

Intimate Partner Homicide in Norway 1990–2012: Identifying Risk Factors Through Structured Risk Assessment, Court Documents, and Interviews With Bereaved

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Objective: To explore possible risk factors for intimate partner homicide by combining structured risk assessment based on information available in court documents and individual risk assessment provided through interviews with the bereaved. **Method:** The aim of this study was to scrutinize intimate partner homicide (IPH) situations and interactions within a retrospective, mixed methods design. All IPHs in Norway that had received a final legal judgment from 1990 to 2012 ($N = 177$) were included. Quantitative data was extracted through structured investigation of the court documents. Risk factors were identified from three validated risk assessment instruments. Qualitative data were retrieved from interviews with a sample of bereaved ($n = 12$). **Results:** The IPH distribution was biased toward low socioeconomic status. Previous intimate partner violence (IPV) was identified in 7 out of 10 IPH incidents. Observed risk by the bereaved was infrequently communicated to health care, police, or support services. Individuals who did communicate risk found that professionals underestimated the reported risk and did not act on their warnings. **Conclusions:** The majority of IPHs did not occur without warning signs. To prevent IPH, structured risk assessments and knowledge of family and friends' perceptions of risk is essential.

Keywords: intimate partner homicide, risk assessment, intimate partner violence, domestic violence

From 1990 to 2015, 891 homicides were committed in Norway. Of these, 217 (24%) were classified as intimate partner homicides (IPHs; Kripos, 2016). Even though women are far more likely to be killed by an intimate partner than by anyone else, IPH is an infrequent occurrence, even in at-risk populations (Campbell & Glass, 2009; Campbell, Glass, Sharps, Laughon, & Bloom, 2007b; Eke, Hilton, Harris, Rice, & Houghton, 2011). Identifying valid risk factors for IPH is fundamental (Norman & Bradshaw, 2013). Recent studies support a combination of both structured professional risk assessment and individual victim risk assessment as the best means of providing complementary information (Connor-

Smith, Henning, Moore, & Holdford, 2011; Heckert & Gondolf, 2004; Regan, Kelly, Morris, & Dibb, 2007). Accordingly, this study aimed to explore possible risk factors for intimate partner homicide by combining structured risk assessment on the basis of information available in court documents, and individual risk assessment, provided through interviews with the bereaved.

Theoretical Framework: Interactional Perspectives on Intimate Partner Violence (IPV)

New theoretical frameworks have been suggested for improving on former IPV theories (e.g., Bell & Naugle, 2008; Dixon, Hamilton-Giachritsis, & Browne, 2008; Emery, 2011; Winstok, 2007). One of the arguments is that IPV theories should be more comprehensive, taking into consideration the perspectives of both victims and perpetrators and integrating views from multiple academic disciplines. An interactional perspective on IPV may increase theoretical understanding of the mechanisms involved in these phenomena (Arriaga & Capezza, 2005; Briere & Jordan, 2004; Cano & Vivian, 2001; Garcia, Soria, & Hurwitz, 2007; Heckert & Gondolf, 2004; Langhinrichsen-Rohling, 2005). The traditional person-situation dichotomy is replaced by an emphasis on the mutual impact of the two variables (Funder, 2006). The main idea is that violence involves an influential and continuous interaction between individuals and the various situations they encounter. The *situation* is defined as an actual situation as it is

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perceived, interpreted, and assigned meaning in the mind of a participant (Magnusson, 1981). Correspondingly, theoretical IPV perspectives and research should address the context and proximal events associated with IPV (Bell & Naugle, 2008; Dixon & Graham-Kevan, 2011; Emery, 2011; Vatnar & Bjørkly, 2008; Winstok, 2007). These authors have encouraged investigation of “the violence process” by examining the nature of the violent relationship, events, and conditions preceding an IPV episode; motivations for violent acts; and the outcomes. According to an interactional perspective, it is crucial to investigate the IPH process by examining the wider set of events and incidents that preceded and ended with the homicide.

Risk Factors for IPH

Estimating violence risk can be categorized into three main groups: unstructured professional judgment, actuarial decision making, and structured professional judgment (e.g., Kropp & Hart, 2015). Unstructured clinical judgment has been described as “informal, subjective, [and] impressionistic” and is rated as the least robust (Grove & Meehl, 1996, p. 293). The actuarial approach is characterized by decision making based on fixed and explicit rules and has been described as “mechanical” and “algorithmic” (Grove & Meehl, 1996, p. 293). Structured professional judgment (SPJ) involves decision making assisted by guidelines developed to reflect the “state of the discipline” regarding scientific knowledge and professional practice.

