New Zealand, I think it’s just a, well I don’t know, I don’t know why people don’t support the training institutes, to develop experience that a lot of the applied behaviour analysis course who of course do become a registered psychologist will do that work”.

This practitioner compares the clinical psychology training that is given in the United Kingdom with that in New Zealand. She notes that New Zealand practitioners do not receive any education about, or opportunities to work with, clients who have a learning disability, whereas it is a recognized component of professional practice in the UK. Due to the lack of available experienced practitioners, this group of clients are not easily able to receive counselling. She also mentioned that there is an erroneous belief that learning-disabled clients are untreatable:

“A kind of misbelief that people with learning disabilities can’t use therapy, therefore there’s no point getting people trained up to do it. You know it is kind of a weird one. [...] You know with the right support people can actually be supported to do it, but I do think they just assume it is too hard, it is too hard for them or I do not know what to do kind of thing. [...] They do not see the lives of people with learning disability as being as worthwhile um as people who are, whose lives are not. Which again is really bizarre aye”

Practitioner Two believes that other therapists think that learning-disabled clients are untreatable due to their impairment (cognitive functioning) and thus difficult to work with. She attributes this to the lack of education and not valuing people living with a learning disability.

Practitioner Three also identified the issue of limited training under counselling or psychology curricula:

“When I was asked to see the clients at xxx I had, we had some training in our clinical psychology training. But it was limited.”

This reinforces that there still is limited training, education and supervision for practitioners when working with sexually abused learning-disabled clients.

4.3.3.3 Supervision

The three practitioners acknowledged the need for supervision in counselling/therapy practice.

Practitioner One explained:

“And so we have to do so many hours every year so um and apart from that everyone who’s working in this field gets supervision. So you go and see someone who has got more experience than you and talk about difficulties and where you’re stuck and what can I try that’s different [...] So I have supervision at least once a fortnight. Because I see a lot of clients!”

This indicates that practitioners can have a supervisor whom they can go to for guidance. It shows that practitioners with more clients might require more supervision and guidance.

This may be a productive approach to gaining more confidence in work with sexually abused learning-disabled clients.

4.4 Conclusion

All three practitioners' identified important aspects and steps of therapeutic practice within the counselling community. In summary, in this chapter, I have described the findings of my study. I have argued for an overarching theme of applying practice underpinned by three subthemes: Accessing therapy, using appropriate therapy and ensuring follow-up.

In the next chapter, I discuss the implications and limitations of my research and make tentative recommendations for research and education.

Chapter Five - Discussion

The purpose of this thesis is to explore practitioners' experiences of working with sexually abused learning-disabled people. In this chapter, I discuss and critically evaluate the findings from the three practitioner interviews and reflect on the three main sub-themes that include accessing therapies, applying appropriate therapies and ensuring follow-up. I examine how these key findings may assist therapy for learning-disabled clients as well as increasing awareness of the different therapies available for effective treatment. After discussing the findings with supporting literature, additional emphasis will be on the implications of the study, as well as the research limitations and recommendations for further studies.

5.1 The Findings

5.1.1 Accessing therapy

The first theme identified by all three practitioners was the issue of accessing therapy for sexually abused learning-disabled people. They identified challenges revolving around: recognising the experience of abuse, how caregivers respond to the recognition of abuse, the involvement of ACC funded support and assessing and lodging sensitive claims for sexually abused learning-disabled clients.

5.1.1.1 Experience of abuse

All practitioners mentioned the process of learning-disabled clients accessing practitioners and the challenges of obtaining therapy. Keilty and Connelly (2001) stated that there are multiple barriers to accessing therapy. One of the significant barriers identified in this current study was the issue of learning-disabled clients not being able to recall or retain the experience of abuse, which could also limit them from testifying to the conviction of perpetrators or receiving treatment themselves.

Practitioners who are trained and experienced in interviewing learning-disabled clients are highly recommended in these situations to enable the client to disclose, minimise distress and enable healing. As identified by Sobsey and Doe (1991), counselling had been the most frequently sought service by their participants who had been victims of sexual abuse. It may also be essential that the people who request counselling support be involved in the therapeutic process as a means of assisting the sexually abused learning-disabled client to heal. The current study highlighted the fact that the referrers may have ideas about the learning disabled person's needs.

5.1.1.2 Caregiver recognition

As learning-disabled people are usually unable to refer themselves, it is the family, carers and GPs or social workers who are expected to ask for therapeutic assistance, possibly due to the learning-disabled person's sudden change in behaviour or evidencing of affective difficulties (Maitland, Tsakanikos, Holt, & Bouras, 2006). Studies further indicated that learning-disabled individuals might only be able to access a practitioner if a family member or carer can identify changes in their daily well-being (Kroese, Dagnan, & Loumidis, 2005). Therefore, self-referrals made by learning-disabled individuals might be less likely. In addition, learning-disabled individuals with challenging behaviour tend to be

marginalised and differentiated from others (Ingram & Lovell, 2011). For that reason, caregivers may be key to obtaining information on the client's physical, behavioural and emotional attributes (Ingram & Lovell, 2011).

After recognising abuse, the next step may involve seeking funded referral support for sexually abused learning-disabled clients.

5.1.1.3 Referral for funding

As mentioned earlier in Chapter Four, New Zealand-based referrals for sexually abused learning-disabled clients are mostly done through ACC as they provide funding and cover for injuries, reimbursements, medical and psychological treatment as well as rehabilitation support for individuals in New Zealand (Frewin, Pond, & Tuffin, 2009).

McGinnity and colleagues (2004) explained that many learning-disabled clients are unaware of the referral, why they were being referred or if they require any therapy.

Therefore, the informed consent of clients for referrals to therapy is vital for their well-being.

It is also important to note that accessing and receiving counselling may not be achieved for all learning-disabled people as one of the practitioners in the current study stated that most learning-disabled clients with severe disabilities are not referred. Keilty and Connelly (2001) stated that learning-disabled clients with severe disabilities are unable to understand the concept of being abused or are unable to communicate the abuse experience.

Nevertheless, there are methods of obtaining information, such as structured assessments, to provide funded counselling for sexually abused learning-disabled clients.

