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BARRIERS TO MALE BATTERER'S HELP-SEEKING BEHAVIOURS: A RETROSPECTIVE CASE ANALYSIS OF DOMESTIC HOMICIDES

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BARRIERS TO MALE BATTERER'S HELP-SEEKING BEHAVIOURS: A RETROSPECTIVE CASE ANALYSIS OF DOMESTIC HOMICIDES

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Abstract

The present study was conducted in order to investigate male batterer's help-seeking behaviours. It was predicted that batterers would be more likely to seek help for more socially acceptable issues (i.e. depression or alcohol abuse) versus issues related to domestic violence. Even when batterers presented socially acceptable issues to those in the helping profession, it was predicted that helpers were not addressing or identifying the underlying issue of violent behaviours. An extensive review of 45 domestic homicide case summaries, provided by the Domestic Violence Death Review Committee of Ontario, were coded and analysed. The results indicated that batterers were more likely to seek specialized professional help for more socially acceptable issues versus issues related to domestic violence. Furthermore, when batterers sought general help from professionals, their violent behaviours were rarely identified and thus very few interventions took place for the underlying issue of abusive behaviours. Implications and suggestions for future research are discussed.

Keywords: help-seeking, male batterer, domestic violence, domestic violence treatment

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Barriers to Male Batterer's Help-Seeking Behaviours: A Retrospective Case Analysis of Domestic Homicides

Domestic violence (DV) against women is a serious social and public health issue. It is reported to be one of the most underestimated and underreported crimes which occurs across all racial, ethnic, and socioeconomic classes (Huang & Gunn, 2001). Given that DV is commonly a private matter, it is difficult to attain accurate estimates of the prevalence of such events. For example, Statistics Canada's 2004 General Social Survey suggested that as few as 36% of female victims and 17% of male victims reported spousal violence to police (Statistics Canada, 2006). Conversely, research continues to provide increasing evidence of the prevalence of DV. As reported in the World Report on Violence and Health (2002), a review of 48 studies conducted around the world indicated on average that 10-69% of women reported at least one incident of physical assault perpetrated by their intimate partner. National studies have also indicated that 40-70% of female murder victims were a result of domestic homicides (World Report on Violence and Health, 2002). Furthermore, in 1999, a survey of approximately 26,000 Canadians suggested 7% of those who are married or living in a common-law relationship had experienced some form of intimate partner violence during the past five years (Canadian Centre for Justice Statistics, 2000). Clearly, DV is an ongoing private issue which needs to be addressed publicly and professionally in order to help reduce the perpetration of intimate partner violence.

To date, there is no consensus on a definition for the term "DV". For the purpose of the present study, DV will be defined as "any physical, emotional, psychological, and

sexual abuse occurring between domestic partners" (Roth, 1997, p.503). A domestic partnership refers to a married, common law, dating, or intimate couple. It is also important to note that the terms "batterer" and "perpetrator of DV" will be used interchangeably in the present paper. A batterer refers to an individual who displays a pattern of abusive behaviours over time, involving multiple incidents of DV, whereas a perpetrator of DV refers to an individual who has perpetrated multiple incidents, or a single act, of abusive behaviours (Jaffe, Crooks, & Bala, 2005).

Although violence between partners is certainly not a new phenomenon, over the past 35 years there has been an increase in public awareness related to issues of DV. As a result of the women's movement in the 1970's, DV became an important social issue. Since then, there is a large body of research targeted at developing effective support and interventions for victims of DV. However, little effort has gone into better understanding how to appropriately address and help the perpetrators of abuse in order to deter further assaults. To help reduce the number of incidents of DV, it is critical that researchers and professionals begin to focus on investigating and identifying appropriate and effective ways of providing support and interventions to the perpetrators of abuse.

Current Efforts

In general, perpetrators of DV are forced into seeking help for their abusive behaviours. An involuntary client is considered an individual, "who is forced to seek, or feels pressure to accept contact with a helping professional" (Rooney, 1992, p.6). These are individuals who are generally reluctant to the idea of receiving help, and typically exhibit resistive behaviours to the services they are required to receive. However, it is important to recognize that an involuntary client can take one of two forms. A

"mandated client" is one who is forced to work with a professional as a result of a legal requirement or court order (Levin, 2006). Frequently, such clients foster a belief that "the system" is working against them and has made a mistake. The second category of "involuntary" client is individuals who are pressured from friends, family, agencies, and other sources to seek help (Trotter, 2006). These individuals are coerced into seeking help through ultimatums or threats made by others.

For the majority of cases, DV offenders complete a batterer's rehabilitative program as a result of a mandate by the court or legal system. Such programs generally foster a feminist psychoeducational, cognitive-behavioural, or anger management perspective (Babcock, Green, & Robie, 2004). Despite all efforts made, batterer's program effectiveness suffers as a result of high attrition rates (Bowen & Gilchrist, 2006; Daly, Power, & Gondolf, 2001; Gerlock, 2001). For example, North American studies have indicated that as many as 90% of batterer group members drop out of treatment (DeHart, Kennerly, Burke, & Follingstadt, 1999; Daly & Pelowski, 2000). A study by Gondolf and Foster (1991) suggested that up to 73% of batterers drop out between the initial inquiry about the program and the intake session. Despite efforts made by court-ordering domestic batterers to rehabilitative programming, the utility of these methods in helping end violence against women is certainly dependent upon the likelihood of rehabilitative program completion.

The presence of such large dropout rates for DV treatment programs is a cause for concern for numerous reasons. First, the success rate of completing a batterer's program is influenced by a high attrition rate. Program effectiveness is based solely on evaluating recidivism rates on intimate partner violence for individuals who have completed

rehabilitative services. Secondly, as Gondolf (1999) suggested, it is important to recognize that batterers who do not complete the program are at greater risk of re-offending against their intimate partner. A study by Dutton, Bodnarchuk, Kropp, Hart, and Ogloff (1997) suggested that up to a year following group drop out, there is an increased risk of repeated violence by batterers compared to program completers. Moreover, research has indicated that such repeated assaults typically result in greater injury and bruising to the victim (Gondolf, 1997). Therefore, poor program attendance equates to batterers not obtaining the benefits from the completion of a treatment program, and thus prevention of future DV is limited.

Additionally, despite efforts made to help rehabilitate male batterers, to date there is limited evidence to suggest that mandated treatment is effective in helping reduce the prevalence of DV. For example, a study by Rosenfeld (1992) indicated that "men who are arrested and complete treatment have only slightly lower recidivism rates than men who are arrested but refuse treatment, dropout of treatment, or remain untreated" (as cited in Babcock et al., 2004, p.1024). Furthermore, some researchers have advocated that by mandating batterers to treatment programs, the battered victims may be at an increased risk for further abuse. For example, such victims may choose to remain in the abusive relationship as a result of fostering a false sense of security (Holtzworth-Munroe, Beatty, & Anglin, 1995). However, controversy regarding program effectiveness remains as a result of methodological issues and influencing factors involved in research evaluating program effectiveness (Gondolf, 2002).

The majority of male batterers are mandated by the legal system to seek help for their abusive behaviours, however, the argument can be made that it would be more

helpful for male batterers to seek assistance prior to committing or escalating DV. One of the greatest challenges with rehabilitative programs is the lack of batterers seeking out the assistance of treatment when needed. Therefore, an important issue with programming relates to a lack of understanding the resistance of batterers to seek help, in addition to the avoidance of professionals and society in general in addressing violence when presented with the issue by male batterers. It is imperative that researchers and professionals begin to place a greater emphasis on appropriately evaluating and assisting perpetrators of domestic abuse. More specifically, researchers need to examine male batterer's help-seeking behaviours and the risks and barriers in seeking help.

Male Health Related Help-Seeking

Men are typically characterized as resistant to assistance from others when experiencing problems in life. For decades, research has supported the notion that men are less likely than women to seek out the help and assistance of health professionals (Addis & Mahalik, 2003; Galdas, Cheater, & Marshall, 2005; Mansfield, Addis, & Mahalik, 2003; Vogel, Wester, & Larson, 2007). Help-seeking behaviour is considered to be any form of communication regarding a problem, issue, or concern which is addressed to another individual in order to obtain advice, support, or assistance (Gourash, 1978). Until recently, men's lower rates of help-seeking were considered normal. Men were thought to utilize health professionals in appropriate degrees, whereas women were believed to be abusing the services (Courtenay, 2000). However, although men were thought to be the "stronger sex", evidence suggests that they too required more help from professionals than they received.

Research findings have consistently shown that men visit primary care physicians and specialists less frequently than do women. As reported by the U.S. Department of Health and Human Services (1998), men are twice as likely as women to have a latency period of two or more years since last being in contact with a physician (DHHS, 1998). A study by Courtenay (2000) suggested that when men seek help, they typically ask fewer questions in relation to women. Moreover, when seeking help from a general practitioner with regards to physical symptoms, men consistently neglect to report or minimize any psychosocial problems or distress as a result of the somatic issue (Corney, 1990). The same trends exist with regards to men seeking psychological services. Research has indicated that less than one third of males, who experience psychological distress, will ever seek help from mental health professionals (Andrews, Issakidis, & Carter, 2001). A meta-analysis of research conducted in the United States suggested that, "men are less likely than women to seek help from health professionals for problems as diverse as depression, substance abuse, physical disabilities, and stressful life events" (Galdas et al., 2005, p.617). Kessler, Brown, and Broman (1981) conducted a study on sex differences in psychiatric help-seeking behaviours and claimed that these differences were due to the fact that women are more likely than men to recognize and identify the problem of their non-specific feelings of psychiatric symptoms. When trying to investigate male batterer's help-seeking behaviours, it is important that researchers recognize that men are typically more reluctant than women to seek help from health professionals.

