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Abstract | Previous research has shown that persons with depression are over-represented among perpetrators of intimate partner homicide (IPH). However, the relationship between IPH and depression is not well understood.

This study explores the role of offender depression within a sample of 199 cases of male-perpetrated IPH in Australia, as described by judges in sentencing remarks.

Over one-third of the IPH offenders had experienced depression at some point in their lifetime. Qualitative information about the onset and cause of depression, co-occurring risk factors and the relationship between depression and culpability is presented. Findings show that depression alone holds limited explanatory value for understanding IPH, and must be considered in the context of other co-occurring risk factors.

The role of depression in intimate partner homicide perpetrated by men against women: An analysis of sentencing remarks

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Introduction

Intimate partner homicide (IPH) is the most common form of homicide in Australia (Bricknell & Doherty 2021). Intimate partner violence is typically characterised by a pattern of physical violence and non-physical coercive and controlling behaviours that aim to intimidate, dominate, undermine or isolate an intimate partner. While there is no one 'type' of intimate partner violence or IPH offender, persons who use violence to control their partners often share common characteristics and psychological vulnerabilities (Boxall et al. 2022; Carney et al. 2023).

Research has identified depression as an important factor in cases of violence against women, with estimates that men with the condition are over-represented among male perpetrators of IPH (Australian Bureau of Statistics 2022; Cheng & Jaffe 2021; Kivisto 2015). Depression is an illness characterised by emotional and physical symptoms including sadness and hopelessness, loss of interest in things previously enjoyed, guilt or low self-worth, changes in appetite and sleep, and difficulty concentrating (American Psychiatric Association 2013). One of the most common mental health disorders, depression can range from mild symptomology and minimal impact on day-to-day functioning, to chronic and severe disablement. Globally, it is estimated that 17 to 56 percent of men who kill their intimate partners have depression (Kivisto 2015).

Intimate partner violence perpetrators who have depression are more likely to use serious physical violence against their partners compared to perpetrators who do not have depression (Danielson et al. 1998), and perpetrators who have other mental illnesses (eg schizophrenia; Yu et al. 2019). Reviews of the research have consistently found a moderate association between mood disorders (including depression) and IPH. Despite the high rates of depression among IPH perpetrators, the link between depression and IPH is not well understood (Elbogen & Johnson 2009; Fazel et al. 2015). Prior research has focused on recording the prevalence of depression among perpetrators of IPH rather than exploring the lived experience of these offenders and the contextual factors underpinning the relationship.

Sentencing remarks provide an opportunity to enrich our understanding of the relationship between perpetrator depression and IPH using case studies. Sentencing is a critical and complex stage in the criminal justice process, balancing recognition of harm done to victims and the protection of the community with the punishment, deterrence, denunciation and rehabilitation of offenders. Unsurprisingly, these aims frequently clash (Walvisch, Carroll & Marsh 2022). For example, when an offender has a mental health problem, their mental impairment may reduce their moral culpability (suggesting the need for a lesser sentence) yet it may also indicate they pose a higher risk of reoffending, emphasising the need to prioritise community safety, such as through a longer sentence (Walvisch, Carroll & Marsh 2022). In cases where there is evidence that an offender's mental impairment contributed to their offending but did not constitute an excuse, their moral culpability (*mens rea,* intent) may be reduced. For this finding to be made, the mental condition must be causally connected to the offending and the impairment in mental functioning must be involuntary (National Judicial College of Australia 2020).

To ensure the right balance between these concerns, sentencing remarks typically incorporate a thorough examination of information drawn from a wide variety of reliable sources (eg police and psychiatric reports). This is largely why sentencing remarks have been used in legal, criminological and psychological research examining mental health and offending (eg Bright, Hughes & Chalmers 2012; Sullivan 2017). In the landmark case of *R v Verdins & Ors* [2007] VSCA 102, the Victorian Court of Appeal outlined a number of principles for sentencing offenders with mental health problems which have since been adopted by all Australian jurisdictions as well as New Zealand. These include additional considerations regarding reduced moral culpability, the nature and conditions of the sentence, the diminished need for general or specific deterrence, how the sentence may weigh more heavily on the offender than on a person in good health, and how imprisonment may adversely affect their mental health.

