# The Lived Experience: A qualitative study of mentally ill women who commit filicide.

Exploring their perceptions of the offence and their experience of the rehabilitation process as the State Patient.

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A research report submitted to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Masters of Medicine in the branch of Psychiatry.

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## DECLARATION

I, Sanushka Moodley, declare that this research report is my own work. It is being submitted for the degree of Masters of Medicine in the branch of Psychiatry to the University of the Witwatersrand, Johannesburg. It has not been previously submitted for any degree or examination at this or any other University.

_____

This _____ day of _____, 2019

## DEDICATION

This work is dedicated to my Parents for their unwavering belief, support and love.

To the brave participants in this study, thank you for entrusting me with the reflections of your journey.  It is my hope that in our understanding of your lived experience we are able to do better, as we know better.

## PRESENTATIONS ARISING FROM THIS STUDY

Oral Presentation: 20 June 2018

Department of Psychiatry: 30th Annual Research Day Presentation - University of the Witwatersrand.

- Recipient of the award for oral presentation (2018).

## ABSTRACT

### INTRODUCTION:

Filicide is defined as the deliberate act by a parent of killing his/her own child and a major contributor to child homicide rates. In order to prevent future homicides of this nature and protect future victims, and contribute to the rehabilitation of those mentally ill women who perpetrated such crimes, it is important to gain a better understanding of the dynamics that may result in filicide, as well as the impact of the mental illness itself. The purpose of this study was to examine the perceptions of women who committed filicide regarding their offences and about their treatment and rehabilitation.

### METHODS:

This was a qualitative study, involving semi-structured interviews conducted with 7 participants between July 2016 and April 2017. Key areas were identified during the interview process, such as: *“Experience of being a State Patient”, “State of mind on the day of the offence”, “Emotions after the event”, “Memories and coping with memories on the day of the offence”, “The process of being admitted as a State Patient”, “The inpatient rehabilitation process”*, and *“Support received by staff, family and the community”.*

**RESULTS:**

It was found that through the experience of being a State Patient there was a realization that treatment was required and some interventions, such as the rehabilitation strategies in place, were perceived as helpful. Most filicidal mothers noted psychosis at the time of the offence, and experienced trauma and regret for their offences and admission as State Patients. Support from the community as well as empathy and unconditional positive regard from the staff, notably psychology and occupational therapy, were reported as being important to the participants' recovery.

**CONCLUSIONS:**

Filicide is rare and not adequately studied, particularly from the perpetrators' point of view. Rehabilitation within a non-judgmental and empathetic environment is a necessity. These findings may serve to improve the outcome for psychiatrically ill women who commit filicide.

## ACKNOWLEDGEMENTS

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# 1. INTRODUCTION

## 1.1. BACKGROUND

Filicide is defined as the deliberate act of a parent killing his/her own child. It is a form of homicide that is considered an unthinkable act in most societies, although not a frequent crime, it is one of the leading causes of death in children in developed countries.[1]

Despite filicide being a major contributor to child homicide rates there is a paucity of literature with regards to the subject of filicide. The literature that does exist comprises mainly of quantitative studies, which focus on the categories of filicide, in terms of types of perpetrators, as well as theoretical understandings underpinning the offence. With regards to forensic rehabilitation there is a dearth in the literature published and even less in the context of maternal filicide.[1,2,3,4]

In order to prevent future homicides of this nature and protect future victims, as well as aid in the rehabilitation of those mentally ill women who perpetrate these crimes, it is important to gain a better understanding of the dynamics that may result in filicide. In order to better meet the needs of mentally ill women who commit these offences it is also important to explore how the rehabilitation processes that are already in place are experienced and the impact these processes have had.

The purpose of this study is to examine the perceptions of women regarding their offences and their perceptions about their treatment and rehabilitation.

## 1.2. PURPOSE AND OBJECTIVES

Currently there are unpublished quantitative MMed research studies with regards to filicide; as well as a nationwide study on female offenders but there is no qualitative data to date with regards to maternal filicide in the South African context.

This study sought to examine the perceptions of mentally ill women charged with filicide regarding their offences, as well as their thoughts and feelings about the treatment and rehabilitation they have undergone. With the aid of a semi-structured interview the objective was to explore the themes and sub-themes that emerge regarding the contextual dynamics (interpersonal and other) at the time of the act, as well as the woman's experience of the emotions that arose post incident and the impact these emotions may have had on recovery. The study also aimed to explore the experience and impact of the inpatient rehabilitation program present at Sterkfontein Hospital had on these women.

## 2. LITERATURE REVIEW

According to the World Health Organisation the highest rates of homicide in children under the age of 5 are in Sub-Saharan Africa and North America and lowest in higher income countries of Europe and Asia.[3]

Filicide is a rare form of homicide, however, it is considered one of the leading causes of child death in developed countries. It is estimated that the global rate of child homicide is 2.93 for boys and 1.92 in girls within the age group 0-17 years old per 100000 inhabitants.[1]

According to global statistics, males are more likely than females to commit homicide. However, the gender distribution with regards to filicide appears to be vastly different. In a register based study in Finland and Austria of all acts of filicide between 1995-2005, the gender distribution of filicide perpetrators in Finland was equal and Austria revealed a greater number of female perpetrators than male.[5]

Additionally, the rates of child homicide are considered to be underestimates due to the crime often being concealed, under-reporting and inaccurate postmortem assessment.[6]

The analysis of incidence rates is difficult as many countries do not have an authority allocated to follow up on infant deaths and therefore infant deaths which are possibly due to filicide are often included in other types of death.[7]

There is an established association between mental illness and homicide.[8, 9] There is a two-fold increase in the relative risk of child homicide in relation to parental mental illness.[10]

In an unpublished study done at Sterkfontein Hospital, Gauteng, forty-two percent of referred cases of child homicide were found to have a history of psychiatric illness.[11]

Within in the South African context, there has been a recent large retrospective study of accused female offenders referred for observation under the Criminal Procedures Act to six forensic mental health institutions. The clinical forensic records of 573 women referred for observation at these institutions were reviewed. There were 175 crimes committed against children and of those sixty-six percent of the victims were biological children. Further, it was found that fifty-two percent of these women had disclosed having a prior psychiatric illness and of those thirty percent had committed filicide.[12]

**Classification of Filicide:**

There are a number of classification systems that exist with regard to filicide. The most well-known classification system is that of Resnick, which categorized filicide into: Altruistic Filicide, Acutely Psychotic Filicide; Unwanted Child Filicide; Accidental Filicide; Spouse Revenge Filicide and Neonaticide.[13]

Almost half of filicidal acts reviewed by Resnick could be categorized as Altruistic Filicide. This category involves an altruistic motive for the act and is considered to be the most important distinguishing factor in filicide as compared to other homicides.

There are two subgroups to Altruistic Filicide and these are filicide associated with suicide; which includes parents who intend to commit suicide and see the act of filicide as preventing abandonment of their children; and filicide committed to relieve suffering; in these cases, parents sought to ease the perceived suffering, whether it be real or imagined, of their children.[14]

The category of Acutely Psychotic Filicide is considered the weakest of Resnick's classifications and includes parents who seem to have committed the act due to the presence of hallucinations, the presence of delirium, the presence of ictal phenomenon, as well as in those cases where no comprehensible motive could be determined.[13]

The category of the Unwanted Child is considered when a parent murders their child because he or she is no longer wanted by the parent. Reasons for this may include illegitimacy, parental intellectual developmental disorder, financial and social burden.[14]

In the category of Accidental Filicide, the parent lacks homicidal intent, this category therefore extends to death of a child as a result of fatal maltreatment, violent outbursts and excessive acts of discipline.[14]

Resnick described Spouse Revenge Filicide as those parents who commit filicide as a deliberate attempt to cause their spouse to suffer.[13]

The final category described by Resnick is Neonaticide. This is defined as the murder of a newborn within the first twenty-four hours of life. Resnick described that these perpetrators were often women who were of a younger age than other offenders and often did not suffer from a mental illness. Many of these perpetrators are women who have concealed their pregnancy and where issues of illegitimacy are at the forefront.[14]

While Resnick's classification is based on motive, the subsequent models proposed by Scott and d'Orban categorizes women who commit filicide according to the source of impulse to commit the act. The six categories according to d'Orban include: Battering mothers, Mentally ill mothers, Neonaticides, Retaliating mothers, Unwanted children, and Mercy killings.[15]

In 1990, Bourget and Bradford put forward a classification system that is based on different types of clinical situations; this included: Pathological filicide - including altruistic motives and extended homicide-suicide; Accidental filicide - including battered child syndrome; Retaliating filicide; Neonaticide – in particular the unwanted child; and Paternal filicide.[16]

The importance of such classification systems are to better understand the aetiology of filicide so as to understand the motives and precipitating factors of this offence in the hope that preventative strategies can be developed.

**Mental illness and female offenders:**

Mentally ill women who committed filicide were found to frequently be diagnosed with psychosis, depression or suicidality prior to the offence.[17] Extended homicide-suicides, which fall into the category of Pathological filicide, have a strong association with severely ill mothers.[18]

The approach to the prevention of filicide needs to be tailored to the woman's motivation. It is important that screening for mental illness begins in the antenatal period and continues postnatally. Women who are depressed and are at increased risk of extended suicide should be identified early and managed as high risk. Thoughts of harming their children should be taken seriously and explored at length. There should also be a lower threshold for admission of women who are mentally ill and are mothers of young children due to the increase risk of extended homicide-suicides. In those women with psychotic illness or psychotic features, delusions and hallucinations specific to their children should be explored, while maintaining a non-judgemental therapeutic relationship.[17]

According to the qualitative literature that does exist regarding women with mental illness who commit filicide, it is difficult to identify risk and prevention strategies; as many women describe being committed caregivers towards their children and gave little or no warning of their filicidal urges.[18,19,20] In the context of their psychosis (most notably where delusions around the child were present) the act of filicide was found to be ego-syntonic. However, once the psychosis had settled and the women had recovered the offence was experienced as ego-dystonic and distressing.[19]

Mentally ill women who were part of qualitative research study focusing on the aspects of recovery post offence described avoiding thoughts about the offence, their memories of the offence were described as patchy but were horrifying in nature. The women also went on to describe intense self-loathing and self-criticism. Family support and relationships with surviving children were important in their recovery process. Support networks and support from the mental health care multidisciplinary team were viewed as important in the rehabilitation process, especially in aspects of the role of the illness in the offence itself.[20] These aspects are all important areas to focus on in order to optimize the rehabilitation of these women.