In order for researchers to begin to understand male batterer's help-seeking behaviours, it is also important to be aware of the stages of help-seeking. Although

presently there is a vast amount of research literature examining the nature and extent of health related help-seeking behaviours, there is no such research on male batterer's stages of help-seeking behaviours (Möller-Leimkühler, 2002). General models of help-seeking have been developed which typically focus on an individual's internal and cognitive processes (Pescosolido, 1992). Drawing from such models, Liang, Goodman, Tummala-Narra, and Weintraub (2005) identified three stages of help-seeking behaviours: problem recognition and definition, decision to seek help, and selection of support providers. Thus, the likelihood of an individual seeking help from others depends greatly upon the way in which they identify or define their problem and its severity (Fox, Blank, Rovnyak, & Barnett, 2001). In other words, the process of male batterers searching for help may not commence until the batterer comes to recognize and defines their behaviours as problematic. Additionally, although one must come to recognize the problematic nature of their abusive behaviours in order to pursue help, the way in which one defines the problem will also be influenced by the helper's perspective and assistance provided (Liang et al., 2005). When attempting to determine possible barriers to male batterer's help-seeking behaviours, researchers must be aware and understand the impact of problem defining with regards to DV.

The Health Belief Model developed by researchers at the U.S. Public Health Service in the 1950s has been utilized in research in hopes of explaining and predicting health behaviours (Becker, 1974). The model suggests that the likelihood of an individual seeking help for health related issues is a function of two factors. First, the individual must perceive a personal susceptibility to a serious disease with severe consequences. Second, the positive benefits to seeking help from a health professional

must outweigh the barriers to help-seeking behaviours (Janz & Becker, 1984). The Theory of Reasoned Action, proposed by Ajzen and Fishbein (1975), was also developed in response to attitude and behaviour research in order to predict behaviours (as cited in Tudiver & Yves, 1999). The model suggests that an individual behaves in a manner which concurs with both personal attitudes and social norms. For example, men will seek help from health professionals under the condition that they themselves foster positive attitudes in doing so, in addition to the presence of an overriding acceptance from society at large. More specifically, research has indicated that a fear of being labelled by such a socially unacceptable stigma is embarrassing and humiliating to the extent that it alone can act as one of the most significant barriers to help-seeking behaviours (Sibicky & Dovidio, 1986; Stelf & Prosperi, 1985). Kushner and Sher's (1989) Approach-Avoidance Conflict Model would aid in better understanding this concept. The model suggests that as one moves closer to the possibility of seeking help due to one's level of distress, avoidance behaviours will become increasingly stronger. Thus, approach and avoidance factors may assist researchers in better understanding individual resistance to seeking help. In order to both understand and provide assistance to perpetrators of DV, it is critical that researchers begin to evaluate and recognize some of the trends, risks, and barriers to male batterer's help-seeking behaviours.

Male Batterer Help-Seeking

Although there is a wide array of research on male health-related help-seeking behaviours, to date there has been minimal research related to male batterer's help-seeking behaviours. One such study, by Ashley and Foshee (2005), examined influencing factors, such as sociodemographic variables, the prevalence of help-seeking,

and systems utilized by adolescent victims and perpetrators of dating violence. The findings of the longitudinal study demonstrated that most adolescent perpetrators avoided seeking help from both professionals and non-professionals; only 29 of 140 perpetrators who participated in the study sought help for their violent behaviours. The likelihood of help being sought out by perpetrators of dating violence was also shown to increase with age. While it is important to note the efforts made by Ashley and Foshee (2005), the study findings relate to both an adolescent sample, and violence present in dating relationships. One cannot generalize Ashley and Foshee's study findings to an adult male population with regards to the perpetration of domestic violence in a married, cohabitating, or dating relationship.

A study by Mendoza and Cummings (2001) addressed some of the issues related to male batterer's help-seeking behaviours by examining gender-role variables. The researchers explored the relationship between help-seeking attitudes and how it related to male batterer's gender-role variables (i.e. reference group identity dependence, masculine behavioural tendencies, and gender-role conflict). Data was collected from 109 individuals who volunteered to participate from a community treatment facility for male batterers prior to completion of the program. This study involved participants completing four questionnaires related to the variables of interest. The results of the study indicated no significant relationship found between gender-role conflict and help-seeking attitudes. However, a relationship did exist between reference group identity dependence and help-seeking attitudes. Male batterers who had negative help-seeking attitudes also had a tendency to feel connected with other men, which suggests that these men may have viewed counselling as an inappropriate activity based on gender role expectations. This

finding is critical when considering barriers to help-seeking in male batterers. Perhaps male batterers who inherit strong masculine ideologies and beliefs about what it means to be "male" would be less likely to seek help because of these beliefs. Moreover, it is possible that male batterers with high masculine ideologies are being dictated by cultural and societal norms regarding masculinity. Although Mendoza and Cummings' (2001) exploratory study utilized sound methodology and rationale, additional research is required in order to further explore all possible factors acting as barriers to batterer's help-seeking. Further research on the barriers to male batterer's help-seeking behaviours has direct implications for helping the perpetrators of abuse and reducing the rate of DV by addressing the source of the problem.

Possible Barriers to Help-Seeking

Masculine Ideologies. In order to better understand why male batterers foster such resistance to seeking help in a time of need, it is important to recognize potential barriers or risks in doing so. As discussed earlier, the concept of masculinity in the context of help-seeking behaviours in male batterers is an important area of focus when attempting to better understand the functions of help-seeking behaviours. From birth, girls and boys are socialized to learn gender specific attitudes and behaviours in the context of cultural norms, values, and ideologies (Addis & Mahalik, 2003). Over time these beliefs may hold constant and enable the individual to be aware of what it means to be a man or a woman. Although these ideologies can vary across persons or groups, it is generally the case that the most dominant ideologies dictate masculine norms (Smiler, 2006). Certain ideologies hold greater power over others, depending on what the members of that culture consider to be the "norm" for masculinity (Addis & Mahalik, 2003). For example, the

most dominant ideologies in the U.S. culture generally originate from White, Protestant, middle-class, and heterosexual subcultures (Mahalik et al., 2003). However, some men may engage in certain behaviours which are contrary to their own masculine beliefs given that it associates with the more dominant ideology (Addis & Mahalik, 2003). For example, although traditional American ideologies suggest that men avoid displaying feelings and emotions, such as sadness or grief, there are still times when men go against this "norm" and cry in front of others. Therefore, professionals need to be aware of both within-person and across-situational variables when considering barriers to help-seeking as a result of masculine ideologies.

It may be the case that male batterers who endorse these traditional masculine ideologies may hold negative attitudes towards seeking help. If this is true, it would then be important to identify ways in which male batterers can seek help, while holding true to their inherent masculine ideologies. Rochlen, Land, and Wong (2004) addressed this issue with a group of men involved in online counselling, and a second group involved with traditional individual counselling. The results of this study suggested that those who ranked high in masculine ideology preferred online counselling over the traditional scenario. Due to the private nature of online counselling, the participants may have felt less judged when not dealing directly with a counsellor. Consequently, perhaps male batterer's feelings of humiliation and embarrassment act as a barrier to help-seeking when going against social norms formed by masculine ideologies. Professionals may need to recognize the difficulties and strides made by batterers who seek help, and approach such individuals with great care and sensitivity. By being aware of masculine ideologies, it is possible for positive changes or shifts to occur in the therapeutic

relationship. Furthermore, although professionals must be conscious of the various strategies utilized when working with batterers, it is imperative that they recognize how masculine ideologies may hinder the help-seeking process.

Gender-Role Conflict. Another possible barrier to male batterer's help-seeking behaviours extends from the aforementioned barrier, regarding the possible negative consequences which result from adopting masculine ideologies. For example, hosting such beliefs that men should not express emotions may cause detrimental effects (i.e. gender-role conflict, GRC) on a man's well being (Courtenay, 2000). Masculine ideologies and GRC differ in that ideologies are ideas and thoughts about what a man should be, whereas GRC is related to one's experience of masculine gender socialization (Mansfield et al., 2003). One's gender role is embedded through a socialization process beginning in child rearing practices, and through the guidance of prevailing societal norms concerning appropriate gendered behaviour (Cochran, 2005). Such pressures to abide by gender specific roles may impact batterers in a way which imposes barriers to help-seeking behaviours.

A measurement tool was developed by O'Neil, Helms, Gable, David, and Wrightsman (1986) to measure different patterns of gender-role conflict in men, such as restrictive emotionality. For example, a study by Blazina & Watkins (1996) investigated the effects of GRC on college men's attitudes towards help-seeking. The findings of the study suggested that those who score high on GRC, typically fostered negative attitudes towards help-seeking behaviours. Good and Wood (1995) identified a similar pattern with higher GRC scores relating to negative views towards seeking professional psychological help. The authors suggested that GRC causes a "double jeopardy" for

men, in that it both increases the chances of depression and decreases the probability of seeking help. Therefore, internalized gender roles may have the ability to cause barriers to help-seeking, most certainly if such behaviours violate central gender roles (Mahalik, Good, & Englar-Carlson, 2003). Mendoza and Cummings (2001) suggested that addressing such gender-role issues with male batterers may aid in making the batterer feel more comfortable in seeking professional help. Professionals might need to adapt the way in which they address each male batterer in order to reflect the degree to which that individual endorses masculine ideologies, or whether they struggle with GRC.

Social Norms. In order to better understand the barriers to male batterer's help-seeking behaviours, researchers must also evaluate the extent to which a fear of adopting a social stigma alone acts as a barrier to help-seeking. A social stigma, as defined by Deane & Chamberlain (1994), is an innate fear of being negatively judged by others as a result of going against the social norm. A study by Sibicky & Dovidio (1986) investigated the stigmas created by social norms with regards to seeking psychological therapy. The findings of the study suggested that one of the most significant barriers to treatment was a fear of the social stigma attached to help-seeking behaviours. For male batterers, it may be the case that seeking help suggests that the batterer has little control over his emotions and thus is weak or disturbed (King, Newton, Osterlund, & Baber, 1973; Oppenheimer & Miller, 1988). Furthermore, research by Overbeck (1977) has suggested that help-seeking is limited for problems or concerns which have a greater likelihood of fostering negative judgments by others (as cited in Vogel et al., 2007). As a result of established social norms and acceptance, perhaps male batterer's greatest barrier to seeking help relates to a fear of social rejection. Nelson and Barbaro's (1985) study supported this

concept with 90% of their study sample agreeing that a fear of adopting a social stigma hindered their likelihood of seeking professional help.