Prior Australian research has described the different factors that judges take into consideration when sentencing offenders, including perpetrators of IPH and other sexual and violent offenders (Hall, Whittle & Field 2016; Lawler et al. 2020). Research analysing sentencing remarks in cases of IPH has found that judges' evaluation of information regarding an offender's psychological state in the lead-up to and at time of the lethal incident is often extensive (Hall, Whittle & Field 2016). Further, judges frequently refer to the offenders' experiences of depression, psychological distress and suicidality or self-harm in explaining their behaviour—more so than any other mental health problem (Hall, Whittle & Field 2016).

Previous research shows that sentencing remarks are a useful resource for examining the role of mental health problems such as depression in offending behaviour. By analysing the thematic content of judges' sentencing remarks about male IPH perpetrators with a history of depression, the current study aims to examine the role of depression in IPH offending. This will add depth to current understanding of the relationship between IPH and depression.

Method

Data

This research used sentencing remarks collected as part of the Pathways to Intimate Partner Homicide (PIPH) project. It involved analysing 199 cases of IPH in Australia during the period 2007–2018 (see Boxall et al. 2022 for further details). Sampling was reflective of the Australian population distribution as well as proportionate to the number of IPH incidents in each jurisdiction and the Indigenous status of the offender.

IPH was defined as any criminal matter where a male offender was charged with the homicide of his female partner, where 'partner' included a wife, de facto, girlfriend or casual dating partner. The PIPH sample included cases where offenders were found guilty of murder, manslaughter or equivalent offences. Judges' sentencing remarks included in the PIPH study dataset were drawn from publicly accessible databases or formally requested where necessary. The final sample of IPH cases included in the current study was limited to those involving an offender with a history of diagnosed or undiagnosed depression prior to the lethal incident. These cases were identified through keyword searches of the sentencing remarks (eg 'depress') as well as through secondary analysis of the PIPH dataset.

Analysis

As discussed, sentencing remarks typically contain careful analyses of cases, drawing on a wide range of information from various sources. This study used the reasoning and analysis of judges as a vehicle for understanding the association of depression and IPH. Thematic analysis was applied to these remarks to examine the role of perpetrator depression in IPH. The approach applied inductive analysis techniques to extract relevant information from sentencing remarks. The research team read the sentencing remarks, assigning codes and then grouping codes into larger themes based on recurring words, ideas and meanings. In line with the emerging narrative of the remarks, perpetrator experiences of depression were assembled according to the three overall themes:

- onset and causes of depression among IPH perpetrators;
- the role of the offender's depression in the lethal violence; and
- mechanisms used to explain the association between depression and IPH.

This flexible analytical framework is suitable for conducting exploratory data analysis where little is known about a construct or relationship of interest (Thomas 2006). The terms 'offender' and 'perpetrator' are used interchangeably throughout in reference to the men who killed their female partners and who are the subjects of this work.

Limitations

In examining sentencing remarks, this study relies on the analysis of IPH cases and perpetrators undertaken by others. While it is reasonable to treat these analyses as sound, given judges' significant qualifications and experience, it must be noted that no independent verification of their analyses or conclusions is possible. The data analysed here are not representative, as they were compiled to support legal proceedings rather than for the purposes of research. Therefore, there is some inconsistency in the information provided and in the factors deemed most relevant to the specifics of each case. There is jurisdictional variability in the level of information provided by judges in their remarks, with some judges giving very detailed accounts of an offender's mental health and others providing scant to no comment on this. The absence of this information is not evidence of absence, and the information discussed is not necessarily indicative of the breadth of evidence considered or available for each case.

Results

The sentencing remarks for 70 cases identified the offender as having a history of depressive symptoms, accounting for over one-third (35%) of the PIPH sample. Among cases where depression was not discussed, in 25 the perpetrator had a mental health problem other than depression (eg post-traumatic stress disorder, a psychotic disorder), and in 12 it was explicitly reported that the offender did not have a mental health problem (depression or otherwise) in the lead-up to the lethal incident. Four offenders who were reported as experiencing depression after the offence were excluded. In the remaining 88 cases, the offender's mental health was not discussed.

IPH perpetrators with a history of depression had a mean age of 41.8 years (*SD*=11.4). Half were born in Australia (*n*=34, 49%) and most (*n*=55, 79%) were non-Indigenous. The majority were charged with murder (*n*=62, 89%) and the remainder were charged with manslaughter (*n*=8, 11%).

