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Depression among Perpetrators of Domestic Homicide

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Graduate Program in Education

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Arts

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DEPRESSION AMONG PERPETRATORS OF DOMESTIC HOMICIDE
(Thesis format: Monograph)

by

Polly Cheng

Graduate Program in Faculty of Education

A thesis submitted in partial fulfillment
of the requirements for the degree of
Masters of Arts, Counselling Psychology

The School of Graduate and Postdoctoral Studies
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London, Ontario, Canada

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Abstract

Background: Depression among perpetrators of domestic homicide and domestic homicide-suicide is present in upwards of 75% of cases. Between 2003 and 2011, the Domestic Violence Death Review Committee (DVDRC) classified 56% of perpetrators with depression in all the cases in Ontario. **Methods**: Secondary data analysis of 133 cases taken from the DVDRC database was conducted to determine whether differences exist between depressed and non-depressed perpetrators. **Results**: Cases with depressed perpetrators had significantly more risk factors present than in cases with non-depressed perpetrators. Depressed perpetrators and perpetrators who committed homicide-suicide were significantly older than non-depressed perpetrators and perpetrators of homicide. Key characteristics of depressed perpetrators include threats and attempts of suicide, perpetrator witnessed violence as a child, prior history of hostage-taking and obsessive behaviour. **Conclusions**: This information is essential to educate mental health professionals because they are more likely to have an opportunity to intervene in light of the presenting depression.

Keywords: domestic homicide, domestic violence, depression, domestic homicide-suicide, risk assessment, risk management, prevention

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Domestic Violence

Domestic violence or intimate partner violence is defined as abuse committed by an intimate partner that can be of a physical, sexual, emotional, and/or financial nature (Webster, Pedrosa, & Lopez, 2012). An intimate partner can be a current or former spouse, common-law partner or a boyfriend/girlfriend. Domestic violence accounts for 12% of violent crime that occurs in Canada (Statistics Canada, 2009). Eighty percent of all reported violence is perpetrated by a spouse (Belfrage & Rying, 2004). In addition to physical injury, domestic violence also results in an array of mental health problems such as post-traumatic stress disorder (PTSD), complex trauma, depression, anxiety and substance abuse (Campbell, 2002). Lifetime prevalence rates of 30-33% for domestic violence within the psychiatric population were found to be the highest compared with other healthcare settings (Alhabib, Nur, & Jones, 2010). Although the rate of domestic violence has been stable in Canada since 2004, 6% of all Canadians experience intimate partner violence in the 5 years preceding the report (Statistics Canada, 2009). Moreover, less than one-quarter of domestic violence victims report the abuse to the police (Statistics Canada, 2009).

Studies have been conducted to better understand the profile of men who perpetrate domestic violence. Three typologies of male batterers have been proposed, they are: family only, dysphoric/borderline and generally violent/antisocial batterers (Holtzworth-Munroe & Stuart, 1994). Table 1 provides a summary of batterer types. Family only (type I) batterers are described as the least violent; they do not exhibit any psychopathology or personality disorder and have low to moderate levels of depression and substance abuse. Family batterers tend to have a moderate level of anger. Dysphoric/borderline (type II) batterers engage in moderate to high levels of both

psychological and sexual abuse. They range low to moderate in terms of general violence and criminal behaviour and moderate to high in terms of marital violence. Dysphoric/borderline batterers frequently have a borderline or schizoidal personality disorder, as the name suggests, have high levels of anger and are highly likely to be diagnosed with depression. Finally, the generally violent/antisocial batterers are also characterized by engaging in moderate to high levels of psychological and sexual abuse. As their typology suggests, they demonstrate high levels of violence and criminal activity inside and outside the home. These batterers typically have antisocial/psychopathic personality disorders who are also highly like to abuse substances. They are unlikely to be depressed and display a moderate degree of anger.

Table 1: Holtzworth-Munroe & Stuart's (1994) Batterer Typology

Dimension and variable	Family-only batterer	Borderline-dysphoric batterer	Generally violent-antisocial batterer
Three descriptive dimensions			
Marital violence			
Severity of marital violence	Low	Moderate-high	Moderate-high
Psychological and sexual abuse	Low	Moderate-high	Moderate-high
Generality of violence			
Extrafamilial violence	Low	Low-moderate	High
Criminal behaviour, legal involvement	Low	Low-moderate	High
Psychopathology-personality disorder			
Personality disorder	None or passive-dependent	Borderline	Antisocial
Depression	Low-moderate	High	Low
Alcohol or drug abuse	Low-moderate	Moderate	High
Anger	Moderate	High	Moderate

Table taken from Holtzworth-Munroe & Stuart, 1994

Perpetrators of domestic homicide are thought to conform to the dysphoric/borderline batterer typology (Belfrage & Rying, 2004). This is further supported by Maiura and colleagues who found that both generally violent men and domestically violent men displayed high levels of anger and hostility, but only the domestically violent men were more likely to be depressed (Maiura, Cahn, Vitaliano, Wagner, & Zegree, 1988).

The extreme act of domestic violence is domestic homicide. Between 2003 and 2012 in Ontario, 73% of domestic homicide cases reported a history of domestic violence (Domestic Violence Death Review Committee, 2012). Between 2000 and 2009, 16% of all solved homicides were committed by an intimate partner (Statistics Canada, 2009). Furthermore, women are more likely to be murdered by an intimate partner than by a stranger or an acquaintance (Statistics Canada, 2009).

Domestic Homicide

Homicide as a whole is typically dominated by men as both perpetrators and victims. However, domestic homicide is characteristically represented by male perpetrators and female victims and these trends are prevalent in even greater proportions in homicide-suicides (Gregory, 2012). Domestic homicide or intimate partner homicide is defined as the killing of an intimate partner (Belfrage & Rying, 2004). There has been a gradual decline of domestic homicide in Canada since 1980 and it has remained stable in recent years (Statistics Canada, 2010). Despite the decline, there are still a disproportionate number of female victims compared to male victims (Statistics Canada, 2010). The sex ratio of killing (SROK) for Canada was 31, meaning that for every 100 men who kill their wives 31 women will kill their husbands (Wilson & Daly, 1992).

Although homicides are typically committed by men, women consist of a small percentage of perpetrators. There are differences with respect to motivations behind the murder. For instance, men typically kill their intimate partner as result of threatened or pending separation while women most commonly kill their intimate partner after long-term battery and abuse by the victim and the murder is in response to violence initiated by the batterer (Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Lund & Smorodinsky, 2001).

One study found that offenders of domestic homicide were typically male, socially disadvantaged, middle aged, permanently unemployed, alcoholics and had a long history of violence (Kivivuori & Lehti, 2011). These traits include some of the risk factors associated with domestic homicide. There are a number of risk factors that have been identified within the literature such as a history of domestic violence, actual or pending separation, mental illness, obsessive behaviour, substance use, and guns (Domestic Violence Death Review Committee, 2012). The most common risk factors will be discussed in this section.

One of the most prevalent risk factors that has been identified in multiple studies is a history of domestic violence (Belfrage & Rying, 2004; Campbell et al., 2007). Interestingly, regardless of the gender of the victim, 67%-75% of cases reported a history of domestic violence against the female partner (Campbell et al., 2007). In addition to the offender perpetrating domestic violence, many offenders frequently witnessed domestic violence or were victims of violence as children (Aldridge & Browne, 2003).

Another risk factor that is common in the majority of domestic homicide cases is either actual or pending separation. Separation can be physical and/or legal and the

combination of both presents the greatest risk for domestic homicide (Wilson & Daly, 1993). The majority of domestic homicide occurs within 3 months of separation so women are at greatest risk at the time of separation (Wilson & Daly, 1993). One study found that 47% of domestic homicide cases occurred within 2 months after separation and 29% within one year (Wallace, 1986, as cited in Aldridge & Browne, 2003).

The next most frequent risk factor is obsessive behaviour. According to the DVDRC (2012), 54% of cases report obsessive behaviour in the perpetrator. An example of this behaviour is stalking. Stalking includes following the victim to and/or from work or school, destroying the victim's property and leaving threatening messages on voicemail (Campbell et al., 2003). Sexual jealousy may also fall under this category. The extreme case of sexual jealousy is morbid jealousy, this is when an individual is obsessed with his/her partner's real or perceived infidelity and frequently invokes circumstantial evidence to support their suspicions (Aldridge & Browne, 2003). Several studies have cited sexual jealousy as a precipitating factor of violence and consequent fatalities (Adinkrah, 2014; Goldney, 1977; Liem & Nieuwbeerta, 2010; Rosenbaum, 1990; Saleva, Putkonen, Kiviruusu, & Lönnqvist, 2007; Starzomski, 2000; Statistics Canada, 2009).

Another pertinent risk factor is the access to firearms. Although prevalence of gun ownership is much higher in some countries, access to firearms still poses a risk in countries with stricter gun laws. A study completed in the United States found that firearms were twice as likely to be used in domestic homicide compared with other homicides (Bailey et al., 1997). In Ontario, guns were used in 27% of the cases and the most common method of killing was stabbing (Domestic Violence Death Review Committee, 2012).

Substance abuse has been a common trait found in many perpetrators. Over 50% of perpetrators had a substance abuse problem with 37.9% having an alcohol problem and 14.7% with a drug problem (Dobash, Dobash, Cavanagh, & Lewis, 2004). However, substance abuse is more prevalent in perpetrators of other types of homicide. Campbell et al. (2003) found 70% of perpetrators to have abused alcohol or drugs at the time of the offence. Perpetrators who abuse alcohol were eight times more likely to abuse their partners and twice as likely to murder their partner (Sharps, Campbell, Campbell, Gary, & Webster, 2001). Despite the high rates of substance use, they do not tend to be significant predictors of domestic homicide (Campbell et al., 2003). Lastly, depression has been identified as a risk factor in many studies of domestic homicide (Hirose, 1979; Malmquist, 1990; Rosenbaum & Bennett, 1986; Rosenbaum, 1990; Schlesinger, 2000) and will be discussed in greater detail within the following sections.

Domestic Homicide-Suicide

Homicide and suicide are distinct acts and are typically studied as separate and independent phenomenon. However, they occasionally occur together, though rarely (Liem, 2010). Incidence rates vary depending on the country, but they range from 0.05 per 100 000 persons per year in England and Wales to 0.38 per 100 000 per year in the United States (Liem, 2010). Domestic homicide-suicide can be defined by the killing of an intimate partner followed by the self-destructive act of suicide (Liem & Roberts, 2009). Different researchers rely on different timelines for the acts. Some state their criteria at 24 hours for both acts to be completed to be classified as a homicide-suicide, others use several days or a week as criterion while some others do not have a time criteria at all (Liem, 2010).

Some of the trademark characteristics of homicide-suicide offenders include White, male, lower middle working class, married, cohabiting or recently separated (Gregory, 2012). Eliason (2009) found that these crimes were more commonly precipitated by the threat of separation in comparison with domestic homicide only. The rates of homicide-suicides have generally been stable over the past 40 years (Eliason, 2009). Similar to domestic homicides, domestic homicide-suicides are predominantly committed by men (Liem, 2010). Perpetrators of homicide-suicide also tend to be older than perpetrators of homicide alone (Eliason, 2009). Lund & Smorodinsky (2001) found the majority of the oldest perpetrators in their sample committed homicide followed by suicide while less than half of the perpetrators who were under 40 years old committed suicide. While substance use in domestic homicides are reported relatively frequently, substance use in homicide-suicide cases are reported half as frequently as homicide only cases with ranges between 15%-32% of cases testing positive for alcohol (Eliason, 2009).

Another distinct feature is a lack of criminal history and the majority of perpetrators were employed. One major risk factor, more pertinent to US populations was access to a firearm. Interestingly, the use of firearms was more likely in homicide-suicide cases than in homicide only or suicide only cases (Panczak et al., 2013). Studies found 16%-100% of homicide-suicides, dependent on geographical location, were carried out with a firearm (Eliason, 2009; Panczak et al., 2013). European Union countries and Canada have more restrictive gun laws, and the rates of homicide-suicides represented a smaller proportion of firearm use but prevalence remained stable. The primary method of homicide was strangulation in the UK (Travis, Johnson, & Milroy, 2007) and trauma due to stabbing in Ontario (Domestic Violence Death Review Committee, 2012). Another

factor in homicide-suicide was depression. An overwhelming number of homicide-suicide cases report perpetrator depression and these rates range from 19%-57% (Eliason, 2009). Lastly, a history of domestic violence was present in 9.6%-54% of cases (Eliason, 2009).