The likelihood of batterers seeking help for their abusive behaviours may also be related to what is considered the "norm" in that individual's close social network. The attitudes and beliefs of family and friends might dictate or influence how a batterer defines or views his abusive behaviours. In some cases the batterer may view his use of domestic abuse as a normative behaviour. It is unlikely that an individual will seek help if they do not recognize or define their behaviours as problematic (Kessler et al., 1981). For example, Robbins and Greenley's (1983) study proposed that individuals who perceive their issues as bothersome or threatening are more likely to seek help than those who view their problems to be less restricting or bothersome. A study by Reitzel-Jaffe and Wolfe (2001) utilized a social learning model to evaluate college men's relationship abuse. The results suggested that violence in men's family of origin, and the association with peers who endorse violent attitudes and behaviours, predicted the development of negative beliefs regarding partner violence. The findings of these studies support the influence of normative behaviours in determining the likelihood of male batterer's help-seeking behaviours. Therefore, the probability of seeking help may depend greatly on whether or not that individual's social network host negative attitudes towards DV. The act of seeking help for perpetrating DV may be avoided as a result of a fear of exposure or loss of social standing (Vogel et al., 2007).

In order to determine the extent to which social norms can take precedence over male batterer's help-seeking behaviours, researchers could investigate the likelihood of male batterers seeking help for more "socially acceptable" issues (i.e. depression or

alcohol abuse). Presently, there is extensive research suggesting that the presence of alcohol and/or depression is correlated with episodes of DV (Fava & Rosenbaum, 1998; Rosenbaum, 1990; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Tolman & Bennett, 1990; O'Farrell & Murphy, 1995; Testa, Quigley, & Leonard, 2003). For example, research on alcohol abuse treatment suggested that 40-60% of patients reported one or more episodes of DV within the year prior to program entry (Fals-Stewart, Golden, & Schumacher, 2003). Pan, Neidig, and O'Leary's (1994) research indicated that a 20% increase in depressive symptoms inadvertently increases the chances of perpetrating severe aggression towards a spouse by 74%. The *Fifth Annual Report of the Domestic Violence Death Review Committee* of Ontario noted that depression in the opinion of non-professionals (63%), and excessive use of alcohol and/or drugs (40%) were common risk factors predictive of lethality. Since DV is likely associated with alcoholism and/or depression, it is important that researchers determine whether batterer's help-seeking behaviours vary depending on society's acceptability with an issue or problem. Furthermore, if it is the case that male batterer's have a greater tendency to seek help for more socially acceptable issues, then it is important that professionals, community support programs, and society in general be aware of this possibility for assessment purposes.

The Role of Professionals and Non-Professionals

An individual may seek help for a socially acceptable issue, but at the same time might be perpetrating DV. If these batterers are seeking help for their more "acceptable" problem, it is then up to the professionals and helpers to be aware of the possibility of DV, and thus provide assistance in dealing with the violent behaviours. Research has

indicated that perhaps DV has been often ignored as a result of professionals not questioning clients about their potential for perpetrating abuse (Douglas, 1991). For example, a study conducted at a family therapy clinic by O'Leare, Vivian, and Malone (1992), indicated that half of the cases, which involved DV, were not identified during routine interviews. Professionals may perceive danger in introducing the topic of DV for fear of challenging or misinterpreting their client. The *Fourth Annual Report of the Domestic Violence Death Review Committee* of Ontario indicated that 43% of the perpetrators of domestic homicides obtained some form of prior counselling (not for DV), however, only 4% of them received counselling and treatment specific to their problems related to DV. In order for professionals to take a stand in helping prevent DV, they must make it a priority with clients to inquire about potential for abusive behaviours. Research has supported this notion with evidence to suggest that clients typically disclose issues related to violent behaviours only after the professional has made a direct inquiry about the behaviour (O'Leare et al., 1992). It would be critical as researchers to determine if helping professionals are prepared to identify and discuss these underlying issues, and make appropriate referrals when necessary.

On the other hand, perhaps male batterers are more likely to seek help from those other than helping professional, such as friends, family members, or neighbours. Research has indicated that counselling is considered as a last resort for most individuals (Hinson & Swanson, 1993). A study by Cusack, Deane, Wilson, and Ciarrochi (2004) supported this notion by investigating the influence of others on men's likelihood of seeking help. The results of the study suggested that 96% of male participants identified some degree of influence by others when deciding to seek professional help. Research

has also demonstrated that 92% of people typically communicate to others within their social network about his or her problem before seeking professional help (Cameron, Leventhal, & Leventhal, 1993). Furthermore, it is important to recognize the possible negative influences social networks can have on inhibiting help-seeking behaviours. Perhaps those closest to the batterer may wish to keep the problem hidden as a result of avoiding negative societal reactions of others towards the batterer's family or friends. Vogel et al. (2007) proposed that the presence of a norm of avoidance towards help-seeking demands that professionals work with clients and their friends and family. By doing so, one can assume that the chances of male batterer's seeking professional assistance for their abusive behaviours will only increase, which consequentially will reduce the potential for future abuse. Therefore, if male batterers initially seek support from friends and family, researchers need to identify whether or not non-professionals have the knowledge to direct these batterers to appropriate resources for their violent behaviours. It would be important to address such questions in order to both better understand the barriers to batterer's help-seeking behaviours, and to educate society in order to limit the frequency of missed opportunities in helping end violence against women.

Purpose of Current Study

There is a large body of research targeted at developing effective support and interventions for victims of DV, but little effort has gone into understanding how to appropriately address and help male batterers. Although it is important that agencies and communities support abused women, it is also critical that communities go right to the source of the issue and try to implement change. It is imperative that researchers begin to

learn and better understand the most effective ways to assist male batterers, in order to appropriately provide support and interventions to end violence against women. The goal of the present study was to investigate male batterer's help-seeking behaviours with formal systems (i.e., health care provider, mental health provider, social services) and informal systems (i.e., friends, family, neighbours, colleagues).

Given there is such limited research related to male batterer's help-seeking behaviours, an exploratory study was conducted as a first step to gain preliminary information. The present study consisted of systematic reviews of domestic homicide case summaries as reviewed by the Domestic Violence Death Review Committee (DVDRC) of Ontario during 2003 to 2007. The files reviewed consisted of tragedies where often individuals around the perpetrator of domestic homicide knew of his violent behaviours, but there was limited or no engagement or assistance to the perpetrator in any form. Such case summaries provided the researcher with the opportunity to explore a variety of factors related to the risks and barriers to male perpetrator's help-seeking. More specifically, the present study entailed a systematic review of case details in order to determine the frequency and likelihood of perpetrator's seeking help for more socially acceptable issues such as depression or alcohol use. The study methodology provided detailed information regarding any contact with helping professionals, either related or unrelated to violent behaviours, in order to evaluate whether assessment or intervention methods were utilized or offered to assist perpetrators in ending DV.

Based on previous literature which examined barriers to help-seeking behaviours, and consistent with Kushner and Sher's (1989) Approach-Avoidance Conflict Model, it was predicted that male perpetrators of DV would be more likely to seek help for more

socially acceptable issues (i.e. depression or alcohol abuse) versus issues related to DV. However, consistent with most literature on professional assistance related to DV, it was predicted that even when perpetrators presented more socially acceptable issues (such as depression or alcohol use) to those in the helping profession, the helpers were not addressing or identifying the underlying issue of violent behaviours. Specific research questions are as follows:

1. Did age (younger vs. older) influence one's likelihood of having a social network of professional supports?
2. If the perpetrator had an alcohol abuse issue, did he seek out help for his alcohol abuse?
3. If the perpetrator demonstrated evidence of depression, did he seek out help for his depression?
4. If the perpetrator sought general help from professionals, was his violent behaviours identified and assessed?
5. If the perpetrator sought out help for his violent behaviours, did he get access to specialized DV resources or interventions?

In conclusion, determining the barriers to male batterer's help-seeking behaviours is an important topic of interest which has been under-investigated in previous research. The present study served as a preliminary examination of batterer's help-seeking behaviours in extreme cases of domestic homicides.

Method

Participants

The current study entailed a retrospective case record analysis of 45 domestic homicide case summaries which have been reviewed by the DVDRC of Ontario from 2003 to 2007. These case summaries constituted a subset of an initial sample of approximately 158 domestic homicide cases that occurred between 2003 and 2007, which have been referred to the DVDRC for review by the Regional Supervising Coroner (RSC) (DVDRC, 2007). It is important to note that cases cannot typically be reviewed in the year in which the homicide occurred as a result of numerous factors such as completion of coroner's investigation, completion of criminal trials and appeals, and receipt of investigative materials relevant to the review (DVDRC, 2006). Consequently, since the establishment of the DVDRC, a total of 62 domestic homicide cases (involving a total of 100 deaths) have been reviewed by the committee (DVDRC, 2007).

Based on the inclusionary criteria of the present study, of the 62 completed case summaries, a total of 45 cases were reviewed and coded for the purposes of data collection. The inclusion criteria required that the domestic homicide cases be reviewed and summarized by the DVDRC, in addition to the offender having perpetrated domestic homicide to an intimate partner, or attempted a serious domestic homicide followed by suicide or being killed by the police. In general, victims of DV fatalities tend to be female, while the perpetrators are predominately males. The DVDRC reviewed cases from 2003-2007 and reported that 92% of the perpetrators were male. As a result, all of the cases selected for review involved a male perpetrator who was over the age of 18 at the time of the homicide.