Onset and causes of depression among perpetrators of IPH

Among offenders in the sample, a history of depression was identified either as a reported or suspected diagnosis, or as symptomology experienced in the context of another health condition. In some cases, the onset of depression was linked to situational factors occurring after the offence (eg detainment and remorse associated with the offence; Cases 117, 142 and 174). However, in the majority of cases, depression was described as having commenced prior to the offence.

While for some offenders the onset of depression occurred in the lead-up to the lethal incident, other offenders had experienced multiple episodes of depression over a number of years prior to it. Where depression was reported earlier in a perpetrator's life, it was frequently related to traumatic experiences including child sexual abuse and neglect (eg Cases 144 and 146), or the onset of other mental health problems such as psychosis and bipolar disorder (eg Cases 125 and 151). In a number of cases, offenders were described as engaging in self-harming and suicidal behaviours during adolescence and young adulthood:

> …he had felt depressed and hopeless in his teens and early 20's and that there were self-harming and suicide attempts… (Case 156)

In some cases, the cause of depression was associated with the chronic illness or death of a loved one. For example, in Case 165 the offender was described as having symptoms of depression and trauma associated with his brother's terminal health condition. Another offender (Case 164) also had a history of depression and post-traumatic stress disorder stemming from his caring responsibilities towards his wife. Where the death of a significant person occurred, the grief was often reported to exacerbate depression and stress associated with other situational factors, such as the perpetrator's own physical or mental illness:

> … [the offender's] general distress appears to have taken on extra dimensions in the wake of his father's death, evolving into what might be regarded as an Acute Stress Reaction and culminating in an explosive fit of rage at the time he killed his wife. (Case 112)

Other significant life events that judges described as being linked to the onset or exacerbation of depression among offenders included physical injuries, health problems, relationship stress, separation and incarceration. In particular, a common narrative that emerged from the sentencing remarks was that, prior to the lethal incident, the offender sustained an injury at work, rendering him incapable of working. This, coupled with chronic pain, resulted in depression:

> …you had a workplace accident… The principal diagnosis immediately after, through extensive testing, was concussion. You subsequently had pain, blurred vision and headaches. You ceased to be able to work. The medical evidence supports a finding that you suffer from depression which arose from the workplace injury… (Case 36)
>
> During the course of that employment he suffered a significant back injury and was unable to continue working as a labourer. I'm told by [the offender] that the chronic pain resulting from that injury led him to be unable to work, as he had done for most of his life, and support his family and that led to depression. (Case 58)

Intimate partner relationship breakdown and separation were also common themes in remarks about the onset of offenders' depression, which for some offenders contributed to emotional distress and feelings of vulnerability, anger and betrayal:

> The offender said that the day before the murder, he saw his general practitioner and said that he was feeling angry and depressed about his marriage. (Case 151)
>
> He felt "pushed" by her apparent "betrayal" and her actions in taking out an ADVO [apprehended domestic violence order]. (Case 156)

A number of related situational stressors coincided with relationship breakdown and separation, which in turn appeared to contribute to the onset or exacerbation of depression. These were primarily related to civil legal proceedings, and the anticipated or actual impacts of these proceedings (as perceived by offenders) on their financial position or access to shared children:

> …The offender had for weeks been showing by his words and his actions that he was depressed at the breakdown of the marriage, concerned about legal proceedings and the consequences for the joint matrimonial property, including the assets of his business, and the custody of the children, and that he was jealous of the man whom the deceased was seeing. (Case 200)

The role of depression in lethal violence

Judges frequently provided detailed descriptions of their process for determining whether an offender's mental state, including depression, was related to the homicide incident and, in turn, their moral culpability. The conclusions judges reached regarding the severity of depression and its relationship to the offender's use of lethal violence ranged from no role at all, to some non-causal association, up to a causal link.

