DOMESTIC VIOLENCE SHELTERS IN TEXAS: RESPONDING TO PROGRAMMING NEEDS OF OLDER VICTIMS OF INTIMATE PARTNER VIOLENCE
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This study examined if domestic violence shelters in Texas are responding to the needs of older female victims of intimate partner violence. Data for this study was collected through online questionnaire surveys of 45% of Texas domestic violence shelters. Findings of this study indicated that less than 10% of Texas shelters are providing specialized programming for older victims of IPV. In Texas, the demographic growth of older adults has remained comparable to increased national trends. The state of Texas will face several policy implications and social issues related to an older population that is rapidly growing. This includes, the importance of addressing certain members of an aging population who continue to fall victim to domestic violence. Furthermore, an unchanged resource of safety for victims of IPV is domestic violence shelters. Therefore, this study challenges current domestic violence shelter policies to address this issue of a rapidly growing segment of the Texas population. This study found less than 10% of shelters in Texas, who participated in this study, were providing specialized programming and outreach for older victims. Important practical implications for domestic violence shelter programming in Texas is provided.
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CHAPTER 1
INTRODUCTION AND OVERVIEW

In the fields of elder abuse and domestic violence, there is increasing recognition of the problem of domestic violence against older women. However, understanding issues surrounding domestic violence against older women is often confounded by a division in current service systems that commonly define elder abuse with little recognition of co-occurring domestic violence. Resulting in a growing awareness of the fact that women over the age of 60 live in violent relationships in their homes or in dating situations and are vulnerable to abuse, neglect and different forms of exploitation. While this population has access to all existing entities that currently target domestic violence, such as domestic violence shelters, this study addressed the question—have domestic violence shelters in Texas failed to address the specific needs of the elder population with regard to outreach and programming specific to older women who may be victims of intimate partner violence (IPV).

Problem Statement

Domestic violence shelters are the primary source of help for women in situations of intimate partner violence. This research looked at how shelters in the state of Texas serve women, age 60 and older. The purpose of this study was to examine programming for older women in IPV shelters in the state of Texas. Currently, domestic violence shelters are addressing the needs of women victims of intimate partner violence but do not account for the specialized needs of the older woman. Moreover, when the older woman is excluded from the IPV discourse, it becomes exceedingly
difficult to develop an appropriate response that will meet their particular needs. The current study was designed to address current trends in providing services to older women in Texas.

Defining Abuse in the Older Woman

The definition of elder abuse has been the mark of much disapproval, as it is expansive and inconsistent (Jonson, & Akerstrom, 2004). “Crimes such as rape and robbery have been lumped together with acts of neglect and even self-neglect. It has been suggested, that elder abuse should only describe acts relating to care and dependency, and that spouse battering should belong in a category of ordinary crime” (Jonson, & Akerstrom, 2004, p. 49). Therefore, for the purpose of this study, IPV was researched as a single category and separate from the umbrella of elder abuse.

Reports of elder abuse are increasing throughout the country (National Center on Elder Abuse, 2006). As the population, particularly the baby boom generation, grows older, information of abuse are expected to increase (Spangler & Brandyl, 2007). In the year 2000, approximately 35 million Americans were over 65 years of age (A.O.A., 2009). Currently, according to projections, the number of Americans who are 65 years of age or older is approximately 40 million in 2010 and will be 54 million by the year 2020 (AOA, 2009). A considerable portion of elder abuse involves an older victim who is in a continuous relationship with the abuser, such as a spouse/partner, adult child or other family member, or caregiver. Zink and Pabst (2005) found that intimate partner violence in later life occurs less frequently than with younger women, but that it still occurs with enough frequency than individuals who provide care to older women should
screen them for IPV. However, for the purpose of this research, IPV in the older woman describes the victim who is in a relationship with an abuser who is the spouse/partner and not the adult child, family member or health care provider. Furthermore, the abuser is defined as one who uses tactics to establish control and power in the relationship (Spangler & Brandyl, 2007).

Traditionally, IPV in the older woman can be found under the umbrella of elder abuse. For the purpose of this research, it was critical to separate IPV from this umbrella to reveal the oversight of older women who are victims of IPV and are lost in the shadows of elder abuse criteria. More specifically, this research reveals that older women are not provided with specialized programming and outreach services in domestic violence shelters.

Definitions

- **Neglect** - is the “refusal or failure to fulfill any part of a person’s obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person/vulnerable adult with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed upon responsibility to an elder” (Teaster et al., 2004, p. 9).

- **Financial or material abuse/exploitation** - “the improper use of an older person’s or vulnerable adult’s funds, property, or assets” (Teaster et al., 2004, p. 9).

- **Physical abuse** - “The use of physical force, which may result in bodily
injury, physical pain or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any are other examples of physical abuse” (Teaster et al., 2004, p. 9).

- Sexual abuse - “The coercion of an older person/vulnerable adult through force, trickery, threats, or other means into unwanted sexual activity” (National Council on Elder Abuse [NCEA], 2010).

This chapter introduces intimate partner violence (IPV) in older women, domestic violence shelters in the state of Texas, aging demographics in Texas and the importance of researching current programming trends in Texas domestic violence Shelters. Current demographic trends of aging women in Texas and increasing life expectancies have set the stage for individuals who work in shelters to be more likely to see older persons whose poor health or injuries are by IPV. In Texas, the growth of older adults has remained comparable to national trends. The results, the state of Texas will face several issues related to an older population that is rapidly growing. (Figure 1)

![Graph showing projected increase in older adult population from 2000 to 2040.](image)

*Figure 1. Projected increase in older adult population from 2000 to 2040.*
According to the Texas State Data Center (TDOAD, 2000) “population growth for adults 60 plus is predicted to increase 193% from 2005 to 2010” (p.10). These anticipated increases add to the significance of domestic violence shelters in Texas developing programming, community education services, and outreach designed to meet the needs of older women. Shelters are built to be the main source of support for women in circumstances of domestic violence; it is important to research how older women are served by this kind of resource.

Review of literature revealed a minimal amount of research has been written in IPV literature regarding older women, on the other hand, much has been written on the issue of elder abuse. According to Straka and Montminy, 2006,

There is very little dialogue across the various forms of family violence, neither by researchers nor practitioners. This can be problematic, especially when one is concerned with types of violence that overlap more than one form. The problem of domestic violence against older women falls into the gap between these two fields, and this may be one reason for its relative invisibility. (p. 252)

Research does reveal that the older victim of IPV has unique needs when domestic violence programming is sought out (Brandyl, Hebert, Rozwandowski and Spangler, 2003). Wolf and Pillemer (1994) revealed that “the domestic violence and elder abuse movement have been operating essentially in separate domains” (p. 89). Nonetheless, little is known about the way that domestic violence victims are served in the domestic violence response system. In an effort to fill this void, this research discusses the lack of domestic violence shelter programming designed to meet the specific needs of older women (60+) in the state of Texas.

To understand the importance of providing programming designed to meet the needs of older women in domestic violence shelters, Straka and Montminy (2006) note
Intimate partner violence is a significant dilemma, which negatively influences the well-being of millions of older women throughout their lifespan, and “often the perpetrator is the spouse” (p. 252). Intimate partner violence is no surprise to those who work in the field of aging; however, lack of domestic violence shelter programming, community education and outreach to older women can provide a gap in their ability to identify appropriately and respond to the needs of older victims of IPV.

Domestic Violence Shelters

Research and history reveal that the development of domestic violence programming for women has been led by the political and legal powers that be. In the end, the goal was to transform the issue of domestic violence from a private matter to a criminal issue (Chornesky, 2000). Therefore, states prioritized for women's safety; which later led to the development of domestic violence shelters (Denham & Gillespie, 1998). Shelters were designed on grassroots standards and to date remain the key location in which victims of domestic violence receive help (Denham & Gillespie, 1998; MacLeod & Kinnon, 1997; Rinfret-Raynor, M., Pâquet-Deehy, A., Larouche, G., & Cantin, S. 1992). In addition, most shelters provide a variety of programming, community education and outreach to their community with the goal of providing a safe environment to women and children. While these services are intended for women of all ages; the majority of shelter services are directed at younger women and their children (Vinton, 1998). This trend, as researched by Vinton (1998), can reduce referrals to shelters from agencies that traditionally work with older adults. Traditionally, shelters receive referrals from a variety of outside sources such as, social workers, health care
workers, and many other community agencies. This research studied domestic violence shelters in Texas and the type of specialized programming for older women they are providing. The goal of this study was to summarize what services are available in Texas shelters to women over 60.

Intimate Partner Violence Grows Old

To further understand the importance of researching Texas shelter programming for older women, it is important to recognize the specialized need of older women who are victims of IPV. Researchers, as well as health care practitioners, gerontologists, and community-based providers often overlook older women in the area of domestic violence. For example, an assumption made by researchers is that domestic violence decreases with age and is not a critical issue for older adults. Until recently, it has become evident that domestic violence does exist for older women and will continue to grow with an aging population (Brandyl & Cook-Daniels, 2002; Hightower, Smith, & Hightower, 2001). Intimate partner violence can start in old age or can be a carry-over from a long-standing marriage, coupled with abuse of the wife. Therefore, recognizing the problem of domestic violence against older women, and how to respond to these women’s needs is therefore the issue at hand. Furthermore, a lack of specialized training in the field of aging and domestic violence for those who have dedicated their career to work with the victims of IPV can benefit services provided to older women. However, specialized courses on intimate partner violence may address elder abuse but may not view it as partner or intimate partner violence. According to the definition described by the Center for Disease Control (CDC, 2000) uniform partner violence,
“partner violence is defined as actual or threatened physical and sexual violence by an intimate partner to cause death, disability, injury, or harm to victims, and psychological abuse used to cause distress in victims” (p. 1). For the purpose of this study intimate partners represent, spouses, non-marital partners, former marital partners, and formal non-marital partners. According to a committee of National Association of Protective Services Association, members defined abuse as “the infliction of physical or psychological harm or the knowing deprivation of goods or services necessary to meet essential needs or to avoid physical or psychological harm” (Teaster, Dugar, Abner & Cecil, 2004, p.10).

To further address the need for specialized programming for older victims of IPV, IPV will be defined. Intimate partner violence has been referred to as (a) intentional actions that cause harm or create a serious risk of harm (whether or not the harm was intended) to a vulnerable elder by a spouse, boyfriend, girlfriend or same sex partner. It can include abuse, neglect, exploitation, and abandonment. It is viewed as an important problem in the realm of family violence, yet domestic violence is a subject that is not often researched. According to Comijs, Smit, Pot, Bouter, and Jonker (1999),

Since the late 1970s, the prevalence of domestic violence in the older adult has been determined to affect from 1.3% to 5.4% of the elderly population, and a number of instruments, protocols, and guidelines have been developed to assist healthcare professionals in the screening, detection, and assessment of domestic violence. (p. 121)

In review of studies, many abusive and destructive relationships were often tolerated by older women. Consequently, long-term coping with serious abuse greatly compromised the quality of their lives; this lead to health decline, and frequent visits to physicians’ offices. Often, an injury caused by the abuser was the turning point for
disclosing the abuse and seeking help. Results from the 1993–2001 national crime victimization survey reported that “an average of 13,100 non-lethal victimizations per year by an intimate partner were committed against women 55 years” (Rennison & Rand, 2003, p. 1497). Victims reported more physical and mental health problem (depression, chronic pain, and gastrointestinal problems) than non-victims. Studies have documented the poorer physical and mental health of domestic violence victims; the older domestic violence victims may seek care in a medical system, but this system is seen as little source of support for the older domestic violence victim (Coker, Smith, Bethea, King, & McKeown, 2000).

