

**MATERNAL FILICIDE:  
GROUNDED THEORISING FROM INTERVIEWS WITH MOTHERS WITH  
A DIAGNOSIS OF MENTAL ILLNESS**

by

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**A thesis submitted for the degree of Professional Doctorate**

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**June 2016**

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## **ACKNOWLEDGEMENTS**

I first and foremost wish to acknowledge the mothers who agreed to take part in this study for their courage in putting their experiences into words. Participants expressed their wish that the study would help to increase others' understanding of maternal filicide. Mothers also hoped that their participation in the study would contribute to others' understanding of their actions and to help other families in similar positions. I hope that within this thesis I have been able to do modest justice to the wishes of those mothers.

I owe a debt of gratitude to the women's medium secure service where I have worked as a consultant clinical psychologist. The clinical team has generously supported the study over the last six years, putting up with me being both preoccupied and somewhat fatigued. I am also immensely grateful to Avon and Wiltshire NHS trust for funding the first three years of my study and providing study leave throughout.

The study could not have been completed without the belief, commitment, encouragement and technical support of my supervisors; Dr Frances Blumenfeld who provided a common sense approach and ensured psychological thinking about the data. The moments when I doubted I could finish the thesis were also the times when Dr Blumenfeld would provide practical steps to keep the writing process going, for which I am indebted. I thank Dr Charles King for his relentless curiosity about the subject and processes of maternal filicide. I benefited enormously in the early stages of the research from Dr King's knowledge and experience of working clinically with mothers who had killed their children. Lastly, I wish to acknowledge Dr Chris Green for sharing his knowledge and experience of using grounded theory methods. I would like to think that the endless discussions about the various aspects of grounded theory were as interesting and illuminating for Dr Green as they were for me - however, I am fairly sure that they were not! Therefore, Dr Green's unstinting interest in my study, willingness to discuss and return to methodological points over and over again, are a testament of his commitment to his role as supervisor.

I also wish to acknowledge all my friends and family who cajoled, encouraged, nagged and consoled me into writing even when my moaning and complaining about the demands of the thesis must have been very boring conversation points!! Particular acknowledgement goes to Drs, Megan Wilkinson-Tough, Julian Walker and Selena Elcombe who provided support, advice and encouragement, for which I am grateful. I also wish to acknowledge the professional support of Professor Paul Hoggett in helping me to navigate the personal impact of researching maternal filicide. Dr Arian Bloodwood, my cousin Tracey Thornborrow and dear friends Dr Sam Shaw and Ruth Lawson gave much valued time in reading and checking through this thesis to provide practical and much needed help. Thank you very much!

I do not believe that I could have submitted my doctoral level thesis without the aid of all these members of my study team, family and friends, and others not formally acknowledged.

## SUMMARY

**Background:** Child homicide represents 11.5% of all homicides and parents are perpetrators in about 67% of all cases<sup>1</sup>. Of parents who kill their children fathers have been found to more often be the perpetrator (filicide) in all age groups except in neonaticides, where mothers are nearly always responsible. Women have been found to be over-represented in rates of filicide. Diagnoses of mental illness (MI) have been found as a moderating variable for mothers who kill older children. The aim of the present study was to explore the conditions, processes and contexts that contribute to the development of maternal filicide (MF) in MI mothers.

**Method:** Four mothers with a diagnosis of MI were interviewed using constructivist grounded theory methods to produce theorising about the development of MF. Due to the sensitivity of the research topic, the vulnerability of the population and the need to ensure support for study participants, the study design included only those mothers still receiving care from secure hospital services (N=30).

**Findings:** The present study produced grounded theorising of a process of *Disintegrating Security* in a number of sequentially related domains: social, economic, relational and psychological as contributing to MF. Consistent with other research on filicide mothers with a diagnosis of MI, mothers were active in caring for their children but became hopeless and suicidal, believing that their own suicide would leave their children alone in a cruel and dangerous world.

**Conclusions:** Mothers committed filicide in a perverse act of maternal love rather than out of anger, or as part of prolonged child abuse. A detailed account of the development of MF in MI mothers has been produced. The findings could be important to increase the understanding of MF for mental health professionals working with filicide mothers, surviving family members and mothers themselves.

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<sup>1</sup> Crime in England and Wales 2002/03

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background to the Study

**1.1.1 Introduction to the area under investigation.** The subject of this thesis is an exploration into the development of filicide (the act of killing of children by their parents) committed by mothers. A sub-group of filicide mothers receive a diagnosis of mental illness at the time of the act and have mostly been found not guilty due to diminished responsibility. Mothers who have received a diagnosis of mental illness at the time of the offence, are sentenced by the court to receive their care in a secure hospital rather than in a prison. The specific focus of this study is an exploration of the experience of filicide (of children aged over one year old) from interviews with mothers who were given a diagnosis of mental illness and who were sentenced to a hospital for treatment. This group is an extremely small population forming the minority of filicide mothers (approximately 37% ; Flynn, Windfuhr, & Shaw, 2009a).

**1.1.2 Personal context for interest in the study area.** As a consultant clinical psychologist in a medium secure service for women I had specialised in working clinically with filicide mothers who had received a diagnosis of mental illness. I had been privileged to listen to women in their therapy sessions as they sought to understand and reflect upon the origins and meanings of their violent and filicidal behaviour. Although understandably this process was fraught with emotional pain for mothers (and not without distress for myself) women were able to explore

and put their experiences into words and reported benefits from increasing their understanding of their acts.

No previous studies had interviewed mothers (with a diagnosis of mental illness) about the development of maternal filicide. In the extant literature there was only a very limited understanding of the causes, contexts and processes that have contributed to the development of maternal filicide (Hatters Friedman, Horowitz, & Resnick, 2005a). The popular depictions of mothers who had killed their children within the context of prolonged child abuse and neglect are often rightly described as failing to care adequately for their children. However, in my clinical experience of working with mothers who had been diagnosed with mental illness there was often no previous abuse of the child. Instead mothers appeared to have been engaged in caring for their children prior to the filicide and to have been considered by others as good mothers. This clinical picture is consistent with research in the maternal filicide literature of women with a diagnosis of mental illness:

*‘...before the homicidal act quite unexpectedly occurred, most of these mothers were reported to have been ‘perfect’ mothers who took good, even meticulous care of their children and were controlled and restrained in their relations with other people’ (p. 233; Haapasalo & Petäjä, 1999).*

I was therefore interested in researching the subject of maternal filicide with a method that would allow me to develop greater understanding of a poorly understood subject. My initial interest in maternal filicide led me to consider the methodology to be adopted in pursuit of the study aim. The use of qualitative methodologies as a research method was indicated by three factors; 1) my professional role as a clinical psychologist had given me theoretical sensitivity to the subjectivity of personal

experience and the role of individual interpretation of events 2) the lack of knowledge in the subject area and the need for more in-depth and detailed understanding about maternal filicide 3) the rarity of the phenomenon and the size of the population. In considering qualitative methodologies, I was most interested in the possibilities that grounded theory (Glaser & Strauss, 1967) offered of producing an in-depth understanding that could account for filicide behaviour by the use of inductive methods.

As a feminist I came to the research process aware of the public portrayal of motherhood and maternal filicide and an acceptance of the critique by feminists of both the concept of mental illness diagnosis in women and gender stereotyping of violent women (Alder & Baker, 1997; Alder & Polk, 2001; Chesler, 2005; Stangle, 2008). I was therefore interested in a methodology that was compatible with feminist considerations. Constructivist grounded theory (GT) method (Bryant & Charmaz, 2010a) with its emphasis on subjectivity and individual interpretations was attractive to me as it offered a means of studying maternal filicide and using an analytical frame on 'taken-for-granted' meanings.

However, any study into the area of maternal filicide would be sensitive, using a vulnerable and difficult to reach population. As a consultant clinical psychologist I had experience and expertise in working therapeutically with filicide mothers and believed that these skills would enable me to conduct an interview study safely. I also had access to professional contacts in the area of forensic and clinical psychology that I thought would be useful resources to facilitate the research. I therefore considered myself as in a unique but well qualified position to be able to conduct an interview

study into the area of maternal filicide. These were important considerations given the very small size of the population and the sensitivity of the subject matter, and persuaded me that I could make a valuable contribution to the area of maternal filicide.

**1.1.3 Rationale for the study.** Previous studies of maternal filicide have generally focused on retrospective case file reviews (McGrath, 1992; Wilczynski, 1997a; Hatters Friedman, et al., 2005a; Hatters Friedman, Hrouda, & Holden, 2005b; Hatters Friedman, Hrouda, Holden, Noffsinger, & Resnick, 2005c; Krischer, Stone, Sevecke, & Steinmeyer, 2007), single or multiple case studies (Welldon, 1992; Kunst, 2002; Motz, 2009) or investigated the causes and characteristics of maternal filicide (Flynn, Shaw, & Abel, 2007; Liem & Koenraadt, 2008; Razali, Salleh, Yahya, & Ahmad, 2015). Research inquiry has also sought to establish typologies of maternal filicide (Resnick, 1969; Scott, 1973a; d'Orban, 1979; Bourget & Bradford, 1990; McKee & Shea, 1998; Meyer & Oberman, 2001), motivational models (Hatters Friedman, Horowitz, & Resnick, 2005a; Mugavin, 2008) and the identification of relevant risk factors in mothers with a diagnosis of mental illness compared to those without (Lewis & Bunce, 2003; Flynn, et al., 2007).

This study uses the term filicide as referring to the less common killing of children over one-year of age by their parents (Bourget & Gagne, 2005; Crime in England and Wales, January 2004). The killing of older children by their mothers has been found to be associated with mental illness in a number of studies (Resnick, 1969; Hatters Friedman, et al., 2005b; Flynn, Shaw, & Abel, 2013). The killing of older children has been considered as counter-evolutionary behaviour and evidence of

psychopathology as the parent kills offspring after the investment of considerable resources and when the parent's own fertility is decreasing (Daly & Wilson, 1984; Bourget, Grace, & Whitehurst, 2007; Krischer, et al., 2007; Hatters Friedman, Cavney, & Resnick, 2012).

This study uses an interview method to explore maternal filicide in the context of a diagnosis of mental illness. No other study has interviewed mothers (diagnosed with mental illness) about their experiences in the development of maternal filicide. Therefore, this study represents a unique approach to the study of filicide and aims to contribute to the extant, but inadequate knowledge about this sensitive topic.

A critical evaluation of the literature and existing knowledge about maternal filicide will be presented in the following chapters of this study, including the relationship with diagnoses of mental illness. The chapter includes a critical evaluation of the concept of mental illness and how mothers who have killed their children have typically been treated within the medico-legal system. I will conclude the chapter by elucidating the position that I have adopted in conducting this research, including how my position has impacted on both the research process and the outcome of the study.