Domestic Violence Death Review Committee (DVDRC)

In Ontario, coroners investigate the particulars regarding a death which is sudden or unexpected, in addition to expected deaths which require further examination (Ministry of Community Safety and Correctional Services, 2007). Coroners are medical doctors who have gained specialized training in the principles of death investigations. Coroner's reports can be made to persons, agencies, or government ministries. These recommendations are made in order to prevent deaths from occurring in similar circumstances.

All deaths related to DV are reviewed by a sub-committee, the DVDRC of Ontario. These cases are only reviewed following the conclusion of any criminal proceedings. This can be a lengthy process, which can result in years before a case is passed onto the DVDRC to be reviewed (Ministry of Community Safety and Correctional Services, 2007).

The DVDRC was established in 2003, and consists of a representative advisory committee of experts in DV. The committee conducts file reviews by evaluating and summarizing all of the appropriate documentation that has been gathered for the various cases. The content of the cases examined consist of reports from sources such as the criminal justice system, law enforcement, healthcare sector, social services and organizations, non-professional acquaintances, the perpetrator, etc. The purpose of the DVDRC is, "to assist the Office of the Chief Coroner in the investigation and review of deaths of persons that occur as a result of DV, and to make recommendations to help prevent such death in similar circumstances" (DVDRC 4th Annual Report, 2006, p.2). Furthermore, one of the main objectives of the DVDRC is, "to conduct and promote

research where appropriate", and the present study will hold up to that objective (DVDRC 4th Annual Report, 2006, p.2).

Materials

The decision to conduct file summary reviews was based on the fact that the DVDRC case summaries may provide valuable insights into the lives of male perpetrators, in addition to serving as a source of information to conduct a retrospective analysis of the frequency of missed opportunities in helping male perpetrators. More specifically, case summaries from the DVDRC of Ontario were reviewed in the present study to examine male batterer's help-seeking behaviours.

A standardized coding instrument was developed for the purposes of this study which enabled the researcher to consistently review and extract information from each case summary (see Appendix A). The coding instrument followed the format of the original case summary form developed and utilized by the DVDRC's committee members when reviewing cases, and additional items were added based on proposed research questions.

To begin, any information related to demographic details were identified and coded, such as information regarding the perpetrator's age, date of birth, marital status, education, employment status, criminal history, treatment history, and family court history. A checklist of potential professional and non-professional contacts was adopted from the original summary form in order to code the perpetrator's history of help-seeking behaviours, history of DV, and the history of the victim's help-seeking behaviours. The researcher utilized such information to evaluate the likelihood of help-seeking behaviours, to determine whether the DV was identified or known to others, and to

determine the proportion of missed opportunities to intervene and help. Furthermore, a list of agencies and institutions taken from the original summary form provided the researcher the opportunity to code the frequency of contact with supports involved with the perpetrator during the time in which DV was occurring. Moreover, the researcher reviewed what assistance, if any, that the helping professional may have offered to the perpetrator with regards to their violent behaviour. In addition to social contacts, the DVDRC developed a 12 item checklist, based on research literature, which identified potential risk factors predictive of lethality from the cases reviewed. These factors were coded in order to investigate potential variables that may influence the likelihood of help-seeking behaviours. The researcher developed additional items in order to identify whether the perpetrator received help for any problems, and how the help was sought out. All relevant information, trends, similarities, and frequencies were identified, coded, and evaluated.

Procedure

The researcher took an oath of confidentiality, and was granted permission to examine the case summaries by the Chief Coroner and the University of Western Ontario's Ethics Review Board (see Appendix B & C). All case summary reviews were accessible to the researcher via electronic files which were located on a password protected computer. To improve reliability of the study's coding, the researcher gained appropriate knowledge with regards to the content, organization, and application of the DVDRC's case summaries. Furthermore, to enhance reliability of the coding instrument, inter-rater reliability was established utilizing a subset of five case summaries. All cases were identified by a study code in order to ensure confidentiality. All information was

kept securely and confidentially on a computer with needed password. All completed study coding was stored in a locked filing cabinet until it was no longer required. Once the study has been published and the records are no longer needed, file contents will be destroyed within seven years of data collection.

Results

Characteristics of the Perpetrators

The cases reviewed in the present study involved male perpetrators ranging in age from 21 to 89 years old at the time of the homicide, with a mean age of 43.09 years (SD=14.20) and a median age of 45 years. In the majority of cases (80%), the perpetrators were citizens of Canada, with fewer identified as documented immigrants (18%) or illegal immigrants (2%). During the time of the homicide, roughly half (53%) of the perpetrators were married or cohabiting with the victim, while 11 (24%) cases involved recent separation or divorce and 10 (22%) cases involved dating couples. The length of romantic partnership between the perpetrator and victim ranged from .5 to 40 years, with a mean of 13.15 years (SD=10.56) and a median of 10 years. The number of children parented by the perpetrator at the time of the homicide ranged from 0 to 7 children, with a mean of 1.91 children (SD=1.65) and a median of 2.00 children. Of the 26 cases in which perpetrator's education was noted, the education levels ranged from some elementary school to post secondary education, with the majority of perpetrators (73%) having completed high school, and as many as 7 (27%) went on to complete college or university. With regards to perpetrator's employment status at the time of the homicide, roughly half (47%) were employed either full-time or part-time, while 16

(36%) were unemployed and 8 (17%) were classified as "other" (i.e. retired, on disability, laid off, etc.).

Of the 45 cases reviewed, 29 (64.4%) involved homicide-suicide, while the remaining 16 (35.6%) cases were homicide only. Domestic homicide risk factors were examined and ranked ordered by frequency of presence across all cases reviewed (see Table 1).

Table 1: Common Risk Factors from Cases Reviewed

Risk Factors	N (n=45)	Percentage
Actual or pending separation	39	87%
History of DV	33	73%
Escalation of violence	32	71%
Depression (or other mental health or psychiatric problems)	32	71%
Obsessive behaviour (including stalking the victim)	29	64%
Prior threats to commit suicide or attempts to suicide by perpetrator	26	58%
Access to or possession of firearms	23	51%
Prior threats to kill victim or threat with a weapon	22	49%
Excessive alcohol and/or drug use	22	49%
New partner in victim's life	17	38%
Perpetrator unemployed	16	36%
Attempts to isolate the victim	16	36%
Extreme minimization or denial of spousal assault history	14	31%
Perpetrator witnessed DV as child	14	31%
Chokes victim	12	27%
Isolation of victim	12	27%
Hostage-taking	10	22%
Child custody or access dispute	9	20%
Forced sexual acts or assaults during sex	9	20%
Youth of couple	8	18%
Victim and perpetrator living common-law	6	13%
Destruction of victim's property	6	13%
Presence of stepchildren in the home	4	9%
Violence against family pets	2	4%
Assault victim while pregnant	1	2%

The most frequent risk factor present in 39 (86.7%) cases was actual or pending separation. The second most common risk factor, found in 33 (73.3%) of the cases, was a prior history of DV. The third recurrent risk factors identified in 32 (71.1%) of the cases was the escalation of violence and the presence of depression or other mental health or psychiatric problems. Furthermore, the "level of risk" for domestic homicide identified

from the perpetrator's risk assessment score was calculated based on the DVDRC's guidelines which suggest that seven or more risk factors represent a "high risk" case. Of the 45 cases reviewed, the majority (73%) of cases were identified as high risk cases, suggesting the deaths may have been predictable and preventable.

Perpetrator's Help-Seeking Behaviour

In order to determine the prevalence of the perpetrator's help-seeking behaviours from the cases reviewed, data from the coding instrument were computed and presented in frequencies. As many as 36 (80%) cases indicated that the perpetrator sought general help from professionals and non-professionals for issues unrelated to perpetrating DV, while nearly half (51%) of the perpetrators actually sought help for their abusive and violent behaviours. Of the 23 who sought help for DV, as few as 13 perpetrators were provided some form of assistance, with an additional 2 perpetrators who received help as a result of a court mandate; however, only 3 (20%) cases reported that the perpetrator received specialized DV help and support (i.e. formalized batterer's intervention programs with professionals trained in treating male perpetrators of DV). When reviewing case summaries and the coding instrument findings, three major help-seeking themes emerged from the data. To better illustrate each theme, actual case summaries from the DVDRC annual reports have been provided below. However, no identifying or personal information was mentioned in order to protect the privacy and confidentiality of each case.

Theme 1: Perpetrator does not seek help in spite of problems

Case#1 (DVDRC, 2007, p.12):

"This case involved the homicide of a female victim by her ex-spouse who had a long history of alcohol abuse and mental health issues. The victim and the perpetrator had been divorced for two years following an eleven-year marriage. They had one child.

The relationship had been plagued with violence and threats by the perpetrator against his spouse, including sexual assaults, threats with a weapon, some of which lead to criminal convictions. Despite numerous appearances before the courts, there were many instances of breach of bail and/or probation conditions.

The perpetrator became increasingly obsessed with reconciliation with his ex-spouse after their separation, with escalating aggression, threats of violence and death, and stalking behaviour. On the day of the homicide, the perpetrator went to the victim's house and broke in after the victim denied him entry. When she again refused his pleas for reconciliation, and while their son was present in the home, the perpetrator stabbed her multiple times."

When DV is present in a relationship, it may be assumed that professionals and/or non-professionals will be sought out for some form of general or violent specific help, which may aid in identifying and treating the abusive behaviours. However, it is not always the case that perpetrators seek help, despite the presence of obvious problems. In a fifth of the cases reviewed, perpetrators avoided seeking any type of help or support from others. More specifically, there were 9 (20%) cases in which the perpetrator did not seek any general help from formal or informal systems and 22 (49%) cases in which no help was sought regarding violent behaviours. There were no cases reviewed in which only help for DV was sought out. If perpetrators are not seeking any general help for issues unrelated to violent behaviours, it is unlikely that such individuals will seek help for DV from professionals and/or non-professionals.