Depression as unrelated to the lethal violence

In a small proportion of cases, judges determined that the offender's depression had little connection to his lethal violence and did not mitigate his culpability. In explaining their decision-making process, judges referred to the high prevalence of depression in the wider community, describing the condition as a common and ordinary mental health problem. This minimised the extent to which judges ascribed the lethal violence to the offender's depression:

> I accept that the offender's depressed state led him to take a bleak view of events and to feel pessimistic about his life and circumstances. I do not, however, regard the evidence as to his depressive state as being capable of significantly mitigating the offender's moral culpability. Depression is a relatively common illness. The offender, in common with many other Australians, suffered and continues to suffer from it. It cannot however, in the circumstances of this case, provide some answer for the offender's crimes. It provides context, but can do little to mitigate these offences. (Case 22)

Judges' decisions regarding the potential role of depression in the lethal incidents were also influenced by an offender's subsequent level of impairment, which appeared to be perceived as synonymous with the severity of their mental illness. In cases where the offender's depression was described as not having a role in the lethal incident, judges typically used the following types of evidence to support their conclusion:

- the absence of a formal diagnosis and treatment;
- the offender providing conflicting accounts of what happened; and
- the offender's efforts to avoid taking responsibility and lack of remorse after the incident.

The last point is evidenced below:

> …the offender's conscious and deliberate misrepresentation of his marriage since his conviction demonstrates a willingness to go to considerable lengths to avoid responsibility for his offence… it tends to undermine the proposition that his depression was at the root of his violent outburst towards his wife. (Case 194)

Some judges described the link between the offender's depression and use of violence as tenuous because the evidence suggested that it had not appeared to impact his decision-making at the time of the offence. Evidence about the offender's behaviour in the immediate lead-up to the lethal violence was considered by judges to determine the extent of their impairment. This included evidence of planning the crime and their ability to engage in 'normal' and routine activities the day of the incident:

> [His conduct] was coldly rational, and in no way indicative of a disordered or chaotic mind. The account of events he gave to police soon after murdering his wife was comprehensive and does not demonstrate mental impairment. It is not enough to establish the existence of a mental disorder to claim a diminution in moral culpability, a reduction in the relevance of general deterrence, and thus a reduced sentence. (Case 151)

> I think a substantial impairment would mean that he would really not be able to think at all well about that situation, not be able [to] contemplate what actions he should take, whereas in this case, he was able to think about the situation to some extent, he was able to plan and talk to friends about it, to plan what was going to happen to his house if he went to [jail], what would happen to his dogs and his horses and make arrangements for that… (Case 102)

Similarly, in Case 183 the offender made comments to police after the offence that indicated he knew what he had done was wrong. In such matters, judges took evidence about the offender's behaviour after the offence to indicate a level of understanding and awareness of his actions and to contest any claim he made that he was suffering a substantial impairment at the time of the homicide.

Depression as related to but not a cause of the lethal violence

In most cases where an offender had depression, judges found that his experience of depression was related to his offending but could not be considered to have caused the lethal violence. Even where there was evidence that the offender's depression had an impact on his cognitive functioning and decision-making, in some cases judges did not believe that the impairment was enough to mitigate responsibility. In these cases, judges pointed to evidence of other motivations for the lethal violence besides disordered thinking:

> Although his depression and unstable personality disorder probably contributed to his anger and offending behaviour, non-psychotic motivations of anger, jealousy, feeling dishonoured and revenge were probably more relevant in terms of his motivations and moral culpability. (Case 156)

In other cases, judges determined that, while the offender's depression was related to his use of lethal violence, it did not reduce culpability. Some judges generally accepted the evidence that depressive symptomology could make people more prone to acting aggressively or behaving in certain ways (see next section), but they argued that it did not *cause* them to do this:

> Although you may have suffered from some degree of depression for some years, it is very difficult to separate that condition from your underlying difficulties and it does not appear to have contributed to your offending. (Case 134)

In cases where depression co-occurred with other underlying mental and physical health issues, as well as distressing life events, judges experienced difficulty disentangling the relative impact of depression on the lethal violence. This in turn made determinations of causation difficult. This was particularly notable in cases where the offender had a substance use disorder. Interestingly, in these cases it was often implied that the offender's decision to 'self-medicate' through the use alcohol and other drugs represented a 'choice' not to pursue traditional and appropriate treatment, reducing the potential mitigatory impact of depression on sentencing:

> [The offender] describes a history of depression although does not appear to have sought formal treatment for this and rather relied upon self-medication or substance use. It cannot be determined whether mood disorder was a consequence of ongoing substance use or was a causative factor in his drug and alcohol use. (Case 134)