## 3. METHODOLOGY

### 3.1. SUBJECT AND METHODS: PROCEDURES

According to South African law a defendant can be referred for a 30 day psychiatric observation at any stage whilst awaiting trial or during the trial in terms of Section 79 of the Criminal Procedures Act 51 of 1977.[21]

The purpose of the 30 day forensic psychiatry observation is to determine whether the accused is suffering from a mental illness or defect that would affect his/her fitness to stand trial and/or criminal responsibility.

Section 77 of the Act is concerned with the capacity of the defendant to understand court proceedings and Section 78 of the Act is concerned with criminal responsibility; which has two considerations: the defendant's ability to appreciate the wrongfulness of his/her act or omission or the ability to act in accordance with an appreciation of the wrongfulness of his/her act or omission.

Whilst undergoing the 30 day forensic psychiatry observation the defendant is assessed by the multidisciplinary team including psychiatrists, psychologists and occupational therapists (where applicable). Nursing observation and collateral information reports compiled by a social worker are also a part of the observation process.

Under the Mental Health Care Act No 17 of 2002 Section 42, if the findings of the forensic psychiatric observation find the defendant of a major offence, such as filicide, not fit and/or not responsible, the defendant may be declared by the court a State patient and referred back to a forensic hospital, like Sterkfontein Hospital, for further inpatient treatment and rehabilitation. Section 45 of the Mental Health Care Act (MHCA) No 17 of 2002, allows the head of the establishment to grant a State patient a leave of absence from the designated health establishment. The decision to grant a State patient leave is based on a variety of factors, including the State patient's current mental health status, the risk of recidivism, the degree of multidisciplinary rehabilitation received prior as an inpatient, the degree of supervision and psychosocial support that will be provided during the leave, as well as the level of insight of the patient and caregivers. Where a State patient is conditionally discharged in terms of Section 47(6) (d) of the Mental Health Care Act No 17 of 2002, the order must specify the terms of the conditional discharge and the period of conditional discharge, and the mental health status of the State patient must be monitored.[22]

## 3.2. SUBJECT AND METHODS: STUDY DESIGN

This was a qualitative study, using a naturalistic paradigm.[23] This study design emphasizes the use of subjective experiences and descriptions by the participants rather than objective explanations, which aimed to give a representation of the participants' lived experience and feelings towards the subject matter. This then allowed for the investigator to explore the emerging sub-themes and concepts that have arisen from the identified themes and organize the most replicated information into a hierarchical assessment.[23]

Qualitative research is unique as it does not focus primarily on the identification and explanation of factual content, but rather a person's interpretation of the facts. The participants in this study are a very specific cohort of the population and this study design was therefore the most appropriate in order to explore the objectives of the study.

## 3.3. SUBJECT AND METHODS: STUDY SITE

The study was conducted at Sterkfontein Psychiatric Hospital in Krugersdorp (West of Johannesburg) and the Leave of Absence Outpatient Clinics attached to Sterkfontein Hospital.

Sterkfontein Hospital, which is a specialized psychiatric referral hospital, provides forensic services by way of observation of awaiting-trial detainees and the subsequent management of State Patients. Additionally, the hospital provides treatment to involuntary mental health care users.

Sterkfontein Hospital is the only psychiatric hospital in Southern Gauteng, which offers psychiatric inpatient care for forensic patients. It offers services for 30 day forensic mental observation cases under Section 79(2) of the Criminal Procedures Act, inpatient care for those observations who are found not fit and/or not responsible for their offences and are made State Patients under section 42 of the Mental Health Care Act. Additionally, there are Leave of Absence clinics for those State Patients who are outpatients, as per the MHCA, under the supervision of their families.

## 3.4. SUBJECT AND METHODS: STUDY POPULATION

Individuals who are admitted as State Patients under Section 42 of the Mental Health Care Act are referred by the court for psychiatric inpatient care. During their inpatient care they receive biological treatment for their psychiatric diagnosis, where applicable they may receive individual psychotherapy as well as attend psychology groups and occupational therapy as part of the rehabilitation process. Social worker intervention is also provided. Should the individual's mental state remain stable for an appreciable time, appropriate and adequate psychological and occupational therapy has been completed, show an improvement in insight and judgement and is no longer deemed to be a threat to themselves or others in the community; they may be considered for a leave of absence under the supervision of responsible caregivers (usually family). During the leave of absence period these individuals are treated as outpatients with strict follow up at the Leave of Absence Clinics. Should the conditions of the leave of absence be adhered to and their mental state remain stable, after a period of extended leaves of absence (usually a period of 2 years), the individual may be considered for a conditional discharge from the Act pending a

judgement by the court. During the period of conditional discharge (usually a period of 2-3 years), the conditions of leave must still be adhered to and should the individual violate the conditions of leave or relapse and become unwell, this can be revoked.

Permission to conduct the study was granted by the CEO of Sterkfontein Hospital. The sample was drawn from females who committed filicide and were suffering from a major mental disorder at the time of the offence between January 1996 and June 2017. Females who, at the time of the study period, were admitted as State Patients to Sterkfontein Hospital, who were previously admitted for inpatient care at Sterkfontein and were on leave of absence as an outpatient, and those who have been or are in the process of being or have been conditionally discharged as State Patients, were selected. Only individuals who were found to have a stable mental state and who were able to give written informed consent were included in the study.

## 3.5. SUBJECT AND METHODS: SAMPLE SIZE

Qualitative studies may have much smaller sample sizes than those used in quantitative studies. This hinges on the principle of saturation which usually occurs between 6-12 participants.[24]

The sample size for the study needed to be large enough to ensure repetition and saturation of subjective content (specifically exploring the participants' perceptions and experiences of their offence and their rehabilitation post the offence). The content obtained was then compared to the existing literature to highlight repetition

of subjective content and to ultimately describe new findings and contribute to the body of existing research.

In a research study by B Marais, Sterkfontein Hospital was found to accept between 250-300 observation cases under Section 79 of the Criminal Procedures Act per year. Of those there are approximately 100-150 new State patients admitted annually, under Section 42 of the Mental Health Care Act, approximately 10 of these State Patients were female.[25]

In the period 1996-2010 there were 20 females that were designated as state patients following a charge of filicide.[26] Eleven females fulfilled the inclusion criteria and were approached to participate in the study. Only those subjects who were able to give written informed consent were recruited for the study.

## 3.6. SUBJECT AND METHODS: MATERIAL

A semi-structured interview was conducted by the researcher following obtaining informed consent. (APPENDIX 1)

Semi-structured interviews are a useful tool in qualitative research. It allows for the in-depth interview of a participant by making use of open-ended questions.[27] This allows the participants the freedom to express their feelings and perceptions of events in their own terms. It is also a useful way of conducting interviews of participants who will only be interviewed once by the researcher where the optimum use of interview time is essential.

The demographic and clinical data of the participants included in the study was captured and documented from case files. The researcher asked the participants for their demographic data in cases where this clinical data was not available in the case files. (APPENDIX 2)

The categories in the demographic questionnaire included:

1. Age
2. Race
3. Highest Level of Education at the time of the offence
4. Whether participants were employed at the time of the offence
5. Whether participants are currently employed
6. Number of people living in their home presently
7. Current marital status
8. Number if surviving children
9. The participants' psychiatric diagnosis
10. Whether the participant is receiving medication and medication adherence
11. Current classification under Section 42 of the MHCA

The topics that were explored in the open ended semi-structured interview included the participant's thoughts around being classified as a State Patient; their experience of the offence and their mental state at the time of the offence; help seeking behaviour post offence; feelings about themselves after the offence; their perception of available support available; the attitude of family and their support systems with regards to the offence; their experience of the rehabilitation process at Sterkfontein

Hospital and an exploration of the participant's memories during their period of recovery, and rehabilitation thus far.

The following key areas were explored in the interview process:

**Question 1: Experience of being a State Patient**

This question aimed to explore the participants' feelings around being a State Patient, exploring not only emotions but potential frustrations and feelings towards themselves. It explores both the participant's experience and perceptions of being classified as a State Patient.

**Question 2: State of mind on the day of the offence**

Attention was given to the perception of the participants' state of mind at the time of the offence, their perception of the support they received and their recollection of the day of the offence.

**Question 3: Emotions after the event**

The participants were encouraged to explore their feelings about the offence and their feelings about themselves following the offence.

**Question 4: Memories and coping with memories on the day of offence**

The participants explored their experience of any traumatic memories and how they coped with these memories and feelings.

**Question 5: The process of being admitted as a State Patient**

The participants explored what it was like to be classified as a State Patient and the process of admission to a forensic inpatient ward at Sterkfontein Hospital.

**Question 6: The inpatient rehabilitation process**

This included the participants' experience of what they found to be helpful to their recovery as well as what they felt would have been more beneficial to their recovery.

**Question 7: The support that the participants received by the staff:**

This included the perception of their support as an inpatient and in an outpatient setting.

**Question 8: The support that the participants received from their families and their community:**

This included the perception of their support as an inpatient and in an outpatient setting.

## 3.7. SUBJECT AND METHODS: DATA COLLECTION AND ANALYSIS

The study was fully explained to the participants at the time of inviting their participation and prior to the interviewing process. The researcher obtained written informed consent from each participant for participation in the study as well as informed consent for audiotaping.