5.1.1.4 Assessment

After referrals to ACC, the next step of accessing therapy involves an assessment. Frewin et al. (2009) explained that there is an initial assessment of the client, which can be made by a doctor, or an ACC approved practitioner. They suggest that ACC is well structured with diagnosing and providing empirically based evidence that may assist their clients to overcome the abuse (Frewin, Pond, & Tuffin, 2009). An article written by Miller (2004) explained that ACC was developed in 1972 by the New Zealand Government to provide compensation for clients who had accidents or were abused and injured, either physically or psychologically. The article stated that ACC funded services also covered living arrangements, medical and counselling costs. The ACC then developed a registered professional membership where practitioners obtained additional training and assessment criterion that specifically involved sexual abuse clients who require funded therapy (Miller, 2004). In other words, practitioners can only be registered by ACC if they have obtained sufficient counselling experience (Miller, 2004). Secondly, that the practitioners have to have knowledge of psychological disorders, personal and interpersonal communication techniques, as well as the cultural and ethical protocols followed by their clients (Miller, 2004), such as Tikanga Māori.

After assessment by ACC, learning-disabled clients can request a sensitive claim for counselling sessions or additional treatments if they require (Accident Compensation Corporation, 2008; Frewin, Pond, & Tuffin, 2009).

5.1.1.5 Additional therapy sessions

Following the process of obtaining therapy for sexual abuse through ACC, the next step may involve the lodging of a sensitive claim for additional therapy sessions. It was identified in Chapter Four that under the ACC guidelines, a sensitive claim could be made

by an individual who had been sexually abused and is psychologically harmed as a result. For example, by assessing levels of cognitive, affective and behavioural changes or impairments identified by the psychologists/practitioners'. After assessing the evidence of abuse, as well as any impairment outcomes, ACC may provide further monetary support for clients' sessions until they are no longer required (Frewin, Pond, & Tuffin, 2009).

5.1.1.6 Additional information - asking for help

It would be highly useful to find ways to access practitioners for sexually abused learning-disabled people. Besides ACC, other organisation such as HELP and Rape Crisis centres based within Auckland provide assistance for sexual abuse victims.

As mentioned earlier, ACC provides funding for the diagnosis and treatment of events that are defined as 'accidents' and provides support services for people with lasting impairments, people in hospital or rehabilitation as well as assistance for people in home care and carer support. The ACC website provides attached information and websites for disabled people on the 'Disability Support Group' (Accident Compensation Corporation, 2015). The group includes online organisations such as the Brain Injury Association of New Zealand, Carer NZ, CCS Disability Action, Head Injury Network for Kiwis and many others.

Sexual abuse is identified as an event that also falls under this umbrella. The ACC website has a 'Help after sexual abuse or assault' (Accident Compensation Corporation, 2015) section with a 'FindSupport' (FindSupport, 2015) webpage that provides information about accessible ACC-funded support for sexually abused people. This section states that New Zealanders as well as people visiting New Zealand, who experience sexual abuse, are eligible for support. They also provide therapy and counselling services.

Other services within New Zealand could assist learning-disabled people who have

been sexually abused. For instance, the 'HELP' support service which provides counselling and therapy for sexually abused women (HELP, 2012). Rape Crisis Dunedin is the only rape crisis website that provides online information and assistance in New Zealand. (Other rape crisis centres within New Zealand can be contacted by telephone or email). Rape Crisis Dunedin is a non-government, community organisation that provides support for women who have been sexually abused. The website provides information for accessing a 24-hour counselling and therapy call service for sexually abused women.

However, gaps and limitations are recognised. For example, Rape Crisis Dunedin is the only rape crisis website available online. In addition, there is no evidence of specific support for disabled people who have been sexually abused. As mentioned earlier, extensive collaboration with the UNCRPD guidelines, as well as government funding and assistance can provide appropriate services for sexually abused people.

Additionally, provisions for disabled men would be greatly valuable. For example, creating a specific website for learning-disabled people with facilities which can help them to access support, counselling, therapy or information. This may include creating readable texts, videos and voiceovers for the website to make it easier for learning-disabled people to access information.

The Rape Crisis Dunedin website provides a social model approach to services as sexual abuse obstacles are identified, and preventative or repeated incident approaches are applied. As the social model relates to disability, developing a link between disabled people and the rape crisis centre services would be very beneficial for the disability population within New Zealand.

Conclusion

Previous literature was unable to recognise that due to the learning-disabled client's lack of verbal communication or cognitive functioning, there are no specific guidelines or methods for police or other authorities, to assist a client recalling the abuse. Health professionals or the client's caregivers might be the only means of recognising the abuse. Having a trusted family member may also be helpful for the process of obtaining therapy.

In New Zealand, we have a unique system for funding therapy for sexual abuse through ACC, and it is a more robust assessment and therapy process than is reflected in the international literature. However, there is a need for appropriate therapy approaches for learning disabled people.

5.1.2 Using Appropriate Counselling Therapies

There is a necessity for more practitioners to counsel sexually abused learning-disabled people. This was quite evident during this current study when searching for participants as very few practitioners were identified as having experience working with sexually abused learning-disabled people in Auckland. Learning-disabled individuals are more vulnerable and susceptible to abuse than other disabled and non-disabled individuals (McGinnity et al., 2004). Similarly, they are more prone to psychological and behavioural consequences. In 2004 McGinnity and colleagues identified that learning-disabled people have difficulties with life changes, sufficient coping responses and problem-solving capabilities. Learning-disabled people are known to have psychological challenges that are influenced by intellectual, physical and verbal difficulties (McGinnity et al., 2004). These issues lead to social deprivation and marginalisation and can eventually lead to abuse. Therefore, there is a need for therapeutic treatment for learning-disabled individuals. In these situations,

counselling and therapy may be highly recommended for sexually abused learning-disabled clients.

The second sub-theme of applying appropriate therapies found that practitioners used different methods to treat their learning-disabled clients. For instance, they elaborated on therapies such as Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Mindfulness therapy as well as other non-verbal methods of breathing, visualisation, drawing and sensory modulation techniques. In these circumstances, tailoring or modifying therapies may be beneficial for sexually abused learning-disabled clients.

5.1.2.1 Modifying therapies

CBT is known to be one of the most common and widely used forms of therapy by clinical psychologists when working with learning-disabled clients (McGinnity, et al., 2004, Jahoda, 2016). Evidence has shown that CBT helps to apply knowledge-based and self-teaching methods, which assisted learning-disabled clients with their cognitive discrepancies, memory retention and managing of emotions (Jahoda, 2016). When working with some learning-disabled clients, certain modifications may be needed to ensure that the learning-disabled client is able to understand and articulate him/herself within the therapeutic treatment processes.

For those learning-disabled clients who have difficulties retaining memories or recalling particular experiences of abuse, the CBT method of therapy could assist retrieving their experiences as well as overcoming them (McGinnity, et al., 2004). According to Jahoda (2016), additional therapy is essential for learning-disabled clients engaging with CBT as this therapeutic approach involves conversations between the practitioner and client and some degree of mutual cognitive understanding. Other challenges may include the

slower process of maintaining focus and attention during therapeutic treatment, which may require an increased number of sessions for those learning-disabled clients who may take longer to understand and cognitively process information (Banks, 2016).