The best national estimate is that approximately 550,000 people aged 60 years or older experienced abuse or neglect, or both, in domestic settings (Lachs, Williams, O’Brien, & Pillemer, 2002). After adjusting for other factors that might affect mortality, Lachs et al., (2002) found that when there is domestic violence there are increased mortality rates among physically abused or neglected elders. According to Lachs et al. (2002),

Although abuse affects many elders and is associated with increased mortality, there are no clear-case finding guidelines, diagnostic tests, or ideal legal or medical system domestic violence interventions in the area of elder abuse. Because of poor public awareness and lack of clear public health or practice guidelines, only 21% of the estimated 550,000 cases of abuse occurring in 1996 were reported to and substantiated by adult protective services. (p. 471)

As stated by Grunfeld, Larsson, MacKay, and Hotch (1996),

The need for domestic violence assessment criteria has evolved from three major factors: the responsibility for identification of domestic violence often falling to the healthcare professional, the unpreparedness of professionals to fulfill this role, and the need for more research on domestic violence inform practice. (p. 1485)
According to Coker et al. (2000), “self-report of domestic violence cannot be relied upon to identify and treat cases, although one study found that older adults reported domestic violence themselves as victims of domestic violence, other studies refute this finding” (p. 451). Several studies have found that elderly are not likely to report episodes of domestic violence and 70% or more of the elders are reported as being abused are from third-party observers and not the older person (Saltzman et al., 2002). Bitondo dyer, Connolly, Guadagno, and Fulmer (2003) report that “Although some older adults may choose not to report domestic violence, many others may be cognitively impaired and therefore unable to make such a report” (pp. 297-304). Older adults do not usually report instances of domestic violence; the responsibility for identification, reporting, and subsequent intervention falls predominantly with healthcare professionals, social service agencies, and police departments. Consequently, specific guidelines for detection and referral of domestic violence are crucial. According to Zink, Regan, Jacobson, and Pabst, (2003a):

Healthcare professionals can develop physical assessment criteria that help delineate age, from disease, and from neglect; it is paramount they take a lead role on this issue. Despite the pivotal role healthcare professionals hold relative to the identification and treatment of mistreatment, there is evidence the groups experience difficulty fulfilling these roles. (p. 1429)

A study by Coker et al. (2000) reported that “only one out of five cases of intimate partner violence is reported” (p. 451). As noted by Seaver (1996):

Battered older women are a silenced and invisible group. They are silenced by ageist assumptions about them as too resistant and hopeless to change or made invisible by the notion that very frail elders are the only victims of elder abuse. Women over 50, abused by partners, are not accurately perceived, consequently not adequately helped by current domestic violence or elder abuse systems. (p.3)
Aging Demographic Trends in Texas

According to the Federal Interagency Forum on Aging-Related Statistics [FIF] (2008), “the current demographics of population aging in the United States (U.S.), suggest that the adult population aged 60 years and older will continue to increase as the baby boomers (those born between 1946 and 1964) reach old age” (p. 23). “If the percentage of older people who are abused by family members remains stable, the number of elder abuse victims can be expected to increase as well” (FIF, 2006, p. 36). Finally, Rennison and Rand (2003) discovered that spouses were perpetrators of “abuse among women aged 55 and older in 62% of the cases of IPV, measured up to 14% of the cases of IPV among women aged 12 to 24 and 44% of the cases of IPV among women aged 25 to 54” (p. 1419).

The population characteristics of older Texans indicate:

- Over 2.7 million Texans are age 60 or older
- Older Texans are relatively young; an estimated 66% of the older population is younger than 75
- The female population outnumbers the male population; there are about 76 males for every 100 females. Disparity between men and women increases with age
Figure 2 illustrates that older females (57%) currently exceeds older males (43%) with a gender ratio of 75.9. More specifically, there are about 76 older males for every 100 older females. Population life expectancy is affected by differences in gender. Women outlive men by about an average of seven years.

According to Texas State Data Center (TDOA, 2000):

The population over 60-plus population will grow more rapidly that the rest of the population in Texas. In addition, the ongoing technological advancements in medicine, improved public health, lifestyles geared toward wellness, will also affect mortality rates in Texas. Bottom line, this increase in the number of older adults has important implications not only for society, but also families and individuals. As a result, Texas will need to prepare for a population that is aging, by improving on policies that reflect the rapidly growing diverse population. (p. 10)
According to the Texas Data Center (TDOA, 2000), future projections of the aging Texas population indicate the following:

- Texans 60-plus are projected to total 8.1 million by 2040, a 193% increase from 2000. By 2040 the 60-plus population is projected to comprise 23% of the total Texas population
- The 60-plus population itself will grow older. In 2000, the 85-plus population totaled over 237,000; by 2040, this population is projected to reach about 831,000, a 249.4% increase
- The disparity between males and females is projected to decrease; males accounted for 44% of the aged population in 2000, this percentage is projected to increase to 47% in 2040
- Minority populations are growing rapidly; by 2040, they will constitute almost half of all older Texans, with Hispanics comprising 31%
- The Austin-San Marcos metropolitan statistical area will experience the largest percent growth in the 60-plus population by 2040, a 321.7% increase
- Hispanic elders will continue to outnumber other race/ethnicities along the Texas-Mexico Border region (p. 11)

Vulnerabilities of Older Victims of Intimate Partner Violence

A number of factors attributing to the fact that women are more likely to experience more difficult challenges while aging include: experiencing difficulties in financial resources, the supposition of family care giving responsibilities, and ageism that commemorates youth over maturity (Garner, 1999). According to Vinton (1999)
“the extensive abuse of women of all ages is often recognized” (pp. 2-3). Steinmetz (1988) states, “Early studies of elder mistreatment suggested that care dependent older adults were most likely to be abused by overwhelmed caregivers” (p. 2). Pillemer and Finkelhor (1988) suggest that other studies, notably a large scale prevalence study conducted in Boston, challenged the findings of early studies. Vinton (1999) suggests instead that there are many differences between care giving older adults who were most at risk of abuse than by those impaired family members for whom they were providing care” (p. 23).

Correlation of Intimate Partner Violence in Life and Younger Victims

Researchers and practitioners acknowledge that the correlation of intimate partner violence in later life, in most cases is often very similar to those experienced by younger victims of IPV (Harris, 1996). Often the abuser has a strong sense of entitlement that gives them the power to retain control of their victims (Bancroft, 2002). The older IPV violence victim is different from the younger woman in a variety of ways. Understanding these differences has significant implications for current IPV resources available to help older victims. According to Zink, Jacobson, Regan, and Fisher (2006) older women follow customary attitudes and values, specifically related to gender roles, marriage, and family. The generational tendencies of the older woman are to be obedient to their husbands and allow whatever comes their way, despite the negative implications. In addition, many older women have a strong sense to maintain secrecy about family matters to help uphold a strong commitment to solidarity of the family (Aronson, Thornwell, & Williams, 1995). These values stop them from discussing family
problems because IPV is a personal family matter. Furthermore, older women grew up in an era when divorce was forbidden, (Wolf, 2000) supported by their strong commitment to conventional religious significance (Zink et al., 2006). All these factors complicate the older women’s ability to seek help or leave abusive marriages.

Another difference is the younger women often face financial barriers that keep them in situations of violence and these may be even greater for older women. Most did not hold paid employment when they were younger; therefore, even women capable of earning a wage are unemployable because of ageism and lack of work experience (Hightower, Smith, & Hightower, 2006) in which younger women are allowed to benefit from job training.

Moreover, older women more often than younger women tend to have physical or functional problems that may increase their dependency for care, and this can exacerbate their ability to seek help or leave their current abusive situation. According to Straka and Montminy (2006) “although some older women are receiving care from their abusive partners, others may be providing care; because of their strong care ethic, it can be extremely difficult for an older woman to leave a dependent and/or abusive husband” (p. 4).

Wolf (2000) found that older women are unaware of the fact that they may have choices, and to their long history of abuse and are unaware of the fact that they may have choices. Numerous losses to their support system because of death, relocation, or the demand of their abusive intimate partner, leave the abusive partner as the older victim’s only support. Whereas, the younger woman may report that she seeks help from family and friends, such options may not exist for the oldest of older women.
In some relationships, IPV does not carry on into later life because of separation or divorce; in others the violent and abusive relationship can continue into old age. In some of these circumstances the violence may, in fact, worsen with age (Penhale, 1999) and be harsher. However, this may be because of increased frailty and vulnerability of the victims (Penhale, 1999). If a person’s vulnerability to injury is affected because of frailty on their part then the experience and result of violence may become more severe.

Late Life Onset of Intimate Partner Violence

Abusive situations between partners may begin in later life because of unexpected changes in the relationship. In addition, the effects of illness, disability or other related trauma on relationships are not always easy to gauge or to anticipate. A relationship that has always been problematic and abusive may deteriorate into abuse if unwanted and unexpected limitations and pressures are suddenly thrust upon a couple.

Deteriorating health, both physical and psychological, thwarted hopes, expectations and plan, a lessening in capacities to function and manage an increase in vulnerability and dependence may all contribute to the development continuation of abusive situations within intimate relationships in old age. A lack of understanding and knowledge about the effects of an illness or disability, particularly in which there is abuse can only exacerbate the victim’s ability to leave the abusive situation.

According to Gordon (1988), older women stay in relationships because of care imperative. The care imperative is the “need to take care of others or to find care for themselves when they can no longer be independent; younger women stay for a marriage imperative, their perceived need to have male partners to be successful
women, as well as to have someone to share economic burdens and care giving duties” (p. 26).

Batterers often use a range of tactics in hope of making the victim sense insecurity and feel unsure. For example, for the older adult some abusers may hide medications or even administer the medications inappropriately, so that the victim becomes confused. The victim often believes the abuse is their fault and will not make others aware that the abuse is occurring. The professional who is working with the older woman can provide support and assurance to the victim by creating an environment that is safe and supportive; it is not uncommon for the victim to sense that they are alone and ongoing education concerning the dangers of IPV can be useful. According to Brandyl and Horan (2002), it is important to provide assurance for the victim and validate the choices they make. Even when the older woman chooses to seek assistance, older women confront external and internal barriers, when they choose to seek assistance with barriers external to internal obstacles.

Despite the growing aging population and the need for services to address IPV, the chances of using these services decline with age. Vinton (1999) describes a significant decline in the rate of use of shelters by women over the age of 45. The reality is that this segment of the population can benefit from similar types of services provided for younger victims (Brandyl & Raymond, 1998).

The services offered to a victim of abuse will depend on the wishes and needs of the older victim. Many victims of abuse benefit from free domestic abuse services including emergency shelter (if they choose to leave the abuser), support groups, peer counseling, and crisis lines. A support group may be extremely helpful, especially a
group with people who are the same ages as the victim. For example, older abused women’s support groups exist in many communities (Seaver, 1996). Some victims will use the legal system to have the abuser arrested, secure a restraining order or divorce, or establish a financial guardian (conservatorship). Other victims may benefit from services offered by aging networks such as transportation, peer support, supportive home care, home delivered meals, or financial counseling. For example, Adult Protective Services (APS) is involved in elder abuse cases. Equally responsible to report suspected abuse or neglect are, social services agencies or their equivalents to investigate cases of elder abuse or abuse of a vulnerable adult. Reports of abuse come to a central agency, which assigns a trained worker to investigate the allegations of abuse or neglect. State statutes vary on how immediately a worker must respond. In some states, alleged victims may refuse the investigation.

Summary

Several barriers and difficulties can interfere with the help seeking capabilities/abilities of the older woman. This includes health, cognitive and financial difficulties, which can negatively add to barriers for accessibility to seek help. The following chapter reviews the literature highlights of service needs of the older woman involved in intimate partner violence and the challenges faced by shelters. In addition, older women are not always aware of existing resources for IPV, and if they are aware, many believe they do not serve older women. Older women in the community require education that addresses the existence of such resources and how to access them.