## **1.2 Child Homicide**

**1.2.1 Rates of child homicide in the UK and comparison countries.** In 2011/2012 in England and Wales there were 47 homicide victims aged 16 years of age and under. The majority of these victims were acquainted with the principal suspect (62%, 29 offences), and in all but one of these cases, they were killed by a



parent or step-parent (Office for National Statistics, 2013; ONS). During the period 1992 to 2002/3 child homicide (where victims were under 16 years of age) accounted for between 7.8% to 13.7% of all homicides in England and Wales. Approximately one third of victims are aged under one year of age (34.3%), and a further one third (31.3%) are aged between 1-5 year while the remainder (34.3%) were aged between 5-15 years old (Crime in England and Wales, January 2004).

Different countries use different reporting and classifying systems that complicate efforts to assess true rates of child homicide by parents. Official statistics do not routinely report rates of filicide, and crime statistics generally refer to child homicide which masks the number of child-killings by parents (Flynn, et al., 2009b).

**1.2.2 Definitions of filicide.** The literature of child-killing by parents and step-parents includes ‘*no single definition of filicide specifying the age or the relationship of the parties involved (i.e. inclusion or exclusion of stepparents)*’ (Flynn, et al., 2009; p5). The term filicide is used to refer to all child murder by parents but other definitions have also been proposed based on the age of the victim. The definitions are presented in Table 1.

**Table 1: Definitions of filicide.**

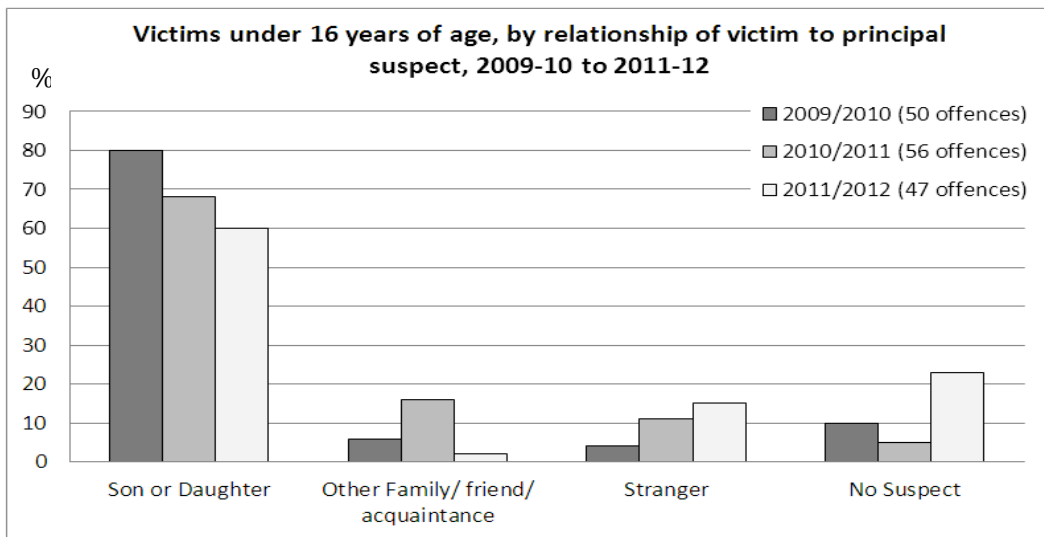
<b>Type of child homicide by parent</b>	<b>Age range of victim</b>
<b>Neonaticide</b>	Children < 24 hours old
<b>Infanticide</b>	Children < 12 months old
<b>Filicide</b>	Children < 18 years of age

Within the general literature of filicide, studies have not only tended to include both neonaticide and the killing of older children but to also include varying upper

age limits of victims. In the study by Bourget & Gagne (2005) victims aged up to 35 years of age were reportedly included whilst other studies have included children aged under 16 years (d'Orban, 1979) and under 18 years of age (Wilczynski, 1997b). This variability in the age of victims and the differing criteria used to define filicide are often unreported in papers, which makes direct comparisons between studies problematic. In addition research has typically focused on prison, psychiatric and population studies making comparisons between studies difficult. A number of authors and studies, however, have suggested that there are distinct but overlapping types of filicide, (Resnick, 1969; Crittenden & Craig, 1990; Marks & Kumar, 1996) and the distinctions between these groups have relevance to the present study.

**1.2.3 Parents as perpetrators of child homicide.** In one of the first published studies of filicide based on an international review of 131 cases of child homicide, Resnick (1969) found that 81% of victims aged under 20 years were killed by one or both of their parents. A more recent review of child deaths in the United Kingdom for the year 2010/2011 (Smith, Osborne, Lau, & Britton, 2012) found that in victims under 16 years of age, two thirds were killed by their parents.

The graph in Figure 1 shows the percentage of perpetrators responsible for the homicide of children under the age of 16 years, and the relative risk to children from a parent compared to the risks posed by other family members, friends, acquaintances and strangers.



**Figure 1: Chart showing percentage of perpetrators by relationship to victims**  
(Reproduced from ONS, 2013, p. 30)

Flynn et al., (2009a) report that data from the National Confidential Inquiry (NCI) show that 48 (30%) out of 162 paternal filicides were committed by stepfathers. Given that the number of children reported living with stepfathers in the UK is reported as being only 10% it is evident that step-fathers are over-represented in filicides.

**1.2.4 Maternal and paternal filicide.** With conclusive evidence that parents represent the greatest threat to their children in terms of homicide, the evidence about whether mothers or fathers present the greater risk is more difficult to establish. There has been found to be an effect of age of victim on the gender of the perpetrator and the differing types of populations studied have likely influenced the variation in findings (Flynn, et al., 2009a; Hatters Friedman, et al., 2012).

In one report (quoted by Flynn et al from unpublished data from the National Confidential Inquiry in the UK) the proportion of fathers who had killed their children

was reportedly higher than mothers (64% v 36%). This finding is broadly consistent with a study in Sweden which reviewed the cases of 79 parents convicted of killing their children over a 10 year period from 1971-1980 (Somander & Rammer, 1991). The authors found that 65% of the perpetrators were men. However, both of these studies used analyses of convicted cases and Wilczynski (1993) and others (Allen, 1987; Rapaport, 2006; Stangle, 2008) have demonstrated that perpetrating mothers and fathers have historically been treated differently in the courts: women are treated more leniently, and often convicted of lesser offences; fathers are over-represented in prison studies or in convicted cases (Stangle, 2008). Filicide mothers are also more likely to be sentenced by the court to psychiatric treatment and care, so clinical populations have found a preponderance of women (Allen, 1987). Mothers have consistently been found to be almost exclusively responsible for neonaticide deaths (the killing of new-born babies, within 24 hours of their birth) and therefore studies that include neonaticide cases alongside those of older children find a greater number of mothers as perpetrators (Marks & Kumar, 1996; Flynn, et al., 2009b; Hatters Friedman, et al., 2012). However, in one of the largest studies of infanticide in England and Wales Brookman and Nolan (2006) reviewed 298 cases of infanticide recorded between 1995 and 2002. In their review, the authors noted that in cases of the killing of biological children aged under one year old, mothers and fathers killed in almost identical proportions (104 cases and 112 cases respectively) demonstrating that age of the victim has an important impact on gender of the perpetrator.

Despite the inconsistencies in the literature it is broadly accepted that fathers more often kill their offspring than do mothers. However, very few studies have examined maternal and paternal filicides together and those that have, have rarely

compared characteristics by gender (Flynn, et al., 2009a) so that there are gaps in knowledge about differences between the risks that mothers and fathers pose, relative to each other.

**1.2.5 Cross cultural rates of filicide.** The United States of America (USA) has consistently been reported as having the highest rate of child homicide by parents in all age groups (Hatters Friedman & Resnick, 2007; Flynn, et al., 2009a) which is likely a consequence of the ease of access to guns. Comparing the rates of filicide in the USA with those in the UK is complicated by the fact that rates of filicide are not routinely reported in the UK literature. Therefore, up to date rates per 100,000 population are unavailable (Flynn, et al., 2009b). However, Table 2 shows the number of child homicides per 100,000 births for a number of countries including England. From Table 2 it is clear that the rate of homicide consistently decreases as the child matures, and the killing of older children by their parents has been found to be much less common than the killing of younger children (Flynn, et al., 2009b).

**1.2.6 Over-representation of women in cases of child homicide.** In the most recent publication from the Office of National Statistics (ONS; Focus on: Violent Crime and Sexual Offences, 2011/12; 2013) out of 559 homicides with 606 suspects, 90% of those convicted were male, and only 10% were female. Generally, women offend less often than men, and when they do they are more likely to commit acquisitive offences and much less likely to commit sexual or violent crimes when compared to men (Rooprai & Clark, 2011). Home Office conviction figures show that women have been found to have committed only 6% of murders, 1.5% of attempted murders, 16% of manslaughters and 7% of woundings. Typically then

rates of female violence and homicide are relatively low for women when compared to men (McKee, 2006; Flynn, et al., 2009b). However, in the cases of filicide mothers are over-represented.

**Table 2: Table showing age-specific rates of child homicide (published by World Health Organization, (WHO) 1988 and 1989 as cited by Flynn, Windfuhr and Shaw (2009a, p. 18)**

<b>Country</b>	<b>*Below 1 year (per 100,000 live births)</b>	<b>1-4 years (per 100,000 population)</b>	<b>5-14 years (per 100,000 population)</b>	<b>Homicide of all ages (inc. adults) (per 100,00 population)</b>
USA	7.17	2.31	1.19	8.55
UK (England/Wales)	3.03	0.73	0.23	0.60
UK Scotland	3.02	1.56	0.32	3.22

\*In countries where the numbers of live births are low, single infanticides may generate a falsely high rate. Caution is required when comparing countries with low birth rates.

### **1.2.7 Differences between neonaticide, infanticide and filicide.**

*Neonaticide.* There is broad agreement in the literature that the most dangerous time in a child's life is the first day of life (Porter & Gavin, 2010; and Hatters Friedman, et al., 2012). There is evidence that neonaticide, the largest group, differs from the non-neonaticide deaths in a number of ways, one such difference is that neonaticide deaths are almost exclusively committed by mothers (Resnick, 1970). Table 3 below, provides a broad summary of the study by Resnick (1970) and summarises the different characteristics found between neonaticide and other filicide mothers. The table shows differences in mental illness diagnoses as well as other factors.

