Intimate partner homicide

Intimate partner homicides (IPH) are fatal violent attacks perpetrated by intimate partners, usually defined as current or former spouses or common-law partners. A systematic review of the global prevalence of IPH indicated that one in seven homicides is committed by an intimate partner (Stöckl et al., 2013). IPH is the most common type of domestic homicide, and is the only homicide category in which the majority of victims are women (e.g., Liem & Roberts, 2009; Matias, Goncalves, Soeiro, & Matos, 2020). Women are far more likely to be killed by an intimate partner than by anyone else (e.g., Campbell, Webster, & Glass, 2009; Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Matias et al., 2020), while the opposite is true for men. The ratio between men and women as perpetrators of IPH is 6:1 (Stöckl et al., 2013). In this chapter, we summarize existing scientific knowledge about intimate partner homicide, focusing on recent theoretical developments in the field, as well as empirically supported risk factors for IPH victimization and perpetration.

Theoretical framework: interactional perspectives on intimate partner homicide

Current comprehension of intimate partner violence (IPV) and IPH can be categorized into sociocultural theories and individual theories. Recent research from a sociocultural perspective finds that the relationship between masculinity and femicide has been ignored, and that new conceptions of masculinities are applicable to intimate partner femicide and “honour” femicides (Johnson, Eriksson, Mazerolle, & Wortley, 2019; Messerschmidt, 2017). New theoretical frameworks including both structural and individual aspects have been proposed in order to make IPV and IPH theories more comprehensive by taking into consideration the perspectives of both victims and perpetrators, and integrating views from multiple academic disciplines (e.g., Bell & Naugle, 2008; Dixon, Hamilton-Giachritis, & Browne, 2008; Emery, 2011; Winstok, 2007; Vatnar & Bjorkly, 2008; Vatnar, Friestad, & Bjorkly, 2017a). The traditional person-situation dichotomy is replaced by an emphasis on the mutual impact of the two variables (Funder, 2006). The main idea within an interactional perspective is that violence involves an influential and continuous interaction between individuals and the various situations and contexts they
encounter. The *situation* is defined as an actual situation and how it is perceived, interpreted, and assigned meaning in the minds of those involved (Magnusson, 1981). Correspondingly, theoretical IPV and IPH perspectives and research should address the situation and proximal events associated with IPV (Bell & Naugle, 2008; Dixon & Graham-Kevan, 2011; Emery, 2011; Vatnar & Bjorkly, 2008; Vatnar et al., 2017a; Winstok, 2007). These authors have encouraged investigation of “the violence process”, examining the nature of the violent relationship, events, motivations, and conditions including structural factors preceding an IPV episode, and outcomes of violent acts. Applied to IPH, an interactional perspective involves investigating the intimate partner homicide process, by examining the wider set of events and incidents that preceded and ended with the homicide (Vatnar et al., 2017a). To determine who have the greatest need for services and which services are most needed, criminal justice and health and victim support professionals need information about, for example, which subgroups are most likely to assault their partners or commit life-threatening violence (Kropp & Hart, 2015).

### Previous intimate partner violence

According to Dobash, Dobash, and Cavanagh (2009), research from the United States, Canada, and the United Kingdom (UK) reveals numerous similarities but also some differences concerning the role of previous IPV in cases of IPH. Studies have found that 65 to 80% of IPH victims had been previously abused by the partner who killed them (Campbell et al., 2007, 2009; Matias et al., 2020; Nicolaidis et al., 2003; Vatnar et al., 2017a). *Repeated* violence against the victim was present in 25% to 65% of the relationships that ended with the murder of a female partner (Aldridge & Browne, 2003; Campbell et al., 2007, 2009; Dobash et al., 2009; Vatnar et al., 2017a). In one study, nearly half of the perpetrators of IPH had previously been violent towards their victim, but had no prior conviction for intimate partner violence (Dobash et al., 2009). Research from the United States, primarily limited to cases with a history of previous IPV, suggests that significant risk factors for IPH may include repeated occurrences of severe IPV, stalking, sexual assault, attempts to strangle, intoxication, threats to kill, a firearm in the home, and threats with or use of a firearm (Campbell et al., 2007; Nicolaidis et al., 2003; Shields, Corey, Weakley-Jones, & Stewart, 2010). Research from the UK, including cases *without* a history of previous IPV, found that previous sexual assault, previous strangulation, and the use of sharp or blunt instruments were important risk factors, but not intoxication or the use of firearms (Dobash & Dobash, 2011; Dobash et al., 2009).

