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**Helpless Helpers: primary care therapist self-efficacy working with intimate partner
violence and aging women**

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Abstract

Purpose: To explore primary care psychological therapists' experiences of working with midlife and older women presenting with intimate partner violence and develop a theoretical framework using a grounded theory approach to identify the experiences of those practitioners working with this phenomenon.

Methodology: Interviews with 17 practitioners were conducted. The data analysis was informed by a grounded theory approach, which requires three states of data coding: open, axial and selective. Data codes were thematically sorted into causal, contextual, strategic, intervening, interactional and consequential conditions.

Findings: A core state of therapist *helplessness* was uncovered. The framework demonstrates that psychological therapists doubt their ability to work meaningfully with women over 45 experiencing IPV. To avoid the core state of helplessness therapists use strategies such as avoiding asking questions about partner violence, making assumptions of how patients interpret their own experiences, addressing symptoms rather than the root cause, and going above and beyond in attempts to rescue patients. The consequence of therapists' helplessness often results in burnout.

Implications: The framework identifies barriers in working effectively with intimate partner violence and women in the mid to older aged populations.

Originality/Value: This study is the first to suggest a framework that is grounded in practitioner experience with the capability to transfer to a range of professionals working with mid to older aged women such as forensic, medical and specialist psychologists.

Keywords: older adults, intimate partner violence, IAPT, psychological therapies, self-efficacy, confidence, domestic violence

Introduction

Intimate partner violence (IPV) is a societal issue that is not bound by age, gender, race or culture. It includes physical, emotional, sexual, financial, and controlling abuse within current and previous relationships across the lifespan (WHO, 2012). UK statistics report that 1.3 million women disclosed IPV related offences from 2014 to 2015 (Woodhouse & Dempsey, 2016). However, the full extent of this crime is still unknown and many incidents go under-reported. Furthermore, statistics within England and Wales fail to collect data from those over 59, thus the true incidence of IPV in later life is difficult to determine (Womens Aid, 2016).

There is a variance in the literature to the thresholds that define 'older' in reference to IPV with ages ranging from 45 to 65+ years of age (for varying definitions see Beaulaurier et al., 2008; Daly et al., 2007; Fisher & Regan, 2006; Lundy & Grossman, 2009; Montminy, 2005; Mouton, 2003 Rennison & Rand, 2003). However, only focusing on those who are 65+ as older misses a cohort of mid-life and aging women who fall between the categories of younger and older. Therefore 'midlife and older' in the present study is defined as women who are 45 and over which is in line with literature that has identified differences in the impact and forms of abuse (Seff et al., 2008; Wilke & Vinton, 2005) and barriers to seeking help (Beaulaurier et al., 2005) when comparing younger women to those who are over 45.

Long-term physical and psychological abuse has a number of negative effects on wellbeing such as increased risk of depression, anxiety (Lazenbatt et al., 2013; McGarry, Simpson & Hincliff-Simth, 2011) and suicide (McGarry & Simpson, 2011). Women in mid to later life were reportedly reluctant to disclose offences to the police or to seek support through specialist domestic violence services; preferring to turn to their doctors' surgery and other primary care facilities for help (Lazenbatt et al., 2013; Vinton, 2003). While clinical

and health care professionals are in a unique position to recognise signs of IPV, Carthy and Holt (2016) argue that they are not always equipped to do so and that it is important that all practitioners working with midlife and older women can effectively recognise the signs of IPV to safeguard and support women a time when they are at their most vulnerable.

Professionals within both national and international primary and secondary care systems have reported a lack of confidence in screening for and successfully treating IPV across the lifespan (Bonomi et al., 2007; Coker et al., 2002; Lutembacher et al., 2003; Elliott et al., 2002; Penhale & Porritt, 2010). Furthermore, in a sample of community health practitioners Rose et al. (2010) identified a reluctance to discuss IPV within the boundaries of their roles and a fear of causing offence in asking direct IPV related questions. In the UK, Penhale and Porritt (2010) found that presentations of low mood or worry stemming from ongoing abuse were medicalized and managed through onward referrals targeting depression and anxiety, rather than the IPV.