Second, the research of Hightower et al. (2006) and Vinton (1999) highlights that
professionals and shelter workers will also require training or formal education concerning the existence of IPV in older women and their needs for help and support feminist approaches to practice with this group. Therefore, workers also need to participate in consciousness-raising experiences to combat their sexism and ageism (Vinton, 1999).

Third, most women’s shelters do not provide resources and programming specifically adapted to older women, nor are most shelters physically accessible for older women (Straka & Montminy, 2006). For those women who do attempt to access shelters such help may be inadequate or even inaccessible in general.

Fourth, shelter interventions encouraging a woman to leave her abusive partner are often not appropriate for older women who generally have much more invested in their marriages and whose barriers to leaving are much higher (Zink et al., 2006).

Finally, the few studies in this area clearly reflect the importance of learning more about the needs of older women experiencing IPV. In addition, how shelter providers understand the problem, lack of collaboration with area agency on aging, lack of training in specialized needs for the older woman and the reasons older women may not use existing resources.
CHAPTER 2
REVIEW OF LITERATURE

Battered Women’s Shelters

In the 1960s the women’s movement brought attention to women who were victims of Intimate Partner Violence (IPV). As studies later revealed, shelters originated as asylums (Cohen, 1992), with the first formal shelter opening in England and in the 1970s one opened in the United States (U.S.). Vinton, (2003) describes the typical residents of domestic violence shelters as younger than 35 years of age and with children. Pillemer and Finkelor (1988) and Tjaden and Thoennes (1988) reveal that middle-aged and older women can experience IPV. Until recently, “neither women’s groups nor the shelter movement have addressed the particular needs of older women until recently” (Vinton, 2003, p. 1504). This review discusses the effect of the lack of knowledge about IPV experienced by the older woman, and the negative impact it has on them. In addition, IPV in the older woman and proposed interventions strategies identified by some researchers are discussed. Finally, shelters are the main source of assistance for victims of domestic violence, and how older women are served by this and other resources was reviewed.

Shelters

Historically, the foundation of response for the victim of domestic violence is to ensure safety. As a result, this response led to the establishment of women’s shelters. A major principle of intervention for domestic violence cases is the use of shelters. Because shelters are the main source of assistance for all women suffering from IPV, it
is important to investigate how older women are served by shelters. This standard is the result of a grassroots effort of women helping women, and shelters continue to be the main location in which women receive help.

Later, according to studies conducted by the American Association of Retired Persons [AARP] (1993) to determine if statistics were being kept on older victims of IPV who were using services, and whether or not specialized programming was available through these offices. After finding only 15 specialized programs in four states for abused older women, the survey revealed that older women were underserved (Pillemer & Finkelhor, 1988; Sengstock, Hwalek, & Petrone, 1990; Vinton, 1991).

In response to the AARP study, elder abuse researchers conducted three studies to review if shelters were providing specialized programming for older victims. Vinton (1992) surveyed 25 women’s shelters in Florida about their services for older women. Florida has a high population of older adults (more than 27% of the population in the areas surveyed). Nevertheless, Vinton discovered that older women did not use these shelters, as they represented only 2.2% (132) of the 6,026 shelter residents in 1991. In addition, only 2 of 25 shelters offered unique programming for older women, and less than 100 of the 29,259 persons served by a range of shelter programs were older women. This study suggests that (a) shelters often do not adapt their services to the needs of older women and, (b) older women tend not to use women’s shelters.

Additionally, a current U.S. survey shows that 3 additional Florida shelters offer programming for older women, and 61 (or 14.8%) shelters nationwide also offer such services (Vinton, 1992). Nevertheless, these studies show an encouraging trend in the U.S. Vinton (1992, 1998, and 1999) suggests that this could be the result of special
attention being paid to this issue at the federal, state, and local levels throughout the 1990s.

A Florida survey by McKibben (1988) revealed that older women were underserved; of 52 domestic violence programs, less than 10 women aged 60 and older had ever used this service. Florida has a high population of older adults (more than 27% of the population are 65 years or older); however, only 1% of women served by Florida shelters were aged 60 and older (Vinton, 1992). A follow-up study (five years later) of Florida’s shelters by Vinton, Altholz, and Lobell (1997) revealed that the number of shelters with programming specific to the older women had increased from 8% of shelters providing specialized programming for older victims of IPV to 22% of shelters providing programming. At the same time, the number of older staff, volunteers, and board members had also increased.

Years later, the AARP (1993) made several recommendations, specifically for the needs of the older victims of IPV. They include the following:

1. Ensuring that appropriate, accessible, safe shelters and other services were available that take into account the needs of older women;

2. Sensitizing and educating all service providers, including the medical and legal professions, counselors, and religious leaders about sexism, racism, and ageism;

3. Instituting cross-training, coordination, and coalition-building between the elder abuse and domestic violence communities;

4. Providing support and social services by creating a comprehensive, integrated support and interventions system;
5. Reaching out to older women by disseminating information about domestic violence through senior centers and home services, health clinics and physicians, civic association, and public benefits officers;

6. Providing victim advocates and creating sister to sister buddy programs between recently battered and formerly battered women. (pp. 23-34)

With regard to domestic violence shelter programming, Brandyl et al. (2003) suggest the use of peer support, validation, and self-help, and have suggested that older women may require groups, specific to their needs since they will often find themselves the oldest members of the support groups.

Wolf (2000) and Smith (1999) pointed out how older women use shelters and barriers and what they may encounter that ultimately can reduce utilization of shelter services. According to Beaulaurier and Seff (2005)

- Shelters may have higher noise and activity levels than is comfortable for older women
- Some older women may have difficulty fulfilling their work assignments because of their physical or mental conditions
- The time limit on occupancy can be inadequate in terms of the complexity of some older women's problems
- Shelter staff are usually unfamiliar with aging and special needs of older people
- Problems with health and mobility can hinder the use of shelters, with many lacking wheelchair accessibility
- Most shelters are not equipped to provide the care needed by some women
with health problems (e.g., assistance with bathing, eating, or other activities of daily living or dispensing medications)

- Older women may find it difficult to arrange medical appointments and services, and most shelters are not set up to provide this kind of transportation and accompaniment (pp. 39-53)

Elder Abuse and Domestic Violence: Commonalities/Shared Approach

To understand the possible reasons for lack of programming and outreach of domestic violence shelters to older women, the commonalities of elder abuse and domestic violence were reviewed. The issue of domestic violence has become a growing concern in the U.S. since the early 20th century. As a result, a variety of forms of family violence are referred to as social problems—child abuse, wife abuse, and elder abuse. However, the lack of dialogue between these forms of violence creates a gap in terms of knowledge between domestic violence and elder abuse (Montminy, 2005). According to previous research on elder abuse, growing attention is paid to older women experiencing domestic violence (Vinton, 1991). Vinton (1991) discussed the main question regarding older victims of IPV. Is it elder abuse or domestic violence? These terms reflect two types of violence as distinguished in two different models: the domestic violence model (battered women) and the elder abuse model (abused elders). According to Montminy (2005), domestic violence refers to violence against younger women in intimate relationships. In contrast, elder abuse refers to all forms of mistreatment against older adults, without reference to perpetrator. Therefore, the issue of violence against women easily falls within both these models and, as Montminy
states, is “viewed quite differently within each” (p. 4). Thus, a review of literature regarding both models of abuse does not adequately reflect the issue of domestic violence experienced by older women. Literature that reflects elder abuse acknowledges that spouses are the most common group of perpetrators; as a result, the research focused on issues regarding family caregivers and does make a distinction in addressing the detailed issues regarding spousal perpetrators.

A Swedish study conducted by Jonson and Akerstrom (2004) analyzed the uncertain manifestation of elder abuse in the feminist perspective. This study further explains possible reasons for lack of development of programming and services for older women who are victims of IPV. The study showed that feminist studies in Sweden have neglected the older woman in discussing the violence against women. The result was the creation of the term theoretical blindness (p. 61) that is being spread among researchers, politicians, and anti-violence advocates. In other words, the young represent the hope for the future with regard to issues of domestic violence.

Earlier research, principally experimental, noted that there is no common profile for battered elderly women, just as there is no such sketch for the younger woman (Davis, 2002). Despite the detailed pressures of old age and the propensity to classify these women as needy and opposed to accepting help, it is no surprise that both younger and older women desire to be free from a violent relationship. However, according to Winterstein and Eisikovits (2009) “they feel trapped in an ambivalent emotional situation involving the desire to maintain the relationship, on the one hand, and the desire to restrict the abusive partner in the hope that he will change, on the other” (p. 165). As a result, younger women tend to continue in the violent relationship
due to the marital imperative and economic dependence, whereas older women stay because of society’s expectation that they are supposed to care for their aging spouses (Band-Winderstein, 2003; Seaver, 1996). To summarize, the detailed needs of the older woman experiencing IPV - specifically, physical, sexual, emotional, or financial abuse - are given little thought and affect development of programs and services for older women needing shelter programming.

To summarize, the assumption is that “domestic violence stops at age 60” (Blood, 2001, p. 1). In essence, the confusion over the distinction between domestic violence and elder abuse has created a lack of literature, research, and guidelines regarding this issue. Often disregarded are the needs of the older woman, resulting in lack of services, and specialized programming.

Barriers Experienced by Older Victims of Intimate Partner Violence and Shelter Services

A significant aspect of older women not seeking assistance from shelters and removing themselves from ongoing abuse is described herein. Beaulaurier and Seff (2005) found six key components for older abused women who face barriers to seeking help: “self-blame, powerlessness, hopelessness, the need to protect the family, and the need to keep the abuse a secret from others” (p. 55). Some older victims choose to maintain contact with their perpetrator for a variety of reasons; some have a fear of being without help, health concerns, generational ties, and personal values developed from religious or spiritual beliefs; and, as is true for younger victims, some older victims are in fear of retaliation. In fact, Zink, Jacobson, Regan, Pabst, and Fisher (2006) found
that older women who remained with abusers were able to change into specific roles, set restrictions with the abusers, and help others in need.

According to Saunders and Anderson (2003), “battered women who leave abusers can go through a variety of shifts in thinking that involves both material and psychological factors before making their final decision” (p. 167). The older victim will review the more practical side of leaving an abuser, such as housing and financial concerns. On a greater level, the desire for some women is for the abuse to end and the relationship to remain intact. Finally, older women are more likely than younger women to have health or functional problems that make them dependent on someone for care, and this makes it more difficult for them to seek help or to leave. Although some older women are receiving care from their abusive partners, others may be providing care. Because of their strong care ethic, it can be extremely difficult for an older woman to leave a dependent or abusive husband (Seaver, 1996; Wolf, 2000).

To summarize, older women living in situations of longstanding abuse do not always realize that there are choices (Wolf, 2000) such as a shelter. Therefore, this lack of utilization may lead shelters to believe older women may not be in need of their services. In addition, the older persons social networks are reduced by the death of their peers, and the abusive spouse may be the only person left in an older woman’s life. To add to the barriers faced by older victims, disclosing any personal issues is not always an option; this includes any disclosure regarding IPV (Saunders & Anderson, 2003). However, when domestic violence is disclosed, safety planning, referrals, and resource information should be offered to the older victim. It is critical for personnel who work in shelters for victims of domestic violence to recognize these barriers and to provide the
necessary interventions to address the specific needs of the older woman. However, current trends in the literature tend to address elder abuse without distinguishing the specific issue of domestic violence in the older woman. This can result in older victims’ of IPV being misplaced between the elder abuse and domestic violence systems (Saunders & Anderson, 2003).