### Sociodemographic, contextual, and clinical factors

Research has identified sociodemographic characteristics that differentiate between victims of IPH and victims of nonfatal IPV (Eliason, 2009; Garcia & Hurwitz, 2007; Liem, 2010; Matias et al., 2020). The risk of intimate partner homicide is higher in cohabiting than in marital relationships and during separation or break up of the intimate relationship (Aldridge & Browne, 2003; Campbell et al., 2007, 2009; Eke, Hilton, Harris, Rice, & Houghton, 2011). Evidence suggests that at the time of a murder, one-third to one half of women killed by a partner were either separated or had expressed an intention to leave the relationship (Dobash et al., 2009; Nicolaidis et al., 2003).

Compared to nonfatal partner violence, IPH occurs more frequently among women and men who are under the age of 40, have a low level of education, are unemployed, and/or have financial and other problems associated with social and economic disadvantage (Barrett & St Pierre, 2011; Dobash & Dobash, 2015; Dobash et al., 2009; Goodman, Smyth, Borges, &
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Singer, 2009). In the United States, ethnicity is considered an important risk factor, although it may be that social and economic disadvantage, rather than ethnicity per se, are the actual, underlying issues (Barrett & St Pierre, 2011; Dobash et al., 2009; Vatnar, Friestad, & Bjørkly, 2017b). The context of pregnancy and childbirth has also been associated with IPH (Campbell et al., 2007; Garcia et al., 2007; Martin, Macy, Sullivan, & Magee, 2007; Shadigian & Bauer, 2005). A population-based study of children bereaved by fatal intimate partner violence in the Netherlands showed that on average, the children were 7 years old at the time of the homicide, most lost their mother, and immigrant children were overrepresented. The majority of the children were present when the killing took place (Alisic, Groot, Snetselaar, Stroeken, & van de Putte, 2017). Alcohol and drug intoxication increase the risk both for perpetrating and for becoming a victim of IPH (Aldridge & Browne, 2003; Eliason, 2009). Some IPH perpetrators, especially homicide-suicide perpetrators, suffer from mental illness, with depression being the most commonly cited disorder (Liem, 2010).

Help-seeking prior to IPH

The common image of a “battered woman” is often grounded in stereotypical representations of learned helplessness. However, empirical findings indicate that survivors of IPV are most commonly actively engaged in a myriad of strategies to cope with their victimization experiences (Barrett & St Pierre, 2011; Martin et al., 2007; Vatnar & Bjørkly, 2014). Recent findings highlight the complexities of help-seeking. Women who have experienced severe forms of IPV were most likely to have sought help through both formal and informal avenues (Barrett & St Pierre, 2011; Nurius, Macy, Nwabuzor, & Holt, 2011; Vatnar & Bjørkly, 2014). Frequency and seriousness of exposure to violence increased the likelihood of help-seeking. Research indicates that the strongest independent predictor of women’s use of supports is fear of their lives being in danger (Barrett & St Pierre, 2011). Studies have also found that women who end up being killed by their partner have sought help from informal sources such as family and friends (e.g., Vatnar et al., 2017a). Help-seeking from both victims and perpetrators had raised concerns and led to several attempts from the bereaved to get help (Vatnar et al., 2017a). Vatnar and colleagues found that concerns were rarely conveyed to professional agencies, but when they actually were, the general experience of the bereaved was that the agencies failed to realize the seriousness and urgency of the reported situations.

Although it is far less focused upon in research, there is some evidence that IPV perpetrators have sometimes sought help before committing fatal violence (e.g., Askeland, Evang, & Heir, 2011; Dobash & Dobash, 2015; Eliason, 2009; Hester et al., 2015; Martin et al., 2007; Vatnar et al., 2017a).

IPH and substance use

Substance use appears to be an important risk factor in IPH, although we currently lack a clear understanding of its explanatory role. Studies of IPH measuring the link between substance use and IPH have typically examined either alcohol use or drug use, but not both or combinations of the two (Aldridge & Browne, 2003; Campbell et al., 2007, 2009; Dobash, Dobash, & Cavanagh, 2009; Dobash & Dobash, 2015; Nicoladis et al., 2003). However, there are recent studies measuring several dimensions of the link between substance use and IPH (e.g., Ontario Death Review Committee in Canada, Lucas et al., 2016; Vatnar, Friestad, & Bjørkly, 2019a). Among the shortcomings in the literature are the lack of consistent definitions of such terms as use and misuse. As well as legal and illegal substances, ongoing
versus previous use, perpetrator’s versus victim’s substance use, and, in particular, the role of substance use in the IPH incident itself.