The majority of this research has been conducted in Westernized countries such as Canada, United States and Europe. In a recent publication, the same trends have been found in Ghana (Adinkrah, 2014). This study examined data obtained from the daily newspaper from 1990 to 2009. The author found that homicides-suicides were predominantly committed by men against women and that the majority of incidences were intimate partner homicides. Both perpetrator and victim typically had a low socioeconomic status. Furthermore, a substantial proportion of the murders were motivated by the suspicion of infidelity. Another main risk factor was the threat of divorce or separation. Lastly, homicide-suicides were most often carried out with the use of a firearm, machetes and knives.

Motivations that include sexual jealousy, poor health and other life stressors were found to be significantly related to homicide-suicides in comparison with other motivators (Dawson, 2005). Furthermore, these men tend to be more controlling and dependent on their partners to the point where this connection is an essential piece of their identity (Liem & Roberts, 2009). Wilson and Daly (1993) theorized that the act of domestic homicide is an attempt to regain control because perpetrators feel that their power and control over the relationship is threatened when their partner wants to leave the relationship. In many cases of homicide-suicide, homicide appears to be secondary with suicide being the primary objective (Saleva et al., 2007). Harper & Voigt (2007)

proposed that the perpetrators have already decided to commit suicide before going through with the homicide, as such, suicide is not a response to the guilt and shame of killing his intimate partner. Instead, the resolve to commit suicide acts as a “free pass” to murder his partner (Harper & Voigt, 2007). This point is illustrated in Oliffe and colleagues' (2003) case examples where men left suicide notes and explained their options of taking their own lives or alternately taking his own life and his family’s lives. These men justified the latter with the belief that their family could not survive without them.

Homicide-suicide and homicide only perpetrators tend to have separate and distinct profiles (Liem & Roberts, 2009; Lund & Smorodinsky, 2001). Homicide-suicide is most commonly perpetrated by an older intimate partner with a firearm (Lund & Smorodinsky, 2001). Lund & Smorodinsky (2001) also found cultural differences: White and Hispanic perpetrators were more likely to follow homicide with suicide in comparison with Black perpetrators. Men who commit domestic homicide were typically younger, have a criminal history, more likely to have a lower socioeconomic status and of a minority group (Starzomski, 2000).

Depression

Depression in Men

Depression has been predominantly diagnosed in women; twice as frequently as in men (Kessler, Chiu, Demler, & Walters, 2005). Branney & White (2008) propose that there may be an underestimation in prevalence of depression in men because their symptoms of depression may be different than those reported by women as defined by the *Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)* (American Psychiatric Association, 2013). There are different theories that postulate this discrepancy. Some

studies suggest that this difference is a result of men and women expressing depression differently (Branney & White, 2008). Women expressed more symptoms during a depressive episode than men (Wilhelm, Parker, & Asghari, 1998). Women tend to experience worry, crying spells, helplessness, loneliness, suicidal ideation, increased appetite and weight gain (Branney & White, 2008). Such symptoms are in accordance with the *DSM-5*. Men tend to experience more somatic symptoms and display externalizing behaviour such as slow movements, lack of movements and slow speech, non-verbal hostility and alcohol and drug abuse (Branney & White, 2008). Other male expressions of depression include sudden irritability, anger attacks, aggressive behaviour and alexithymia (Winkler, Pjrek, & Kasper, 2006). The difference in the expression of male depression is often viewed as “masked” as a result of gender norms in Western culture (Addis, 2008). Societal norms for men to have a drive to be masculine create a belief where seeking for help for depression might be a sign of weakness or contradictory of masculinity (Branney & White, 2008). Men rarely seek out help, they are especially less likely to seek help through mental health services (Addis & Mahalik, 2003).

Men’s responses to depression are different from women’s responses (Nolen-Hoeksema, Morrow, & Fredrickson, 1993).These authors proposed that, while women tend to ruminate when they are experiencing depressed moods, men tend to use self-distractions. Furthermore, the way that one responds to depressive mood influences the likelihood of falling into a depressive episode. Nolen-Hoeksema and colleagues (1993) suggest that individuals who ruminate tend to become more depressed and the symptoms evolve into a more severe and lengthy depressive episode while those who self-distract are less likely to develop depression. In addition to differing responses, men and women

also react differently to triggering events. While men respond to marital disruption, divorce or separation with greater degrees of depression (Bruce & Kim, 1992), women tend to experience symptoms of depression as a result of a wider range of interpersonal relations or family related stressors (Nazroo, Edwards, & Brown, 1997).

The “big build” model illustrates that men express depression differently (Brownhill, Wilhelm, Barclay, & Schmied, 2005) (see Figure 1 for illustration). This model suggests that men first act inwards and eventually act outwards with destructive behaviours. They begin by avoiding emotional distress, such as depression, by using self-distraction like overworking. When that is ineffective they attempt to numb the distress through self-medication. The next step in the trajectory begins with externalizing behaviours in an effort to escape the distress and one example may be engaging in extramarital affairs. Distress accumulates because the emotions are inadequately resolved. As distress builds-up there is an escalation of violence that may result in suicidal behaviour.

The “big build” complements the theory of anger attacks. As depression is often externalized, anger has been one of the symptoms identified in “male depressive syndrome” (Rutz, Knorring, Pihlgren, Rihmer, & Walinder, 1995). Anger attacks are a sudden onset of rage and anger that is often perceived as an overreaction and inappropriate (Winkler et al., 2006). The most common physiological symptoms of an anger attack include tachycardia, feeling aggressive towards others, feeling out of control, shortness of breath, sweating and guilt or regret after attacks. Depressed men were more likely to be irritated and overreact in response to minor annoyances compared to women

who were depressed (Winkler, Pjrek, & Kasper, 2005). This lends support to the idea that hostility and aggression during depression can lead to homicidal behaviour.

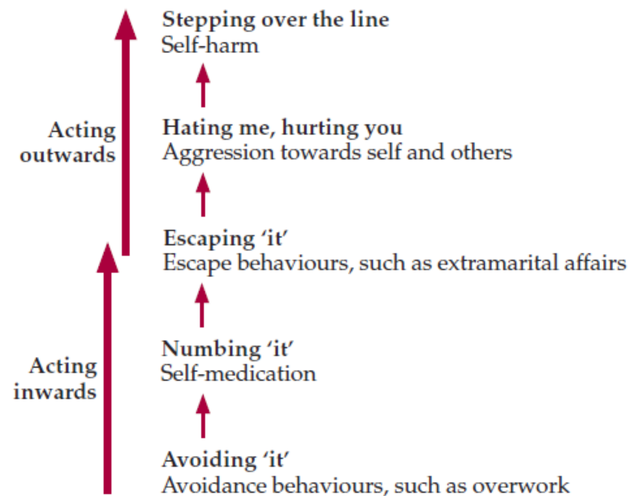

Fig. 1 The 'big build': the upward trajectory of the masculine enactment of emotional distress (after Brownhill *et al*, 2005).

Figure 1: The "Big Build" Model (taken from Brownhill et al., 2005)

Life Stressors, Triggers and/or Loss Associated with Depression

Stressful life events are frequently found to be highly correlated with major depression (Kendler, Karkowski, & Prescott, 1999). Kendler and colleagues studied the relationship between dimensions of loss, humiliation and entrapment and the onset of major depression (Kendler, Hettema, Butera, Gardner, & Prescott, 2003). The onset of major depression was significant within the month of the event for all categories of loss (Kendler et al., 2003). On the humiliation dimension, only other-initiated separation significantly impacted the onset of major depression. The results for entrapment were inconclusive. This study lends support that individuals who experience loss, especially loss of an intimate partner, are substantially impacted by these events and consequently puts the individual at greater risk for the onset of depression.

Harper & Voigt's (2007) integrated model of homicide-suicide illustrates the pathway towards homicide-suicide. The sequence of events is initiated by some sort of intense conflict that results in negative relationships. These conflicts lead to blocked needs or goals such as money, sex, masculine status or autonomy, the loss of a partner or meaning in life, the threat or presentation of negative stimuli such as verbal or physical abuse, rejection or abandonment. Blocked goals lead to frustration. For example, loss of a partner leads to hopelessness; a sense of failure or threat of failure lead to a sense of loss of control. These factors contribute to a perpetrators drive towards homicide. Harper & Voigt found that the greater emotional involvement between perpetrator and victim(s), the greater the intensity of violence. Comparing familicide-suicides, public killing sprees and domestic homicide-suicide, the authors found the central theme of power imbalance as the common dynamic specifically between perpetrator and victim(s) of domestic homicide-suicide. These behaviours include patriarchal dominance, obsessive behaviours, sexual jealousy, high dependency on one another, and controlling behaviours. The overwhelming feelings of failure and loss create a sense of loss of control. The resulting violence is an attempt to end their frustration, humiliation and suffering. In addition, feelings of guilt, shame, resolve and disgust emerge as a result of their planned actions and in a last attempt to resolve these feelings they turn to suicide. (See Figure 2 for an illustration).

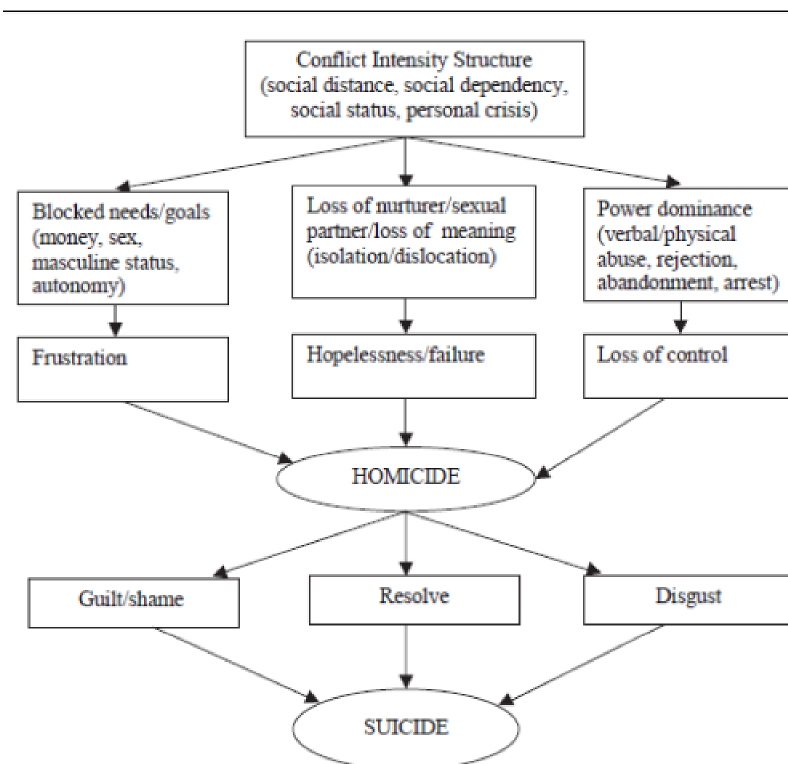

Figure 2: An Integrated Theoretical Model of Homicide Followed by Suicide (taken from Harper & Voigt, 2007)

Depression and Domestic Homicide

As humiliation and loss have been shown to precipitate the onset of depression, the perpetrator is likely to react as a result of damaged pride and shame, also known as narcissistic injury, or react as a result of object loss such as death or real or perceived separation (Rosenbaum & Bennett, 1986). These narcissistic injuries begin, as the "big build" model suggests, with a loss of self-esteem and depressive affect and culminate with an outburst of aggression that may result in fatal violence. Murders committed out of rage tend to be more violent (Aldridge & Browne, 2003). Intimate partner homicides committed by men were much more violent than murders of other types of victims (Casenave & Zahn, 1992, as cited in Aldridge & Browne, 2003). These behaviours have been associated with some type of mental illness (Oram et al., 2013).

Mental illness has been commonly ascribed to perpetrators. Twenty-seven percent of perpetrators were labeled with mental health problems (Dobash et al., 2004). Another larger scale study found 20% of perpetrators displayed symptoms of mental illness at the time of their offence (Oram, Flynn, Shaw, Appleby, & Howard, 2013). In this study of 1180 perpetrators, Oram et al. examined the relationship between mental illness and domestic homicide and found that 7% of these perpetrators experienced symptoms of psychosis while 13% experienced symptoms of depression. Approximately one-third of these perpetrators had a lifetime diagnosis of mental illness: 17% were diagnosed with affective disorder, 6% were diagnosed with schizophrenia and other delusional disorders and 7% were diagnosed with a personality disorder. A large proportion of perpetrators are suffering from mental illness, primarily mood disorders.