**Table 3: A comparison of Resnick's data on neonaticide and filicide. Reproduced from West (2007, p. 53)**

	Neonaticide	Filicide
Age	89 % under the age of 25	23% under the age of 25
Marital Status	19% married	88% married
Psychosis <sup>2</sup>	17% psychotic	66% psychotic
Depression	9% depressed	71% depressed
Suicide attempt following the crime	0%	33%
Motive	83% unwanted child	56% altruistic

Mothers who commit neonaticide have consistently been found to be younger than mothers who kill older children (McKee, 2006; Krischer, et al., 2007), tending to be in teenage years, single and experiencing adverse psychosocial circumstances (Resnick, 1970; d'Orban, 1979; Crittenden & Craig, 1990; Haapasalo & Petäjä, 1999). In perhaps the largest study of neonaticides, Spinelli (2001) conducted a systematic review of 16 deaths and found that mothers had denied the unwanted and unplanned pregnancy which was usually concealed from others. The main differences between the neonaticidal and non-neonaticidal deaths are the higher association of diagnoses of mental illness and suicide with non-neonaticides, a finding that has also been found in a number of other studies (Resnick, 1970; Haapasalo & Petäjä, 1999; Porter &

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<sup>2</sup> **Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions.**

The two main [symptoms of psychosis](#) are:

- **hallucinations** – where a person hears, sees and, in some cases, feels, smells or tastes things that aren't there; a common hallucination is hearing voices
- **delusions** – where a person believes things that, when examined rationally, are obviously untrue – for example, thinking your next door neighbour is planning to kill you

The combination of hallucinations and delusional thinking can often severely disrupt perception, thinking, emotion and behaviour.

Experiencing the symptoms of psychosis is often referred to as having a psychotic episode.

Gavin, 2010). It is generally accepted that neonaticide deaths are not positively associated with suicide (Hatters Friedman, et al., 2005a; Hatters Friedman, et al., 2005c).

Comparison between the neonaticide and filicide perpetrators shows a difference in the reported motives for the killing of the child (Hatters Friedman, et al., 2005a). The majority of perpetrators who kill neonaticides are classified as killing unwanted children, while non-neonaticide killings have been classified in a number of studies as motivated by altruism (Resnick, 1969; Lewis & Bunce, 2003; Porter & Gavin, 2010). I would argue that the notion that altruism could be a motive for a homicide is contentious. As Lewis and Bunce (2003) point out, in killing a child the motive of the parent may be unrelated to altruistic goals, and simply a reflection of what the parent perceives as best for them. Nevertheless, the use of the term altruism to describe motives for filicide persists in the literature.

***Infanticide.*** The second category of child-killing by parents, refers to the deaths of children aged under one year old, but older than one day. This category probably owes its existence to the use of specific legal defences than for any real, tangible differences between victims from this age group compared to older but still pre-school aged children. In England, Canada and most former Commonwealth countries, the killing of children aged one year or younger by mothers is categorised as infanticide. In English law the Infanticide Act of 1922 (amended in 1938) proposes that the unique effects of childbirth act as mitigating circumstances for filicide perpetrators where the murder occurred in the 12 months following the birth



of the child. The Act provides that a mother found guilty of infanticide should be dealt with as though guilty of voluntary manslaughter:

*'...where the balance of her mind was disturbed by reason of her not having fully recovered from the effects of giving birth to the children or by reason of the effect of lactation consequent upon the birth of the child'* (Infanticide Act, sect.1).

A post-partum period of increased risk of harm to the infant has been found and the time in a women's life immediately after giving birth is a time when she is at greatest risk of mental illness. Post-partum psychosis has been found to affect 15% of mothers (Hatters Friedman, et al., 2012) and untreated post-partum psychosis carries a 4% risk of infanticide and a 5% risk of suicide (Hatters Friedman, Resnick, & Rosenthal, 2009). So, the specific diagnoses of post-partum psychosis, has been found to increase the risk of harm to the child from the mother (Porter & Gavin, 2010). However, the use of arguments about the biological basis of any mitigation for mothers who kill their children beyond this immediate period after birth, has been broadly criticised (Stangle, 2008). The legally defined notion of post-partum risk that extends to one year after birth is at odds with the accepted view that hormonal changes are limited to six weeks post-birth (as defined by the World Health Organisation; Porter & Gavin, 2010). In addition, theorists in maternal filicide are critical of the reliance on unproven assumptions about hormonal changes as causal to maternal aggressiveness following childbirth (Stangle, 2008). The issues related to the medico-legal debates surrounding violent women generally and specifically mothers who have killed their children are discussed more fully in section 1.5.1 of this chapter.

*Filicide.* Independent of the issues pertaining to the legal defence of infanticide, much of the literature on filicide has delineated the population under investigation quite clearly around the groups of neonaticide, infanticide and the killing of older children (Porter & Gavin, 2010). Other authors have tended to group filicides together making it difficult to compare studies. Other studies have tended to delineate groups of victims into either pre-school (Crittenden & Craig, 1990; Somander & Rammer, 1991), early or mid-childhood (Flynn, et al., 2009a).

Notwithstanding these difficulties in the literature, infancy has been described as the most at risk age-group for homicide across a lifetime (Porter & Gavin, 2010). Fifty five percent of all filicide victims are aged under one year of age (Marks & Kumar, 1996; Flynn, et al., 2009b) and 40% of filicide victims will be killed by their parents within the first three months of their lives (Flynn, et al., 2007). These findings indicate that the one-year post-birth period is associated with increased risk of parental violence for the infant child compared to risks for older children.

### **1.3 Maternal Filicide**

**1.3.1 Classifications of filicide.** A large part of the existing literature about maternal filicide has aimed to classify the acts within typologies. However, there have been no studies that have investigated the inter-rater reliability of typologies of filicide with specific cases. In addition, cases overlap with each other, and this weakens the argument that the categories successfully differentiate between types of filicide. None-the-less the literature classifying the different types of filicide has been influential and adopted in a number of studies (Farooque & Ernst, 2003). It is beyond the scope of this study to provide a detailed review of the various typologies but given

the importance of this work in the literature of filicides, a short summary is provided as it addresses the hypothesised motives.

**1.3.2 Motives for filicide by typology.** Resnick (1969) documented the first typology of child murder and D'Orban (1979) further refined his classification system into five categories:

- Mentally ill women (who kill a child as a result of suffering an acute psychosis)
- Retaliating women (who kill a child to avenge the other parent by making them suffer. Also called the medea complex)
- Those rejecting an unwanted child
- Those that commit 'mercy' or 'altruistic' killings; their motive being to stop or prevent the child's real or imagined suffering
- Battering mothers; those who inadvertently kill their child whilst physically assaulting them.
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It is evident from the above classification system that the categories are not mutually exclusive and that they indeed overlap. It is also evident that some of the categories are based upon the perceived motivation of the perpetrator and this has been criticised for not only being subjective (Scott, 1973; Mugavin, 2005) but also because it uses retrospective and subjective decisions about categories (Lewis & Bunce, 2003).

**1.3.3 Altruistic motives.** Many studies have adopted and persisted in terming filicides as motivated by the altruism of the perpetrator. Resnick (1969) controversially described altruistic filicides as occurring 'out of love'. As Harder has pointed out, in killing a child the motive of the parent may be unrelated to any

altruistic goals. The act of filicide, may simply be a reflection of what the parent perceives as best for themselves:

*...there is no doubt that the statement 'what was best for the children' is only an expression of the fact that the perpetrator himself or herself thought that the infanticide was the best way out...., (1967, p. 237, as cited by Lewis & Bunce, 2003).*

The widely accepted use of the term altruistic to describe filicide may be related to how difficult it is for society to conceive of parents as capable of filicide. This difficulty may be even more evident in respect of mothers, where there is a belief and commitment to the myth that women are always 'loving mothers' even during murder (Porter & Gavin, 2010). Nonetheless, in the literature there is a persistent use of the term altruism to describe types of filicide and the label will be used in this thesis although not accepted uncritically.

**1.3.4 Filicide-suicide motives.** Other theorists have included in their typologies a category of parents who kill in the context of suicide (Bourget & Bradford, 1990). Suicide has consistently been reported within the literature of parental filicide and this has been explored in mothers who have attempted or completed suicide at the time of the filicide (Hatters Friedman, et al., 2005c; Hatters Friedman, Holden, Hrouda, & Resnick, 2008; D'Argenio, Catania, & Marchetti, 2013; McKee & Egan, 2013). Bourget and Bradford (1990) conceptualised the type of filicide that followed suicide as an extended homicide-suicide. In this type of filicide it was hypothesised that a psychological and/or emotional identification with the child-victim has occurred which has increased the risk of filicide. The child's death results from the parent perceiving suicide to be an act of abandonment of the child. In a clearly distorted logic, the parent kills the child as they consider it a preferable course of action than to leave the child through suicide.

A number of studies have been conducted into the differences between types of filicide, however before these are presented, other research about the various characteristics of victims and filicide parents will be reviewed and summarised.

**1.3.5 Characteristics of maternal filicide perpetrators.** In a review of 39 studies Hatters Freidman, Horowitz & Resnick (2005a) found that in infanticide cases, mothers were in their early twenties. Reviewing a number of studies, West (2007) summarised some key differences found in a number of studies between mothers who commit, neonaticide, infanticide and filicide (see table 4).

**TABLE 4: An Overview of filicide based on perpetrator characteristics. Reproduced from West, 2007 p.52)**

Perpetrator/ Characteristics	Maternal Filicide	Infanticide	Neonaticide
Age of parent	29 years old	23.8 years old	21.2 years old
Sex of parent	Female	Both	Female
Age of victim	3.2 years old	5 months old	>24 hours old
Psychiatric issues	Common	Common	Uncommon
Suicide	36.4%	Unknown	Rare
Methods of murder	<ul style="list-style-type: none"> <li>• Head trauma</li> <li>• Drowning</li> <li>• Suffocation</li> <li>• Strangulation</li> </ul>	<ul style="list-style-type: none"> <li>• Head trauma</li> <li>• Battery</li> <li>• Assault</li> </ul>	<ul style="list-style-type: none"> <li>• Suffocation</li> <li>• Drowning</li> <li>• Exposure</li> </ul>
Other characteristics	<ul style="list-style-type: none"> <li>• Socially isolated</li> <li>• Unemployed</li> <li>• Personal history of abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Limited education</li> <li>• Lack of prenatal care in mothers</li> </ul>	<ul style="list-style-type: none"> <li>• Unmarried</li> <li>• Primiparas</li> <li>• Concealment of pregnancy</li> </ul>

Another difference between neonaticide and non-neonaticide perpetrating mothers has reportedly been their marital status. Some studies have reported that filicide mothers were married at the time of the filicide (88%; Resnick, 1969; Wilczynski, 1997b;

52%). However, the findings are not consistent and later figures from the National Confidential Inquiry (Flynn, et al., 2009a) in the UK showed that only around 44% of filicide mothers were either married or in a longer-term relationship. The lower rates of mothers being married found by Flynn, et al., is likely as a result of the decrease in marriages generally which has been reflected in later studies. Another reason for a lack of consistency in the findings is that different populations have been used in studies. For example, studies of prison populations have typically found maternal filicide perpetrators to have been unmarried at the time of the offence (Crimmins, Langley, Brownstein, & Spunt, 1997), whereas those mothers from a psychiatric population have generally been found to more often be married (Hatters Friedman, et al., 2005a).