Risk assessment is a cornerstone of effective case management in contemporary policing, corrections, and forensic mental health (Andrews & Bonta, 2006; Guy, Douglas, & Hart, 2015). *IPV risk assessment* may be defined as the process of gathering information about people to make decisions regarding their risk of perpetrating intimate partner violence (Kropp & Hart, 2015, p. 2). The concept of risk is inherently contextual, varying according to the risks posed as well as the conditions under which a person is likely to live. IPV risk assessment does not necessitate nor imply a deterministic view of human behavior. A preliminary review of the literature indicated that some sociodemographic, contextual, clinical, and previous IPV factors may predict increased risk of IPH (Vatnar & Bjørkly, 2011).

Previous IPV. Research from the United States, Canada, and the United Kingdom reveals similarities but also differences concerning the role of previous intimate partner violence in cases of lethal versus nonlethal IPV (Dobash, Dobash, & Cavanagh, 2009). Factors include the nature of the relationship, the source of conflict, possessiveness and jealousy, separation and termination of the relationship, previous violence to the victim, as well as distinct factors associated with the nature of the violence (Dobash et al., 2009). Findings from North America and the United Kingdom indicate that 65% to 80% of IPH victims had been previously abused by the partner who killed them (Campbell & Glass, 2009; Campbell et al., 2007b; Nicolaidis et al., 2003). Repeated violence against the victim was present in 25% to 65% of intimate relationships that ended with the murder of a female partner (Aldridge & Browne, 2003; Campbell & Glass, 2009; Campbell et al., 2007b; Dobash et al., 2009). In one study, nearly half of the perpetrators of IPH had previously committed violence against the victim, even though the initial investigations suggested that they had no history of this offense (Dobash et al., 2009). Findings from the United

States, primarily limited to cases with a history of previous IPV, suggest that significant risk factors for IPH may include frequent occurrences of severe IPV, sexual assault, attempts to strangle, intoxication, threats to kill, a firearm in the home, and threats with or use of a firearm (Campbell, Glass, Sharps, Laughon, & Bloom, 2007a; Nicolaidis et al., 2003; Shields, Corey, Weakley-Jones, & Stewart, 2010). Research from the United Kingdom, including cases with and without a history of previous IPV, found that sexual assault, strangulation, and the use of sharp or blunt instruments were important risk factors, but intoxication and the use of firearms were not (Dobash & Dobash, 2011; Dobash et al., 2009). The robust nature of the findings of previous IPV (also apparent for repeated intimate IPV) suggests a significant escalation link between IPV and IPH and the importance of continuity regarding IPV and IPH (Dobash et al., 2009).

Sociodemographic, contextual, and clinical risk factors.

Research has identified sociodemographic characteristics that distinguish victims of IPH from victims of nonfatal IPV (Eliason, 2009; Garcia et al., 2007; Liem, 2010). The risk of killing an intimate partner is higher in cohabiting than in marital relationships and during separation or break up of the intimate relationship (Aldridge & Browne, 2003; Campbell & Glass, 2009; Campbell et al., 2007a; Eke et al., 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 with nonfatal violence against a partner, 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 who 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, & Singer, 2009). In the United States, ethnicity is considered an important risk factor. However, 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). The context of pregnancy and childbirth has also been associated with IPH (Campbell et al., 2007a; Garcia et al., 2007; Martin, Macy, Sullivan, & Magee, 2007; Shadigian & Bauer, 2005). 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. A population-based study showed that survivors of IPV engaged in a wide range of help-seeking behaviors in response to IPV (Barrett & St Pierre, 2011). 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 and suggest that women who had experienced severe forms of IPV were most likely to seek help through both formal and informal avenues (Barrett & St Pierre, 2011; Nurius, Macy, Nwabuzor, & Holt, 2011; Vatnar & Bjørkly, 2014). Women exposed to a higher number of violent incidents and women with physical injuries directly caused by the violence

were significantly more likely to seek all forms of help compared with women with fewer violent incidents. Although there are significant sociodemographic variations in women's IPV help seeking, recent 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). There is some research on IPV perpetrators' help seeking (e.g., Askeland, Evang, & Heir, 2011; Hester, Ferrari, Jones, et al., 2015). Nonetheless, there appears to be a paucity of research on IPH perpetrators' help seeking (Dobash & Dobash, 2015; Eliason, 2009; Martin et al., 2007).

The aim of this study was to scrutinize the results of combining a structured risk assessment and an individual risk assessment as a means of informing a new approach to identifying individual and interactional risk factors of IPH in Norway.