The literature relating to practitioner experiences in working both with IPV and with women in mid to later life is dominated by quantitative studies (Roberto et al, 2013; Bonomi et al, 2007; Mouton, 2003). Although quantitative methods are useful in identifying generalizations and their impact, the consequences of these generalizations on practice are difficult to establish using quantitative methods (Toomela, 2010). It is important to account for experiences within practice to accurately inform intervention and training programmes that will improve detection, assessment, and treatment when working with IPV later in the lifespan. Furthermore, the qualitative studies that are available within the UK focus on voluntary and statutory service responses and not on mental health workers in primary care. There is a current gap in knowledge that explores how front-line mental health professionals experience and manage mid to late life IPV during their practice (Penhale & Porritt, 2010). This is a critical in the literature as mental health issues often develop as a result of IPV, yet

IPV is commonly overlooked in clinical settings (Usta & Taleb, 2014). Professionals may refer women to PCMH services to treat the mental health problems rather than exploring if IPV could be part of the cause. Currently there is a lack of a theoretical framework to support experiences of PCMH staff working with patients that disclose IPV in the aging population (Roberto et al., 2013).

Social Cognitive Theory (Bandura, 1994) may provide a psychological framework for understanding practitioner experiences of working with older women and IPV. SCT purports that individuals tend to engage with tasks they believe can be accomplished and avoid tasks associated with failure. Appraising potential success depends on the amount of mastery experiences a person already holds. For practitioners this can be achieved through direct training (theoretical mastery) or successful therapeutic outcomes (experiential mastery). SCT provides a strong psychological framework to develop a credible understanding of the accounts of behaviours disclosed by participants, which Braun and Clarke (2006) argue, will strengthen the interpretive aspects of qualitative research.

Primary care mental health services (PCMH) in England and Wales currently operate under the improving access to psychological therapy (IAPT) initiative. IAPT offers short-term therapy for mental health disorders experienced across the lifespan, such as anxiety and depression (Kendrick & Pilling, 2012). PCMH typically employ cognitive behavioural therapists, counsellors of varied therapeutic approaches and psychological wellbeing practitioners who deliver guided self-help using CBT approaches. Currently no literature exists which accounts for the experiences of PCMH practitioners working with mid-life and older women and IPV. This cohort of women are often referred to PCMH services for low mood and anxiety, rather than an IPV presentation. Therefore it is important to explore potential blocks or facilitators to practice within PCMH services.

The aim of this study is to address the gap in literature concerning the key conditions PCMH therapists experience when working with women over the age of 45 presenting with IPV, the impact of those conditions on therapists' perceived abilities to practice, and to ground workers' experiences to a psychological framework to identify future directions for policy and practice.

Research Question

What experiences do primary care mental health workers report when working with intimate partner violence and women in mid to later life, and how do those experiences block or facilitate their practice?

Method

Data

Practitioners were recruited using a purposive sampling strategy. Each participant was required to be a mental health worker who had worked therapeutically with a female patient aged over 45.

The definition for women in mid to later life was defined as those age 45 and above. The rationale for setting the definition of 'mid to later life' at 45 was in line with Wilke and Vinton's (2005) work which argues that the age of 45 is a critical point where refuge seeking at specialist IPV services rapidly declines. Participants were recruited from services in the North of England.

Seventeen practitioners took part in the study. The sample included counsellors (n = 8), psychological wellbeing practitioners (n = 4) and CBT therapists (n = 5). One participant was excluded based on the inability to preserve their anonymity. The remaining sixteen

participants all identified as female and were aged between 25 and 59 with a mean age of 36. Years of experience ranged from 1 to 20 years with a mean of 6.8 years. All participants stated that they had received no specific training regarding IPV and women in mid to later life. The interviews lasted between 27 and 65 minutes. The total amount of data collected was 12 hours and 49 minutes.

Procedure and ethics

Ethics was approved by the lead authors' University Ethics Committee and permission was sought and approved from each service taking part. Participants gave informed consent before taking part in a face-to-face interview. The interview schedule began with the core question "What experiences do you have of working with older women experiencing domestic violence?" which was addressed to every participant. Participants were invited, where necessary, to self-select a particular experience to reflect upon. The interview schedule followed with open questions to gather practitioner experiences of working with women over 45 in therapy, the difficulties and successes of therapists when working with IPV in mid to later life patients, and the strategies therapists employed as a result of their learning from experiences. In line with a grounded approach, the interview schedule evolved over the course of data collection based on earlier participants' responses. Extensive memos and file notes were taken at the time of the interviews to facilitate new lines of enquiry and to clarify information at the close of each interview. Interviews were audio recorded and transcribed verbatim.

To maintain confidentiality participants were assigned pseudonyms. Identifying information participants disclosed about themselves, those they worked with or their places of employment were removed from transcripts. To mitigate against distress participants were

assured prior to interview that they could stop recording at any time, decline to answer questions and were provided with withdrawal information during the debrief.