Due to the limitations that some learning-disabled clients might have of distinguishing and properly recognising affective awareness, practitioners identified other means of treatment. This included visual and non-verbal materials, drawing, toys, symbols and storytelling to help identify the core issues that clients are experiencing (McGinnity, et al., 2004). Similar to McGinnity and colleagues (2004), the practitioners in the current study use visual and other non-verbal means of receiving therapeutic treatment as well as mindfulness and breathing techniques.

DBT is another therapeutic technique derived from a third wave CBT with similar techniques of self-teaching and cognitive reforming (Lippold, 2016). Additional methods in DBT included mindfulness to reduce self-harming and techniques for regulating emotional distress (Lippold, 2016.).

As DBT requires verbal and communicative means to apply therapy for clients, learning-disabled clients may be required to engage with a modified or tailored approach. These modifications may include shorter session times to ensure the learning-disabled client is able to understand the treatment as well as him/herself (Lippold, 2016). In other words, using simplified or rephrased versions of treatment methods to ensure that the clients understand the therapy process. Other modifications include visual or pictorial materials as well as Mindfulness therapy (Lippold, 2016).

In this current study, both practitioners mentioned the use of Mindfulness therapy. Different from other psychological therapies that require social or physical elements for

change, Mindfulness therapy entails a more accepting and open-minded approach to therapy in the current experience or environment (Kabat-Zinn, 2012, Gore & Hastings, 2016).

Learning-disabled clients taking part in introductory mindfulness therapy workshops positively viewed these (Chapman, & Mitchell, 2013). A systematic review of studies on mindfulness training for people with learning-disabilities found that these clients reported experiencing lower levels of hostility and sexual activity. Furthermore, this approach improved the family member's well-being and assisted in developing a stronger bond between them and the learning-disabled individual (Chapman, et al., 2013). Support service members also benefited from this approach as they became less stressed and more content with their work (Chapman, et al., 2013).

Another important factor that can influence the therapy process for learning-disabled clients is the relationship between the practitioner and their client. It is important that there be a level of respect and trust between them to ensure positive outcomes from the treatment (Jahoda, 2016). The compassion and respect for their clients was evident in the participants in the current study.

5.1.2.2 Non-verbal approaches to therapy

As mentioned above, non-verbal approaches were identified by practitioners as useful for working with their clients. Another therapeutic approach discussed in this current study is art therapy. One practitioner used this method of treatment with her learning-disabled clients. Art therapy can provide a greater means of obtaining emotional and psychological understanding about a client (McGinnity, et al., 2004). On the one hand, art therapy can assist treating clients who are verbally and cognitively challenged. On the other, the same

therapeutic approach can provide insight towards a client's reflective comprehension of their experiences and the process of exploration with their counsellors (McGinnity, et al., 2004). Clients can create a practical means of using art to represent and conceive their thought processes, which could then assist them to interact with others (McGinnity, et al., 2004). Art therapy is based on the client's ability to communicate at a different level, to increase their self-esteem and self-confidence and to gain independence with communication.

5.1.2.3 Conclusion

Under this sub-theme, what was not identified in most previous articles but evident in this study is the three practitioners aimed to combine different methods of therapy (i.e. CBT and DBT with Mindfulness and breathing or visual, drama and dance with art therapy) to cater for the learning-disabled client's level of cognitive or behavioural abilities. This may be a highly significant factor assisting practitioners to consider specialised therapy methods adapted to cater for learning-disabled clients. One of the main advantages of using art therapy may be that art therapy is not dependent on verbal interaction and enables clients to communicate in different ways, either through painting, drawing, sand art or other forms.

These methods of therapeutic treatment, together with consistent supervision and follow-ups may be beneficial for sexually abused learning-disabled clients.

5.1.3 Ensuring Follow-Up

The last sub-theme of ensuring follow-ups or continued therapeutic strategies for learning-disabled clients found that there is a need for collaboration and cooperation between practitioners, government, support services, stakeholders, family and communal members

to ensure that there is some level of trustworthiness or rapport (Accident Compensation Corporation, 2008).

5.1.3.1 Collaboration and partnership

Collaboration involves the cooperation between individuals/groups with intent to produce a required result (Green & Johnson, 2015). Collaboration occurs in education, research as well as health and well-being. In this current topic of sexually abused learning-disabled people, collaboration may involve the interaction between the practitioners and the government, support services, communal groups and interpersonally with an aim to ensure the needs of this population are met.

When collaboration takes place in a healthcare setting, knowledge is shared to influence health practice and patient awareness with an aim to resolve complex issues (Green & Johnson, 2015). However, it is not always easy to use collaboration as a means to achieve results. Barriers may be encountered such as multicultural views or an inability to develop partnerships (Green & Johnson, 2015).

Nonetheless, collaboration may assist to achieve a common goal (Tse, 2016). Traditional and modern therapeutic practices can be connected to build a supportive environment (Tse, 2016) that can assist learning-disabled people. Tse (2016) discussed the “Doing Well Together Framework” (p. 24) that involved incorporating the practitioners’ beliefs, values, practice and cognitive abilities. The framework also focused on developing new and innovative ideas with an intention to learn from others and create a two-way connection. Although practitioners who are funded to work with individual learning-disabled clients may not provide therapeutic services to caregivers, it is essential to involve them. Equally, it is vital that other practitioners and the wider community may assist to

create a safer environment for learning disabled individuals. This is to ensure that they are supported and self-motivated to live a healthy and productive life.

All three practitioners acknowledged the importance of collaboration and partnership and that there still might be a need for further involvement. It is essential that practitioners and learning-disabled clients, as well as their caregivers, feel supported and secure enough to disclose their issues. Kliem and Feather, (2013) emphasised the significance of collaborative partnerships between clients and practitioners. Their focus revolved around reflective practice where practitioners examine the different aspects of therapy and how the therapeutic approach affects relationships with their clients. (Kliem & Feather, 2013). This method of reflection may assist clients with their recovery.

Similarly, ACC guidelines demonstrate the need for practitioners to maintain a positive, reassuring and safe environment where the client feels respected (Accident Compensation Corporation, 2008). It is also necessary to create goals with clients and caregivers, as well as service providers, and communities to make sure that sexually abused clients are provided with effective therapeutic treatment. Additional factors may include follow-ups post-therapy or further monitoring, as this might help to identify any sudden changes in mood, behaviour or coping mechanisms that may affect their overall well-being (Accident Compensation Corporation, 2008).