Depression as severe, disabling and causally linked with the lethal violence

In a minority of cases judges determined that the offender's moral culpability was significantly reduced because of his depression. In these cases, the offender's depression was described as being linked to the homicide either directly (causally) or indirectly (eg depression led to other co-occurring health problems which in turn led to the lethal violence). In these cases, judges determined that it was unlikely that the lethal incident would have happened if it had not been for the offender's depression:

> At the relevant time, the combination of mental health conditions outlined above, would have severely affected his ability to control his emotions, to think clearly, to make calm reasoned decisions or to make appropriate judgments. In the absence of these conditions, there is nothing to suggest that [the offender] would have been motivated to act as he did. I therefore conclude that his mental health conditions were major causal factors in his offending. (Case 123)

When the offender's mental impairment was assessed to be substantial, his depression usually coincided with a range of other mental health issues, along with a history of complex trauma:

> The offender was of Aboriginal descent and came from an impoverished background. His family often went without basic necessities. (Case 146)
>
> [The offender] could be described in summary as an extremely psychologically vulnerable individual – an emotional cripple, a victim of a most tragic set of negative circumstances, deprivations and events. (Case 144)

As noted previously, judges' decisions regarding the moral culpability of offenders with depression were influenced in part by the severity of the mental illness. An important indicator judges used to assess the severity of depression was whether the offender had been referred for treatment. However, in cases where the offender had a history of engaging with support services for depression but not complying with recommended treatment plans, some judges believed this increased the offender's culpability for the crime, or at least countered any mitigatory impact of the depression (and other co-occurring health problems) on his moral culpability. In particular, it was suggested that by engaging with treatment providers, the offender had been provided with the necessary support and space to recognise that there was a relationship between his mental health problems and his violent behaviour. By making a choice to not accept support, or to not comply with treatment regimes, these offenders were described as being indifferent to or ignoring the potential risk that they posed to themselves or others:

> Although [the offender's] ability to control himself was significantly impaired, this was principally because he had refused to recommence his anti-depressant medication even though he was well aware that he had become more irritable and had been asked to do so by the deceased. Instead he sought to medicate himself with alcohol and cannabis even though he must have known from past experience that there was a relationship between his use of those substances and his uncontrollable anger. (Case 198)
>
> …it is inconceivable that the offender was unaware of the link between his alcohol consumption and his violent behaviour. I am satisfied that his decision to become as intoxicated as he was on the night of the offending was clearly reckless, and that this further aggravates the offending. (Case 146)

In these examples, judges describe the intersections between depression, substance use, choice and personal responsibility in offenders' reasoning processes. The offender had knowledge that alcohol would likely make him violent, as it had in the past, and he had been given a chance to interrupt the cycle of violence related to his depression (such as by engaging in treatment). Therefore, his culpability was not reduced. In these cases, the recklessness of the offender is highlighted as he was seen to be actively and deliberately avoiding taking responsibility for his actions.

Mechanisms explaining the link between depression and lethal violence

In assessing the role of depression in the homicide, judges frequently described the mechanism by which an offender's depression contributed to his use of lethal violence. The primary mechanisms identified by judges were certain elements of the symptomology of depression (most notably cognitive and decision-making deficits), co-occurring risk factors such as drug and alcohol use, and certain pre-existing personality traits that exacerbated, or were exacerbated by, the offender's depression. As explained below, these mechanisms are not mutually exclusive, and interact in complicated ways with other individual and contextual factors in cases of IPH.

Depression symptomology

Judges spent considerable time describing the symptoms of depression that were reportedly experienced by offenders. Offenders were often in contact with health and support services as a result of their severe mental health problems and self-harming behaviours, with a quarter of cases involving a history of self-harming and suicidal behaviours (*n*=17, 24%). This occasionally led to them receiving in-patient mental health care (eg Case 125). Other symptoms of depression that impacted on the day-to-day functioning of some offenders were impairments to sleep, appetite, energy and motivation:

> …his lack of sleep and his interrupted sleep, together with his loss of appetite, his significant weight loss, his constant rumination on negative themes, and his impaired mental performance, were all demonstrative of a significant depressive illness. (Case 158)

> He reported an ongoing depressed mood, feelings of hopelessness, a lack of enjoyment of life, and poor sleep over some months. (Case 160)