Depression is identified as a risk factor in several studies (Hirose, 1979; Liem & Koenraadt, 2008; Rosenbaum & Bennett, 1986; Rosenbaum, 1990; Saleva et al., 2007). The prevalence of depression in some studies include 75% of the perpetrators (n=18) (Rosenbaum, 1990), another reported 56% of 39 perpetrators in Quebec were depressed (Buteau, Lesage, & Kiely, 1993). Yet, in another study, the perpetrator exhibited signs of depression in 12% of all 1431 domestic homicide cases (Oram, Flynn, Shaw, Appleby, & Howard, 2013). They found that depressed perpetrators tended to be older and were less likely to have previous convictions or a history of drug or alcohol abuse. When depression is such a frequent occurrence among domestic homicide offenders, it is surprising that the research is so scarce. There was a similar rate of occurrence of major depression in homicide and homicide-suicide groups: homicide only offenders represented 75% of the sample and homicide-suicide offenders represented 87%

(Rosenbaum & Bennett, 1986). They also found that depressed perpetrators were more likely to have both a history of homicidal and suicidal behaviour compared with non-depressed perpetrators. Other factors included personality disorder, historical child abuse, drug or alcohol abuse and sexual infidelity as a precipitating event. Despite the prevalence of depression in studies, there is a paucity of research conducted specifically examining the relationship between depression and domestic homicide. The available literature has a greater emphasis on the relationship between depression and domestic homicide-suicide.

Depression and Domestic Homicide-Suicide

Many studies examining depression did not differentiate between homicide-only and homicide-suicide. Homicide-suicides are rare and it is difficult to contrast the differences between the two groups with respect to specific characteristics that distinguish one from the other.

Eliason (2009) reported findings from different studies of domestic homicide-suicide that ranged from 19%-57% of perpetrators who were depressed. On an international level, a review of mental illness in homicide-suicide cases revealed that depression was the most frequent mental illness occurring in 39% of cases (Roma et al., 2012). In a sample of 36 couples, all the perpetrators of homicide resulting in suicide were depressed (75%) while the homicide only perpetrators were not (Rosenbaum, 1990). Furthermore, the depressed perpetrators were found to have a personality disorder, violent behaviour, in a long-term relationship with the victim, a history of separations and reunions and the couple were experiencing separation at the time of their offence. In another study conducted by Rosenbaum & Bennett (1986), the non-depressed

perpetrators also had a personality disorder, substance abuse, antisocial behaviour, and separation was also imminent at the time of the offence. Premeditation was most likely found in homicide-suicide cases but perpetrators who were depressed were even more likely to have premeditated the crime (Dawson, 2005).

A number of studies have identified age as a risk factor in domestic homicide-suicides (Bourget, Gagné, & Whitehurst, 2010; Eliason, 2009; Lund & Smorodinsky, 2001; Oram et al., 2013). Roma et al 's (2012) review found that depression existed with an even higher prevalence of 60% in older offenders. In older offenders, homicide-suicide is more common as a result of the stress from caring for a partner. Caring for an ill partner is highly correlated with depression (Bourget et al., 2010).

Suicidal ideation is characteristic of major depressive disorder (American Psychiatric Association, 2013). A feature found in some studies is that perpetrators have threatened suicide prior to the offense (Belfrage & Rying, 2004). Furthermore, one study found that many depressed perpetrators were prescribed antidepressant medication but out of the 65% of perpetrators who were depressed, none of them tested positive for antidepressants on the autopsy (Malphurs & Cohen, 2005). These studies emphasize the significance of depression as a risk factor, especially since very few, if any, perpetrators get treatment for it.

Fear of abandonment is one of the motivations or triggers commonly associated with homicide-suicide (Liem & Roberts, 2009). The depressed perpetrator’s profile is linked with a dependent personality disorder and so the threat of separation has a huge impact on the perpetrator. This dependency is also because there is an element of symbiosis between the couple and the threat of separation is perceived as a loss of part of

the self and a loss of control, as explained by Harper & Voigt's (2007) model. Since the perpetrator cannot have her, he kills her in an effort to be reunited in death (Liem & Roberts, 2009). Perpetrators who kill out of a fear of abandonment and commit suicide are more likely to kill their victim by strangulation compared with homicide only cases (Liem & Roberts, 2009).

The fear of abandonment can also be perceived as fear of losing a loved one and is commonly a precursor to depression (Klein, 1975, as cited by Liem & Roberts, 2009). Consistent with Harper & Voigt (2007), homicide-suicides are often perceived as an extension of suicide. The perpetrator cannot bear to live without the victim and consequently experiences aggression and frustration. Killing his partner has been proposed as a displacement of the perpetrator's suicidal ideation or a way of eliminating the distress (Liem & Roberts, 2009; Harper & Voigt, 2007). He also feels that his victim cannot carry on without him and as a solution, he forces her to join him in death (Batt, 1948; Rosenbaum, 1990; Scott & Resnick, 2006).

Depression is often linked with suicide. When mental health professionals are screening for depression, there are inquiries regarding suicidal ideation but they rarely ask about homicidal thoughts. Moreover, individuals experiencing homicidal thoughts are unlikely to reveal this information (Batt, 1948). Through structured interviewing and direct questioning, clinicians reported 5% of patients in the emergency department reported homicidal thoughts (Rhine & Mayerson, 1973, as cited by Rosenbaum & Bennett, 1986). Another possibility is that depression is most likely underreported in domestic homicide cases (Parker, 1979). This is because the offenders may not be

obviously ill at the time of their offence and so a psychiatric assessment is not ordered by the courts.

A small proportion of perpetrators access mental health services. One study found 14% of perpetrators had contact with a mental health professional within the year before their offence and 22% were receiving some sort of support at the time of offence (Oram et al., 2013). Another 13% of perpetrators were suspected to have not been taking their medications. In another study, 15% of perpetrators accessed mental health services within one year of the murder (Morton, Runyan, Moracco, & Butts, 1998) and 21% accessed mental health services in another study (Buteau, Lesage, & Kiely, 1993).

Rationale/Implications of the Current Study

There is disagreement within the literature regarding the profile of a depressed perpetrator of domestic homicide. The findings of this study will contribute to the elucidation of these characteristics and add to the literature regarding domestic homicide and depression. It is important to be able to identify risk factors because many of the deaths appear preventable with appropriate risk assessment and risk management strategies. With more research and information, community awareness can be raised through efforts to educate mental health professionals and other professionals who may encounter this population, such as counselors, psychologists, doctors, support workers, crisis line workers, and law enforcement officers. Education implies the ability to identify the risks to prevent future homicidal offences. With more knowledge of the depressed individuals who commit domestic homicide, this information can be used to identify specific features that pose a serious risk to women. Through this, we can develop improved assessments and screening techniques to prevent future deaths. If depressed

domestic homicide offenders are indeed different from non-depressed offenders, then interventions tailored towards their needs will be more effective. There is a dearth of information regarding how depression influences domestic homicide among perpetrators. This research can provide a clearer picture of who these men are.

Purpose

The purpose of this study was to identify a set of demographic and risk factors that distinguish depressed domestic homicide perpetrators from non-depressed domestic homicide perpetrators. This study focused on male perpetrators because a disproportionate number of perpetrators are men (Statistics Canada, 2011). The goal was to identify characteristics that distinguish depressed perpetrators from non-depressed perpetrators. In addition to characteristics, the aim is to identify a group of risk factors that are associated with depressed perpetrators of domestic homicide. The following hypotheses were formulated based on the existing literature in the field outlined in the previous sections.

Hypotheses

Hypothesis 1: We expect depressed perpetrators to be older than non-depressed perpetrators.

Hypothesis 2: We expect perpetrators of domestic homicide-suicide to be older than perpetrators of domestic homicide only.

Hypothesis 3: We expect more cases of domestic homicide-suicide to be committed by depressed perpetrators versus non-depressed perpetrators.

Hypothesis 4: We expect the prevalence of separation to be greater in cases with depressed perpetrators than in non-depressed perpetrators.

Hypothesis 5: We expect a greater number of depressed perpetrators to have threatened to kill the victim.

Hypothesis 6: We expect a greater number of depressed perpetrators to have threatened and/or attempted to commit suicide.

Hypothesis 7: We expect more depressed perpetrators to have experienced historical child abuse.

Hypothesis 8: We expect more depressed perpetrators to have abused drugs and/or alcohol.

Hypothesis 9: We expect more violence in domestic homicide only cases compared with homicide-suicide cases. We also expect more violence in depressed perpetrators compared with non-depressed perpetrators.

Hypothesis 10: We expect an overall greater number of stressful life events in depressed perpetrators than in non-depressed perpetrators and for there to be more historical stressors in depressed perpetrators.

Methods

Participants

Data was obtained from the Domestic Violence Death Review Committee in Ontario (DVDRC). The DVDRC was established in 2003 by the Office of the Chief Coroner. The committee is multidisciplinary and comprised of individuals from a diversity of fields such as criminal justice, law enforcement, health care and social services. The DVDRC reviews homicide cases when all proceedings, such as criminal trials, are completed. The data contains information for the 9-year period between 2003 and 2012. This information was obtained from police files, professionals and agencies involved with perpetrator and victim, interviews of friends, family members, and co-

workers. This data set contains 183 cases involving 183 perpetrators and 275 deaths. Of these cases, 57% were homicides while 43% were homicide-suicides.

The Ontario Domestic Violence Death Review Committee. The dataset used in this study consisted of male perpetrators between the ages of 18 and 89 (M=43.85; SD=14.367). The types of cases include homicide (47.4%), homicide-suicide (33.3%), attempted homicide-suicide (8.3%), attempted homicide (0.6%), multiple homicide (4.5%), & multiple homicide-suicide (5.8%). Fifty-five percent of the perpetrators were identified as depressed either by a professional and/or by friends or family. Depression was further categorized into 4 different groups: depressed in opinion of friends/family (28.2%), depressed by a professional diagnosis (6.4%), depressed in opinion of friends/family and a professional (20.5%) and no depression or any other mental health concerns (44.9%). See Table 2 for summary of sample demographics grouped into different depression categories. Almost half of the perpetrators were employed (46.8%) followed by 32.7% who were unemployed. The majority of relationships between perpetrator and victim were in a legal marriage (53%). Twenty-eight percent of couples were living in common-law and a small percentage were couples who were in a dating relationship (19%).

Table 2: Sample Demographics

	Depressed in opinion of friends/family	Depressed-professional diagnosis	Depressed in opinion of friends/family and/or professional	Depressed in opinion of friends/family and professional	Other mental health and depression	No depression and no other mental health problems	Total
Number of cases	76	43	87	34	31	46	133
Mean Age (years)	X(SD)						
Victim	42.00 (13.90)	44.60 (16.87)	42.76 (14.65)	44.12 (16.34)	40.42 (12.07)	38.50 (14.39)	41.29 (14.65)
Perpetrator	44.86 (14.08)	48.37 (15.68)	46.10 (14.46)	47.00 (15.55)	43.52 (11.82)	39.50 (14.83)	43.82 (14.87)
Type of Case							
Homicide/Suicide	40	25	45	22	16	12	57
Homicide	28	14	32	9	14	29	61
Relationship Status							
Legal Spouse	50	25	55	22	7	20	75
Common-Law	60	10	20	5	9	14	34
Dating	10	8	12	7	5	12	24

Measures

The current study examined the risk profile of perpetrators of domestic homicide to determine if there are differences between depressed and non-depressed perpetrators. All data was obtained from the DVDRC database. The coding form used to collect data can be found in Appendix D. Additional file review was required to code a new variable – historical and current life stressors. A sample of 40 cases with 20 depressed and 20 non-depressed perpetrators without any other mental health or psychiatric problems were chosen at random. A 12-item inventory (Slopen, Williams, Fitzmaurice, & Gilman, 2011) was adapted to 9 items and each case was coded according to this inventory. See Appendix A for the full list of events. The measure includes health stressors, social stressors, job stressors and legal stressors. Historical life stressors were any stressful life event that occurred more than one year prior to the homicide. Current stressors are stressful events that occurred within 12 months of the homicide. The cumulative stress score is the total number of stressful events present for each historical and current categories.

Risk Factors. The DVDRC has identified 39 risk factors with the majority of cases identifying seven or more risk factors present (for a complete list of risk factors, refer to Appendix B; for a description of each factor, refer to Appendix C). This arbitrary cut-off score of seven was chosen by the DVDRC indicating high risk perpetrators where the homicide should have been predictable and preventable. We selected 33 risk factors to be compared and excluded 6 risk factors whose expected cell count was under 5.