The interviews were conducted during the period July 2016 and April 2017. All participants were interviewed by the researcher. For those participants who were on leave of absence or in the process of conditional discharge the interviews were conducted following their appointments with the treating doctor. Thus participants were reassured that their participation in the study had no impact on their leave of absence under Section 42 of the MHCA, and in doing so strengthened the conformability of the interviews. The duration of each interview ranged from 50-60 minutes. The interviews were audiotaped and transcribed by the researcher. When obtaining informed consent, the researcher took care to reassure the participants of their anonymity and that their participation in the study had no impact on their classification as a State Patient and subsequent leaves of absence or potential conditional discharges or reclassification. The researcher contacted each participant one week post-interview to check if the interview process had caused the resurfacing of any traumatic memories. This was to assess the emotional and mental state of the participants, given the emotionally charged nature of the interview, so as to refer them to their treating doctor and multidisciplinary team should they require.

**Field Notes**

A thematic analysis approach is a form of qualitative research method that focuses on examining repeated themes within the interviews and emphasizes organization and a rich description of the data set, which in this study takes the form of a semi-structured interview. Thematic analysis makes use of the concept of supporting assertions with data from grounded theory, which entailed constructing theories grounded in the interviews themselves. The process of data analysis was inductive, meaning that the process of coding was undertaken without trying to fit the data to into a pre-existing frame or model.[27,28]

The interviews with the participants were audiotaped and transcribed with their consent. The interviews were analyzed guided by the concepts of consensual qualitative research (CQR) described by Hill *et al.*[28]

The process of CQR involves a number of steps. Firstly, open-ended questions are posed (in this case, in the semi-structured interview format) allowing for collection of consistent data between participants, which included an in-depth exploration of participants' subjective experiences. The interviews are recorded and transcribed and two other judges are required to make their own subjective assessments thus fostering multiple perspectives of the same data. A consensus is drawn between judges and researcher, to allow for internal and external homogeneity. Finally, there is cross-analysis of the themes, sub-themes and ideas.

The process involves 3 general steps, which include the participants' responses in an interview consisting of open ended questions which aim to cover different

identified key areas of interest. The themes were then constructed from the interviews of the participants regarding these key areas. The core themes were then cross analyzed. This involved the development of categories which described consistencies in the core
themes.[28]

Field notes were used during the analysis of the transcribed interviews. The seven interviews were labeled and the pseudonyms were given to depict each participant. Within each question, of each interview, the subjective answers were analyzed for emerging data. Each interview was completely analyzed and repetitive answers (i.e. repeated data between interviews 1-7) were categorised into themes when information became saturated. If data was repeated within the themes, this was categorised into ideas. Quotes from the individual interviews were identified as follows: Pseudonym 1, Question 2.

The process of coding was necessary to construct the themes for each key area. Coding is a process which involves the formation of categories that pertain to certain replicated segments of text in the interviews. The aim of this process is to express the data in terms of concepts. The researcher made use of open-ended coding which involved coding the text paragraph by paragraph and in its entirety. These annotations and themes are attached to units of meaning which classify expression. This may be in the form of single words or short sentences of words.[28]

The first step in the process of coding was to analyze the transcribed interviews with the participants. The interviews were studied for the presence of persistent words,

ideas and images. This resulted in the formation of provisional themes. These provisional themes were then arranged into categories. The analysis of the data involved scrutinizing these categories for internal homogeneity ("Does this information within this category belong there?"; "Does the category make sense in answering the questions regarding filicide?") and external homogeneity (referring to the relationship between categories and the differences between the categories). The participant's responses to the open ended questions were deconstructed until saturation of the themes or categories was reached. The data was then re-modelled with conclusions being drawn from the saturated data.[28]

Qualitative research tends not to focus on validity and reliability but rather on trustworthiness. The researcher considered Guba's strategies of trustworthiness in the analysis of the data. These strategies include: credibility, transferability, dependability and conformability: [29]

1. *Credibility:* this strategy endeavors to ensure that the study measures and tests are valid. This involves the researcher asking themselves the question: "how congruent are the findings with reality?"

2. *Transferability:* this strategy is the generalization of the study findings to other situations and contexts. However, this strategy is often not considered a viable research objective.

3. *Dependability:* this strategy employs techniques to show that if the research was conducted in the same context with the same study design, methods and same participants, the results obtained would be similar to the original study.

4. *Confirmability:* this strategy involves ensuring that so far as possible the research findings are as a result of the participants' experiences and their own ideas as opposed to that of the researcher.

The process of triangulation assists with ensuring the validity of the research. This involved a second and third person to analyze the transcripts and draw their own themes and conclusions. The analysis of the transcripts was initially conducted independently by the researcher, the supervisor of the study and a senior psychologist well versed in qualitative research, who does not work with female State Patients. Following the initial analysis, the transcripts were analyzed collectively to increase the likelihood that as many key areas and themes were identified. The process of triangulation assisted with the comparison of themes and assisted in the validity and trustworthiness of the methodology used.

## 3.8. SUBJECT AND METHODS: ETHICS

Ethics Approval was received by the Human Research Ethics Committee (Medical) at the University of the Witwatersrand on the 29th of July 2015. (APPENDIX 3)

As the subject matter of the study was sensitive and emotive, ethical considerations were paramount to prevent any potential clinical deterioration of the participants. The participants were identified by the treating psychiatrist and multidisciplinary team, to ensure that the participants were mentally stable enough to participate in the interview process. Had any of the participants become psychiatrically unstable during the interview process, provisions were made to provide the treatment they may require. If after the interview process an inpatient became psychiatrically unwell the treating psychiatrist would be informed and inpatient care would be optimized. If

an outpatient who attended the leave of absence clinics became unwell the consultant of the clinic would be informed; and should that participant require inpatient care she would be readmitted as a State patient and managed accordingly. Additionally, should a participant require further psychological intervention as an outpatient, provision would be made for this by the attending psychologist at the Leave of Absence (LOA) clinic. The researcher had telephonic contact with each of the participants following their involvement in the research study to assess their emotional and mental state as well as to offer reassurance and psycho-education. Confidentiality of the participants was maintained at all times as no names or identifying data was recorded in the data collection process. The participants' identities were only known to the principle researcher.

## 3.9. SUBJECT AND METHODS: BUDGET

The principal researcher funded all costs incurred in South African Rand:

| | |
|---|---|
| Travel | R 1000 |
| Stationery | R 700 |
| Printing and Binding | R 800 |
| Other | R 500 |
| Total | R 3000 |

# 4. RESULTS

## 4.1. PARTICIPANTS' DEMOGRAPHIC PROFILE

The following figures are tabulated representations of the results from the demographic questionnaire:

Table 1: Demographic Details of Participants

| | N | % |
|---|---|---|
| ***Age (years)*** | | |
| 20-25 | | |
| 26-30 | 1 | 14 |
| 31-35 | 3 | 43 |
| 36-40 | 2 | 29 |
| 41-45 | | |
| 46-50 | | |
| 51-55 | | |
| 56-60 | 1 | 14 |
| ***Race*** | | |
| Black | 5 | 72 |
| White | 1 | 14 |
| Mixed-race | 1 | 14 |
| Asian | | |
| Other | | |
| ***Highest Level of Education*** | | |
| None | | |
| Primary School Level | 2 | 29 |
| High School Level | 4 | 57 |
| Tertiary Level | 1 | 14 |
| | | |
| | | |
| | | |

| ***Employment*** | | |
|---|---|---|
| Employed at the time of offence | 2 | 29 |
| Unemployed at the time of offence | 5 | 71 |
| Currently employed | 1 | 14 |
| Currently unemployed | 6 | 86 |
| ***Number of people currently living in their home*** | | |
| 0-3 | 2 | 29 |
| 4-7 | 4 | 57 |
| 8-10 | 1 | 14 |
| >10 | | |
| ***Current Marital Status*** | | |
| Single | 2 | 29 |
| Married | 3 | 42 |
| Divorced | | |
| Separated | 2 | 29 |
| Widowed | | |
| ***Number of surviving children*** | | |
| 0 | 2 | 29 |
| 1 | | |
| 2 | 3 | 42 |
| 3 | 2 | 29 |

Table 2: Psychiatric Diagnosis

| | N | % |
|---|---|---|
| ***Psychiatric Diagnosis*** | | |
| Psychotic Disorder | 3 | 42 |
| Mood Disorder | 2 | 29 |
| Substance Induced Disorder | | |
| Due to Another Medical Condition | 2 | 29 |
| Other | | |

Table 3: Number of Participants currently on medication

| | N | % |
|---|---|---|
| ***Prescribed Medication*** | | |
| Yes | 7 | 100 |
| No | | |

Table 4: Current classification under Section 42 of the MHCA

| | N | % |
|---|---|---|
| ***Current Classification*** | | |
| Inpatient | 2 | 29 |
| Leave of Absence | 3 | 42 |
| In the process of Conditional Discharge Application | | |
| Conditionally Discharged | 2 | 29 |
| Unconditionally Discharged | | |

## 4.2. QUALITATIVE RESULTS

The eight key areas listed in the methodology were a guide to the basic structure of the interviewing process. Because the interview was informal, in which the individual participants could express themselves openly, honestly and without being conformed to a specific format, the individual questions are not listed in the results section. Instead themes were drawn for the replicated responses as saturation was reached. The themes emerging form the key areas of interest are highlighted below.