A recent review of male perpetrators of IPH (Kivisto, 2015) suggested that most of them, despite generally high substance misuse rates, were not under the influence of drugs or alcohol at the time of the IPH. However, another often-quoted study (Campbell et al., 2007) found that 80% of the male perpetrators had been drinking at the time of the murder; two-thirds were described as intoxicated, and one quarter had consumed both alcohol and drugs. Also Garcia and Hurwitz (2007) in their literature review found that in two-thirds of IPH, including IPH attempts, the perpetrator had consumed alcohol, drugs, or a combination of both. As well, a review of perpetrators of spousal homicide found that 22% of the male perpetrators believed their partner had consumed alcohol prior to being killed, and 44% characterized their partner as having had a drug problem at the time she was killed (Aldridge & Browne, 2003). In summary, reviews and recent original studies of IPH vary considerably in their estimates (4%–80%) of the percentage of perpetrators being intoxicated at the time of an IPH incident. Furthermore, in these same reviews and studies, the results are mixed and inconclusive pertaining to the role of substance use in IPH (Aldridge & Browne, 2003; Campbell et al., 2007; Garcia & Hurwitz, 2007; Kivisto, 2015; Vatnar et al., 2019a).

It is generally difficult to identify perpetrators’ substance misuse at the time of IPH without laboratory analyses of blood or saliva samples taken at the time of the crime (Campbell et al., 2007). As reviews and recent original studies of IPH indicate, such data are generally lacking, and those studies that do include accurate identification of perpetrators’ substance use at the time of the IPH are most often based on small and selected samples (Kivisto, 2015). However, a 22-year cohort study found few differences and many similarities between IPH perpetrated under the influence of substances or not (Vatnar et al., 2019a). Still, the following findings from this study need further investigation: biological traces of substance use were found in more than half of the perpetrators and in 40% of the victims; perpetrators’ and victims’ substance influence at time of crime was positively associated; IPH perpetrators’ type of influence at the time of the homicide was positively associated with their substance abuse in general (Vatnar et al., 2019a). These findings parallel results from a study finding victim–offender similarity in police-reported violent crimes in general (Aaltonen, 2016). This indicates a positive association between socioeconomic/criminal background and victimization being enhanced by the intensity of the perpetrator’s criminal background (Aaltonen, 2016). Equally, a longitudinal cohort study examining the link between crime and drug misuse and social inclusion and exclusion in adult life showed that drug misuse is central both to processes of continuity and desistance from crime and to life chances and mortality in adulthood (Nilsson, Estrada, & Bäckman, 2014). These findings of IPH and other violent crimes concur with research indicating that established psychological and criminological theories of IPH should be expected to generalize across population groups (Skardhamar, Aaltonen, & Lehti, 2014).

A recent study conducted in Sweden indicated decreasing prevalence of alcohol influence among both perpetrator and victim in the period from 1990 to 2013 (Caman, Kristiansson, Granath, & Sturup, 2017). This pattern was not significant in a Norwegian IPH cohort study (Vatnar et al., 2019a). Campbell and collaborators’ (2007) review of IPH indicated that males are more likely to be chronic alcohol misusers as victims than as perpetrators. Moreover, male victims or perpetrators are more likely to chronically misuse alcohol than females in either category. This concurs with the Caman and coworkers’ (2017) findings indicating a declining trend over time in the proportion of male–perpetrated IPHs involving alcohol at the time of the crime or being preceded by a known history of IPV. However, the majority of female-perpetrated
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IPHs involved alcohol and a history of known IPV. In addition, Campbell and colleagues’ review indicated that alcohol use was not a unique risk factor for IPH for women as victims, but rather a common risk factor for female victims across homicide categories. A review of IPV and homicide from 2007 reported data indicating that male offenders were more likely than their female victims to drink alcohol or use drugs at the time of incidents (Garcia & Hurwitz, 2007). However, this research did not distinguish between IPH, attempted IPH, or the most severe incident of IPV. A recent study found no significant differences for sex and substance use at time of crime after controlling for other group differences (Vatnar et al., 2019a).