**1.3.6 Socioeconomic factors.** A number of studies have also investigated the socioeconomic circumstances within which filicide takes place. They have identified housing problems, financial concerns and limited social support as relevant to filicide mothers from both clinical and population studies (Wilczynski, 1997b; McKee & Shea, 1998; Lewis & Bunce, 2003; Mugavin, 2005; McKee, 2006; Hatters Friedman & Resnick, 2007; McKee & Egan, 2013). Nearly two thirds of the sample of 48 maternal filicide case files referred to the Crown Prosecution Service in the UK were found to have housing and financial difficulties (Wilczynski, 1993). Additionally a lack of financial independence may increase the vulnerability of mothers to domestic abuse and exploitation from partners and decrease opportunities to leave abusive situations (McKee, 2006).

**1.3.7 Experiences of abuse.** Many studies have reported that filicidal mothers are often in abusive and violent relationships at the time of the filicide (McKee, 2006). Crimmins et al (1997) found that 52% of the mothers in their prison sample were living with abusive partners. Wilczynski (1993) established that 18% of mothers reported having been a victim of domestic violence prior to the filicide. Meyer and Oberman's (2001) study, found that domestic violence was very prevalent in their sample of cases of women who had committed filicides; 40% had been abused by their partners. In McKee and Shea's study (1998), 43% of women reported that they were in violent relationships. Interestingly, in the study by McKee and Shea, half of the mothers reported experiencing domestic abuse in a previous relationship as well, suggesting that abuse experiences often have a longer history.

The existence of childhood abuse experiences in the lives of women who have committed filicide has been established in a number of studies. However, there has been considerable variation in the rates reported most likely, resulting from the different populations and definitions of abuse used. Spinelli (2001) found that 53% of the infanticidal mothers in her study had been victims of childhood physical and/or sexual abuse. McKee and Shea (1998) found that 20% of their sample had been child abuse victims, and d'Orban (1979) identified 16% of mothers as having experienced childhood abuse. In Wilczynski's (1997b) sample of maternal filicide perpetrators, 39% reported childhood victimisation.

Crimmins et al's (1997) study of 217 homicides committed by women in America included 86 filicide mothers who had been convicted and sentenced to prison. The mothers in Crimmins et al's study reported a history of childhood

victimisation including serious physical and sexual assault (74%). Crimmins et al's study made use of life history interviews and so the rate of childhood abuse is self-reported. However, the study provided information about the early lives of mothers, and this included their experience of being 'motherless mothers'; that is that for 64% of the filicide mothers in the study, their own mothers were unavailable to them, through absence (17%; either neglect or death), alcoholism (38%), mental health problems (7%) or as a result of serious physical abuse (19%) or serious or prolonged verbal abuse (14%). In summary, while definitions of abuse may vary between studies, it is broadly accepted that abuse of some kind will have been a feature in the lives of filicide mothers.

## **1.4 Mental Illness and Filicide**

**1.4.1 Maternal filicide and diagnosis of mental illness.** There is support in the literature for the association of diagnoses of mental illness and filicide from a number of sources in the UK. The National Confidential Inquiry into Suicide and Homicide (NCISH; unpublished but cited by the National Patient Safety Agency (NPSA; 2009) highlighted the risk of filicide in parents with a diagnosis of mental illness in a review of 254 homicide convictions in England and Wales between 1997 and 2004. Of these, 94 (37%) of the perpetrators had a mental disorder. Similarly, in the local Safeguarding Children Boards' report (Ofstead, 2008), mental illness was identified as a significant factor in the deaths of child victims in 14 of the 50 identified cases. A Danish study found that the absolute risk of child homicide victimisation in their study was 0.009% (95% confidence interval (CI); 0.007-0.010), but that the risk was elevated to 0.051% (95% CI; 0.033-0.069) if one parent had previously been admitted to a psychiatric hospital (Laursen, et al., 2011). A study of



infant homicide in England and Wales found one-quarter of the maternal and paternal offenders had received a diagnosis of mental illness at the time of the offence. The highest risk children were generally those younger than five years old with a mother who had been diagnosed with psychotic or mood disorder (Flynn, et al., 2007).

The MacArthur Violent Risk Assessment study (Monahan, et al., 2001) sampled 1,136 admissions to acute civil facilities in United States of America who had diagnoses of thought or affective disorder<sup>3</sup>, substance misuse or personality<sup>4</sup> disorder in order to establish risks of violence after discharge from psychiatric hospital. The findings identified a number of risk factors associated with future risk of violence. The most common risk factors that occurred included a prior history of violence, age, being male, unemployed, having a diagnosis of personality disorder (particularly antisocial), and a history of child abuse. Other clinical issues such as the presence of substance abuse, anger control difficulties and violent fantasies were also found to be positively associated with risk of future violence. Due to dissatisfaction with how the study may have obscured the differences between male and female violence, other researchers (de Vogel, de Vries Robbe, van Kalmthout, & Place, 2012) have added to the list identified by Monahan et al., (2000) and proposed additional factors relevant to future risk of violence in women with a history of mental illness. The factors included experiences of trauma and victimisation *after* childhood and the presence of a history of prostitution, parenting difficulties, suicidality/self-injury and pregnancy at young age. Experiencing problematic intimate relationships and childcare responsibilities were also risk factors. Although

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<sup>3</sup> A mental disorder characterized by a consistent, pervasive alteration in mood, and affecting thoughts, emotions and behaviours.

<sup>4</sup> A deeply ingrained and maladaptive pattern of behaviour of a specified kind, typically apparent by the time of adolescence, causing long-term difficulties in personal relationships or in functioning in society.

the later research by de Vogel et al., (2012) was conducted on a much more limited sample it has utility for considering the specific risk factors for violence in women with a previous history of mental illness.

Diagnoses of mental illness have consistently been associated with maternal filicide in a number of studies (Resnick, 1969; Silverman & Kennedy, 1988; Bourget & Bradford, 1990; Hatters Friedman, et al., 2005b; Flynn, et al., 2007; Kauppi, Kumpulainen, Vanamo, Merikanto, & Karkola, 2008; Flynn, et al., 2013). However, drawing firm conclusions from studies about the precise nature of any association has been difficult as there has previously been an absence of 'reliable, standardised criteria to discern diagnoses both between countries and over time' (Flynn, et al., 2009b, p. 31). In addition a number of studies have used clinical populations or prison populations are expected to have higher rates of mental illness diagnoses generally. However, a UK population study by Flynn et al., (2013) analysed 297 cases of filicide between 1997-2006 by mothers and fathers drawn from a national index of homicide perpetrators. As earlier studies have been criticised for relying on small sample sizes or using samples from psychiatric and prison populations, the study by Flynn et al., represents a relatively large population study, albeit based on convictions, but which included suicide mothers and cases judged too mentally ill to appear in court. These cases have previously been excluded from study samples. The findings showed that compared to fathers, mothers were more likely to have a history of mental illness diagnoses (66% v 27%) and reported symptoms at the time of the offence (53% v 23%). However, the authors concluded that when analysing the data from mothers and fathers, mental illness diagnoses were over-represented as identified in 40% of cases. In summary, the presence of mental illness diagnosis is widely accepted as

being a risk factor and the NCISH report highlighted the risk of filicide in parents with a diagnosis of mental illness.

**1.4.2 Types of mental illness diagnoses relevant to maternal filicide.** In respect of mental illness diagnoses for mothers Flynn et al., reported that mothers were most often found to have affective disorder (14%), which would include depression<sup>5</sup>. This finding is consistent with a review of studies by Friedman et al., (2005a) that concluded that the strongest factor associated with maternal filicide, was a history of suicidality, depression and psychosis. Other studies have vindicated this finding, reporting that in mothers who have killed their children rates of depression have ranged from 52-82% (Resnick, 1969; Haapasalo & Petäjä, 1999; Lewis & Bunce, 2003).

Mental illness diagnoses of schizophrenia<sup>6</sup> or other delusional disorders<sup>7</sup> were also relevant in filicide mothers. A diagnosis of psychoses or schizophrenia has been identified in a number of studies of maternal filicide (53%; Resnick, 1969; 40%; Lewis & Bunce, 2003 ). Other studies have investigated mental illness diagnoses but have reported lower rates of diagnoses of psychosis in their samples of reviewed cases (8%; Bourget & Bradford, 1990), and (16%; d'Orban, 1979). It is generally accepted that reported studies of the presence of mental illness diagnoses in cases of maternal filicide have varied widely as a function of not only the different populations used,

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<sup>5</sup> Depression is a common mental disorder, characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration.

<sup>6</sup> A long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behaviour, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation.

<sup>7</sup> A mental disorder marked by well-organised, logically consistent delusions of grandeur, persecution, or jealousy.

differing cultural contexts and small sample sizes, but also due to variations in the criteria used between countries to diagnose conditions. Therefore, it is necessary to be cautious when comparing findings from different studies.

**1.4.3 Intellectual impairment.** Another clinical risk factor reported in studies of maternal filicide has been the presence of intellectual impairment in perpetrators. Meyer and Oberman (2001) found that 13% of filicides in an ‘*abuse*’ category of filicides suffered from low intellectual functioning. Farooque and Ernst (2003) in a review of 19 cases of filicide by both mothers and fathers who had undergone forensic evaluation found that there was a significant association between filicide and intellectual impairment (8 out of 19 cases; 42%). The authors suggest that the area of intellectual impairment and the role it plays in filicide has been a neglected area of research.

**1.4.4 Substance and alcohol abuse.** The presence of histories of substance and alcohol misuse in the histories of mothers who have committed filicide has been reported in a number of studies. Some studies reported a positive relationship with substance misuse and parents who have killed their children (Bourget & Bradford, 1990; Lewis & Bunce, 2003; McKee & Egan, 2013) whilst other studies found no such association (d’Orban, 1979; McKee & Shea, 1998). Interpreting the findings is complicated by the use of differing strategies of researchers to explore this area. For example, Lewis and Bunce (2003) reported that of their sample of filicide mothers 38% were found to have a past history of substance misuse. However, the study collated findings from both psychotic and non-psychotic mothers and there were statistically significant differences between the groups; 48% of psychotic mothers

were found to have a history of substance misuse compared to only 27% of non-psychotic mothers. Another source of variance in findings results from the widely differing populations investigated.

No studies have focused specifically on whether parents were intoxicated at the time of the filicide, although in McGrath's (McGrath, 1992) detailed study of the characteristics of 115 filicide mothers admitted to Broadmoor between 1919 and 1969. In 2 out of 115 mothers (who had killed children over one year of age) they were intoxicated at the time of the offence. Furthermore, in their analysis of 39 cases of women diagnosed as having severe mental illness, Hatters Friedman, Hrouda and Holder (2005b) found that three of their sample had been intoxicated at the time of the offence.