Theme 2: Perpetrator seeks professional help for issues other than violent behaviour

Case #5 (DVDRC, 2002, p.16):

"This is a case of homicide-suicide. In 1995, the perpetrator was diagnosed as suffering from paranoid schizophrenia and alcoholism. He had been receiving anti-psychotic medication from his family physician. He had a history of verbal abuse and harassing behaviour towards his wife, which increased over time. The perpetrator was known to have been to his wife's place of business to speak to her co-workers, as well as to monitor her activities and accuse her of infidelity. He also had a persisting delusion that his wife and daughter were trying to kill him by poisoning his food. Their son reported knowledge of one incident where the perpetrator had slapped his mother, but the abuse tended to be more of a verbal and emotional nature.

The victim resided with her son in the family home and was separated from her husband. Notwithstanding their separation and divorce, he frequently visited the residence and maintained contact with his ex-wife. His ex-wife felt he did not properly care for himself, so she fed him and allowed him to stay at the house from time to time. While he was under the care of a physician, he was not always compliant with taking medication. Due to his disturbing behaviour, the family sought help from their rabbi who spoke with him and his ex-wife. There is no indication that the family was referred to or involved with outside agencies such as police, children's aid society, family and/or social services. There was some indication that, because of "shame" expressed by the family about the perpetrator's mental illness and behaviour, there may have been cultural barriers to their seeking assistance from outside services."

It might be assumed that if a perpetrator has contact with both professionals and non-professionals that such contact will result in both identifying and assisting the individual in ceasing their abusive behaviours. Yet, such assumptions cannot be born out from the present study's case review. If a perpetrator sought help for other reasons from a professional with the hopes of addressing their violent tendencies, the likelihood of the professional identifying the perpetrator's violent behaviour and intervening is limited. When reviewing the total number of independent professional contacts involved with the perpetrator, just over half (52%) of the professionals had identified the perpetrator's abusive behaviours. However, these calculations included the involvement of professionals in the criminal justice system (e.g. police, court, lawyers, etc.), whom are already likely involved with the perpetrator as a direct result of their violent behaviours. Once omitting contacts with professionals involved in the criminal justice system, the study findings demonstrated that out of 90 independent contacts with professionals, only 16 of such contacts actually identified the perpetrator's battering behaviour. In only 18% of the cases in which a perpetrator had contact with a professional for general purposes was his violent behaviours ever identified. Additionally, a close examination of specific professional contacts revealed compelling data. Only 3 (17%) of 18 contacts with

professionals in the mental health system, 3 (12%) of 26 contacts with health care professionals, and 5 (45%) of 11 contacts with professionals in child protection identified the perpetrator's violent behaviours.

If being in contact with professionals influences a perpetrator's chance of recognizing and rehabilitating their abusive behaviours, in comparison to perpetrators with limited or no professional support, then it is also important to address what may influence one's likelihood of seeking such supports. One particular variable of interest in the present study was to investigate how age can possibly influence one's likelihood of having a social network of general professionals. The perpetrators were divided into two separate groups based approximately on the mean age; 1) Less than 40 years of age was coded as "younger", and 2) 40 years of age or older was identified as "older". Although group assignment based on Statistics Canada's (2005) proposed high risk age group (i.e. 24 years of age and younger) versus low risk age group (i.e. older than 24 years of age) would have been preferred, such grouping resulted in significantly unequal group sizes, equating to subjective findings (i.e. 6 cases identified as "younger", while the remaining 39 cases represented "older"). When considering the number of professional systems involved in the perpetrator's life, the older group were more likely to have additional supports when the number of professionals involved ranged from one to four; the older group had a total of 52 professional systems involved, in comparison to the younger group which had a total of 27 supports. There were no group differences in professional network size when number of contacts involved in perpetrator's life ranged from five to eight (see Table 2).

Table 2: Professional Network Size vs. Age of Perpetrator

Group	Number of Professional Systems Involved in the Perpetrator's Life									Total
	0	1	2	3	4	5	6	7	8	
Younger	3	2	3	5	1	1	1	3	0	19
Older	2	5	8	5	4	0	0	1	1	26
Total	5	7	11	10	5	1	1	4	1	45

In addition to age having an influence on a perpetrator's network of professional contacts, the data revealed several other factors which influenced the perpetrator's likelihood of seeking general help or support from professional systems. For example, when evaluating length of relationship, perpetrators involved in a relationship for 1 to 10 years were most likely to seek general help from professional agencies. Of the 36 cases in which the perpetrator sought general help, 19 (53%) cases represented a relationship of 1 to 10 years, 9 (25%) cases involved 20 plus years, and 8 (22%) cases involved 11 to 20 years. Neither of the two perpetrators, whose relationships lasted less than a year, sought general help from professional contacts. Moreover, perpetrators who were married or cohabitating with the victim at the time of the homicide were most likely (58%) to seek general assistance from a network of professionals. With regards to the perpetrator's education level, those who completed high school or further education were more likely (73%) to seek general help when needed in comparison to perpetrators with some high school education or less. Not surprisingly, the data also suggested that having employment greatly increased the perpetrators likelihood of seeking general help; 18 (50%) of the 36 cases in which general help was sought involved full-time or part-time employed perpetrators. What was compelling from the study findings was the fact that the greater the number of children parented by the perpetrator, the greater the likelihood of seeking general help by the perpetrator (see Table 3).

Table 3: Number of Children vs. Perpetrator Seeking General Help

Number of Children	Did the Perpetrator Seek General Help from a Professional?		Total
	YES	NO	
No children	6	4	10
One child	8	1	9
Two or more children	22	4	26
Total	36	9	45

Lastly, in order to address the role of social norms in male perpetrator's help-seeking behaviours, the present study also investigated the likelihood of perpetrators seeking general help for more socially acceptable issues such as depression and alcohol abuse. The presence of depression was identified in 30 (67%) of the 45 cases, of which as many as 13 (43%) sought out specialized help for the purposes of treating the depression. Furthermore, 71% of cases reviewed identified depression as a common risk factor on the risk assessment tool. The presence of alcohol abuse was identified in 21 (47%) of the 45 cases, of which 5 (24%) sought specialized help for alcohol abuse. Interestingly, when examining the data at face value, the findings indicate that the likelihood of seeking help for depression and alcohol abuse was similar to that of perpetrator's seeking help for DV (see Table 4). However, when evaluating the method in which case summary information was identified and coded, critical findings related to the type of help sought by the perpetrator materialized. It is important to note that help-seeking for depression and alcohol abuse were coded based on formal specialized help-seeking, in comparison to help-seeking for DV which was coded based on formal and informal methods of help-seeking. Thus, although Table 4 suggests that help-seeking for DV occurs as frequently as help-seeking for depression, one must also consider the type of help sought (i.e. support of friends vs. specialized treatment) and the way in which it

was sought out (i.e. disclosing abuse to friends vs. directly seeking help from a specialized DV professional (see Table 5).

Table 4: Help Sought for Socially Acceptable Issues vs. DV Help

Perpetrator Sought Help	Reason for Seeking Help		
	For Depression	For Alcohol Abuse	For DV
Yes	13	5	23
No	17	16	22
Total	30	21	45

Table 5: Specialized Help Sought from Formal Systems for Socially Acceptable Issues vs. DV Help

Perpetrator Sought Help	Reason for Seeking Formal Help		
	For Depression	For Alcohol Abuse	For DV
Yes	13	5	0
No	17	16	45
Total	30	21	45

Theme 3: Perpetrator seeks professional and non-professional help for violence but minimal assistance offered

Case #2 (DVDRC, 2004, p.12):

"This case involves the homicide of a woman by her husband. The victim and perpetrator had been married for approximately ten years. They had two children together. The victim was well educated and had become very successful in her position with a large international corporation. Her husband, on the other hand, had been unemployed for most of the marriage, and while he attempted to find jobs, he had been largely unsuccessful.

The victim and perpetrator's marriage began to deteriorate, and in the spring of 2002 they separated. He had unfounded suspicions that his wife was having an affair. At one point, Children's Aid Society was called because the children had been seen wandering around the neighbourhood and appeared to be un-kept and unsupervised. They were, at the time, in the perpetrator's care...

Between the time of separation in the spring and the homicide in the fall of 2002, the perpetrator made several attempts to get back together with the victim. He made excuses to see her and sent her emails requesting that she and the children come home. She refused. They did agree between themselves as to the terms of custody and access to the children. However, during the fall of 2002, they began to have disputes over the division of assets. While the perpetrator had hired a lawyer, the victim did not feel she needed one. She continued to meet directly with her husband to try and resolve the disputes, notwithstanding having several people tell her that he had made threats against her life. His sister called the victim at one point and told her that he had said that he if he found her with someone, he would kill her. He told a counsellor he had been seeing that he was afraid he would snap and strangle her to death. The counsellor called her and warned her of the threat. When told of these threats, she did not convey any sense of concern.

The husband suffered from depression, and at the treatment centre where he was receiving additional counselling, he had completed workbook sketches showing him killing his wife. The workbook also contained written messages expressing thoughts of rage against her because of his belief that she would get everything and he would be left with nothing".

Although only a small percent of perpetrators of DV may actually seek help for their abusive behaviours, it is important to be aware of with whom perpetrators are seeking help and support from, and the frequency of missed opportunities for social networks to help identify and intervene in order to prevent the perpetrator's violent behaviours. In only half (51%) of the 45 cases reviewed, the purpose of seeking help was related to a concern about the perpetration of DV. When reviewing the systems that the perpetrators may have sought help from regarding their abusive behaviour, including non-professionals, a total of 32 systems were contacted (i.e. friend, family, neighbours, mental health professionals, health care professionals, social services, etc.). Of the 32 systems contacted, 14 (44%) were informal systems, and the remaining 18 (56%) were formal systems. Furthermore, analysis of the data revealed that of the 23 cases in which DV help was sought out, 7 (30%) perpetrators sought help from both formal and informal systems, while 8 (35%) sought formal help only and 8 (35%) sought informal help only. If a perpetrator sought help for their violent behaviours, they were about equally likely to seek assistance from both formal and informal systems, or exclusively from either system of support.

