

Domestic Homicide and Homicide-Suicide: The Older Offender

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The importance of clarifying the features characteristic of older homicide offenders is highlighted by recent research that indicates an increase in rates of homicides followed by suicides of older perpetrators. In a retrospective study of data from coroners' files on domestic homicides involving individuals killed by an older spouse or family member (65+ years of age) over a 15-year period in Quebec, Canada, we identified several specific offender and victim characteristics and circumstances surrounding the offenses. The homicide was frequently followed by the suicide of the perpetrator. Several victims had pre-existing medical illnesses, indicating that the offenses may have been committed by individuals who were caregivers to chronically ill spouses. At the time of the offense, most of the perpetrators had a mental illness, usually depressive disorder, but few had received psychiatric help. The impact of mental illness on domestic homicide-suicide is indicated, underscoring the importance of identifying existing psychopathology.

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It is not surprising that research on older homicide offenders is limited, as most homicides are committed by perpetrators younger than 35 years.¹ However, the number of older people convicted of crimes has increased over the past decade in Canada, the United States, and the United Kingdom.^{2–4} Identifying factors associated with older homicide offenders seems warranted, particularly in view of the continuing expansion of the elderly population in both number and longevity. The importance of clarifying features characteristic of older offenders is heightened by recent U.S. reports that indicate an increase in rates of homicides followed by suicides of older perpetrators.^{5–7}

Risk Factors for Homicide by Older Offenders

Most homicides committed by offenders aged 65 and older occur in a domestic context. In Canada, incidence rates of family homicide against people in this age group have increased in recent years, with spouses or ex-spouses accused in 42 percent of deaths of older women and 25 percent of deaths of older men. Most of the perpetrators of spousal homicide (77%) were close in age to their spouses.⁸ This finding differs from results in U.S. studies that indicate that female spousal homicide victims are usually younger than the perpetrators,⁶ and that the risk of homicide victimization increases as the age difference between spouses increases.^{9,10}

A history of domestic violence is a major risk factor for spousal homicide for female and male victims of any age. Lethal violence is often a result of long-term abusive behavior by a man against his female partner,^{11–13} and some women kill their intimate partners in a severe reaction to longstanding abuse.^{14–17} Spousal violence often continues into old age.¹⁸ In the past decade in Canada, 37 percent of older adults

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accused of spousal homicide had past incidents of domestic violence. Older male spousal homicide victims were more likely than older female homicide victims to have a history of domestic violence against the accused.⁸ While this finding is consistent with those in previous research that indicate a continuation of spousal violence into old age,¹⁸ it is important to note that the perpetrators of previous domestic violence cannot be established from available police reports. It should also be noted that, for various reasons, the prevalence of domestic violence is likely to be higher than reports indicate and that the apparent association with spousal homicide would therefore also be underreported.

Although research conducted in different countries indicates high rates of psychiatric morbidity in prisoners aged 60 and over,^{19,20} few researchers have investigated the presence or absence of pre-existing mental health disorders in older perpetrators of homicide. However, psychopathology is implicated in homicide by older offenders in recent studies.^{21–23} Fazel and Grann²² investigated psychiatric diagnoses of 210 offenders aged 60 and older who were referred by Swedish courts for psychiatric assessment. Twenty-three percent of the offenders had committed homicide. Principal diagnoses of all offenders aged 60 and over included psychosis, personality disorder, substance abuse and dependence, depressive and anxiety disorders, schizophrenia, and dementia. In an investigation of psychiatric characteristics of older offenders (65 and older) who had been referred to a medium-security forensic unit in the London area over a 13-year period, Tomar *et al.*²³ identified diagnoses of schizophrenia and dementia in three of four homicide perpetrators who had offended after the age of 65. Coid *et al.*²¹ recorded index offenses and lifetime diagnoses of mental disorder in 52 older offenders (aged 60 and older) admitted to seven secure forensic psychiatric services in the United Kingdom over a seven-year period. The investigators found that schizophrenia, other delusional disorders, organic brain syndrome, and depressive disorder were the most prevalent lifetime diagnoses for the offenders, most of whom (82%) had committed homicide or attempted homicide.²¹ In contrast, a study of 32 patients aged 65 and older who were referred to a regional secure forensic service in the United Kingdom reported that homicide was the index offense of only three patients, with sexual offenses the most common (56%) in this group.²⁴ There was no diag-

nosis of mental disorder in at least half (56%) of the patients, of whom two-thirds were referred for sexual offenses. Dementia was the most common diagnosis, followed by depression and chronic paranoid schizophrenia.²⁴ It should be noted that the likelihood of a sampling bias is high in these studies, as the individuals were referred for psychiatric assessment. However, research on the prevalence of psychiatric morbidity in the total population of elderly offenders is extremely limited and does not allow comparison.