However, judges often spent the most time considering the impact of depression on an offender's cognitive and decision-making capacity. The symptoms primarily described by judges when discussing cognitive impacts related to executive dysfunction, such as difficulty concentrating, problem-solving and decision-making; and impaired ability to exercise appropriate judgement and control impulses and emotions:

> [The expert] considered it likely that [the offender's] depression was, at least in part, causally associated with the offence, and resulted in impairment of judgment and a reduced capacity to think clearly and make calm and rational choices. In my view, this is a factor that reduces [the offender's] moral culpability, but only by a very modest degree. (Case 116)

Taken together, judges outlined these symptoms to describe how the experience of depression reduced an offender's ability to manage and resolve negative emotions, particularly those that emerged in the context of acute environmental stressors such as relationship conflict and breakdown, illnesses and deaths in the family.

Concurrent alcohol and substance use

Another prominent mechanism described by judges was the co-occurrence of depression with alcohol and substance use disorders. In a high proportion of cases (*n*=40, 57%) the offender had a history of alcohol and other drug problems. It was suggested that offenders used alcohol and other drugs to manage their feelings of distress and other symptoms associated with their depression (ie depression led to alcohol and substance use), and/or to cope with other significant challenges in their lives (ie depression and alcohol/drug use were attributable to the same underlying risk factors). For example, as noted previously, some IPH offenders with a history of depression were also managing long-term health conditions including chronic pain, which may have involved the abuse of prescription medications:

> Since the accident, you have developed problems with anger, mood and substance abuse, primarily benzodiazepine. (Case 142)

Both judges and offenders commented on how an offender's use of alcohol and other drugs had a negative impact on him, exacerbating the symptoms of his depression and affecting cognitive processing capacity and emotional regulation skills:

> [The expert] went on to say that persons suffering from depression have pervasive alterations of mood so that they perceive events in a negative light, out of proportion to the situation. Their judgment may be compromised by their mood state so that they are less able to understand a situation correctly and to act appropriately. The use of alcohol compounds the situation and may lead to impairment of the ability to behave in an appropriate and mature manner. (Case 176)

Despite offenders' efforts to use alcohol and other drugs to self-medicate symptoms of depression and other health problems, judges noted that this behaviour only intensified their problems, contributing to their deterioration and to the lethal violence occurring.

Personality characteristics

The final mechanism identified by judges was the co-occurrence of depression and personality disorders or personality-related risk factors for interpersonal violence. It is difficult to examine the interactions between personality traits, depression and IPH with these data, and in particular to ascertain whether these traits made depression more likely (particularly in response to certain events or experiences) or whether an offender's depression exacerbated these traits in some way. It is clear that, in many cases, offenders were described as having a fear of abandonment and as being jealous, possessive, paranoid, irritable, impulsive, rigid, avoidant and distrustful of others:

> It was [the expert's] opinion that you have shown evidence of an emotionally dysregulated temperament for most of your life, which has manifested in the expression of depressed mood, anxiety, frustration intolerance and anger… Fear of rejection transitioned into interpersonal suspiciousness and paranoia… you interpret ambiguous events or behaviours directed at you through an overly negative or hostile lens. (Case 1)

Relationship jealousy was frequently associated with the onset, persistence and exacerbation of depressive symptoms. Offenders with depression were often described as having a 'possessive nature' and as having 'unravelled' in response to perceived rejection by a partner. This rejection was often attributed to the victim's decision to leave the offender or re-partner with someone else, or the offender's belief that she was planning to do so. Judges often remarked that accusations about the victim's infidelity were not supported by evidence but rather demonstrated the offender's own paranoia and delusional belief system (eg Case 44).

In reference to the presence of both a controlling personality style and depressive symptoms among IPH offenders, some judges expressed difficulty determining whether the motivation for the crime related to an offender's stable personality characteristics and worldview, or to symptoms of mental health problems such as depression:

> Your personality, [the expert] opines, is vulnerable to stressors and you are prone to low mood in response to adverse life events. (Case 135)
>
> People who are depressed have a view of the world that is pervasively negative… Inflexible thinking arising from [the offender's] unusual personality contributed to the severity of the impairment in his reasoning he experienced at the time of the offence. (Case 186)

Some offenders with depression were described as becoming more and more fixated on the victim's perceived infidelity, which then led to obsessive thoughts and feelings of hopelessness:

> [The expert] referred to what he described as your "fixated" belief that your wife and children had conspired to ruin you financially and also that your wife had been unfaithful to you. It is this fixation that has resulted in this terrible tragedy. (Case 128)

Offenders who had depressive symptoms combined with jealousy and obsession with the perceived infidelity of the victim were often diagnosed as having adjustment disorder with depressed mood. Adjustment disorders were commonly diagnosed when the offender experienced a significant, excessive or disproportionate response to separating from their partner prior to the homicide (eg Case 123).