A descriptive analysis was conducted to identify the prevalence of traits related to depression and domestic homicide within the literature. Two separate analyses were

completed. The first analyses described traits identified within Type II dysphoric/borderline batterers (Holtzworth-Munroe & Stuart, 1994). The second analyses described general traits that are prevalent in depressed perpetrators. Twenty-three risk factors and variables were identified to differentiate the prevalence of traits that distinguish each type of batterer. Table 3 summarizes traits used to capture the dimensions describing the three types of batterers include:

Table 3: Variables for Batterer Typology Analysis

Dimension	Risk Factor or Other Variable
Severity of marital violence	History of domestic violence Domestic violence arrests Prior domestic violence treatment
Extrafamilial violence	History of violence outside the home
Psychological and sexual abuse	Prior threats to kill victim Prior attempts to isolate the victim Controlled most or all of victim's daily activities Prior threats with a weapon against victim Prior hostage-taking and/or forcible confinement Prior forced sexual acts and/or assaults during sex
Criminal behaviour, legal involvement	Perpetrators with at least one arrest and/or violation Failure to comply with authority
Alcohol/drug abuse	Substance abuse arrests Excessive alcohol and/drug use Prior substance abuse treatment
Depression	Depression in the opinion of non-professionals and/or professionals Prior threats to commit suicide Prior suicide attempts Family history of suicide Prior counselling Prior mental health treatment
Anger	Prior anger management treatment Anger management program contact

Seven additional risk factors used to capture depressed perpetrators in literature:

- Obsessive behaviour
- Sexual jealousy
- Actual or pending separation
- The perpetrator was abused and/or witnessed domestic violence as a child
- Perpetrator unemployed
- Evidence of excessive violence used to cause death

Procedures

Exclusion Criteria. Due to the limited number of female perpetrators (n=16), cases where perpetrators and/or victims are under the age of 18 (n=3) and same-sex relationships in the database (n=2), we chose to exclude these cases from our analysis. In addition, the remaining cases where data for depression was absent and/or unknown were also removed (n=16). Lastly, the cases where depression was absent but another mental health problem was present were also removed (n=13). The total number of cases that were used for this study was n=133.

Variables. Factors investigated include socio-demographic information of perpetrators such as age, employment status, criminal history, prior counselling, and the relationship between the victim and the perpetrator. Another factor examined was the type of homicide (homicide only, homicide-suicide). Help seeking behaviour was investigated to determine whether or not the perpetrator sought out counselling or treatment and whether it was for depression, alcohol abuse and/or domestic violence. The DVDRC has also identified 39 possible risk factors and 75% of cases indicate the presence of 7 or more risk factors (Domestic Violence Death Review Committee, 2012).

Perpetrators were separated into two groups: depressed and non-depressed.

Depression of the perpetrator was either determined by a clinical diagnosis or in the opinion of family and/or friends. We compared 2 groups: depressed (either by a clinical diagnosis and/or in the opinion of family and/or friends) and non-depressed (without any other mental health or psychiatric problems). The aim was to identify common factors that are specific to depressed perpetrators and compare them with specific factors that are associated with non-depressed perpetrators.

Statistical analysis

Risk factors and other variables were compared across depression groups (depressed versus non-depressed). T-tests were conducted with continuous variables such as age and number of risk factors. All other comparisons used a chi-squared test to examine which risk factors are more likely to co-occur with depression. For each comparison, only cases with known values were selected and cases with unknowns were omitted from analysis. Independent comparisons were made between depression and all the variables listed in the previous section. Due to the large number of comparisons, a significance level of $\alpha = 0.01$ was used for comparisons without an a priori hypothesis.

Results

Socio-demographic Characteristics.

Socio-demographic factors such as employment, number of children, relationship status, and help-seeking behaviours were examined to provide a broader depiction of the sample. One-third of perpetrators compared with 20.3% of victims were unemployed. Other employment included disability, retired, etc. Most couples were in a legally married relationship while 27% were in a common-law relationship and 18% were in a dating relationship. The majority of perpetrators and victims had biological children with

a very small percentage, 6.8%, undergoing a child custody or access dispute. Table 4 provides a summary of socio-demographic characteristics of perpetrators and victims.

Table 4: Socio-demographic Characteristics of Perpetrators and Victims

Characteristic	Perpetrator		Victim	
	n	%	n	%
Age M(SD)	43.82(14.87)		41.29 (14.65)	
Employment Status				
Employed	62	47.0	67	50.4
Unemployed	44	33.3	27	20.3
Other	23	17.4	22	16.5
Unknown	3	2.3	12	9.0
Relationship Status with Victim				
Legal Spouse	76	57.1		
Common-Law	36	27.0		
Dating	24	18.0		
Children				
Biological	96	72.1	98	73.7
Stepchildren	24	18.2	14	10.5
Nil	34	25.6	34	25.6
Child Custody Dispute Present with Victim	9	6.8		

Help-seeking behaviour was compared between perpetrators and victims (Table 5). Sixty-five percent of perpetrators compared with 34.6% of victims have had prior counselling. Two times more perpetrators than victims have had mental health treatment (44.4% of perpetrators versus 22.6% of victims). More victims (17.3%) than perpetrators (3%) had domestic violence treatment. Perpetrators were more likely to have substance abuse treatment (12.9%) and anger management treatment (13.6%) compared with victims. Overall, depressed perpetrators accessed more counselling or treatment programs than non-depressed perpetrators.

Table 5: Help-Seeking Behaviours of Perpetrators and Victims

Help-Seeking Behaviour	Perpetrator				Victim	
	Depressed		Not Depressed			
	n	%	n	%	n	%
Prior Counselling	40	38.1	28	26.7	46	34.6
Mental Health Treatment	43	37.4	8	7.0	30	22.6
Substance Abuse Treatment	13	11.7	4	3.6	6	4.5
Domestic Violence Treatment	4	3.5	0	0	23	17.3
Anger Management	15	13.3	3	2.7	0	0

Table 6 summarizes the prevalence of common risk factors found within perpetrators of domestic homicide in our dataset. Actual or pending separation was most prevalent, present in 67.7% of cases. More than half the perpetrators demonstrated obsessive behaviour (52.6%) and 33.8% displayed sexual jealousy. Thirty-nine percent of perpetrators were unemployed and 21.8% of perpetrators had a history of domestic violence as a child. These risk factors along with 28 other risk factors were independently analysed alongside depression to determine whether any relationship exists between the two variables.

Table 6: Prevalence of Risk Factors in Perpetrators of Domestic Homicide

Risk Factors Used to Capture Perpetrators in Literature:	N = 133	%
- Actual or pending separation	90	67.7
- Obsessive behaviour	70	52.6
- Sexual jealousy	45	33.8
- Perpetrator unemployed	52	39.1
- The perpetrator was abused and/or witnessed domestic violence as a child	29	21.8

Descriptive Analyses of Type II Dysphoric/Borderline Batterer

Risk factors were identified that would depict the general characteristic of Holtzworth-Munroe & Stuart's (1994) Type II Dysphoric/Borderline batterer. Since the dataset comprises solely of perpetrators of domestic homicide, no comparisons were made with another group. The prevalence of each factor is shown in Table 7.

Type II batterers exhibit low to moderate levels of general violence and criminal behaviour. This was captured by perpetrator's criminal history with 54.1% of perpetrators with at least one arrest or violation and 42.1% of perpetrators who have a history of violence outside the home. Perpetrators may have been arrested for any type of violence, substance abuse, sexual offences, violations of restraining orders, bail and/or probation.

Psychological and sexual abuse was captured by perpetrator's threatening and controlling behaviour. The most common form of psychological abuse was prior threats to kill the victim (40.6%) followed by controlling behaviours. Controlling behaviours such as attempts to isolate the victim and controlling victim's activities had almost equal rate of occurrence. There was a minimal level of forced sexual acts and/or assaults during sex.

Sixty-five percent of perpetrators are reported to be depressed and almost half (49.6%) have threatened to commit suicide. Approximately one-third of perpetrators have accessed counselling and/or mental health treatment. Seventeen percent of the perpetrators have been arrested as a result of substance abuse and 30.8% endorsed excessive alcohol and/or drug use. Thirteen percent received treatment for substance abuse.

Perpetrator levels of anger were measured by contact of anger management program and prior anger management treatment. A small proportion of perpetrators received anger management treatment (13.5%) or had contact with an anger management program (9.8%).

Table 7: Prevalence of Type II Batterer Characteristics

Dimension	N = 133	%
Severity of marital violence		
History of domestic violence	97	72.9
Domestic violence arrests	41	30.8
Prior domestic violence treatment	4	3.0
Extrafamilial violence		
History of violence outside the home	56	42.1
Criminal behaviour, legal involvement		
Perpetrators with at least one arrest or violation	72	54.1
Failure to comply with authority	41	30.8
Psychological and sexual abuse		
Prior threats to kill victim	54	40.6
Prior attempts to isolate the victim	65	39.6
Controlled most or all of victim's daily activities	48	36.1
Prior threats with a weapon against victim	32	24.1
Prior hostage-taking and/or forcible confinement	21	15.8
Prior forced sexual acts and/or assaults during sex*	10	7.5
Substance Abuse		
Excessive alcohol and/or drug use	41	30.8
Substance abuse arrests	23	17.3
Prior substance abuse treatment	17	12.8
Anger		
Anger management program contact	13	9.8
Prior anger management treatment	18	13.5
Likelihood of depression		
Depression	87	65.4
Prior threats to commit suicide*	66	49.6
Prior suicide attempts*	28	21.1
Family history of suicide**	3	2.3
Prior counselling*	46	34.6
Prior mental health treatment*	45	33.8

*greater than 20% of cases unknown
**greater than 50% of cases unknown

***t*-tests for Age.**

A *t*-test was used to determine if there was a statistically significant difference in the ages of perpetrators with and without depression and between perpetrators who committed domestic homicide versus domestic homicide-suicide.

In more than 65% of cases, perpetrators were depressed (n=87). Depressed perpetrators had a mean age of 46.09 years whereas the mean age of non-depressed

perpetrators (n=45) was 39.93 years. There is a significant difference of age between depressed and non-depressed perpetrators (t (130) = 2.31, $p < .05$). A statistical significance was also found between homicide groups (homicide vs. homicide-suicide) (t (103) = -3.66, $p < .01$). Perpetrators of domestic homicide-suicide (n=45) had an average age of 49.78 years and were significantly older than perpetrators of domestic homicide (n=60; M=39.20 years).

Differences between Depressed and Non-Depressed Perpetrators

Between each group (depressed as diagnosed by professionals and/or non-professionals and not depressed and no other mental health problems) 33 risk factors and 10 additional variables were individually examined. Independent chi-square tests were performed and statistically significant relationships were found for 11 of the 43 variables examined. Refer to Appendix E for a full list of the results of each chi-square comparison of all the risk factors.

Homicidal versus Homicide-Suicide. A chi-square comparison was used to determine if a relationship exists between the type of homicide and depression. Attempted homicide and attempted homicide-suicide were collapsed into homicide and homicide-suicide groups because the attempted murders would have been completed if emergency services did not arrive. Multiple homicide and multiple homicide-suicide cases were omitted from this analysis due to the limited number of cases. A significant relationship was found between the type of homicide and depression, $\chi^2(1, N=118) = 9.12$, p =.01). Of the 61 homicide cases, 53% (32) of perpetrators were depressed and 48% (29) of perpetrators were not. Of the 57 homicide-suicide cases, 79% (45) of perpetrators were depressed and 21% (12) were not.

Separation and Depression. Separation is the loss of a relationship and may be a contributing factor towards depression. A chi-square comparison was used to determine if a relationship exists between the separation and depression. A significant relationship was not found between separation and depression, $\chi^2(1, N=127) = 2.95$, $p = .09$). Of the 90 couples who were separated, 70% (63) of perpetrators were depressed and 30% (27) were not depressed. Of the 37 couples who were not separated 54% (20) were depressed and 46% (17) were not.

Homicidal and Suicidal Tendencies. To determine if depressed perpetrators have a greater homicidal tendency, the risk factor of threats to kill the victim was used. A significant relationship was not found between threats to kill victim and depression, $\chi^2(1, N=113) = 0.39$, $p = .53$). Of the 54 cases where perpetrators had threatened to kill the victim, 67% (36) of perpetrators were depressed while 33% (18) were non-depressed. Although there was no significant relationship, 50% more of depressed perpetrators have displayed homicidal threats against their partner than non-depressed perpetrators.

To determine if depressed perpetrators have a greater suicidal tendency, prior threats to commit suicide and prior suicide attempts were examined. For these comparisons, cases with no depression and other mental health problems present (n=146) were included to reduce the sample bias for depression. In 45.4% of cases, depressed perpetrators had threatened to commit suicide and 20.3% had attempted suicide. As expected, a significant relationship was found for both prior threats to commit suicide and depression, $\chi^2(1, N=119) = 25.62$, $p = .00$), and prior suicide attempts, $\chi^2(1, N=118) = 5.71$, $p = .02$).

