The Dynamics of Murder-Suicide in Domestic Situations

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This paper explores dynamics involved in the commission of homicide followed by suicide. British and U.S. government and advocacy sources are used in addition to news accounts to examine this phenomenon. Domestic violence-related crimes are contrasted with elderly “altruistic” murder-suicide, school shootings, and political terrorism. Suicide is argued to be a primary motive in many domestic homicide situations. Limitation of the availability of firearms is seen as an important means of prevention in conjunction with a harm reduction safety plan. [Brief Treatment and Crisis Intervention 8:274–282 (2008)]

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In the United States and Britain, as elsewhere, a woman is more vulnerable to violence in her home than in public. In the United Kingdom, domestic violence costs the lives of more than two women every week (Home Office, 2005b), and in the United States, with a much larger population, estimates are that more than three women a day are killed by their intimate partners (Rennison, 2003).

Homicide is a leading cause of traumatic death for pregnant and postpartum women in the United States, accounting for 31% of maternal injury deaths (Family Violence Prevention Fund, 2006). In the United Kingdom, pregnancy is a period of high risk as well.

Whereas in the United States, women who are killed are most often killed by guns, in England and Wales, three times as many women are killed by a sharp instrument or by strangulation as by shooting. Over the past decade, about four times as many females who were killed as males who were killed were partners or ex-partners of the murderer (Home Office, 2005a). As in the United States, far more males than females are victimized by homicide of a general nature; they are killed often in fights with other men (Bureau of Justice Statistics, 2005).

An extensive search by Aldridge and Browne (2003) revealed 22 empirical research studies on risk factors for spousal homicide. In the United Kingdom, 37% of all women who were murdered were killed by their current or former intimate partner compared to 6% of men. The most common cause of an intimate partner’s death in England and Wales was being attacked with a sharp implement or being strangled. By contrast, the most common cause in the United States for spousal homicide was getting shot. Nine major risk factors are found that may help predict the probability of a partner homicide and prevent future victims (Aldridge & Browne, 2003).
As anyone who reads or watches local or national news reports in the United States will be aware, a spate of murder-suicides is taking place. The dynamics are relatively similar; a battered woman had told her partner or he had inferred from her behavior that she was making a break in the relationship; the man loaded his gun and shot her and then himself, killing them both. Most of these domestic cases are not reported nationally; they are in headlines in the local paper.

Because government data in the United Kingdom and the United States providing national statistics on homicide that ends in suicide are hard to come by, other, less official and comprehensive sources must be consulted. A recent development in the United States is a promising development, however, for future research. The emerging state-based National Violent Death Reporting System (NVDRS) recently has begun providing data on homicide-suicide for a sample of American states. The majority of the research that is available, however, is not focused on domestic homicide situations.

Homicide-Suicide in the United Kingdom

An analysis of the London Times’ reports of murder (1887–1990) by Danson and Soothill (1996) revealed a total incidence of 6% of 2,274 cases of murder followed by suicide in the United Kingdom. Around the turn of the 20th century, as the researchers suggest, this figure of murder-suicides was much higher at approximately one in three. Murder-suicides, according to Danson and Soothill, are mostly family affairs, especially in cases of female perpetrators. There is a much higher proportion of British male murder-suicides, in general, however, and males much more likely than females to commit their crimes with guns. Overwhelmingly the women committing murder-suicide in the study tended to kill their children and then themselves. Men, on the other hand, tended to kill their spouses or partners.

More recently, in the first epidemiological study of instances of homicide-suicide in England and Wales, Barrachlough and Harris (2002) studied death certificates for all murder-suicides over a 4-year time span. They found that 3% of male, 11% of female, and 19% of child homicides were of this type. Similarly, of all suicides, 0.8% male and 0.4% female deaths occurred in homicide-suicide incidents. The typical cases involved families of low socioeconomic status.

Data provided by the Home Office (2005a) for England and Wales, which are difficult to analyze because the circumstances and timing of suicides following homicide are not clearly spelled out, provide support for earlier findings by Barrachlough and Harris (2002) of a low incidence of murders ending in suicide. One can determine that of the 659 homicides that were committed in 2004, 19 individuals committed suicide before indictments could be issued. We do not know the nature of the homicides, however.