The great majority of studies on IPH and substance use did not have joint operational definitions and measures pertaining to variables, such as intoxicated, under the influence of, substance use, and alcohol use, or drinking. Accordingly, some of the mixed findings might result from applying different measures of substance use.

IPH and immigration

Systematic reviews of the literature show that IPH committed by immigrants is not a major contributor to the overall prevalence of IPH, as most IPHs are committed by and toward the majority population. Still, because several studies have shown that immigrants are proportionally overrepresented in the IPH statistics (see, e.g., Echeburua, Fernandez-Montalvo, de Corral, & Lopez-Goni, 2009; Edelstein, 2016; Garcia & Hurwitz, 2007; Matias et al., 2020; Sabri, Campbell, & Dabby, 2016), empirical knowledge about IPH among immigrants is important to consider.

Some researchers have raised concerns that focusing on crime among immigrants might increase stigmatization of this group of people (e.g., Sarnecki, 2006). Others assert that established psychological and criminological theories of IPH should be expected to generalize across population groups, covering both immigrant and native populations (e.g., Skardhamar et al., 2014). To be sure, if certain groups are proportionally overrepresented with registered crime, then increased attention to those groups is warranted. Otherwise, a possible risk factor would be neglected, leaving a vulnerable group of IPV victims at increased risk. However, a higher risk among foreign citizens, both as perpetrators and as victims, might be due to contextual factors such as barriers to help-seeking faced by both perpetrators and victims, which may be due to fear of involving the police and potentially jeopardizing their immigration status. It may also be caused by sociodemographic and contextual factors of being an immigrant. The finding of perpetrator’s source of income (unemployed) as a risk factor in IPH by foreign and naturalized citizen perpetrators concur with studies indicating that social and economic disadvantage, rather than ethnicity or immigration per se, are the actual, underlying issues and risk factors for IPH (Barrett & St Pierre, 2011; Dobash & Dobash, 2015; Dobash et al., 2009; Vatnar, Friestad, & Bjorkly, 2017b). However, IPV as a major risk factor for IPH is true for immigrants as well – for both foreign and naturalized citizen perpetrators (e.g., Vatnar et al., 2017b). At the same time, there might be some specific risk factors associated with immigrants or some immigrant groups, even after adjusting for other group differences. It has been asserted that IPHs committed by immigrants (mainly from patriarchal cultures) have unique characteristics such as jealousy-oriented triggers, methods of killing and use of excessive force (“overkilling”) that differentiate them from other low SES groups (e.g., Campbell et al., 2007; Edelstein, 2013; Sabri et al., 2016). However, findings showing that immigrants were ascribed different motives and received longer sentences than majority population perpetrators in IPH cases, call for research into how the formal sanctioning system interprets crime committed by minority groups (Vatnar...
et al., 2017b). In addition, the finding indicating identical sex distribution among native and foreign perpetrators is intriguing (Vatnar et al., 2017b), signifying that the proportion of native perpetrators of female IPH were identical with foreign or immigrant perpetrators.