5.1.3.2 Involving caregivers

In addition to learning disability, client-centred therapy, Banks (2004) also recognised the importance of caregiver involvement in the treatment process. When appropriate, the inclusion of family members in therapy can help them and the learning-disabled client to share their experiences and issues (Raffensperger M. K., 2009). This form of therapy can

help explore the specific roles each member has in the family (McGinnity, et al., 2004).

Therefore, caregiver involvement is essential to ensure that the learning-disabled client is well supported interpersonally and in therapy.

5.1.3.3 Lack of education and training

The sub-theme also concluded that there is a need for education and knowledge-based work, supervision as well as training for practitioners and caregivers within the therapeutic environment. Banks (2004) identified that there is a need for information, training and education for all practitioners and caregivers on the guided protocols of working with learning-disabled clients. As sexual abuse or any other sensitive issue might be difficult to discuss, it is essential that practitioners be well-informed and trained to work with learning-disabled clients. It is important that there be training, knowledge and educational resources that are accessible to all practitioners (McGinnity, et al., 2004).

One of the main reasons why many practitioners are cautious about treating some learning-disabled clients is because there is no clear training or guidelines for them to follow. Consequently, it becomes harder to identify relevant information to therapeutically treat learning-disabled clients (Raffensperger & Miller, 2005). Raffensperger and Miller (2005) further recognised that New Zealand practitioners had limited training in the field of therapeutic rehabilitation for learning-disabled clients. Their findings indicated that most of the practitioners had limited knowledge of specific programme guidelines for working with learning-disabled clients. Similar to practitioners, the learning-disabled clients' caregivers face difficulties, as there is limited knowledge about specific ways they could access help for learning-disabled people.

5.1.3.4 Supervision

In this study, practitioners recognised the importance of supervision as an aspect of educating and sharing knowledge within a practitioner's discipline. Therapy supervision in New Zealand involves encouraging other fellow practitioners, sharing and receiving information, feedback or ideas, as well as eliminating cultural, gender or discriminatory barriers (Herkt & Hocking, 2010). Supervision ensures that practitioners incorporate the counselling requirements that support their field of work, they are well assessed in sessions and that they are professionally initiated under strict guidelines (Herkt & Hocking, 2010). The professional relationship between a supervisor and supervisee encompasses rapport, reflection and gaining knowledge while accepting critique and excluding discrimination or prejudice.

5.1.3.5 Conclusion

There may be a strong need for all practitioners, government agencies, support services and caregivers to be well educated about assisting sexually abused learning-disabled clients. Appropriate training and supervision, before and while working with sexually abused learning-disabled clients might be necessary for practitioners so they are prepared and more comfortable with clients (Raffensperger & Miller, 2005). A lack of knowledge may perpetuate stereotypical viewpoints, which may restrict clients from living well in their daily lives (Raffensperger & Miller, 2005).

Under the current study, this sub-theme focused on areas that were identified as future requirements for practitioners. For instance, using current therapeutic approaches that can be adapted for learning-disabled clients as well as developing new programmes or guidelines to validate their therapy.

5.2 Implications

This current study has provided some insight into the working lives of three practitioners and the challenges of their roles to empower, encourage, be non-judgmental and demonstrate positivity towards their clients. However, a lack of sufficient resources, knowledge and education for practitioners working with sexually abused learning-disabled clients may have negative consequences.

The findings of this study might assist in identifying how therapy practice and services may assist learning-disabled people who have been sexually abused. Further, this research might help to influence specific practitioners and their therapeutic methods when working with clients who have a learning disability. As mentioned earlier, this study might influence future development for learning-disabled people and change global perceptions of their different abilities.

5.2.1 Implications for accessing therapy

Not having therapy at all may affect the person with a learning disability's daily living standards, which may affect their behaviour. Consequently, how society responds or reacts towards them may lead to their isolation. Ingram and Lovell (2011) explained that insufficient information could lead to inept assessment or limited treatment guidelines. This may then increase the client's behavioural issues or disabilities.

5.2.2 Implications for appropriate therapy

There may be possibilities that not having appropriate therapies can also affect the learning-disabled client who has experienced abuse, leading to low self-esteem or self-destructive behaviour. There are many reasons for sexually abused learning-disabled clients to access

and use therapeutic treatment for abuse and the related issues of depression, relationship issues or personal challenges (Raffensperger & Miller, 2005). There is a possibility that these issues may continue or increase if they are not treated. As acknowledged by Raffensperger and Miller (2005), historically, prescribed medications or behavioural approaches were used as a treatment instead of therapeutic counselling. Evidently, the cost of medications and their administration might have an effect on the disability community. It may prove too expensive for the Government to subsidise expenses for disability services, medications or medical treatments, which can, in turn, have a residual effect on caregivers.

Sexually abused clients seeking therapy move through stages of overcoming the traumatic experience (Martinet & Legry, 2014). This may include resurfacing the past traumatic event and balancing the current lifestyle, while managing affective responses (Martinet & Legry, 2014). Therapy can help ensure that clients are in a safe and secure environment where they can gradually return to their daily living. As this treatment occurs, the traumatic experience of abuse slowly diminishes, which can assist the process of obtaining new and positive memories, and awareness as well as self-stability (Martinet & Legry, 2014). Without therapy, clients might not be able overcome the traumatic abuse. More importantly, learning-disabled clients might not be able to express their emotions or communicate which may have bigger implications, such as causing harm to oneself or others around them.

5.2.3 Implications for ensuring follow-up

Green and Johnson (2015) state that collaboration between support services and health providers can be beneficial. Without any collaboration, less may be achieved in research, education and health practice, which may lead to limited patient care resulting in an increase of in-patients, and other complications.

Rafensperger (2009) identified elements that can influence the result of therapeutic counselling for learning-disabled clients. She acknowledged the positive outcomes of therapeutic counselling, which can include social support, community encouragement and adaptive treatments. The distinctive views and characteristics of problem-solving practitioners may also be effective.

It can be concluded that the outcomes of therapy for learning-disabled clients have the potential to be highly beneficial and that the negative factors identified above, if not addressed, may result in adverse implications.

5.3 Limitations

In my research study, I aimed to identify the issues relating to practitioners' experiences developing appropriate therapeutic approaches when working with sexually abused learning-disabled people. Similar to all research methodologies and analyses, there were some limitations.

Firstly, the current study did not directly involve interviews with sexually abused learning-disabled individuals about the barriers they face. Instead, the practitioners' experiences, challenges and perspectives of treating their clients was assessed. This was mainly due to the fact that I am not professionally educated to properly communicate with learning-disabled clients to obtain their experiences of abuse, whereas practitioners are well qualified in this field.