First, on the basis of information from IPH court documents from 1990 through 2012, the research questions were as follows:

1. To what extent is it possible to identify risk factors drawn from three risk assessment instruments (DA-R20, SARA, SIVIPAS) in Norwegian IPH cases?
2. Were there significant differences between IPH incidents with or without prior IPV incidents pertaining to (a) sociodemographic, contextual, and clinical factors; (b) IPH characteristics; and (c) help seeking prior to the IPH incident?
3. Were there significant differences between IPH incidents with repeated IPV incidents and those without concerning (a) sociodemographic, contextual, and clinical factors; (b) IPH characteristics; and (c) help seeking prior to the IPH incident?

Second, if the bereaved had observed what they in hindsight perceived as risk factors for IPH, the questions were as follows:

4. What type of risk factors had been observed and how?
5. What kind of action had been taken by the bereaved in response to the risk factors?

Method

This was a mixed-methods study combining quantitative and qualitative data in a convergent parallel design (Creswell & Plano Clark, 2011). The purpose of the convergent design is to obtain different but complementary data on the same topic (Morse, 1991, as cited in Creswell & Plano Clark, 2011). The intent is to bring together the differing strengths of quantitative methods (i.e., large sample size, trends, generalization) with those of qualitative methods (for in-depth details, see Patton, 1990, as cited in Creswell & Plano Clark, 2011). This study was designed to investigate risk factors for IPH by combining structured risk assessment based on court documents and risk assessment and information provided by the bereaved. To our knowledge, only three studies have taken a qualitative approach to understanding this kind of risk assessment (Connor-Smith et al., 2011; Heckert & Gondolf, 2004; Regan et al., 2007).

This study was approved by the Norwegian National Research Ethics Committee. The Norwegian Higher Prosecuting Authority

provided legal access to the court documents. Interviews were based on written informed consent.

Participants

The qualitative data stems from interviews with a stratified sample of bereaved participants ($n = 12$; 9 female and 3 male). The stratification was done according to the following variables: gender of perpetrator, victim and participant, marital status of perpetrator and victim, ethnic origin of perpetrator and victim, source of income of perpetrator and victim, substance addiction of perpetrator and/or victim, mental health problems in perpetrator and/or victim, help-seeking factors (e.g., contacting the police, health, and social services), and previous IPV between perpetrator and victim. The cases were selected so that all subcategories for these variables were represented in the sample. The bereaved were relatives or friends of the couple or previous couple. They were selected among those who were identified as core informants/witnesses in the court documents. Core informants were selected on the basis of the criterion that they, through the court documents, were one of the bereaved that could provide the best range and depth of information pertaining to the IPH and risk factors. Only one person from each selected case was interviewed.

Materials

IPH has been specified as an independent category of murder (violation of §233) in the official Kripas statistics since 1990. All IPHs in Norway from 1990 to 2012 that had received a final judgment ($N = 177$) were included in the study, including cases involving homicide-suicide (25%) and cases with insane perpetrators, who were unfit to plead (12%). The quantitative material was extracted from the court documents pertaining to these 177 cases. Court documents contain all documents and information collected and used during the court trial.

Procedures

Any risk for IPH that the bereaved had observed was assessed by asking whether they could now, in retrospect, identify any risk or signals for IPH in the case that had caused their bereavement. Open-ended questions were asked about these perceptions of possible risk factors and warning signals and how they now perceived their own risk assessment. The interviews were conducted by a specialist in clinical psychology (first author). All interviews were audiotaped and later transcribed and saved for analysis in word processing files.

Quantitative data were collected by traveling to each police district in charge of the case, manually going through the set of documents for each case, and coding the information into quantitative data based on a predefined codebook. The reliability of this procedure was supported by an interrater reliability test—intraclass correlation, average measures = 0.835, CI (0.714 – 0.923)—based on two independent raters' coding of data from 20 randomly selected cases. One coder coded all 177 cases. This coder was one of the two coders in the interrater reliability test.

Measures

Most IPV risk assessment instruments aim at measuring risk of IPV, not IPH. The predictive validity of risk assessment for IPH is

lower than that for IPV instruments due to the low base rates of IPH. In a preliminary review of IPH, we found three validated risk assessment instruments with items on IPH (Vatnar & Bjørkly, 2011): Danger Assessment Revised 20-item (R20DA; Campbell et al., 2009), Spousal Assault Risk Assessment (SARA; Kropp & Hart, 2000), and Severe Intimate Violence Partner Risk Prediction Scale (SIVIPAS; Echeburúa, Fernández-Montalvo, de Corral, & López-Goñi, 2009). R20DA and SIVIPAS are drawn from the actuarial tradition and SARA, which are from the structured professional judgment (SPJ) tradition. This study is conducted in the SPJ tradition. Hence, no total scores on measures were computed. Some of the risk factors identified by our preliminary review of the literature are included in all three instruments, whereas other factors were only included in one of the scales. Together they cover a substantial number of possible risk factors of IPH (Vatnar & Bjørkly, 2011). The SPJ guidelines have been developed to reflect the state of the discipline, with respect to scientific knowledge and professional practice. SPJ is an approach that attempts to bridge the gap between the unstructured clinical judgment and actuarial decision making approaches. It appears to be a viable approach to assessing risk for intimate partner violence, and to be suited to the requirements of criminal justice professionals (Kropp & Hart, 2015).