**IPH-suicide**

Homicide-suicide incidents make up a relatively small proportion of homicides overall, but occur more frequently in IPH (Dobash & Dobash, 2015; Galta, Olsen, & Wik, 2010; Knoll & Hatters-Friedman, 2015; Liem, 2010; Liem, Barber, Markwalder, Killia, & Nieuwbeerta, 2011; Malphurs & Cohen, 2005; Marzuk, Tardiff, & Hirsch, 1992; Matias et al., 2020; Salari & Sil- lito, 2016). Homicide-suicide refers to a homicide of one or several individuals immediately followed by the perpetrator dying by suicide (e.g., Dobash & Dobash, 2015; Knoll & Hatters-Friedman, 2015). Commonly, cases are included in which the homicide(s) and the suicide are likely parts of the same action (Galta et al., 2010), as operationalized in terms of a time interval between homicide(s) and suicide ranging from the typical 24 hours (Dobash & Dobash, 2015; Knoll & Hatters-Friedman, 2015) to as long as one week (Eliason, 2009; Marzuk et al., 1992). Findings from Sweden and Norway showed that 24% and 25% respectively, of perpetrators of IPH with a female victim died by suicide after the homicide. This is about four times the rate of suicides completed after lethal violence under other circumstances (Belfrage & Rying, 2004; Vatnar, Friestad, & Bjørkly, 2019b). Studies from the United States have found that 27% to 32% of IPH was IPH-suicide (IPHS) (Bossarte, Simon, & Barker, 2006; Campbell et al., 2007). There is a widespread perception borne out by prior research that homicide-suicide perpetrators differ from the prototypical “killer”. Instead of emphasizing more general homicide risk factors, some researchers have argued that perpetrators of IPHS suffer from reactions to situational circumstances, such as distress over relationship termination (e.g., Galta et al., 2010; Eliason, 2009). Research has described these perpetrators as less socially marginalized, better educated, and more often employed compared to other homicide perpetrators (Campbell et al., 2007; Dobash, Dobash, Cavanagh, & Lewis, 2004; Eliason, 2009; Galta et al., 2010; Panczak et al., 2013). Common risk factors for IPH such as previous IPV, alcohol or substance use, family problems, mental illness, or a criminal record are less likely to apply to perpetrators of IPHS (Banks, Crandall, Sklar, & Bauer, 2008; Dobash et al., 2004; Eliason, 2009; Knoll & Hatters-Friedman, 2015; Panczak et al., 2013). Homicide-suicide studies have shown that substance involvement was about half of that found in homicide alone (Eliason, 2009). However, Panczak et al.’s (2013) meta-analysis indicated the influence of alcohol, history of IPV, and unemployment as common risk factors in both IPH and IPHS. Campbell et al. (2007) also emphasized unemployment as the strongest demographic risk factor for both IPH and IPHS. Previous suicide attempts were more common among perpetrators of homicide-suicide than among homicide perpetrators (Panczak et al., 2013). Across cultures, however, a high prevalence of previous physical IPV has been reported in IPHS, supporting this as an important risk factor also for this IPH subgroup (Eliason, 2009; Knoll & Friedman, 2015; Liem, 2010; Malphurs & Cohen, 2005; Vatnar et al., 2017a).

The statement that homicide-suicide perpetrators are different from the typical profile of a “killer” has also been supported by interviews with the bereaved (Vatnar et al., 2017b). However, even if perpetrators of IPHS are less likely than perpetrators of IPH to have a criminal record, qualitative data indicated previous violations of the law that were undetected or that did not incur criminal consequences (Vatnar et al., 2017b). Some bereaved have pointed out that linking the homicides to ordinary stressful situations like a heavy workload or the termination of a partnership caused anxiety and concern, at least in the local community (Vatnar et al., 2017b).
On the contrary, interviews with the bereaved indicated that the IHPS was perceived as intentional and planned, not an accidental reaction to situational circumstances (Vatnar et al., 2019b). In addition, the bereaved felt that the loss of hope or loss of a future in combination with an inability to cope with severe life disappointments was an important risk factor. This finding adds some perspective to previous findings that homicide-suicide perpetrators are commonly more depressed and their motives are failure and loss compared to homicide perpetrators (Campbell et al., 2007; Eliason, 2009; Holland, Brown, Hall, & Logan, 2018; Knoll & Hatters-Friedman, 2015; Liem, 2010; Salari & Sillito, 2016).

Within the IHPS group, there is a subgroup of ailing spouses, for which research have emphasized the role of economic strain, as well as changing health in one or both of the partners (Liem, 2010). Perpetrators of IHPS often experience mental illness, with depression being the most prevalent disorder, and were more likely than perpetrators of IPH to have been seen in health or mental health services due to depression or threats of suicide in the year prior to the incident (Campbell et al., 2007; Eliason, 2009; Knoll & Friedman, 2015; Salari & Sillito, 2016).

A comparison of IHPS perpetrators by age found that a known history of IPV was most common in young dyads (Salari & Sillito, 2016). In terms of personality characteristics, men who commit IHPS are described as over-controlling and dependent (Marzuk et al., 1992; Liem, 2010). It has also been suggested that when the continuation of a relationship is threatened, a breakthrough of aggression can take the shape of IHPS (Liem, 2010). These circumstances share jealousy as a motive, the trigger leading up to the event being the perceived rejection by the female partner and an immediate threat of separation and estrangement. Perpetrators of IHPS are hypothesized to be unable to cope with life's disappointments, such as a terminated relationship, illness, and financial difficulties (Knoll & Hatters-Friedman, 2015; Liem, 2010; Salari & Sillito, 2016; Vatnar et al., 2019b). Others have suggested that suicidal men who commit IHPS may do so because they view their partners and children as part of an “extended self” (Bossarte et al., 2006; Knoll & Hatters-Friedman, 2015; Salari & Sillito, 2016). To speculate, IHPS could be interpreted as the Caucasian male’s version of honour-based homicide (Vatnar et al., 2019b).