Analysis

The Straussian method of grounded theory was applied and considered the best approach to assist in drawing out a theoretical framework as a starting point to account for the target phenomenon. The principles of this approach focus on experiences that are formed through responding to causal and consequential processes of behaviour (Corbin & Strauss, 2008). This method offers a systematic method of analysis which produces categories of data that are coded for causal, contextual, strategic, intervening, interactional, and consequential conditions of the target phenomenon. Thus exploring the ‘why and the how’ participants work with older women and IPV

The data moved through open, axial, and selective coding stages as set out by Corbin and Strauss (2008). During open coding transcripts were screened for early categories of information that linked to each other, thus determining theoretical saturation which occurred at interview sixteen with no new lines of enquiry emerging at this stage of data collection. During axial coding the initial codes generated from transcripts were compared against one another for recurring themes. This was performed using the constant comparison technique which Corbin and Strauss define as a process of integrating substantial amounts of open codes into meaningful concepts. This stage uncovered prominent blocks of information that developed into abstract conceptual categories that presented across the interviews. The remaining categories were analyzed for relationships between each other. Finally, during the selective coding process, categories that emerged from the axial process were analyzed to identify a central category that underpinned all other categories and was consistent with the central narrative of the phenomenon.

Rigour

Credibility was met through the field researcher engaging fully in the reflexive process of memo writing for each interview and a final reflexive account. Dependability was met through a transparent open coding process for each transcript, creating individual case summaries and a final framework matrix of all sixteen participants. Providing an audit trail of transcripts and coding paradigms meant analyses by other researchers could be carried out to test the resulting theory. Two researchers were involved in validating the final framework and subsequent themes. Confirmability was accomplished by underpinning the resultant framework with psychological theory, with transferability of the results being applicable in their reach to professions outside of psychological and medical fields.

The Framework of Helpless Helpers

The framework is presented in figure 1. The core category of helplessness is explained via underlying themes within the contextual and causal conditions along with intervening conditions blocking or aiding therapists' abilities to strategize during their practice. The strategies put in place to resolve helplessness and the consequences of those approaches are also discussed. The participants responded to the core question of "What experiences do you have of working with older women experiencing domestic violence?" The quotes that are used to support the framework reflect those experiences as described by the participants.

INSERT FIGURE 1 ABOUT HERE

Contextual Conditions

Hidden referrals. The journey of helplessness began at the initial referral, as patients' previous experiences of IPV were unknown to the therapists. Patients are often referred to

PCMH by GPs for low mood, bereavement and anxiety. Underlying causes of those mental health issues such as IPV are not routinely screened for before the initial therapy session. This resulted in therapists being unprepared for patients identifying as being in their mid to later life presenting with severe cases of IPV.

“...When something looks on paper or at first assessment to be quite mild, and then in a room with someone it’s not mild at all, it’s very severe, that’s when it gets overwhelming...”
(Naomi)

The sense of therapist helplessness at this stage emerged from pressure to contain a lack of preparation with the added responsibility to manage the expectations of the patient and the referring GP.

Presentation severity. During therapy patients reported a range of violations perpetrated by their partners including financial, psychological, physical and sexual abuse. The participants questioned their own therapeutic ability on hearing these narratives from their patients.

“...I come out and think ‘What can we do with this?’ This person could potentially be killed because she’s in a position of risk...” (Kris)

“...What’s the point doing therapy with somebody when they’re going home, lying on the settee living in constant fear? You can’t do therapy when somebody’s living like that...”
(Teri).

Therapists reported that balancing therapeutic work, managing risky patients, and accepting the likelihood of patients staying in abusive relationships negatively impacted on their confidence to work effectively.

Practitioner experience. Despite participants describing previous adult safeguarding training covering elder abuse and in some cases IPV training, they all confirmed that they had received no specific training or guidance in working with mid-life to older women with IPV. With no clear account from the referral and a lack of training to draw on, therapists reported using coping strategies that were drawn from previous therapeutic experiences, rather than from concrete training or experiences with similarly aged patients to guide the work.

“...There’s no set ‘right I’m gonna do this, this and this with each patient’ its all very much based on my past experience and what has or hasn’t worked with others...” (Tasha)

Therapists also reported using tenuous sources to help with gaps in their knowledge such as information obtained from internet searches.