Secondly, the availability of practitioners restricted or limited the data collection phase of the research. It had taken me five months (September 2015 – February 2016) to recruit three practitioners who were willing to participate in the study. Finding enough

practitioners was the most significant issue encountered in this research study. Hence, a decision was reached in early February 2016, to stop recruitment and commence data analysis. Should I have been able to recruit more participants another limitation may have been practitioners employing different kinds of therapeutic approaches on their clients, although those who did participate used a range of modalities. Furthermore, participants were restricted to the Auckland region. While some attempts to recruit practitioners outside of Auckland were made, no one was interested or available for the study.

5.4 Personal Reflections on the Research Process

The main purpose of this study was to explore practitioners' experiences of working with sexually abused learning-disabled clients. After interviewing three practitioners, I was also able to gain knowledge about sexual abuse and its effects on learning-disabled people. This could assist me to identify certain issues that health professionals and learning-disabled people face on a daily basis.

This study was also focused on exploring a personal journey of understanding my own viewpoints on important issues in society. The process encouraged me to understand myself as a researcher and as a human being, as well as how my opinions and thoughts affected the current study.

I made an effort to talk with practitioners about my journey and how my disabilities affect daily life. I wanted to reassure them that I was passionate and genuinely committed to conducting this research. Being a disabled person, I made an effort to portray myself as a researcher and a human being who wanted to make a difference and influence future researchers to gain knowledge about 'differently-abled people'. However, my disabilities

became more of a hindrance when my inability to cope with the deadlines caused stress, which affected my health. Due to my experiences with a brain haemorrhage, I had difficulties immediately grasping information.

My supervisor suggested I make an appointment with a university disability advisor to conduct a neurological assessment, which assisted me to manage my study. The assessment made me aware that I still have physical, neurological and cognitive disabilities, which may never change and that there are certain things that I will not be able to do. Oddly, I was relieved and thankful, realising that there is no point stressing about the situation. I am very grateful that I was able to carry out this study as it helped me to gain some self-realisation and the confidence to continue with my work as a researcher.

5.5 Recommendations

5.5.1 Practice

One recommendation is to create an intersubjective therapeutic environment where the practitioner and client are able to absorb information from one another (Capri, 2014). This would involve understanding the other person's experience and gaining knowledge from them. In other words, entering into and understanding the other person's views or perspectives of their life experiences (Capri, 2014). However, this approach may be limited by the inability of some learning-disabled clients to verbalise their experiences. Instead, practitioners may use alternative approaches such as art, dance, visual, drawing, sand art or mindfulness breathing as a means of interaction and communication.

A particular issue may be the lack of therapeutic approaches specifically tailored to the needs of sexually abused learning-disabled clients. I would suggest the adaptation of

appropriate therapies to assist them during their treatment journey. As Taylor (2010) identified, one of the reasons for flawed counselling services emerged from the use of the term 'disability' and its negative connotations for people with different learning abilities. Providing appropriate access for sexually abused learning-disabled clients may enable specific and appropriate therapeutic techniques to emerge.

5.5.2 Education, training and resources

Another recommendation would be to work with the government to develop appropriate guidelines, new programmes and strategies for practitioners to use when working with learning-disabled clients. The role of practitioners is to treat and provide therapy for their clients in a respectful manner, without discrimination or marginalisation (Raffensperger & Miller, 2005). Taylor (2010) identified that practitioners were not willing to work with learning-disabled clients because of communication difficulties and the challenges of developing healthy patient-client connections.

Other recommendations to consider might include promoting accessible resources and cost-effective means of assisting learning-disabled clients (Nehring & Lindsey, 2016). In other words, it would be helpful to obtain international and national resources, information education, knowledge, expertise and training for practitioners based on client-centred services. Developing counselling/therapy workshops for practitioners working with or willing to work with sexually abused learning-disabled people would also be beneficial. Having background knowledge of therapeutic approaches suitable for learning-disabled clients may be a great advantage for current and future practitioners who focus on building a better life for their clients.

5.5.3 Prevention of future abuse

Keilty and Connelly (2001) identified that sexually abused learning-disabled clients feel powerless when talking about the abuse. Practitioners and caregivers also mentioned more challenges working with sexually abused learning-disabled people than non-disabled individuals. In many cases, the accusations made by sexually abused individuals with lower levels of learning-disability are ignored under the justice system (Keilty & Connelly, 2001). This is mainly for the reason that these individuals are not medically categorised to receive higher support services due to limited supporting evidence that can validate their disability. Keilty and Connelly (2001) further acknowledged that police and the justice system need training and to acquire proper skills when working with learning-disabled clients. Typical myths or assumptions about sexually abused learning-disabled clients are that they are more sexually active and that their accusations are not reliable due to their disabilities (Keilty & Connelly, 2001). When relating these assumptions to the current study, while New Zealand has a relatively sophisticated process with ACC for sexual abuse counselling, I suggest that more knowledge and further research may be needed to ensure that sexually abused learning-disabled people are well looked after.

5.5.4 Further research

There may be an urgent need for further research on the topic of practitioners' experiences working with sexually abused learning-disabled people.

A significant aspect of developing future projects could involve the replication of the current study throughout New Zealand. This may assist in recognising the magnitude of this issue and also the therapeutic approaches found useful by practitioners. Another avenue for future research involves conducting a review of educational and training programmes

for practitioners. This may assist in recognising the need for modified or tailored agendas, plans and policies that can cater to practitioners working with sexually abused learning-disabled people. Similar programmes or training within the legal, justice and policy systems about the sexual abuse of learning-disabled people may also be considered. This may eventually help to change social views towards learning disabled people.

It is evident that further research is needed in the field of disability related therapy. There is a need for contemporary and individualised treatment approaches (McGinnity, et al., 2004). In addition, methods of recognising predictors of sexual abuse may assist in preventing them from happening. Services such as 'abuse prevention education' or treatment programmes, may be highly recommended to avoid future abuses (Sobsey & Doe, 1991).

Sharing and developing knowledge may also be considered when approaching therapeutic treatment methods for sexually abused learning-disabled people. Further knowledge about psychotherapeutic methods and models, appropriate interviewing and analytical approaches towards treating learning-disabled people, and the issues that they face, may make it easier for both the psychologists and their clients while conducting the research. Although current therapeutic treatments such as CBT are used with sexually abused and learning-disabled clients, new and innovative methods of treating learning-disabled clients might be highly beneficial and different approaches could be effective. For example art, dance, instrumental music and mindfulness therapy. Moreover, sharing the personal experiences of practitioners may also be beneficial for other practitioners as these can be an important learning tool.

5.6 Conclusion

This study is an exploration of how three practitioners manage the issue of sexual abuse towards learning disabled people. I aim to create awareness of the challenges and procedural difficulties faced by practitioners and sexually abused learning-disabled people. Further, it should also be noted that the under-representation of learning-disabled people and their challenges prompted me to conduct this research.