Historical Child Abuse. Three variables were used to examine if depressed perpetrators were more likely to have experienced historical child abuse: perpetrator abused or witnessed violence, perpetrator physically abused as child, and perpetrator sexually abused as child. Of the known cases concerning whether perpetrators were abused or witnessed violence as a child, 40% were depressed. Of the known cases where perpetrators were physically abused as a child, 35% were depressed and 16.7% were depressed who have experienced sexual abuse. Interestingly, there was a statistical significance between perpetrator abused or witnessed violence and depression, $\chi^2(1, N=60) = 6.54$, $p = .01$) however, no statistical significance was found for the variables of physical and sexual abuse.

Drug/Alcohol Abuse. Two variables were used to determine whether a drug and/or alcohol abuse was independent of depression: excessive alcohol and/or drug use and prior substance abuse treatment. Twenty-five percent of perpetrators who excessively used drugs or alcohol were depressed and 13.4% were non-depressed. Almost 12% of depressed perpetrators received prior substance abuse treatment while only 3.6% of non-depressed perpetrators received treatment. No statistical significance was found between depression and excessive alcohol and/or drug use, or prior substance abuse treatment.

Level of Violence in Homicide vs. Homicide-Suicide. To test whether depressed perpetrators are more violent the risk factors “history of violence outside family” and “history of domestic violence” were used to compare across depression groups. The variable “evidence of excessive violence used to cause death” was used to compare across homicide and homicide-suicide cases. Thirty-one percent of depressed perpetrators had a history of violence outside the family compared with 16.1% of non-depressed

perpetrators. Similarly, 54.1% of perpetrators who were depressed had a history of domestic violence compared with 25.4% who were not depressed. No statistical significance was found between violence and the type of homicide or depression. Overall, there were less than 10% of cases where excessive violence where victims were shot or stabbed multiple times was used.

Stressful Life Events. There were more current stressors than historical stressors for both depression groups. *T*-tests were conducted and there was no statistical significance between depression and the total number of stressful life events. There was also no statistical significance between depression and the number of historical and current stressful life events. Table 8 displays the summary of the number of stressful life events in each category. The most common event was separation and divorce with 40 occurrences followed by criminal activity with 23 occurrences. Health-related events, living situation and unemployment had an equal number of occurrences (14) followed by financial crisis with 13 occurrences.

Table 8: Stressful Life Events in Depressed vs. Non-Depressed Perpetrators

Inventory Item	*Not Depressed*		*Depressed*		*Total*
	Historical	Current	Historical	Current	%
Death of a family member or close friend	0	0	3	2	3.8
Serious Illness or injury to self or family member or close friend	2	4	4	4	10.5
Moved or someone moved-in	5	2	5	2	10.5
Fired or laid off	3	3	0	2	6.0
Unemployed	0	7	0	7	10.5
Separated or divorced	5	13	8	14	30.1
Interpersonal issues	0	2	0	0	1.5
Financial crisis	2	4	0	7	9.8
Trouble with the police, get arrested or sent to jail	8	3	5	7	17.3
Total	25	38	25	45	100% (133)

Risk Factors. A *t*-test was conducted to compare the means of the total number of risk factors in each case between depressed and non-depressed perpetrators. There was a significant difference between the two groups where depressed perpetrators had 1.4 times more risk factors present than non-depressed perpetrators (t (131) = -3.15, $p < .01$). Depressed perpetrators had an average of 11.91 (SD=5.50) risk factors while non-depressed perpetrators had an average of 8.72 (SD=5.69) risk factors.

Thirty-three risk factors out of 39 were analysed to determine whether a relationship exists with the presence of depression (Appendix E). In addition to risk factors predicted to be significant in our hypothesis, 2 additional factors were significant: hostage taking (χ^2(1, N=128) =6.52, p =.01); and obsessive behaviour χ^2(1, N=124) =8.81, p <.01). For both comparisons, the prevalence of each risk factor was higher in depressed perpetrators than in non-depressed perpetrators. Almost 15% of depressed perpetrators took victims as hostages or forcibly confined her compared with 1.6% of

perpetrators who were non-depressed. Forty-two percent of depressed perpetrators engaged in obsessive behaviour compared with 13.7% of perpetrators who were not depressed. Table 9 summarizes the significant chi-square comparisons.

Table 9: Summary of Significant Chi Square Comparisons in Relationship with Depression

Variable	*Depressed*		*Not Depressed*		χ^2	*df*	*p*
	n	%	n	%			
Type of homicide							
Homicide	32	27.1	29	24.6	9.12	1	0.01
Homicide-suicide	45	38.1	12	10.2			
Prior threats to commit suicide	54	48.6	12	10.8	24.58	1	0.01
Prior suicide attempts	24	22.2	4	3.7	7.24	1	0.01
Perpetrator abused or witnessed violence	24	40	5	8.3	6.54	1	0.01
Hostage taking	19	14.8	2	1.6	6.52	1	0.01
Obsessive behaviour	53	42.7	17	13.7	8.81	1	0.01

Discussion

This retrospective study examined risk factors and variables present in cases of domestic homicide and explored possible differences between depressed and non-depressed perpetrators. Due to the paucity of literature and divergent evidence in identifying risk and background factors prevalent in depressed perpetrators, the purpose of this study was to contribute evidence for a clearer depiction of depressed perpetrators of domestic homicide drawn from a substantial dataset.

The goal of this study was to determine a group of traits to distinguish depressed perpetrators from non-depressed perpetrators and use this information to create a risk profile for perpetrators of domestic homicide. There have been very few studies that have compared depressed perpetrators with non-depressed perpetrators and many more articles characterizing domestic homicide perpetrators as a whole. One of our aims is to expand the limited amount of literature in existence and to support the current evidence describing depressed perpetrators of domestic homicide.

Summary of Findings

As expected, in a large percentage of cases (67.7%) there was a pending or actual separation at the time of the homicide. More than half of the perpetrators displayed obsessive behaviour, and one-third expressed sexual jealousy. Almost 40% of perpetrators were unemployed. These are common traits found in perpetrators of domestic homicide. However, without a comparison population, the degree of relevance of these findings has only modest meaning. Without a context we cannot determine if these percentages are significant.

Type II batter typology. Belfrage & Rying (2004) identified type II borderline/dysphoric batterer (Holtzworth-Munroe & Stuart, 1994) to be most representative of perpetrators of domestic homicide. The prevalence of specific characteristics of Type II borderline/dysphoric batterers were gathered to determine the proportion of perpetrators in our database that are representative of this typology. Type II batterers typically have a moderate to high severity of marital violence and a low to moderate level of general violence. Our results indicated that a high proportion of perpetrators (72.9%) had a history of domestic violence and a moderate number of perpetrators (42.1%) had a history of violence outside the home. To further support evidence of criminal behaviour, 54.1% of perpetrators have a criminal record with at least one arrest or violation.

Type II batterers engage in a moderate to high level of psychological and sexual abuse. Our sample indicates that between 35-40% perpetrators have threatened to kill the victim, have attempted to isolate the victim, and have controlled most or all of the victim's daily activities. Sexual abuse was not as well captured and a lower proportion of perpetrators (7.5%) have prior forced sexual acts and/or assaults during sex. Our sample would classify a low to moderate level of psychological and sexual abuse, contrary to the typology.

Anger was not well-captured in our sample. The measures used to determine anger are related to treatment and do not capture any value of anger and thus cannot be used to assess the level of anger, especially since there are large numbers of perpetrators with anger issues who do not receive treatment.

The most distinguishing characteristics of batterer typology are the differences in psychopathology. The likelihood of depression is high in type II batterers. In our sample, 65.4% of perpetrators were found to be depressed by either friends or family or by a professional.

Moderate levels of alcohol and/or drug abuse are expected in type II batterers and approximately 30% of perpetrates were identified with excessive alcohol and/or drug use. This number may be lower than expected. Lastly, the dimension of personality disorder was not able to be determined because this information is not present in the database.

Although there was some overlap with the qualities of family-only batterers, especially in the dimension of marital violence where there may be lower than expected prevalence, as a whole, perpetrators of domestic homicide possess the majority of the characteristics that are most common in borderline/dysphoric batterers.

Depressed perpetrators had significantly more risk factors present than non-depressed perpetrators. Depressed perpetrators had almost 1.5 times the number of risk factors than non-depressed perpetrators. The elevated number of risk factors in depressed perpetrators poses a greater risk for their intimate partners. We will examine some of these risk factors in detail in relation to depression.

As predicted, our study found that depressed perpetrators were significantly older than non-depressed perpetrators. We also found that perpetrators of homicide-suicide are significantly older than perpetrators of homicide. Similarly, a chi-square comparison yielded a significant relationship between depression and the type of homicide. There

were more cases of perpetrators of homicide-suicide who were depressed than expected and fewer cases of perpetrators of domestic homicide who were depressed than expected.

A statistically significant relationship exists between depression and whether the perpetrator witnessed violence as a child. Perpetrators with historical child abuse were more likely to be depressed. Trauma and violence have also been recognized as contributors to an individual's depression. The literature suggests that exposure to abuse as a child has direct implications into adulthood – depression in adulthood is associated with childhood exposure to different forms of abuse (Levitan & Parikh, 1998; Liu, Jager-hyman, Wagner, Alloy, & Gibb, 2012). This finding supports extant literature and reinforces the significance of recognizing childhood trauma, specifically exposure to violence as a risk factor of domestic homicide.

Suicidality is a common symptom of depression. As expected, depressed perpetrators were more likely to have threatened to commit suicide in the past and have more prior suicide attempts. Wolford-clevenger et al. (2014) found 22% of men entering a batterer intervention program had suicidal ideation within 2 weeks of admission. Another study found that 45.5% of men involved with family court for domestic violence have threatened suicide and 12.9% had prior suicide attempts (Conner, Cerulli, & Caine, 2002). They concluded that depressed perpetrators of family violence who have threatened or attempted suicide are more violent and have a greater degree of general domestic violence. This implies that a subset of domestically violent perpetrators is at an increased risk for suicide.

New unanticipated findings included the result where hostage-taking and/or forcible confinement and obsessive behaviour had a significant relationship with depression. Both of these traits are more likely to occur within depressed perpetrators. One study examined hostage-taking in the context of domestic violence (Booth et al., 2010). The study suggests there is a lack of mental health professionals involved at the time of the crisis for improved handling of a hostage situation. Although their study did not yield significant results of perpetrators with existing psychiatric or mental health problems, they believe that a large number of perpetrators experience depression. Our study has been able to lend support to their hypothesis.

Obsessive behaviours are characterized by stalking, that includes following the victim, spying, and making intrusive phone calls, etc. (Domestic Violence Death Review Committee, 2012). McFarlane, Campbell, & Watson (2002) reported stalking was present in 68% of the sample of femicides and present in 45% of the sample of women experiencing domestic violence. There is no literature to support a relationship between obsessive behaviour and depression. However, characteristics of men who stalk share some commonalities with depressed perpetrators that have been identified in the current study. Some of these common traits include alcohol abuse and a history of abuse (Burgess et al., 1997). Goranson, Boehnlein, & Drummond (2012) have suggested a link between homicide-suicide and stalking. They believe perpetrators with obsessive behaviour operate under a belief that “if I can’t have the victim, nobody can.” Similarities in stalking cases and homicide-suicide cases include predominantly male perpetrators and female victims, threat or actual separation, and suspicion of infidelity. Given the

relationship between depression and homicide-suicide, the significance between obsessive behaviours and depression is not surprising.

Studies have shown the significance of loss, specifically separation and divorce in men, and its contribution to the risk of depression (Bruce & Kim, 1992; Kendler et al., 1999). We were surprised not to find any relationship between separation and depression even though there were more cases of actual or pending separation with depressed perpetrators (70% vs. 30% of cases). An explanation for the lack of significance may be that the study did not address depression in the broader population of perpetrators of domestic violence. As such, other issues contributing to the deterioration of the relationship may be confounding the results.

Men have been found to externalize their depression (Branney & White, 2008; Winkler et al., 2005). Men have been hypothesized to build up an aggressive response to depression (Brownhill et al., 2005), behaviours along this trajectory include substance abuse, aggressive towards self and others and ultimately results in suicide. We examined three variables in relation to this: prior threats to kill the victim, excessive use of alcohol and/or drugs, excessive violence used in murder. For all variables, there were more depressed perpetrators than non-depressed perpetrators. For instance, 25.2% of depressed perpetrators had an excessive use of alcohol and/or drugs compared with 13.4% of non-depressed perpetrators. Contrary to our hypotheses, there was no significant relationship between homicidal tendency or excessive use of alcohol and/or drugs and depression. There is some existing evidence to suggest that men do indeed externalize their depression (Magovcevic & Addis, 2008). Men who conformed to the masculine norm

were more likely to externalize their emotions while men who internalized depression conformed to the *DSM*-5's description of depression (American Psychiatric Association, 2013). Externalizing behaviour included yelling, anger, substance abuse, and violence (Magovcevic & Addis, 2008). Based on this finding, it is possible that the reason our current study did not result in any significance between violence or externalizing behaviour and depression is that we could not account for "men's adherence to hegemonic masculine norms". For future studies researchers could include another variable for men's adherence to masculine norms.