However, studies are claiming that homicide-suicide cannot be categorized either as homicide or as suicide, but is actually a distinct behaviour (Eliason, 2009; Knoll & Hatters-Friedman, 2015; Marzuk et al., 1992; Panczak et al., 2013). Nevertheless, it seems naive to assume that homicide-suicide shares no characteristics with other forms of fatal violence or that its typology is exhaustive (Marzuk et al., 1992; Vatnar et al., 2019b).

Perpetrators of IHPS seem less socially marginalized and more often employed, compared to perpetrators of homicide generally (Campbell et al., 2007; Dobash et al., 2004; Eliason, 2009; Galeta et al., 2010; Panczak et al., 2013; Vatnar et al., 2019b). Still, IHPS perpetrators emerged as more similar to, than different from, IPH perpetrators in findings from multivariate analysis comparing other sociodemographic characteristics in a recent study (Vatnar et al., 2019b). Research has found that perpetrators of IHPS were more likely than perpetrators of IPH to have used health or mental health services due to depression or threats of suicide in the year prior to the incident (Campbell et al., 2007). Yet, a recent study found that compared to that of perpetrators of IPH, information on IHPS perpetrators’ previous contact with police, health, and social services was more often absent in the court case documents (Vatnar et al., 2019b). Hence, we need more research before this issue can be settled.

**Differentiating female and male IPH perpetrators**

Consistent with the heavily skewed sex distribution, most research on IPH has solely studied male perpetrators and male-perpetrated IHs with female victims (Caman, Howner, Kristiansson,
Solveig Karin Bø Vatnar et al.

Sturup, 2016; Weizmann-Henelius et al., 2012). This leaves a gap in our knowledge concerning potential differences between IPHs committed by female and male perpetrators. It has been suggested that female and male IPH perpetrators are distinct groups (e.g., Campbell et al., 2007; Caman et al., 2016; Weizmann-Henelius et al., 2012), but the empirical evidence is weak due to few studies and mixed results. We are currently unable to conclude whether IPH committed by women is qualitatively and interactionally different from those perpetrated by men. The lack of research and clarity concerning potential sex-specific risk factors for IPH is a serious shortcoming in the IPH literature and a potential obstacle to targeting preventive interventions.

Studies investigating the phenomenon of IPH across genders have suggested both differences and similarities between female and male perpetrators. With regard to marginalized population groups, economic disadvantage, and ethnicity, no significant sex differences have emerged (Campbell et al., 2007; Weizmann-Henelius et al., 2012). One study reported no significant sex difference regarding abuse of alcohol (Weizmann-Henelius et al., 2012). However, a recent investigation suggested that female perpetrators are more likely to be unemployed, to have suffered from a substance abuse disorder at some point in their lives and to have been subjected to violence by the victim of the IPH (Caman et al., 2016). Another study identified sex differences in four risk factors that increased the risk for female-perpetrated IPH: the victim being intoxicated, the perpetrator being unemployed at the time of offence, quarrels due to intoxication, and self-defence being the motivating circumstance of the crime (Weizmann-Henelius et al., 2012).

Several studies have suggested that male perpetrators are more often motivated by jealousy and involuntary break-up, separation, or divorce (e.g., Belfrage & Rying, 2004; Dobash & Dobash, 2015). Female perpetrators’ motives are more often linked to self-defence after being systematically victimized by IPV (Caman et al., 2016; Campbell et al., 2007; Serran & Firestone, 2004; Swatt & He, 2006; Walker & Browne, 1985). Furthermore, Campbell and colleagues (2007) found that the risk of female-perpetrated IPH increased when the male victims had abused the women or their mutual children.