Discussion

This study examined the experience of depression among IPH perpetrators and its association with IPH, as reported by judges in sentencing remarks. In the first instance, we found that over one-third of offenders in the sample experienced symptoms of depression. This is in line with previous research showing IPH perpetrators experience depression at disproportionate rates compared to the general population (Australian Bureau of Statistics 2022; Cheng and Jaffe 2021; Kivisto 2015).

The role of depression in lethal violence perpetrated by men against their female partners varied significantly across cases. Differing assessments regarding the impact of depression on perpetrators reflect the illness's continuum of severity. In a minority of cases, judges determined either that the perpetrator's depression was unrelated to his violent behaviour and so did not mitigate responsibility for the offence, or that the offender's depression was so severe and disabling that it was inextricably and causally linked with the lethal violence. It was most common for judges to report that the perpetrator's depression was modestly, but not causally, related to IPH.

A key factor in determining culpability was the level of impairment the offender experienced in the lead-up to and during the incident. For example, evidence of planning or efforts to evade detection post-offence were taken as indicators of reasoned decision-making and limited impairment. In other cases, offenders had been offered professional support and had not accepted or not complied with recommended treatment, or they had dismissed suggestions from those close to them that they seek help. Judges often assessed these as deliberate attempts to avoid taking responsibility for their behaviour, which increased their moral culpability. In other words, severity of impairment was in some cases mitigated by the offender's level of knowledge about their mental illness and by their conscious refusal to address their depressive symptoms.

In explaining the link between depression and lethal violence, many judges reported on the cognitive symptoms associated with depression, including poor impulse control and impaired cognitive function. This reflects an understanding that people with poor executive function can be prone to aggression due to their limited problem-solving capacity, which can be compounded by the use of alcohol (Hoaken, Shaughnessy & Pihl 2003; Øverup et al. 2015). Indeed, many of the offenders in this study also had serious alcohol use problems and had been using alcohol heavily in the lead-up to the homicide incident to cope with their depressive symptoms. Hostility and alcohol dependence are associated with depression among men (Cavanagh et al. 2017) and interviews with men who use violence against women highlight anger and shame, alcohol use, and poor communication and emotional regulation skills as important treatment needs (Curtis et al. 2021). These findings are consistent with evidence that individualised treatment focusing on common co-occurring problems (ie mental health and substance use) is current best practice (Butters et al. 2021).

A number of IPH perpetrators with depression demonstrated personality traits such as jealousy, possessiveness, paranoia, irritability, impulsivity, rigidity, low trust in others and avoidance, in line with past research (Kivisto 2015). Depression and personality disorders commonly co-occur and meta-analyses show poorer recovery outcomes for people with comorbid depression and personality disorders than for those with depression alone (Newton-Howes, Tyrer & Johnson 2006). Importantly, the data analysed here do not allow us to disaggregate the effects of mental health and personality traits on offending. However, the study highlights that depression in the context of personality risk factors is a common experience among IPH perpetrators. Future research should investigate the interaction further to inform intervention and prevention efforts.

Service providers and health practitioners are important points of intervention to identify individuals who are having difficulty coping with their circumstances, who are expressing depressive, suicidal or homicidal thoughts, and who may be at high risk of harming themselves or their partners. However, this sample of IPH offenders with depression was characterised by intersecting experiences of unresolved trauma, substance use, and physical illness and disability, demonstrating the importance of holistic, multi-systemic responses. As this study shows, violence is not attributable to a single cause and intervention should be implemented across health, school, justice and community settings more broadly.

Conclusion

This research highlights the importance of qualitative examinations of perpetrator experiences of depression in IPH offender samples. While depression is common among IPH perpetrators, on its own it appears to have limited explanatory value and must be understood in the context of other co-occurring risk factors.

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