Older Women and Intimate Partner Violence

The current literature on IPV describes domestic violence as a subset of elder abuse. As a result, at times the topic of elder domestic violence is ignored. Furthermore, particular difficulties are faced by older women who are victims of IPV. For instance, domestic violence was not always regarded as a crime (when they were younger); therefore, legal safeguards were not always available. The older woman can be led to believe that this way of life is normal and accepted by society. On the other hand, research suggests that the attitudes of older women have changed from when they were younger; they are more likely to acknowledge that abuse is unacceptable (Scott, McKie, Morton, Seddon, & Wasof, 2008).

Pritchard (2000) and Brandyl and Cook-Daniels (2002) suggest that images portrayed in the mainstream media depict the victims of IPV as younger women with children, therefore giving the impression that domestic violence does not occur in later life. The literature often reflects that older women were taught to avoid discussion of family problems; subsequently they may never disclose the abuse. Moreover, the trend toward isolation for the older woman can affect her willingness to seek help. Pritchard (2000) suggests that professionals who work in social work or health fields may not
discovery IPV in the older woman because of the amount of time required to address the issue, or may not have knowledge of the appropriate resources necessary to address this matter. Penhale (2003) described differences in the etiology of abuse for each individual, depending on physical and mental frailties and the level of dependence. Economic and housing issues, for example, can affect the level of dependence. Furthermore, older women experiencing domestic violence are generally less aware of available services than are younger women experiencing domestic violence (Pritchard, 2000). Older women may believe that services are specifically for younger women, or for women with children (Scott et al., 2008). Life stressors, physical or mental frailties, financial dependency, leaving their personal homes, or fear of ongoing retaliation by the abuser may prevent older women from seeking assistance. As a result of the aforementioned barriers, older women are more likely to be underrepresented in domestic violence organizations or in agencies that provide counseling and support to victims of domestic violence, specifically in crisis shelters.

**Interventions**

*Shelter Response to Older Victims of Intimate Partner Violence*

Little has been written on the issue of older women and domestic violence. However, it is evident that researchers are acknowledging that domestic violence and elder abuse are two separate problems in reference to victim interventions. But there is an obvious overlap in the types of violence experienced by older victims, which results in the older women falling between the cracks. Older female victims of domestic violence are different from younger women who receive assistance for issues of IPV.
Traditionally, the younger female victim dominates the feminist domestic violence dialogues, leading to the absence of the experiences and voices of older women (Aitken & Griffin, 1996; Harbison, 1999). Exclusion from dialogue can create a limited response to the older victim and a disregard for their specific needs.

A study conducted by Wilke and Vinton (2005) to examine the nature and extent of domestic violence and its effect on psychosocial functioning among women of different age groups stated that:

About 40% of the older women in this study had injuries as the result of violence. In addition, older women were more likely than were the younger women to have prescriptions for psychotropic medications; thus, older women do visit health care providers. Bias against older women, can lead shelter providers either to miss the clues or not to refer older women to resources. (p. 326)

In health care settings, professionals should be certain to evaluate women of all ages for domestic violence and to provide assistance in the education of service providers about domestic violence in old age (Wilke & Vinton, 2005). Straka and Montminy (2006) suggest two types of intervention systems that can assist older women who are experiencing IPV: 1) “The women’s shelter network in the community, which uses a feminist domestic violence approach, and 2) aging resources (including adult protective services [APS]) in the health and social services network, which use an elder abuse approach; the first of these is grounded in a gender perspective, but does not account for age; the second is grounded in an aging perspective but does not account for gender” (p. 253).

It is evident that any woman experiencing IPV will require social, physical, and emotional support. The literature revealed that too few domestic violence shelters, aging agencies, and social service agencies have initiated support groups and counseling
specifically designed to assist older victims of IPV; though small in number, these could provide direction as model programs (Brandyl, Hebert, Rozwadowsi, & Spangler, 2003; Vinton, 2003).

Despite the aging and size of the baby-boom generation and the knowledge that domestic violence has no age limit, few of these programs are aimed at women aged 50 and older. Demographic imperatives and data from the national violence against women survey (NVAWS) suggest that now is the time to make middle-aged and older victims of domestic violence more visible (Straka & Montminy, 2006).

Community Response to Intimate Partner Violence

Literature revealed that community response, to meet the needs of elder women who are victims of IPV although commonplace, fails to provide for these women as needed. To summarize, states have created laws to enforce mandatory reporting requirements for suspicion of elder abuse, self-neglect, and exploitation. Adult Protective Service (APS) agencies, health care settings, and community resources traditionally have provided services to victims of elder abuse. The assumption with APS is that caregiver stress is the primary cause of elder abuse (Brandyl & Horan, 2002). However, according to Wolf (2000), though stress may be a causal factor, the research does not maintain that stress is the principal cause of elder abuse. Wolf (2000) states, “Family violence in later life often involves an abuser using a regular pattern of coercive acts to control, dominate, or punish the victims” (p. 43). Many believe APS is the best way to ensure the rights of adults and look after those most helpless. However, there is the possibility that this method patronizes older adults and violates their rights to freewill
According to Straka and Montminy (2006), as opposed to referring for shelter services, “in one-fifth of the cases the abuse was resolved by placing the abused older person into a long-term care setting. Legal services were used in one-fourth of the cases, most often to institute a protective regime and place one of the parties under guardianship. Other interventions included the use of private home care services (33%), interim placements (13%), psychiatric interventions (15%), and placement of the perpetrator into care (9%). It is evident how different these kinds of services are from those offered by women’s shelters” (p. 260). To summarize, research reveals shelters do not focus on the types of services necessary to meet the complex needs of the older woman. For example, the aforementioned services provide case-management to older women who are victims of abuse. Case management addresses the multifaceted needs of the older woman, therefore, providing a variety of health and social services (Lithwick, Beaulieu, Gravel, & Straka, 1999; Milner, 1997; Reis & Nahmiash, 1995).

Community organizations can also provide help; however, these may not always be found in areas in which the APS and healthcare services are dominant (Straka & Montminy, 2006). Many community organizations offer advocacy programs and legal support. Community organizations can provide case management and home care services. As a result, few of these community resources have attempted to develop a response based on a domestic violence model, applying this to all types of elder abuse, not just abuse by a spouse (NCFV, 2000). Straka and Montminy (2006) state, “A domestic violence approach to elder abuse emphasizes crisis intervention, a strong
legal approach, support groups for both abused and abuser, emergency shelters, counseling, and a range of health, social, and legal services” (p. 261).

In summary, both APS and health care services help clients with complex health and social problems. IPV against the older woman receives minimal attention because the focal point spreads across these two settings as opposed to domestic violence shelters. For example, APS workers have received minimal or no training in IPV (Brandyl, 1997). Brandyl (1997) recommends training to meet this need. If the APS worker is trained to specifically meet the needs of older victims of IPV, shelter services may be utilized more effectively. Therefore, increasing referrals to shelters may trigger the need for development of specialized services for the older victim of IPV.

With regard to healthcare and community agencies, it is already difficult to meet all the health and social needs of the older person. In addition to providing education on IPV, the case manager must assess any psychological or mental incapacity and must manage any physical issues. Therefore, incidents of IPV are often ignored or missed because the focus is on care giving and physical health issues (Brandyl & Raymond, 1996). “The question of responsibility for the abuse is, consequently much more blurred in elder abuse than it is in the domestic violence model” (Straka & Montminy, 2006, p. 262). To summarize, Beaulaurier and Seff’s (2005) findings report that older women were not aware of how to seek help about any current services for IPV. In addition, older women believed that there were no services to meet their specific needs.

Crisis Intervention

Literature reveals the domestic violence approach to crisis intervention, which
 inadvertently may reduce shelter services to older victims of IPV. This approach requires crisis intervention, which is not always appropriate for the older woman. Crisis intervention services can include focus on gender and immediate relocation of the victim; thus, not all shelters provide programming that is specific to the needs of older women. They may find themselves housed with older men, which may be an issue for some older women. Current literature on domestic violence deems domestic violence resources to be appropriate, yet they may still fail to meet the needs of the older woman (Straka & Montminy, 2006). Straka and Montminy (2006) also refer to the challenges for this model as unable to address the issue of intentional neglect, challenges in addressing older women who are physically and cognitively challenged, and a failure to address the specific issues of IPV for the older woman. Whereas elder abuse interventions can address the health and social needs of the older woman, they are not able to address the specific challenges of IPV. As a result, there is a lack of understanding in shelter staff, thus there is a lack of specialized services provided for older female victims of IPV with domestic violence shelters.

Domestic Violence Programming and Services

As a result of the women’s movement, shelters and programming emerged for abused women and their children in the 1960s and 70s. The concept was to provide immediate safety from the abuser. Today there are more than 1,612 shelters in the U.S. (National Center on Domestic and Sexual Violence [NCDSV], 2005). Many groups have banded together to create and enhance programming, support groups, peer counseling, and community outreach for abused women, with the result that services, legal
assistance, and programming have become a common method of assistance at local shelters. Referrals are then made to social service agencies, job training programs, housing, and childcare (Chornesky, 2000).

In the late 1970s, the elder abuse movement gained force, resulting in the passage of laws that created APS; the programs were designed to investigate allegations of abuse, protection and all needed service that vulnerable adults may need (Vinton, 2001). According to Fisher, Zink, Pabst, Regan and Rinto (2003), given “the fact that definitions of domestic violence were embedded in elder abuse legislation, the amount of attention the women’s movement gave to violence against older women was grossly overshadowed by the attention focused on violence against younger women” (p. 68).

In 1988 a study conducted by Pillemer and Finkelhor (1988) shed light on the fact that spouses are the primary abusers in a large proportion of IPV against women. Their response was “services need to be provided that are tailored to the problem of spouse abuse among the elderly” (p. 57), despite the findings of Pillemer and Finkelhor (1988), as well as other studies that address the issue of providing programming, outreach and services to meet the needs of the older female victims of IPV (Brandyl, Rozwadowski, Spangler & Hebert, 2003; National Clearinghouse on Abuse in Later Life [NCALL]; Vinton, 1992). Little remains known “about how a state-wide domestic violence community has responded to the needs of older abused women after the passage of the Violence against Women Act of 1994 (VAW act)” (Fisher et al., 2003, p. 69).

Although domestic violence community response in the U.S. for women has continued to improve, shelters continue to lack specialized programming and services to
older victims of IPV. Additionally, screening and risk assessment tools are in place to assist health and social service professionals in identifying possible victims of domestic violence. Varieties of programs have been developed within shelters to assist the victims of domestic violence in gaining independence from their abuser. However, according to Straka and Montminy (2006), this process was designed to address the needs of younger women, with few services designed to meet the needs of the older woman who is a victim of IPV.

Summary

In summary, first, the literature emphasized that a number of older women are not served by domestic violence shelters. Second, the research of Hightower et al. (2001) and Vinton (1999) noted that professionals and shelter workers are lacking the training and education that provides awareness on domestic violence in the older woman. Third, most women’s shelters do not provide resources and programming tailored to older women. Finally, the few studies in this area clearly recognize the barriers of older women experiencing domestic violence and the reasons that shelters do not collaborate with local area agencies on aging.

In general, specialized programming, outreach, and community collaboration is absent. However, this work is limited to understanding how well shelters serve the specific needs of older women. It is imperative that shelters and community agencies address the needs of older women who are victims of IPV. Furthermore, research promotes more effective aging-sensitive intervention programs for older victims of IPV.
CHAPTER 3

METHODOLOGY

The methodological approach for this study is discussed in this chapter, which describes current programming specific to older women in domestic violence shelters in the State of Texas. This chapter further describes the methodology used for the study, including the research, sampling design, data collection process, and ethical considerations as they relate to this descriptive research study.