**1.4.5 Diagnoses of mental illness and suicide in filicide.** A consistent finding for filicide offenders generally is the presence of suicide, either completed or attempted, generally occurring within 24 hours of the filicide. Rates of infanticide have been said to parallel suicide rates rather than homicide rates, and a number of authors have suggested that filicide is related to the dynamics of suicide for both mothers and fathers (Hatters Friedman & Resnick, 2007; Putkonen, Weizmann-Henelius, Lindberg, Eronen, & Hakkanen, 2009).

The association between suicide and mental illness factors has been found in a number of studies of filicide mothers (Somander & Rammer, 1991; Vanamo, Kauppi, Karkola, Merikanto, & Rasanen, 2001; Bourget & Gagne, 2002). Bourget and Gagne (2002) used coroners reports and found that 56% (15/27 cases) of filicidal mothers

had committed suicide, and a further four others had attempted to kill themselves. Nock & Marzuk (1999) report that between 16% and 29% of mothers who commit filicide, also killed themselves. Hatters Friedman and Resnick (2007), however, point out that many mothers also make non-fatal suicide attempts associated with filicide suggesting that suicides may be more common than the reported rates of filicide-suicide suggest.

**1.4.6 Contact with mental health services.** A number of studies have found that filicide offenders have had some contact with mental health services prior to the filicide (Bourget, et al., 2007; Hatters Friedman & Resnick, 2007; Flynn, et al., 2013). Flynn et al., (2007) have noted that more mothers than fathers had had previous contact with services prior to the filicide. In a UK study by Flynn et al., (2013) over half of the filicide parents had had previous contact with mental health services and 20% of the total sample had been treated before the offence.

**1.4.7 A critical analysis of psychiatric diagnoses in filicide mothers.** It is broadly accepted that a diagnosis of mental illness is a significant risk factor in filicide (Stanton, et al., 2000; Spinelli, 2004; Hatters Friedman, et al., 2005b; Flynn, et al., 2009). A number of authors have been critical of the validity and reliability of mental illness diagnoses generally (Szasz, 1961; Chesler, 2005) and cast doubt upon the legitimacy of the psychiatric system of classification of mental illness. There is also a known effect of gender on rates of mental illness diagnoses, which has typically resulted in more women than men being diagnosed with mental illness (Showalter, 1987; Chesler, 2005; Ussher, 2005, 2006). Women have also been found to more often seek or be referred for psychiatric or psychological treatment and are at greater

risk of being hospitalised when considered ‘unable to cope’ (Chesler, 1972; as cited by Alder & Baker, 1997). These factors contribute to more women than men being diagnosed with mental illness. It is beyond the scope of this thesis to review all the literature pertinent to the issue of gender and psychiatric diagnoses. However, the presence of literature which has critically examined rates of psychiatric diagnoses in women (Showalter, 1987; Chesler, 2005) is persuasive in arguing that there has been a tendency towards the psychiatrisation of women and this is most true for violent women (Maden, 1997; p245). One explanation for the tendency for women to be diagnosed with mental illness so often, relates to how social constructions of femininity are at odds with violent actions (Steffensmeier & Allan, 1996). Within this study, then the concept of mental illness diagnoses cannot be accepted uncritically.

**1.4.7.1 Gender stereotyping.** In addition to these factors related to mental illness, issues related to gender stereotyping have been argued to influence sentencing considerations in violent women, including filicide mothers (Morris & Wilczynski, 1993; Stangle, 2008). Wilczynski, (1997b) has documented the different way that the criminal justice system responds to men who have killed their children compared to women. Silverman and Kennedy (1988) found that police officers were significantly more likely to classify the motive for women who kill their children as ‘mentally ill’ than they were for women who had killed their spouses. In another important study investigating this issue, Allen (1987) compared psychiatric and social inquiry reports prepared for women and men convicted of serious violent offences, noted that reports for female offenders invariably addressed their mental state where for men the focus was on their behaviour. Allen concluded that this focus on the mental state of the women (as opposed to the lifestyle and behaviour of male offenders) was because the

reports were prepared within a context that placed ‘*women... within the discourse of the pathological*’. (p206).

Investigations into the way that the legal system has previously managed female cases suggests that there are also important gender differences in how men and women get sentenced; These findings clearly have a bearing on maternal filicide as they indicate that the criminal justice system’s response to child homicide by mothers is affected by the ‘chivalry hypothesis’ (Alder & Baker, 1997), where there is a lower likelihood of mothers being sentenced to prison (10% of mothers compared to over half of fathers), and a greater numbers of mothers who are sentenced to both probation (two fifths of mothers compared to 10% of fathers) and psychiatric care compared to men (three times as many mothers than fathers receive a defence of ‘diminished responsibility’; Wilczynski, 1997a).

In summary, then the greater rates of mental illness in maternal filicide offenders, are likely a result of issues related to the rate at which women present to mental health services and the ways that courts tend to judge violent women as mentally ill and in need of help. Therefore, the issue of mental illness in women generally and specifically in maternal filicide perpetrators should not be accepted uncritically.

**1.4.7.2 *Legal Considerations in maternal filicide.*** The work of Allen (1987) and others (Wilczynski & Morris, 1993) suggests some important ways that the perception and social construction of women may influence both rates of mental illness identified in filicide mothers and also in how they are dealt with by the legal



system. Rapaport (2006) has also suggested that there may be difficulties for society in accepting that filicide mothers can be both ‘lethal **and** sane’ (emphasis my own). This difficulty is evident in the finding that mothers have been reported as being dealt with within the legal system in more lenient ways than men (Wilczynski, 1997a). Table 5 shows the court outcomes of infanticide cases where the special legal category of infanticide was used as a defence for mothers. What is most marked in table 5 is that for 15% of mothers involved in a court process for infanticide, no further proceedings were progressed. In addition the table shows the higher rate of men being convicted of murder and manslaughter (68%) compared to mothers (29%).

**Table 5: Court Outcomes of Infanticide Cases. (Brookman & Nolan, 2006; p. 874)**

Male Perpetrated (154 cases)		Female Perpetrated (115 cases)	
Murder	23.4%	Murder	5.2%
Manslaughter	44.8%	Manslaughter	23.5%
		Infanticide	21.7%
Lesser offense	1.3%	Lesser offense	3.5%
Acquitted	11.7%	Acquitted	13.1%
Proceedings discontinued	1.9%	Proceedings discontinued	1.7%
No proceedings	2.5%	No proceedings	14.8%
Proceedings pending	11.7%	Proceedings pending	10.4%
Other	2.7%	Other	6.1%

There has been a tendency in society to think about filicide mothers as either, sick and pathological or aberrant and bad, and in all these conceptualisations there is a denial of any personal agency by the mother.

**1.4.7.3 Women as “mad”, “sad” or “bad”.** Female violence has been constructed, as either resulting from pathology (mad), being victimised (sad) or from deviance (bad) (Ussher, 2006; Africa, 2010). Such conceptualisations of women have

also been considered in respect of mothers who have killed their children (Alder & Baker, 1997; Stangle, 2008; Africa, 2010). Africa argues that conceptualising maternal filicide perpetrators as mad, sad and/or bad, results in the actions of mothers being perceived as devoid of personal agency. Instead the filicide act is construed as performed as a result of circumstance or aberration.

In terms of maternal filicide, notions of madness have previously been proposed as argument that mothers have not known what they were doing. Invoking the concept of madness to explain maternal filicide is partly related to how the dominant understandings of motherhood are socially constructed. The act of maternal filicide itself is understood as *de facto* evidence of mental illness (Alder & Baker, 1997; Wilczynski, 1991). Ussher (1991) suggests that common notions of femininity held in society have been directly related to explanations of '*madness*':

*A diagnosis of madness denotes an absence of reason, this implies that women who commit crimes, who are violent, are not in control of their senses. Is this because criminality, violence or aggression cannot be reconciled with our conceptualisation of femininity, and thus the woman must be mad? (p172).*

Alder & Baker (1997) suggest that an emphasis on pathologising discourses shows a lack of a detailed understanding about how the social and economic contexts are 'manifested and reproduced in the everyday experiences of mothers with the family' (p23). Several other authors have taken a critical stance toward the treatment of normal women as ill and not responsible for their actions (Maden, 1997; Alder & Polk, 2001; Rapaport, 2006; Stangle, 2008; Africa, 2010).

Similarly, in using constructions of female 'badness' in explaining maternal filicide, it has been suggested that mothers are seen as deviant in transgressing their

gender stereotype. Wilczynski (1993) found that judgments about *mothers* who had killed their children were made on the basis of judgments about them as *women*. Women were identified as either ‘good’ or ‘bad’; ‘bad’ women being those who were viewed as acting in ways inconsistent with traditional gender stereotypes. Bad women were seen as ‘selfish, cold, neglectful, uncaring and sexually active’. On the other hand, ‘good’ women were viewed as ‘passive’, ‘submissive’ and ‘asexual’ (Morris & Wilczynski, 1993). One of the other criticisms of using ‘badness’ to explain female violence is that it often gains credence by identifying high-risk groups for violence (Africa, 2010). As such ‘badness’ becomes located in typically marginalised groups of women. ‘Badness’, to a certain extent is utilised as a means to define perpetrators as ‘other’ and unrelated to ‘normal’ women. Notions of evil and badness are utilised to an even greater extent where the victim is the women’s child (Morris & Wilczynski, 1993).

Lastly, the construction of ‘sadness’ as an explanatory concept for maternal filicide, has previously been advanced to suggest that mothers have been victims of their circumstances (Africa, 2010). In Africa’s well-argued thesis she states that the popular stereotypes of women as ‘helpless, weak and passive’ (p. 82) are further entrenched when their violent acts are construed as resulting from their victimisation. Africa and others (Alder & Baker, 1997; Smithey, 1997) have criticised the unconditional acceptance of this approach as it proposes that women’s agency is limited or absent.

There is a considerable amount of literature questioning the validity and reliability of psychiatric diagnosis, and will not be reproduced in full here. However,

the research relevant to questions about the effects of gender on both diagnoses and sentencing considerations has been presented. My own position is that there is a lack of agreement about the validity and reliability of mental illness diagnoses generally (Johnstone & Dallos, 2006) and well established knowledge about the effect of gender on not only the rates of diagnosis of mental illness (Showalter, 1987) but also in respect of the legal system (Stangle, 2008). In this thesis I have adopted a critical view towards the literature relating to diagnosis of mental illness and take the stance that mental illness diagnoses are influenced by social constructions of gender.