### EXPERIENCE OF BEING A STATE PATIENT

How the participants feel about being a state patient and how it made them feel about themselves:

***Themes:***

***1. Negative experiences of being a State Patient:***

***1.1. Time wasted***

***1.2 Lack of freedom***

***1.3 Loss of Autonomy***

***1.4 Anger***

***1.5 Regret***

***2. Positive experiences of being a State Patient:***

***2.1 Access to Health Care***

***2.2 The opportunity for Leave of Absence***

The participants expressed that there were advantages and disadvantages of being classified as a State Patient. The following themes were identified upon analysis of the 7 interviews:

**1.1 Time Wasted**

One participant expressed that she was frustrated as she felt that being made a State Patient meant that ". . .my time is being wasted and then I need to go out and look for a job so that I am able to look after my children . . ." (Lucy, Q1)

Another participant described being a State Patient as ". . . it's been difficult, the fact that you have to stay in hospital for a long time, away from my family and children. . ." (Dineo, Q1)

**1.2 Lack of Freedom**

All the participants expressed varying degrees of lack of freedom following being classified as State Patients. This theme was replicated in all interviews and was expressed multiple times in the interview process. Quotes to support this include:

". . . not so great, because it's not easy to get out of it, you now. It's not easy you become a normal patient and that is what I really want. I want to get out of this place now. . ." (Sophie, Q1)

A similar description of being restricted was described by this participant:

". . . I didn't know in the beginning that it was something forever. . ." (Sophie, Q1)

Another participant described feeling ". . .locked up. Nobody likes being locked up. It's being cooped up in the ward all the time with anything to do. . ." (Zama, Q1). This participant went on to describe that she felt ". . .like you've been buried alive, you can't breathe sometimes, like there is no freedom. . ." (Zama, Q1)

One participant described that she experienced being a State Patient as ". . . You feel as if you are being locked up. . ." (Dineo, Q1)

### 1.3. Loss of Autonomy

The loss of autonomy experienced while inpatients was a significant theme and replicated in all the interviews. The participants expressed the inability to make decisions regarding personal freedoms, as described by these two participants:

". . .the only time you go out is for OT and IT, you need to be granted parole and it's not simple. . ." (Zama, Q1)

". . .like you are not allowed to - when you go on LOA you are supposed to have somebody all the time to watch over you and you are not allowed to go anywhere and you just want to go and do the things you want to do . . ." (Dineo, Q1)

". . .Like you can't do your own things, you go according to routines: this is the time to sleep, this is the time to wake up, this is the time to eat. . ." (Dineo, Q1)

Two significant emotions were described by participants and identified as themes as they were replicated by the participants:

### 1.4 Anger

Three quotes supporting this emotion are:

". . . I get cross. . ." (Angela, Q1)

". . . I don't feel anything, just cross. . ." (Angela, Q1)

". . . In the beginning I was angry. . ." (Lerato, Q1)

### 1.5 Regret

One participant emphasized this emotion by saying:

". . .  I just don't feel very good about what I did. And I really wish I could reverse it. If I could, I would. . ." (Sophie, Q1)

Another participant expressed regret in that her life had changed since the time of offence and being classified as a State Patient:

". . .My life - everything, I did it according you the way I wanted it to be. Now it's difficult. . ." (Dineo, Q1)

### 2.1 Access to health care

All the participants identified that their mental state was altered during the time of the offence and many expressed that admission as a State Patient provided them access to health care and a multidisciplinary team:

". . .I had frustrations at first but not anymore, I have been here and got treatment and help from psychology so I am better. . ." (Lerato, Q1)

". . .I was offered to go to rehab, and that was something for me, it was something amazing. . ." (Jane, Q1)

### 2.2 The Opportunity for Leave of Absence

The participants seemed to view the opportunity of Leaves of Absence as a benefit of being made a State Patient and seemed to view this as a positive experience:

". . .Being on leave is wonderful. You get to spend time with your family. You get to go wherever you like, to malls, you know to buy yourself some ice-cream or have some KFC, go to Church. It's nice being normal. . ." (Zama, Q1)

". . . you get a chance to go on LOA, in prison you don't get that. . ." (Angela, Q1)

One participant expressed frustration with the process of Leave of Absence and the process of Conditional Discharge:

". . .I'm tired of coming here all the time, every three months, every six months, I just want to be discharged and go back home and live my life. . ." (Sophie, Q1)

One participant expressed that attending the Leave of Absence Clinic was a reminder of the offence and brought up emotions for her:

". . .if I'm outside I forget, I don't think of it much but when I come here I panic. . ."(Angela, Q1) This participant reported that her previous emotions resurfaced during the week of the Leave of Absence visit and that when she leaves the appointment she felt a ". . .pain for my child, in my heart" (Angela, Q1)

Some of the participants identified and described the benefit of being classified as a State Patient. They recognised that having to abide by the restrictions of Section 42 of the MHCA they gained access to resources that might not have been as readily available (and possibly not as beneficial) as if they had been left out of the process of rehabilitation.

## EMOTIONS TOWARDS AND PERCEPTIONS OF BEING CLASSIFIED AS A STATE PATIENT

***Themes:***

**1. Concern over family and surviving children**

**2. Access to health care**

**3. No understanding about what being a State Patient means**

**4. Better than prison**

### 1. Concern over family and surviving children

". . .because they want their mummy. . ." (Angela, Q5)

". . . it was like I knew I was going to lose my job, I'm going to be away from my children, my husband and my family. I didn't even know how long I was going to stay here. . ." (Dineo, Q5)

". . .all I worried about was my children. . ." (Lerato, Q5)

### 2. Access to health care

". . .so being in hospital they are going to heal me and cure me. . ." (Lucy, Q5)

". . .ok I am a State Patient but on the other hand I would think, ok I could be in prison, you know things could be worse, here I get help. . ." (Zama, Q5)

". . .health wise I was not ok….I stayed here and got treatment. . ." (Lerato, Q5)

". . .the more I stayed in hospital, the more I actually learned what this is about and I've actually somehow made you know, peace with it. . ." (Jane, Q5)

**3. No understanding about what being a State Patient means**

". . .at that time I didn't understand what was going on, what being a State Patient was, the investigating officer had told me I was to come here as a patient and be admitted, that I was not ok, I didn't even ask why. . ." (Lerato, Q5)

". . .No, I don't understand what is a State Patient, I'd like you to explain more what is a State Patient please. . ." (Lerato, Q5)

". . .then he told me I'm going to come here and stay here, that's what was said to me, no detail or whatever. . ." (Jane, Q5)

**4. Better than prison**

". . .In prison, you don't get that, there are some advantages, you are taken care of by the sisters. . ." (Zama, Q5)

". . .in hospital is where they are going to help me not like being on the other side in Sun City (prison). . ." (Lucy, Q5)

". . .prison was quite scary actually, it's very very cold and you lie on a mat in a room and you're locked in a cell. . ." (Sophie, Q5)

## STATE OF MIND ON THE DAY OF THE OFFENCE

Feelings towards and recollection of the incident which lead them to be State Patients.

***Themes***

***1. Clear recollection of the incident***

***2. Not in a sound state of mind at the time of the incident***

### 1. Clear recollection of incident

Within this sub-theme the participants used various words and phrases describing the incident. These have been expressed as anecdotes rather than as replicated ideas, as the sample number of participants is limited to 7. These anecdotes are highlighted and supported by quotes in the text.

The participants were asked to share their memories about the day of the incident. Six of the participants had a good recollection of the incident and the events that lead to the offence. The participants were able to give very detailed descriptions of the events that led up to the incident as well as the incident itself. From the recollections of the incidents many of the participants' expressed that their actions were influenced by factors that were considered external to themselves; such as auditory hallucinations ". . .I heard voices saying that I must go to the station. . ." (Angela, Q2) or the belief that God wanted them to carry out the act ". . . God wanted me to sacrifice my baby. . ." (Dineo, Q2). There was a general sense of not being in a sound state of mind at the time of the incident: ". . .that week, like I was not myself, I was saying things that didn't make sense. . ." (Dineo, Q2).

Examples of the participants' recollection of what occurred on the day of offence was as follows:

*". . .I was from a prophet and then there was a voice and that told me that I must give my child methylated spirits to drink. I took the spirits and gave it to the child to drink and then I took the child to the hospital and when I reached the hospital they told me that the child is now dead and then from there I was arrested. . ."*

*". . .I was doing laundry that day and a thought came to mind that, you know what, my husband has been cheating and I can't even provide for my children so that's what happened. Then I bought poison for me and my children, three of the children drank the poison. The second one passed away, only the first and third born were remaining…all I kept on thinking about was how my husband wanted to take a second wife and I was against that. So, he'd come home and beat me up, so for that day, when I was busy doing the laundry, all I could think of was how I could get out of the situation and I couldn't leave my children with him. So the only thing was to take mine and all my children's life. . ."*

*". . .I remember I woke up in the morning and everything was normal in the house. I did my cleaning and everything and then suddenly I went into my bedroom with my daughter, who was three months, and then when we got there I just started to have strange thoughts, like I don't know if it was voices or what, like I had to sacrifice my baby. That God wanted me to sacrifice my baby, ja. . ."*

*". . .I've killed my son on the 22nd January, I'm not sure about the date I think it was the 22nd, or anyway ja. And then, I killed my son and I wanted to take my life as well and I was admitted at hospital and then after being admitted at Baragwanath hospital I was sent to prison and then I stayed there a couple of months. . ."*

Of the 7 participants 1 reported actively avoiding recalling the day of the offence: ". . .actually I don't want to think about it too much because…when I start thinking about it too much, it stresses me out. . ." (Dineo, Q2)

**2. Not a sound state of mind at the time of the incident**

Not all the participants had detailed memories of the day of offence. There was one participant who said she still could not recall what had happened on that day ". . . at the time I had 120 voices in my head, at that moment I didn't know which one I-I was just confused. . ." (Jane, Q2).

Another participant seemed to avoid speaking about the incident and only spoke about what occurred after the incident. ". . .umm, I don't remember it that well, I know I had a lawyer, and my dad paid for the lawyer for me and I explained the problem to him and then he put me in this place. . ." (Sophie, Q2). When the interviewer tried to probe and asked why she was taken to the police station her response was that she had committed a crime and she did not want to open up about the incident. The interviewer was mindful of the sensitive nature of the content and as the participants' mental health and stability was of paramount importance the interviewer chose to not probe further.