Recent findings indicated that female-perpetrated IPHs occurred in the most marginalized segments of this generally disadvantaged group (Caman et al., 2016; Vatnar, Friestad, & Bjørkly, 2018; Weizmann–Henelius et al., 2012). Previous studies have argued that mental illness is more often an important risk factor in female-perpetrated IPHs than in male-perpetrated IPHs (e.g., Flynn & Graham, 2010). However, recent studies (Caman et al., 2016; Vatnar et al., 2018) did not find sex differences concerning diagnosis. Previous findings have been conflicting regarding demographic characteristics and substance abuse (Weizmann-Henelius et al., 2012). Substance abuse problems have been found to be less likely among males perpetrating IPH than other types of homicide (Dobash & Dobash, 2015). In this same study, neither drug use nor alcohol abuse by the victim was independently associated with the risk of being a victim of IPH. However, a recent study found that female-perpetrated IPHs more often involved a substance-addicted victim (Vatnar et al., 2018). The most striking sociodemographic difference in Vatnar et al.’s study was that no female perpetrators had mutual children with their victims, in contrast to 56.4% of the male perpetrators. One hypothesis may be that female-perpetrated IPH occurs in different kinds of partnerships and in other contexts (substance misuse) than the majority of male-perpetrated IPHs. In relation to this, a systematic literature review found that familicides were almost exclusively committed by men, that relationship problems, mental health problems, and financial difficulties often precede the offence. About half of the familialide cases led to the suicide of the offender (Karlsson et al., 2019).

The empirical literature on IPH characteristics and perpetrators of IPH, based mainly on research on males, indicates that previous IPV is a major risk factor for IPH. Some studies
have found that when females used lethal violence, they did so in self-defence and as a result of having been victimized by the IPH victim (Aldridge & Browne, 2003; Bailey et al., 1997; Caman et al., 2016; Campbell et al., 2007; Swatt & He, 2006; Weizmann-Henelius et al., 2012). Accordingly, it has been suggested that there are motivational sex differences related to the dynamics of the relationships (Caman et al., 2016; Liem & Roberts, 2009; Serran & Firestone, 2004; Weizmann-Henelius et al., 2012). A recent study using multivariate analyses did not find support for sex differences concerning previous IPV in the IPH relationship (Vatnar et al., 2018). However, there were bivariate findings indicating that mutual IPV was more often present in the cases of female-perpetrated IPH, 87.5% compared to 51.8% (Vatnar et al., 2018).

Recent research has revealed that women do not commit IPHs solely in self-defence, as has often been supposed previously (Dutton & Nicholls, 2005; Weizmann-Henelius et al., 2012). Quarrelling when drinking was also often reported, and a majority of female perpetrators were alcohol dependent (Weizmann-Henelius et al., 2012). This is consistent with findings of quarrelling as the most prevalent motive for female-perpetrated IPHs as well (Vatnar et al., 2018). By and large, establishing motives is complex and may be subject to bias. Because no exact criteria exists regarding how to measure the motive for IPH, it is easy to find results that converge with long-held myths and previous findings, and to ignore or overlook findings diverging from a priori interpretations and expectations. Previous research has suggested that female and male perpetrators of IPHs are distinct groups (Caman et al., 2016; Campbell et al., 2007; Eriksson & Mazerolle, 2013; Serran & Firestone, 2004; Weizmann-Henelius et al., 2012). However, the current empirical evidence for this conclusion is weak due to mixed results.

**Discussion and analysis**

Previous IPV is seen in 65% to 80% of IPHs, and repeated previous intimate partner violence is seen in 25% to 65% of IPHs (Campbell et al., 2007, 2009; Nicolaïdis et al., 2003; Vatnar et al., 2017a). This means that in the majority of cases at-risk individuals could be identified and interventions employed by multi-agency, coordinated community responses, and structured professional risk assessment and management, with considerable preventive potential (Contini & Wilson, 2019; Kropp & Hart, 2015; Robinson & Tregidga, 2007).

IPH is very rare compared to non-lethal intimate partner violence, and because of the low base rate, it is not possible to obtain valid results by using the traditional “risk prediction” format to IPH. The only scope of risk prediction is to identify a context-free risk of future violence for the actual person. In contrast to this, multi-agency, coordinated community responses, and structured professional risk assessment has two main aims: (1) to identify violence risk as an interactional or situational/contextual phenomenon and (2) to develop measures that can mitigate this risk. Instigating preventive efforts is an integrated part of this approach.