Personal correspondence with Kathryn Coleman of April 10, 2007, of the Direct Communications Unit of the Home Office provided data on suicide following homicide in which the victim was a partner or ex-partner. From the years 1997–2006, there were on average 12 cases each year of male-on-female homicides that ended in suicide. Official Home Office sources reveals that there are around 100 male-on-female homicides for each year (see e.g., Home Office, 2004). So this means that only a small percentage—around 10% of these intimate homicides ends in suicide in England and Wales. As further indicated in the government report, the methods of homicide were by means of a sharp instrument, poison or drugs, beating, and strangulation.
Homicide-Suicide in North America

A rare finding in the American literature is the research presented by Bossarte, Simon, and Barker (2006) who analyzed data from the NVDRS. This active state-based surveillance system includes data from seven states for 2003 and 13 states for 2004. The incident-level structure facilitates identification of homicide/suicide incidents. Results revealed that within participating states, 65 homicide/suicide incidents (homicide rate $= 0.230/100,000$) occurred in 2003 and 144 incidents (homicide rate $= 0.238/100,000$) occurred in 2004. Most victims (58%) were current or former intimate partners of the perpetrator. Among all male perpetrators of intimate partner homicide, 30.6% were also suicides. A substantial proportion of the victims (13.7%) were the children of the perpetrator. Overall, most victims (74.6%) were females and most perpetrators were males (91.9%). A recent history of legal problems (25.3%) or financial problems (9.3%) was common among the perpetrators.

From Statistics Canada (2005), we learn that over the past 40 years, 1 in 10 solved homicides were cases in which the suspect took his or her own life following the homicide. About three-quarters of these victims were killed by a family member. Virtually all the incidents (97%) involved female victims killed by a male spouse. And, as Eastal (1994) demonstrated in an earlier study, one-third of “spousal” homicides in the United States and Canada end in suicide. Few other varieties of homicide end in this way.

Probably related to the availability of guns, the homicide rate in the United States is much higher than the British rate, although the difference has diminished in recent years. According to an international comparative study, the homicide rate in the United States is 0.04 per 1,000 residents, whereas in the UK, the rate is 0.014 per 1,000 residents (NationMaster.com, 2007). The difference in homicide rates between large American and British cities is even more pronounced.

Guns are by far the most common weapon used in these crimes (Violence Policy Center [VPC], 2006). One could speculate that if you shoot someone, it is relatively easy to then turn the gun on yourself. If you stab or strangle someone, however, suicide becomes much more difficult. In any case, the high rate of spousal murder-suicides is consistent with the murder-as-extended-suicide hypothesis of Palermo (1994).

Notably, in 1992, the Journal of the American Medical Association (JAMA) reviewed the epidemiology, patterns, and determinants of murder-suicide and made a strong case for the need for systematic data gathering so that prevention strategies can be developed (Marzuk, Tardiff, & Hirsch, 1992). Although there is no standardized definition of murder-suicide, the JAMA report proposed that the term murder-suicide be restricted to a situation in which the suicide follows the homicide by 1 week at the most. Extrapolating from the test statistics available, it is probable that in the United States the murder-suicide represents 1.5% of all suicides and 5% of all homicides annually, according to this review. In Denmark, on the other hand, 42% of homicides are of this variety.

JAMA’s summary of data on the mother/child murder-suicide indicated that only a tiny fraction of mothers who commit infanticide kill themselves although they often attempt or plan to do so. Mothers who kill their children typically suffocate, drown, or stab them; firearms are rarely used. The depressed, suicidal mother may psychotically perceive her child as an extension of herself. A form of “deluded altruism” may be the motive, according to this report.

According to the VPC (2002), at least 662 people died in murder-suicides in the United States during the 6-month period of the 2002 study.
That averages out to about two such killings per day. Three-fourths of the murder-suicides involved “intimate partner” situations; of these, 94% involved male attacks on women.

The most recent study by VPC (2006) reported 591 murder-suicide deaths nationwide between January 1 and June 30, 2005. This averages out to 10 murder-suicide events each week. Of those, Texas had 18 cases. Other statistics from the VPC include:

- Male offenders: 94%
- Cases involving an intimate partner: 74%
- Occurred in the home: 75%
- Involved a firearm: 92%
- Average age difference between offender, primary victim: 6.3 years

In Iowa, a Midwestern state with a relatively low crime rate, between 1995 and 2005, 106 Iowans killed a partner or spouse in a domestic situation. The main factor appeared to be a pending breakup. Ninety-six of the killers were men; about half committed suicide shortly afterward. In Pennsylvania, of 97 homicide incidents in 2001, 81 of the perpetrators were males and 16 females, 58 of the victims were shot, and 29 of the perpetrators committed suicide (Pennsylvania Coalition against Domestic Violence, 2003).

