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Prior Help-Seeking and Intuition of Danger in Domestic Homicide Victims.

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

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Abstract

Domestic violence and homicide can be reduced when victims seek effective and timely assistance or friends, family and community professionals offer support. One important factor in help-seeking is a victim's intuitive sense of fear. Several factors related to this fear were examined including the presence of children in the home, perpetrator's controlling behaviours, and mental health and/or addiction concerns of victims of DH. A retrospective case analysis was performed using domestic homicide case data reviewed by the Domestic Violence Death Review Committee (DVDRC) in Ontario, Canada. Victims who displayed an intuitive sense of fear were compared to victims who did not display an intuitive sense of fear. A major finding of the current study was when victims experienced an intuitive sense of fear, they disclosed the abuse to a friend more often than victims who did not experience an intuitive sense of fear. In addition, victims who were fearful of their perpetrators were exposed to higher numbers of risk factors than victims who did not possess an intuitive sense of fear. These victims would disclose their abuse to co-workers and neighbours more often than victims who did not experience an intuitive sense of fear. This study demonstrates the complexity of victim's intuitive sense of fear, and their informal and formal help-seeking behaviours while highlighting the powerful role of presence of children, perpetrator's controlling behaviours, and victim mental health and/or addiction concerns can have on victim's intuitive sense of fear. The implications for public awareness and professional training are outlined.

Keywords: domestic violence, domestic homicide, intuitive sense of fear, help-seeking, formal, informal.

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I would like to begin by expressing my gratitude to my advisor, Dr. Jaffe – thank you for being so attentive, diligent, and most importantly hilarious. You made the process of writing a thesis beyond enjoyable, and your relentless support is something that I will forever reflect fondly on. You truly know how to motivate your students while maintaining an aura that is welcoming and compassionate, and I am so grateful that I could work under your seemingly unlimited wisdom.

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Violence against women is a topic that I hold dear to my heart and has continuously provided me with the motivation to write this thesis. My humbled aspiration is for DV survivors

to benefit from this study, and I am so grateful for this opportunity to positively influence the lives of survivors who are experiencing violence.

Table of Contents

Abstract……………………………………………………………...………………………i

Acknowledgements……………………………...………...……………………………...ii

List of Tables.....................…………………………...……...…...……………….....……vii

List of Appendices.........………………………………...………...………………..………viii

Prior Help Seeking and Intuition of Danger in Homicide Victims………………………………1

What is Domestic Violence……………………………………………………………………2

What is Intuitive Sense of Fear and Help-Seeking Behaviours…………………………..………..3

Literature Review……………………………...…………………………………………5

History of the Domestic Violence Death Review Committee (DVDRC)……………………...5

Risk Factors of Domestic Homicide....................……………....…...……..…………...6

Where Do Victims Go to Get Help? ....………………………………..…............8

Barriers for Seeking Help....................……………………………...……...…...…..10

Origins of Intuitive Sense of Fear……………………………………………………..12

Fear: Present....................…………………………...……...…...……….13

Fear: Present not Expressed....................……………………………….....……14

Fear: Absent....................……………………………...……...…...………..15

Summary of Victim's Intuitive Sense of Fear…………………………………………...16

Mental Health Concerns, and Addictions……………………...……………………...17

Depression..................……………………………...……...…...……………18

Post-Traumatic Stress Disorder..................……………………………….....…18

Addiction Concerns.................................……………………………….....…19

Perpetrator's Controlling Behaviours and Victim's Fear…………………………..……19

The Impact of Children on DV and DH…………………………..…………………….20

Formal and Informal Help-Seeking.......……………………………...……...…........23

Formal Help-Seeking.......……………………………...……...…....................23

Informal Help-Seeking.......……………………………...……...…..................24

Rationale of Current Study......27

Current Study......28

Methodology......30

Design......30

Data Collection......31

Participants......31

Materials......31

Procedure......33

Results......33

Statistical Analyses......33

Sample Characteristics......34

Intuitive Sense of Fear and Risk Factors......35

Victim Intuitive Sense of Fear and the Presence of Children in the Home......36

Victim Intuitive Sense of Fear and Informal/Formal Help-Seeking Behaviours......37

Victim Intuitive Sense of Fear and Perpetrator's Controlling Behaviours......40

Victim Intuitive Sense of Fear and Mental Health Concerns and/or Addictions......41

Perpetrator's Controlling Behaviours as a Moderating Variable......43

Discussion......43

Will the Number of Risk Factors Present Influence Victim's Sense of Fear?......44

Will Victim's Sense of Fear Influence their Formal/Informal Help-Seeking?......46

Informal Help-Seeking......46

Formal Help-Seeking......48

Children in the Home and Victim Intuitive Sense of Fear......49

Perpetrator's Controlling Behaviours and Victim Intuitive Sense of Fear......49

Victims who Experience Mental Health Concerns and Fear......51

Victims who Experience Addiction Concerns and Fear......51

Implications......52

Future Research and Practice……….......…..…............…………………………….55

Limitations……….......…..…............……………………………………………..57

Conclusion……….......…..…............……………………………………………..60

References……….......…..…............………………………………………………..…….62

List of Tables

Table 1: T-Test Results for Number of Risk Factors on Victim's Fear…………………………..35

Table 2: Top Ten Risk Factors Where Victim's Fear was Present/Not Present…………………35

Table 3: Chi-Square Results for Presence of Children on Victim's Fear………………………..37

Table 4: Chi Square Results for Informal Help-Seeking and Victim's Fear…………………….39

Table 5: T-Test Results for Formal Help-Seeking and Victim's Fear…………………………...40

Table 6: Chi Square Results for Perpetrator's Controlling Behaviours on Victim's Fear…..…...41

Table 7: Chi Square Results on Mental Health/Addictions on Victim's Fear…………………...42

Table 8: Moderation of Perpetrator's Controlling Behaviours on Victim's Fear and Friends…..43

List of Appendices

Appendix A: Non-Medical Research Ethics Board Study Approval Notice……………………….69

Appendix B: Domestic Violence Death Review Committee Risk Factor Coding Form………...70

Appendix C: Domestic Violence Death Review Committee Risk Factor Descriptions…………73

Appendix D: Domestic Violence Death Review Committee Data Summary Form……………..78

Appendix E: Curriculum Vitae…………………………………………………………………..93

Prior Help-Seeking and Intuition of Danger in Homicide Victims

Violence against women is a major public health problem, and a violation of women's human rights (WHO, 2017). Often, domestic homicides appear predictable and preventable because of the number of warning signs present prior to the homicide (Juodis, Starzomski, Porter, & Woodworth, 2014). This study will focus upon one of these risk factors – victim's intuitive sense of fear. Prior research suggests that victim's intuitive sense of fear is present in roughly half of instances of domestic homicide (Campbell et al., 2003) with victims engaging formal and informal sources of support. Informal sources of support may include friends or family, and formal sources of support may be police or community services. Despite prior literature, little is known about the differences between victims who experience fear, and those who do not. This study sought to examine the findings from a Domestic Violence Death Review Committee to explore these differences between groups and investigate how fearfulness may impact help-seeking behaviours, and the association with other identified risk-factors. Additional factors that may increase or limit help-seeking behaviours are investigated such as the presence of children, victims' mental health concerns, and perpetrator's controlling behaviours.

This study was guided by a feminist perspective, with the intention to keep women safe who are at an elevated risk of lethality. This study advocated for women who may be experiencing systemic barriers when seeking to decrease their elevated risk and originated from a perspective that supports societal and systemic processes that hold perpetrators accountable. The feminist perspective which guided this study supports community education targeting men who are at an elevated risk to perpetrate, and perpetrators who choose to act violently towards their victim.

What is Domestic Violence?

The effects of domestic violence have been well documented by researchers around the world, with one in three of all women experiencing domestic violence by their perpetrator and as many as 38% of murders of women being an act of domestic homicide (WHO, 2017). A study investigating the number of domestic homicides in Canada between 2010 and 2015 reported that 337 women died as a result of domestic violence (CDHPI, 2018). These powerful findings depict a societal issue that has had a measurable impact on the health and economic well-being of individuals and society both in the present and for subsequent generations (Statistics Canada, 2014). This study utilized the Ontario Domestic Violence Death Review Committee data which focused on victims of domestic violence (DV) and will define DV as “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours” (WHO, 2016).

The risk towards victims who are exposed to DV is extensive, with victims potentially finding themselves at risk for developing mental health concerns such as depression, post-traumatic stress, anxiety disorders, sleep difficulties, eating disorders, and suicide attempts (WHO, 2017). In addition to the risk of developing mental health concerns, exposure to DV can have fatal consequences on victims, and may lead to outcomes such as domestic homicide or suicide (WHO, 2017). Domestic homicide (DH) can be defined as “all homicides that involve the death of a person, and/or his/her child(ren) committed by the person’s partner or ex-partner from an intimate relationship” (DVDRC, 2016). DH can unfold in different ways including Homicide/Suicide, where a perpetrator commits DH, and then completes suicide (Knoll & Hatters-Friedman, 2015). Although many articles describe instances of Intimate Partner

Homicide or Intimate Partner Violence, this study will hereafter use the terms Domestic Violence and Domestic Homicide as it is consistent with DVDRC annual reports and data.

What is Intuitive Sense of Fear and Help-Seeking Behaviours?

Research concerning women's formal help-seeking for domestic violence is relatively sparse despite victims of DV citing fear for their lives and their children's lives as barriers to seeking formal help (Leone, Lape, & Xu, 2014). Given this gap in the literature field, this study aims to investigate victim's intuitive sense of fear, and their help-seeking behaviours. This study utilizes Domestic Violence Death Review Committee data, which has outlined 40 risk factors that may be associated with domestic homicide including Victim's Intuitive Sense of Fear. According to the DVDRC, victim's intuitive sense of fear is understood as a victim who "knows their perpetrator best and can actively gauge his level of risk" (DVDRC, 2016). Victim's intuitive sense of fear is also understood as the woman communicating her fearfulness to others of the perpetrator harming herself or her children. Victim's fear is intuitive because victims may be aware that future violence is possible but may not be able to articulate this fearfulness to others. Given prior research on victim help-seeking, there is an identified need for more investigation on victim's intuitive sense of fear and the absence of help-seeking behaviours.

Some victims may engage in help-seeking behaviours when feeling fearful which includes seeking support from their formal and informal sources of support. Victims who sought support engaged in help-seeking behaviours, which can be defined as "the act that a victim may engage in, when attempting to seek help from the abusive relationship they find themselves in" (DVDRC, 2016).

In contrast, an area that requires additional research are victims who do not engage in help-seeking behaviours despite recognizing their elevated risk while feeling fearful of their perpetrator. This can be attributed to a number of different factors such as feelings of hopelessness, depression, or fearfulness of perpetrator retaliation and the gap in the literature requires investigating (Leone, Lape, & Xu, 2014).

Victims who display fearfulness but do not engage in help-seeking behaviours may have their experience understood through a physical and emotional approach. Fearfulness can be understood as an emotional reaction to something that threatens security or safety and can physically create a Fight, Flight or Freeze response (Lamia, 2011). This system has evolved to support human beings in responding to a variety of threats in their environment (Skinner, Edge, Altman, & Sherwood, 2003). Within the context of this study, victims of domestic violence may perceive DV as threatening and may display Fight, Flight or Freeze responses. Fight or Flight can be defined as "the state in which the body prepares to fight or flee during the presence of a stressful event" (Merriam-Webster, 2018). In contrast a victim that is fearful of her perpetrator may not seek help during DV – otherwise known as "freezing". Freezing can be understood as a response to involuntary engagement, where behaviour is stilled, and attention is compelled toward the stressful transaction (Skinner, Edge, Altman, & Sherwood, 2003).

Cognitive Theory and Trauma Theory serve as the theoretical basis as well as provide the reader with a conceptual understanding of this study's findings. Cognitive Theory can be understood as the cognitive process victims of DV undergo as they identify their help-seeking pathways available to them. This theory helps the reader understand how victims engage in the help-seeking process. Trauma Theory can be understood as the aftermath of DV and how the

victim is impacted. By repressing feelings of violation in their DV relationship, victims may suffer from mental health concerns which can inhibit their help-seeking behaviours.

Literature Review

History of the Domestic Violence Death Review Committee (DVDRC)

Information on risk factors has developed from large scale retrospective studies of DV homicides such as Campbell et al. (2003) which looked into almost one thousand cases that did not result in DH. In addition, more information on risk factors has emerged out of the development and research by DVDRC's around the world, including in Ontario.