Spousal Homicide-Suicide by Older Offenders: Risk Factors

Spousal homicide-suicide occurs most frequently in the older population. Recent studies conducted in the United States showed that spousal homicide-suicides by offenders aged 55 and older account for at least one-third of total annual homicide-suicide deaths.^{5,25} In Canada in the past decade, 41 percent of spousal homicides involving victims aged 65 and older ended in the suicide of the (older) offender, higher than the level of homicide-suicide across all age groups of spousal offenders (25%). Older men were much more likely to kill their spouses and then themselves (51%) than were older women (14%).⁸

According to U.S. studies, a history of domestic violence is characteristic of older spouses involved in homicide-suicide.^{6,7} Marital conflict involving divorce is indicated in about one-third of homicide-suicides among older couples.^{5,6,26} Increased use of alcohol may also be a precipitating risk factor.^{5,7}

Homicide-suicide in older couples is associated with physical illness in the perpetrator, the victim, or both.^{5–7,27–31} Cohen and colleagues^{5,6} found that many homicide-suicide perpetrators had experienced a recent perceived or actual significant decline in health before the act. Spouses facing a separation, such as a move to a long-term care residence, were even more vulnerable.^{5,25} In about half of homicide-suicides involving older spouses, the husband was caregiver for a wife with a longstanding disabling or terminal chronic illness.^{6,29} Most of the men had untreated depression or another undiagnosed mental illness, and most indicated that they could not adequately care for their wives.^{6,7,29,30,32–35}

Malphurs and colleagues^{7,29} compared clinical and psychosocial characteristics of older male perpetrators of spousal homicide-suicide to those of older men who committed suicide only, to clarify factors contributing to the risk of spousal homicide-suicide.

While pre-existing untreated depression was prominent in both groups of men, several differentiating factors were identified. A history of domestic violence was noted in 25 percent of the homicide-suicide perpetrators compared with 5 percent of the men who committed suicide. Homicide-suicide perpetrators were much more likely to be caregivers for their wives. Men who committed suicide had more physical health problems, and many were receiving care from their wives. However, more men who committed homicide-suicide had experienced a recent change in health status. Malphurs and Cohen⁷ emphasize the importance of depression in both homicide-suicide and suicide and point to the influence of associated differentiating factors, such as the stress of caregiving in perpetrators of homicide-suicide and physical health problems in care-receiving men who commit suicide.

The purpose of our investigation was to identify the clinical factors characteristic of older perpetrators of homicide and homicide-suicide, to enable a more comprehensive profile of these offenders. We examined characteristics of perpetrators and victims of homicide and homicide-suicide and the circumstances associated with the offenses.

Methods

This retrospective clinical study was based on the examination of coroners' files on domestic homicide pertaining to individuals killed by either a family member or a spouse in the province of Quebec from 1992 to 2007. We identified 27 cases of homicide by individuals aged 65 or older during this 15-year period. The study was conducted with the Quebec Coroner Head Office. Collection and analysis of the data were performed in an anonymous manner. The coroners' files typically contained the victim and offender characteristics, the circumstances of death, the location of the homicide, the type of weapon used in each case, the coroner's report for the particular death (including opinion and recommendations), the police investigative report, the autopsy report, and biochemical laboratory findings. Medical records were also part of the files, when available. From these files we extracted information and circumstances surrounding the homicides and demographic and clinical factors pertaining to victims and offenders. All records were reviewed and compiled by the same two investigators, who are coroners with a medical specialty in psychiatry. Access to the relevant

material was granted by the Quebec Coroner Head Office. The information reported herein is a matter of public record. The design of this descriptive study raised no ethics-related concerns and the conduct of the study was authorized by the institutional Research Ethics Board.