“...I had up ‘what is domestic violence’ on my computer as I was doing it cos I didn’t really have a clue and I wanted to make sure I was asking the right questions...” (Lara)

Participants described feeling unable to act in the right way and ask the correct questions due to having no prior training or concrete experiences to draw on, further supporting the core condition of helplessness.

Causal Conditions

Perceived incompetence. Therapists believed they were unable to work effectively with women in mid to later life disclosing IPV due to their lack of training and perceived inexperience of this phenomenon.

“...What it is that makes me feel incompetent? lack of knowledge...” (Georgina)

Therapists reported entering a cycle of feeling stuck between asking bad questions and causing offence or asking good questions and coming to a dead-end through not having the

knowledge to act on the response. The core category of helplessness was further triggered by therapists' perceived incompetence directly affecting their own emotional state.

Emotional state. Therapists described a strong feeling of anger towards the perpetrator when hearing disclosures of IPV.

"...The anger was around that 'that isn't right', I could hear what she was experiencing and for me it struck a chord as in that's not ethical, that's not right, that's not how you should be treated..." (Cadance)

Strong emotive responses described by the participants reflected their concern towards their patient's safety between sessions. Some therapists reported anger and frustration at the patient for continuing to return to the abusive relationship, despite acknowledging the unique financial and societal circumstances women in mid to later life face with IPV.

"...It keeps them unsafe, keeps them at risk or keeps them unhealthy, being around that is a challenge not only from the rescue point of view but from the sadness, that people will not see any other option than to be there..." (Jenny)

Emotional states were used as moral barometers by the therapists which resulted in the therapy session becoming informed by the therapists own emotions. Therapists reported high states of emotion; both in their responses to the patients' presentation and to their own perceived incompetence to help. The increasing severity of the patient's psychological and physical risk of harm also underpinned the therapists' key experience of helplessness.

Core Category

Helplessness. In the framework helplessness is defined as an absence of hope amongst participants in their confidence to work appropriately with women disclosing IPV. This is supported by the therapists' belief that the intervention offered would not have a positive

impact on the patient. Therapists defined a positive impact as the patient leaving the abusive relationship. One participant spoke of her wish to ‘fix’ a patient despite stating that she had no idea how to help.

“...If you’re a therapist you want to fix someone. If somebody talks about something that you have no idea about, it makes you feel helpless because you feel like you can’t do anything to help them...” (Georgina)

Therapists described feelings of helplessness that fated them in feeling out of control during the sessions which led some to question their ability to help their patient.

Strategies

Assume. Without concrete information to guide their practice, therapists described making assumptions of how women over 45 would interpret their abuse. Notably, age differences among the therapists determined the type of assumption made. Therapists over 45 years assumed midlife and older women would be less likely to disclose IPV due to having the belief of ‘putting up and shutting up’.

“...They’ve had the same education which is ‘you put up and shut up and get on with it, that’s what men do.’ If you wanna be safe you’re with the man, the man provides and you do what you’re told...” (Ora)

In contrast their younger counter-parts made assumptions about female patients in mid to later life being less likely to disclose due to the therapists’ relative age; assuming patients would be more forthcoming with older therapists. In explaining their rationales, therapists reported drawing on how women in mid to later life were seen in the media to make up for their lack of concrete experiences. The process of assuming resulted in therapists using uncorroborated evaluations of patients to influence their therapeutic strategies.

Avoid. Therapists reported trying to avoid asking questions during sessions that would relate to disclosures of IPV.

“...I didn’t even approach it, but I think its my confidence and my fear in that if I do bring it up then am I not going to be able to contain it?...” (Abigail)

This strategy allowed therapists to avoid approaching IPV, even if it was disclosed, which helped maintain their own self-confidence by avoiding feelings of helplessness; allowing them to continue with their agenda for the session. Furthermore, some therapists avoided questions about IPV to bypass the reportedly frustrating process of forwarding psychological abuse to outside teams such as social services and police, only for these referrals to be passed back for failing to meet the threshold for social care assessment or for police intervention:

“...You think ‘this is gonna be a hard frustrating process’ which is what puts you off when you hear something low level and you think ‘oh that could be left’ when maybe you shouldn’t...” (Ellie)

Treat the symptoms. Therapists reported working at a symptom level to help with the anxiety and low self-esteem expressed by their patients. Treating the symptoms instead of the root causes of the symptoms gave therapists hope for something to focus on in the ‘dreariness and drudgery’ of this specific work.