## MEMORIES AND COPING WITH MEMORIES ON THE DAY OF OFFENCE

***Themes:***

***1. Psychosis***

***2. Concern about surviving children***

### 1. Psychosis

The participants were asked to share their thoughts about their mental state at the time of the incident. Some of the participants expressed that they felt that they were not in a sound mental state at the time and made reference to 'hearing voices'. One of the participants shared that she was hearing voices at the time of the incident ". . . at the time I had 120 voices in my head, at that moment I didn't know which one I-I was just confused. . ." (Jane, Q4). A participant expressed that she had not been herself the week of the incident and that others had told her that she was saying things which did not make sense. Another participant described ". . .I used to be speaking outside, I was cuckoo. . ." (Zama, Q4)

### 2. Concern about Surviving Children

One of the interesting findings which emerged from the interviews and reaffirmed that the participants believed that they were not in a sound state of mind at the time of the incident was that almost all participants were concerned about their surviving children following stabilisation of their mental state. Their frustrations towards being made State Patients were related to being away from their surviving children. One of the participants spoke about the need to provide for their children and how being a State patient has prevented this: ". . .Ja it's difficult…you have to stay in hospital for a long time, ja, away from my family and my children" (Dineo, Q4)

## THE FEELINGS THE PARTICIPANTS HAD FOLLOWING THE INCIDENT

***Themes:***

***1. Regret***

***2. Remorse***

***3. Loneliness***

***4. Faith***

The participants were asked to share the emotions they experienced after the incident and how they felt about themselves following the incident. The most replicated emotions were that of regret, guilt, loneliness and faith. The themes of regret and remorse are closely linked and difficult to separate; remorse is felt when something is intentionally done to cause harm or pain where regret is as a result of inadvertently causing harm and wishing to change the past. Both these feelings were replicated in the interviews and it was thought to be significant to include both as they infer subtle but possibly meaningful differences in feelings.

### 1. Regret

Quotes to support this theme include:

". . .I started to get my mind straight when I was in prison, so after that I realised what had happened, I was so sad. It was traumatising. . ." (Dineo, Q3)

". . . I just don't feel very good about what I did. And I really wish I could reverse it. If I could, I would. . ." (Sophie, Q3)

". . .just feel regret, I wish I hadn't done that I did. Just regret. . ." (Sophie, Q3)

**2. Remorse**

Quotes to support this theme include:

". . .Because I committed a crime, it's an inexcusable crime that I committed. . ." (Sophie, Q3)

". . .terrible, terrible. I called myself a murderer. I lost my appetite, I would cry overtime I saw a baby on TV, you know, it's a terrible emotion. I had terrible emotions. . ." (Mama, Q3)

". . .I think I hated everyone, including myself, I wished I could've died. . ." (Jane, Q3)

". . .I was crying at the time thinking that my child would get up, will get better. . ." (Lucy, Q3)

**3. Loneliness**

Quotes to support this theme include:

". . .I felt lonely. . ." (Jane, Q3)

". . .I had lost my child, I was alone. . ." (Lerato, Q3)

**4. Faith**

As the participants expressed their feelings following the incident there was a sense of hope linked to the importance of religion and faith. The participants spoke of their feelings following the incident as something which was in the past and there was a sense that the emotions which they had felt had been processed and they had moved passed them ". . .I feel much better I'm much stronger. . ." (Jane, Q3).

Some of participants mentioned that they felt that they were now in a better place. The reasons for this included treatment received as an inpatient and outpatient and religion, more specifically the Bible. One participant, who mentioned that she visited

her child's grave often, reflected that this gave her a sense of closure and in that way she was still able to love her child.

". . .I've also learnt the part of forgiveness, making amends. I've learnt about a God of my understanding. . ." (Jane, Q3)

". . . I was crying, but there's the Bible. . ." (Angela, Q3)

". . .I normally pray. . ." (Angela, Q3)

**MEMORIES OF WHAT HAPPENED ON THAT DAY**

Each participant's memories were deeply personal and care was taken through all interviews to therapeutically 'hold' the participants as she remembered her trauma and her loss. Each participant had unique ways of expressing her memories, both with words and through body language. The participant's accounts and willingness to share experiences has been expressed in individual quotes, to capture a sense of each individual person.

". . .I felt bad at that time…why did God take the child and not me - my plan was for all four of us…so God took one and I had to stay behind. . ." (Lerato, Q4)

". . .after that I realised what had happened, I was so sad, I was so depressed and I was always crying…I didn't eat. It was traumatising. . ." (Dineo, Q4)

". . .I didn't care about myself, I didn't even think about, you know, what is going to happen in a minute after this. For me it was just - I wish I could have died, because I couldn't go on anymore. . ." (Jane, Q4)

". . .my own child could not breathe at the time. When I reached the hospital I gave my child to the doctor. The doctor told me that I must come inside and said 'let me tell you, your child is now gone'. . ."(Lucy, Q4)

“. . .I wouldn’t sleep at night…I would see a vision of her sometimes. . .” (Zama, Q4)

“. . .an inexcusable crime…an inexcusable crime that I committed. . .” (Dineo, Q4)

“. . .I was sitting with my daughter, and nothing, she didn’t look hurt…I called to her and she didn’t reply…I felt such pain. . .” (Angela, Q4)

The participants were asked whether they still thought about the day of the offence in order to explore the residual memories they had of the incident. If these memories were experienced as traumatic, the interviewer then endeavored to explore how the participants dealt with these memories. Some participants shared that they still thought about the day of offence, while other participants reported that they did not think about the day of the offence any longer. From those who reported that they still thought about the day of the offence there was 1 participant who seemed to have difficulty talking about the memories she experienced. This participant expressed that she really wished that she had not committed the offence and cried during this part of the interview. Another participant mentioned that she would hear the voice of her child crying and that this had improved and ceased after the doctor allowed her on a short leave of absence to put a gravestone at her child’s grave. With regard to dealing with the memories the participants did have, 1 participant reported that she now allowed herself to remember and feel whatever it is she was feeling, and this appeared to be helpful to her. One participant reported that she used the coping techniques she had learnt from psychotherapy to deal with her memories. From those participants who reported that they did not think about the day of offence there was a sense that they had made a conscious decision to not to think about the incident. A participant reported that she believed it was senseless to think about what could have been as she would not be able to change what had occurred.

Each interview was unique in its subjective nature of both the experiential memory and emotional responses of the participants. However, objectively, 3 general themes became evident, despite the personal nature of the accounts.

***Themes:***

***1. Emotional about the incident***

***2. Decision not to dwell on what happened***

***3. Closure***

**1. Emotional about the incident**

". . .I cried, I felt hurt, why did God take my child and not me. . ." (Lerato, Q4)

". . .I would just cry, the thing I did most is cry . . ." (Zama, Q4)

**". . .**hurt, I look back and my husband looks at photos of the well, the person I - and what I did and I wish I could bring him back. . ." (Sophie, Q4)

". . .it's heartbreaking you know, when you lose someone you love, you know. . ." (Sophie, Q4)

". . .I was crying. . ." (Angela, Q4)

**2. Decision not to dwell on what happened**

". . .I feel, ummm I let it be you know, I shut them out. . ." (Zama, Q4)

". . .I don't think about what happened. . ." (Jane, Q4)

"…I forget it, it's the past . . ." (Angela, Q4)

". . .I just have to carry on, it's all I can do. . ." (Sophie, Q4)

**3. Closure**

". . .I felt bad at that time but now it has passed and I accepted what I did, I go to the graveside. . ." (Lerato, Q4)

". . .I feel much better, I'm much stronger. The pain is there, the pain will - you know, as time goes on, it will, you know, go away - it might never go away, but I'm much better now…I understand it now. . ."(Jane, Q4)

## INPATIENT EXPERIENCES THAT WERE HELPFUL TOWARDS RECOVERY

The participants were asked to share what they experienced as helpful in their recovery while they were admitted as inpatients.

***Themes:***

***1. Occupational Therapy (OT) and Industrial Therapy (IT)***

***2. Nursing Staff and Doctors***

***3. Psychotherapy***

### 1. Occupational Therapy and Industrial Therapy

The activity that was most replicated by the participants as helpful towards their recovery was Occupational Therapy and Industrial Therapy. The participants reported they enjoyed cooking and baking because being involved in this kind of activity helped to distract them from their problems and that they were tasks that reminded them of being at home. In Industrial Therapy activities like knitting and making Christmas decorations gave the participants a sense of comfort and reminded them of their life outside the hospital.

". . .OT is the one that helps me…we are sewing, we are cooking, we are baking. That's the one. . ." (Lucy, Q6)

". . .the Occupational Therapist, when they get involved it also helps a lot. . ." (Jane, Q6)

". . .I was quite cheerful because the OT was helping me. . ." (Sophie, Q6)

". . .the OT helps a lots because at least when you do something you tend to focus on that thing you are doing and not your problems and your stressors. . ." (Dineo, Q6)

". . .I loved IT, I enjoyed it a lot, being creative is my strong point. . ." (Zama, Q6)

**2. Nursing Staff and Doctors**

Many participants expressed that they felt that the care experienced from both nursing staff and doctors, as well as the medical treatment, was helpful in their rehabilitation process.

". . .the stigma is there yes, I was sitting one day with one of the sisters and we were talking about it, some people think you've just gone mad, after talking to her I realised that yes you do get some judgmental people but you do get people who understand too. . ." (Jane, Q6)

". . .the nurses were nice to me, they would comfort me. . ." (Dineo,Q6)

". . .it calms patients down you know when they speak to a doctor. It enlightens you when you speak to a doctor, it always gives you hope. You know the doctor can help with that, it's nice to tell them your problems. . ." (Sophie, Q6)

". . .there were three Sisters that I've grown attached to - I could always go to them in an emergency and they were always there to listen. . ." (Jane, Q6)

**3. Psychotherapy**

Of the participants that were in individual therapy most identified that the process of psychotherapy was beneficial to their rehabilitation.

". . .The psychologist also, she helped a lot because at least she helps you talk about your experiences and all that stuff, ja, unresolved issues and stuff. . ." (Dineo, Q6)

". . .it was therapy all the way, I knew that every Tuesday I go to therapy, I talk about my emotions so that I can get better, Ja and look at me now (laughs). . ." (Zama, Q6)

There was one participant who reported that she did not find psychotherapy to be beneficial or contribute positively to her rehabilitation process: ". . . it was compulsory oh, I shouted at them (laughs)…it was in the afternoon and I was dying to sleep, I told them that I don't like this and they were like - unfortunately, you just have to. . ."(Jane, Q6)

**SUPPORT RECEIVED AT TIME OF INCIDENT**

***Themes:***

***1. Support received from family***

***2. Support received from neighbours***

The participants generally felt supported by their family and some mentioned support from neighbours. Most participants reported that the support they received during the time of the incident was sufficient and that they did not feel the need for more support.