## **1.5 Differences Between Maternal Filicide Offenders**

Notwithstanding the caveats to not uncritically accept the literature about mental illness diagnoses, studies of mental illness diagnoses in maternal filicide offenders have produced important findings. These studies, which I discuss below, allow for some tentative conclusions to be made that have relevance to understanding how filicide in mothers with a diagnosis of mental illness may be different from other types of child homicide.

**1.5.1 Differences between mothers with a diagnosis of mental illness and those without.** In the study by Lewis and Bunce (2003) 55 mothers referred for assessment were identified through retrospective case file review<sup>8</sup>. The study objective was to compare mothers with a diagnosis of psychosis with those mothers without. The mothers diagnosed with psychosis were more likely to have been divorced or separated, and although in this study they were found to have been better educated they were more often unemployed than non-psychotic mothers. There was

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<sup>8</sup> There are some important limitations to Lewis and Bunce's study, such as small sample size and the fact that those with diagnosis of more serious mental illness would not have been well enough to undergo the evaluation and may have been excluded from the study.

also an association with incidences of suicide and having used a weapon to kill their children. Another difference was that mothers with a diagnosis of psychosis had more often expressed homicidal thoughts and concerns to their family or to a psychiatrist and had also confessed to the filicide afterwards. The authors also noted that in contrast the mothers who were judged as not having psychosis were found to have been responsible for 86% of filicides by beating, and for all the filicides that occurred as a result of neglect or negligence. The mothers in these cases intended to discipline their children, but in doing so unintentionally killed them. The findings of this study give credence to the conclusion that mothers with a diagnosis of mental illness differ from other filicide mothers in a number of important ways.

**1.5.2 Fatal child abuse, battering and filicide.** In younger children, the most common cause of death is fatal child abuse, where the homicide by the parent is unplanned and unintentional but is the final outcome of abuse and neglect (Husain & Daniel, 1984; Hatters Friedman, et al., 2008). Various in the literature these types of child homicide have been labelled as resulting from battered child syndrome, fatal child abuse or fatal maltreatment, where the child is killed as part of a disciplinary measure ‘gone awry’ (Silverman & Kennedy, 1988). Battering involves the sudden impulsive killing and explosive temper of the perpetrator fatally interacting with the stimulus from the victim (crying, vomiting, toileting needs; Stanton, Simpson, & Woules, 2000). In Resnick’s (1969) early study he defined accidental filicide as the unintentional killing of a child, and noted that the death usually occurred from battering. In d’Orban’s (1979) study of 89 women admitted to Holloway prison in the UK between 1970 and 1975, the fatal abuse category of mothers was the largest group. Mothers in this category were noted to have frequently lost their temper with some

aspect of the child's behaviour (e.g., the child crying, or having feeding difficulties or incontinence).

**1.5.3 Characteristics of fatal maltreatment filicides.** Fatal maltreatment filicides have been found to occur along a continuum of abuse that predates the killing. In a study by Crittenden and Craig (1990) which reviewed cases (in the USA from 1956-1986) of child homicide in under 12 year olds, evidence of past abuse or neglect was found in 60% of children aged between 1 month and 5 years. The authors also reported that victims in this age group were more than twice as likely to have been killed as a result of fatal abuse than were neonates or older children (52% compared to 17% of neonates and 21% of school aged children). In only 7% of neonates and 10% of school-aged children was there any evidence of previous abuse or neglect. One interpretation of this finding is that older children did not precipitate the angry response of the parent and that the filicide was therefore less related to impulsivity problems in the parent.

In a Canadian study by Bourget and Bradford (1990) a high frequency of borderline personality disorder was found amongst the 'accidental filicide-battered baby syndrome group' of mothers. The sample was drawn from 13 cases of filicide referred for psychiatric assessment, of which nine were women. Likewise in a comparative study by d'Orban (1979), in contrast to non-battering mothers, battering mothers were characterised by chaotic and violent home backgrounds, parental separation in childhood, marital violence, housing problems and with a family history of crime. In the battering group, 47% of mothers had a prior history of assaulting either the child-victim or a previous child. These studies of prison population

mothers provide further evidence that filicide mothers who kill their children in the context of mental illness are qualitatively different from those mothers without a diagnosis. These differences are relevant to the present study that focuses specifically on filicide mothers with a diagnosis of mental illness.

McKee and Egan (2013) conducted a case-series study of 21 women from the UK who were convicted of murder or manslaughter of their child. They identified three distinct groups of filicides; neonaticides; mothers who planned to kill their child(ren) (and sometimes themselves); and a sub-group of mothers who fatally maltreated or neglected their children in conjunction with their partners. Among those mothers who had planned to kill their children there was a theme of feeling that their maternal role was threatened. Mothers ended their child's life (and often their own) as a result of life pressures such as relationship and finance problems that they believed could not be overcome. The authors concluded that this group of mothers could not tolerate their children living with the incompetent mother that they perceived themselves to be and so this was the motivation for the filicide. In these cases the mothers had initially planned to kill themselves but had extended to killing their child. The authors reported that in mothers with a diagnosis of psychosis although they were emotionally detached from their children they appeared to have a different motivation for the filicide than those in the fatal maltreatment group. These findings are important as they indicate differences in the types and motives of filicide mothers, which are relevant in understanding the phenomenon of filicide.

#### **1.5.4 Comparisons between abusive and non-abusive mothers.**

Similarly, in a small study by Husain and Daniel (1984) abusive and non-abusive

filicide mothers were compared with each other. The study authors found that the non-abusive mothers had major psychiatric disorders whereas the abusive mothers were marked by an absence of such disorders. Another important difference in the study by Husain and Daniel, consistent with the study findings of Crittenden and Craig, (1990) was that filicide mothers were found to have rarely abused their children before they had killed them.

## **1.6 Theories of Maternal Filicide**

A number of theoretical approaches have been developed which aim to contribute to increasing understanding about the development of maternal filicide. Psychoanalytic approaches have been developed from case studies of maternal filicide (Kunst, 2002) and elaborated further by theorists (Motz, 2009). Evolutionary theory has also been suggested as relevant to maternal filicide (Daly & Wilson, 1984; Hatters Friedman, et al., 2012) and is summarised here as relevant to the present study as it relates to filicide of older children. A sociological perspective of filicide has also been advanced and is briefly presented (Smithey, 1997). Mugavin (2005, 2008) has also developed a theoretical model of the motivations for maternal filicide. Both the sociological perspective of Smithey (1997) and the maternal filicide theoretical model of Mugavin (2008) provide a general overview of factors which have been found to be associated with maternal filicide.

**1.6.1 Psychoanalytic theory.** Given that very few mothers who have a diagnosis of mental illness go on to kill their children, it is broadly accepted that other intra-psychic factors are likely to contribute to filicide (Papapietro & Barbo, 2005). The psychoanalytic perspective offers one of the few strictly psychological



perspectives about the development of maternal filicide. However, most of the published articles using psychoanalytic theory rely on the presentation of clinical case studies (Kunst, 2002; Motz, 2009) and have not made use of other research modalities (with the exception of the study by Crimmins et al., (1997) that used a self-psychology perspective in interviewing imprisoned filicide mothers).

A psychoanalytic perspective of maternal filicide argues that there is a maternal over-identification with the child who is seen as an extension of herself (Welldon, 1992; Pines, 1993; Motz, 2009). Motz (2009) emphasises the impact of early negative and traumatic experiences that mothers who have killed their children have had and suggests that this has critical implications when women become mothers. By virtue of the process of gestation, Motz suggests that '*perverse mothers*' are those that are able to use pregnancy and their offspring to re-create the destructive patterns of their own birth and childhood. The tenets of psychoanalytic theories of child abuse and maternal filicide suggest that the child becomes an innocent victim of the murderous rage enacted by the mother due to failures of differentiation between herself and her child. In this conceptualisation the fatal violence on the child is presumed to have symbolic rather than literal significance; the mother enacts repressed rage upon the child as the child represents an unwanted aspect of herself (Papapietro & Barbo, 2005).

**1.6.2 Sociological theory.** Alongside the various psychoanalytic theories there is also a sociological perspective about filicide that suggests that a combination of social learning (having had abusive parents, parental substance abuse, which allowed for the formation of a poor role model and attachment figure and having an

abusive or unsupportive parent), economic deprivation and self-attitude are factors contributing to filicide (Smithey, 1997). Whilst this approach has relevance to understanding maternal filicide it is not widely referred to in the literature and appears to provide a broad, somewhat generic approach to the aetiology of maternal filicide. However, the theory has some support from the literature related to maternal filicide, primarily in relation to economic deprivation and the role of early experiences. However, the self-attitudes of filicide perpetrators are the least understood and have not yet been empirically explored.

**1.6.3 Evolutionary theory.** Daly and Wilson (1984) provided the earliest analysis of filicide from an evolutionary perspective positing that filicide is an adaptive reproductive strategy. The theory is built on the fact that filicides are found in all cultures and is often used as a means of doing away with defective or unwanted children in a variety of cultures. Daly and Wilson reviewed extensive anthropologic literature from a number of different cultures and identified reports of filicide in most of them. The authors divided filicide motives into four broad categories; 1) as a result of scarce resources 2) poor quality or deficient offspring 3) paternal uncertainty, and 4) coercion by others. Because filicide in older children does not conform to the predictions as set out in evolutionary theory of maternal filicide, some authors have contended that the killing of older children is '*counter-evolutionary*' behaviour (Bourget, Grace, & Whitehurst, 2007; Krischer, Stone, Sevecke, & Steinmeyer, 2007). The mother's fertility is decreasing and the offspring is in less need of resources as they mature, so the killing of older children is not consistent with evolutionary considerations. One possible conclusion about maternal filicide from an evolutionary perspective is that filicide is evidence of abnormality and the presence of

pathology precisely because it contravenes the tenets of evolutionary theory (Hatters Friedman, et al., 2012). Therefore, the theory has relevance to the present study with its emphasis on filicide mothers with a mental illness.

**1.6.4 Theoretical framework of motivation for maternal filicide.**

Mugavin (2008) has described a theoretical framework outlining the motivation for maternal filicide based upon family systems theory, feminist theory and propositions from the knowledge of neurobiology of trauma. The framework was derived from correlations of an analysis of 33 case studies and two classic articles including that of Resnick, (1969). The model does not discriminate between neonaticides or the killing of older children, which limits its applicability for mothers who kill older children, however because of its link with extant knowledge it is worth summarising here (Table 6). The theoretical model suggests that filicide results from an interaction between a number of predisposing factors and triggers.