Interestingly, the present study also examined the frequency of supports contacted by the victims in the reviewed cases in order to assess the number of missed opportunities in helping end violence against women. Not surprisingly, the victims sought help from nearly five times the number of professional and non-professional systems contacted by

the perpetrators of abuse. Of the 132 systems contacted by the victims for help related to DV, 75 (57%) contacts involved individuals from formal systems, while 57 (43%) contacts involved informal systems. It should be recognized that although as many as 164 independent systems were specifically informed, either by the perpetrator or the victim, about the occurrence of the DV occurring in the relationship, little efforts were made to help intervene and provide the appropriate support and assistance to the perpetrator. In some of these cases, an intervention may have avoided the ultimate tragedy of domestic homicide. The results demonstrated the frequency of missed opportunities to intervene and help end the occurrence of DV, even in circumstances in which DV help was sought out by the perpetrator himself. Furthermore, analysis of the data revealed that as many as 41 (91%) cases involved victims who sought help for DV, of whom 25 (60%) sought both formal and informal help, 8 (20%) sought formal help only, and 8 (20%) sought informal help only. When examining help-seeking behaviours by both partners in the abusive relationship, the perpetrator and victim, statistically significant sex differences emerged ($x^2 = 22.60$; $p = .0005$). Victims were not only more likely to seek help for DV, but they predominantly sought help from both types of systems, formal and informal, almost four times more often than perpetrators (see Table 6).

Table 6: Type of help sought for DV by Perpetrators and Victims

Gender	Help Seeking Behaviours			Total
	No Help Sought	Formal or Informal Help Sought	Both Formal and Informal Help Sought	
Female Victim	4	16	25	45
Male Perpetrator	22	16	7	45
Total	26	32	32	90

With regard to type of help received, a review was conducted on the various forms of treatment options provided and completed by the perpetrators. As mentioned earlier, of the 23 perpetrators who sought help regarding their violent behaviours, as many as 13 (57%) were provided some form of assistance in relation to their abusive behaviours, while an additional two perpetrators completed mandated DV treatment involuntarily. A total of 15 (33%) cases reviewed entailed perpetrators who received some form of help or treatment related to their violent behaviours. Surprisingly, of those who received some form of DV help, only 3 (20%) cases identified perpetrators who received specialized treatment for DV, of which all completed treatment involuntarily. Additionally, a total of 5 (33%) of the 15 obtained help regarding their abusive behaviours by completing anger management treatment, of which again all completed treatment involuntarily. Individual counselling was completed by 4 (27%) of the perpetrators who received help for their violent behaviours, however 3 of which completed treatment voluntarily. For the remaining treatment options, marital counselling and clergy counselling, each type of treatment was sought out voluntarily in 4 (27%) of the cases reviewed.

When reviewing the 23 cases in which help was sought out regarding the perpetration of DV, the data again revealed several influencing factors related to the perpetrator's likelihood of seeking help from a professional or non-professional regarding their domestically abusive behaviours. For example, perpetrators were more likely to seek help for their violent behaviours if involved in a romantic relationship for 1 to 10 years (see Table 7).

Table 7: Length of Relationship vs. Perpetrator Seeking DV Help

Length of Relationship	Did the Perpetrator Seek Help Regarding their Violent Behaviour?		
	YES	NO	Total
0 to .99 years	0	2	2
1 to 10 years	13	11	24
11 to 20 years	5	4	9
20+ years	5	5	10
Total	23	22	45

Perpetrators who were married or cohabitating with the victim at the time of the homicide were also most likely (48%) to seek DV help. With regards to the perpetrator's education level, those who completed high school or further education were more likely (71%) to seek specialized violence treatment when needed in comparison to perpetrators who fostered some high school education or less. In contrast to general help seeking findings, the data indicated that employment status did not significantly influence a perpetrator's likelihood of seeking help for violence. When reviewing the influence of number of children parented by the perpetrator, the data again suggested that the greater the number of children parented by the perpetrator, the greater the likelihood of the perpetrator seeking help for DV (see Table 8).

Table 8: Number of Children vs. Perpetrator Seeking DV Help

Number of Children	Did the Perpetrator Seek Help Regarding their Violent Behaviour?		Total
	YES	NO	
No children	4	6	10
One child	5	4	9
Two or more children	14	12	26
Total	23	22	45

In addition to various demographic variables, it is important to discuss the influence of presenting risk factors with regards to the probability of a perpetrator seeking help for their violent behaviours. To begin, the overall level of risk from the risk assessment conducted in each case summary was examined in order to determine the

likelihood of seeking help when several risk markers were present. Not surprisingly, the data suggested that high risk perpetrators were more likely (83%) to seek help regarding their violent behaviours, in comparison to low risk perpetrators. Next, the top three common risk factors found in the cases reviewed were examined in order to determine the influence such variables had on the perpetrator who sought help for their abusive behaviours. It should be noted, 20 (87%) of the 23 cases, in which DV help was sought, presented the most common risk factor, actual or pending separation. The second most common risk factor, prior history of DV, was present in 19 (83%) of the cases. Lastly, the third most likely risk factors present in the cases reviewed, escalation of violence, was present in 17 (74%) of the cases, and depression was found in 18 (78%) of the cases. Therefore, the data suggested that the larger the number of risk factors present in the life of a perpetrator, the greater the likelihood of seeking help for violent behaviours.

Inter-Rater Reliability

A random selection of five cases was chosen to report on inter-rater agreement in eliciting information from case summaries for the purposes of the coding instrument. Two independent raters coded the subset of cases, yielding a 92% overlap in the agreement on data coding.

Discussion

The purpose of the present study was to investigate and better understand male batterer's help-seeking behaviours. This was achieved by examining the factors which influence help-seeking behaviours, and the prevalence of helping professional's lack of awareness to assess and treat individual's DV. Given the limited amount of research on male batterer's help-seeking behaviours, an exploratory methodology was utilized in

order to gain preliminary information on such matters. The study involved an extensive review of domestic homicide case summaries as reviewed by the DVDRC of Ontario during 2003 to 2007. The summaries provided details regarding the perpetrator's help-seeking behaviours, a population that is typically known to possess a history of abusive behaviours. Based on previous literature which examined barriers to help-seeking behaviours, and consistent with Kushner and Sher's (1989) Approach-Avoidance Conflict Model, it was predicted that perpetrators of DV would be more likely to seek help for more socially acceptable issues, such as depression or alcohol abuse, in comparison to issues related to DV. Furthermore, it was predicted that even when perpetrators present more socially acceptable issues to those in the helping profession, that helpers were not identifying or providing an intervention for the underlying issue of violent behaviours.

Presenting Themes

Upon review of the study findings, three major themes related to perpetrator's help-seeking emerged from the data. Firstly, some perpetrators of DV chose not to solicit any kind of help from others. As many as 9 (20%) cases reviewed involved a perpetrator who did not seek help from professionals or non-professionals. Perhaps for these individuals, social barriers played a part in prohibiting their help-seeking behaviours. For example, if the perpetrator endorsed traditional masculine ideologies, they may have held negative attitudes towards seeking help (Rochlen, Land, & Wong, 2004). Furthermore, social norms could have been a factor in preventing these perpetrators from reaching out and seeking help. As discussed earlier, an innate fear of being judged by others as a result of going against social norms may have prohibited help-seeking behaviours

(Sibicky & Dovidio, 1986; Nelson & Barbaro, 1985). It may have been a result of certain attitudes and beliefs of family and friends which influenced how the perpetrator viewed his abusive behaviours (Cusack et al., 2004). Regardless of the reasons in which no help was sought, it is critical to recognize the influence and role of non-professionals in encouraging and facilitating perpetrators to seek the appropriate support regarding their abusive behaviours.

The second theme which surfaced from the present study findings related to perpetrator's general help-seeking behaviours. When perpetrators actually sought help from professionals, the majority did so for reasons other than addressing their violent behaviours. Although the data indicated that perpetrators of DV are just as likely to seek help for DV as compared to seeking help for more socially acceptable issues such as depression or alcohol abuse, these results must be further examined. When the researcher coded a perpetrator as "sought help for DV", behaviours such as disclosing the perpetration of abusive behaviours or seeking help from informal systems was coded as help-seeking behaviours. Given the private nature of DV, it was important that the researcher recognize that any form of disclosure or discussion regarding abusive behaviours to non-professionals may have been an attempt of getting some type of help or assistance. Therefore, informal help-seeking was recognized and coded as "sought help for DV", even though the perpetrator may not have been directly seeking specialized professional help for DV. Of the 23 perpetrators who sought help for DV, none voluntarily pursued or completed treatment options specializing in DV. When coding help-seeking related to depression or alcohol abuse, all such cases involved perpetrators seeking specialized formal treatment or help. The perpetrator was frank and direct in

seeking the specific resources required in order to receive appropriate professional treatment specific to depression or alcohol abuse. Due to the limited information provided in the case summaries, and the fact that the general content of the summaries focused specifically on factors related to the perpetrator's violent behaviours, the researcher was unable to code perpetrator's help-seeking from informal systems for socially acceptable issues. When evaluating the prevalence of help-seeking from formal systems only, perpetrators were much more likely to openly seek out specialized professional help for more socially acceptable issues versus issues related to DV. This concept may be best understood using the Approach-Avoidance Conflict Model (Kushner & Sher, 1989). The model suggests that even if perpetrators decide to seek help for DV, it may be as a result of their increasing distress of disclosing socially unacceptable problems that in turn avoidance behaviours become increasingly stronger. Therefore, perhaps perpetrators would be more likely to seek specialized DV help if such behaviours were more encouraged and accepted by society at large.