After the DH of Arlene May in 1996 and Gillian Hadley in 2000, the Domestic Violence Death Review Committee of Ontario (hereafter referred to as the DVDRC) was established in 2002. The purpose of this committee was to assist the Office of the Chief Coroner in the investigation and review of deaths that occur as a result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances (DVDRC, 2016).

When a domestic homicide, or a homicide-suicide occurs in Ontario, the Regional Supervising Coroner notifies the DVDRC and basic case information is recorded. Case review can begin once judicial and other proceedings have ended (DVDRC, 2016). Once case review is able to commence, the case file is assigned to a reviewer who reports their findings to the DVDRC. Case files may contain records from sources such as Children's Aid Society, healthcare professionals, counselling professionals, courts, probation and parole, etc. (DVDRC, 2016). The reviewer for the case will conduct a thorough analysis of the facts within the case and present their findings to the DVDRC with the objective to develop a comprehensive understanding why domestic homicides occur, and how they can be prevented (DVDRC, 2016). The DVDRC

maintained consistency in the review process by creating definitions to help assist in the identification of risk factors. These definitions assist the committee when making the determination whether there was a presence of a risk factor or not in a specified case (Dawson, Jaffe, Campbell, Lucas, & Kerr, 2017). Presently, there are 40 identified risk factors to DH. These risk factors were identified by the DVDRC as having prior research demonstrating an association between them and domestic homicide or domestic violence recidivism.

Risk Factors of Domestic Homicide

There are multiple risk factors associated with domestic homicide. Some of these factors have been identified in prior literature, and through the ongoing work of domestic violence death review committees. For example, the Ontario DVDRC examines cases of DH and identifies risk factors that can inform community professionals and services in the prevention of future DH (Fairbairn, Jaffe & Dawson, 2017). Identification of the 40 risk factors is completed through the DVDRC risk factor coding form, and each risk factor is coded as present, absent, or unknown (DVDRC, 2017). By identifying potential risk factors of DH and making recommendations to professionals who work with victims and/or perpetrators of DV, the DVDRC hopes to increase awareness of domestic homicide, prevent future domestic homicides, and promote safety for victims (Fairbairn et al., 2017).

Prior literature reports that a sizable number of domestic homicides display predictable patterns and precursors, such as the majority of DH's involving physical abuse of the female by the male before the murder (Juodis, Starzomski, Porter, & Woodworth, 2014; Campbell et al., 2003). DV can be understood as a gender-based crime since women primarily find themselves at the greatest risk of DV, with 35% of women worldwide having experienced DV (Sheehan et al., 2015; WHO, 2017). This risk of DV increases among women in common-law relationships,

while women who are pregnant find themselves at a higher risk of becoming a victim of both DV and DH (DeJonghe, Bogat, Levendoky, & Von Eye, 2008; Weizmann-Henelius et al., 2012).

A primary risk factor that can increase the risk of DH are women who have experienced prior abuse in their DV relationship, with 70% of total DH victims being physically abused before their deaths by the same intimate partner who killed them (Campbell et al., 2003). The presence of prior abuse can become complicated when victims of domestic violence retaliate against their perpetrators which can elevate their risk for DH. In addition, children who have experienced DV during their childhood are at an increased likelihood to become involved in a DV relationship later in their lives (Freyd, 1994).

Ending a DV relationship can be extremely dangerous for women, with separation or the risk of separation being identified as a risk factor of DH. During this time, perpetrator personality traits such as jealousy can heavily influence the risk of DV. Perpetrator jealousy may revolve around the loss of the intimate relationship, or a woman having a new partner (Juodis et al., 2014). Jealousy over a failed relationship may also serve as a catalyst in the perpetrator committing an act of DV or DH and perpetrator jealousy can appear through acts of stalking with 23% of DH victims experiencing stalking prior to their homicide. In contrast, risk factors may also communicate to the victim of her elevated risk and can be especially useful knowledge for victims who otherwise believe themselves to be safe (Weisz, Tolman, & Saunders, 2000).

Physical location becomes an important element to consider when assessing risk, as handgun ownership contributes to risk of DH (Sheehan et al., 2015). The intersection between gun ownership and demographics becomes important since rural areas have higher rates of gun ownership for the purposes of hunting and protection from animals (Kirkland, 2013). The higher number of guns in rural areas can create an increasingly dangerous climate for domestic violence

victims, with Campbell et al., (2003) reporting a "much greater likelihood of using a gun in the actual homicide." This heightened level of danger is acknowledged by the United States Department of Justice, in which they reported women whose partners threaten them with a gun or other weapons are twenty times more likely to be murdered than other abused women (USDJ, 2013).

Despite these emerging themes, prior literature reports that little is known about the way risk factors may co-occur together. Researchers have concluded that a higher number of risk factors may elevate risk for DV and DH and may further escalate if the victim engages in help-seeking behaviours - but this relationship is not necessarily linear (Dawson & Piscitelli, 2017). Nevertheless, there is a call for a better understanding surrounding the presence of one risk factor, as well as multiple risk factors on the likelihood of DV and DH. An investigation into how risk factors work together and their influence on DV is necessary with particular sets of characteristics, social situations, or symptoms together potentially increasing the risk of DV (Dawson & Piscitelli, 2017).

Where Do Victims Go to Get Help?

There is a growing body of evidence suggesting that healthcare professionals may be the first point of contact for victims of DV (Murphy, Liddell, & Bugeja, 2016). These professionals may be able to provide advice on support pathways for patients at high risk since only a small percentage of abused women seek help from specialist family violence services (Murphy, Liddell, & Bugeja, 2016). Despite these promising findings, doctors and nurses rarely ask about abuse, often fail to see the signs of DV in their patients and may not know how to respond to a disclosure of abuse (Evans & Feder, 2014).

Unfortunately, previous literature reported that professionals are not aware that patient help-seeking behaviours are greatly influenced by the opinions of healthcare professionals and how they define DV and DH (Murphy et al., 2016). From a cognitive theory perspective, patients who disclose DV have successfully defined their problem, decided to engage in help-seeking behaviours, and have selected their medical professional to disclose their concerns to whilst seeking support. Professionals who are not comfortable responding to disclosures of abuse may have negative influences on future help-seeking behaviours of the victim. Given these findings, there is an emphasis for doctors to display empathetic communication and validation of their situation (Evans & Feder, 2014). When survivors utilize healthcare professionals as a source of support, there was a demand for professionals to refrain from potentially stigmatizing judgement, while understanding the relationship between victim's frequent visits and the presence of DV in their lives (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). To improve victim help-seeking behaviour, women reported that they wished professionals would conceptualize the problem with them in an empathetic and understanding way, so both parties feel validated and understood. As well, women reported the need for professionals to identify how they may have faced stigmatizing situations regarding their abusive situation (Murray, Crowe, & Brinkley, 2015).

Despite the invalidating experience victims of DV may experience in medical settings, there is an opportunity for healthcare professionals to contribute to the well-being of children exposed to DV. Previous literature reported that pediatric emergency departments have been identified as a unique opportunity for children to become screened for DV (Randell, Bledsoe, Shroff, & Pierce, 2012). Signs of DV that medical professionals should be alert for include: wounds, bruises and fractures, as well as chronic neck and back pain, headaches, abdominal pain, sexually transmitted diseases, dizziness, anxiety, depression, and substance abuse

(Prosman, Lo Fo Wong, & Langro-Janssen, 2014). Despite a need for increased awareness of DV among children populations, the mother may feel reluctant to disclose DV in the home and a physician may feel hesitant on asking and providing appropriate support – which can lead to underreporting (Prosman, Lo Fo Wong, & Langro-Janssen, 2014).

When incorporating theory into disclosure of DV to formal sources of support, a trauma theory perspective explains that the patient may have felt reluctant to disclose DV in the home if they believed little could have changed in their situation. This perspective may have been caused by feelings of helplessness and can serve as a barrier to help-seeking. In relation, physicians have identified their own barriers to providing support, such as: time constraints, limited incentives, deficiency of policy and guidelines, lack of education, and insufficient victim services (Johnson, Ferguson, & Shirley, 2017). Without an increased emphasis on discussing and identifying clients at risk for DV, dysfunctional practitioner/client dynamics will continue and DV may remain undetected which increases risk for victims of DV.

Previous literature has highlighted underreporting of DV in the healthcare system and research suggests that mental healthcare professionals need to become better informed on risk factors for DV, how to identify a client who may be in danger, and how to engage in non-judgmental but constructive conversation with their client. Women exposed to DV reported that awareness to not re-stigmatize them by the professional was necessary for disclosure of their DV situation (Murray, Crowe, & Brinkley, 2015).

Barriers for Seeking Help

Prior literature suggests that victims of DV may exhibit five identified barriers to help-seeking, which include: Denial of DV, lack of awareness about the consequences of DV,

inhibitive thoughts, negative experiences with professional support, and fear of their partner (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). Victims who exhibited denial of their DV included survivors who denied being in an abusive relationship, those who did not consider their relational problems as partner abuse, and victims who did not consider professional help (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). Survivors who were not aware of the consequences of DV did not connect their psychosomatic and psychosocial problems to DV. For example, a sample of fourteen women experienced a lack of enjoyment in their lives in combination with poor concentration, sleeping problems, and agitation (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). Regarding children exposed to DV, these women stated that their children suffered from learning and behavioural problems – but they did not realize this connection until after (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). When incorporating field research into theory, trauma theory demonstrates that these women were displaying varying degrees of depression or helplessness regarding their abuse. These feelings can serve as a barrier to help-seeking behaviours and may increase their risk for further harm due to an inability to identify their elevated risk for DV. From a cognitive theory perspective these survivors of DV may not have defined the problem of DV and without an acknowledgement of their abuse, women will be less likely to engage in help-seeking behaviours.

Inhibitive thoughts served as a barrier to help seeking, with the same sample of fourteen women believing they could solve their DV on their own. These women allowed the stigma of help-seeking to inhibit them from engaging in help-seeking behaviours. Others believed that formal services could not help them, or mental health services were too confrontational. Lastly, some participants believed that DV shelters were solely for migrant women (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). Unfortunately, the survivors who demonstrated inhibited

thoughts have had uncomfortable experiences with formal sources of support such as police services, which may limit future help-seeking behaviours by the victim in the future. An example of a victim of DV who did not feel supported by formal supports involved a survivor who called police on her abuser. Police questioned her perpetrator and sent him home– which placed the survivor at a heightened level of risk for perpetrator retaliation (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014).

Although inhibitive thoughts serve as a barrier to help-seeking behaviours, researchers have also identified the self-esteem of survivors of domestic violence as a barrier to help-seeking. Victims of domestic violence are more likely to feel guilt, shame, and self-blame for being abused, which contributes to a negative self-concept – and ultimately decreases help-seeking behaviours (Karakurt, Smith, & Whiting, 2014). Within community services, self-esteem damage can occur when professionals place blame on the survivor for the violence and for not preventing the abuse from occurring (Karakurt, Smith, & Whiting, 2014). From a cognitive perspective, feelings of shame, guilt, and self-blame may have further inhibited the victim to properly identify DV as danger since these survivors had internalized the DV they were experiencing. With respect to the impact risk factors have on help-seeking and self-esteem, it could be speculated that those who engaged in help-seeking behaviours may have reduced the number of risk factors present and improved their self-esteem because they had sought the appropriate services for their needs.

Origins of Intuitive Sense of Fear

Victims who experience an intuitive sense of fear may present their fear in various ways. Some victims may be fearful, and express this fear through their actions (i.e., formal and

informal sources of support). However, others may experience an intuitive sense of fear and not express this fear, whereas some victims may not be fearful and take no action. The following sections will discuss victim fear, the variety of ways victims may display it and some rationale supporting the presence and/or absence of fearfulness.

Fear: Present

There are numerous emotional outcomes for survivors of DV such as experiencing feelings of anger, fear, becoming more cautious or less trusting, and lowered self-esteem (Statistics Canada,1994). This finding highlights the danger that victims of DV find themselves in, and the potentially damaging repercussions. Survivors who demonstrate an intuitive sense of fear may be uniquely impacted in comparison to victims who do not demonstrate an intuitive sense of fear. Such variables include victims of DV being fearful of the danger they find themselves in, being fearful for theirs or their children's lives, or being physically prevented to seek help by their perpetrator – and by extension instilling fear in the survivor for her safety.