Our final hypothesis where we predicted a greater number of stressful life events and historical stressors in depressed perpetrators was also not statistically significant. We did not find any relationship between the number of life stressors and depression. The likely explanation for the greater number of current stressful events compared with historical events is that information for current events was more accessible whereas historical events were unreported. A national study with over 30 000 respondents conducted by Slopen et al. (2011) found that the number of stressful life events is correlated with a greater likelihood for major depression in males. More meaningful results may surface if the whole dataset was coded initially rather than after the review for stressful life events as it would generate a larger sample and thus a more accurate depiction of the relationship between stressful life events and depression.

This study supports the existing literature on depressed perpetrators of domestic homicide. Depressed perpetrators are indeed older, are more likely to perpetrate domestic homicide-suicide, more likely to have a history of suicidal behaviour, and witnessed

violence as a child. Some new findings that add to the risk profile of domestic homicide perpetrators are hostage taking and obsessive behaviour. Although our analyses did not reach statistical significance for other characteristics, the trends indicate for almost every comparison made that depressed perpetrators had a greater prevalence for the factor in comparison with non-depressed perpetrators. This trend extends to our predictions that were not significant: separation, a history of domestic violence, extrafamilial violence, threats to kill the victim, excessive use of alcohol and/or drugs, and excessive violence used to cause death. We hope to address these short-comings in future research.

Implications

The most significant implications of this study are related to risk assessment, risk management, intervention and prevention. The most direct application of our findings is to create a risk profile that distinguishes depressed perpetrators from non-depressed perpetrators. This distinction is useful because depressed perpetrators were more likely than non-depressed perpetrators to access mental health services and treatment programs. Many treatment programs conduct assessments upon intake and frequently assess suicidal ideation but not homicidal ideation (Batt, 1948). This assessment is especially relevant to batterers who have a prior history of domestic violence, substance use and anger.

The Oklahoma Domestic Violence Fatality Review Board (2005) has published a depression screening recommendation for use by mental health workers. This screening includes specific questions for men and women regarding assessment of suicide and homicide, sense of safety, risky behaviours, access to firearms and referrals (Oklahoma Domestic Violence Fatality Review Board, 2005). These questions are based on the risk factors that have been studied. Some of the gender specific questions include assessing if

the women are in a violent and/or unsafe relationship with questions such as "Do you feel safe in your present relationship?" and "Do you have current contact with him?" Male specific questions include questions about violent behaviours against their partner. Another recommendation is to ask about homicide and suicide by focusing on the behaviours associated with it such as, "Have you thought of hurting yourself or others?" and "Have you ever forced someone to do something they didn't want to do?" For the full list of recommendations, refer to Appendix F.

In addition to specific risk factors for domestic homicide, a depression dimension for men would also be relevant. With evidence suggesting that men tend to externalize their depression, in contrast to the more traditional internalizing symptomatology, depression in men often is undetected. An example of externalization of depression can be found in an incarcerated population. One study showed that severely depressed men were most commonly detained for causing bodily harm (Lanz & Diaz, 2013). In another example, depression was diagnosed in 39% of the male clinical sample using the Gotland Scale of Male Depression compared with 17% using standard criteria (Zierau, Bille, Rutz, & Bech, 2002). By including the Gotland Scale or the scale developed by Magovcevic & Addis (2008) that specifically measures male depression as part of a risk assessment, mental health professionals are able to capture depressed men who may otherwise have been missed. Training frontline workers in administering and interpreting the assessment would be the next step. Educating professionals and the community would raise awareness on the risk factors at play in domestic homicides. Professionals can screen for women at risk of femicide and men at risk for perpetration. Increasing community awareness can help friends and family protect their loved ones if they are able

to identify certain risk factors and intervene. The DVDRC has made recommendations for family, friends and colleagues in numerous reports from 2002, 2004, 2005, 2006 and 2007. In the 2007 Annual Report they recommend education for the community to understand the dynamics of domestic violence and the need to act on information of ongoing abuse. They specify awareness of risk factors such as separation, depression or suicidal and homicidal thoughts that increase the potential of homicide (Domestic Violence Death Review Committee, 2007). An example of how research into domestic homicide has contributed are awareness campaigns and initiatives from the Centre for Violence Against Women and Children such as Neighbours, Friends & Families (http://www.neighboursfriendsandfamilies.ca) that provide information on how to identify and help women at risk, how to talk to abusive men and safety planning for women who are abused. Another initiative is “Make it Our Business” (http://makeitourbusiness.com), a website providing information on domestic violence in the workplace. The website provides information on how to recognize domestic violence in the workplace and guidelines for the workplace for policies and procedures.

One of the most significant implications for research of this type is prevention. In this sample, depressed perpetrators accessed more treatment programs than non-depressed perpetrators. Although victims are typically more likely to seek help, the current results have an opposite trend with more perpetrators accessing services than victims with the exception of domestic violence treatment where victims were more likely to have had treatment. However, except for anger management treatment, victims were more likely to access substance abuse, domestic violence, counseling and mental health treatment compared with non-depressed perpetrators. Other studies have shown

that 66% of victims compared with 41% of perpetrators have accessed health care agencies (Sharps et al., 2001). There is denial or resistance from perpetrators to address violent behaviours even when they have reached out for help regarding their intimate relationships (Campbell, Neil, Jaffe, & Kelly, 2010). They also showed that perpetrators were also more likely than victims to abuse substances, including alcohol, but victims were still more likely to receive alcohol and/or drug treatment. With almost half of these women accessing the health care system, there are many missed opportunities to prevent their deaths. The DVDRC (2008) has recommended, "training for all mental health professionals should include assessment and intervention strategies dealing with male depression and the link between depression, suicidal ideation and domestic homicide". Risk assessments and trained professionals would be instrumental in identifying individuals who need help. Strategies can be devised to implement safety plans and provide other forms of assistance to increase the safety of victims. Since perpetrators are at such high risk of depression, increase in the awareness of suicide assessment and training in suicide prevention and intervention for all health service providers would mitigate these risks. Furthermore, training should not be restricted to professionals, students in post-secondary education for health services should also have these types of training incorporated into their education.

For example, the DVDRC has recommended that physicians with patients with a mental health issue to "assess for the potential for lethal violence". They recommend that this practice is mandatory for patients who are depressed, who have been admitted for a suicide attempt, or are seeking help as the result of a separation. The recommendation also indicates that it is important not to rely solely of the patient's self-report that abuse

has truly ended but to also have regular contact with the former intimate partner and/or workplace to confirm the patient's report (Domestic Violence Death Review Committee, 2007).

The development of a sound risk assessment for potential perpetrators to be used as a part of intake procedures allows frontline workers to determine and consequently specific interventions that are most appropriate to decrease violence and to prevent homicide. Studies have shown that interventions that are specific to the level of risk and needs of the perpetrator are more effective in preventing recidivism (Bonta & Andrews, 2007; Dowden & Andrews, 2000; Lowenkamp, 2006). Furthermore, specific interventions that are designed for a specific population yield greater success. For example, modifying interpersonal psychotherapy as an intervention for suicide risk targeted towards older adults over the age of 60 was found to significantly reduce depression and improve quality of life (Heisel, Talbot, King, Tu, & Duberstein, 2015). In a similar way, substance abuse, domestic violence and anger management treatment programs can be tailored towards depressed batterers for a more effective intervention with goals of reducing aggression and externalization of depression.

Limitations

This study lends support to the limited existing literature on depressed perpetrators of domestic homicide. The limitations of this study need to be considered. One limitation is that the sample was not randomly selected. The sample was derived from all the domestic homicides within Ontario that occurred between a specific time span of 10 years. As such, we did not have any comparison group such as depressed

perpetrators of domestic violence as opposed to homicide groups to compare with. The generalizability of the results may not be applicable to domestic violence cases.

A second limitation to this study is its retrospective nature. Although this is the only method to study homicide, it also limits the generalizability of the results. Furthermore, all the information gathered for the secondary dataset is derived from case reports and interviews. This creates the potential for error due to individual interpretation despite having a standardized coding form. Information that may be pertinent to this study could have been omitted if it was not part of the coding protocol and this was the case for stressful life events which required a case review to gather the information. There is also an abundance of missing information as a result of incomplete or unavailable case files. The amount of information for each case depends on how much contact the individuals had with community agencies and the justice system that are able to document these encounters. The variability in the content of case files limits the amount of information available for a complete analysis and contributes to the missing or unknown pieces of data.

A third limitation is the inability to determine whether depressed perpetrators are indeed at greater risk of committing domestic homicide. Since our sample only consists of both depressed and non-depressed perpetrators who have murdered their partners, we do not have the resources for a longitudinal study with a comparison group of depressed and non-depressed domestically violent men to assess the likelihood of depressed individuals to perpetrate domestic homicide.

A fourth limitation of this study is the loose definition of depression that was utilized. In the DVDRC database, depression was determined either by documentation from a health-care professional that provided an official diagnosis or based on the comments of family and/or friends made to investigating police officers. There was no uniform assessment in the determination of depression. A professional diagnosis may not have been a result of a formal assessment with a depression inventory. The varying definitions of depression are a methodological concern.

A fourth limitation is the small sample size for the stressful life events analyses. The small sample size limits the power of the analysis. We were not able to conduct inter-rater reliability of the coding of the events. This also limits the validity of the analysis.

A fifth limitation of this study was the inability to control for interaction effects, indirect effects of other variables were not controlled so we cannot guarantee that another variable is not influencing the relationship between two variables. Although individual factors were examined, a larger sample may provide the possibility to discover the impact of multiple factors that represent a significant pattern. For example, Campbell and colleagues found that results were more powerful when controlling behaviour and separation were analyzed together than when analyzed separately (Campbell, Webster, & Glass, 2009).

Future Research

Owing to the paucity of literature available on depression among perpetrators of domestic violence, this research could take a number of different directions. One

direction that would grant greater generalizability to the study is by expanding the research to include different comparison groups. It would be meaningful to compare our sample to domestically violent men and men who have committed suicide or attempted suicide for a more robust analysis. Other combinations of comparison groups may include perpetrators of other forms of homicide. Other ways to expand the research is to conduct a similar study on female perpetrators and perpetrators in same-sex relationships.

To further expand on the current study, a cluster analysis can be conducted to determine if variables are interacting with each other. In a similar manner of Holtzworth-Munroe & Stuart (1994)'s batterer typology, a cluster analysis can help determine variables that fall under specific dimensions. This will require a larger sample size for more robust results.

Other variables that would be interesting to examine are the specific mental health or psychiatric problems that are coded in the database. This information is helpful because some studies have demonstrated that in addition to depression, substance abuse and psychosis were the next most common psychiatric disorders in perpetrators of homicide-suicide (see Roma et al., 2012 for a review).

Another variable for future studies to examine is male attitudes towards "hegemonic masculine norms." As studies have found that male attitudes and adherence towards male gender roles have a direct impact on whether depression is externalized or internalized (Branney & White, 2008; Magovcevic & Addis, 2008). Another study found that financial stress was the trigger for homicide-suicide (Oliffe et al., 2014). The inability to provide for their family created a belief of a loss of power and authority,

consistent with Harper & Voigt (2007) and Wilson & Daly (1993), the final act of homicide-suicide is the perpetrators attempt in regaining control. Other studies have demonstrated similar patterns where perpetrators feel their family is an extension of himself and cannot survive without him (Batt, 1948; Liem & Roberts, 2009; Rosenbaum, 1990; Scott & Resnick, 2006). The examination of hegemonic masculine attitudes may provide a broader picture of how to identify depression in men, and add to the risk profile of depressed perpetrators.

A research design to study depression and domestic homicide or violence is one of a longitudinal nature. This ambitious design allows for researchers to follow batterers over a lengthy period of time and gather all the relevant data through psychological assessments such a specific depression measures for men, self-report measures and other methods. This method is the only way we can truly compare perpetrators of domestic homicide with perpetrators of domestic violence to determine the difference between the two groups for the development of a more accurate risk profile.

Lastly, other important avenues to investigate are the protective factors against domestic homicide and domestic violence. Some of these factors have already been identified as arrest, shelter, high school education, never cohabited, meeting basic needs such as food, clothes and housing (Campbell et al., 2003, 2007; Goranson et al., 2012; Juodis, Starzomski, Porter, & Woodworth, 2014). It would be interesting to investigate if different protective factors exist for depressed perpetrators in comparison with non-depressed perpetrators.