This current study contributes to research about the therapeutic experiences of sexually abused learning-disabled people. It has the prospect of becoming part of a summarised research report for publication. A documented outcome such as this research report could stimulate the development of a set of guidelines for proper practice.

I also aim to ensure that this study progresses, with the results being further investigated and used to improve the social status of learning-disabled clients. Further involvement of the justice and health systems may be needed to ensure that the unheard voices of learning-disabled people are heard. By doing so, and with appropriate support networks, learning-disabled individuals may gain the confidence to make a stand and progress the issues.

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Appendices

Appendix I – Literature review table

Authors, year title journal etc.	Paradigm (QUAN or QUAL) Methodology and methods	Participants and sampling	Research question or hypothesis (for quant studies if they are making cause effect claims then I list the variables they measured)	Findings	Recommendations	Limitations
Hays et al (2007). Group treatment for men with intellectual disability and sexually abusive behaviour: Service user views. <i>Journal of Intellectual and Developmental Disability</i>	Qualitative Service User Semi-structured interviews	ID men with sexually abusive tendencies Purposive sampling N=16 Male participants Age: 18-65 years United Kingdom	The effects of CBT on ID men who sexually abuse others	CBT treatment highly effective Gained sexual education	Further education and collaboration in other different treatment approaches.	Not using other therapeutic approaches Cognitive and communicative difficulties when interviewing ID clients
Becker (2015) Intergrating art into group	Mixed-method	Sexually abused individuals with PTSD	Investigating the practicality of group treatment	The use of art therapy, CBT and group activities	Ways of using new or collaborative	Limited participants

treatment for adults with post-traumatic stress disorder from childhood sexual abuse: A pilot study. <i>Journal of the American Art Therapy Association</i>	Survey questionnaires Open-ended questionnaire	N=5 1 male 4 females Age: 39-58 years California, USA	that combined art therapy and CBT	showed evidence of a decrease in PTSD symptom levels and depression	methods of treating clients	Not using other therapeutic treatment methods with art therapy
Faccini and Saide (2011) Psychologists' experience with interviewing and analysing abuse allegations of adults with intellectual disabilities. <i>Sex Disability</i>	Quantitative Survey questionnaires	Psychologists That worked with ID clients N=32 Work experience range: 1-35 years New York and Long Island, USA	Exploring the manner in which psychologists train, supervise and process Intellectually Disabled (ID) sexual abuse accusations through interviewing and analysis techniques	Not all psychologists used appropriate interviewing and analysis methods of assessing ID sexual abuse cases.	More training and supervision on psychologists and their interviewing and analysis method	Limited findings on psychologists experiences
McConkey and Ryan (2001). Experiences of staff in dealing with client sexuality in services for teenagers and	Qualitative Open-ended questionnaires	Health professionals who provide support and assistance for ID individuals N=150	Lived experience of health professionals who were sexually abused by ID clients	2/3 of health professionals had received inappropriate sexual behaviour by ID clients.	Knowledge and education	Self-reported data – can restrict validity and reliability of research

adults with intellectual disability. <i>Journal of Intellectual Disability Research</i>		85% Female or 128 15% Male or 22 Northern Ireland				
Niehaus, Kruger, and Schmitz's (2013), Intellectually disabled victims of sexual abuse in the criminal justice system. <i>Psychology-Scientific Research</i>	Mixed-method - Survey questionnaires Semi-structured interviewing Quasi-experimental method Content analysis	Convenience sampling N=3059 Austria, Germany and Switzerland	To gain knowledge about the certain circumstances ID abuse victims face in the justice system Research question 1: identify what type of health professionals are involved in the criminal processes RQ 2: analyzing the literature RQ3: survey questionnaires RQ4: analyze recorded criminal processes RQ5: experiences of sexually abused ID people	It was identified that there was less literature and less knowledge on the ability of the justice system and the health professionals More reluctant to help ID people	Professional training and assistance to help ID people Education	Limited knowledge on psychologists experiences

<p>Eastgate, Scheermeyer, van Driel, and Lennox, (2010), Intellectual disability, sexuality and sexual abuse prevention: A study of family members and support workers. <i>Australian Family Physician</i></p>	<p>Qualitative Semi-structured interviews</p>	<p>Family, friends and carers of ID people</p> <p>N=28</p> <p>23 Females 5 Males</p> <p>Aged 18 years and older</p> <p>Australia</p>	<p>To obtain information about the methods of informing ID people on sexuality and prevention of sexual abuse</p>	<p>Findings showed that ID people are seen to be isolated, discouraged from building relationships and are prone to sexual abuse</p>	<p>Educating family and carers Provision of sex education for ID people</p>	<p>Lack of availability of ID people</p> <p>Limited sample size</p>
<p>Nijnatten & Heestermans, (2010), Interviewing victims of sexual abuse with an intellectual disability: A dutch single case study. <i>Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community</i></p>	<p>Qualitative Single Case-Study</p> <p>Post-event clinical analysis</p>	<p>Sexually abused ID client</p> <p>N=1 Female Aged 32 years</p> <p>Netherlands</p>	<p>To explore different methods of interviewing ID people and identify issues that health professionals face when they interview sexually abused ID people</p>	<p>Findings indicated that the three different approaches of interviewing had assisted in identifying and recognising the clients sexual abuse encounters with another ID client.</p>	<p>Professional training and assistance.</p>	<p>Interviews were transcribed in Dutch and translated into English which would have altered or limited the descriptions of what the participant had said.</p> <p>Limited sample size</p>

Hollins and Sinason (2000), Psychotherapy, learning disabilities and trauma: New perspectives. <i>British Journal of Psychiatry</i>	Not applicable	Review of therapeutic approaches	To availability of various psychotherapeutic approaches of individuals with learning disabilities and their psychological well-being	Evidence of therapeutic treatment approaches Identified lack of attachment, communication and connectivity	Provision of sexual education for learning disabled individuals More collaboration between therapeutic treatment and sexual abuse	Article not related to sexual abuse No reliable data used
Doran (2015), Working with sexual trauma. <i>Healthcare Counselling & Psychotherapy Journal</i>	Qualitative Phenomenology Interpretive	Counsellors working with sexually abused individuals N=4 England and Wales	Exploring the therapists' experiences of working with sexually abused clients	Key themes 1: environment of support for sexually abused 2: challenges faced by counsellors 3: key guidelines and coping mechanisms 4: psychological and physical strain on treating clients	Developing and sharing knowledge	Limited sample size ID people not included
Etherington (2009), Supervising helpers who work with the trauma of sexual abuse. <i>British Journal of Guidance and Counselling</i>	Reflective article of researcher's work Interactive discussion	Therapists and counsellors	Identifying supervisor's duties to teach and support counsellors and therapists who treat sexually abused individuals	Key issues found: Vicarious traumatisation and Empathic strain Counsellors and psychologists experiencing stress and depression.	Professional support and supervision Education	Use of self- reported data can create unreliability