Results

Characteristics of Victims

Twenty-four of the 27 (89%) homicide victims were female. The victims' ages ranged from 12 to 82 years (mean, 62.4; SD, 16.0). Twenty-two victims were Caucasian, three were African-Canadian, and one was Asian. The race of one victim was unknown.

Twenty-three of the 27 (85%) victims were the current spouses of the homicide perpetrators. Eighteen (67%) of those victims were in registered marriages, and five (18.5%) were in common-law relationships. Two (7%) victims were ex-spouses (separated or divorced) of the perpetrators. The other two (7%) victims were daughters of the male perpetrators.

History of Violence

Information about prior family violence was available for 17 of the 27 victims. Of the 17 victims, 5 (29%) had been victims of family violence and 12 (70%) had no history of family violence.

Prior Physical and Mental Health Status

Information about medical antecedents was available for 11 of the 27 offenses. Ten (90%) of the 11 victims had pre-existing medical conditions. Information about psychiatric antecedents was available for 9 of the 27 offenses. Four of the 9 (44%) victims had pre-existing psychiatric conditions.

Characteristics of Offenses

Most of the homicides (25/27; 93%) took place in the victims' homes. One offense occurred in a public location, and one took place in another location.

Methods of killing (*n* cases) were firearm (7), strangulation (8), stabbing (4), blunt instrument (3), hanging (1), carbon monoxide poisoning (1), asphyxiation (1), other (1), and unknown (1).

Two female victims were killed by one offender (his wife and daughter). One other homicide was categorized as an assisted suicide. In another incident, the female victim survived an attempted homi-

Table 1 Mental Health Status of Older Homicide Offenders

Mental Illness	Offenders, <i>n</i> (%)
Major depression	15 (75)
Other psychiatric disorder	2 (10)
Other psychosis	2 (10)
Acute intoxication	1 (5)

cide that was followed by the suicide of the perpetrator.

Spousal Violence

Homicide in the context of spousal violence was indicated in 4 (15%) of the 27 homicides. It is unknown whether deaths were related to spousal violence in 8 other offenses.

Homicide-Suicide

A homicide-suicide dynamic was present in 19 (70%) of the 27 offenses. Thirteen (48%) homicides ended with the suicide of the perpetrator, while five homicides were followed by the attempted (incomplete) suicide of the perpetrator. Suicide notes were found in 11 offenses.

Concomitant Substance Use

Toxicology results revealed substance use by victims at the time of the offense in 5 (18.5%) of the 27 homicides (unknown for 3 victims). Associated substances (*n* victims) were alcohol (1), antidepressants (tricyclic antidepressant and SSRI (selective serotonin reuptake inhibitors)) (1), benzodiazepines (1), and a combination of substances (2).

Characteristics of Offenders

Twenty-five of the 27 homicide perpetrators were male (93%). Offenders ranged in age from 65 to 81 years (mean, 71.2; SD, 4.2). Offenders were current spouses (21 males; 2 females) in 23 homicides, ex-spouses in 2 homicides, and fathers in 2 homicides.

Mental Health Status

Table 1 displays information on mental health status at the time of the offense; data were available for 20 homicide offenders. Seven (35%) of the 20 offenders had been in contact with health professionals, family, or others about their problems before the homicide.

A psychiatric motive for the homicide was determined in 18 offenders. Information pertaining to intentionality was available for 14 offenses. Homicides were determined to be committed with intent in 12 (86%) of the 14 cases.

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Characteristics of Homicide-Suicides

Homicide-suicide dynamics were present in most of the offenses (19/27; 70%). Thirteen (68%) of the 19 offenses ended in the completed suicide of the perpetrator. Eleven (85%) of the 13 fatal homicide-suicides were perpetrated by males. One male offender murdered two victims before killing himself. In another offense, the victim survived an attempted homicide, which was followed by the suicide of the perpetrator.

Perpetrators of homicide-suicide ranged in age from 65 to 78 years. Twelve (63%) of the homicide-suicide offenders were in registered marriages (11 males, 1 female), three (16%) were in common-law relationships (2 males, 1 female), and three (16%; all males) were separated or divorced.

Homicide-suicide in the context of spousal violence was indicated in four offenses. Whether homicide-suicide occurred in the context of spousal violence was unknown for four other offenses. Substance use at the time of the offense occurred in six cases.