Analysis

Initial comparison of IPHs with and without previous IPV and repeated IPV were conducted by simple cross-tabulations. Univariate and multivariate logistic regression analyses were used to measure the association between risk factors and the dependent variables: (a) IPH incidents with previous IPV versus IPH without IPV and (b) IPH with repeated previous IPV and without repeated previous IPV (Altman, 1991). In the first multivariate analyses, Step 2 variables with significant univariate differences when comparing (a) IPHs with and without previous IPV and (b) with and without repeated previous IPV were adjusted for other significant group differences within the target categories: (a) sociodemographic (including gender), contextual, and clinical factors; (b) IPH characteristics and sentencing issues; and (c) help-seeking prior to the IPH incident. Significant differences from Step 2 were forwarded to Step 3 where they were adjusted for differences in Categories A, B, and C. Suitability for multivariate logistic regression analysis was investigated by the Hosmer-Lemeshow test. Cox & Snell R^2 and Nagelkerke R^2 were used to estimate the proportion of explained variance in the multivariate models. Values were estimated as model fit indices for the regression models. Statistical analyses were performed using SPSS (Version 21.0).

Transcribed text from the interviews (228 pages) was analyzed by systematic text condensation (STC) (Malterud, 2001, 2012). The procedure consisted of the following steps: (a) total impression—from chaos to themes; (b) identifying and sorting meaning units—from themes to codes; (c) condensation—from code to meaning; and (d) synthesizing—from condensation to descriptions and concepts (Malterud, 2012). Qualitative analyses were performed using NVIVO (Version 10). In the interpretation stage of the study, the results of the qualitative and quantitative parts were combined to integrate data in a mixed method design.

Results

In the majority of IPH cases (70.6%), one or more previous incidents of IPV had been identified. In five out of 10 IPHs, more than five previous incidents of intimate partner violence had been identified (see Figure 1). In 86.9% of IPH cases with previous IPV, there was information about physical IPV; in 79.4%, there was information about psychological IPV; and in 19.5%, there was information about sexual IPV. These categories were not mutually exclusive. There was information describing a combination of episodic IPV and IPV characterized by continuity and long duration (e.g., controlling, stalking). Marginalized population groups characterized by accumulated welfare deficiencies were most at risk, both as perpetrators and as victims of IPH (see Tables 1 and 2).

In most cases, police, health care, and support services, as well as friends or relatives, had observed risk factors drawn from the three validated risk assessment instruments (see Table 3). Six out of 10 perpetrators, and seven out of 10 victims had sought help from friends and family prior to the homicides. The qualitative interviews showed that the bereaved had observed what they in hindsight perceived as risk factors for IPH and that these disclosures had raised concern and several attempts to help among those who had been contacted.

When she came back from the emergency room into the car, I talked with her friend on the phone and then I suggested that we'll just run over to the police and get him reported now. So we discussed it for quite some time, but she refused.

Exploring the other side of the lethal dyad showed that one out of three perpetrators had disclosed IPH intentions in private conversations prior to the homicide. However, friends' and family members' concerns were rarely conveyed to the health care, police, or support services.

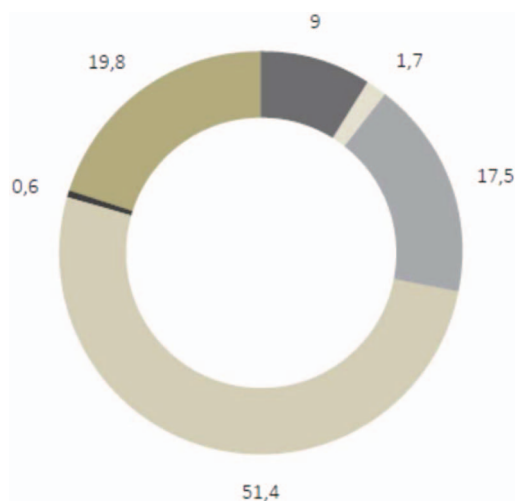


Figure 1. Prevalence of previous intimate partner violence (IPV) 51.4%-Repeated previous IPV (more than 5 episodes), 17.5%-Previous IPV (2–5 episodes), 1.7%-Previous IPV (1 episode), 9.0%-Explicitly stated no previous IPV, 19.8%-Information about previous IPV lacking in court documents, 0.6%-Other. See the online article for the color version of this figure.