In addition, the presence of children, mental health concerns, and/or addictions, complicates the decision-making model for survivors of DV. For some victims, the presence of children may result in a reluctance to disclose DV in the home, for fear of children's protective services becoming involved, the breakdown of the family unit, or directly involving their children in the process of leaving an abusive relationship (Dutton & Dionne, 1991). This finding was highlighted in prior literature where child protective services were contacted only 31% of the time in homes where DV was present, which can have negative effects on the victim, and family structure (Statistics Canada, 2014).

Victim mental health concerns and/or addictions may inhibit the victim from adequately assessing risk and engaging in help-seeking behaviours, which may place the victim at a heightened risk. Unfortunately, victims of DV are at a higher chance of developing mental health concerns such as depression, anxiety, post-traumatic stress disorder (PTSD), substance abuse, and low self-esteem (Karakurt, Smith, & Whiting, 2014). The elevated risk of developing mental health concerns may influence victim help-seeking behaviours, and in some instances, victims who suffer from mental health concerns and/or addiction concerns may be afraid to consider the possibility that their abuser might kill them (Weisz, Tolman, & Saunders, 2000)

Overall, when victims of DV experience fearfulness and communicate this fear to others, these concerns must be taken seriously even when other markers fail to identify a risk (Weisz, Tolman, & Saunders, 2000). These findings support the notion that victims of DV possess intimate knowledge about their DV situation and should be taken seriously by community professionals and social supports when voicing their fearfulness.

Fear: Present not Expressed

Victims who engage in help-seeking behaviours may have been fearful, yet never expressed their fear through help seeking behaviours. In some instances, these victims may become fearful because of feedback from informal sources of support which may have led to victim help-seeking behaviours. Informal sources of support include family, friends, co-workers, and neighbours who may have expressed their fearfulness for the victim or knew about the abuse. With 68% of victims confiding in one or more informal sources of support, opportunities to communicate fearfulness to the victim would be available (Statistics Canada, 2014). By communicating concern over elevated risk to the victim, this may influence victim intuitive sense of fear, and eventually lead to the victim engaging in help-seeking behaviours. The importance

of help-seeking is highlighted with prior findings that suggest victims of DV have the most to fear from their current and/or former male partners. This finding highlights the overarching elevated risk that female victims of DV find themselves in, and the importance of recognizing risk as soon as possible (Dawson, Jaffe, Campbell, Lucas, & Kerr, 2017).

Prior literature highlights the importance of help-seeking behaviours when victims minimize the risk they experience but help-seeking can become difficult when there is strong stigmatization against DV. Stigmatization of domestic violence impacts help-seeking in DV relationships (Murray, Crowe, & Brinkley, 2015). This can create a climate where it is difficult for survivors to receive help. These findings create an opportunity for public education, but unfortunately hinders the recovery process for survivors during a period in which help-seeking is critical.

Fear: Absent

In comparison, survivors who do not demonstrate an intuitive sense of fear may find themselves facing a number of barriers to engaging in help-seeking behaviours. Victims who are living in rural or remote locations may experience isolation in their community, and have little support offered to them. This lack of support may inhibit a victim's intuitive sense of fear and limit them from recognizing their elevated risk.

A lack of financial independence may also influence victim help-seeking behaviours. Victims who experience financial concerns may choose to ignore their fearfulness if they are unable to support themselves financially without their partner. Victims who identify as an ethnic minority may also feel as if they cannot communicate their fearfulness or engage in help-seeking behaviours if there are cultural barriers. Cultural values have been identified in previous

literature as a factor that may inhibit feelings of fearfulness. Victims who identify as an ethnic minority may see DV as a normal or accepted part of their culture which will inhibit their intuitive sense of fear towards their perpetrator. Victims who are not fearful of their perpetrator due to cultural beliefs may not recognize their increased risk or communicate their fearfulness to others.

An additional contributor to a lack of fearfulness displayed in victims are victims who experience mental health and/or addiction concerns. These individuals may not be able to identify the severity of the abuse they have experienced, or they may internalize the belief that their mental health concerns are caused by them and not the abuse they have experienced (Leone, Lape, & Xu, 2014). This internalization can become more severe if victims fear being hospitalized due to their mental health concerns if they engage in formal help-seeking and authorities become involved. This belief may stem from perpetrators who manipulate their victims and their mental health concerns to diminish the possibility of victim help-seeking behaviours (Leone, Lape, & Xu, 2014). A sample of 177 domestic violence survivors reported that they may further doubt their judgement if their perpetrator continuously told them that they were “stupid” or “crazy”, while other women may fail to recognize their increased risk (Weisz, Tolman, & Saunders, 2000). Not only does a lack of fearfulness elevate risk for women, but it also serves as a coping mechanism for unmanageable anxiety and fear experienced in a DV relationship (Weisz, Tolman, & Saunders, 2000).

Summary of Victim’s Intuitive Sense of Fear

In summary, victim intuitive sense of fear can be understood as a risk factor that has a profound impact on victim help-seeking behaviours. Victim’s fear has been identified as one of the 40 risk factors of DH and by developing a better understanding of these risk factors, elevated

risk to the victim may become reduced. Elevated risk to the victim may result in DV related injuries, mental health concerns, complications in pregnancy, and at its most extreme, DH (WHO, 2017). It is important for victims to engage in help-seeking behaviours, yet many barriers stand in the way of victim safety. The subsequent sections will discuss victim intuitive sense of fear in relation to the following variables: victim mental health and/or addictions, perpetrator's controlling behaviours, the presence of children in the home, and formal and informal help-seeking behaviours.

Mental Health Concerns, and Addictions

Victims who are exposed to domestic violence may have developed mental health problems in coping with their abuser, which can be understood as mental health concerns that are suspected by friends and family, and mental health concerns that were diagnosed by a mental health professional. Given this information, this study defined Mental Health Concern (Diagnosis) as "the presence of a mental health concern within cases, or the victim was prescribed psycho-pharmaceuticals" consistent with the DVDRC definitions (DVDRC, 2016). Additionally, this study defined Mental Health Concern (Suspected) as the victim having "no formal mental health concerns that were identified. In contrast to friends and family who indicated the possibility of an undiagnosed condition, or evidence supporting the presence or inclination of an undiagnosed mental health concern" (DVDRC, 2016). Unfortunately, survivors of DV are at a higher chance of developing mental health concerns such as depression, anxiety, post-traumatic stress disorder (PTSD), substance abuse, and low self-esteem (Karakurt, Smith, & Whiting, 2014). Given the gender-based nature of DV, female victims of DV were 22% more likely to report mental health concerns such as PTSD compared to male victims, who reported PTSD symptoms 9% of the time (Statistics Canada, 2014).

The role of fear and helplessness on the development of PTSD in DV survivors was investigated, with researchers concluding that fear of recurrence of trauma and a sense of helplessness were the strongest predictors of PTSD (Salcioglu, Urhan, Pirinccioglu, & Aydin, 2017). When incorporating theory into previous literature, cognitive theory explains that mental health concerns and/or addiction concerns may inhibit victims from identifying their DV as dangerous and threatening to their life – and may impact their help-seeking behaviours.

Depression

Victims of DV are at risk to develop depression. Depression can be understood as a mental health concern which impacts sleep, causes changes in appetite and energy levels – and the general ability to function. In some instances, depression may eventually lead to suicide ideation or suicide attempts (Karakurt, Smith, & Whiting, 2014). The risk towards domestic abuse survivors is startling, with survivors of severe DV being four times more likely than non-victimized women to be depressed and/or attempt suicide (Karakurt, Smith, & Whiting, 2014). Although this relationship puts survivors in an acute and immediate risk, depression levels decreased when DV ceased, which may indicate a correlational relationship between mental health concerns, and DV (Karakurt, Smith, & Whiting, 2014).

Post-Traumatic Stress Disorder

In addition to the risk of developing depression, survivors of DV also find themselves at a heightened risk of developing PTSD – with 40% to 60% of survivors suffering from this psychological diagnosis, with women being more likely to experience negative psychological outcomes such as PTSD (Karakurt, Smith, & Whiting, 2014; Salcioglu, Urhan, Pirinccioglu, & Aydin, 2017). PTSD develops when an individual is exposed to traumatic stressors such as

violence, followed by fear for one's safety and a sense of helplessness to control the situation (Karakurt, Smith, & Whiting, 2014). Symptoms can present themselves as re-experiencing the event via flashbacks and nightmares, avoidance of reminders of the event, emotional numbing, and increased physical arousal (Karakurt, Smith, & Whiting, 2014).

Addiction Concerns

Many female survivors of domestic abuse who may be experiencing PTSD or other mental health concerns may turn to drugs and alcohol as coping mechanisms – and do so more often than women who are non-victimized (Karakurt, Smith, & Whiting, 2014). This finding has been established in the literature, with 12% of women who have experienced DV reporting their use of alcohol, drugs, or medication to help cope with their situations (Statistics Canada, 1994). To replicate this finding, researchers studied a sample of 102 women in a domestic violence shelter, where it was discovered that over two-thirds of the women scored in a moderate/high category for risk of substance abuse (Karakurt, Smith, & Whiting, 2014). Those who are at a moderate/high risk for substance abuse may have increased their risk if they experienced emotional abuse. This finding is supported with 31% of women who experienced emotional abuse, turning to alcohol or drugs more often to cope (Statistics Canada, 1994). The severity of being exposed to DV has dangerous implications for women who have experienced frequent instances of victimization, and these adverse experiences are linked to a greater likelihood of substance use among victims of DV (Karakurt, Smith, & Whiting, 2014).

Perpetrator's Controlling Behaviours and Victim's Fear

Additionally, if a woman is experiencing a small network with weak interconnections – as a result of a controlling partner – then her opportunities for help-seeking are further limited

(Evans & Feder, 2014). Perpetrators who display coercive behaviours can serve as a barrier to help seeking, while creating an environment where the woman may feel pressured to conform to her partner's demands (Robertson & Murachver, 2011). According to Statistics Canada (2014), 14% of Canadians have reported being emotionally abused by a current or former spouse, or common-law partner at some point during their lifetime. Given the high prevalence of emotional abuse, perpetrators of DV may display this behaviour as a means to control their victim (Robertson & Murachver, 2011).

The Impact of Children on DV and DH

Children exposed to DV is one of the most frequent forms of maltreatment in Canada, and accounts for more than one-third of abuse cases involving children (CDHPI, 2018).

There are numerous negative outcomes of childhood DV exposure such as impaired psychosocial development, learning difficulties, maladaptive coping skills, increased risk of household criminal activity, substance abuse, or even death from physical child abuse (Randell, Bledsoe, Shroff, & Pierce, 2012). In the context of domestic violence, when children are killed it is most often resulting from a history of violence and separation. In many cases, the motive appears to be an act of revenge to punish the adult victim for leaving the intimate relationship (CDHPI, 2018).

When contemplating formal and informal sources of support, many women find themselves considering their children when choosing to not engage in help-seeking. Children can further complicate a domestic situation since women may believe that maintaining the family structure is the best choice for her children, while minimizing the danger she is coping with (Dutton & Dionne, 1991). Despite the negative outcomes, the survivor may remain in the abusive relationship to prevent their children from having to take an "active role in the process of

leaving" which includes talking to police, going to a shelter, providing translation, or even providing testimony in court.

In addition, the decision to leave may depend on the financial situation of the victim, and if she is financially dependent on her abuser. The victim may feel that if she leaves without financial stability, she may be placing hers and her children's lives at risk (Kemp, 2016). Barriers such as these can result in reduced help-seeking behaviours, with roughly half of all instances of DV being reported to law enforcement and approximately 20% of those producing an arrest (Greenfeld et al. 1998).

In contrast, mothers who are survivors of domestic abuse will often place their children's needs above their own safety needs. This can also take form through the mother hiding household DV from her children to protect them (Thomas, Goodman, & Putnins, 2015). In instances where the child cannot be shielded from DV in the home, the detrimental impacts of DV on children become the catalyst for the victim to seek help (Randell, Bledsoe, Shroff, & Pierce, 2012; Thomas, Goodman, & Putnins, 2015). To build off findings that children can become the catalyst for victim help-seeking, some survivors would reference their children's needs as a decision-making strategy. For instance, if a safety effort led to harmful consequences for her children, the survivor would view this option quite negatively (Thomas, Goodman, & Putnins, 2015).

From a cognitive theory perspective, the presence of children may influence how a survivor conceptualizes the danger that she is in. Depending on the woman, she may wish to keep her family intact and not identify DV as a concern. From a trauma theory perspective, women who have experienced DV that do not engage in help-seeking behaviours may

experience symptoms of PTSD such as depression or helplessness which is consistent with previous findings surrounding the victim's belief that little can be done to prevent future abuse.