Available information indicated the following methods of suicide (*n* cases): firearm (6), carbon monoxide or other poisoning (3), stabbing (1), hanging (1), and other (2). Information about previous suicide attempts was available for seven offenders. Only one of the seven (4%) offenders had a history of attempted suicide.

Mental Health Status

Table 2 displays information about mental health status at the time of the offense; data were available for 15 of the 19 homicide-suicide perpetrators. Of the 15 offenders with mental illness at the time of the offense, 6 (40%) had contacted a family member or other source about their problems before the homicide-suicide.

A psychiatric motive was determined for 16 homicide-suicide offenders (undetermined for 3 others).

Table 2 Mental Health Status of Older Homicide-Suicide Offenders

Mental Illness	Offenders, <i>n</i> (%)
Major depression	13 (87)
Other psychiatric disorder	1 (6)
Other psychosis	1 (6)

Clinical Case Examples

Case A

One of the 27 homicides was categorized as an assisted suicide, which was followed by the suicide of the perpetrator, a 74-year-old woman (Mrs. A.). She killed her 79-year-old husband, a retired engineer who had Alzheimer's disease and was completely dependent on her support. Her husband had explicitly expressed his wish to die with his wife. Years earlier, his mother had died by assisted suicide in another country. Mrs. A. had several significant medical conditions and was depressed and suicidal. She had been seeing a psychiatrist and had spoken of her suicidal ideation often in previous months. Despite their respective conditions, the couple had refused to be placed in a specialized setting. Both ingested the poison Final Exit before Mrs. A. asphyxiated her husband and committed suicide. There was no evidence of a history of spousal or family violence. Intentionality and a psychiatric motive were determined for the offense.

Case B

The other female offender in the sample was a 65-year-old woman (Mrs. B.) who fatally shot her 70-year-old husband, then herself. Mrs. B.'s husband, a military veteran and a member of the Canadian Legion, had Alzheimer's disease. His condition was advanced to the point that he had to be restrained. Mrs. B. was her husband's trustee and had indicated that she wanted her husband to receive an injection to end his life and did not want to see him suffer any longer. Her husband was to be transferred to a long-term institution the following day. She had depression and had seen a psychiatrist regarding suicidal ideation. She had bought a firearm one year earlier. No history of spousal or family violence was evident. A psychiatric motive was determined for the offense.

Case C

In a case of filicide, Mr. C., a 76-year-old retired engineer, fatally shot his 35-year-old daughter before shooting himself. Mr. C.'s daughter was physically and psychologically handicapped and required constant care from her father. A widower, he was isolated to the point of reclusiveness. He had always cared for his daughter and was depressed at the thought of having to place her in an institution, because of his advanced age. There was no history of family vio-

lence. Intentionality and a psychiatric motive were determined for the offense.

Case D

Mr. D. was a 70-year-old man who fatally shot his 39-year-old wife before committing suicide by firearm. Mr. D. had severe depression with delusional thinking and had indicated that he knew his wife had a lover. Both Mr. D. and his wife had been drinking alcohol at the time of the offense. A history of spousal or family violence was inconclusive. A psychiatric motive was determined for the offense.

These cases were selected to illustrate the various clinical factors interplaying in cases of homicide and homicide-suicide in the older domestic-offender population, including the role of psychological factors on motivation and intentionality. While Case A reflects the dynamics of an assisted suicide scenario, Cases B and C are more illustrative of an altruistic homicide. Case C illustrates a rare case of filicide among older offenders. Case D, in contrast to the previous three, depicts a scenario of an extended homicide-suicide based on a psychotic motive.

Discussion

This study, albeit limited in scope due to the low base rate occurrence of older domestic homicide, shows several findings and raises clinical considerations that merit further discussion and analysis. The rate of homicide in older persons was one to three per year over the 15-year period, and there was no month or seasonal pattern that could be determined. Most of the homicide and homicide-suicide perpetrators in our sample were male spouses or ex-spouses of their victims. Most of the victims were killed by firearm or strangulation. Spousal violence was indicated in 15 percent of the homicides in our sample, substantially less frequently than in other reports, indicating that between a quarter and three-quarters of men who commit homicide have a history of domestic violence with the victim.^{7,11-13,29} Our finding that spousal violence was not characteristic of homicide-suicide also differs from the results of U.S. studies in which the researchers found that antecedent spousal violence was a common circumstance in homicide-suicides perpetrated by older offenders.^{6,7}

A homicide-suicide dynamic was present in nearly three-quarters of the offenses, with most ending in the completed suicide of the perpetrator. The majority of homicide-suicide perpetrators in our sample

were male, consistent with findings of U.S. studies indicating that older homicide-suicide offenders are predominantly men.^{6,7,26} The use of alcohol or other substances at the time of the offense was rare.