Table 1
Frequency Distribution of Sociodemographic Factors (N = 177)

Variable	n	%
Gender perpetrator		
Male	157	88.7
Female	20	11.3
Marital status		
Married	75	42.4
Cohabiting	58	32.8
Separated	15	8.5
Divorced	7	4.0
Former cohabitants	22	12.4
Ethnic origin perpetrator		
Norwegian	118	66.7
Immigrant (Norwegian citizenship)	17	9.6
Non-Norwegian citizen	42	23.7
Ethnic origin victim		
Norwegian	129	72.9
Immigrant (Norwegian citizenship)	10	5.6
Non-Norwegian citizen	38	21.5
Source of income perpetrator		
Employed	77	43.5
Unemployed	24	13.6
Student	5	2.8
Homemaker	1	.6
Social security	56	31.6
Retirement pensioner	7	4.0
Other	6	3.4
Unknown	1	.6
Source of income victim		
Employed	80	45.2
Unemployed	19	10.7
Student	6	3.4
Homemaker	12	6.8
Social security	51	28.8
Retirement pensioner	7	4.0
Other	1	.6
Unknown	1	.6

Note. Gender of victim is the opposite of gender of perpetrator. There were no same gender couples in this material.

... when we talked to his wife later ... [we] said that NN needs help and has to talk to someone. He must go and get help. There is something wrong. But we do not know if anything was done. I do not think it was done anything then. I do not think he went and talked to someone.

Individuals who had contacted any of these professional services were left with the impression that none of these agencies had appreciated the gravity of the situation (see Figure 2).

But you must admit that the clumsy way it was handled was very difficult ... and we are a little unsure if the family doctor understood the seriousness and severity here, despite the fact that he got a concern in from our youngest sister (adult). And she was honestly fighting. ... Or we talked a lot after and before her contact with the family doctor about what to say and she was absolutely honest and described all those things and observations we had.

That damned confidentiality. Well, take for example, when the police came to the (name of the village). I do not know if there was any communication between the agencies on such things. And they must, God in heaven, communicate, people need to talk. The confidentiality is more to protect social agents. In this case, it was completely wrong.

IPHs with previous IPV had risk factors that differed from IPH without prior IPV, pertaining to sociodemographic, contextual, and clinical factors, IPH characteristics, and help-seeking prior to the IPH incident. In cases with prior IPV, the likelihood that health care, police, or support services had coded risk of future violence and homicides from contact with victims was 10 times higher, even if this type of risk coding was found in only 40% of all IPHs. Perpetrators in cases with prior IPV had lower levels of education and were more likely to have had a criminal record (see Table 4). Only 10% of all perpetrators had had a previous conviction for intimate partner violence. There were no significant differences between male and female IPH perpetrators pertaining to previous IPV.

IPHs with repeated previous IPV had risk factors that differed from IPH without repeated prior IPV pertaining to sociodemo-

Table 2
Frequency Distributions of Clinical Factors (N = 177)

Variable	N	%
Substance addiction perpetrator	No	82 46.3
	Alcohol	35 19.8
	Illegal drugs	11 6.2
	Abuse of prescription drugs	5 2.8
	Alcohol and abuse of prescription drugs	10 5.6
	Alcohol and illegal drugs	22 12.4
	Other	1 .6
Substance addiction victim	Unknown	10 5.6
	Missing	1 .6
	No	106 59.9
	Alcohol	24 13.6
	Illegal drugs	6 3.4
	Abuse of prescription drugs	— —
	Alcohol and abuse of prescription drugs	15 8.5
Mental health problems perpetrator	Alcohol and illegal drugs	12 6.8
	Other	13 7.3
	Unknown	— —
	Missing	1 .6
	No	42 23.7
	Symptoms registered, no diagnosis	60 33.9
	Diagnosed	65 36.7
Diagnosis perpetrator	Unknown	9 5.1
	Missing	1 .6
	Depression	20 11.3
	Addiction	20 11.3
	Psychosis	13 7.3
	Personality disorder	8 4.5
	Other	5 2.8
Mental health problems victim	None	111 62.7
	No	81 45.8
	Symptoms registered, no diagnosis	33 18.6
	Diagnosed	45 25.4
	Unknown	17 9.6
	Missing	1 .6
	Diagnosis victim	Depression
Addiction		19 10.7
Psychosis		5 2.8
Personality disorder		2 1.1
Other		6 3.4
No diagnosis		131 74.0

Note. Only diagnoses made by health professionals qualified to make mental health diagnosis (clinical psychologists and medical doctors) were included in the variables diagnosis perpetrator and diagnosis victim.