<b>Phenotypic Vulnerabilities</b>	<b>Triggers</b>
Predisposition to mental illness	Religiosity
History of, or exposure to, abuse (physical, sexual and/or emotional)	Substance misuse
History of exposure to substance abuse	Revenge
Inadequate maternal role development	Inability to parent
Social environment/constructs	Desperation
	Mercy Killing
	Lack of interest in parenting/unwanted child
	Good mother stress

Some of the phenotypic vulnerabilities proposed by Mugavin are self-explanatory and need little in the way of further discussion. However, it is worth describing the relevance of social environment/constructs as proposed by Mugavin. Social environment/constructs include the impact of poverty on the destruction of

traditional family constellations. Mugavin suggests that in modern society single mothers have been left isolated and with only limited access to support that may previously have been more available in closer communities and traditional families. These social factors are proposed as presenting a vulnerability factor for maternal filicide.

Mugavin's framework (2008) also includes a number of triggers for the development of maternal filicide. Religiosity is defined as distinct from faith and religion in others, but is a morbid concern for religion that is likely indicative of a disturbance in personality. Another trigger proposed by Mugavin is the concept of '*good mother stress*' which refers to the pressure women experience in trying to achieve both their own and society's expectations. Mugavin suggests that fulfilling the ideals of motherhood causes stress for mothers, and that the stress is exacerbated by both the reality of the role and the lack of social validation for it.

#### **1.6.5 Relevance of theories of maternal filicide to the present study.**

Psychoanalytic conceptualisations of maternal filicide offer a means of understanding some of the psychological processes that might be related to maternal filicide. However, there is little if any empirical support for the psychoanalytic concepts even though they appear to make good clinical sense. The greatest utility of the psychoanalytic theories is the degree to which they have introduced the notion of perverse mothering. Evolutionary theory proposes a context for understanding child-killing by parents but does not provide for any individual sociological or psychological motivations for filicide. Mugavin's (2008) theoretical model offers a constellation of factors and triggers in the development of filicide in mothers. However, the model also includes factors associated with neonaticide and so may not

be specific enough to the present study with its focus on filicide of children over one year of age. The sociological model is also one that has a broad, generic relationship to maternal filicide but lacks specificity. However, the theories presented are relevant to the subject area of maternal filicide.

### **1.7 Brief Summary of Review of Literature and Rationale for This Study**

The review of filicide literature established that whilst child homicide is a rare event it is most often committed by the child's parent. The younger the child the more likely the perpetrator will be the mother whilst older children are more often killed by their fathers (or step-fathers). Mothers are over-represented in cases of filicide. When mothers kill older children, diagnoses of mental illness have been found to be one of the most significant risk factors. The killing of older children by their mothers has been thought of as 'counter-evolutionary' and as evidence of psychological abnormality. However, previous research has not yet explored the process of maternal filicide in mothers diagnosed with mental illness and so there is a lack of understanding and knowledge about the contexts, conditions and processes that contribute to the development of maternal filicide. This study aims to explore the development of maternal filicide through interviews with mothers with a diagnosis of mental illness. No previous study has interviewed mothers themselves about their experiences and therefore this study represents an important contribution to the current state of knowledge of maternal filicide.

### **1.8 Aim and Objective of Study**

**Aim.** The aim of the study was to explore the development of maternal filicide in mothers with a diagnosis of mental illness. The particular foci of the study

were to explore:-

- What were the circumstances in which mothers committed filicide
- What were the motivations for mothers in deciding to kill their children?
- What were the psychological processes that contributed to the development of maternal filicide?

**Objective.** The objective of the study was to interview 6-8 mothers with a diagnosis of mental illness who were currently under the care of mental health services and who had been convicted of having killed their child(ren). The objective was also to use grounded theory method with a constructivist methodology to develop grounded theorising about the development of maternal filicide for mothers with a diagnosis of mental illness.

## CHAPTER TWO

### METHODS

#### 2.1 Introduction

In chapter one I have argued that research into maternal filicide is not yet adequate and as a consequence there is a significant gap in the literature about the conditions, contexts and processes that contribute to the development of filicide in mothers with a diagnosis of mental illness. As there is a very limited understanding of how filicide develops a qualitative approach to achieving the research aims is indicated. In areas where there is limited knowledge in a subject then a qualitative approach to theory generation is often advocated. (Silverman, 2005; Bryman, 2008). A qualitative approach arguably allows for an in-depth understanding of the world of participants (Bryman, 2008) in an area or with a subject that has not been previously been investigated. It has also been claimed that it is also a useful approach for sensitive research topics as it allows for sensitivity in interviews (Fahie, 2014). An in-depth understanding of maternal filicide is much needed and given that the social circumstances, perspectives and histories of participants are included in the foci of qualitative inquiry (Denzin & Lincoln, 2003) it was an appropriate choice of method for the present study's aims.

It has been asserted that decisions about the choice of research strategies are inextricably linked to the philosophical assumptions held by the researcher (Annells, 1997a, 1997b; Cresswell, 2009). It has also been argued that the choice of research strategy is dependent upon how the problem under investigation is to be defined and what it is that the inquiry aims to achieve (Crotty, 1998). In turn, any choice of

research methods to explore the phenomenon is related to how the researcher philosophically understands both the nature of reality (ontology) and the nature of knowledge and knowing (epistemological concerns). As a researcher, I accept the influence of my own subjectivity of these issues and therefore, before describing the research methods adopted in this study I will first provide an account of the epistemological and ontological positioning I have adopted in this study.

## **2.2 Philosophical Underpinnings of the Study**

Questions about the philosophical assumptions within any research activity are not merely theoretical. As a beginning researcher I was aware that I brought to the research process my own experience as a clinical psychologist, a woman and a feminist. I chose the topic of exploring the development of maternal filicide primarily because of my clinical experience of mothers who had killed their children. I was also interested in making a contribution to an under-researched area and using an interview method to investigate how women constructed their accounts of what contributed to their filicide behaviour. As women have previously been portrayed as mad, bad and/or sad, I was interested in an investigation from a perspective that refuted that approach and was informed by feminist considerations.

Inherent in the qualitative approach is the tenet that the world view, and values of the researcher influence all stages of the research activity. A world view is defined as '*a set of basic beliefs which guide action*' (Guba, 1990; p17). As Charmaz (2006) suggests the researcher does not come to the research scene '*... untouched by the world*' (p15). The basic world view of the researcher is acknowledged as influencing the choice of strategies that she brings to the research activity, as well as having an



influence at every stage of the implementation of any study (Cresswell, 2009). Indeed my own basic world view had a major influence on my choice of methodology, and also defined the strategies I used to investigate the area of maternal filicide. At the beginning of the study my beliefs were already inherently constructivist; I perceived people as constructing meanings about the world that they inhabited and that this process was iterative, resulting in constructions of meanings and knowledge that were constantly evolving. This world view meant that I was very interested in using an interview method to investigate the ways that filicide mothers interpreted their experience, and make known the contexts within which filicide occurred, which in my view had been previously hidden or poorly understood.

I acknowledge that as a researcher my basic beliefs influenced and determined all aspects of the study, including the design and the analytical frame used to interpret the data. Within the process of conducting the research I was able to develop a more explicit and coherent understanding of the implications of the ontological and epistemological decisions I made upon the research project.

**2.2.1 Influence of feminist theory upon research.** At the beginning of the research the development of my philosophical assumptions about research paradigms was also influenced by a number of feminist writers who were critical of objectivism in earlier research. The criticisms were focused on a lack of acknowledgement of the contexts within which knowledge had been constructed within previous empirical work and the impact that these omissions had had on articulating the different perspectives for women (Harding, 1987; Wuest, 1995; Kitzinger, 2004). For example Kitzinger has articulated a critique of previous research arguing that it has failed to

take account of the differing social location that women inhabit. Kitzinger, argues that previous research endeavours have mostly been defined by men, and this has led to a particular influence on the production of knowledge:

*..men define reality on their own terms, to legitimate their experience, their own particular version of events, while women's experience, not fitting the male model, is trivialised, denied or distorted. (p. 155)*

These criticisms influenced the choice of research design and methodology I have adopted to explore the subject area of maternal filicide. It was important to me to identify a methodology that could be equated as compatible with feminist thinking. Although there are no specific feminist methodologies there are distinct methodological approaches with epistemological and ontological assumptions that are consistent with feminist approaches to inquiry (Harding, 1987). My choice to use an interview method to research filicide was strongly influenced by my aim to explore and make known the contexts within which filicide occurred, and which in my view had previously been hidden, or poorly understood.

My particular world view was consistent with both feminist and constructivist approaches. However, it was necessary to make explicit the philosophical positioning of the study and how the philosophical approach adopted was both implicated in the particular choice of methodology and methods of inquiry (Guba & Lincoln, 1985; Annells, 1996). Therefore, before describing the particulars of the methods I will first explicate the methodology within this study.

**2.2.2 Ontological and epistemological positioning.** Qualitative methodologies with their emphasis on the subjective experience were clearly

appropriate to the present study's aims. Ontologically this study adopted a relativist approach; assuming that reality reflects multiple and relative perspectives and contextualised realities that may conflict, but may also converge in a consensus (Guba & Lincoln, 1985). Reality is not viewed as '*out there*' and independent of the '*knower*', but instead, as integral to the action of knowing. Therefore, within this study what would be produced could not be considered as objective, or independent but would need to acknowledge the influence of myself as researcher.

Interpretivist epistemology is based on the theory of symbolic interactionism proposed by Mead (1962) and later articulated by Blumer (1969), in which the concept of the self is mediated through social interaction. Three basic premises were suggested by Blumer as cited by Annells (1996):

- 'The meanings that things (such as persons, institutions, objects, situations and combinations of such) have for persons will determine what actions will occur toward those things.
- This meaning is derived from social interactions.
- An interpretive process is used to direct and modify the meanings as the situation is dealt with by the person' (p381).

These premises emphasise actions and practices as the starting place for any analysis and inquiry, but importantly these actions can be interpreted as influencing not just the '*inquired-into*' but the inquirer as well. Therefore, methodologically, the researcher or inquirer co-creates knowledge through interpreted constructions of the data.

With ontological roots in relativism, constructivist approaches assume that reality is subjective or inter-subjective and that the *'the viewer is part of what is viewed'* (Charmaz, 2011). Epistemologically, this study assumes an interpretivist perspective, which emphasises how knowledge is constructed from the interpretations of events. Charmaz (2006) asserts that:

*Interpretive theory calls for the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities, indeterminacy; facts and values as inextricably linked, truth as provisional; and social life as processual. (p127)*

Epistemologically, then this study assumes that study participants have interpreted their experiences and have found meanings within them. As the researcher in the study, I also acknowledge the integral influence my own interpretations and meanings have had on the study process. My own prior clinical and professional training have meant that I have arrived at the study process with a certain amount of theoretical sensitivity in the area of maternal filicide. This sensitivity will have influenced not only the choice of subject area but also how I have approached the task of investigation.