Purpose of the Study

This study has relevance to domestic violence shelters, healthcare providers, and professionals in the field of aging because understanding older victims of intimate partner violence (IPV) will help providers be better able to serve these victims. In addition, they will be able to understand interventions, outreach services, programming needs, and training to create changes that will benefit the older victims of IPV.

Intimate partner violence is a growing social and health concern for the older woman. The literature reveals that barriers preventing older women from seeking help are multifaceted: lack of economic resources and financial independence, health concerns, cognitive issues, housing concerns, and lack of knowledge of outreach services for victims of IPV. Attention paid to domestic violence shelter programming and services specific to older victims of IPV has been minimal, despite the critical increase of IPV against older women.
Research Questions

The lack of research in the area of IPV in the older woman leads to significant questions regarding this growing issue:

1. Are older women targeted by intimate partner violence shelter outreach programs in Texas?
2. What type of programming and resources are specifically adapted to older women in Texas shelters?
3. Are Texas shelters partnered with local area agencies on aging?

Selection of the Participants

The population of executive directors from 66 domestic violence shelters was invited to participate; the participants were under human subject protection. Out of the approximately 66 domestic violence shelter executive directors that were invited, 32 participated. All participants were cognitively able to consent to participate in this research. There was no exclusion of participants based upon race, ethnicity, or religion. A list of domestic violence shelters was obtained from the Texas council on domestic violence. The inclusion criteria for this study are as follows: (1) domestic violence shelter must be in the state of Texas; (2) participant must be an executive director or designated representative of a domestic violence shelter and (3) participant must be able to read and speak English. The inclusion criteria required that the shelters meet these requirements.
Data Collection Procedures

Data collection for this research took two forms: (1) an online survey in which participants participated by completing a 20-item survey to examine specific programming for older female victims of IPV in the state of Texas; and (2) interviews conducted with respondents selected from those shelters who stated on the online survey that programming for older women was provided. Data was gathered relating to current domestic violence shelter programming for victims of IPV in the state of Texas. Data collected through a survey questionnaire from a previous study of domestic violence shelters conducted by Vinton (1998) were collected. Names and contact information were obtained from the Texas council on family violence website. A total of 66 shelters were identified in Texas, and 34 responses were counted by the online survey service. Upon further investigation, two response sets were incomplete because the respondents exited the survey prior to completion.

Survey Instrument Tool

The survey instrument tool was borrowed from a previous study of domestic violence shelters conducted by Vinton (1998). This instrument consists of 20 closed-ended questions (Appendix A), which inquire about: a) handicap accessibility; b) types of services offered; c) basic shelter demographics; d) size of target population; e) older victims outreach efforts; f) percentage of 60+ older population in the area of the shelter; g) programming for older female victims of IPV; h) community education provided to 60+ groups; and i) programming for older female victims of IPV. Conclusions drawn from this study support the fact that domestic violence shelters do not provide programming
specifically designed to meet the needs of the older victim of IPV. The survey was
disseminated to 66 domestic violence shelters via email after IRB approval. The survey
provided the data to function as a descriptive analysis of information from the survey.
However, the data collected provided an unexpected opportunity to add an exploratory
component by adding follow-up questions. Furthermore, the data did not lend itself to a
quantitative analysis and thus created a limitation to the generalizability of this study.
Therefore, the descriptive component of this study provides the characteristics of Texas
domestic violence shelters and gives information about the programming they provide
for older women.

Qualitative Follow-up

The online survey service provided the synopsis and a description of the data
collected with regard to the demographic characteristics of the domestic violence
shelters in Texas. The data is presented in two forms: (a) as tables with percentages
and frequency distributions describing the demographic characteristics of domestic
violence shelters; (b) as Excel spreadsheets in actual values as well as in numerical,
which are easily transferrable to an SPSS® www.spss.com data file for computer
statistical analysis.

The data collected from a follow-up study was analyzed to provide additional
substance to the survey. Fifteen questions were designed that specifically addressed
those shelters that were actively providing programming for older women who were
victims of domestic violence. Participants were asked the 15 follow-up questions, and
the answers were reported as additional exploratory research.

Three structured interviews were conducted, each lasting approximately 45
minutes. All respondents were asked the same open-ended questions (Appendix B) and responses were transcribed (Appendix C). The data collected from the interviews was examined and the response themes categorized for interpretational analysis.

Protection of Human Subjects

Prior to participation in this study, each potential respondent was provided with a written description regarding the nature of the study using the research consent form (Appendix D). After agreeing to participate in this study voluntarily, participants were informed of their rights, including the right to withdraw from the study at any time without consequences. No identifying information was entered on the study instrument tool in order to protect the identity and maintain the confidentiality of participants. Contact information for the principal investigator and the chair of the dissertation committee was provided in case respondents should need any additional information regarding the study.

An application for the approval of investigation involving human subjects was submitted to the University of North Texas Institutional Review Board (IRB), and approval was granted (Appendix E). Data collection did not occur until approval was granted from the IRB. No major risks were anticipated for participants in this study. Inconvenience was reduced by allowing the participants to submit completed surveys via email or at their convenience. No invasive procedures were included in the study, and no existing medical records were used. Participants received no monetary reward for participation in the study. They should not have perceived any type of coercion to participate in the study.
Summary

In summary, this study consisted of collecting data from 32 domestic violence shelters in the state of Texas. The focus of this study was to determine what domestic violence shelter programming is available for older female (60+) victims of IPV.
CHAPTER 4

RESULTS

This study was conducted to examine Texas domestic violence shelters and programming provided to older victims of intimate partner violence (IPV). A survey invitation was sent to 66 domestic violence shelter directors in the state of Texas. Each invitation was sent via email. Valid responses were received from 32 domestic violence shelter directors. A total of $N = 32$ responses to the survey were received which provided approximately 48% response rate. This percentage is considered average among email surveys where there is a tendency for recipients to not read their email (Sheeham, 2001). This chapter presents an explanation of the survey instrument tool and description of the basic features of data in the study. This chapter describes what the data revealed, including follow-up interviews.

The domestic violence survey was used to examine the specific programming for older female victims of IPV. The survey was based on a previous study conducted by Vinton (1998). This instrument consisted of 28-close-ended questions that inquired about programming, services, and outreach to women over 60 years of age, including types of services offered, community education and outreach. Outreach and community education questions addressed the participant's perception of the importance of outreach and community education efforts to women over 60. Vinton (1998) describes that to distinguish any differences between what the participants thought should be offered and what other shelters should offer, the first “item inquired about the importance of specialized outreach for shelters in general, and the second item asked about the importance for the participants own shelter” (p. 563). In addition, questions
included information regarding basic demographics of each shelter; such as, number of beds, funding sources, size of target population, number of total women and children sheltered for the 2009 calendar year, medication storage and handicapped accessibility.

Shelter Demographics

The organization and summarization of the data collected as to the demographic characteristics of all the domestic violence shelter directors were gathered from the online survey and is presented in tables with frequency distributions and percentages. Forty-five percent ($N = 32$) of 66 Texas domestic violence shelter executive directors who received a survey instrument participated in the study. Two participants were removed who said they did not operate or have a shelter; 30 cases were left in the sample. Participants reported their shelters had been in operation ranging from 5 to 37 years. The mean age was 24 years ($SD = 9$). The average number of beds was 58 (range = 12-174; $SD = 43$). The average length of stay of residents was 25 days (range = 9 - 60; $SD = 16$). In reference to funding, 90% of participants received federal monies, 100% received state funds, 80% received county funds, and 77% received local funds. In addition, 93% of participants reported United Way funding. Sixty percent of shelters described themselves as private, 20% grassroots and 20% public. (Figure 4)
Figure 3. United Way funding.

Figure 4. Funding types.
Accommodations for Residents with Disabilities

The importance of shelters providing accessibility for individuals is critical when providing specialized care for older women, therefore reviewed in this study. One-hundred percent of participants reported their shelters were handicapped accessible. With regard to a policy question about distribution of medication, 60% reported they stored but did not dispense medication to residents, 13% reported they stored and dispensed medication, 27% reported they have other types of policies including never storing medications for residents. (Figure 5)

![Medication policies](image)

*Figure 5. Medication policies.*
Table 1

*Texas Domestic Violence Shelters’ Residents 2009*

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child residents (<em>N</em> = 12993)</td>
<td>433</td>
<td>233</td>
<td>517</td>
</tr>
<tr>
<td>Adult female residents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ages (<em>N</em> = 11970)</td>
<td>399</td>
<td>245</td>
<td>399</td>
</tr>
<tr>
<td>Age 60 and older (<em>n</em> = 274)</td>
<td>9</td>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>

Residents

The median and mean numbers of residents for the participants’ shelters are shown in Table 1. The number of children sheltered outnumbered the adults. Of the number of adults sheltered in 2009, 2.28% of the women were over 60 years old; (*n* = 274). Of the 30 shelters reporting, 20% reported housing no women over 60 years old, over half 56.6% reported housing between 1-3 older women, 13.3% reported housing between 4-9 older women, and only 10% of the facilities had sheltered 10 or more women over 60.

Table 2

*Texas Domestic Violence Shelters’ Paid Staff and Board of Directors 2009*

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female paid staff members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ages (<em>n</em> = 1026)</td>
<td>22</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Age 60 and older (<em>n</em> = 82)</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Female board of director members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ages (<em>n</em> = 437)</td>
<td>15</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Age 60 and older (<em>n</em> = 53)</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add male numbers for board members
On average shelters reported 41 paid female staff and an average total of 17 female board of directors. The participants reported only 7.99% of paid staff members over 60 and 12.1% of board of directors were over 60 years old. Four percent of the participants reported having no paid staff members over the age of 60. More than 40% of participants reported (43.3%) had no board members over 60 years of age. Over half of participants reported (53.3%) had between 1-4 board members over 60 years of age and one shelter reported over 10 board members over 60 years old.

Table 3

*Community Education Provided by Texas Domestic Violence Shelters (%) 2009*

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students/teacher</td>
<td>76.6%</td>
<td>23.4</td>
</tr>
<tr>
<td>Civic Groups</td>
<td>76.6%</td>
<td>23.4</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>83.3%</td>
<td>16.7</td>
</tr>
<tr>
<td>Adult Protective Services Staff</td>
<td>70.0%</td>
<td>30.0</td>
</tr>
<tr>
<td>Attorneys/Judges</td>
<td>70.0%</td>
<td>30.0</td>
</tr>
<tr>
<td>Child Protective Services Staff</td>
<td>73.3%</td>
<td>26.7</td>
</tr>
<tr>
<td>Senior Centers</td>
<td>53.3%</td>
<td>46.7</td>
</tr>
<tr>
<td>Home Health Agency Staff</td>
<td>23.3%</td>
<td>76.7</td>
</tr>
<tr>
<td>Community Area on Aging Agency Staff</td>
<td>30.0%</td>
<td>70.0</td>
</tr>
<tr>
<td>Hospital Staff</td>
<td>76.6%</td>
<td>23.4</td>
</tr>
</tbody>
</table>

Participants revealed 100% provided community education regarding domestic violence. Table 3 indicates groups provided community education during 2009. Three groups focused on the care of older adults were senior center staff, community area on aging staff and adult protective services staff.
Figure 6. Texas domestic violence shelter outreach to older women.

As noted in Figure 6 only 10% of shelters reported they have specialized programming for older victims of domestic violence, whereas 90% reported they do not provide any programming for older victims of domestic violence. Participants', who answered yes to this question, were then asked to identify specifically the type of programming they provided for older victims. Participants' reported specialized outreach to older women and specialized training for staff that includes elder abuse, potential for abuse, and caregiver abuse. In addition, one shelter reported support groups for older shelter victims.