To determine the recent frequency of reports at the national level, I went to www.google.com, typed in murder-suicide, pressed “search,” then went to news in the row above, which gives recent news stories for that item. Indeed, the frequency was high; there are at least two or more reports of these double or triple murders for each day, and we have to keep in mind that all newspaper headlines are not recorded on google. So we can conclude that even two of these events per day is an underestimate. My search as of June 10, 2005 (reported by van Wormer & Bartollas, 2007), yielded the following recent incidents for that week:

**Ansonia, CT:** A 27-year-old man strangled his wife, and then jumped off the roof to his death. The two were Albanian; theirs was an arranged marriage, one reportedly fraught with difficulty.

**Milwaukie, OR:** A couple in their 80s who had often been seen strolling arm-in-arm was found dead of gunshot wounds, a case of suspected murder-suicide.

**Union, SC:** Problems with money and child custody seemed to be precipitating factors in this murder-suicide committed by a husband in his 20s.

**New Providence, NJ:** An elderly couple was found dead in what authorities called a murder-suicide. The husband’s note seemed to confirm this.

**Lakewood, WA:** A couple in their 20s was found shot to death in an apparent homicide and suicide. Police said the man had broken into his ex-girlfriend’s home with a hammer. There was a history of stalking.

**Landenberg, PA:** A man who shot and killed his wife and two sons before killing himself was said to be suffering from depression.

All these cases took place in the space of several days. That the stories were typical was confirmed in later checks on www.google.com. As can be seen from these illustrations, this form of suicide, unlike other instances of suicide, is hardly a solitary act. During the 6-month period of the VPC study, more people died from murder associated with the suicide—369—than from suicide itself—293. Children in the family were orphaned, and others were left in a state of despair.

As reported by the VPC (2006), the pattern of the murder-suicide is predictable: a male perpetrator, female victim, decision by the woman to leave the man, and a gun. The typical Florida pattern (Florida had the largest number at 35 of the 2002 total) involved an elderly male caregiver overwhelmed by his inability to care for an infirmed wife.
Types of Murder-Suicide

From her Internet search, I delineated five basic patterns and that the driving force for each is different. The basic types are:

- Suicide bombings
- Suicide by cop
- Murder-suicide in the family where murder is primary
- Suicide-murder—three types where suicide is primary
- Altruistic suicide-murder (of the elderly)

In some situations, such as that of mass terrorism performed by suicide bombers, homicide is the predominant motive; in other situations, the motives are a combination of murder and suicide; in still others, the key element apparently is suicide.

“Suicide-by-cop” is the term used to describe a situation in which a person wants to commit suicide and die in a dramatic way, so he (almost always a man) threatens an armed police officer (sometimes with a toy gun) in order to have the officer pull the trigger on him first. There is no homicide here except for the police officer’s killing of the suicide victim.

As an example of “murder-suicide in the family,” we can consider war veterans such as soldiers who have fought in Iraq. These returning troops have a high rate of both murder and suicide and sometimes both. A report from Washington state sees such events as a risk factor distinct to the military in which armed men are trained to kill, and many later carry the invisible scars of war. It is impossible to tell whether the externalized aggression (homicide) or internalized aggression (suicide) is primary.

Consider these two cases from 2003:

- Army Specialist Thomas R. Stroh, 21, strangled his wife and son at their Fort Lewis home. He later committed suicide by driving head-on into a semitruck. The soldier had a record of abusing his wife and being drunk on duty.
- Young Marine Renee Di Li Lorenzo was shot and killed by her boyfriend who had been discharged earlier from the Marines. He then turned the shotgun on himself.

Some researchers argue that murder is the primary motive in such cases. Certainly, the urge to kill is the overwhelming factor; the urge can be described as self-destruction including the destruction of people who were once loved. Regarding murder and suicide in such cases, it may not be a case of either-or but of both-and.

I am introducing the term “suicide-murder” to refer to killings, in whichever age group, that is suicide-driven. There are several basic types of suicide-murders. The first is the elderly couple situation in which an elderly man kills his frail, usually dying wife and himself. The elderly man is old and feeble and does not want to go to a nursing home.