". . .I mean my husband was always there and we had a nanny around the house…so they were supportive. . ." (Dineo, Q7/8)

". . .The only support that I got was probably my mum and my neighbours, yes they went together with me. . ."(Lucy, Q7/8)

However, one participant expressed that she felt betrayed and abandoned by her brother at the time of the incident. She went on to explain she felt that her brother should not have left her alone with her child as she believed she was mentally unstable at the time of the incident and believed that her brother was aware of this.

". . .Betrayed, like my brother left me with the baby alone. He was supposed help me out with the baby. . ." (Zama, Q7/8)

## SUPPORT RECEIVED AS AN INPATIENT FROM STAFF AND FAMILY

The participants shared their perceptions of the support that they received from the staff and their families during their admission and inpatient stay.

***Themes:***

***1. Support was unexpected***

***2. Support from family***

***3. Support from staff***

***4. Negative attitude of staff***

### 1. Support was unexpected

". . .I felt loved because I felt after what I had done, I thought people would reject me, that they would forget about me…I felt grateful. . ." (Lerato, Q7)

". . .I was appreciative. . ."(Sophie, Q7)

". . .I was worried they would be different towards me but they weren't. . ." (Angela,Q7)

**2. Support from family**

". . .they would come and visit me and bring me things. Their support has made me strong. Just to think that there are some people out there who still care about you, you know, it makes you strong. . ."(Zama, Q7)

". . .they brought me things to get me through the week and that helped. . ."(Sophie, Q7)

". . .I was very lucky and I am grateful to have them because they are supporting me throughout - they were here like every weekend and if they didn't come they would phone me. I used to get whatever I want, they used to phone me like everyday. So I was very lucky. . ." (Jane, Q7)

**3. Support from staff**

". . . I feel good about it because they are trying their best, they are always there, they are always supportive and they always check up on us if everything is fine. . ." (Dineo, Q7)

". . .as for the hospital staff, I felt grateful that there were people who would look after me. . ." (Lerato, Q7)

". . .the support I had was good from the doctors concerned and OT and nurses…I was appreciative…the support system was quite good. . ." (Sophie, Q7)

". . .the staff were supportive, eventually you know I will thank them some day. . .(Zama, Q7)

**4. Negative attitude of staff**

There were two participants who noted that during their second admission to the ward as a State Patient, following acute relapse, they experienced some negativity from staff: ". . .people talk and they gossip quite a lot and were gossiping amongst one another and you know the patients can hear. . ." (Jane, Q7)

". . .sometimes they're nice, sometimes they're bad and they've got funny comments…like that I'm after the food here and just lazing around doing nothing. It made me feel really bad. . ." (Zama, Q7)

**SUPPORT RECEIVED AS OUTPATIENTS**

The participants shared their experience as outpatients, with regards to the support they received from the clinic, family and community. Their experiences were similar to the experiences described as inpatients. The participants reported that they perceived the support they received as sufficient. They reported continued support from their families which was identified as having an important role in their recovery. The participants generally did not expect their communities to be supportive of them. They reported being pleasantly surprised by the perceived love and support they received from their communities. They reported that their recovery would have been made more difficult if they did not receive the support of their community.

***Themes:***

***1. Support from family***

***2. Support from community***

***3. Sense of belonging to the community***

***4. Fear of judgement***

***5. Inefficiency of outpatient clinics***

**1. Support from family**

". . .The support is great, my family is there for me, I grew since I got out of rehab and then I went back home…our relationship is very good at this moment in time. . ." (Jane, Q8)

". . .my husband, he is very wonderful and supportive. . ." (Zama, Q8)

". . .they love me. . ." (Angela, Q8)

**2. Support from community**

". . .it was important for me, for my wellbeing, you know, they received me well. . ." (Zama, Q8)

". . .right now it's overwhelming, because everyone seems to be caring for me. . ." (Lerato, Q8)

**3. Sense of belonging to community**

". . .I'm part of the community. . ." (Zama, Q8)

". . .I got to go home for Christmas, so many people came to my house, the whole community…it was like 'wow' I didn't expect this… . ." (Jane, Q8)

". . .the community have accepted me back and the love they have for me…they still support me. . ." (Lerato, Q8)

**4. Fear of judgement**

". . .I thought maybe they would be judgemental towards me…but no they just act normal towards me. . ." (Dineo, Q8)

". . .because it was a thing of - how are you going to manage going to the shop, what are people going to say, you know how are people going to treat you. . ."(Jane, Q8)

". . .yah but then they weren't different. . ." (Angela, Q8)

". . .I was very, very worried. I thought they wouldn't receive me very well…but no, nothing like that. . ." (Zama, Q8)

**5. Inefficiency of outpatient clinics**

Those participants who were on longer leaves of absence as per Section 42 of the MHCA, were required to follow up monthly at their local clinics and follow up 6 monthly at Sterkfontein hospital. These participants expressed frustrations with the local outpatient clinic support.

". . .That's horrible hey. You see, to wake up early and then you just have to be there. Sometimes they don't have medication, that's what happens most of the time. They don't have medication. . ." (Jane, Q8)

". . .the government knows that we should be supplied with medication, I mean why is there a shortage. . ." (Jane, Q8)

". . .I had to phone them to get my medication to South Rand all the time, I don't mind that but you know, I wish I didn't have to phone them. . ." (Sophie, Q8)

# 5. DISCUSSION

## 5.1 PARTICIPANTS' DEMOGRAPHIC PROFILE

The demographic profile of the seven participants was in keeping with recent review of 573 female offenders across six forensic mental health institutions in South Africa by *Nagdee et al. (2019).*[12] This study found that the majority of offenders were aged 21-50 years old which is similar to this study where eighty six percent of participants fell within this age group. Seventy-one percent of participants in this study had a high school level of education or higher which is higher than that of female offenders across the six South Africa forensic mental health centres. This may suggest that the participants' level of education was not a major contributing factor to the offence but perhaps more influenced by other socio-demographic and socio-economic factors. The contribution that socio-economic stressors may have was further strengthened by seventy-one percent of participants being unemployed at the time of the offence and eighty-six percent remained unemployed at the time of interview. Additionally, seventy-one percent of participants had 4-10 people currently living in their home.

Interestingly, seventy-one percent of participants reported being married or in a common-law partnership at the time of the offence and forty-two percent were married at the time of the interviews, suggesting support offered by partners following an offence of this nature and strengthened by the importance of support structures highlighted in the qualitative findings of this study.

*Nagdee et al. (2019)*, found relatively high rates of serious mental illness among female offenders in the South African context, this was similar to the findings of this study, where all participants presented with severe psychopathology with psychotic disorders most prevalent in forty-two percent of cases. Focusing on more targeted

screening of at risk females with possible serious mental illnesses may indeed lead to earlier detection and prompt institution of treatment which may prevent such offences.

## 5.2 QUALITATIVE RESULTS

This research aimed to identify and describe the qualitative nature of the filicidal act as well as the subjective experience of the individual, who were classified as State Patients (that is, the individuals were assessed to not be fit to stand trial at the time of the offence and/or due to the nature of their psychiatric diagnosis, were not deemed responsible for the crime).

This particular act of filicide has been poorly described in the literature. Much of what is evident is quantitative in nature and does not attempt to describe the subjective quality of the crime. It is an interesting and ethically thought-provoking subject in Forensic Psychiatry and with more qualitative work, research such as this, might assist in preventing further acts of filicide, and assist with a more evidence-based and individually sensitive rehabilitation process.

In South Africa it is believed that many acts of filicide go unrecognized and infant deaths which are possibly due to filicide are often included in “other types of death”.[12] As described there is an established association between filicide and mental illness.[11]

The interview process was a specific experience of its own. The primary researcher conducted all the interviews included in the study and had her own subjective encounters with the participants and the information that was provided. It was initially a tentative atmosphere, particularly with the first interview. The interviewer was

aware of the emotionally sensitive and potentially traumatic nature of the content that the participants were being asked to share. At times there was an overwhelming sense of regret and sadness sensed by the interviewer. The interviewer was mindful to conduct the interviews at the individual participants pace and to only discuss content that the participants were comfortable with. The participants mental health and emotional stability was a priority throughout the interview process. When recollecting memories of the offence many participants became emotional, often crying when expressing these details and the interviewer was concerned that the emotional content would overwhelm the participants. Interestingly, this did not seem to be the case. Following the semi-structured interview, participants were given an opportunity to express anything that they felt was not covered and if they wished to share or ask questions that they may have had. During this time the participants expressed that the interview process had not been overwhelming and some found it to have been beneficial in their healing. This feeling of the positive effect of having the opportunity to share their emotions was re-iterated in the one week follow-up telephonic check in with the participants.

Qualitative research allows for the exploration of the subjective experience of participants. The process of qualitative data collection which involves semi-structured interviewing, allows the participants to reflect on their experience and on the feelings they may have towards themselves. This process can translate to a sense of validation and normalizing of their experience and be therapeutic for the participants.[30]

Within the forensic setting, the understanding of the participants' feelings towards their mental disorder and the implications thereof can have important implications in terms of reducing the risk of recidivism.[31]

**Experience of being a State Patient**

The overall subjective experience of being classified as a State Patient was that of frustration. Participants described lacking freedom and being bound to rules and regulations of the facility. Despite being granted a Leave of Absence there continued to be a general sense of anger and regret. One of the participants expressed that attending her mandatory LOA Clinic visits were a reminder to her of her offence and caused the resurfacing of her emotions at that time. Additionally, the participants also expressed that they were unclear as to the process around being a made a State Patient, specifically around time frames and how this impacted on their experience of a lack of freedom and loss of autonomy. Most participants expressed that they would want to know more about the process. These sentiments are similar to the findings in *Shepard et al* (2015) which found that a lack of clarity around the participants' length of stay as well as the pathways out of care lead to a loss of hope and frustration.[32]

**Perceptions of being a State Patient**

Although most of the participants had little understanding of the nature and meaning of being classified as a State Patient, as previously discussed, there was a general sense of negativity towards this label and its consequences. A specific theme pertaining to the negativity was centred around the participants continued concern with the care of their surviving children and family. This was highlighted as a theme in other questions during the interview process.