The third and last theme related to professional and non-professional's inadequacy in assessing and intervening when a perpetrator discloses a concern regarding DV. Of the 23 cases in which the perpetrator sought help for DV, as many as 13 received some form of intervention or treatment. However, it is critical to note that of the cases in which help for violent behaviours was provided to the perpetrator, treatment options most specialized in DV were all completed involuntarily, in comparison to voluntary participation with what may be considered more socially acceptable forms of treatment (i.e. individual counselling, marital counselling, clergy counselling). Therefore, for all the cases in which help was sought out regarding the issue of violent behaviours,

specialized DV help was never offered or completed in order to appropriately address and stop the abusive behaviours. It may be the case that professionals or helpers are ill prepared to identify and discuss these underlying issues, and thus lack the ability to refer perpetrators to appropriate types of specialized DV treatment or help. As Alpert suggested "The ability of most health professionals to effectively identify, assess, and respond to domestic violence has lagged far behind societal awareness and community responses" (2007, p.666). Perhaps professionals have a tendency to minimize the overall level of risk or danger of the perpetrator in committing future abuse, and as a result believe less specialized forms of treatment are all that is required in order to help cease such individuals from perpetrating abusive behaviours. In any case, if perpetrators are actively seeking help for DV, it is critical that these systems not fail such individuals and thus professionals must be adequately prepared to provide appropriate referrals for specialized DV treatment.

Major Influencing Factors

Apart from the common themes which surfaced when reviewing the present study findings, further data analysis also revealed some important factors which may influence a perpetrator's likelihood of seeking help for DV. Demographic details such as the perpetrator's age, education, employment status, marital status, and length of relationship all had an influence in perpetrator's help-seeking behaviours. For example, an older perpetrator, who has achieved at least a high school education, is married or co-habitating for a period of 1 to 10 years, and is employed either full time or part time, is a very likely individual to seek help for DV. That being said, although such factors have been found to influence one's likelihood of seeking help for DV, it is important to recognize that

these factors alone do not equate to the assurance that perpetrators will seek and receive the required help and support

What was most interesting to uncover was the influence of number of children parented by the perpetrator at the time of the homicide. The findings suggest that, in relation to both general and specialized DV help-seeking behaviours, the greater the number of children, the more likely help may be sought by the perpetrator. Perhaps it is common sense to assume that as the number of children parented by an individual increases, so too does the parent's sense of responsibility, thus being more likely to seek help for DV when help is needed. However, what is most critical to note from this finding is the unique opportunity for systems involved with children (i.e. Child Protective Systems, such as Children's Aid Society) to assess and intervene when there is reason to suspect the perpetration of DV. If the number of children in a perpetrator's life increases the perpetrator's likelihood of being open and willing to seek or accept help for DV, then human services involved with children should take advantage of the opportunity of having contact with perpetrator's whom are likely to accept help for their abusive behaviours.

Role of Professionals

With regards to the role of professionals, the findings further suggest that when perpetrators sought general help from professionals, their violent behaviours were rarely identified and as a result very few interventions took place for the underlying issue of abusive behaviours. For example, the perpetrator's violent behaviours were identified in only 18% of the cases in which contact was made with a professional for general purposes. As a result of this discovery, the researcher conducted further analysis on

specific professional systems in order to determine the frequency of missed opportunities to identify and help perpetrators cease their abusive behaviours. When perpetrator's were in contact with professionals as a result of seeking general help, mental health professionals appropriately identified the abusive behaviours in only one in six cases, while health care providers identified the violence in as few as one in eight cases. Furthermore, research by Gerbert et al. (2002) also supported this finding in demonstrating that health professionals have typically ignored the presentation of DV, and worst yet have avoided taking responsibility to intervene to provide help and treatment to those perpetrating DV. Such systems are in an optimal position to help prevent future perpetration of DV given their contact with perpetrators, knowledge, and ability to refer to appropriate resources. However, human services have been slower to identify violence against women given that they frequently overlook discussing the presence of abusive behaviours.

Implications

The present study findings suggest that helping professionals may overlook identifying the perpetration of abusive behaviours, and thus have missed opportunities to intervene and provide help and treatment to male batterers. The findings bring to light the importance of training professionals on the ways in which they can help male perpetrators of DV. In order to begin to help a batterer arrest their abusive ways, professionals need to first know how to recognize and identify the risk or presence of violent behaviours. Once professionals become skilled at identifying the perpetration of DV, they must acquire the proficiency of adequately assessing the perpetrator's level of risk of harming their intimate partner or subsequent family members. Lastly, once it is

determined that an individual is at risk of perpetrating DV, professionals must be capable of providing risk management skills and community referrals to appropriate agencies, making specialized help for DV available to the perpetrator. In order for professionals to adopt such knowledge and skills, opportunities such as academic programs, workshops, training sessions, conferences and other learning resources must take the responsibility of teaching professionals how to identify, assess, and intervene when required in order to help male batterers address their issue of violent behaviours. Human services such as social services, health care and mental health care are some of the most critical systems to address and provide training given their increased likelihood of being in contact with male batterers. The importance of such training is highlighted in the study findings which suggest that high risk perpetrators of DV are most likely to seek general help from formal systems of support. Thus, the greatest missed opportunity to identify, assess, and intervene with perpetrators occurs when high risk perpetrators seek formal help, and as a result numerous identifying risk factors related to the possibility of DV are present, yet professionals are overlooking the perpetration of DV.

Apart from professional's role in helping end woman abuse, it is also important not to forget the influence of non-professionals in the help-seeking process. As the present study findings suggest, perpetrators may be just as likely to seek help from both professionals and non-professionals. Additionally, close family members and friends are generally aware of the occurrence of violence within an intimate relationship but do very little to help cease the abuse. For example, a 2007 Father's Day poll was conducted in the United States which questioned men about their awareness and knowledge related to the victimization of DV (Family Violence Prevention Fund & Verizon Wireless, 2007).

Results of the poll indicated that one-quarter of the men were aware of a family member, friend, and/or an acquaintance that had experienced some form of woman abuse. Consequently, both professionals and the general public must be informed and better educated on the ways in which one can assist and prevent future perpetration of DV. Therefore, in addition to implementing DV training for professionals, it is also critical that educational campaigns and intervention initiatives develop in order to equip both professionals and non-professionals with the appropriate tools to effectively engage with male perpetrators of DV.

Presently there are few resources and campaigns directed at encouraging society and professionals to approach male batterers in order to provide the necessary help and support for their violent behaviours. The *White Ribbon Campaign* is one of the founding educational campaigns and the largest effort in the world which targets men and boys by addressing their role in arresting violence against women. The campaign was established in 1991 and its primary role is to educate the general public by challenging others, educating the young, raising public awareness, and working with other organizations to involve men and boys (White Ribbon Campaign, 2005). The campaign emphasizes engaging and discussing DV with men and boys, in order to both prevent future violence against women and to encourage engaging and helping perpetrators or non-perpetrators who are at risk of abusive behaviours. Another campaign developed in Australia in 1998, the *Freedom from Fear Campaign against Domestic Violence*, had a similar goal of reducing and preventing DV by addressing the source of the problem, male batterers (Freedom from Fear Campaign against Domestic Violence, 1998). Lastly, the *Neighbours, Friends, and Family Campaign*, established in London, Ontario in 2006, was

created to provide public education on how to effectively intervene and engage with known male batterers (Neighbours, Friends, and Family, 2007). Nevertheless, even though campaigns such as these address how to speak to perpetrators of DV, to date there has been little research in learning and better understanding how effective these campaigns are in helping overcome batterer's resistance to seeking help.

Limitations of the Study's Design

Although the present study revealed some interesting and important findings, there are a few limitations to be addressed as a result of the exploratory nature of the study design. To begin, one very crucial limitation of the present study was the possibility of missing information as a result of conducting file reviews from case summaries. Due to the fact that the researcher did not have the ability to question or speak to the perpetrators themselves, no clarification of any missed or wrongfully interpreted information was possible. If pertinent information related to the study focus had been neglected when putting together the summaries, there was no alternate ways in which the researcher could have gained access to that information. However, the summaries contained reports from police interviews with friends, family, and professionals, providing the researcher with a broad spectrum of information from various reliable sources.

An additional limitation to the present study relates to the use of domestic homicide cases. Given the fact that domestic homicide cases provide the researcher with the most extreme cases of DV, the representativeness of the study findings cannot be generalized to the male battering population as a whole. Furthermore, it is important to note that the ratio of homicide versus homicide-suicide cases reported in the present

study did not reflect the norm reported in the DVDRC's annual reports. Typically, annual reports are comprised of roughly 60% homicide cases, with only 30% of the cases being homicide-suicide. However, due to the inclusionary and exclusionary criteria set out in the present study, 64% of the cases reviewed were identified as homicide-suicide. Again, the generalizability of the study findings is limited. Lastly, the researcher dealt strictly with cases in which society lacked in providing adequate help and support in order to avoid the ultimate tragedy of domestic homicide. It would have been beneficial for the researcher to compare the study findings with perpetrators who actually sought, received and benefited from formal and informal help for DV. That being said, the present study findings are important to consider given that the cases reviewed represented a sample of individuals in which multiple warning signs and risk factors were present, yet existing systems failed to prevent the ultimate tragedy of domestic homicide. The study provided an initial starting point of analysis in order to provide a basis for future research.