Table 3
Frequency Distribution of Help-Seeking Factors (N = 177)

Variable	Response	N	%
Perpetrator in contact with police, health, and social services	No	22	12.6
	Yes	137	78.7
	Unknown	15	8.6
Assessed risk (in contact with perpetrator)	No	76	42.9
	Yes	58	32.2
	Unknown	35	19.8
	Missing	8	5.1
Victim in contact with police, health, social services	No	13	7.4
	Yes	126	72.0
	Unknown	38	20.6
Assessed risk (in contact with victim)	No	50	28.2
	Yes	70	39.5
	Unknown	52	29.4
	Missing	5	2.8
Help-seeking family, friends, perpetrator	No	48	27.1
	Yes	104	58.8
	Unknown	22	12.4
	Missing	3	1.7
Concern forwarded to police, health, social services, perpetrator	No	123	69.5
	Yes	18	10.2
	Unknown	10	5.6
	Missing	26	14.7
Help-seeking family, friends, victim	No	27	15.3
	Yes	122	68.9
	Unknown	24	13.6
	Missing	4	2.3
Concern forwarded to police, health, social services, victim	No	122	68.9
	Yes	33	18.6
	Unknown	10	5.6
	Missing	12	6.8

graphic, contextual, and clinical factors; IPH characteristics; and help-seeking prior to the IPH incident. In cases with repeated previous IPV, perpetrators more often had antisocial traits and criminal affiliations than perpetrators in cases without repeated previous IPV. Although recorded in only 32% of all IPH, coding by the health care, police, and support services from contact with perpetrators of risk of future violence or homicide was seven times more likely in cases with repeated previous IPV. Victims of repeated IPV had been in contact with health care, police, and support services more often than those with less than five incidents. In cases of repeated previous IPV, police, health care, and support services were aware of the violence and the associated elevated risk (see Table 5). There were not significant differences between male and female IPH perpetrators pertaining to repeated previous IPV.

IPH cases without previously identified intimate partner violence emerged as the smallest category of intimate partner homicides, constituting only 9% of all cases (see Figure 1). IPH without previous partner violence differed from other IPH incidents in the following aspects: The perpetrators were more highly educated, they were less likely to have a criminal record, it was more likely known if the victim had expressed a desire to separate or break up, and it was less likely that the victim's contact had prompted the welfare services to record risk of IPV or IPH (see Table 4). About 20% of the homicides lacked information about previous IPV in the court documents.

Discussion

The main findings were as follows: (a) The majority of IPHs in Norway (88.6%) were committed by men in relationships where there had been previous IPV (70.6%); (b) marginalized population groups were most at risk for IPH, both as victims and as perpetrators; and (c) according to the experiences of the bereaved, the concerns about risk that they had conveyed to the police, health care, and support services had not been taken seriously enough. Accordingly, it was possible to identify risk factors drawn from three validated risk assessment instruments (i.e., R20DA, SARA, SIVPAS) in Norwegian IPH cases based on information provided by examination of court documents and interviews with the bereaved. There were significant differences between IPH incidents with or without previous IPV, and with and without repeated previous IPV for sociodemographic, contextual, and clinical factors; IPH characteristics; and help-seeking prior to the IPH incident.

In 71% of IPHs in Norway, one or more previous incidents of intimate partner violence were identified. This is significantly higher than the prevalence of IPV in the general population in Norway, which is estimated at 14% to 25% (Haaland, Clausen, &

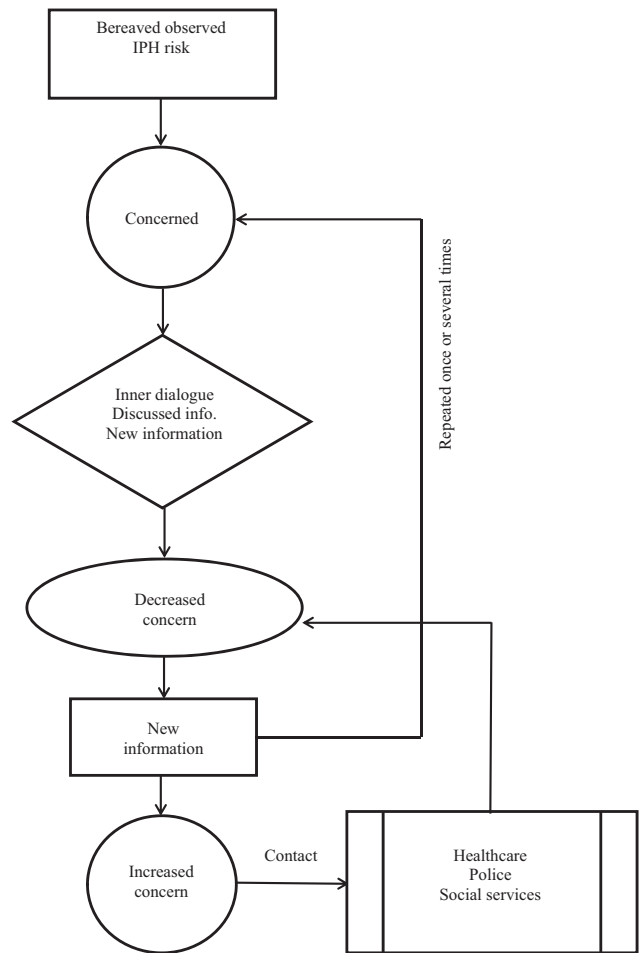


Figure 2. Process of bereaved's risk observation, concern, and help seeking.