Interestingly, however, an overall sense of gratitude for the access the participants gained to healthcare was also described. When this was explored participants reported that they believed that if they had gone to jail they would not have had the

opportunity to be treated and rehabilitated effectively. *Skeem et al* (2010) described that the criminal justice system not only had a disproportionate representation of individuals with serious mental illness but additionally that these individuals were disproportionately more likely to fail, with regards to recidivism, under correctional supervision. Further, it was suggested that recidivism reduction is mediated by mental health services and symptom improvement and this should play a larger role in managing the risk and long term rehabilitation of these individuals.[33]

Advocacy with regards to rehabilitation and treatment of criminal offenders who suffer from severe mental illness is imperative to decrease the risk of recidivism and stigma. This however, must be balanced against the risk that these individuals may pose to themselves and society.

This serves to emphasis the importance of identifying psychiatric patients in the context of a forensic system. The illness itself needs to be holistically treated in order for an effective rehabilitative process to be expected.

**State of mind on the day of the offence**

This was a particularly important key area to explore, as the psychiatric illness itself would have caused symptoms that could have resulted in the act of filicide. The participants could most often remember the day's events clearly and were able to give clear and descriptive accounts of their psychiatric symptoms. However, some participants could not give a clear account of the day of the offence with one participant avoiding the incident itself and rather described what had happened after the act. The findings were similar in a qualitative study exploring the act of filicide by mentally ill mothers by *Stanton et al* (2000) where most participants were able to give an account of the act and of their psychiatric symptoms at the time. Additionally,

in this study the experience of psychiatric symptoms was a main theme when exploring the event.[19]

**Memories and coping with memories on the day of offence**

This key area included the participants' perceptions of their state of mind (mental state) on the day of the offence. The presence of psychosis was the predominant finding, however most of the participants did not acknowledge a psychiatric diagnosis prior to the offence, other than one participant who spoke of being diagnosed with Bipolar Disorder.

Another theme that re-emerged was that the participants were concerned for the safety of their surviving children and there was a general feeling of concern that they were not able to provide for their surviving children as a result of the charge and being classified as a State Patient. The presence of this theme in other questions perhaps emphasizes that the participants' ongoing responsibility of being a mother to surviving children is one of significant importance. This concern seemed to be a significant stressor for the participants and directly affected their experiences. This theme has been replicated in similar qualitative research done by *Stanton et al* (2006). The study explored the aspects of recovery as described by mentally ill perpetrators of maternal filicide, and the *role of the mother* was described as an important theme. The participants in this study also described concern over their surviving children and worry over lack of access to their children.[5] These concerns are similar to those raised by the participants in this study. Discussion around the participants' surviving children might be incorporated into the psychotherapeutic process of participants who describe this specific concern as this may aid with recovery and their experience of rehabilitation.

**The feelings the participants had after the incident**

These emotions were predominantly negative in nature. There was a great sense of regret and guilt associated with the incident, with some participants describing a feeling of isolation and loneliness. The importance of this question was to identify specific psychotherapeutic targets in the rehabilitation process. Many participants noted that the interview process itself and being able to share and label these emotions was helpful to their healing. Addressing feelings of regret and guilt in the psychotherapeutic process may aid with healing from the aftermath of the offence as well as aid with the perception these women may have of others towards them.

The role religion played in the grieving and rehabilitation process was found to be important to all the participants. Participants described being able to 'heal from these difficult emotions' through a religious support structure. More qualitative research is needed to further describe this sub-theme as the role of religion and faith may be an important topic to explore in the rehabilitation process.

**Memories of what happened that day**

Much like the theme regarding the participants' thoughts about the day of the offence, this exploration of specific memories pertaining to the actual day of the offence assisted in describing greater detail of the subjective account of the participants' entire experience.

Four themes emerged, specific to this group of participants. Those who had clear memories of the day of the offence could then describe both the traumatic nature of those memories as well as the ways they dealt with these memories.

The emotionality attached to the incident and the subsequent rehabilitation received at Sterkfontein Hospital allowed for participants to describe a sense of closure as well as a conscious decision not to ruminate on the past.

**Things which were found to be helpful towards recovery**

Four specific themes were described. The first three pertained to specific rehabilitation programs, namely Occupational Therapy, Industrial Therapy and Psychotherapy.

This helps to emphasize both the need for such therapies in such a setting but also encourages future research describing the long-term outcomes for both patient and family following the three modalities of therapy. Many participants reported that tasks performed in Occupational Therapy reminded them of tasks they would be required to perform in their everyday lives, should they not be in a hospital. There was a general feeling that the familiarity of these tasks gave the participants a sense of hope. These tasks seemed to engender a sense of purpose. Additionally, performing such tasks seemed to distract participants from dwelling on the emotions of the offence and facilitate healing.

The ongoing support and physical presence of nursing staff was also highlighted as important in the participants' recovery process.

Religion was again emphasized as being integral in the recovery process for these participants.

**Support received around the time of the incident**

The predominant theme was that of support, both from family and the close community in which they resided. Although this cannot be generalized to all families and communities, it is interesting to describe the forgiving, supportive and inclusive

nature of such persons, despite the serious nature of the crime. Most participants felt that the support they received around the time of the incident was sufficient for them. Often when relaying the support received the participants seemed to experience the level of support as the antithesis of their expectations. This may reflect the participants' perceptions of themselves at the time of the incident. In a study by *Bourget D Bradford et al* (1990) mothers who commit filicide tended to report high levels of stress and lack of support. These women described multiple psychosocial stressors, were often the primary caregivers of their children, were unemployed with financial and relationship stressors, as well as lacked social support.[16] Exploration as to why the support received was unexpected by the participants and the themes that may emerge around this may be a focus in further psychotherapeutic rehabilitation goals.

**Support received from staff and family as an inpatient**

The predominant theme was that of contentment at the level of support these participants experienced from staff whilst at Sterkfontein Hospital. However, one participant felt unsupported and "hurt" by the perceived "unwelcome" attitude of the staff. This is an anecdotal example of a subjective emotion of being an inpatient and would need further exploration as training staff to be empathetic and non-judgmental is imperative to a therapeutic and rehabilitative environment. Indeed, *Shepard et al* (2016) also emphasized safety and security in the forensic hospital environment as a necessary base in the recovery process. The clinical staffs' ability to provide appropriate boundaried but supportive and close care for patients and indeed the nature of an institution, like that of Sterkfontein Hospital, has been highlighted as important in the personal recovery of patients within the forensic setting.[32]

All participants felt wholly supported by their families, which is particularly encouraging as families are integral to the rehabilitation team. Engaging with the families, therefore, may prove to be a compelling resource in the rehabilitation process.

The experience of adequate support, whether it be at the time of the incident, as an inpatient or as an outpatient, was described as being unexpected but deeply valued by all participants. When this was explored with participants', the reasons for not expecting the support they received included: a sense of regret and remorse around the incident and a fear of judgement by their families and community. During inpatient rehabilitation it may therefore be useful to explore the role of being mentally unwell at the time of the offence in order to help process and manage feelings of being undeserving of support.

**Support received from clinic, family and community as outpatients**

The overarching experience by the participants was that of good support. This included support from their family and their community which seemed to foster a sense of belonging, this was especially noted when on Leave of Absence. The participants expressed that they had initially anticipated and feared judgment from their community. This underpins the importance of support structures as a protective factor for the participants living within the aftermath of filicide and is a promising finding which should be regarded as a positive predictor of outcomes for these individuals.

Two participants reported that the outpatient clinics were "inefficient" (specifically regarding the availability of medication and long delays that might have resulted in a return date as the specific clinic could not assist on her booked date). Attending the Leave of Absence clinics seemed to also remind the participants of their past

offence. Although most participants had described a sense of closure in terms of their offence, attending the outpatient clinic seemed to be a reminder of the emotions at that time as well as reliving past trauma. One participant remarked that when she was at home and in her community, she did not think of her time as an inpatient State Patient or the time of the offence but when she was due to attend clinic she would begin to "panic".

She reported: "You forget it, but when you come here…"

"Starting to panic, it's for a week before and a week afterwards"

(Angela Q6)

The need for specialized clinic risk assessments in these high risk individuals needs to be balanced against them being assessed in the community setting. Perhaps the use of quantitative risk assessment forms may assist in decreasing the emotional re-trauma these visits may precipitate. Future studies, focusing on complicated grief and potential post-traumatic stress disorder, would assist in developing and describing this concern and possibly assist with ways of intervention to improve this process.

**Researcher's Reflections**

At the centre of this qualitative research was the exploration of the lived experiences of mentally ill women who commit filicide. In capturing these stories, the researcher was struck by the non-verbal language and behaviour of the participants. The interviews in their entirety appeared to be an emotional experience for the participants. Initially the participants' body language suggested being anxious at the start of the interview with many participants approaching the questions tentatively with a defensive body language. As the interviews progressed, however, the

participants' body language appeared to be more relaxed and open and they appeared to engage better. All the participants became emotional when recounting the events of the day of the offence and the emotions they experienced. When relaying their perceived support received as inpatients and outpatients the participants' body language was open, more relaxed and the mood in the interview appeared to lighten. The participants appeared to be more comfortable with the content of this part of the interview than they appeared when relaying the events leading up to becoming a State Patient. The researcher was aware that because of the sensitive nature of the study the emotions that the participants experienced may be of a painful nature. However, all participants thanked the researcher following the interview and reflected that speaking about the incident and their subsequent rehabilitation, though painful, was a positive experience to them. The researcher contacted each participant one week post-interview to identify if the interview process had caused the resurfacing of any traumatic memories. All the participants reported that their emotional and mental states were stable, this was corroborated by collateral provided by family members, and none showed signs of requiring referral to the treating multidisciplinary team. One participant reported feeling a "sense of relief" from having the opportunity to express herself. When the researcher enquired around this "sense of relief" she reported that since she had been treated and completed her multidisciplinary team rehabilitation people do not enquire about the details of her experience or the incident itself. She reported that she felt more ready to talk about that time in her life and would want to talk about it as she felt it would help with her "healing". Another participant, who also verbalized that the interview was helpful, said that by talking about her experience she realized "how far she had come" with regards to her mental rehabilitation.