Our finding that nearly all of the offenders had a psychiatric disorder at the time of the offense supports indications of a relationship between psychopathology and homicide²¹⁻²³ and homicide-suicide^{6,7,29,30,32,34} by older offenders. As reported previously,^{6,7,29,30} depression was common in the perpetrators of homicide-suicide.

A consensus was reached by two psychiatric investigators as to the likely presence or absence of a psychiatric motive, based on a review of available information for each offense. Determining the presence of a psychiatric motive encompasses a variety of conditions for which there was a connection between the reported mental state of the offender and the resulting behavior. A psychiatric motive was determined to be present in offenses in which significant clinical symptoms were considered to have played a role in the commission of the homicide-suicide, where applicable. In our sample, a psychiatric motive was determined for 84 percent of the homicide-suicide perpetrators, most of whom were depressed. Nearly half of these offenders were known to have pre-existing medical conditions, supporting the reported association between homicide-suicide and physical illness in the perpetrator.^{5,6,25}

Over three-quarters (80%) of the victims known to have a pre-existing medical condition at the time of the offense were victims of homicide-suicide. While information as to the nature of the medical condition was not available for all the victims in our sample, this finding may indicate that many of the victims suffered disabling illnesses, similar to results of U.S. studies that show that many homicide-suicides are committed by men who are caregivers for chronically ill wives.^{7,29} Spousal caregiving is associated with an increased risk of depression,³⁶ a prominent characteristic in older perpetrators of homicide-suicide. It has been suggested that the caregiver's longstanding severe depression evokes a sense of hopelessness that precipitates the offense.^{5,30}

In sum, our findings appear to indicate the need for a higher index of suspicion when particular characteristics are present in the potential perpetrator. Specifically, an older man who has untreated depression and is caring for his chronically ill or disabled spouse is potentially at risk of killing his spouse and

himself. The risk may increase with marital conflict or a pending separation. There is a clear need for careful interviews of one or both members of an older couple who present for medical appointments, and intervention must include intensive treatment of depression and support for people in caregiving situations.

While additional research is necessary to enable the development of predictive criteria for homicide by older offenders, it is hoped that this review will be useful in the development of a clear profile of older homicide perpetrators. However, potential limitations of our study should be acknowledged. While it is based on a review of coroners' files and includes all domestic homicides by offenders aged 65 and older in the province of Quebec over a period of 15 years, the study is limited by the fact that it is a retrospective, postmortem analysis. Because of missing data in some cases, including clinical data, we were unable to explore certain possible relationships. Another shortcoming of our study concerns the small sample size, which limits extension of results to the population of older homicide offenders.

Further studies comparing clinical and psychosocial characteristics of older homicide offenders to those of persons who commit homicide-suicide could help to identify differentiating factors. Similarly, studies comparing older homicide-suicide offenders to those who commit suicide only could further clarify factors that contribute to the risk of homicide-suicide.

Homicide and homicide-suicide involving older people in caregiving situations are likely to increase as the population grows in number and longevity. Prevention of homicide and homicide-suicide begins with the identification of high-risk individuals and the delineation of the precipitating factors involved. It is evident from our study that many of the offenders failed to get help, despite the fact that some had been in contact with others, including health care professionals, regarding their problem. Early recognition and effective treatment of psychiatric illness is essential, particularly when suicidal ideation is indicated. There is a clear need for improvement in the detection and treatment of depression, which according to a U.S. report, remains unrecognized by professionals in 80 percent of the older population.²⁵ It is important that the strain of caregiving experienced by older spouses be recognized and adequately treated. The risk of homicide-suicide should be assessed in older patients in a longstanding relationship

and in those who have health problems or evidence of marital conflict. Direct questions as to the status of the marital relationship and family violence may help to identify older individuals at risk of homicide and homicide-suicide.

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