When deciding an appropriate next step for the entire family, mothers are forced to consider the values they communicate to their children through their help-seeking behaviours. For instance, if mothers do not challenge their abusers' behaviours, then they are communicating to their children that abuse is normal and acceptable (Thomas, Goodman, & Putnins, 2015). Unintended harm to children may also occur if authorities are notified that domestic violence is occurring in the home. Depending on the individual case, if a mother decides to call the police on her abuser, she also runs the risk of involvement from the child welfare system, or even the removal of her children from the home (Thomas, Goodman, & Putnins, 2015).

When exploring internal and external motivators for DV help-seeking, mothers explained that they wished for a better life for their children while changing their perception of what a healthy romantic relationship looks like – and realizing their relationship did not fit this image (Randell, Bledsoe, Shroff, & Pierce, 2012). Despite a complete separation from their abusive partner, victims of DV may continue to find their safety being compromised during exchanges of children in cases of shared custody. Within their sample, Thomas, Goodman, and Putnins (2015) interviewed 301 female DV survivors and one exclaimed,

"I do not know my abuser and what he is capable of. He is very persistent about seeing his son, which puts me in a compromising position. Even though I am afraid, I still meet him in an open space to bring him his son" (p. 174).

This anecdote successfully conveys the danger that persists when co-parenting children, even after a victim successfully leaves her DV relationship.

Formal and Informal Help-Seeking

Formal Help-Seeking

Formal and informal support for women experiencing DV and DH can play a vital role in improving their safety, and their physical and mental health outcomes (Evans & Feder, 2014). When seeking formal sources of support, survivors of DV were motivated to seek help once they recognized that were unable to make a change without the help of a community agency (Evans & Feder, 2014). Women who were seeking out formal sources of help were specifically seeking someone outside of their social networks whom could provide them non-judgemental advice (Evans & Feder, 2014). Furthermore, these women wished to protect their children and family members from further abuse, reduce their social isolation, and increase their understanding of DV to avoid it in the future (Evans & Feder, 2014).

Despite the dangerous situations that survivors of DV find themselves in, many women did not accept their abuse until after contacting a community agency and internalizing the label of being domestically abused. This experience allowed survivors to reframe their experience, while reaching out to others (Evans & Feder, 2014). From a cognitive theory perspective, these women have successfully defined the problem of experiencing DV, have decided to seek help, and have identified community agencies as their source of support. Although help-seeking can be rewarding for survivors of domestic violence, the experience can also prove to be difficult. Victims who perceive their DV with distress or fear may feel powerless or helpless, which renders the survivor less likely to take action in defending herself (Salcioglu, Urhan, Pirinccioglu, & Aydin, 2017).

Formal help-seeking may be a choice for some survivors of domestic violence. Over half

engage with police services (56%) (Reaves, 2017). From a trauma theory perspective, the 44% of victims who did not engage in police services may have utilized another source of support or minimized the DV that they experienced due to feelings of depression or helplessness. Feelings of helplessness may have been consistent with characteristics of PTSD which may elevate the victim's risk for future DV. These findings identify the demand for future research that investigates the role of formal and informal help-seeking behaviours, in order to gain a holistic understanding of domestic violence.

Informal Help-Seeking

Women with access to informal support systems were more likely to disclose to friends rather than to family, with friends offering emotional support and family offering instrumental support like financial help (Evans & Feder, 2014). Unfortunately, women also described that seeking informal support resulted in them not being taken seriously, or that their experiences were "normalized" (Evans & Feder, 2014). Some examples highlighted in prior research included friends or family favouring the abusive partner, rather than the victim – or urging the woman to leave the relationship before she was ready (Evans & Feder, 2014).

Despite the complexities of seeking informal help, women described an improvement in their emotional well-being over time and a gradual return of self-esteem – which speaks to the powerful impact that help-seeking can have on survivors of DV. To increase help-seeking behaviours, researchers discovered that survivors can benefit from online peer support or a mentorship from community service workers (Evans & Feder, 2014).

Intuitive sense of fear may result in help-seeking behaviours and increase a victim's risk for DH and DV (Dawson & Piscitelli, 2017). Despite this elevated risk, informal supports were

utilized more often when the survivor displayed an intuitive sense of fear which may also reduce her elevated risk. It has been determined in the literature that utilization of social supports allow the survivor to recognize the danger she was in while increasing the chances for help-seeking behaviours (Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). Given these findings, additional research must further investigate the role that survivor's intuitive sense of fear has on their informal help-seeking behaviours.

The relationship between help-seeking behaviours and victim intuitive sense of fear requires exploration. Scholars have argued that a woman's intuitive sense of fear should be taken seriously given its accuracy and the intimate knowledge victims have on their perpetrator (DeBecker, 1997; Hart, 1994). This intimate knowledge was strongly associated with subsequent violence, with survivors being especially skilled at knowing when their partner will be violent, and when he will not (Weisz, Tolman, & Saunders, 2000). In contrast, instances of DV with a female victim were four times as likely as male victimizations to go unreported due to fear of reprisal (Reaves, 2017). This finding suggests a gender difference, as well highlighting the powerful role that intuitive sense of fear can have on victim help-seeking behaviours.

Underreporting of DV is a common occurrence, with 22% of women who experienced DV refraining from disclosing their abuse and a further 10% who feared for their lives but remained silent (Statistics Canada, 1994). Statistics such as these depict an environment where women are fearful yet silent which highlights the potential life-threatening consequences that victim intuitive sense of fear has when it goes unrecognized. Given these findings, additional research must further investigate the presence and absence of intuitive sense of fear in victims, and the impact that fear has on their help-seeking behaviours.

This study represents a retrospective analysis on case files collected from 2003-2015 of the Domestic Violence Death Review Committee annual reports. The purpose of this study was to investigate the influence that victim's intuitive sense of fear has on help-seeking behaviours, which has been identified as one of the 40 risk factors to DH. Victim intuitive sense of fear and help-seeking will be investigated in relation to the following variables: the presence of children, mental health concerns and/or addictions concerns, and perpetrator's controlling behaviours. Limited research has been completed investigating victim's intuitive sense of fear, and additional research may inform professionals working with victims of DV on how to recognize fear while encouraging help-seeking behaviours. In addition, this study may also inform professionals who work with victims that are not intuitively fearful of their perpetrators. These victims are at an elevated risk of DH in part because they may not recognize the severity of their situation, and the elevated risk they live in.

This study is guided by the following hypotheses:

1. Victims who experience an intuitive sense of fear will be exposed to a higher number of risk factors.
2. Victims who experience an intuitive sense of fear will be more likely to engage in formal and informal supports related to help-seeking.
3. Victims who have children present in the home will be more likely to experience an intuitive sense of fear.
4. Victims who experience controlling behaviours from their perpetrator will be less likely to experience an intuitive sense of fear.
5. Victims who experience mental health concerns and/or addiction concerns will be less likely to experience an intuitive sense of fear.

Rationale of Current Study

Two theories will help create a theoretical rational to guide this research study. The first is a cognitive theory derived from general literature which explains help-seeking in “stigmatizing” situations. This theory suggests three relevant processes or stages of seeking help in the DV context: 1. Defining the problem, 2. Deciding to seek help, and 3. Selecting a source of support (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). When individuals experience this intuitive sense of fear, it can be considered recognizing the problem of their abusive relationship and the danger it creates, by identifying the problem of experiencing DV, this may influence the victim’s decision to seek help, and the selection of a help-provider. In contrast, if a victim did not possess an intuitive sense of fear then they are likely not recognizing the problem of their abusive relationship, which may influence their help-seeking behaviours and the selection of the help-provider. Within the context of this study, victims that did not display an intuitive sense of fear may not have selected a source of support. The absence of help-seeking behaviours may have played a pivotal role in their domestic homicide.

The second rationale is “Trauma Theory” in which victims of abuse are focused on. This theory states that individuals who have been violated by a figure in their life will repress their trauma to survive and allow for the maintenance of necessary relationships (Freyd, 1994; Smith & Freyd, 2014). Those who have been violated by figures in their life may find themselves at an increased risk of developing mental health concerns such as Post Traumatic Stress Disorder (PTSD) (Karakurt, Smith, & Whiting, 2014; Salcioglu, Urhan, Pirinccioglu, & Aydin, 2017). Symptoms of PTSD may include feelings of helplessness which can directly impact the victim’s help-seeking behaviours. This is transferrable to victims of DH, since they have been victimized by their abuser. Victims of DV may have not engaged in help-seeking behaviours due to feelings

of helplessness, and a lack of control over their abusive situation which could have severely impacted their intuitive sense of fear, and help-seeking behaviours.

The Current Study

The purpose of this current study is to investigate the differences between domestic homicide victims who exhibited an intuitive sense of fear, and victims who did not. Some argue that survivor's assessments are the most accurate because they know their perpetrator better than anyone else does and may become attuned to their partner's cycles of violence over time. This prediction is supported in previous research indicating that women's assessment of their perpetrator's dangerousness should be emphasized, and strongly supported (Weisz, Tolman, & Saunders, 2000). Given the importance placed on victim's intuitive sense of fear, this study will be identifying missed opportunities for victims to survive their DV relationship. A comparison was made between victims who were fearful, and victims who were not fearful with respect to the following variables: formal/informal help-seeking behaviours, the presence of children, mental health concerns and/or addictions concerns, and perpetrator's controlling behaviours. The selection of these variables for the current study was informed by prior research conducted by Campbell et al. (2003) who demonstrated the association between several risk factors and DH.

Gaps in the literature helped inform this study on whether to include victim mental health and/or addictions. Perpetrators who abused substances were at a higher risk of committing DH (Campbell et al., 2003), but limited research investigated the role of victim mental health concerns and substance abuse on DV relationships. The current study sought to investigate the role of victim mental health and/or addiction concerns on their help-seeking behaviours.

Prior research conducted on the presence of children in the DV home provided the inclusionary rational for this current study. The presence of children in the home has been identified by the DVDRC as a risk factor that increases the risk of DH, specifically “a child of the victim by a previous partner that was living in the home” (Campbell et al., 2003). Children who live in a home with DV can find themselves experiencing elevated risk, as most children who were killed in the context of DV were living in the same residence as the accused (CDHPI, 2018). These findings influenced the decision to investigate the presence of children in the home on victim’s intuitive sense of fear.

Perpetrator behaviours such as the need to control their victims was selected as a variable. This was based on prior literature which stated that perpetrators who demonstrated the need to control their victim’s daily activities may have increased their risk for lethality (Campbell et al., 2003). This finding guided the current study’s decision to investigate perpetrator’s controlling behaviours on victim fearfulness and was operationalized through the perpetrators need to control the victim’s daily activities.

Victim help-seeking behaviours was selected and understood as formal and informal help-seeking. Formal help-seeking will be operationalized through total formal agency contact that the victim was involved in, which communicates that the victim sought services from a formal agency. Informal help-seeking behaviours will be conceptualized through the victim disclosing her abuse to her family, friends, co-workers, or neighbours. This variable demonstrated that the victim may have been seeking help from the informal supports in her life and disclosing her abusive relationship to them.

Methodology

Design

The design was a retrospective case analysis which used quantitative data. The sample consisted of 219 cases from 2003-2015 from the Ontario Domestic Violence Death Review Committee Annual Report (DVDRC) with victim's age ranging from 15 years to 88 years. Cases that consisted of same-sex couples, or female perpetrators were not included in analyses due to the limited number of cases present. Victims who demonstrated an intuitive sense of fear were studied against a comparison group consisting of victims who did not demonstrate an intuitive sense of fear based on a comprehensive review of interviews with friends, family and co-workers as well as social service, police and mental health records. Case information based on third-party involvement varied from case to case and required verification and agreement by the multidisciplinary DVDRC committee.

Variables for analysis included victim intuitive sense of fear, informal and formal help-seeking behaviours, the presence of children in the home, perpetrator's controlling behaviours, and victim mental health and/or addiction concerns. When operationalizing informal help-seeking behaviours it included neighbours, friends, family, and co-workers who were made aware of the abuse included. It was believed that these variables would have provided a holistic understanding in the many ways informal help-seeking behaviours can present itself. Formal help-seeking behaviours was operationalized as the number of agencies that the victim engaged in. This involvement ranged from zero, one to five, and more than five agencies utilized. The presence or absence of children in the home was considered. Children who were present were under the age of eighteen, with the primary adult victim being 55 years old or younger. Perpetrator's controlling behaviours was understood as attempts from the perpetrator to control

the daily activities of the victim. Victim mental health concerns was operationalized through suspected mental health concerns by friends and family, and medically diagnosed mental health concerns by a professional. Victim addiction concerns was operationalized through reports of substance abuse. Given the limited nature of the secondary data, disclosure to formal or informal supports will be conceptualized as formal and informal help-seeking behaviours.