Participants were asked if they provided any special outreach efforts to older women as described in Table 4. Special outreach efforts focused on the specific outreach plans of each shelter. Outreach programs are minimal to older women, specifically with regard to print and digital campaigns.
Table 4

Types of Special Outreach Efforts for Older Victims of Domestic Violence Offered by Participants’ Shelters

<table>
<thead>
<tr>
<th>2009</th>
<th>Yes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Campaigns’ (older women)</td>
<td>6</td>
<td>23.1%</td>
</tr>
<tr>
<td>Target older women-Radio/TV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feature older women – brochure</td>
<td>1</td>
<td>3.0%</td>
</tr>
<tr>
<td>Presentation to Senior Citizen Groups</td>
<td>25</td>
<td>83.3%</td>
</tr>
<tr>
<td>Medical Community (M.D., R.N., E.R’s)</td>
<td>25</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Participant Follow-up Responses

In this study three interviews were conducted. As these data were collected, the researcher noticed a few common themes emerging. The interviews were structured and all participants were asked the same questions in almost the same way. As a result, themes became obvious: (a) type of programming for women over 60 years of age; (b) specialized funding available, specifically for programming for older women over 60; (c) training for staff on domestic violence issues of older victims is provided one time per year; and (d) support groups for older women were provided on and off site of shelter.

Type of Programming

Interviewees were asked what particular type of programming was provided for older victims of IPV. All respondents reported specialized programming for women over the age of 60. This included support groups, group therapy and individual therapy. Each respondent reported therapy provided by a licensed therapist. Although, this service
seems commonplace for a shelter, it is not common for most shelters to provide specialized therapeutic services for women over the age of 60 years.

**Specialized Funding**  
Interviewees were asked if funding was available specifically designated to provide programming and services to older women. Each respondent reported funding was designated specifically to care for older victims of domestic violence. Primarily to provide training for staff, additional support staff to provide support groups and marketing materials designed to outreach older women.

**Staff Training**  
Interviewees were asked if training in the field of IPV, aging, and older women was available for staff. Each respondent reported that the staff was required to attend an annual training once per year in the area of aging and IPV issues. In addition, the staff was encouraged to attend training outside of work to enhance needed skills in working with older women.

**Support Groups**  
Interviewees were asked if support groups for older women who were victims of IPV were available onsite and/or offsite. Each respondent reported that support groups were scheduled one time per week, and all but one respondent reported offsite support groups for clients were not part of a resident in the shelter.
CHAPTER 5
DISCUSSION OF FINDINGS

In summary, this revealed and described the demographic data and research questions. Review of data has lead to significant questions regarding domestic violence shelter programming in the state of Texas for older victims of intimate partner violence (IPV). This research identifies current levels of programming and resources specifically adapted to the older women in Texas domestic violence shelters, targeting or lack thereof of older women by shelter outreach programs in Texas, and collaborative efforts between Texas domestic violence shelters and local area agency on aging. To study how the older woman age 60 and older is served by domestic violence shelters in Texas, 66 shelters in the state of Texas were surveyed. This study includes a descriptive review of multiple components of domestic violence shelters, including infrastructure, and review of personnel, outreach services, programming, medication policies, and community education. It is important to reinforce that domestic violence shelters are the primary source of help for women in situations of IPV. Therefore, this research was initiated to determine how shelters in the state of Texas serve women, age 60 and older. Several survey questions asked the executive director and/or representative about current programming, community education, and outreach trends for their shelter. In addition, demographic data was collected for 2009.

This chapter presents a discussion of the research findings concerning aforementioned research questions; review of these findings is discussed, in addition to the study’s implications for policy, practice, and future research studies.
Summary of Findings

Different levels of programming, outreach services, and community education of Texas domestic violence shelters were studied. The study revealed several issues with regard to aforementioned research questions. First, shelters in the state of Texas were not likely to provide specialized programming for older victims of domestic violence. More specifically, only 10% of shelters reported they have specialized programming for older victims of domestic violence. Further studies of this issue may reveal numerous reasons as to why programming does not exist.

Comparable studies, for example Hightower, Smith, Ward-Hall and Hightower (1999) surveyed 48 shelters in western Canada finding only 4 of 44 respondents had special programming for older women. In addition, Vinton (1992) surveyed 25 shelters in Florida, revealing only 2 of 25 shelters offered special programming for older women. In addition, a study by Vinton (1998) revealed (14.8%) shelters nationwide showed an improving trend in the 90s, by adding programming for older women. These findings reveal that programming for older women in domestic violence shelters, in the state of Texas coincides with the findings of Hightower et.al. (1999) and Vinton (1992, 1998). This may be a result of several issues; 1) minimal outreach of shelters to older women, 2) lack of specialized training in the area of gerontology and 3) lack of partnership between area agencies on aging and domestic violence shelters.

Likewise, use of shelters by older women involves certain barriers as described by Wolf (2000) and Smith (1999):

1. Higher noise level
2. Physical and mental disabilities
3. Reduced average length of stay, effecting complex problems older women may encounter
4. Lack of training by staff in the area of gerontology
5. Lack of support for reduced activities of daily living
6. Limited access to healthcare and accompaniment, by shelter staff

In addition, survey questions revealed specific questions that could assess the shelter responding to the needs of older victims of IPV.

Handicapped Accessibility

Executive directors of Texas shelters were asked if their facilities were handicap accessible. All of the shelters revealed that their shelters were accessible. This can be because 100% of shelters were receiving state, federal or both type of funding and the requirement for accessibility is expected for an organization who received this type of funding. The inference is that these shelters are required to provide handicap accessibility. This question reveals an improvement compared with Vinton (1998) who revealed 76.2% of shelters were handicap accessible. Nonetheless, providing handicap accessibility for older women reduces a barrier and can lead to easier access to services within the shelter for the older woman.

Shelters Policy about Dispensing or Storing Medications

This study revealed that 60% of shelters were storing, however not dispensing medications. In addition, 13% revealed they stored and dispensed medications. A study by Vinton (1998) revealed that 24.7% of facilities stored and dispensed medications,
compared to Texas at 13%. It can be inferred that in those shelters with a designated policy including dispensing, and storing medications, could be the result of perceived liability, lack of staffing, or need of training. Therefore, without this service to the community a barrier is then created in providing service to the older woman who may need assistance with dispensing of medications.

Number of Female Staff over 60, Board Members over 60 Years of Age

Executive directors were asked to reveal paid staff over the age of 60, as well as, board members. Of paid staff members 7.9% were over 60 years of age and 12.1% of board members were over 60. Vinton’s (1998) study revealed paid staff members over 60 (42.4%) and (68.9%) revealed having female board members over 60. The importance of this question is inferred when a shelter may seek support from its board members and staff to provide specialized care for the older woman. It of course does not mean that younger men and/or women do not support care of the older woman who is sheltered; however, it lends itself to an empathetic ear.

Community Education about Domestic Violence

This question revealed only 30% of education was provided to area on aging agency staff, 53.3% to senior centers; however, 70% of community education was provided to adult protective services staff and 76.6% to hospital personnel. The inference is that each of these organizations provides services to older women. The importance in providing community education regarding domestic violence is to reveal the importance of assessment and referral for older victims of IPV violence. The
question for further study assess the specific age discussed during these sessions, as well as specific education regarding assessment and evaluation of domestic violence to include, signs of abuse in the older woman. In addition, community awareness of the issues revolving around the older victim of IPV violence is necessary and critical in reducing barriers for the older woman who is a victim of IPV.

Importance in Providing Outreach to Abused Women over 60

Participants were asked to reveal the importance of shelters including outreach to older women; in they were asked to rank the importance of their own shelter providing outreach to older women. Shelters revealed that 13.3% of the time it is extremely critical for outreach to be provided to older female victims of domestic violence (for shelters in general as well as their own shelter).

When asked to describe the specific type of outreach efforts, shelters identified the following in order of importance:

1. Specifically target older battered women in print media/campaign ads
2. Contact with Adult Protective Services
3. Feature older women along with younger women in media campaign, brochures or TV ads
4. Make contact with medical community and lastly ranked
5. Give presentations to senior citizens’ groups

When asked to provide any of the aforementioned outreach programming services shelters identified the following in order of importance:

1. Make contact with medical community
2. Give presentations to senior citizens groups
3. Have contact with APS workers
4. Feature older women along with younger
5. Only six participants specifically targeted the older woman in a print media or radio or TV ad campaign
6. Only one participant stated they feature older women along with younger women in a media campaign (Brochures)

The above information is reflective of the low census of older women at each of the shelters for 2009. It can be inferred that without outreach to older women, older victims may not seek or be aware of services that could meet their needs. For example, AARP (1993) made several recommendations to specifically meet the needs of the older victim. Included, were: sensitizing and educating all service providers, and reaching out to older women by disseminating information about domestic violence through community aging agencies; health clinics; physicians; and senior centers. These recommendations were reflective of research conducted in the 90s, which revealed the importance of outreach to older women who may be victims of IPV.

Special Programming for Older Women within Shelters

Only 10% of shelters reported special programming for older women. Participants described programming as support groups, caregiver abuse, community education and potential for abuse education sessions. Research by Vinton et al. (1997) was a five year follow up survey of Florida’s domestic violence shelters that examined special programming for older battered women. Results of the study revealed an
increase in special programming for older victims of IPV, including an increase in older residents and a small increase in adding older paid staff and/or board members. Obviously, efforts toward providing special programming to older women over 60 will increase the number of older women who utilize this service.

Number of Women Sheltered in 2009/ Number of Women over 60 Sheltered

The number of children sheltered outnumbered the adults. Of the number of adults sheltered in 2009, 2.28% of the women were over 60 years old. Of the 30 shelters reporting, 20% reported housing no women over 60 years old, over half, 56.6% reported housing between 1-3 older women, 13.3% reported housing between 4-9 older women, and only 10% of the facilities had sheltered 10 or more women over 60.

According to Pillemer and Finkelhor (1988) and Vinton (1991) the propensity is to view older women as abused elders and not battered women. This in turn can result in low admissions to domestic violence shelters. In addition, the research suggests that the inclusion of programming for older women will increase admission to shelters (Vinton, et al., 1997). Overall, it can be inferred that low census could be a result of minimal programming for older women, minimal outreach to aging communities, and the inability to distinguish between elder abuse and IPV.

These findings present opportunities for providing improved and specialized services to older women who are victims of domestic violence. In addition, generating funding and awareness at local, federal, and state levels will provide the financial and research support necessary to fund increased programming. The next section discusses the implications of these findings for older women who are victims of IPV and the field of gerontology.
Implications

Since the 1960s the battered women’s movement is responsible for bringing attention to women who are victims of domestic violence (Vinton et al., 1997). However, the specialized needs of older victims of IPV was not been addressed by shelters and/or women until the 1990s. According to Vinton et al. (1997), there were several efforts in the 90s to initiate discussion regarding older IPV. Therefore, over ten years later the implications of this research reveals that this subject is still an issue for communities, and older victims of IPV. In addition, with the current rapid growth rate of the U.S. aging population the implications are even greater. The purpose of this study was to learn about current programming in shelters in the state of Texas. The findings reveal multiple implications that can be utilized in the field of gerontology. Suggestions for the future policy and research agendas regarding the older victim of IPV will be reviewed below.

Implications for the State of Texas

In this study, the implications for designating specific funding for programming for older women who are victims of IPV is critical. This study revealed that shelters in Texas have adapted their programming to meet the needs of younger women and children. However, with designated funding to provide programming for the older woman this will lead to availability of services and increase in utilization of shelter services.