“...In a way that helps with the dreariness and drudgery of the background, here are things that these women can begin to do, that will, although it may only have a very tiny one, begin to have an impact. That gives me something to hang onto...” (Jenny)

In the short-term this approach gave therapists hope that their therapeutic interventions were making a difference. However, many therapists acknowledged that only treating the symptoms did little to deal with the IPV which was often the root cause.

“...You work at this at a sort of symptom level, if you want to create change you have to go to another level but be prepared for a longer term piece of work...” (Teri)

Refer to others. Therapists reported trying to seek longer-term solutions for patients by referring to specialist IPV services. This approach prevented therapists from becoming overwhelmed with the circumstances of their patients.

“...If someone else is gonna do something that’ll benefit them more and could also stop me feeling completely out of my depth and overwhelmed that’s the best outcome for both of us...” (Naomi)

CBT therapists described referring the patient to another service as the best outcome.

However, for counsellors there was a reluctance to refer on as this would often deny them the positive experience of seeing patients progress through the therapeutic process.

“...I might have to, reluctantly on my part, because I want to see them from beginning to end, is refer them on to another service that can offer long term support...” (Tasha)

Rescue. Therapists would try to ‘rescue’ patients by going above and beyond their normal role both during and out of sessions. This ranged from calling patients from withheld numbers to limit suspicion from perpetrators to working on days off.

“...I used to go home and be in tears worried that people were at risk and I should do more and I used to go out of my way, I’d be going in on my days off...” (Zoe)

Rescuing gave therapists relief in the short term especially if they came up against conflict from patients in mid to later life to participate in the strategies they believed would improve their quality of life.

“...The rescuer comes out in me, wanting to make their lives better but again, something that’s not gonna happen...” (Jenny)

Rescuing resulted in therapists assuming sole responsibility for their patients’ well-being in an attempt to restore their own self-belief. As a result, therapists described feeling like they were placed in positions that they would not have normally allowed. This was often beyond the remit of their therapeutic practice.

Break the rules. Primarily, therapists gave themselves more time with patients in order to begin to address the IPV by breaking the rules.

“...There’s no flexibility to it, well there is, but only if you break the rules...” (Jill)

Breaking the rules included working on days off or adding on extra sessions. Therapists assumed these were practices not viewed favorably in the wider organizational context of IAPT. However, the benefit of getting a positive outcome with patients was worthy of the cost of being disciplined.

“...I’d rather get into trouble. It goes against the grain of what I ever come into the job for...” (Daphne)

Of all the strategies, breaking the rules was reported to fit best with therapists’ occupational oaths to protect patients against harm and for them justified the use of this strategy.

Intervening Conditions

Facilitator: Supervision. Talking through difficult cases with senior clinicians in a supervised environment helped therapists gain confidence in their therapeutic abilities and in the interventions they were implementing.

“...Having time set aside for supervision, even just to offload, get that off your chest and for somebody to give you direction in where you should go...” (Lara)

Supervision helped therapists build their knowledge base, helped to correct prior assumptions made in therapists’ earlier cognitive processes and work together to address the transition of existing IPV knowledge to practice given the gaps with women over 45. The use of supervision therefore helped with limiting the potential impacts of using previous assumptions.

Facilitator: Hope for a happy ending. The hope that talking therapies would result in women in mid to later life escaping IPV was a powerful driver that spurred therapists on to implement different strategies. The hope for a happy ending continued even when patients repeated cycles of terminating and then returning to therapy.

“...I was hoping, because she’d come then gone then found the strength to come back, that this might be the time to look at this and leave that life behind...” (Tasha)

Therapists described hope as a driver for both their strategies to rescue and strategies to avoid referring patients on for longer-term work.

Block: Time limits. All therapists described time as a block in working with women in mid to later life disclosing IPV. Limitations on the amount and duration of therapy sessions influenced what therapists believed could be realistically accomplished with patients. Lack of time was reported to reduce ability to build rapport with older women and restricted the level of depth explored in sessions. Thus increasing therapists’ negative emotional states and feelings of incompetence.

“...Six to eight sessions, it’s ridiculous. How can you build self-esteem up or deal with trauma, give someone the confidence to carry on what they’re doing or leave in six sessions? It’s bizarre...” (Ora)

The implications of time limits forced therapists to ethically question their positions within PCMH: a framework that advocates short-term therapy. In presentations as embedded as IPV in older populations, the limitations on therapists’ time and amount of sessions to spend with the patient intensified the core category of therapeutic helplessness. Participants described short-term therapy as unsuitable for women in mid to later life disclosing IPV.