Conclusion

In summary, the initial findings of the present study suggest differences exist between depressed and non-depressed perpetrators of domestic homicide. Depressed perpetrators have a higher level of risk, are more likely to perpetrate different forms of violence and are also more likely to access mental health services. Some of the key characteristics identified in depressed perpetrators include: older age, prior threats to commit suicide and prior attempts of suicide, witnessed violence as a child, prior hostage-taking and/or forcible confinement and obsessive behaviour. This information is essential to educate mental health professionals because they are more likely to have an opportunity to intervene in light of the presenting depression.

Given the number of high profile domestic homicides that occur on the news on a regular basis, it is of utmost importance we uphold the work Domestic Violence Death Review Committees around the world and enforce their recommendations. Furthermore, implementing interventions for both victims and perpetrators of domestic violence before the violence escalates to homicide is significant because of the many missed opportunities that have already occurred. By viewing perpetrators of domestic homicide through a depression lens, we develop an understanding of the differences that exist and the importance of recognizing them so that we can implement them into our policies and practices to provide training that will contribute to the most effective outcomes.

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Appendices

Appendix A: Stressful Life Events Inventory

1. Did any of your family members or close friends die?
2. Did you or any of your family members or close friends have a serious illness or injury?
3. Did you move or immigrate or have anyone new come to live with you?
4. Were you fired or laid off from a job?
5. Were you unemployed and looking for a job for more than month?
6. Did you get separated or divorced or break off a steady relationship?
7. Have you had serious problems with a neighbour, friend, or relative?
8. Have you experienced a major financial crisis, declared bankruptcy, or more than once not been able to pay your bills on time?
9. Did you or a family member have trouble with the police, get arrested or get sent to jail?

Appendix B: Ontario Domestic violence Death Review Committee Risk Factors

1. History of violence outside of the family by perpetrator
2. History of domestic violence
3. Prior threats to kill victim
4. Prior threats with a weapon
5. Prior assault with a weapon
6. Prior threats to commit suicide by perpetrator
7. Prior suicide attempts by perpetrator *(if previous item checked, counts as one factor)*
8. Prior attempts to isolate the victim
9. Controlled most of all of victim's daily activities
10. Prior hostage-taking and/or forcible confinement
11. Prior forced sexual acts and/or assaults during sex
12. Child custody or access disputes
13. Prior destruction or deprivation of victim's property
14. Prior violence against family pets
15. Prior assault on victim while pregnant
16. Strangulation of victim in the past
17. Perpetrator was abused and/or witnessed domestic violence as a child
18. Escalation of violence
19. Obsessive behaviour displayed by perpetrator
20. Perpetrator unemployed
21. Victim and perpetrator living common-law
22. Presence of stepchildren in the home
23. Extreme minimization and/or denial of spousal assault history
24. Actual or pending separation
25. Excessive alcohol and/or drug use by perpetrator
26. Depression – in the opinion of family/friend/acquaintance – perpetrator
27. Depression – professionally diagnosed – perpetrator *(if previous item checked, counts as one factor)*
28. Other mental health or psychiatric problems – perpetrator
29. Access to or possession of any firearms
30. New partner in victim's life
31. Failure to comply with authority – perpetrator
32. Perpetrator exposed to/witnessed suicidal behaviour in family of origin
33. After risk assessment, perpetrator had access to victim
34. Youth of couple (18 to 24 years of age)
35. Sexual jealousy – perpetrator
36. Misogynistic attitudes – perpetrator
37. Age disparity of couple (age difference of 9 or more years)
38. Victim's intuitive sense of fear of perpetrator
39. Perpetrator threatened and/or harmed children
40. Other factors that increased risk in this case? Specify:

Appendix C: Risk Factor Descriptions

Perpetrator = The primary aggressor in the relationship
Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

1. Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).

2. Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or is in, an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; coworkers; counselors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.

3. Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."

4. Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).

5. Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).

6. Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.

7. Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.

8. Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never

like it when your parents come over" or "I'm leaving if you invite your friends here").

9. Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).

10. Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).

11. Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.

12. Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.

13. Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.

14. Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.

15. Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.

16. Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).

17. As a child/adolescent, the perpetrator was victimized and/ or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.

18. The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.

19. Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.

20. Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income

assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

21. The victim and perpetrator were cohabiting.

22. Any child(ren) that is(are) not biologically related to the perpetrator.

23. At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).

24. The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.

25. Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.

26. In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.

27. A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.

28. For example: psychosis; schizophrenia; bipolar disorder; mania; obsessive-compulsive disorder, etc.

29. The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.

30. There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life.

31. The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.

32. As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.

33. After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.

34. Victim and perpetrator were between the ages of 15 and 24.

35. The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.

36. Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."

37. Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.

38. The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, "I fear for my life", "I think he will hurt me", "I need to protect my children", this is a definite indication of serious risk.

39. Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counselors; medical personnel, etc)

Appendix D: Data Summary Form

Domestic Violence Death Review Committee
Office of the Chief Coroner of Ontario
Data Summary Form

OCC Case #(s): 200_- **OCC Region:**
OCC Staff: ____

Lead Investigating Police Agency:
Officer(s): D/Sgt. Mario DiTommaso/ Det. Wayne Banks _____________________
Other Investigating Agencies: ____
Officers: ____

VICTIM INFORMATION

***If more than one victim, this information is for primary victim (i.e. intimate partner)*

Name

Gender	
Age	
DOB	
DOD	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	
If yes, check those that apply…	____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance

	____ Prior arrest record for DUI/possession ____ Juvenile record
	____ Total # of arrests for domestic violence offenses ____ Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history	
If yes, check those that apply…	____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history	
If yes, check those that apply …	____ Prior domestic violence treatment ____ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify ______________________________ ____ No info
Victim taking medication at time of incident	
Medication prescribed for victim at time of incident	
Victim taking psychiatric drugs at time of incident	
Victim made threats or attempted suicide prior to incident	

Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END VICTIM INFORMATION --

PERPETRATOR INFORMATION
***Same data as above for victim*

Name

Gender	
Age	
DOB	
DOD	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	

If yes, check those that apply…	____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record
	____ Total # of arrests for domestic violence offenses _____Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history	
If yes, check those that apply…	____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history	
If yes, check those that apply …	____ Prior domestic violence treatment ____ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify ______________________________ ____ No info
Perpetrator on medication at time of incident	

Medication prescribed for perpetrator at time of incident	
Perpetrator taking psychiatric drugs at time of incident	
Perpetrator made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END PERPETRATOR INFORMATION --

INCIDENT

Date of incident	
Date call received	
Time call received	
Date of death	
Incident type	
Incident reported by	
Total number of victims ***Not including perpetrator if suicided*	

Who were additional victims aside from perpetrator?	
Others received non-fatal injuries	
Perpetrator injured during incident?	
Who injured perpetrator?	

Location of crime

Location of incident	
If residence, type of dwelling	
If residence, where was victim found?	

Cause of Death (Primary Victim)

Cause of death	
Multiple methods used?	
If yes be specific …	
Other evidence of excessive violence?	
Evidence of mutilation?	
Victim sexually assaulted?	
If yes, describe (Sexual assault, sexual mutilation, both)	
Condition of body	
Victim substance use at time of crime?	
Perpetrator substance use at time of crime?	

Weapon Use

Weapon use	
If weapon used, type	
If gun, who owned it?	
Gun acquired legally?	
If yes, when acquired?	
Previous requests for gun to be surrendered/destroyed?	
Did court ever order gun to be surrendered/destroyed?	

Witness Information

Others present at scene of fatality (i.e. witnesses)?	
If children were present:	How many minor children were present? _____ List ages of all children present _____ ____ ____ ____ Did they hear fatal incident? _______ Did they observe the fatal incident? _______ Were children directly involved? _______
What intervention occurred as a result?	

Perpetrator actions after fatality

Did perpetrator attempt/commit suicide following the incident?	

If committed suicide, how?	
Did suicide appear to be part of original homicide?	
How long after the killing did suicide occur?	
Was perpetrator in custody when attempted or committed suicide?	
Was a suicide note left? *If yes, was precipitating factor identified*	
Describe: *Perpetrator left note attached to envelope and within the envelope were photos of the victim and her boyfriend and correspondence regarding the purchase of a house in North Dakota and money transfers etc.*	
If perpetrator did not commit suicide, did s/he leave scene?	
If perpetrator did not commit suicide, where was s/he arrested/apprehended?	*(At scene, turned self in, apprehended later, still at large, other – specify)*
How much time passed between the fatality and the arrest of the suspect:	*(Hours, days, weeks, months, unknown, n/a – still at large)*

-- END INCIDENT INFORMATION --

VICTIM/PERPETRATOR RELATIONSHIP HISTORY

Relationship of victim to perpetrator	
Length of relationship	
If divorced, how long?	
If separated, how long?	
If separated more than a Month, list # of months	

Did victim begin relationship with a new partner?	
If not separated, was there evidence that a separation was imminent?	
Is there a history of separation in relationship?	
If yes, how many previous separations were there?	*(Indicate #, unknown*
If not separated, had victim tried to leave relationship	
If yes, what steps had victim taken in past year to leave relationship? (Check all that apply)	_____ Moved out of residence _____ Initiated defendant moving out _____ Sought safe housing _____ Initiated legal action _____ Other – specify

Children Information

Did victim/perpetrator have children in common?	
If yes, how many children in common?	
If separated, who had legal custody of children?	
If separated, who had physical custody of children at time of incident?	
Which of the following best describes custody agreement?	
Did victim have children from previous relationship?	
If yes, how many?	*(Indicate #)*

History of domestic violence

Were there prior reports of domestic violence in this relationship? Not reported to police

Type of Violence? *(Physical, other)* ____
If other describe: ____
____
____

If yes, reports were made to: (Check all those that apply)
__ _ Police
__ _ Courts
____ Medical
____ Family members
____ Clergy
____ Friends
____ Co-workers
____ Neighbors
____ Shelter/other domestic violence program
__ _ Family court (during divorce, custody, restraining order proceedings)
____ Social services
____ Child protection
____ legal counsel/legal services
____ Other – specify ____

Historically, was the victim usually the perpetrator of abuse?
If yes, how known?
Describe: ____
____
____

Was there evidence of escalating violence?
If yes, check all that apply:
____ Prior attempts or threats of suicide by perpetrator
____ Prior threats with weapon
____ Prior threats to kill
____ Perpetrator abused the victim in public
____ Perpetrator monitored victims whereabouts
____ Blamed victim for abuse
____ Destroyed victim's property and/or pets
____ Prior medical treatment for domestic violence related injuries reported
____ Other – specify ____

-- END VICTIM-PERPETRATOR RELATIONSHIP INFORMATION --

SYSTEM CONTACTS

Background

Did victim have access to working telephone? ______________________________

Estimate distance victim had to travel to access helping resources? (KMs) __________

Did the victim have access to transportation? ______________________________

Did the victim have a Safety Plan? ______________________________

Did the victim have an opportunity to act on the Plan? ______________________________

Agencies/Institutions

Were any of the following agencies involved with the victim or the perpetrator during the past year prior to the fatality? ______________________________

***Circle who had contact, describe contact and outcome. Locate date(s) of contact on events calendar for year prior to killing (12-month calendar)*

Criminal Justice/Legal Assistance:

Police (Victim, perpetrator, or both) **Victim**
Describe:______________________________
____
Outcome:______________________________

Crown attorney (Victim, perpetrator, or both)
Describe:______________________________
____
Outcome:______________________________

Defense counsel (Victim, perpetrator, or both)
Describe:______________________________
____
Outcome:______________________________

Court/Judges (Victim, perpetrator, or both) **Both**
Describe:______________________________
____
Outcome:______________________________

Corrections (Victim, perpetrator or both)
Describe:____
____
Outcome:____

Probation (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Parole (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Family court (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Family lawyer (Victim, perpetrator, or both)
Describe____
____
Outcome:____

Court-based legal advocacy (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Victim-witness assistance program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Victim Services (including domestic violence services)

Domestic violence shelter/safe house (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Sexual assault program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Other domestic violence victim services (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Community based legal advocacy (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Children services

School (Victim, perpetrator, children or all)
Describe: (Did school know of DV? Did school provide counseling?)
____
____
Outcome:____

Supervised visitation/drop off center (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Child protection services (Victim, perpetrator, children, or all)
Describe:____
____
Outcome:____

Health care services

Mental health provider (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Mental health program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Health care provider (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Regional trauma center (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Local hospital (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Ambulance services (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Other Community Services

Anger management program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Batterer's intervention program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Marriage counselling (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Substance abuse program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Religious community (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Immigrant advocacy program (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Animal control/humane society (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Cultural organization (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Fire department (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

Homeless shelter (Victim, perpetrator, or both)
Describe:____
____
Outcome:____

-- END SYSTEM CONTACT INFORMATION --

RISK ASSESSMENT

Was a risk assessment done?
*If yes, by whom?*____

When was the risk assessment done?____

What was the outcome of the risk assessment?_______________________________

This is a summary checklist. (*Check all the risk markers that were present in this case)*

____ Prior history of domestic violence
____ Actual or pending separation
____ Escalation of violence
____ Prior threats to kill victim or threats with a weapon
____ Prior threats to commit suicide or attempts to suicide by perpetrator
____ Obsessive behavior (including stalking the victim)
____ Access to or possession of firearms
____ Excessive alcohol and/or drug use
____ Depression (or other mental health or psychiatric problems)
____ Isolation of victim
____ Forced sexual acts or assaults during sex
____ Child custody or access dispute
____ New partner in victim's life
____ Perpetrator unemployed

____ Presence of stepchildren in the home
____ Victim and perpetrator living common-law
____ Hostage-taking
____ Destruction of victim's property
____ Violence against family pets
____ Extreme minimization or denial of spousal assault history
____ Attempts to isolate the victim
____ Controls most or all of victim's daily activities
____ Assaulted victim while pregnant
____ Chokes victim
____Youth of couple
____ Perpetrator witnessed domestic violence as child
____ Other factors that increased risk in this case? Specify: ________________________

DVDRC COMMITTEE RECOMMENDATIONS

Was the homicide (suicide) preventable in retrospect? (Yes, no)

If yes, what would have prevented this tragedy?