Little and Hamby (1999), Gender differences in sexual abuse outcomes and recovery experiences: A survey of therapist - survivors. <i>Professional Psychology: Research and Practice</i>	Mixed-method Survey questionnaires Open-ended questionnaires	Therapists who were sexually abused N=131 71% Female or 93 29% Male or 38 Average Age: 31-50years Vermont, USA	To understand the gender differences between the men and women therapists who had been sexually abused as children How they coped with the abuse How they were able to effectively treat others with similar experiences	No substantial evidence of gender differences Female therapists/counsellors had a more harmful impact from the abuse than male therapists Females had better recovery than men	Additional supervision and support for sexually abused therapists Gender-related therapeutic techniques	Limited research on gender related differences
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Table 2: Literature review summation

Appendix II - E-mail to counselling services/organization newsletter webpages.



To whom it may concern,

My name is Snehaa Chand and I am studying at Auckland University of Technology as a Public Health Masters student. I am currently conducting a thesis paper on ‘Counsellors experiences of working with sexually abused Learning Disabled (LD) people’. This is a qualitative exploratory study design.

To conduct this study, I would like to interview counsellors (this may also include therapists’, psychologists’ and psychotherapists’) who have experience in working with sexually abused learning-disabled people, within the Auckland region. This is a very sensitive topic to discuss and your involvement would be highly appreciated. It is hoped that the study results will assist those who work with this vulnerable population. Being a disabled person myself, I am very passionate about finding out the level of support and facilities that may be available for disabled people and the issues they face.

Counsellor/s/psychologists/psychotherapists who are interested in this study, can contact me via e-mail – chand_snehaa@hotmail.com or via mobile phone 0211774991.

Further detailed information on this research study can be obtained after the first initial contact is made with the counsellor. Next, a Participant Information Sheet and a Consent Form will to given to initiate the interview process.

Any additional enquires can be made with the above e-mail and mobile phone number.

Kind Regards,

Snehaa Chand

Appendix III – Participant Information Sheet



Date Information Sheet Produced:

25/06/15

Project Title

Counsellors' experiences of working with learning-disabled people who have been sexually abused – A thematic analysis

An Invitation

My name is Snehaa Chand and I am studying at Auckland University of Technology as a Public Health Masters student. As part of my Master's degree, I am carrying out a study which investigates counsellors' experiences of working with learning-disabled people who have been sexually abused.

I would like to invite counsellors' (including therapists, psychologists and psychotherapists') practicing in the Auckland region and who have experience in working with sexually abused clients who have a learning disability to take part in my study.

What is the purpose of this research?

The incidence of sexual abuse of learning-disabled people is high both internationally and here in New Zealand. Counselling from qualified therapists can help victims of sexual abuse, however, little is known about counsellor's experiences of working with people who have a learning disability. Therefore the purpose of the study is to find out what are the experiences and issues for counsellors when working with this group of clients.

The study will help me complete my Masters in Public Health degree. The findings from my study may also be presented at a conference and published in one or more journals.

The findings may also assist in facilitating best practice when working with sexually abused clients who have a learning disability.

How was I identified and why am I being invited to participate in this research?

I have advertised the study on the New Zealand Psychological Society and New Zealand Association of Counsellors websites. I have also drawn on the ACC public website's list of registered sexual abuse counsellors to advertise my study.

You have responded to one of these approaches and are being invited to participate as you are a registered counsellor/therapist/psychologist practicing in the Auckland region, and have experience in working with sexually abused people who have a learning disability.

What will happen in this research?

If you decide to participate in this research study, you will be asked to take part in an interview with me at a place chosen by you.

The interview may be done at your workplace, your home or in an Auckland University of Technology booked room. The dates and times of the interview will be discussed with you as to when is most suitable to you.

During the interview, I will ask you to talk about your experiences of working with people who have a learning disability and have been sexually abused. I will; ask you to talk about your experiences, the practice methods you used and the challenges that you may have faced. This information will be used as data for my thesis.

An approximate interview time would take up to one to one and half hours and you would need to sign a Consent Form before the interview commences.

With your permission, the interviews will be audio recorded and these will be transcribed verbatim. Transcription of the interview will be done either by me or a professional transcriber who has signed a Confidentiality Agreement form. You will be sent a copy of the transcribed interview and the final report if you choose.

What are the discomforts and risks?

As this is a sensitive topic, you may experience some discomfort when recalling such experiences, discussing your clients' issues and identifying and ensuring that your clients' needs were met.

Should you choose to be interviewed at your workplace, there may be the possibility that your involvement in the study could become known, particularly if you work in a shared office setting or in an institution.

How will these discomforts and risks be alleviated?

Where the interview takes place is your choice. During the interview you can choose not to answer some of the questions. At any time during the interview, you can request a break or ask for the recording to be stopped. You can also discontinue the interview. You also have the right to withdraw from the study up until the analysis stage begins.

At the beginning of the interview you will be asked to give a pseudonym by which you will be known in the study. Any information that might identify you or your clients will be removed from the transcript, for example, names and place names. We will also ensure that your employers will not know of your participation in this research.

You can choose to receive a copy of the interview transcript and ask to remove certain sections of the data.

Should you experience significant distress or discomfort as a result of the interview, please seek the appropriate advice from your professional supervisor.

What are the benefits?

One benefit of taking part is that you may enjoy the opportunity to reflect on and talk about your work and your experiences of working with learning-disabled people. It is hoped that the findings of the study will help in recognising the issues that counsellors/therapists/psychologists' face when working with ID people who have been sexually abused. The study's finding might help to identify how counselling practice and service could help ID people. This may then influence counselling practice and treatment techniques in the future.

Furthermore, the findings and outcomes may also provide a basis for future research.

How will my privacy be protected?

All/any information provided by you, will be discussed in strict confidentiality. That is, your name will not be used during the interview process. Your client's name and contact details will not be required. The transcriber employed to transcribe this interview will be required to sign a Confidentiality Form.

What are the costs of participating in this research?

Time is the main cost for you if you choose to take part. This will include the length of the interview process which will take up to 1 and a half hours. Should you choose to come to AUT for the interview, there would be the travelling cost of going to and from the interview location. I highly appreciate your time and acknowledge that you would voluntarily participate in this study. I will provide tea and coffee during the interview.