“...No the sessions you have aren’t suitable, it’s not suitable for anybody. Its unethical to go to someone ‘I’m gonna help you’ and you’re sitting in front of someone and you’re thinking ‘oh man, you’ve had this for twenty odd years and we’re offering you this and really we’re not gonna’...” (Daphne)

Block: Conflict. Participants reported sharing disclosures of risk with outside agencies like social services or the police often resulted in patients becoming defensive and threatening. Threats included the patient leaving therapy if the therapist told anyone else about the abuse.

“...I said ‘if you’re at risk I might have to inform people’ and she said ‘if you do that then I’m not gonna engage in this therapy...” (Lara)

In such cases therapists felt an accelerated state of powerlessness to help, particularly when the patient was imminently at risk of physical danger by the abuser. Often therapists believed that patients minimized their experience of the abuse when suggestions to change circumstances were made.

“... 'This is it, this is as good as its' gonna get', 'oh it's not so bad now, it's now just verbal'. They minimize what's happening, there's lots of fear attached to making changes...” (Kris)

Therapists reported tension between maintaining their professional responsibility to ‘do no harm’ and acknowledging their patients fears and respecting their confidentiality after disclosures of IPV.

Consequences

Burnout and vicarious traumatization. The final part of the framework reflects on the consequences of the strategies: assuming, rescuing, and avoidance on the core category of helplessness. Burnout relates to emotional exhaustion, which is experienced from the limited support a therapist can offer to neutralize the distress of their aging patients.

“...That's what we do all the time, is hold that balance and I think there's an effect, I think that's what can lead to burnout and traumatization, probably burnout more than anything because you can't do what you know you could do...” (Jill)

As a consequence of prolonged therapeutic helplessness some therapists developed a disassociation to subsequent disclosures of IPV in mid to later life. Additionally, as some descriptions of abuse to older women were ‘so outside any realm of understanding’ therapists reported physical somatizations of their emotional states.

“...The things that they tell me, it hurts my ears to hear because it's so outside any realm of understanding where you think a human being could treat another human being in that way...” (Kris)

For some, details of the abuse suffered by their patients permeated their thoughts long after the sessions.

“...If somebody tells me something, I have my own image of that, and that’s real difficult to get rid of because it’s in there. I think the experiences we have could easily become vicarious trauma...” (Tasha)

Obtaining the desired outcome of mid-to older aged patient leaving the abusive relationship permitted against symptoms of burnout and vicarious traumatization. However, when this was not achieved the positive opportunity was lost. Therapists reported cycling through the strategies of avoiding IPV related questions, assuming that women in mid to later life wouldn’t want to discuss abuse, treating the symptoms of anxiety and low mood, referring to others or attempting to rescue the patient. These strategies resulted in therapists entering their own cycle of helplessness, thus reporting symptoms of burn out due to the lack of positive experiences with this patient group.

Discussion

The aim of the study was to explore the key conditions that PCMH therapists experienced when working with IPV and women in mid to later life and it was successful in doing so. The use of a grounded theory approach uncovered a theoretical framework of ‘therapeutic helplessness’. Factors that contributed to the core state of helplessness included internal barriers perceived by therapists, outward systemic barriers in terms of time constraints posed by services and reluctances from patients to leave their abusers. This framework is the first to provide a psychological underpinning to account for frontline PCMH clinician experiences working with women older than 45 who present with IPV during therapy. The findings suggest a relationship between internal difficulties with self-efficacy and systemic constraints resulting in the use of strategies that go beyond the remit of their working practice. Furthermore, failure to obtain positive outcomes with patients often

produced a negative impact on the therapist believing they could work positively with future patients of similar ages with similar presentations.

The structure of helplessness within the framework can be explained with Bandura's (1994) SCT, in particular the behavioural mastery and self-efficacy components. In the case of PCMH staff, mastery happens when the patient outcome is deemed successful. For women over 45 that presented with IPV this included securing a happy ending for a patient via them leaving an abusive relationship. Victims of IPV can take multiple attempts to leave their abusers and during help seeking or leaving the abuser is when women are most vulnerable to serious violence or domestic homicide (Brandl, 2002). With additional barriers preventing theoretical and behavioral mastery, such as being unable to gain concrete training on mid to later life IPV, working under time constraints and working with incomplete referrals, therapists set themselves unattainable benchmarks to obtain mastery with this patient group. Whilst the participants touched on in interview some of the reasons why mid-life and older women may refuse to leave a perpetrator (losing financial stability, losing family members and loss of identity) it is noted that they continued to pursue the goal of their patient leaving that abusive environment as a marker for success. It could be suggested that by pushing on with this goal, therapists set themselves up for failure from the outset which imparts a negative impact on their own self-efficacy.