A second type of killing in which the suicide impulse is prominent is the “mass school or college shooting,” such as has occurred in the United States when boys (who had been bullied) brought guns to school and killed their fellow students and then themselves. Facts pertaining to the recent case of the largest such massacre on record—the killings of 32 students and faculty at Virginia Tech by Seung-Hui Cho, fit this category as well. Details from media accounts reveal a history of school victimization by taunting, a mental disorder, possibly autism from childhood, stalking women, referral by the campus police for suicidal ideation, and continual fantasies of extreme violence and revenge.

The third and most common variety of suicide-murder is the case of “intimate violence.” From the dozens of cases I have read about from news reports, a consistent pattern emerges. The intimate couple is usually in the 20- to 35-year-old range. The man is abusive, psychologically
and/or physically. Obsessed with the woman to the extent that he feels he cannot live without her, he is fiercely jealous and determined to isolate her. Characteristically, suicidal murderers have little regard for the lives of other people; they would be considered, in mental health jargon, to be antisocial. So dependent are these men on their wives or girlfriends that they would sooner be dead than to live without them. But for them, suicide is hard—they cannot get the nerve—so they have to find a way to force themselves to do it. I am speculating here with this scenario, which is that for some they know if they kill another it will be easier than to turn the gun on themselves. After committing a homicide, the only way out is suicide.

An alternative scenario is that the urge to kill the source of their obsession is so strong in some men that if they cannot have these women they want to end it all for them both. In the intimate-partner situation, the girlfriend/wife makes a move to leave. Her partner is absolutely distraught in the belief that he cannot live without her. This pattern of dangerously obsessive love often involves a history of stalking. The man decides at some point, if they cannot live together they can die together, and if he cannot have her, no one will. He hates the woman as (he thinks) the source of his passion and pain and self-destruction. He kills her because he (obsessively) “loves” and wants to possess her. (O.J. Simpson once was quoted in the popular press as saying that if he did kill Nicole, his ex-wife, it would have been because he loved her.)

Milton Rosenbaum (1990) of the Department of Psychiatry at the University of New Mexico compared 12 cases of murder-suicide to 24 couple homicide cases through interviews with family members and friends. The most striking finding was that the perpetrators of murder-suicide were depressed and almost all these killers were men, whereas the perpetrators alone of homicide were not depressed and one-half were women.

Other studies by psychiatrists describe the young male perpetrators as intensely jealous with a history of suicide attempts (see e.g., Shaw & Flynn, 2003). Women who kill their children and then themselves are almost always depressed and highly suicidal.

Cases of “elderly suicide,” as mentioned above, are more often defined by love and hate, but almost always depression based on serious health factors in old age. They can be considered altruistic because the belief is the world is better off without them. The typical scenario is the wife with late-stage Alzheimer’s cared for by an increasingly frail husband who can no longer care for her. So instead of going to a nursing home, he takes their lives in his own hands (see Malphurs, Eisendorfer, & Cohen, 2001).

Reducing the Risk

The prediction of the duration, intensity, and lethality of woman battering are among the most critical issues in forensic mental health and social work. Nevertheless, the courts, mental health centers, family counseling centers, intensive outpatient clinics, day treatment and residential programs, public mental hospitals, and private psychiatric facilities rely on clinicians to advise judges in civil commitment and criminal court cases. Based on interviews of family members and friends of 220 female victims of domestic homicide, compared to a control group of 343 victims of physical violence, Campbell et al. (2003) found that a combination of factors increased the likelihood of intimate partner homicide. The strongest risk factor that emerged in this study was an abuser’s lack of employment compounded by a lack of education. Significant relationship variables are separating from an abusive partner and having a child in the home who is not the partner’s biological child. Other factors that can help predict homicide are an abuser’s use of illicit drugs.
and access to firearms. Threats of use of a weapon were common in cases where the partner actually did so.

The discussion in this paper in terms of the lower rates of domestic homicide and murder-suicide in the United Kingdom has implications related to the control of weapons. Tightening gun control laws and restricting the access to firearms by convicted batterers is a serious step in reducing rates of lethal violence. A striking fact, as reported by a former city attorney of San Diego and head of a domestic violence unit, and relevant to gun ownership, is the way in which domestic violence offenders use firearms to intimidate and threaten their partners, even when the gun is out of sight (Gwinn, 2006). “In fact,” as Gwinn indicates, based on his personal experience, “most common use of a firearm in the home of a batterer may well be to threaten the female victim” (p. 239). Firearm prohibitions involving domestic violence restraining orders, as he further asserts, do make a difference. States that carefully limit access to guns by individuals under a restraining order have significantly lower rates of intimate partner homicide than do states without these laws.