Data Collection

The DVDRC reviewed all instances of domestic homicide violence, and homicide-suicide in Ontario, and strives to develop a comprehensive understanding on why domestic homicides occur and how they might be prevented (DVDRC, 2016). Each case file may have consisted of records from the police, Children's Aid Society (CAS), healthcare professionals, counselling professionals, courts, probation and parole, etc. (DVDRC, 2016). It was expected that group differences would be able to inform community agencies how to foster an intuitive sense of fear, and help-seeking behaviours within this vulnerable population.

Participants

The sample consisted of 219 individuals who were domestic homicide victims from 2003-2015 and reviewed by the DVDRC (M_{age} = 35.5) which included most domestic homicides in Ontario during this period. Victims' ages ranged from 15- 88 years.

Materials

IBM SPSS. Statistical Analysis was completed through IBM SPSS. To maintain confidentiality, access to data and analyses were conducted at the Center for Research and Education on Violence Against Women & Children (CREVAWC) on encrypted computers in a locked office.

DVDRC risk factor coding form. The DVDRC risk factor coding form (see Appendices B and C) was created by the DVDRC to code information pertaining to each of the DVDRC's 40 risk factors. The committee determined whether each risk factor was present (P), absent (A) or unknown (Unk) based on all available information and standardized definitions. The risk factors were chosen based on existing literature on domestic violence as well as repeated presence in prior domestic homicide cases. The focus of this study was to investigate victim's intuitive sense of fear, and its relationship with formal and informal help-seeking behaviours, the presence of children, perpetrator's controlling behaviours, and victim mental health and/or addiction concerns. Victim intuitive sense of fear was defined by the DVDRC as "the victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women disclosed to anyone her fear of the perpetrator harming herself or her children, for example statements such as, "I fear for my life", "I think he will hurt me", or "I need to protect my children" (DVDRC, 2016). In this study, victim disclosure to a formal source of support was coded identically to a disclosure to an informal source of support. All 40 risk factors are available online within annual reports on the web-site of the Chief Coroner. Consensus is required by the DVDRC member to include a risk factor for each case (full report at https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/coroners_pubs.html).

DVDRC data summary form. The second coding form (see Appendix D) is a 15-page summary based on all case information, including information pertaining to the perpetrator. This form gathered socio-demographic information, service involvement, criminal history, case type, third party knowledge, and substance use at the time of the homicide. Service involvement spanned across 34 different service providers including mental health agencies, and child

protective agencies. Third party knowledge was gathered by determining if prior reports of domestic violence had been made.

Procedure

Ethics for this study was obtained from the Western REB (see Appendix A). Certain ethical concerns were considered, to protect the identities and information of victims of DH. Confidentiality was upheld through the following ways. Computers with DVDRC data were kept behind locked doors, and remained password protected and encrypted. In addition, researchers were forbidden to transfer this dataset to personal computers, or outside of the graduate laboratory space for reasons of sensitivity and confidentiality. Since all participants had been victims in a domestic homicide, there was no way to obtain consent. The purpose of the DVDRC was to conduct a thorough examination of history, circumstances, and conduct of the perpetrators, victims, and their families. Primary risk factors and possible points of intervention were identified, and recommendations were developed to assist with the prevention of similar future deaths (DVDRC, 2016). Statistical analyses consisted of Frequency Tables, Chi-Square analyses, Independent t-tests, and Multinomial Regressions, with supplementary analysis when needed.

Results

Statistical Analysis

Chi-square tests of independence were used to compare the four variables of interest on victim's intuitive sense of fear. Comparisons were made based on the presence of children in the home, perpetrator's controlling behaviours, victim mental health diagnoses, and victim help-seeking behaviour. Formal help-seeking behaviour included total number of agencies the victim

was involved in, and informal help-seeking included the availability of family support for the victim, and involvement of co-workers, and neighbours. Unknown variables, same-sex couples, cases with female perpetrators, and cases with the primary victim being over the age of 55 were excluded from statistical analysis.

Sample Characteristics

Female victims and male perpetrators were the focus of analysis due to the small sample size of female perpetrators and male victims. The sample consisted of 219 cases of domestic homicide. Professional mental health diagnoses can be understood as victims who were diagnosed by a mental health professional. Victims who had a professional mental health diagnosis accounted for 14% (n = 32) of cases. Suspected mental health concerns were understood as concerns that friends and family of the victim had regarding the victim’s mental health. Victims who had a suspected mental health concern accounted for 23% (n = 52) of cases. Victims who had addiction concerns accounted for 14% (n=31) of cases. Victims who experienced controlling behaviours at the hands of their perpetrators accounted for 34% of the cases (n = 76). Victims who experienced an intuitive sense of fear accounted for 47% of the cases (n = 103). Victims who did not experience an intuitive sense of fear accounted for 33% of the cases (n = 72), and cases where victim’s fear was unknown consisted of 20% of the cases (n = 44). The presence or absence of children in the home was coded in 169 cases of domestic homicide. Victims who were confirmed to have had the presence of children in their home were involved in 59% (n =100) of 169 cases that fit specified criteria. Victims who did not have the presence of children in their home were involved in 41% (n=69) of 169 available cases that fit specified criteria.

Intuitive Sense of Fear and Risk Factors

An independent samples t-test was conducted to determine if there were differences in the number of risk factors present when victims experienced an intuitive sense of fear. Victims experienced a higher number of risk factors when they were fearful (*M* = 13.73, *SD* = 4.91) compared to when they were not fearful (*M* = 7.24, *SD* = 4.66). There was a statistically significant difference between the groups, $t(173) = -8.79$, $p < .05$ (Refer to Table 1 for additional information). Ten of the most prevalent risk factors emerged when focused on victims who displayed an intuitive sense of fear, and those who did not (Refer to Table 2 for this data)

Table 1. Independent Samples T-test on Average Number of Risk Factors when Intuitive Sense of Fear was Present.

	Victim Intuitive Sense of Fear			
Average # of Risk Factors.	Yes **(n = 103)**	No **(n = 72)**	*df*	*t*
	M *(SD)*	M *(SD)*		
Average # of Risk Factors:	13.73 (*4.91*)	7.24 (*4.66*)	173	-8.79*

Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review. *p < .001.

Table 2. Descriptive Analysis on Top Ten Risk Factors when Fear is Present/Not Present.

Top 10 Risk Factors in Cases Where Intuitive Sense of Fear was Present.		Top 10 Risk Factors in Cases Where Intuitive Sense of Fear was not Present.	
Risk Factor	n (%)	Risk Factor.	n (%)
History of Domestic Violence in Current Relationship.	94 (93.1)	Actual or Pending Separation	39 (55.7)

Actual or Pending Separation	84 (82.8)	History of Domestic Violence in Current Relationship	38 (52.8)
Obsessive Behaviour by Perpetrator	66 (75.0)	Perpetrator Depressed (Professional)	37 (54.4)
Escalation of Violence	64 (74.4)	Perpetrator Depressed in Opinion of Family and Friends	30 (45.5)
Prior Attempts to Isolate Victim	59 (68.6)	Obsessive Behaviour Displayed by Perpetrator	28 (41.2)
Prior Threats to Kill Victim.	57 (68.7)	Prior Threats to Commit Suicide (Perpetrator)	27 (44.3)
Perpetrator Depressed	56 (64.4)	Excessive Alcohol/Drug Use by Perp	25 (35.7)
Perpetrator Jealous of Victim	53 (62.4)	New Partner in Victim's Life Real/Perceived	21 (30.4)
Controlled Victim	52 (61.9)	Perpetrator Unemployed	21 (30.0)
Prior Threats to Commit Suicide – Perp	52 (67.5)	Perpetrator Professionally Diagnosed with Depression	19 (29.2)
Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review		*Note.* Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review.	

Victim Intuitive Sense of Fear and the Presence of Children in the Home

A chi-square test of independence was conducted to examine the role of the presence of children in the home, on victim's intuitive sense of fear. These results are presented in Table 3. Results did not reveal a statistically significant association between the presence of children in the home, and victim's intuitive sense of fear, $\chi^2(2) = .333$, $p = .564$. There was a small

association between victim's intuitive sense of fear and the presence of children in the home, (Cohen, 1988), Cramer's V = .049.

Table 3. Chi Square Analyses of Victim Sense of Fear and Presence of Children in the Home.

Presence of Children in the Home	Victim Intuitive Sense of Fear		χ^2
	Yes **(n = 85)**	No **(n = 51)**	
	% (n)	*% (n)*	
Yes	52.0 (44)	57.0 (29)	.333
No	48.0 (41)	43.0 (22)	

Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review.

Victim Intuitive Sense of Fear and Informal/Formal Help-Seeking Behaviours

A chi square test of independence was conducted investigating the role of victim's intuitive sense of fear on informal help-seeking behaviours. This analysis investigated the role of victim's intuitive sense of fear on presence of victim's family support. There was not a statistically significant association between victim's intuitive sense of fear and presence of victim's family support, $\chi^2(6) = 3.460$, $p = .749$. The association was small (Cohen, 1988), Cramer's V = .094.

A chi-square test of independence was conducted which investigated the role of victim's intuitive sense of fear on the involvement of friends. These results are presented in Table 4. Results revealed a statistically significant association between victim's intuitive sense of fear and

the presence of friends, $\chi^2(1) = 19.56$, $p = .000$. In particular, 71% of victims who experienced an intuitive sense of fear had friends who were aware of the abusive situation, versus 29% of victims who were not fearful, but had friends who were aware of the abuse. There was a moderately strong association between victim's intuitive sense of fear and the presence of friends, (Cohen, 1988), Cramer's V = .300, $p < .001$.

A chi-square test of independence was conducted which investigated the role of victim's intuitive sense of fear on the involvement of co-workers. These results are presented in Table 4. There was a statistically significant association between victim's intuitive sense of fear and the involvement of co-workers, $\chi^2(1) = 8.634$, $p < .001$. Analyses demonstrated that 71% of victims who were fearful, also had co-workers who were aware of their abusive situation, versus 30% of victims who were not fearful, but had co-workers who were aware of their abusive situation. There was a small association between victim's intuitive sense of fear and the presence of coworkers, (Cohen, 1988), Cramer's V = .258, $p = .003$.

A chi-square test of independence was conducted investigating the role of victim's intuitive sense of fear on the involvement of neighbours. These results are presented in Table 4 There was a statistically significant association between victim's intuitive sense of fear and the involvement of neighbours, $\chi^2(1) = 10.30$, $p < .001$. Findings demonstrated that 69% of victims who experienced an intuitive sense of fear had neighbours who were aware of their abusive situation. In contrast, 31% of victims who were not fearful disclosed their abusive situation to their neighbours. Findings suggest that fearful victims engaged in more informal help-seeking behaviours, than victims who did not experience an intuitive sense of fear. There was a small association between victim's intuitive sense of fear and the presence of neighbours (Cohen, 1988), Cramer's V = .297, $p < .001$.

Table 4 presented the findings between victim's intuitive sense of fear, and victim's family support, as well as support from friends, co-workers, and neighbours.

Table 4. Chi Square Analysis of Victim Sense of Fear and Informal Help-Seeking.

	Victim Intuitive Sense of Fear		
Help-Seeking Behaviours	Yes	No	
Informal Help-Seeking	*% (n)*	*% (n)*	χ^2
Victim Family Support	**N = 62**	**N = 52**	
Yes	53.2 (50)	46.8 (44)	2.197
No	60.0 (12)	40.0 (8)	
Friends	**N = 98**	**N = 57**	
Yes	71.1 (91)	28.9 (37).	19.56***
No	25.9 (7)	74.1 (20)	
Co-Workers	**N = 76**	**N = 54**	
Yes	70.6 (48)	29.4 (20)	8.63**
No	45.2 (28)	54.8 (34)	
Neighbours	**N = 64**	**N = 53**	
Yes	68.9 (42)	31.1 (19)	10.30**
No	39.3 (22)	60.7 (34)	

Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review. ** $p < .01$, ***$p < .001$.

An independent samples t-test was conducted to determine if there were differences in formal help-seeking when victims experienced an intuitive sense of fear. Victims engaged in more formal help-seeking behaviours when they were fearful (M = 3.50, SD = 3.20) compared to

when they were not fearful (*M* = 2.23, *SD* = 2.47). There was a statistically significant difference between the groups, *t*(163) =-2.89, $p < .05$. Refer to Table 5 for additional information.