____
____
____
____
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____

What issues are raised by this tragedy that should be outlined in the DVDRC annual report?

____
____
____
____
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____
____

Future Research Issues/Questions:____

Additional comments: ___

Appendix E: Chi-Square Comparisons of Risk Factors and Other Variables Across Depression and no Depression

Risk Factor/Variable		Depressed		Not Depressed		χ^2	df	p
	N	n	%	n	%			
History Of Violence Outside Family	118	37	31.4	19	16.1	0.80	1	0.37
History of Domestic Violence	122	66	54.1	31	25.4	2.24	1	0.13
Prior Threats to Kill Victim	113	36	31.9	18	15.9	0.39	1	0.53
Prior Threats With a Weapon	110	21	19.1	11	10.0	0.16	1	0.69
Prior Assault With a Weapon	110	7	6.4	8	7.3	1.92	1	0.17
Prior Threats to Commit Suicide*	119	54	45.4	15	12.6	25.62	1	0.00*
Prior Suicide Attempts*	118	24	20.3	7	5.9	5.71	1	0.02**
Prior Attempts to Isolate Victim	126	35	27.8	13	10.3	2.10	1	0.15
Prior Attempts to Control Victim	125	36	28.8	12	9.6	2.58	1	0.11
Hostage taking	128	19	14.8	2	1.6	6.52	1	0.01**
Child Access Disputes	130	7	5.4	2	1.5	0.73	1	0.39
Destruction of Property	123	12	9.8	7	5.7	0.04	1	0.85
Choked Victim in Past	97	11	11.3	10	10.3	1.27	1	0.26
Perpetrator Abused or Witnessed Violence	60	24	40.0	5	8.3	6.54	1	0.01*
Escalation of Violence	122	47	38.5	19	15.6	4.05	1	0.04*
Obsessive Behaviour	124	53	42.7	17	13.7	8.81	1	0.00**
Perpetrator Unemployed	131	38	29.0	14	10.7	1.72	1	0.19
Common-Law	130	20	15.4	14	10.8	0.88	1	0.35
Step Children	133	9	6.8	6	4.5	0.22	1	0.64
Minimization Denial	114	22	19.3	4	3.5	5.30	1	0.02*
Separation	127	63	49.6	27	21.3	2.95	1	0.09
Alcohol Drugs	127	32	25.2	17	13.4	0.02	1	0.89
Other Psychiatric*	131	31	23.7	10	7.6	8.22	1	0.00**
Firearms	127	32	25.2	14	11.0	1.05	1	0.31
New Partner Real or Perceived	121	30	24.8	13	10.7	0.59	1	0.44
Failure to Comply with Authority	127	25	19.7	16	12.6	0.51	1	0.47
Access to Victim	124	9	7.3	5.0	4.0	0.00	1	0.99
Sexual Jealousy	112	35	31.2	10	8.9	5.26	1	0.02*
Misogynistic Attitudes	98	22	22.4	13	13.3	0.01	1	0.93
Age Disparity	133	15	11.3	7	5.3	0.09	1	0.77
Victim's Fear	117	41	35.0	21	17.9	1.17	1	0.28
History of Violence or Threats Toward Children	112	20	17.9	10	8.9	0.30	1	0.58
Perpetrator Exposed to Violence As Child	41	19	46.3	5	12.2	3.16	1	0.08
Perpetrator Physically Abused As Child	40	14	35.0	3	7.5	2.15	1	0.14
Perpetrator Sexually Abused As Child	30	5	16.7	1	3.3	1.29	1	0.26

Evidence Of Excessive Violence	128	8	6.2	5	3.9	0.04	1	0.84
Help Seeking Behaviour								
Prior Domestic Violence Treatment	113	4	3.5	0	0	2.10	1	0.15
Prior Substance Abuse Treatment	111	13	11.7	4	3.6	0.48	1	0.49
Prior Mental Health Treatment*	115	43	37.4	8	7.0	26.02	1	0.00**
Anger Management Treatment	113	15	13.3	3	2.7	2.28	1	0.13
Prior Counselling*	105	40	38.1	28	26.7	12.29	1	0.00**

*Compared groups with no depression and other mental health problems present (n=146)

Appendix F: Oklahoma Mental Health Response

MENTAL HEALTH RESPONSE

By Janet Sullivan Wilson, PhD, RN

Over the past four years the Board has had the opportunity to review several cases in which the perpetrator and/or victim had contact with a mental health provider prior to the homicide. In response, a mental health practitioner on the Board developed the following suggestions for others in the field to incorporate in their practice.

Presenting Mental Health Problem	Standard Mental Health Practices	Emerging Intimate Partner Violence Practice Recommendations
Depression, suicidal thoughts, thought disorder	Assessment of suicide/ homicidal ideation: e.g., Are you thinking about suicide? Homicide? Do you have a plan for suicide or homicide? What are the voices telling you to do? Who are the voices telling you to harm? -Mental status exam -Medications for depression, anxiety -Individual, group, family counseling referral for outpatient -sometimes a no-suicide/ homicide contract Discharge to outpatient counseling	1. Ask all women: Do you feel safe in your present relationship? Has anyone ever forced you to have sex when you didn't want to? If yes, who? Do you currently have contact with him? Have you ever been kicked, slapped, punched, choked, forced to do something you didn't want to do? If yes, by whom? Do you have current contact with him? (Use danger assessment if she does not feel safe.) 2. Use alternative words other than suicide/homicide. Focus on behaviors, e.g., Have you thought of hurting yourself or others? How? By what means? When? Who else do you want to see hurt? Have you ever forced someone to do something they didn't want to do? Have you ever kicked, slapped, punched, choked someone or an animal? Have you made threats to other people, now or ever? Have you tried to hurt yourself now or ever? Tell me about what happened and how you tried to hurt yourself/others before. 3. Screen men for hurtful behaviors toward partners. Men who are depressed, alcohol users, or victims of childhood abuse are at a higher risk for violence against partners (Oriel & Fleming, 1998) Use Conflict Tactics Scale (CTS) to screen 4. Even if a client says there is no plan to hurt self and/or others, assess for presence and access to weapons: Do you or your partner have access to guns? Other weapons? How many guns do you own or are in your house? Do you or your partner have access to guns through other people? Where are the guns located? Where do you keep the ammunition? Do you have a license for the guns? Have you been in the military? Do you know how to use a gun? 4. Couples counseling where there has been possible or known intimate partner violence is contraindicated. 5. Recommend counselors who are trained in trauma/ violence specific therapy

Appendix G: Ethics Approval

Research Ethics

Western University Health Science Research Ethics Board
NMREB Delegated Initial Approval Notice

Principal Investigator: Dr. Peter Jaffe
Department & Institution: Education\Faculty of Education,Western University

NMREB File Number: 105372
Study Title: Depression among Perpetrators of Domestic Homicide
Sponsor: Social Sciences and Humanities Research Council

NMREB Initial Approval Date: July 02, 2014
NMREB Expiry Date: April 30, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Data Collection Form/Case Report Form	Coding Form	2014/06/09
Western University Protocol	Western Protocol added to footer of revision version date: 06/09/2014	2014/06/09

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

This is an official document. Please retain the original in your files.

Western University, Research, Support Services Bldg., Rm. 5150
London, ON, Canada N6A 3K7 t. 519.661.3036 f. 519.850.2466 www.uwo.ca/research/services/ethics

Appendix H: Curriculum Vitae
POLLY CHENG

EDUCATION

Masters of Arts, Counselling Psychology (Candidate) September 2013 - Present
Faculty of Education, Western University, London, ON

Honours Bachelor of Science, Psychology Class of 2013
Department of Psychology, McMaster University, Hamilton, ON

Honours Bachelor of Science, Biology Class of 2010
Department of Biology. McMaster University, Hamilton, ON

RESEARCH EXPERIENCE

Master's Thesis Research Study September 2013 – Present
Western University
Advisor: Dr. Peter Jaffe Ph.D., C. Psych

- Studied the relationship between domestic homicide and depression

Psychology Undergraduate Honours Thesis September 2012 - Present
McMaster University
Advisor: Dr. Geoffrey Hall Ph.D.

- Studied social skills deficits in children with Autism by aiding in the development and piloting of a series of computer-based subtests to assess social skills

Psychology Undergraduate Practicum September 2012 – Present
Brain Injury Services
Advisor: Dr. Bruce Linder Ph.D., C. Psych, BCBA-D

- Gathering data on discrete trial training for staff recognition with a client with acquired brain injury to determine effectiveness of multi-trial training programs
- Adjust training procedures based on training progress

Research Assistant October 2011 – April 2012
MacAnxiety Clinic
Advisor: Beth Patterson, BScN

- Conduct extensive literature searches on various drugs relating to anxiety disorders including OCD, GAD, SAD, PD, PTSD as well as ADHD
- Summarize results from literature searches into easy-to-read and organized tables

Independent Study Project August 2011 – April 2012
McMaster University
Advisor: Dr. Irina Trofimova Ph.D., C.Psych

- Studied the biological basis of individual differences in behaviour
- Organize data regarding studies of psychosemantics and temperament with the use of scales
- Transcribe interviews for a documentary

TRAINING

Counselling Internship September 2014 – Present
Centennial College, Toronto, ON

- One-on-one client sessions with students dealing with personal, academic issues
- Conducted sessions in different modalities including, solution-focused therapy, narrative therapy and CBT
- Designed, implemented and co-facilitated LGBTQ support group

Teaching Assistant Training Program September 5-7, 2014
Western University, London, ON

- Learned about fair grading practices, diversity in the classroom, lecturing, and giving students feedback on written work
- Conducted 2 micro-teaching sessions to apply teaching skills and techniques with a small group of peers, gave and received helpful, constructive feedback
- 2.5 day session

CONFERENCES/WORKSHOPS ATTENDED

Introduction to Dialectical Behaviour Therapy (DBT) for Counsellors November 8, 2014
Centre for Innovation in Campus Mental Health, Toronto, ON

Trauma Talks 2014: Advancing Cultural Understandings in Trauma-Informed Care May 30, 2014
Women's College Hospital, Toronto, ON

Working Together to Support Children and Youth with Sexual Behaviour Problems February 11, 2014
Children and Parent Resource Institute, London, ON

Social Media and Sexual Violence November 7-8, 2013
Western University, Ontario, London, ON

Sexual Behaviours Clinic Education Day October 24, 2013
Centre for Addictions and Mental Health, Toronto, ON

VOLUNTEER EXPERIENCE

Crisis Line Counsellor June 2013 – Present
Salvation Army, Hamilton, ON

- Responding to crisis calls on a 24/7 line
- Supported individuals who were in distress over the phone by expressing empathy and providing resources they can access to help with the problems they are facing
- Conducted emergency calls if necessary, ie caller is attempting suicide

AWARDS, RECOGNITIONS & MEMBERSHIPS

- Student member of CCPA 2014
- Western Graduate Research Scholarship (WGRS) 2014
- Social Science and Humanities Research Council (SSHRC) 2014
- Western Graduate Research Scholarship (WGRS) 2013