A further consideration more specifically relates to prevention of homicide in connection with suicide. Because the suicide rate is much higher among perpetrators of intimate homicide compared to homicide in general, suicidal ideation in battering men might be considered a possible risk factor for murder-suicide.

Because of imminent threats and danger, it is important to respond quickly to battered women and provide immediate crisis intervention in a systematic manner. To meet this need, Roberts (2000) and Roberts and Roberts (2005) developed and customized a seven-stage model for crisis intervention, a model which is a frequently used time-limited intervention model with battered women. Roberts’ (2007) Seven-Stage Crisis Intervention Model crisis assessment and crisis intervention begins significantly with an assessment of risk to loss of life. Stage 1 provides for an assessment of lethality. Assessment in this model is ongoing and critical to effective intervention at all stages, beginning with an assessment of the lethality and safety issues for the battered women. With victims of family violence, it is important to assess if the caller is in any current danger and to consider future safety concerns in treatment planning and referral. In addition to determining lethality and the need for emergency intervention, it is crucial to maintain active communication with the client, either by phone or in person, while emergency procedures are being initiated.

Additional stages as delineated in the Crisis Intervention Model are (a) establishing rapport and communication, (b) identifying the major problems, (c) dealing with feelings and providing support, (d) exploring possible alternatives, (e) formulating an action plan, and (f) follow-up measures.

To plan and conduct a thorough risk assessment, the crisis worker needs to evaluate the following issues: (a) the severity of the crisis, (b) the client’s current emotional state, (c) immediate psychosocial and safety needs, and (d) the level of client’s current coping skills and resources. In the initial contact, assessment of the client’s past or pre-crisis level of functioning and coping skills is useful. However, past history should not be a focus of assessment unless related directly to the immediate victimization or trauma. The focus of crisis intervention is on assessing and identifying critical areas of intervention, while also recognizing the duration and severity of violence and acknowledging what has happened. Crisis intervention can be the starting point of a longer journey that will not end until the woman’s health and life are no longer at risk.

A safety plan is crucial. The crisis worker must help the client look at both the short-term...
and long-range impacts in planning intervention. Such a plan is designed to ensure the woman’s safety even if she chooses to remain in a threatening situation. The safety plan involves memorizing relevant phone numbers of domestic violence and legal services, a coded statement that can be conveyed to trusted relatives in telephone calls or email messages to signal that help is needed, the storing in another place duplicates of personal records and resources that the woman and her children might use later in the event of emergency relocation, and finally some thought given to a specific plan of a safe place to which one ultimately might escape.

Conclusion

Domestic violence is harmful, destructive of one’s mental and physical health, and sometimes fatal. This chapter has focused on cases in which domestic violence ends in the death of one of the parties, most often the woman. In cases of domestic homicide, the gender differences are pronounced. The overwhelming majority of the women who had killed their partners and who were serving time in prison for this act received specific lethal threats in which the batterer gave every indication that he would kill her, maybe then, maybe later.

This paper has revealed facts from government sources on the fatal victimization in domestic violence and cases of homicide followed by suicide. Domestic-type situations were contrasted with other forms of murder-suicide such as mass school shootings.

The Seven-Stage Crisis Intervention Model by Roberts (2007) was discussed as an organizing framework for helping women choose a plan for their and their family’s safety.

It is important for all social work, psychiatric, and criminal justice practitioners to document the duration and intensity of battering histories among clients in order to provide the best possible safety planning, risk assessments, crisis intervention, and effective social services. Before court decisions are made, they should take into account whether or not battered women are at low, moderate, or high risk of continued battering; life-threatening injuries; and/or homicide. All assessments should start with an evaluation of the psychological harm and physical injury to the victim and the children in the family, the duration and chronicity of violent events, and the likelihood of the victim escaping and ending the battering cycle (Roberts & Roberts, 2005).

In knowing such facts about the dynamics of life-threatening situations that might end in the death of one or both of the partners, health care practitioners and social workers can be cognizant of the indicators that can serve as a basis for preventive intervention crisis and, in collaboration with the potential victim of domestic homicide, the development of a safety plan at the earliest possible moment.

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References