Table 5. Independent Samples T-test on Victim Sense of Fear and Formal Help-Seeking.

Formal Help-Seeking.	Victim Intuitive Sense of Fear			
	Yes **(n = 95)**	No **(n = 71)**	*df*	*t*
	M *(SD)*	M *(SD)*		
Agency Involvement	3.50 (*3.20*)	2.23 (*2.47*)	164	-2.89*

Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review. *p = .004.

Victim Intuitive Sense of Fear and Perpetrator's Controlling Behaviours

A chi-square test of independence was conducted which investigated the role of victim's intuitive sense of fear on perpetrator's controlling behaviours (Refer to Table 6 for findings). There was a statistically significant association between victim's intuitive sense of fear and perpetrator's controlling behaviours, $\chi^2(1) = 26.11$, $p = .000$. To elaborate, 79% of victims who experienced an intuitive sense of fear also had their daily activities controlled by their perpetrator versus 21% of victims who were not fearful and had their daily activities controlled by their perpetrator. These findings suggest that victims who experience high levels of controlling behaviours by their perpetrators may have experienced higher levels of intuitive fear, compared to victims who were not experiencing controlling behaviours. There was a moderate association between victim's intuitive sense of fear and perpetrator's controlling behaviours, (Cohen, 1988), Cramer's V = .414, $p = .000$.

Table 6 presented the findings between victim's intuitive sense of fear and perpetrator's controlling behaviours. Perpetrator's controlling behaviours was understood through the lens of controlling most or all of the victim's daily activities.

Table 6. Chi Square Analyses of Victim Sense of Fear and Perpetrator's Controlling Behaviours.

Perpetrator's Controlling Behaviours	Victim Intuitive Sense of Fear		χ^2
	Yes **(n = 84)**	No **(n = 68)**	
	% (n)	*% (n)*	
Yes	78.8 (52)	21.2(14)	26.11***
No	37.2 (32)	62.8 (54)	

Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review. ***p < .001.

Victim Intuitive Sense of Fear and Mental Health Concerns and/or Addictions

A chi-square test of independence was conducted which investigated the role of victim's intuitive sense of fear on victim substance use. There was not a statistically significant association between victim's intuitive sense of fear and victim substance use, $\chi^2(1) = .390$, $p = .532$. The association was small (Cohen, 1988), Cramer's V = .051.

A chi-square test of independence was conducted which investigated the role of victim's intuitive sense of fear on victim mental health diagnosis. There was not a statistically significant association between victim's intuitive sense of fear and victim mental health diagnosis, $\chi^2(1) = .000$, $p = .997$. The association was non-existent (Cohen, 1988), Cramer's V = .000.

A chi-square test of independence was conducted which investigated the role of victim's intuitive sense of fear on suspected victim mental health concerns. There was not a statistically significant association between victim's intuitive sense of fear and suspected victim mental health concerns, $\chi^2(1) = .930$, $p = .335$. The association was small (Cohen, 1988), Cramer's V = .085.

Table 7 presented the findings between victim intuitive sense of fear and victim substance use, victim mental health diagnosis, and suspected mental health concerns. This accounts for victim mental health concerns and/or addiction concerns, from a professional and informal standpoint.

Table 7. Chi Square Analysis on Victim Sense of Fear and Mental Health Concerns and/or Addictions.

	Victim Intuitive Sense of Fear		
Mental Health and Addictions	Yes	No	χ^2
Mental Health	*% (n)*	*% (n)*	
Professional Diagnosis	**N = 78**	**N = 55**	
Yes	58.6 (17)	41.4 (12)	.997
No	58.7 (61)	41.3 (43)	
Suspected (informal)	**N = 76**	**N = 52**	
Yes	53.5 (23)	46.5 (20)	.335
No	62.4 (53)	37.6 (32)	
Addictions	**N = 90**	**N = 63**	
Yes	53.6 (15)	46.4(13)	.532
No	60.0 (75)	40.0 (50)	

Note. Numbers represent observed frequencies. *N* values may vary due to large amounts of data missing from the file review.

Perpetrator's Controlling Behaviours as a Moderating Variable

A multinomial regression was conducted which investigated the relationship between victim's intuitive sense of fear and friends who were aware of the abuse was explored with the moderating effects of perpetrator's controlling behaviours being included in analysis. Refer to Table 8. The addition of perpetrator's controlling behaviours did improve the fit between model and data, $\chi^2(1) = 11.95$, $p < .001$. The Likelihood Ratio Tests determined that perpetrator's controlling behaviours is an independent, statistically significant moderating variable on the relationship between victim's intuitive sense of fear, and friends who were aware of the abuse, $\chi^2(1) = 4.69$, $p < .05$. This finding suggests that victims who experience a controlling perpetrator will disclose their abuse to their friends when experiencing an intuitive sense of fear, $\chi^2(1) = 1.37$, $p < .05$.

Table 8. Perpetrator's Controlling Behaviours Moderating the Relationship between Victim Intuitive Sense of Fear, and Friends Aware of the Abuse.

Predictors	B	Standard Error	*df*	*p*
Perpetrator's Controlling Behaviour	1.372	.688	1	.046*
Intuitive Sense of Fear	-1.634	.573	1	.004**

Note. Numbers represent observed frequencies. * p < .05, ** p < .01.

Discussion

This study examined prior intuitive sense of fear in domestic homicide victims. The purpose was to identify the impact of several factors on this sense of fear; namely the presence of children in

the home, perpetrator's controlling behaviours, and victim mental health and/or addiction concerns. This study utilized Ontario Domestic Violence Death Review Committee data to determine differences between fearful victims, and victims who did not express fear.

Victims were more fearful when faced a significantly greater number of risk factors. Overall, this study determined that victims were not more fearful when children were present in the home but were more likely to disclose the abuse to informal supports such as friends, co-workers, and neighbours when feeling fearful. As well, victims who were fearful found themselves more likely to engage in formal supports such as community agencies. If a perpetrator displayed controlling behaviours, his victim was more likely to experience fearfulness, and those who were fearful experienced higher numbers of risk factors. This study found that the relationship between victim's fearfulness and friends who were aware of the abuse was significantly moderated by perpetrator's controlling behaviours, and the top ten risk factors for fearful and not fearful victims was highlighted.

Will the Number of Risk Factors Present Influence Victim's Sense of Fear?

When comparing victim's intuitive sense of fear and the number of risk factors present in their case, there was a significant finding. It was hypothesized that victims who experienced an intuitive sense of fear would experience a higher number of risk factors pertaining to their DV situation, and this is reflective of previous literature in the field. When investigating the role of risk factors in DV relationships, it has been identified that lethality may increase with more rather than fewer risk factors, which may influence victim's fearfulness (Dawson & Pisctelli, 2017). This finding suggests that fearfulness may be partly due to the increased number of risk factors present which can elevate risk and danger for the victim. In contrast, this finding also reveals that victims may be fearful based on an increase in risk factors, and not necessarily due to

their own intuition or knowledge of the perpetrator's dangerousness. Victims may also experience an intuitive sense of fear based on the reality of their situation – which is dependent on their accurate knowledge of the DV relationship.

Despite a higher number of risk factors for victims who were fearful, victims who were not fearful were still exposed to an average of seven risk factors. This finding creates an opportunity for community supports such as counselling services to reach out to victims of DV who may be reluctant to seek help, or who do not recognize their elevated risk. These victims may present as women who are suffering from mental health concerns or addictions, or women who believe that they deserve their abusive relationship due to manipulation by the perpetrator or prior abusive relationships. Future research is necessary to explore the origins of victim fearfulness, opportunities to communicate fear by community supports, and the influence that risk factors may have on the victim's ability to recognize their risk.

The top ten risk factors were also identified for victims who experienced an intuitive sense of fear, and victims who did not experience an intuitive sense of fear. Victims who did not experience fearfulness towards their perpetrator experienced risk factors that revolved around the perpetrator's mental health, perpetrator addictions, or the loss of employment by the perpetrator. This finding suggested that victims may be concerned with their partner's mental health and/or addictions, or experienced financial instability which may result in the victim missing the opportunity to recognize their elevated risk for lethality.

Victims who did experience fearfulness towards their perpetrator were exposed to risk factors that were consistent with aggressive and overtly dangerous acts by the perpetrator such as an escalation of violence, prior threats by the perpetrator to kill the victim, perpetrator's controlling behaviours, attempts to isolate the victim, and obsessive behaviours by the

perpetrator. These findings create opportunities for community supports who come into contact with the victim to identify ways to reduce the victim's risk such as staying in a VAW shelter, creating a safety plan, and informing social supports in the victim's life of the abusive situation.

Will Victim's Sense of Fear Influence their Formal/Informal Help-Seeking?

Informal Help-Seeking

When comparing victim's fear and victim family support, there were no significant differences between the two groups. This finding was not predicted, and it was hypothesized that victims who displayed an intuitive sense of fear would utilize an informal support such as the support of their families more often than victims who were not fearful. The absence of significant findings sheds insight on the complexity of involving family members in DV relationships.

Previous research conducted which focused on victim family support was consistent with this study's findings. Victims who feared that their perpetrators would hurt their family members in retaliation for helping them was investigated while highlighting one victim's testimonial that stated, "He may hurt me worse, or the people I love, because of my efforts to keep away from him" (Thomas, Goodman, & Putnins, 2015). This finding supports the notion that victims may have not disclosed to their families for concern over their safety, and that further research should be conducted on the complexities of family dynamics within DV situations. In addition, formal agencies should safety plan with their clients around techniques to mitigate risk towards their immediate family, and techniques to lower their risk (i.e., changing locks to doors, travelling with another person, police services being aware of their elevated risk) if this were to arise as a concern of the victims.

Analyses from the current study revealed that victim intuitive sense of fear was present in 71.1% (n = 91) of cases, when friends were aware of the abusive relationship. This finding was hypothesized and is consistent with previous research that victim intuitive sense of fear would have a positive relationship with informal supports related to help-seeking. This finding is supported through Leone, Lape, & Xu (2014) in which "victims of domestic violence might rely on familiar people to validate their experiences, make recommendations about counseling or anger-management, and/or provide a place to 'cool off'" (p. 1870).

Although findings regarding disclosure to friends were positive, victims of DV tended to disclose to their co-workers. When investigating the influence of victim fear on disclosure of DV to co-workers, this study revealed statistically significant group differences. Fearful victims disclosed their abuse to their co-workers 70.6% (n = 48) of the time, compared to victims who were not fearful who disclosed to their co-workers 29.4% (n= 20) of the time. This finding is supported in pre-existing literature by Thomas, Goodman, & Putnins (2015) that investigated the journey victims took in order to achieve safety from their perpetrators. This study reported victims "turning outwards in their efforts to become safer, which included seeking help from informal sources such as coworkers" (p. 171). This finding suggests that victim fear is more likely to result in a disclosure of violence to coworkers and emphasizes the need for future research involving safety management and disclosure protocol for DV in the workplace. In addition, efforts to provide training for domestic violence in the workplace can educate co-workers on how to appropriately act during disclosures of domestic violence and high-risk situations.

This study conceptualized informal help-seeking to include neighbours who were aware of the victim's abuse. Analyses revealed that there were significant group differences between

fearful and non-fearful victims, when disclosing information about their abusive relationship to neighbours. Fearful victims disclosed their abuse to neighbours 68.9% ($n = 42$) of the time, compared to victims who were not fearful, in which they disclosed to their neighbours 31.1% ($n = 19$) of the time. This finding is consistent with previous literature, which stated that neighbours are an informal resource, and a positive opportunity for victims to cope (Hardesty, Campbell, McFarlane, & Lewandowski, 2008). This finding creates the notion that neighbours can play a large role in DV situations and should be incorporated into victim safety plans when appropriate or possible.

Formal Help-Seeking

Another major finding of this study was the relationship between victim's intuitive sense of fear and formal help-seeking behaviours, operationalized through agency involvement. On average, victims who displayed an intuitive sense of fear were involved with one and a half formal agencies. This finding suggested that fearful victims were engaged in formal agency contact more often than non-fearful victims. This finding was hypothesized and supported in previous literature, that highlighted fearful victims utilizing formal and informal sources of support. Researchers suggested that "disclosure to a friend or family member may act as a precursor to formal help-seeking" (Evans & Feder, 2014). Community agencies should provide adequate training to their staff on how to support clients who are experiencing an intuitive sense of fear, or a lack of fearfulness towards their partner. This training may include responding appropriately to disclosures, providing robust and comprehensive safety plans, and minimizing the amount of risk that the client is currently experiencing.