Recommendations for Future Research

Although noteworthy results were discovered in the present study, given the prevalence of DV and the limited amount of research to date on male batterer's help-seeking behaviours, it is crucial that further research be conducted in order to appropriately provide support and interventions to perpetrators of abuse. Moreover, to enhance the reliability and validity of the present study findings, future studies should involve going directly to the source, male batterers, in order to determine how to provide support with the hopes of serving as a significant step towards achieving the goal of ending DV. Additionally, subsequent research will inform the development of future public education campaigns which extend to both male batterers and their friends and

families, in addition to professionals, to educate and inform the ways in which one can encourage men to talk about and seek help for their violent behaviours. Lastly, future research on this topic could lead to the development of effective screening tools and assessment methods for identifying male batterers in order to determine the presence and severity of DV.

Summary

In conclusion, although it is important that agencies and communities support abused women, it is also critical that society go right to the source of the issue in order to try to implement change. As the present study suggested, victims of DV are receiving attention and help in order to promote their safety and health, but the perpetrators of abuse are being overlooked by both helping professionals and researchers, even though they are the primary problem at hand. This study promotes the development of intervention initiatives and educational campaigns in order to begin to actively address the issue of help-seeking by perpetrators of DV. Without such efforts, the fight to end woman abuse is bleak as a result of never truly ceasing the abuse from occurring, but simply applying a bandage approach to a likely preventable issue.

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Appendix A: Coding Instrument

Date: _____

Participant Code: _____

Gender	
Age	
DOB	
DOD (if applicable)	
Marital status	_____ Single (never married) _____ Married or cohabitating _____ Separated/divorced
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 DV 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 DV 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 DV 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:	

History of Help Seeking

Did the perpetrator seek help for any problem? If yes, what type of help?
(Check all those that apply)
Police: _____
Courts: _____
Health Care provider: _____
Mental Health provider: _____
Family members: _____
Clergy: _____
Friends: _____
Co-workers: _____
Neighbours: _____
Shelter/other DV program: _____
Family Court: _____
Social services: _____
Child protection: _____
Legal counsel/legal services: _____
Other – specify _____

History of DV

Were there prior reports of DV 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
___ Health Care provider
___ Mental Health provider
___ Family members
___ Clergy
___ Friends
___ Co-workers
___ Neighbours
___ Shelter/other DV program
___ Family court (during divorce, custody, restraining order proceedings)
___ Social services
___ Child protection
___ Legal counsel/legal services
___ Other – specify _____

Did the perpetrator receive help for his violent behaviours? ___ Yes ____ No
If yes, how was help sought out?
____ Self disclosure (looked for help on his own)
____ Someone noticed (hindsight – help provided after violence recognized by others)

How was help sought out?
___ Voluntarily
___ Non-coerced by partner
___ Coerced by partner ("I'm leaving")
___ Ordered by Court

History of Victim Help Seeking

Did the victim seek help related to the DV? If yes, what type of help?
(Help seeking not related to perpetrator's involvement)
(Check all those that apply)
Police: _____
Courts: _____
Health Care provider: _____
Mental Health provider: _____
Family members: _____
Clergy: _____
Friends: _____
Co-workers: _____
Neighbors: _____
Shelter/other DV program: _____
Family Court: _____
Social services: _____
Child protection: _____
Legal counsel/legal services: _____
Other – specify _____

Agencies/Institutions

Were any of the following agencies involved with the perpetrator during the time in which DV was occurring?

Criminal Justice/Legal Assistance:

Police
Describe: _____
_____
_____
Number of times in contact? _____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Crown attorney

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Defence counsel

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

Court/Judges
Describe:_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

Corrections
Describe:_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

Probation
Describe:_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____
_____
_____

Parole
Describe:_____
_____
_____
Number of times in contact?_____ Over how many years? _____
Outcome:_____
_____
Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____
_____
_____

Family court
Describe:_____
_____
_____
Number of times in contact?_____ Over how many years? _____
Outcome:_____
_____
Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____
_____
_____

Family lawyer
Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____

_____

_____

Victim Services (including DV services)

Community based legal advocacy
Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____

_____

_____

Children services

School
Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Supervised visitation/drop off center

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Child protection services

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Health care services

Mental health provider (psychiatrist, psychologist, counselor, therapist, etc.)
Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____

_____

_____

Health care provider (physician, nurse, specialist, etc.)
Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____
Outcome:_____

_____

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____

_____

_____

Regional trauma center
Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Local hospital

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Ambulance services

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Other Community Services

Anger management program

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Perpetrator's intervention program

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know

___ Don't ask

___ Asked, but no assessment of extent of risk or intervention

___ Asked and assessed extent of risk, but no intervention

___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Marriage counselling

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Substance abuse program

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

_____

_____

Religious community

Describe:_____

_____

_____

Number of times in contact?_____ Over how many years? _____

Outcome:_____

_____

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened

If intervened, what type of intervention was provided?

_____

Immigrant advocacy program
Describe:

Number of times in contact? Over how many years?
Outcome:

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

Animal control/humane society
Describe:

Number of times in contact? Over how many years?
Outcome:

Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

Cultural organization
Describe:

Number of times in contact? Over how many years?
Outcome:

Was violent behaviours assessed or identified?

___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____
_____
_____

Fire department
Describe:_____
_____
_____
Number of times in contact?_____ Over how many years? _____
Outcome:_____
_____
Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____
_____
_____

Homeless shelter
Describe:_____
_____
_____
Number of times in contact?_____ Over how many years? _____
Outcome:_____
_____
Was violent behaviours assessed or identified?
___ Don't know
___ Don't ask
___ Asked, but no assessment of extent of risk or intervention
___ Asked and assessed extent of risk, but no intervention
___ Asked and assessed extent of risk and intervened
If intervened, what type of intervention was provided?

_____
_____
_____

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 DV
____ 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 DV as child
____ Other factors that increased risk in this case? Specify: _____

Comments:

Appendix B: Letter of Permission by the Chief Coroner

Regional Supervising Coroner
Central Region
24 Queen Street East, Ste 700
Brampton ON L6V 1A3

Telephone:
Facsimile:

Coroner Superviseur Régional
Région du Centre
24, rue Queen, Est, Ste 700
Brampton ON L6V 1A3

Téléphone:
Télécopieur:

December 21, 2007

Dr. Peter G. Jaffe
Professor, Faculty of Education
1137 Western Road, Room 118
Faculty of Education Building
The University of Western Ontario
London ON N6G 1G7

Re: Research Proposal regarding "Barriers to Male Batterers' Help-Seeking Behaviours"

Dear Dr. Jaffe:

As I indicated to you in our conversation of December 19th, although the Office of the Chief Coroner is supportive in principle of this research project, regrettably we are not able to allow it to proceed at this time in the manner that you had initially proposed.

As you are aware, our Office is currently under severe constraints pertaining to manpower, physical space and resources. The Chief Coroner has therefore decided that no research projects will be undertaken at our Head Office for the foreseeable future, at least until the end of March 2008.

As Chair of the DVDRC, I am prepared to allow Ms. Guay to have access, through you and off-site, to electronic copies of the final reports on the cases that have been reviewed, in order to allow her to do some preliminary analyses. Although I cannot personally guarantee if or when she might have an opportunity to review the complete case files in our possession, we may be in a better position to re-evaluate the situation some time after the end of March.

Our Office provides this modified approval based on the following understanding:

1. Ms Guay will take an oath of confidentiality in regards to her access to the information about DVDRC cases.
2. She will be supervised by yourself, and any electronic transmission of committee reports will be from our office to you, as a member of the Committee. You in turn may provide them to Ms. Guay.
3. She will not impact on our current resources of physical space or personnel by remaining off-site.

4. All personal information pertaining to the decedents or any parties involved in the cases remains in our Office and any coding done protects the identity of individuals being studied.
5. Access to the electronic final reports will be coordinated through our administrative assistant, Julie McCreary.

Yours truly,

William J. Lucas, MD CCFP
Regional Supervising Coroner
Central Region

WJL/vgm
cc. Ms. Julie McCreary

Appendix C: Ethics Review Board Approval Form

THE UNIVERSITY OF WESTERN ONTARIO
FACULTY OF EDUCATION

USE OF HUMAN SUBJECTS - ETHICS APPROVAL NOTICE

Review Number: 0805-1
Applicant: Jenny Neil
Supervisor: Peter Jaffe
Title: *Barriers to male batterer's help-seeking behaviours: A retrospective case analysis of domestic homicides*
Expiry Date: May 31, 2009
Type: MEd Thesis
Ethics Approval Date: June 12, 2008
Revision #:
Documents Reviewed & Approved: UWO Protocol

This is to notify you that the Faculty of Education Sub-Research Ethics Board (REB), which operates under the authority of The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects, according to the Tri-Council Policy Statement and the applicable laws and regulations of Ontario has granted approval to the above named research study on the date noted above. The approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the REB's periodic requests for surveillance and monitoring information.
No deviations from, or changes to, the research project as described in this protocol may be initiated without prior written approval, except for minor administrative aspects. Investigators must promptly report to the Chair of the Faculty Sub-REB any adverse or unexpected experiences or events that are both serious and unexpected, and any new information which may adversely affect the safety of the subjects or the conduct of the study. In the event that any changes require a change in the information and consent documentation, newly revised documents must be submitted to the Sub-REB for approval.

for Dr. Jason Brown (Chair)

2007-2008 Faculty of Education Sub-Research Ethics Board

Dr. Jason Brown	**Faculty (Chair 2008)**
Dr. Elizabeth Nowicki	**Faculty**
Dr. Jacqueline Specht	**Faculty**
Dr. Wayne Martino	**Faculty**
Dr. J. Marshall Mangan	**Faculty**
Dr. Immaculate Namukasa	**Faculty**
Dr. Robert Macmillan	**Assoc Dean, Graduate Programs & Research** (*ex officio*)
Dr. Jerry Paquette	**UWO Non-Medical Research Ethics Board** (*ex officio*)

The Faculty of Education
1137 Western Rd.
London, ON N6G 1G7

Karen Kueneman, Research Officer
Faculty of Education Building

Copy: Office of Research Ethics