What opportunity do I have to consider this invitation?

After three weeks of sending you this Participant Information Sheet, if I have not heard from you, I will contact you to find out if you are still willing or not, to participate in this study.

How do I agree to participate in this research?

If you have any questions please do not hesitate to contact me, or if you prefer one of my supervisors – see our contact details below.

If you decide to take part in this study, please contact me either by email or phone – see my contact details below. I will then work out with you a time and place for the interview. I will contact you the day before the interview to make sure that this is still convenient for you. Before we start the interview I will ask you to sign a Consent Form.

Will I receive feedback on the results of this research?

You can receive feedback on the results of this research if you tick the box on the Consent Form that asks if you would like a copy of the research findings. A copy of the report will be e-mailed to you.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Assoc Prof Deborah Payne, dpayne@aut.ac.nz; Ph. 09 921 9999 ext. 7112

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Snehaa Chand: chand_snehaa@hotmail.com; Ph. 021 177 4991

Project Supervisor Contact Details:

Primary Supervisor- Assoc Prof Deborah Payne: dpayne@aut.ac.nz; Ph. 09 921 9999 ext. 7112

Secondary Supervisor- Dr Jacqueline Feather: jackie.feather@aut.ac.nz; Ph. 09 921 9999 ext. 7693

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC
Reference number *type the reference number*.

Appendix IV – Research Safety Protocol

Researcher Safety Protocol 1

Name of Interviewee: XXX

Phone Number of the Interviewee:

Address of the interview location:

Date of the interview:

Interview Time Starts:

Interview Time Ends:

Interview Duration: 1 hour

A confirmation process phone call will be made to the Primary and the Secondary Supervisors as the data collection and interview is being done at the interviewee's home. The confirmation process phone call will take place before and after the interviews to ensure the safety of the Primary Researcher.

Appendix V – Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: Counsellors' experiences of working with learning-disabled people who have been sexually abused.

Project Supervisor: Primary Supervisor Assoc Prof Deborah Payne, Secondary Supervisor Dr Jacqueline Feather

Researcher: Snehaa Chand

- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):

Email:

Date:

Project Supervisor's Contact Details (if appropriate):

Primary Supervisor- Assoc Prof Deborah Payne: dpayne@aut.ac.nz; Ph. 09 921 9999 ext. 7112

Secondary Supervisor- Dr Jacqueline Feather: jackie.feather@aut.ac.nz; Ph. 09 921 9999 ext. 7693

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number*

Note: The Transcriber should retain a copy of this form.

Appendix VI - AUT Health Counselling and Wellbeing support



MEMORANDUM

To Snehaa Chand
 CC
 FROM Stella McFarlane
 SUBJECT AUT Counselling services for research participants
 DATE 12.8.2015

Dear Snehaa

As manager of AUT Health Counselling and Wellbeing, I would like to confirm that we are able to offer confidential counselling support for the participants in your AUT research project entitled:

'Counsellors'/Therapists'/Psychologists' experiences of working with sexually abused Intellectually Disabled (ID) people'

The free counselling, for participants who require it, will be provided by our professional counsellors for a maximum of three sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and counselling on our website http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Current AUT students also have access to our counsellors and online counselling as part of our normal service delivery.

Yours sincerely

Stella McFarlane
 Manager
 Health, Counselling and Wellbeing

From the desk of Stella McFarlane

Health, Counselling and Wellbeing
 Private Bag 92006, Auckland 1010
 Main Entrance, 55 Wellesley Street, Auckland.

Tel: 09 921 9999 ext 8193

Appendix VII - Interview Guide

What are the counsellors' experiences when working with learning-disabled people who have been sexually abused?

Indicative Questions:

Opening question: Tell me about your experiences of working with people with learning disability

1. What challenges do you face when working with learning-disabled people who have experienced sexual abuse?
2. How do you deal with these challenges?
3. What types or levels of disabilities do your clients (learning-disabled people) have?
4. How were your clients (learning-disabled people) able to access the counselling services that you provide?
5. What stages do your clients (learning-disabled people) go through when asking for or requiring counselling?
6. What therapeutic approaches do you use
7. What would that involve?
8. What type of training or support do you get?
9. Are there any other approaches that can be used?
10. What do you experience when working with learning-disabled people?
11. Has their treatment process impacted on your wellbeing in any way?
12. Any other issues that you may or have faced?
13. What new and/or useful practice methods do you use when working with your clients (learning-disabled people)?
14. Are there any recommendations for other counsellors who may face similar issues or experiences as you?
15. Are/is there anything else that you think we have not covered?

How the data will be recorded?

Audiotape will be used to record the interviews. Each interview would possibly take one to one and a half hours.

Appendix VIII - Auckland University of Technology Ethics

Committee (AUTEC) application 15/233

27 August 2015

Deborah Payne
Faculty of Health and Environmental Sciences

Dear Deborah

Re Ethics Application: **15/233 Counsellors' experiences of working with learning-disable people who have been sexually abused: A thematic analysis.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 26 August 2018.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 26 August 2018;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 26 August 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Snehaa Chand, chand_snehaa@hotmail.com, Jacqueline Feather

Appendix IX- AUTECH Consent form

Consent Form



Project title: Counsellors' experiences when working with learning-disabled people who have been sexually abused.

Project Supervisor: Primary Supervisor Assoc Prof Deborah Payne, Secondary Supervisor Dr Jacqueline Feather

Researcher: Snehaa Chand

- I have read and understood the information provided about this research project in the Information Sheet dated 25/06/2015.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes No

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

.....

.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on **type the date on which the final approval was granted** AUTEK Reference number **type the AUTEK reference number**

Note: The Participant should retain a copy of this form.

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Student ID No	0948731	Name	Snehaa Chand	
Faculty	Health and Environmental Sciences	School/Dept	Centre for Midwifery & Women's Health Research/School of Clinical Sciences	
Programme	Master's in Public Health	Year of submission (for examination)	2017	
Research Output	Thesis <input checked="" type="checkbox"/>	Exegesis <input type="checkbox"/>	Dissertation <input type="checkbox"/>	Points Value 240
Thesis Title	Counsellors' experiences of working with learning disabled people who have been sexually abused: A thematic analysis			

DECLARATION

I hereby deposit a print and digital copy of my thesis/exegesis with the Auckland University of Technology Library. I confirm that any changes required by the examiners have been carried out to the satisfaction of my primary supervisor and that the content of the digital copy corresponds exactly to the content of the print copy in its entirety.

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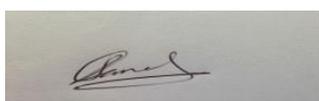
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Student's Signature



Date 16/08/17