Will Children in the Home Influence Victim's Intuitive Sense of Fear?

A sample of victims who displayed an intuitive sense of fear was compared to a sample of victims who did not display an intuitive sense of fear. There was not a significant difference between these two groups, and this result was not predicted. It was hypothesized that victims who had children present in the home would experience an intuitive sense of fear more so than a victim who did not have children present in the home.

These findings are consistent with previous research, which focused on a sample of 301 survivors of domestic violence, and their perception, evaluation, and expectation of the costs surrounding their safety-seeking efforts (Thomas, Goodman, & Putnins, 2015). These women have stated that "some stayed in their DV relationship to prevent their children from having to take an active role in the process of leaving" (Thomas, Goodman, & Putnins, 2015). Consistent with previous recommendations from the DVDRC (2016), the Ontario Association of Children's Aid Societies should ensure that "all child welfare workers receive training on how to effectively respond to families who are experiencing or have experienced domestic violence." These suggestions may help child welfare workers better attend to women's needs and ensure that women who are not fearful for their children's welfare receive adequate and appropriate support when recognizing their risk, and their children's risk.

Will Perpetrator's Controlling Behaviours Influence Victim Intuitive Sense of Fear?

Although this study sought to investigate the relationship between victim's intuitive sense of fear and their help-seeking behaviours, a focus on perpetrator's controlling behaviours provided a more comprehensive understanding of DV situations. There were significant group differences between fearful and non-fearful victims, when their perpetrator displayed efforts to

control their daily activities. Upon analyses, 78.7% (n = 52) of victims experienced an intuitive sense of fear when they were experiencing a controlling perpetrator versus, victims who did not experience an intuitive sense of fear 21.2% (n = 14) when controlled.

Although the presence of victim's fear is notable, the absence of fear can also be a powerful indicator to the complexity of DV. Victims who did not experience a sense of fear and had a controlling perpetrator highlights the impact that controlling behaviours can have on fearfulness. This finding may be due to large numbers of unknown data regarding victim's fear or victims who are exhibiting characteristics of "freezing". When in threatening situations, victims can demonstrate fight, flight, freezing, and submission, which are designed for survival (Haskell & Randall, 2009).

During a traumatic event such as DV, a victim finds herself under intense and chronic threat, thus may be unable to process information. This may leave victims unable to remember an event, and how it was endured, and unable to make a decision on how to proceed (Haskell & Randall, 2009). These findings suggest additional research surrounding victim's expression of fear when experiencing chronic threat. These findings are consistent with previous literature and speaks to the level of stress associated with a controlling, abusive partner. Victims who experience a controlling perpetrator may engage in "placating" whereby the victim will attempt to avoid challenging the abuser's controlling behaviours by keeping the household calm or avoiding provocation as two examples (Thomas, Goodman, & Putnins, 2015). This finding speaks to the length victims will go to accommodate their partner's controlling behaviours, out of fear towards the repercussions if they do not comply.

Consistent with recommendations from the DVDRC (2016), information should be made available to the public that discusses "the potential risk of lethal violence at the time of

relationship breakdown, and recommendations on how to engage in and/or support a “safe” separation for couples experiencing domestic violence.” Public education such as this may help mitigate the negative effects of perpetrator’s controlling behaviours and ensure a safe separation that decreases the likelihood of violence directed towards the victim.

Will Victims who Experience Mental Health Concerns be Fearful?

Mental health concerns were operationalized as a professional diagnosis, and a suspected diagnosis. For both considerations of victim mental health concerns, there were no group differences between fearful and non-fearful victims. Interactions between these variables have been discussed in previous literature, in which “victim’s perceptions of social support may directly affect their mental health by moderating their sense of well-being” and that their “perceptions of social support may mediate the relationship between abuse and mental health” (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). In these instances, victims of DV may not perceive social support to be useful, if they are not fearful of the DV situation they find themselves in. These findings suggest that victim mental health may be a critical component when assessing for risk and danger, as well as social support and help-seeking behaviours.

Will Victims who Experience Addiction Concerns be Fearful?

Victims who were fearful and addicted to substances were compared to victims who were not fearful and addicted to substances. There were no significant group differences between the two groups, suggesting that victims who were addicted to substances did not significantly differ in their fearfulness compared to victims who were not addicted to substances. Previous literature investigating the role of addictions in abusive relationships discusses various barriers that addictions pose for victims. Sheehan, Murphy, Moynihan, Dudley-Fennessey, & Stapleton

(2015) reported that “victims who are addicted to substances may have a lack of access to substance abuse services, which removes the ability to recover from their addictions, and participate in a healthy intimate relationship” (p. 280). These findings suggest that victims may not experience fearfulness due to their preoccupation with their substance abuse concerns, or an inability to access community agencies which leaves them in a highly dangerous and vulnerable position.

Consistent with recommendations from the DVDRC (2016) that state “all mental health and addictions services in the province mandate training for all staff of the co-occurrence of domestic violence, mental health problems, and substance abuse.” This study encourages formal agencies to engage in training opportunities such as (http://dveducation.ca/makingconnections/) to develop a cohesive understanding on the co-occurrence of mental health concerns, addiction concerns, and DV.

Implications

The implications of this study translate to a variety of service providers, such as community agencies, police services, and informal supports such as families, neighbours, co-workers, and friends. Each source of formal and informal support has a unique role in supporting victims and survivors of domestic violence.

When community agencies and police services encounter victims who have disclosed their abuse to informal supports such as their friends, co-workers, and neighbours, this should be understood as a display of their fearfulness and should not be taken lightly. The findings of this study point to victim’s informal help-seeking behaviours as indicative of their intuitive sense of fear. Given this, professionals should interpret these informal disclosures with as much

weighting as a formal agency disclosure. In addition, disclosures made to informal supports will give insight to agencies regarding a victim's fearfulness and its severity, which can be ambiguous and subjective at times to identify.

When assessing a victim's intuitive sense of fear, referring to previous agency involvement allows victim's fearfulness to be assessed. As reported in this current study, fearful victims sought help from a higher number of formal agencies compared to victims who were not fearful. This knowledge can assist professionals when working with individuals who are in an abusive relationship, and especially when assessing for fear. Additionally, this fear can inform professionals on the likelihood that victims would contact a formal agency in comparison to victims who are not fearful which may have implications for professional practice.

Victims who are not fearful are less likely to utilize formal agencies which limits opportunities for help from community professionals. Instead, victims of DV who are not fearful may have their elevated risk communicated to them by informal supports. The findings from this study suggest that informal supports may be in a unique opportunity to communicate their fear to women who are not fearful of their perpetrator, with the intention of the woman recognizing her elevated risk and the associated danger that comes along with it. This opportunity for public education can be extended varying types of informal support such as friends, family, co-workers, and neighbours. Additional information for discussing abuse with a victim of DH is available on the web-site of Neighbours, Friends, & Families (full report at http://www.neighboursfriendsandfamilies.ca/content/sncit-conversation-framework-see-it-name-it-check-it).

Victims who had a controlling perpetrator can use these experiences to reflect on how fearful their perpetrator's controlling behaviours made them. Victim's intuitive sense of fear can

be difficult to acknowledge, and community supports can help a victim of DV identify her fearfulness towards her perpetrator by focusing on their perpetrator's controlling behaviours. When using controlling behaviours as a gateway to discuss victim's fear, it allows the professional to discuss concepts such as power and control to get victims to potentially recognize their fearfulness towards their perpetrator.

Lastly, victims who are experiencing a higher number of risk factors will be more likely to experience an intuitive sense of fear. Their intuitive sense reflects the reality of their situation. Previous literature has stated that "it is recognized that risk of lethality may increase with the presence of more rather than less risk factors" (Dawson & Piscitelli, 2017). Information pertaining to number of risk factors is important when assessing for risk of lethality, but also victim's intuitive sense of fear. As lethality increases, the victim may be subjected to elevated risk which may influence her intuitive sense of fear. By recognizing this increase in lethality and intuitive sense of fear, this may provide the motivation to safely leave an abusive relationship with support of a formal agency and/or community services. In contrast, this finding could be indicative of victims of DV who are exposed to higher number of risk factors that are aware of their elevated risk of danger, and not necessarily fearful.

Overall, the findings of this study provide an understanding of victim fearfulness, it's influence on formal and informal help-seeking, and its relation to other identified risk factors. Community agencies and services are responsible for ensuring their client's safety, and client disclosure of their abuse provides critical information to assist community professionals on achieving this safety, while facilitating help-seeking behaviours if it is safe to do so.

Future Research and Practice

Based on the findings of this current study, future directions for research and practice are suggested below as a way to support victims affected by domestic violence.

Victims who were not fearful of their perpetrators require future research that addresses the most effective strategies on supporting victims who are living with their perpetrator of DV, but are not recognizing their elevated risk, or fearfulness. Victims in these situations are experiencing elevated risk for DV and DH and by remaining not fearful, these women continue to put their lives at risk.

Future research should focus on the complexities of family dynamics within DV situations, with an emphasis on victim disclosure of DV to their families. By developing a better understanding of the family dynamics within an DV framework, families can become aware of how to best support their family member who is experiencing violence. Families may help by raising concerns about the potential dangers and foster the positive benefits of fear in taking action rather than being paralysed by these feelings. Victims who are fearful of their perpetrator and have the support of their family may be more likely to engage formal and/or informal support systems which may decrease their risk. Without the support of their family, victims of DV may not decrease their risk which highlights the importance of a strong family support system.

Previous literature has identified informal help-seeking behaviours as an effective precursor to formal help-seeking behaviours. Given these findings, community agencies may have a unique opportunity to utilize a victim’s informal support network when completing a safety plan with victims. Future research should identify the protective factors that friends,

family, neighbours, and co-workers offer and how these supports can work in tandem with formal community agencies to provide support, safety, and protection from their perpetrator.

When investigating help-seeking behaviours, a victim's response to chronic threat may vary and may present as a "freezing" response in which the victim is focused solely on their survival. These victims may be women who are not displaying an intuitive sense of fear. Future research should focus on the phenomenon of "freezing" in DV relationships and its impact on victim's intuitive sense of fear and formal and informal help-seeking. By orientating research in this direction, community agencies may be able to develop effective strategies for clients who are not fearful and displaying characteristics of chronic traumatic stress.

As well, there is an opportunity to address the perpetrator's use of violence which has not been utilized to its fullest extent. Additional efforts towards ending men's use of violence against women must be targeted towards men who have perpetrated, and men who are at high risk of perpetrating violence against their partners.

Lastly, future research should identify how to best support victims of domestic violence who are also experiencing addiction concerns. Prior research indicated that these victims may become addicted to substances as a means to cope, but that this may inhibit her ability to recognize her elevated risk. Future directions include formulating strategies to best support victims during their transition away from DV. This population is complex, since victims may not wish to recover from their addiction, and best practices must be identified given their increased state of vulnerability.

Limitations

This study has several limitations. Given the nature of the data, this study did not have a comparison group of women who survived their abusive relationship. This limitation does not allow for the opportunity to recognize the influence that fearfulness and community support had on the victim's survival, along with the potential benefits. Despite this limitation, it is recognized that there were multiple paths to these tragedies, and each case may have required its own unique solution depending on whether the victim was fearful and sought help or not fearful and refrained from seeking help.

Regarding victim intuitive sense of fear, there is uncertainty of the origins of victim intuitive sense of fear. Women may have developed an intuitive sense of fear on their own, or it could have developed through friends and family communicating their fearfulness to the victim. This limitation creates some uncertainty surrounding victim's intuitive sense of fear, and ambiguity on the impacts that informal sources of support may have on this fear. In addition, when exploring victim intuitive sense of fear and formal agency utilization, the issue of temporal precedence exists. It is impossible to identify whether a victim's fear developed before they reached out for help or after they reached out for help and received messages from professionals stating that the victim "should be fearful". Given this concern, researchers are unable to determine if the victim became fearful independently from external influences, or if these external influences pushed fear into the victim's consciousness. Future research should be conducted on the process and sequence of events between victim's intuitive sense of fear, and the influence of formal and informal sources of support on victim's fear-based cognition.