Aging Services

There are also implications for aging services who want to improve their services
to older women who are victims of domestic violence. Aging services such as Adult Protective Services, Area Agency on Aging and Senior centers can begin discussions to request training from shelters to evaluate the needs and assessment tools for older women who are victims of IPV. These practical methods of improving care to older victims of IPV are implied by the research findings.

Staff Training and Development

The findings present implications for a variety of opportunities for staff training and development. Staff development should include ongoing training in the field of aging, including abuse, IPV, caregiver issues, marital issues for older adults, and physical and social aspects of aging. Recent trends in the areas of IPV and the older woman can only improve their care and accessibility to these victims. In addition, the shelter should hire at least one staff person with background in working with older women and men. Training provides staff with the knowledge, background and skills to develop special programming for older victims in their shelter.

Community Education

Although most of the shelters were providing some form of community education and outreach, this study revealed the importance of focusing on senior centers, area agency staff and home health agency staff. This included shelters to begin, continue or improve community education on the topic of IPV and the older woman within their communities. Agencies can include medical communities, adult protective services, civic groups, law enforcement, attorneys, judges, senior centers, home health agency
staff, and community area on aging agency staff. Extending this study to assess current community education topics provided by shelters may reveal little or no discussion on the older woman and IPV. This can encourage the shelter to develop a community education plan to assure agencies are trained on IPV and the older woman.

**Outreach to Older Women**

Improving outreach to older women was an implication of this study. Women were not targeted by shelters in Texas; however, participants did agree this was important. Improving outreach for older women through media, brochures, TV ads, radio, and other forms of print provides accessibility for a much needed service to improve accessibility. Further research is needed to assess specific outreach practices of shelters to older women. Finally, local gerontologists’, executive directors, and aging regulators in the design and assessment process of shelters to meet the needs of this neglected population. Organizations receiving federal and state funding should reveal their efforts in providing care to all age groups.

**Research for Best Practices**

This study revealed a need for further research on shelters that are providing programming to older women. Research in this area should include examples of programming, outreach, training, and community education. Extending this research to include the development of these shelters across the nation would inform services needing change to meet the needs of older victims of IPV. This would also include community-centered research on barriers between shelters and local area on aging agencies.
Qualitative Studies on Older Women who have Utilized Shelter Services

This study revealed the need for researching older women who have used these programs, including benefits they received or would have like to have received. This would help address possible barriers to access.

Concluding Recommendations

1. A staff member designated as the representative or geriatric case manager trained in providing support groups, individual counseling to older victims of IPV.

2. Staff training and education offered within shelters to provide knowledge and skills in caring for the older victim of IPV. This could include cross-training between shelter personnel and local aging organizations. Training topics can include elder IPV, aging process, elder abuse, and aging services resources. Groups to attend should include, law enforcement, medical personnel, health and mental health organizations, social services, legal personnel, and home health organizations.

3. Development of planned outreach designed to provide education to older women in the community. In addition, shelters could collaborate with local organizations whose primary purpose is to serve the aging community.

4. Develop a task force within each community, to include aging services and shelters. This task force would meet monthly to discuss with aging agencies and shelters ongoing development of making their shelter elder ready, including programming design for local shelters.
5. Duplicate this study and the study conducted by (Vinton, 1998) on a national level to seek further updates to current practices for shelters and programming for older women who are victims of IPV.

6. Workshop for APS and domestic violence increase APS and domestic violence shelter interaction to improve collaboration of efforts. Specifically, IPV referrals, assessment, and consultations regarding older victims of IPV and best outcomes for safety.

7. Emergence of new aging entities be mandated to fulfill these responsibilities.

8. Advocacy programs to make sure agencies are accountable and fulfill these responsibilities.

9. Explore solutions from other states and countries whose shelters are providing specialized programming to older women.

10. “We provide a shelter without walls; to meet the needs of elder victims of domestic violence. We utilize resources from within the Jewish Home for the Elderly, such as assisted living apartment, nursing home room and/or apartment” L. Snow (personal communication, September 17. 2010).

Delimitations

1. Studies restricted to Texas

2. Focus only on IPV

Limitations of Study

1. The study relied on multiple choice questions that may not have included all possible choices for each participant.
2. The study requested data that may not have been readily available to executive directors and some of the choices may have been assumed.

3. The study was only conducted in Texas, difficult to generalize to all shelters.

4. Other variables exist that may have decreased the number of admissions for older women; however, this study did not address these.

Conclusion

The goal of domestic violence shelters is to provide safety, support, and education to women and children who are victims of domestic violence. In the 1990s there were factors that contributed to draw attention to older women who were victims of IPV. As factors that contribute to this trend continue in 2010, such as changing demographics, and acknowledgement of IPV among older women, we must address the needs and create public awareness of this issue. McKibben (1998) stated that the older woman has been excluded from the battered women’s movement. In addition, research to address the needs of the older woman has been meager within the past decade. This study affirms the realization that shelter services for older women are limited; therefore, addressing the potential barriers to serving older women who are victims of IPV is not impossible but the ethical responsibility of those who serve victims of IPV.
Domestic Violence Shelter Survey

1. Default Section
   1. Do you operate a shelter?
      O Yes
      O No

2. What year did your shelter begin operating?
   Answer: ___________________________

3. How many beds does your shelter have?

4. Please check your agency’s type
   □ Private     □ Grassroots     □ Public

5. Check the governmental sources that you receive funding from:
   □ Federal     □ State     □ County     □ Local

5a. Do you receive United Way funding?
   O Yes
   O No

6. What is the size of your target population (population in the areas served)?

7. What is the percentage of persons aged 60 and over in your target area?
Domestic Violence Shelter Survey

8. Is your shelter handicapped accessible?
   - Yes
   - No

9. How many women did you shelter during 2009?
   Answer: __________

9a. Of the total number of women sheltered in 2009, how many were aged 60 and over? (Please estimate percentage if your records do not include age)
   Answer: __________


11. What was the average length of stay in 2009 for your shelter?
   Average Length of Stay __________

12. What is the shelter’s policy about dispensing or storage medication?
   - We store it for residents but do not dispense it.
   - We store it and help dispense it.
   - We do not store it for residents.
   Other ______________________________________

13. Do you provide community education about domestic violence?
   - Yes
   - No
<table>
<thead>
<tr>
<th>Domestic Violence Shelter Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>13a. If you answered yes to #13, check the groups you addressed from among those listed.</td>
</tr>
<tr>
<td>O Hospital</td>
</tr>
<tr>
<td>O Law</td>
</tr>
<tr>
<td>O Attorneys/Judge</td>
</tr>
<tr>
<td>O Students/Teachers</td>
</tr>
<tr>
<td>O Senior Centers</td>
</tr>
<tr>
<td>O Civic Groups</td>
</tr>
<tr>
<td>13b. If you checked Civic Groups, how often did the audience consist of a majority of persons who were aged 60 and over?</td>
</tr>
<tr>
<td>O Occasions 1 Occasion 2-4 Occasions 5 or more occasions</td>
</tr>
<tr>
<td>14. How many paid female staff members does your program have?</td>
</tr>
<tr>
<td>Answer:</td>
</tr>
<tr>
<td>14a. Among your paid staff members, how many are women aged 60 and older?</td>
</tr>
<tr>
<td>Answer:</td>
</tr>
<tr>
<td>15. How many volunteers did your program have in 2009?</td>
</tr>
<tr>
<td>Answer:</td>
</tr>
<tr>
<td>15a. Among these volunteers, please estimate the percentage who were women aged 60 and over.</td>
</tr>
<tr>
<td>Answer:</td>
</tr>
</tbody>
</table>
Domestic Violence Shelter Survey

16. Do you have a Board of Directors?
   O Yes
   O No

16a. If yes, how many persons are on your Board?
   Answer: __________

16b. How many of your Board members are women aged 60 and over?
   Answer: __________

17. Do you have any special programming that focuses on the abuse of older women?
   O Yes
   O No

17a. If yes, please describe. ___________________________________________
     ___________________________________________
     ___________________________________________

18. On a scale of 1 to 10 - with 10 being the most critical, how important would you say it is for shelters in general to provide outreach to abused women aged 60 and over? (Mark the response)

   Scale: 1 Not Critical  2  3  4  5 Moderately Critical  6  7  8  9  10 Extremely Critical
19. On a scale of 1 to 10 – with 10 being the most critical, how important would you say it is for your own shelter to provide outreach to abused women aged 60 and over?

| Scale: Not Critical | 1 | 2 | 3 | 4 | 5 | Moderately Critical | 6 | 7 | 8 | 9 | Extremely Critical | 10 |

20. Please rank the outreach efforts below in terms of outreach to abused women aged 60 and over. Use “1” to indicate most important outreach effort and “5” the least important. Also indicate if your program already does this type of outreach.

Feature older women along with younger women in a media campaign (e.g., brochures or TV ads) or TV ads

Have contact with Adult Protective Services workers

Give presentations to senior citizens’ groups

Make contact with medical community (e.g., physicians, Public health nurses/clinics)

Specifically target the older battered woman in a Print media or radio or television ad campaign

20a. Check here if your shelter provides any of the following programming services. (check all that apply)

- Feature older women along with younger women in a media campaign (e.g., brochures or TV ads picturing older women).
- Have contact with Adult Protective services
- Give presentations to seniors
- Make contact with medical community (e.g., physicians, public health nurses/clinics)
- Specifically target the older woman in a print media or radio or television ad campaign
APPENDIX B

INTERVIEW QUESTIONS
Interview Questions

1. HOW MANY YEARS HAS YOUR SHELTER PROVIDED PROGRAMMING TO OLDER WOMEN OVER THE AGE OF 60?

2. WHAT PROMPTED YOUR FACILITY TO PROVIDE A SERVICE TO OLDER WOMEN?

3. WHAT PARTICULAR PROGRAMMING FOR WOMEN OVER 60 YEARS DO YOU PROVIDE IN YOUR SHELTER?

4. DOES YOUR SHELTER PROVIDE PROGRAMMING FOR OLDER WOMEN OUTSIDE OF THE FACILITY?

5. WHAT TYPE OF OUTREACH PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60?

6. WHAT TYPE OF CONTINUING EDUCATION PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60?

7. PLEASE NAME SPECIFIC LOCATIONS YOUR FACILITY PROVIDES OUTREACH AND CONTINUING EDUCATION.

8. DOES YOUR FACILITY PROVIDE SPECIFIC ACCOMODATIONS FOR WOMEN OVER 60 YEARS OF AGE? CAN YOU IDENTIFY THESE ACCOMODATIONS?

9. WHAT ARE YOUR PLANS IN THE FUTURE FOR IMPROVING PROGRAMMING FOR OLDER WOMEN?

10. DO YOU RECEIVE ANY SPECIFIC FUNDING TO BE UTILIZED ONLY FOR OLDER VICTIMS OF DOMESTIC VIOLENCE?

11. DOES YOUR ORGANIZATION PROVIDE TRAINING FOR YOUR STAFF IN MANAGING WOMEN OVER THE AGE OF 60? WHAT ARE SOME OF THESE TITLES?

12. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM ADULT PROTECTIVE SERVICES FOR SHELTER FOR OLDER WOMEN?

13. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM LOCAL AREA AGENCY ON AGING FOR SHELTER FOR OLDER WOMEN?

14. DO YOU BELIEVE MORE ORGANIZATIONS SHOULD PROVIDE PROGRAMMING TO WOMEN OVER 60 YEARS OF AGE?
15. WHAT ADVICE WOULD YOU PROVIDE TO SHELTERS WHO WANT TO BEGIN PROVIDING SPECIFIC SERVICES FOR WOMEN OVER 60 YEARS OF AGE?
APPENDIX C

INTERVIEW TRANSCRIPT RESPONDENTS - 1, 2, AND 3
1. HOW MANY YEARS HAS YOUR SHELTER PROVIDED PROGRAMMING TO OLDER WOMEN OVER THE AGE OF 60?  18 years

2. WHAT PROMPTED YOUR FACILITY TO PROVIDE A SERVICE TO OLDER WOMEN? “I'm not really sure, I think because of our city and high percentage of seniors.”