In the case of self-efficacy this occurred when therapists believed they had a realistic prospect of experiencing positive encounters with patients in mid to later life. When workers anticipated negative reactions from patients the level of 'social persuasion' from a perceived incompetence in their skills increased, which was reported to result in therapists withdrawing from discussing IPV. Therapists avoided asking questions about IPV or focused on treating symptoms as a strategy to limit the damage to their self-efficacy. Although these strategies produced short-term benefits, longer-term consequences included losing opportunities for

behavioural mastery. This is supported by Fisherman, et al., (2010) who found allied health professionals also altered their strategies with aging women when the professional perceived themselves as not good enough help with IPV. In this research professionals either referred patients to other services or only treated the physical symptoms of IPV. Regardless of whether professionals are working within the medical or psychological field, both parties experience difficulties in mastering work with aging victims of IPV and in believing that they can positively impact this patient group.

Strategies based on commonly used heuristics were presented which helped therapists overcome internal and external barriers to practice (Kahan, 2015; Young et al., 2000). Heuristics are short cuts to decision making that help to minimize cognitive load particularly when under pressure to make decisions (Kahan, 2015; Young, et al., 2000). The framework demonstrates how therapists draw on heuristics anchored on limited knowledge such as patient age, gender, and social position to assess the likelihood of clinical success to mitigate against internal barriers (e.g. emotional states and perceived incompetence) and external barriers (e.g. time constraints). Through using heuristics, therapists continued to miss opportunities to develop mastery and self-efficacy, continuing the cycle of helplessness.

While patients were not initially referred to PCMH services for IPV treatment, our sample were able to discuss instances of working with older women experiencing IPV. This supports the link between mental health issues and IPV, particularly for this patient group. Oram et al., (2016) highlighted the need for incidence studies of IPV in PCMH services, which is supported by the findings of the current study. Although therapists could draw from more than one experience from their working practice, a limitation is that the number of experiences of working with aging women who had disclosed IPV was not formally recorded. Therefore, an avenue for future research is identify the incident rate of women over 45

presenting to PCMH teams with IPV as an underlying factor to determine the prevalence of the problem.

The study took a multi-generational approach in setting 45 as the age cutoff, which is acknowledged as a limitation. However, this age definition allowed practitioners to reflect on their working experiences of a wider range of mid-life to older women. The use of a grounded theory approach allowed a new theoretical framework that accounts for barriers to helping women above the age of 45 and over, who are typically missed out of mainstream IPV research or services. Future research should further explore the impact of age on assessment and interventions PCMH services.

Worker helplessness is influenced by the relationship between internal perceptions of ability and systemic barriers restricting what they can realistically achieve. The framework suggests that lack of previous knowledge and experience has a negative impact on therapists' self-efficacy. When IPV is disclosed in women over 45 therapists need to overcome numerous restrictions such as patient threats to terminate therapy or disappointing onward referrals which leads to perceived rather than actual incompetence. Front line workers like those within primary care, social services and law enforcement are bound by duties to care and act on information that suggests a serious risk of imminent harm to those in their charge. The professional and personal implications of mishandling IPV in all populations include several negative outcomes for staff such as burnout, low self-efficacy and sanctions to registrations to practice. Reporting a helplessness to act in the interests of a patient is not a justifiable defence and the wider implication of therapeutic helplessness is a continued culture of ineffective screening, treatment, and management of IPV particularly in aging populations (McGarry, 2008; Carthy & Holt, 2016). This indicates a significant issue for policy makers in a range of institutions to specifically address the safety and wellbeing of all

women living with IPV, as opposed to assuming current legislation can bridge the gaps between accounting for abuses to gender and age.

Conclusion

Frontline PCMH professionals reported a framework of helplessness in working effectively with female patients in their mid to later life experiencing IPV. Professionals try to avoid discussions of IPV in sessions, change the focus of therapeutic goals and make assumptions to bridge gaps in their knowledge base. Systemic barriers such as time limits and reported reluctances of multi-disciplinary teams to take disclosures seriously force therapists to employ strategies to cope. When met with resistance from patients to escape threatening environments, therapists experience hopelessness; negatively affecting their perceived ability to work well in the future with similar presentations from women in their mid to later life. Whilst movements have been made by domestic violence services and through local authorities to address the needs of older adults currently no best practice guidelines exist for PCMH staff when the disclosures of IPV in this patient group. The framework of helplessness presented in this study is the first exploratory step in helping stakeholders translate how learning from existing training and legislative guidance is being put into practice. Further work is required to address national policies and frameworks, particularly within PCMH to offer practitioners adequate time to work therapeutically with female patients in their mid to later life that have complex issues as a result of IPV.