Victim help seeking behaviours may not be rooted in fear, and this is reflected in the literature, with 43% of victims displaying an intuitive sense of fear (DVDRC, 2016). It is

important to acknowledge that some women may seek help and are not intuitively fearful of their partner. In contrast, being fearful of one's abuser does not always indicate that the woman will seek help. Although this study sought out to examine the relationship between victim's intuitive sense of fear and help-seeking behaviours, we understood that this relationship is not necessarily bidirectional, given the complex nature of domestic violence and domestic homicide. An exploratory analysis of help-seeking behaviours that are not rooted in fear is necessary to better understand this behaviour.

Additionally, victims who were fearful of their perpetrator but did not engage in help-seeking behaviours may have demonstrated a freezing response to their DV. A freezing response can be understood as a response to involuntary engagement, where behaviour is stilled, and attention is compelled toward the stressful transaction (Skinner, Edge, Altman, & Sherwood, 2003). This survival response may provide insight as to why some victims of domestic violence did not engage in help-seeking behaviours, and future research should investigate freezing responses in victims of domestic violence, while adopting a trauma-informed approach on how it may influence their help-seeking behaviours.

Unfortunately, there was a potential for bias during information gathering from police officers, and from individuals who knew the victim and perpetrator. This provides a large opportunity for informants to influence the data in their favour or against the victim or perpetrator, depending on the emotional climate of the informants. This current study was retrospective in nature, therefore it was impossible to interview victims of DH before their death and gather information regarding their experiences with domestic violence. The study is limited by depending on the third-party sources available after the fact. This limitation provides

researchers with the challenge of solely relying on reports from agencies who were in contact with the individuals, and other community services.

Given this limitation, cases exist where data is not available describing the depth of disclosure victims engaged in with friends and family. Therefore, disclosure could have been a victim confiding in an informal source of support with or without the intention of seeking help from them. There may have been disclosures not documented or reported to the police. To add to the complexity of disclosure to informal sources of support, family members may have been aware of the abuse but chose to not involve themselves for an array of reasons. Seeking sources of support is a delicate and complicated matter and by better understanding the many ways that disclosure can appear, an opportunity to educate formal and informal sources of support arises. Future directions include investigating the complexity of disclosure and help-seeking behaviours with an aim to better understand the support victims require that is dependent on their disclosure style.

Despite victim’s intuitive sense of fear being an internal process, victim’s fear can only be conceptualized through recorded behaviours given the retrospective sample. This creates ambiguity on whether an intuitive sense of fear within a victim may have been present, but never acted upon. Moving forward, the complexities of disclosure and help-seeking behaviours should be researched among domestic violence survivors, to better understand how victims communicate their intuitive sense of fear, and to provide a comparison group for what was successful in keeping victim’s safe.

In addition, there was a limited sample size due to the high instances of unknown data. This was accounted for in the data analyses but removed the opportunity for analyses to be completed on a larger, and potentially more powerful sub sample. Despite the intentions to

gather detailed and meaningful data for every instance of domestic homicide, certain files may possess richer information than others. Unfortunately, there are many agencies and professionals who partake in the data collection process which can create the opportunity to varying amounts of information to result.

Lastly, agency involvement may be confounded by children being present in the home, or victim mental health concerns. There may be an increase in agency involvement within an abusive relationship if children are present, not because the woman is fearful but because agencies are concerned for the well-being of the children. In relation, victim mental health concerns may result in community agencies becoming involved – and not victim intuitive sense of fear. Future research should place an emphasis on survivors of domestic violence, with the intention to gain a holistic understanding of the impacts of agency involvement in a home with DV.

Conclusion

In summary, findings illustrate that victims of DV exhibit an intuitive sense of fear that is dependent on their contextual situation. This fear is more than intuitive and may reflect reality since these victims faced a greater number of known risk factors. Due to the complexity of DV, it is important to recognize victim fearfulness while encouraging the use of their formal and informal social support systems. Survivors of DV need to feel supported, listened, and protected. Gathering information on formal agency involvement, perpetrator's controlling behaviours, and certain informal sources of support may have had unique influences on a victim's intuitive sense of fearfulness. Furthermore, community agencies can improve their efforts to support a wide range of victims by developing a more detailed understanding around the complex interactions between victim's fear, and their formal/informal help-seeking behaviours. These informal

systems can be enhanced through public awareness campaigns. The findings of this current study demonstrated the need for service providers to be informed of victim's fearfulness through nuanced aspects that are beyond tangible instances of victim disclosure.

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Appendices

Appendix A

Western University

Non-Medical Research Ethics Board

Study Approval Notice

Date: 14 June 2018

To: Dr. Peter Jaffe

Project ID: 111970

Study Title: Prior Help-Seeking and Intuition of Danger in Homicide Victims.

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: July 6 2018

Date Approval Issued: 14/Jun/2018

REB Approval Expiry Date: 14/Jun/2019

Dear Dr. Peter Jaffe

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Data Summary Form	Other Data Collection Instruments		

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix B

Domestic Violence Death Review Committee Office of the Chief Coroner of Ontario

Risk Factor Coding Form (see descriptors below)

A= Evidence suggests that the risk factor was not present

P= Evidence suggests that the risk factor was present

Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factor	Code (P,A, Unk)
1) History of violence outside of the family by perpetrator/	
2) History of domestic violence- past partners	
3) History of domestic violence- current partner	
4) Prior threats to kill victim	
5) Prior threats with a weapon	
6) Prior assault with a weapon	
7) Prior threats to commit suicide by perpetrator	
8) Prior suicide attempts by perpetrator*(if check #6 and/or #7 only count as one factor)	
9) Prior attempts to isolate the victim	
10) Controlled most or all of victim's daily activities	
11) Prior hostage-taking and/or forcible confinement	

12) Prior forced sexual acts and/or assaults during sex	
13) Child custody or access disputes	
14) Prior destruction or deprivation of victim's property	
15) Prior violence against family pets	
16) Prior assault on victim while pregnant	
17) Choked victim in the past	
18) Perpetrator was abused and/or witnessed domestic violence as a child	
19) Escalation of violence	
20) Obsessive behaviour displayed by perpetrator	
21) Perpetrator unemployed	
22) Victim and perpetrator living common-law	
23) Presence of stepchildren in the home	
24) Extreme minimization and/or denial of spousal assault history	
25) Actual or pending separation	
26) Excessive alcohol and/or drug use by perpetrator	
27) Depression – in the opinion of family/friend/acquaintance - perpetrator*	
28) Depression – professionally diagnosed – perpetrator (If check #26 and/or #27 only count as one factor)	
29) Other mental health or psychiatric problems – perpetrator	
30) Access to or possession of any firearms	

31) New partner in victim's life	
32) Failure to comply with authority – perpetrator	
33) Perpetrator exposed to/witnessed suicidal behaviour in family of origin	
34) After risk assessment, perpetrator had access to victim	
35) Youth of couple	
36) Sexual jealousy – perpetrator	
37) Misogynistic attitudes – perpetrator	
38) Age disparity of couple	
39) Victim's intuitive sense of fear of perpetrator	
40) Perpetrator threatened and/or harmed children	

Appendix C

Domestic Violence Death Review Committee Office of the Chief Coroner of Ontario Risk Factor Descriptions

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

*see Appendix B to match numbers with the appropriate risk factor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21) Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

22) The victim and perpetrator were cohabiting.

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

24) At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility

for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).

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

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

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

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

29) For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.

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

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

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

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

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

35) Victim and perpetrator were between the ages of 15 and 24.

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

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

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

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

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

Appendix D

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

OCC Case #(s): _____________ OCC Region: Central
OCC Staff: ____

Lead Investigating Police Service provider:
Officer(s):
Other Investigating Agencies: _
Officers: __

VICTIM INFORMATION

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

Name:

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

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

Victim made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	

Exposed in childhood or adolescence to domestic violence?	

-- END VICTIM INFORMATION --

PERPETRATOR INFORMATION

**Same data as above for victim

___

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

If yes, check those that apply...
____ Prior domestic violence arrest record
____ Arrest for a restraining order violation
____ Arrest for violation of probation
____ Prior arrest record for other assault/harassment/menacing/disturbance
____ Prior arrest record for DUI/possession
____ Juvenile record
____ Total # of arrests for domestic violence offenses
____ Total # of arrests for other violent offenses
____ Total # of arrests for non-violent offenses

____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history
If yes, check those that apply... ____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history
If yes, check those that apply... ____ Prior domestic violence treatment ___ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management _____Other – specify ______________________________ ____ No info

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

-- END PERPETRATOR INFORMATION –

INCIDENT

Date of incident:

Date call received:

Time call received:

Incident type:

Incident reported by:

Total number of victims:
**Not including perpetrator if suicided

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

Location of crime

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

Cause of Death (Primary Victim)

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

Weapon Use

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

Witness Information

Others present at scene of fatality (i.e. witnesses)?	
If children were present:	
Matthew Jr.	
Michelle	
Andrea	
What intervention occurred as a result?	

Perpetrator actions after fatality

Did perpetrator attempt/commit suicide following the incident?	
If committed suicide, how?	
Did suicide appear to be part of original homicide?	

How long after the killing did suicide occur?	
Was perpetrator in custody when attempted or committed suicide?	
Was a suicide note left? If yes, was precipitating factor identified	
Describe: Perpetrator left note attached to envelope and within the envelope were photos of the victim and her boyfriend and correspondence regarding the purchase of a house in North Dakota and money transfers etc.	

If perpetrator did not commit suicide, did s/he leave scene? .	
If perpetrator did not commit suicide, where was s/he arrested/apprehended? (At scene, turned self in, apprehended later, still at large, other – specify)	
How much time passed between the fatality and the arrest of the suspect: (Hours, days, weeks, months, unknown, n/a – still at large)	

-- END INCIDENT INFORMATION –

VICTIM/PERPETRATOR RELATIONSHIP HISTORY

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

Children Information

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

History of domestic violence

Were there prior reports of domestic violence in this relationship?

Type of Violence? (Physical, other) ____

If other describe: ____
____
____

If yes, reports were made to: (Check all those that apply)

____ Police
____ Courts
____ Medical

____ Family members

____ Clergy
____ Friends
____ Co-workers

____ Neighbors

____ Shelter/other domestic violence program
____ Family court (during divorce, custody, restraining order proceedings)

____ Social services
____ Child protection

____ Legal counsel/legal services
____ Other – specify ____

Historically, was the victim usually the perpetrator of abuse? _____________________

If yes, how known? ____

Describe: ____
____
____

Was there evidence of escalating violence?

If yes, check all that apply:

____ Prior attempts or threats of suicide by perpetrator

____ Prior threats with weapon
____ Prior threats to kill
____ Perpetrator abused the victim in public

____ Perpetrator monitored victim's whereabouts
____ Blamed victim for abuse
____ Destroyed victim's property and/or pets
____ Prior medical treatment for domestic violence related injuries reported

____ Other – specify ____

-- END VICTIM-PERPETRATOR RELATIONSHIP INFORMATION --

SYSTEM CONTACTS

Background

Did victim have access to working telephone? __________________________________

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

Did the victim have access to transportation? ___________________________________

Did the victim have a Safety Plan? ____

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

Agencies/Institutions

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

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

Criminal Justice/Legal Assistance:

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

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

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

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

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

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

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

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

____
Outcome:____

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

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

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

<u>Victim Services (including domestic violence services)</u>

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

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

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

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

<u>Children services</u>

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

____
Outcome:____

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

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

Health care services

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

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

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

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

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

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

<u>Other Community Services</u>

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

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

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

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

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

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

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

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

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

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

-- END SYSTEM CONTACT INFORMATION --

RISK ASSESSMENT

Was a risk assessment done?

If yes, by whom?____

When was the risk assessment done?____

What was the outcome of the risk assessment?________________________________

DVDRC COMMITTEE RECOMMENDATIONS

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

If yes, what would have prevented this tragedy?

____

____

____

____

____

____

____

____

____

____

____

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

Future Research Issues/Questions:

Additional comments:

Appendix E

Curriculum Vitae

Name: Kristina Giacobbe

Post-Secondary Education:

Master of Arts, Counselling Psychology 2017-2019
Western University
London, Ontario, Canada

B.A. Honours Specialization in Psychology 2013-2017
King's University College at Western University
London, Ontario, Canada

Related Work Experience:

Counselling Internship 2018-2019
Psychological Services, Student Development Centre
Western University
London, Ontario, Canada

Group Facilitator 2018-2019
M3 Group
Merrymount Family Support and Crisis Centre
London, Ontario ,Canada

Group Facilitator 2018-2019

ACTing for Wellness

Western University

London, Onario, Canada

Graduate Student Assistantship 2018-2019

CREVAWC

Western University

London, Ontario, Canada