Subsequent conversations and exploration of the lived experience of this specific population may be beneficial for their long term rehabilitation and well-being and may be a future study interest. Indeed, *Michelle Oberman* (2016) described that beginning to understand the lives of the women who commit this crime should be a key in the eliminating of maternal filicide.[34]

**Limitations**

The nature of qualitative research, especially a study of this nature with a very specific sample of participants, means that the sample size is small. For this reason, it is difficult to generalize the findings of this study to other populations.

There is a dearth in qualitative literature regarding the topic of maternal filicide committed in the context of mental illness; therefore, at times it was difficult to find data to support the findings of this study. Further study into this important topic is necessary to guide further research.

The researcher was aware of the potential for asymmetry in the power dynamics between herself and the participants. The researcher is a medical practitioner who was training in Psychiatry; as a result, the participants may have been concerned that the details disclosed during the interview process may have had an influence on inpatient care, the opportunity for Leave of Absence or Conditional Discharge. Attempts were made to pre-empt and avail these concerns. The researcher remained non-judgemental, impartial and empathic throughout the interview process and in subsequent follow up with the participants. Prior to commencing the interview process, the researcher explained that the information disclosed had no influence on the procedures related to being a State Patient. Additionally, the researcher was not

part of the treating multidisciplinary team involved in the participants' care and confidentiality would only be breached if the distress protocol was required.

The interviews were conducted in English and the participants reported being comfortable with this. However, the nature of this qualitative research encouraged the participants to express their lived experience in their own words. As a result, the interviews not being conducted in some of the participants' home language may have neglected some nuances in their stories. Additionally, the researcher was from a different cultural background to some participants; it is possible that this may have influenced the interpretation of results. However, in the triangulation process, the interviews were analyzed by members of different cultural and linguistic backgrounds.

# 6. CONCLUSIONS AND RECOMMENDATIONS

To the researcher's knowledge, this is the first qualitative study looking at the lived experience of mentally ill women who commit filicide in the South African population. There is a dearth of qualitative work looking specifically at the offenders and their personal experiences of the act itself and resulting outcomes.

There are a number of important conclusions that can be described from the 7 interviews.

The experience of being a State Patient is a predominantly negative one, whereby the participants felt they had limited control over their own lives and their freedom. There was an overall sense of frustration despite accessing what was described as, effective and important, rehabilitation. This may reflect a perceived lack of clarity regarding the process and course of being a State Patient and addressing this lack of clarity may be a way to impact more positively on the experience of being a State Patient.

Most of the participants could describe the symptoms of their mental illness on the day of the offence. *Resnick et al*, found that seventy-five percent of parents who commit filicide displayed psychiatric symptoms before the offence.[13] This re-emphasizes the fact that amnesia to a crime is not the predominant finding in the mentally unwell and certain psychiatric symptoms might need to be investigated further to more clearly associate them with the potential committing of certain crimes.

Further, though most participants had not been diagnosed at the time of the incident with a psychiatric diagnosis, they did seem to be aware of symptoms. There is a need for psychiatric services and close monitoring in the peripartum period as well as appropriate screening in this very vulnerable population. Most participants

recognized that they were mentally unwell at the time of the offence and emotions expressed were that of regret and guilt; strategies to improve insight regarding psychiatric symptoms and conditions as well as effective treatments thereof may assist in the psychological rehabilitation of these women.

Almost all the women had very positive feedback regarding how the family and their community assisted in their reintegration and rehabilitation back into society. This is a crucial support system that would need further study as the concept of de-institutionalisation of the mentally unwell is a prominent topic in Johannesburg. By actively involving such support structures within the rehabilitation process, it can be hypothesized that personal and psychological healing will continue for these women as they are finally discharged from the forensic inpatient unit.

Specific inpatient rehabilitation modalities were discussed with the participants. Occupational-, Industrial- and Psycho-therapies were the three branches of the therapeutic process described by most of the participants as beneficial. The participants described benefiting positively from the current rehabilitation modalities in place. Religion and faith and its role in the rehabilitation process were discussed on a number of occasions in the individual interviews. It may be useful to explore the importance of this in further research as faith may be an important factor in holistic rehabilitation.

For a mentally unwell person to remain healthy and functional, access to efficient outpatient clinics (with regular availability of medication and therapeutic services) is essential. It is unknown whether this theme is relevant to other or all community clinics in Johannesburg or elsewhere, but it is a potential topic to investigate in future research. The need for assessing these individuals' mental state, risk of recidivism,

and risk to self is imperative and forms a part of their rehabilitation. However, this must be balanced against re-traumatizing offenders who have reached sense of closure from the offence, so as not to do further harm.

The process of qualitative research requires a process of active listening during conducting the semi-structured interviews. This process seemed to allow the participants the space to reflect on their journey thus far. Research evidence supports that the process of interviewing in qualitative research helps to validate and normalize the participants' experiences and may be regarded as therapeutic. Therefore, further qualitative research in vulnerable populations, such as the women included in this study, should be explored.

The paucity of available literature has allowed for these particular outcomes to add substantial knowledge delving into the emotionally charged and sensitive nature of the lived experiences of these women.

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# APPENDICES

## APPENDIX 1: SEMI STRUCTURED INTERVIEW

An open ended semi-structured interview will be conducted by the researcher. Topics that will be covered in the interview will include the subject's thoughts about children and experience of parenting, their experience of the offence, help seeking behaviour post offence, perception of available support available, attitude of family with regards to the offence and towards themselves post offence, experience of rehabilitation processes, their accounts during their period of recovery, and rehabilitation thus far. The following are prompts that will be used to explore the topics that are mentioned above.

*We will now begin with the interview, some of the questions may be quite difficult to talk about and if you become uncomfortable at any stage or find that you need a break, please let me know and we will stop and continue at a later stage, if you are willing. I hope that you would share with me as much as you are comfortable sharing about your experience. Do you have any questions before we begin?*

*1. You have been a State Patient for a number of years now, I wonder what that has been like for you?*

*- Exploring the process of how the subject became a State Patient, what it feels like to be a State Patient, exploring emotions and potential frustrations and feelings about themselves.*

*2. Could you share with me what you remember about the day that led to the event?*

*- Exploring the subjects mental state at the time, their perceived support and their recollection of the day of the offence.*

*3. I realize that talking about the event is difficult and may bring up many emotions but I wonder if you could describe to me how you felt after the event?*

*- Exploring feelings about the offence and feelings about themselves.*

*4. Do you still think about what happened on that day?*

*- Exploring memories that the subject may have, whether they experience any traumatic memories and how they deal with the memories or feelings they may have.*

*5. Can you describe for me what it was like to be admitted as a State Patient?*

*- Exploring what it feels like to be a classified as a State Patient and the emotions at that time.*

*6. I wonder if there was anything you experienced in the ward that you have found to be helpful in your recovery?*

*- Exploring the subject's experience of the treatment received and perceptions of the inpatient rehabilitation process, exploring what they feel would be helpful to their recovery.*

*7. How do you feel about the support you received in hospital?*

*- Exploring the perceptions of support received from staff and family while an inpatient.*

*8. How do you feel about the support you have received while on leave and/or conditional discharge?*

*- Exploring the perceptions of support received as an outpatient from clinics, family and the community.*

## APPENDIX 2: DEMOGRAPHIC DATA

Participant Number:

Age:

| |
|---|
| |

Race:

| Black | White | Coloured | Asian | Other |
|---|---|---|---|---|
| | | | | |

Highest Level of Education:

| None | Primary School | High School | Tertiary Level |
|---|---|---|---|
| | | | |

Employed at the time of the offence:

| Yes | No |
|---|---|
| | |

Employed currently:

| Yes | No |
|---|---|
| | |

Number of people living in the house:

| | | | |
|---|---|---|---|
| 0-3 | 4-7 | 8-10 | >10 |
| | | | |

Marital Status:

| | | | | |
|---|---|---|---|---|
| Single | Married | Divorced | Separated | Widowed |
| | | | | |

Number of surviving children:

| | |
|---|---|
| Male | Female |
| | |

Psychiatric diagnosis:

| | | | | |
|---|---|---|---|---|
| Psychotic Disorder | Mood Disorder | Substance Induced Disorder | Due to Another Medical Condition | Other |
| | | | | |

On Medication:

| Yes | No |
|---|---|
| | |

Current Classification:

| Inpatient | On Leave of Absence | Conditional Discharge or in the process of being conditionally discharged |
|---|---|---|
| | | |

## APPENDIX 3: Ethics Approval

R14/49 Dr Sanuska Moodley

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**

**CLEARANCE CERTIFICATE NO. M150625**

| | |
|---|---|
| **NAME: (Principal Investigator)** | Dr Sanuska Moodley |
| **DEPARTMENT:** | Psychiatry<br>Sterkfontein Hospital |
| **PROJECT TITLE:** | The Lived Experience: A Qualitative Study of Mentally Ill Women Who Commit Filicide, Exploring their Perceptions of the Offence and Their Experience of the Rehabilitation Process as the State Patient |
| **DATE CONSIDERED:** | 26/06/2015 |
| **DECISION:** | Approved unconditionally |
| **CONDITIONS:** | |
| **SUPERVISOR:** | Prof U Subramoney |
| **APPROVED BY:** | Professor P Cleaton-Jones, Chairperson, HREC (Medical) |
| **DATE OF APPROVAL:** | 29/07/2015 |

**This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.**

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature _____ Date _____

**PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES**

## APPENDIX 4: TURNITIN

**See enclosed Turnitin Report**