In the challenging task of identifying individuals in contexts at high risk of either perpetrating or being a victim of IPH, sociodemographic, contextual and clinical factors are relevant (Matias et al., 2020). Research shows that IPHs follow a socially biased pattern, with socially and economically marginalized groups being at highest risk (Aldridge & Browne, 2003; Dobash et al., 2009; Garcia et al., 2007; Vatnar et al., 2017a). Then, in addition to individual factors, IPH needs to be addressed at a societal level, as well. This is consistent with research on recorded crime and homicide in general. Thus, the news media’s well-documented tendency to present IPH as happening out of the blue is at odds with the evidence (Peelo, Francis, Soothill, Pearson, & Ackerley, 2004; Taylor, 2009).

The socially biased distribution of IPH presents several prevention challenges. First of all, people with complex and accumulated problems are among the most challenging groups...
to reach effectively with adequate and sufficient preventive interventions (Whitfield, Anda, Dube, & Felitti, 2003). Furthermore, risk factors such as mutual partner violence, criminal involvement, substance abuse, and mental health problems are often misinterpreted. Rather than being correctly regarded as indicators of heightened vulnerability, they may be used to underestimate the severity of a violent episode (Vatnar et al., 2017a).

If victims and bereaved have somewhat similar thresholds for help-seeking from official sources (police, health services, etc.), it is relevant to emphasize that studies investigating help-seeking have shown that the most important independent predictor is the victim’s fear of being killed. Research indicates that the actual threshold for help-seeking in IPH populations is high (e.g., Vatnar et al., 2017a). Still, even if helping agencies believe that they have a low threshold for individuals to access help, this appears not yet realized. It is very important for help-providing agencies to be aware of this discrepancy in order to avoid misinterpreting reports of risk and running the risk of fatal outcomes. When concerns about intimate partner violence are actually conveyed to official help-seeking resources, urgent action is often required.

Most IPH cases end in court. If different IPH perpetrator subgroups are systematically ascribed different motives, and the motives influence the length of sentences, then such perceptions might be interpreted as indicating racial or gender bias in the justice system (Vatnar et al., 2017b, 2018).

Conclusions

The majority of IPHs do not occur without warning signs. In the majority of IPHs, risk and vulnerability factors, such as previous IPV, sociodemographic, contextual, and clinical factors, have been observed by professionals as well as by friends and family. As IPH is very rare compared to other IPV, it is important to emphasize the difference between conducting valid risk assessment of IPV to prevent repeat episodes and the complexity in accurate prediction of IPH. Further research on IPH and clinical work within this field should focus on two strongly associated issues: risk identification and prevention of IPH. First, this means to prioritize research and clinical work on assessments of situations, contexts, persons, and the interactions/interplay that may increase risk of IPH; and second, to implement multi-agency, structured professional risk assessment and coordinated community interventions to mitigate this risk.

Critical findings

- Empirical research indicates that the majority of IPHs have identifiable warning signs.
- Previous intimate partner violence is the best-documented risk factor for IPH.
- The IPH distribution is biased toward low socioeconomic status, with marginalized groups characterized by accumulated welfare deficiencies being at highest risk.
- In the majority of IPHs, risk and vulnerability factors have been observed by professionals as well as by friends and family. However, there is a void of communication to health care, police, or support services and between the services. Research indicates that the actual threshold for help-seeking in IPH populations is high.
- A significant number of IPHs are IPH-suicide. Studies claim that homicide-suicide cannot be categorized either as homicide or as suicide, but is actually a distinct behaviour. Nevertheless, it would be naive to assume that homicide-suicide is unique and shares no characteristics with other forms of fatal violence.
- The empirical evidence to conclude that females who commit IPHs are qualitatively and clinically different from their male counterparts is weak due to mixed results.
Intimate partner homicide

Implications for policy, practice, and research

Policy

- The actual threshold for help-seeking in IPH populations appears to be high. Increased efforts are thus needed in order to realize the officially stated intent of providing low threshold services to this vulnerable group.

Practice

- If certain groups are found to have greater involvement in IPH, then increased attention to those groups is warranted. The alternative would be to neglect possible risk factors and leave a vulnerable group of intimate partner violence (IPV) victims at increased risk.

Research

- Further research on IPH and clinical work within this field should focus on two strongly associated issues: risk identification and prevention of IPH. This means prioritizing research and clinical work on assessments of situations, contexts, persons, and the interactions/interplay that may increase risk of IPH, and implementing interventions to mitigate this risk. Uniform operational definitions of supporting/opposing mandatory reporting and validated instruments are prerequisites for reliable and valid findings.

References


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