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Table 4
The Association between Intimate Partner Homicide With and Without (Baseline) Previous Intimate Partner Violence, Multivariate Logistic Regression (N = 116)

Independent variable	Adjusted odds ratio	95% CI	p
Model 1			
Perpetrator education	.811	.666–.987	.036
Victim intended break-up			.014
No (baseline)			
Partly	1.097	.240–5.022	.905
Yes	2.765	.724–10.556	.137
Unknown	.114	.018–.717	.021
Perpetrator previously convicted	1.944	1.106–3.418	.021
Assessed risk victim in contact with police, health care, social services			.006
No (baseline)			
Yes	10.318	2.047–52.012	.005
Unknown	.769	.225–2.625	.675
Mental health problems victim	3.936		.268
Assessed risk perpetrator	.054		.974
Perpetrator help-seeking family, friends, etc.	2.511		.285
Victim help-seeking family, friends, etc.	.192		.909
Model 2			
Victim intended break-up			.008
No (baseline)			
Partly	.712	.137–3.699	.687
Yes	1.564	.374–6.533	.540
Unknown	.038	.004–.350	.004
Perpetrator previously convicted	2.270	1.201–4.293	.012
Assessed risk victim in contact police, health care, social services			.094
No (baseline)			
Yes	5.940	1.191–29.629	.030
Unknown	1.612	.415–6.273	.491
Sentences			.598
Strl. § 233, first subsection (baseline)			
Strl. § 233, second subsection	2.514	.300–21.087	.396
Strl. § 228–234	520169780.0	.000	.999
Strl. § 239, first subsection	.000	.000	1.000
Insane (unfit to plead)	1.138	.248–5.220	.868
Not proceeded perpetrator dead	.293	.068–1.253	.098
Other	.000	.000	1.000
Perpetrator education	1.099		.294
Motive	5.902		.316

Note. Multivariate binary logistic regression, forward stepwise (Wald). Model 1, Cox & Snell $R^2 = .303$; Model 2, Cox & Snell $R^2 = .355$; Strl. = Straffeloven. Bold values indicates Significant results.

Schei, 2005; Thoresen & Hjemdal, 2014). In 51% of all IPHs, more than five incidents of previous intimate partner violence were identified. These results correspond to international studies where 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 & Glass, 2009; Campbell et al., 2007a; Nicolaidis et al., 2003). This means that in the majority of IPHs in Norway, at-risk individuals could be identified and interventions employed, with considerable preventive potential. As intimate partner homicide is very rare compared to other intimate partner violence, it is important to emphasize the differences between structured risk assessment and the more limited approach of risk prediction. The only scope of risk prediction is to identify a context-free risk of future violence for the actual person. In contrast to this, structured professional risk assessment has two main aims: (1) to identify violence risk as an interactional or

situational phenomenon and (2) to develop measures that can mitigate this risk. Instigating preventive efforts is an integrated part of this approach.

IPHs in Norway follow a socially biased pattern, with groups characterized by welfare deficiencies being at highest risk. This is consistent with research on recorded crime in general, as well as other IPH research (Aldridge & Browne, 2003; Dobash et al., 2009; Garcia et al., 2007). Thus, the news media's well documented tendency to present intimate partner homicide as happening out of the blue is at odds with current 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,

Table 5
The Association between Intimate Partner Homicide With and Without (Baseline) Repeated Previous Intimate Partner Violence