3. WHAT PARTICULAR PROGRAMMING FOR WOMEN OVER 60 YEARS DO YOU PROVIDE IN YOUR SHELTER? “Not much programming for older women, we only have a support group on campus, once per week. We also do one support group off campus for older victims of domestic violence.”

4. DOES YOUR SHELTER PROVIDE PROGRAMMING FOR OLDER WOMEN OUTSIDE OF THE FACILITY? Support group

5. WHAT TYPE OF OUTREACH PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60? “We have a brochure, safety plan.” “We do some work with senior centers, and really any group that calls us.” Nothing special.

6. WHAT TYPE OF CONTINUING EDUCATION PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60? “We offer many types of continuing education; however, continuing education to elders is limited. We do offer CE to senior centers on domestic violence.”

7. PLEASE NAME SPECIFIC LOCATIONS, YOUR FACILITY PROVIDES OUTREACH AND CONTINUING EDUCATION. “Senior centers, that’s about it.”

8. DOES YOUR FACILITY PROVIDE SPECIFIC ACCOMMODATIONS FOR WOMEN OVER 60 YEARS OF AGE? CAN YOU IDENTIFY THESE ACCOMMODATIONS? Yes. “We are ADA accessible.”

9. WHAT ARE YOUR PLANS IN THE FUTURE FOR IMPROVING PROGRAMMING FOR OLDER WOMEN? “None at this time.”

10. DO YOU RECEIVE ANY SPECIFIC FUNDING TO BE UTILIZED ONLY FOR OLDER VICTIMS OF DOMESTIC VIOLENCE? “We have had a small grant for this purpose from a private donor.”
11. DOES YOUR ORGANIZATION PROVIDE TRAINING FOR YOUR STAFF IN MANAGING WOMEN OVER THE AGE OF 60? WHAT ARE SOME OF THESE TITLES? “Yes, we offer training on aging and domestic violence.” “Can’t recall the titles.”

12. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM ADULT PROTECTIVE SERVICES FOR SHELTER FOR OLDER WOMEN? “Yes, we have referrals from APS.”

13. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM LOCAL AREA AGENCY ON AGING FOR SHELTER FOR OLDER WOMEN? “Not that I can recall.”

14. DO YOU BELIEVE MORE ORGANIZATIONS SHOULD PROVIDE PROGRAMMING TO WOMEN OVER 60 YEARS OF AGE? “Yes, I am surprised there are not more.”

15. WHAT ADVICE WOULD YOU PROVIDE TO SHELTERS WHO WANT TO BEGIN PROVIDING SPECIFIC SERVICES FOR WOMEN OVER 60 YEARS OF AGE? “Start slow, support group, and spend time at locations where seniors are there.”
Interview Transcript: Respondent 2

1. HOW MANY YEARS HAS YOUR SHELTER PROVIDED PROGRAMMING TO OLDER WOMEN OVER THE AGE OF 60? “Since we opened in 1991.”

2. WHAT PROMPTED YOUR FACILITY TO PROVIDE A SERVICE TO OLDER WOMEN? “Nothing in particular, we offer services to all ages, and have always spent some time specializing our services as needed.”

3. WHAT PARTICULAR PROGRAMMING FOR WOMEN OVER 60 YEARS DO YOU PROVIDE IN YOUR SHELTER? “I would say our support group for 65+.”

4. DOES YOUR SHELTER PROVIDE PROGRAMMING FOR OLDER WOMEN OUTSIDE OF THE FACILITY? “We have a 65+ support group for women.”

5. WHAT TYPE OF OUTREACH PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60? “Nothing specific I can think of.”

6. WHAT TYPE OF CONTINUING EDUCATION PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60? “We do offer some CE, of all types, we do offer a course called domestic violence after 60.”

7. PLEASE NAME SPECIFIC LOCATIONS, YOUR FACILITY PROVIDES OUTREACH AND CONTINUING EDUCATION. “Don’t know” for sure, anywhere that calls really.”

8. DOES YOUR FACILITY PROVIDE SPECIFIC ACCOMODATIONS FOR WOMEN OVER 60 YEARS OF AGE? CAN YOU IDENTIFY THESE ACCOMODATIONS? “Yes”

9. WHAT ARE YOUR PLANS IN THE FUTURE FOR IMPROVING PROGRAMMING FOR OLDER WOMEN? “Nothing at this time.”

10. DO YOU RECEIVE ANY SPECIFIC FUNDING TO BE UTILIZED ONLY FOR OLDER VICTIMS OF DOMESTIC VIOLENCE? “Yes, we have an amount designated in our budget from grant money.”

11. DOES YOUR ORGANIZATION PROVIDE TRAINING FOR YOUR STAFF IN MANAGING WOMEN OVER THE AGE OF 60? WHAT ARE SOME OF THESE TITLES? “Not all the time, one of our therapists has a lot of experience in aging and she does some training for us.”
12. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM ADULT PROTECTIVE SERVICES FOR SHELTER FOR OLDER WOMEN? “Yes, not that much.”

13. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM LOCAL AREA AGENCY ON AGING FOR SHELTER FOR OLDER WOMEN? “Not really.”

14. DO YOU BELIEVE MORE ORGANIZATIONS SHOULD PROVIDE PROGRAMMING TO WOMEN OVER 60 YEARS OF AGE? “Yes”

15. WHAT ADVICE WOULD YOU PROVIDE TO SHELTERS WHO WANT TO BEGIN PROVIDING SPECIFIC SERVICES FOR WOMEN OVER 60 YEARS OF AGE. “I think it would be training to places like APS and Senior Centers, we don’t get many referrals from them.” Also, add more training for your staff.”
1. HOW MANY YEARS HAS YOUR SHELTER PROVIDED PROGRAMMING TO OLDER WOMEN OVER THE AGE OF 60? “Since we opened in 1978 (I think that was the year!”

2. WHAT PROMPTED YOUR FACILITY TO PROVIDE A SERVICE TO OLDER WOMEN? “I wouldn't say that we provide "specialized" programming to women over 60. We will serve anyone who needs our services.”

3. WHAT PARTICULAR PROGRAMMING FOR WOMEN OVER 60 YEARS DO YOU PROVIDE IN YOUR SHELTER? “Nothing specific to those over 60—we will accommodate any special needs that anyone in shelter has. If a woman over 60 identifies that she needs something, specific we will provide it.”

4. DOES YOUR SHELTER PROVIDE PROGRAMMING FOR OLDER WOMEN OUTSIDE OF THE FACILITY? “We have a 65+ support group for women.”

5. WHAT TYPE OF OUTREACH PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60? “N/A”

6. WHAT TYPE OF CONTINUING EDUCATION PROGRAMMING DOES YOUR FACILITY PROVIDE TO OLDER WOMEN OVER 60? “N/A”

7. PLEASE NAME SPECIFIC LOCATIONS, YOUR FACILITY PROVIDES OUTREACH AND CONTINUING EDUCATION. “We will provide to whoever asks for it.”

8. DOES YOUR FACILITY PROVIDE SPECIFIC ACCOMODATIONS FOR WOMEN OVER 60 YEARS OF AGE? CAN YOU IDENTIFY THESE ACCOMODATIONS? “Yes. Whatever the client asks for we will provide if we can.”

9. WHAT ARE YOUR PLANS IN THE FUTURE FOR IMPROVING PROGRAMMING FOR OLDER WOMEN? “None”

10. DO YOU RECEIVE ANY SPECIFIC FUNDING TO BE UTILIZED ONLY FOR OLDER VICTIMS OF DOMESTIC VIOLENCE? “Yes, we have a small designated amount.”

11. DOES YOUR ORGANIZATION PROVIDE TRAINING FOR YOUR STAFF IN MANAGING WOMEN OVER THE AGE OF 60? WHAT ARE SOME OF THESE TITLES? No
12. DOES YOUR ORGANIZATION RECEIVE REFERRALS FROM ADULT PROTECTIVE SERVICES FOR SHELTER FOR OLDER WOMEN? “Yes, but very rarely.”

13. DO YOU BELIEVE MORE ORGANIZATIONS SHOULD PROVIDE PROGRAMMING TO WOMEN OVER 60 YEARS OF AGE. “I don’t know” WHAT ADVICE WOULD YOU PROVIDE TO SHELTERS WHO WANT TO BEGIN PROVIDING SPECIFIC SERVICES FOR WOMEN OVER 60 YEARS OF AGE. “Nothing specific—I would just say to be open to accommodating the needs of anyone and everyone who needs your services. Ask them what they need, how they can feel comfortable in shelter and if their needs are being met, and then do whatever is within your mean to make these accommodations. Train staff to try and tailor services to specific needs and desires of each client, as everyone is different. Don’t be afraid to ask the client what they need. Don’t be afraid to make accommodations.”
APPENDIX D

INFORMED CONSENT FORM
Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** Domestic Violence Shelters in Texas: Responding to the needs of Older Victims of Intimate Partner Violence (IPV).

**Principal Investigator:** Yvonne Lozano, Doctoral Student, University of North Texas (UNT) Department of Applied Gerontology.

**Purpose of the Study:** You are being asked to participate in a research study which involves seeking to increase knowledge and understanding regarding domestic violence shelter programming for older women who are victims of intimate partner violence (IPV).

**Study Procedures:** You will be asked to complete a 20 question web-based survey that will take about 30 minutes of your time.

**Foreseeable Risks:** No foreseeable risks are involved in this study.

**Benefits to the Subjects or Others:** We expect the project to benefit you by promoting effective aging sensitive intervention programs for older victims of domestic violence. Literature suggests that in order to meet the needs of the older battered women programming designed to address the needs of the older woman will enhance services. Note: IRB studies cannot guarantee results.

**Compensation for Participants:** You will receive no payment or compensation for your participation.

**Procedures for Maintaining Confidentiality of Research Records:** The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

**Questions about the Study:** If you have any questions about the study, you may contact Yvonne M Lozano.

**Review for the Protection of Participants:** This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.
Research Participants’ Rights:

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Yvonne M Lozano has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

________________________________
Printed Name of Participant

________________________________                             ____________
Signature of Participant                                      Date

For the Principal Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

______________________________________                    ___________
Signature of Principal Investigator or Desigenee   Date
APPENDIX E

UNT IRB APPROVAL FORM
April 14, 2010

Dr. Stan Ingman
Department of Applied Gerontology
University of North Texas

RE: Human Subjects Application No. 10-163

Dear Dr. Ingman:

In accordance with 45 CFR Part 46 Section 46.101, your study titled “Domestic Violence Shelters in Texas: Responding to the Needs of Older Victims of Intimate Partner Violence” has been determined to qualify for an exemption from further review by the UNT Institutional Review Board (IRB).

Enclosed is the consent document with stamped IRB approval. Please copy and use this form only for your study subjects.

No changes may be made to your study’s procedures or forms without prior written approval from the UNT IRB. Please contact Jordan Smith, Research Compliance Analyst, ext. 3940, if you wish to make any such changes. Any changes to your procedures or forms after 3 years will require completion of a new IRB application.

We wish you success with your study.

Sincerely,

Patricia L. Kaminski, Ph.D.
Associate Professor
Chair, Institutional Review Board

PK:js
REFERENCES

Retrieved October 1, 2010 from


Texas Department on Aging Demographic Profile of the Elderly in Texas (2000).

Texas Department on Aging [TDOA]: Austin, TX.