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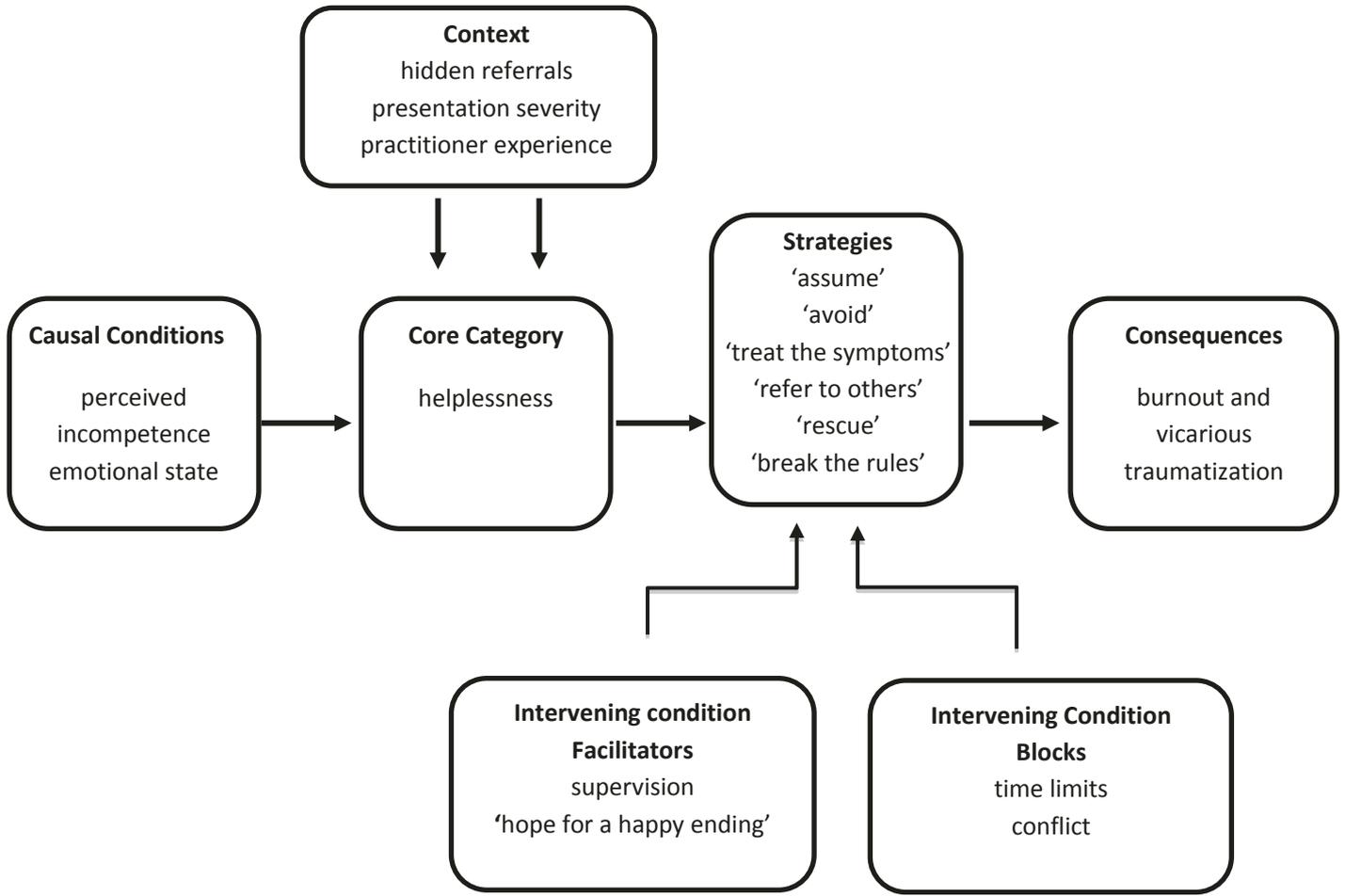


Figure 1. The Framework of Helplessness