Independent variable	Adjusted odds ratio	95% CI	<i>p</i>
Model 1			
Perpetrator general antisocial conduct			.045
No (baseline)			
Partly	4.025	.950–17.065	.059
Yes	3.465	1.091–11.003	.035
Unknown	.541	.081–3.621	.526
Perpetrator previously convicted	2.203	1.377–3.527	.001
Assessed risk perpetrator in contact with police, healthcare, social services			.010
No (baseline)			
Yes	6.959	2.178–22.234	.001
Unknown	3.252	.841–12.572	.087
Victim in contact with police, healthcare, social services			.002
No (baseline)			
Yes	.870	.122–6.200	.890
Unknown	.059	.006–558	.014
Perpetrator ethnic origin	2.687		.261
Marital status	2.764		.598
Perpetrator access to weapons (guns)	9.321		.097
Mental health victim	4.509		.211
Forwarded assessed risk	1.675		.433
Victim expressed mortal danger	3.334		.343
Perpetrator expressed intention to kill	2.887		.409
Model 2			
Perpetrator general antisocial conduct			.007
No (baseline)			
Partly	4.498	1.202–16.834	.026
Yes	5.084	1.743–14.829	.003
Unknown	.798	.157–3.963	.773
Perpetrator previously convicted	2.139	1.378–3.319	.001
Assessed risk perpetrator in contact police, health care, social services			.002
No (baseline)			
Yes	7.294	2.568–20.716	.000
Unknown	3.414	.959–12.148	.058
Victim in contact police, healthcare, social services			.002
No (baseline)			
Yes	.751	.134–4.222	.745
Unknown	.064	.009–.479	.007
Sentences			.228
Strl. § 233, first subsection (base line)			
Strl. § 233, second subsection	3.759	1.068–13.227	.039
Strl. § 228–234	25.769	1.264–525.340	.035
Strl. § 239, first subsection	.000	.000	1.000
Insane (unfit to plead)	1.561	.382–6.380	.535
Not proceeded perpetrator dead	1.952	.517–7.363	.324
Other	.000	.000	1.000
Perpetrator intoxicated time of crime	9.909		.078

Note. Multivariate binary logistic regression, forward stepwise (Wald). Model 1 ($N = 133$), Cox & Snell $R^2 = .435$. Model 2 ($N = 167$), Cox & Snell $R^2 = .435$; Strl. = Straffeloven. Bold values indicates Significant results.

risk factors such as mutual partner violence, criminal involvement, substance abuse, and mental health problems are often misinterpreted. Rather than these being regarded (correctly) as indicators of heightened vulnerability, they may be used to underestimate the severity of a violent episode. Our results indicate that the highest risk of IPH may be found among the most complex and demanding intimate partner violence cases.

Our results indicate that 6 out of 10 perpetrators and 7 out of 10 victims had sought help from friends/family. This is consis-

tent with studies finding that women who end up being killed by their partner have sought help from informal sources (e.g., Regan et al., 2007). In this study, we found that help seeking from both victims and perpetrators had raised concerns and led to several attempts from the bereaved to get help. Concerns were rarely conveyed to professional agencies, but when they actually were, the general experience of the bereaved had been that the agencies failed to realize the seriousness and urgency of the reported situations. 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. Both the quantitative and the qualitative results of this study indicate that the actual threshold for help seeking in IPH populations is high. The officially stated intent of a low threshold appears to not yet have been realized. It is very important for help-providing agencies to be aware of this discrepancy to avoid misinterpreting reports of risk, misinterpretations that could have fatal outcomes. Both the quantitative and qualitative results of this study indicate that the actual threshold for help seeking in IPH cases is very high. When concerns about intimate partner violence are actually conveyed to official help-seeking resources, urgent action is required.

Limitations

Criminal documents relating to each of the 177 IPHs were the only source for obtaining quantitative data for this study. The term *criminal case documents* refers to the total amount of documentation used for illuminating a criminal case. Hence, these documents were not made for research purposes and, of course, did not provide exhaustive data to illuminate our research questions. Accordingly, there may be a risk of false negatives, though the use of this source of data carries only a small amount of risk for false positives. It has to be noted that the study design was retrospective in nature and that participants' and views in records may be vulnerable to hindsight biases, and that practice by professionals may have changed since the time period of the study. In addition, some findings may represent underestimates because it was evident that the IPH victims were unable to report on their IPV and IPH experiences. About 20% of the homicides lacked information about previous intimate partner violence in the court documents. Though this may be a limitation in our study, it is not a major threat to the reliability and validity of our findings.

Moreover, our approach to integrating findings in a mixed methods design may have been biased. It is easy to find converging results and to ignore divergent findings because there are actually no decision criteria on how to integrate results in mixed methods research. Despite this, the concurrent consistency between findings from the qualitative and quantitative parts of the study indicates good internal validity. Finally, the investigation covered the total prevalence of IPH in Norway within the actual time period. This strengthens the external validity of the findings, at least for IPH in Norway.

Clinical and Policy Implications

In the majority of IPHs in Norway, risk factors had 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 differences between structured risk assessment and the more limited approach of risk prediction in terms of risk management.

Research Implications

Further research on IPH may want to focus on two strongly associated issues: risk identification and prevention of IPH. This means prioritizing research on structured professional assessments of situations and persons that may increase risk of IPH and implementing interventions to mitigate this risk.

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