**2.2.3 Chosen methodology - constructivist grounded theory.** The original GT approach of Glaser & Strauss, (1967) has been credited with providing an alternative approach to inquiry, using a method of investigating individual experiences in pursuit of theory development (Dey, 1999; Clarke, 2005; Bryant & Charmaz, 2010b). However, the original GT method has undergone a number of revisions and re-interpretations, one of which is the development of a constructivist

approach. The main proponent of constructivist GT, Charmaz, (1988; 2006; Bryant & Charmaz, 2010a) argues that GT is a set of principles and methods that can be used strategically to address a particular research question. GT constructivist method, however, retains key characteristics of the original method. It retains an emphasis on being an inductive approach to knowledge production, eschewing the use of a priori hypotheses (Mills, Bonner, & Francis, 2006).

Constructivist GT methodology was chosen as the most appropriate strategy to address the research question in this study partly because it was consistent with the epistemological and ontological assumptions within this study. Through the use of constructivist GT methodology the present study aims to provide an *'interpretive portrayal of the studied world'* (Charmaz, 2006, p10) of filicide, whilst acknowledging that my own theoretical sensitivity will influence what is produced. Given the paucity of research into filicide and the lack of data produced from those with personal experience I adopted the grounded theory method in this study aiming to *'see the world the way research participants do – from the inside'* (Charmaz, p14), whilst at the same time, recognising that my own world view will define any interpretations I make.

In identifying the appropriate methodological approach for use in this study I was influenced by the writings of Thomas and James (2006) and Clarke (2005) who provide persuasive and cogent arguments against the idea that a single theory can be produced from GT method. Charmaz (2006) provides powerful argument that any grounded theory is partial and provisional and in a state of flux or development. In

this study I adopt the use of the term grounded theorising rather than grounded theory with its emphasis on a singular definition of theory development.

In using the GT method I aimed to follow Charmaz's advice to '*use a keen eye, open mind, discerning ear and steady hand*' (p. 14) to get close to mothers' experiences in the development of MF. I used this advice in collecting data and in the questions posed within the interviews. I kept an open mind in the process of analysis of the data, working at being open to the possibilities within the data. It has been argued that GT acknowledges the importance of a multiplicity of perspectives and '*truths*' (Strauss, 1987) and allows a reconstruction of theory that is both richer and more reflective of the context within which participants are situated (Mills, et al., 2006).

***Feminist perspective.*** As a psychologist who worked clinically with women I was already familiar and sympathetic concerns from a feminist perspective about the lives of women in modern society. I also came to the research project with knowledge about the impact of gender on violence and an interest in the feminist perspective in relation to both motherhood and female violence. Therefore, in considering the methodology to be adopted in the present study I was keen to consider approaches that took account and were consistent with feminist perspectives. I was attracted to constructive GT approaches, as they had been posited as consistent with feminist approaches to inquiry (Wuest, 1995; Keddy, Sims, & Stern, 1996; Wuest & Merritt-Gray, 2001). It was also claimed that GT approaches allowed for the voices of participants to be heard, as they tell their story (Keddy, et al., 1996). In addition, Wuest (1995) and others (Keddy, et al., 1996; Wuest & Merritt-Gray, 2001) have

argued that GT methods are consistent with feminist epistemological underpinnings. Therefore, the use of constructivist GT methodology appeared to offer an approach that would be consistent with feminist perspectives.

Feminist theory advances that women are the experts about their experience, and that subjective experience is considered valid data (Kitzinger, 2004), which is consistent with GT. Another commonality with GT and feminist theory is that epistemology is considered as contextual. Women can therefore, be '*knowers*', and their experience can be seen as a legitimate source of knowledge. However, although feminist theory has advocated that women's voices should be acknowledged and encouraged within public discourses, Kitzinger (2004) has criticised this approach on methodological grounds, emphasising that research cannot legitimately represent participants' views or '*their voice*' (Kitzinger, 2004). Instead, Kitzinger argues that all that can be offered is a reconstruction or a co-production of accounts that have inherent within them the influence of the researcher. This criticism is accepted within the methodology adopted in this study and instead there is an acceptance of the assumption that:-

*'...the talk of individual research participants in interviews...is always a collaborative production. That is, the way people talk about their experiences depends on who they are talking to, what they have been asked, what shared knowledge they think can be assumed, and what kinds of reactions they anticipate and receive'* (p133; Kitzinger).

Kitzinger, urges the feminist researcher to focus on the experience of study participants and not on '*their voice*'. This advice is incorporated into this study and the activity represents my own interpretation of the mothers' reports of their experiences in the development of maternal filicide.

## **2.3 Aim, Design, Conduct and Ethics Adopted in this Study**

**2.3.1 Aim.** The aim of the study was to explore the development of filicide in mothers with a diagnosis of mental illness. The particular foci of the study were:-

- What were the circumstances in which mothers committed filicide?
- What were the motivations for mothers in deciding to kill their children?
- What theories did mothers hold about why they had killed their children?

**2.3.2 Design.** The study used constructivist GT methodology and an interview method to retrospectively explore the development of filicide from interviews with mothers with a diagnosis of mental illness.

**2.3.3 Ethical considerations in conducting the study.** Given the sensitivity of the research topic and the potential vulnerability of the study participants, a commitment to and clear understanding of ethical conduct was an essential part of the study design and implementation, consistent with the assertion of Mertens (1998), that *'Ethical issues form an integral part of the research planning and implementation process,'* (p23). It is recognised that sensitive psychological research can pose special ethical problems (Sieber & Stanley, 1992). Knowledge and guidance for the ethical principles in this study, were obtained from a number of sources; Beauchamp and Childress (2012), Research Governance Framework for Health and Social Care (Department of Health, 2005, [DOH]), the National Health Service (NHS), *Confidentiality: Code of practice* (DOH, 2003) and the ethical principles set out by the British Psychological Society code of practice (BPS, 2011).



***Protection and safe-guarding of study participants.*** There are important ethical imperatives involved in researching such a sensitive subject with such a vulnerable and complex group as filicide mothers with a diagnosis of mental illness. Sensitive research has been defined as research *‘which potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding and/or dissemination or research data’* (Lee & Renzetti, 1990 p512 as cited by; Fahie, 2014). Potential participants in this study were also likely to have experienced trauma related to the filicide, complex mental health issues and to be experiencing a number of other life events that suggest that there would be a substantial threat of the potential for psychological harm from participation in the study. Therefore, and in accordance with the ethical imperative of *‘doing no harm’*, the study design incorporated the clinical team to be responsible for the of mothers well-being during the study. The team would make clinical assessments about whether mothers were considered mentally well enough to participate in the study. Excluded from the study were any filicide mothers without a clinical team. These mothers would not be able to access professional support should they have been unduly distressed from involvement in the study. The gate-keeping role of the clinical team in decisions about inclusion into the study introduced bias in to the recruitment process but was considered an essential element of the study design.

***Anonymity of study participants.*** Study participants are from an extremely small population and have often been the subject of intense media scrutiny. They are also vulnerable in the sense that they have been diagnosed with a mental illness and perhaps more saliently they are likely to be suffering from a range of emotional and

psychological difficulties related to grief processes and guilt. It is also likely that in the lives of filicide mothers and in the aftermath of the filicide, relationships with partners, the child's father, wider family members and friendship networks are going through significant changes which may involve more loss and distress both for mothers and for their families. Therefore, and in accordance with Sieber and Stanley's (1992) advice about conducting sensitive research, maintaining the anonymity of mothers was a central consideration in the study design. Lee (1993) has identified that issues of causing stigmatisation are important considerations for sensitive research and so a number of measures were adopted in this research to ensure that participants could not be identified. They included limits upon personal information obtained, the use of pseudonyms in this thesis, the removal of any information about the gender or age and location of the victims and an adherence to issues of confidentiality. Therefore in conversations with supervisors the true identity of participants was never disclosed.

***Ethical approval.*** The study received ethical approval from the South West Research Ethics committee (Appendix A(i) and (ii)). The purpose of an Ethics committee is to reduce the risk of potential harm and to anticipate any potential risks of any research proposal that they review. The feedback from the committee was positive about the proposals to manage any risk of potential harm for study participants, but interestingly did not consider the risks of potential psychological harm to the researcher. McCosker, Barnard and Gerber (2001) have identified potential risks to researchers from engaging in sensitive research and suggest the need to plan for the management of any adverse psychological reactions. I therefore planned supervision sessions with a trained psychotherapist.

A panel of health service users in my local trust were used to review all the written communication to potential study participants to ensure that it was as sensitive as possible (The feedback from the review can be found in Appendix B). The involvement of service users in all phases of research is recommended. However, given the sensitivity of the study subject, no other service user involvement was sought. The study was also reviewed a number of times by different NHS research governance panels as part of the approval processes required to conduct research on NHS-owned sites.

#### **2.3.4 Study settings, sampling and recruitment.**

***Study settings.*** The study was conducted primarily in inpatient and outpatient forensic mental health services in England and Wales, although recruitment efforts also included settings in Scotland. Both NHS and private forensic psychiatric services were approached as part of the recruitment process, but only NHS services participated. The study therefore involved multiple sites.

***Sampling.*** The study sought to interview mothers who had received a diagnosis of mental illness and who had been convicted of having killed their child(ren). Sampling aimed to use a purposive method with participants being selected on the basis of extending and developing theory (Glaser, 1992).

The criteria for inclusion in the study were:-

- Female
- Aged between 18-65 years
- Has been convicted of having killed one or more of her own children
- The filicidal act has occurred within the last 10 years

- Has received a diagnosis of mental illness from a Responsible Clinician (Consultant Psychiatrist) with or without a co-morbid diagnosis of personality disorder
- The victim of the offence must be over 1 year and under 18 years of age
- Is currently receiving clinical care within mental health services

The criteria for exclusion from the study were:-

- Has a significant learning disability
- Claims to have killed a child but has not been convicted
- Has killed a child who is under 1 year of age (legal category of Infanticide)
- Has a primary diagnosis of personality disorder
- Judged by their clinical team as unable to participate in the study

Before going on to describe the procedures used in the study the reasons for choosing specific delimiters of the study sample will be described. The age limits for inclusion of participants into the study were set at 18-65 years as these age limits were congruent with the limits set by services from which participants would be sampled.

The age range of victim was also an important delimiter to the sample included in the study. The purposes of this study were to explore the less common killing of older children and so mothers who had killed children below the age of 1 year of age were excluded from the study. The age limit for victim of maternal filicide perpetrators, participating in this study was set at 18 years to try to maximise the number of potential participants to the study. The age range is consistent with that recommended by Hatters Friedman et al., (2005a) who advocate consistency within studies researching filicide. Participants were also required to have received a conviction of having killed their children. This criterion was necessary so as to

exclude any mothers who had made false claims to having killed their children, and also to exclude mothers who were still awaiting the outcome of legal processes.

A further inclusion criterion to participate in the study was that the filicidal act should have occurred in the preceding 10 years. The chosen time period was somewhat arbitrary and was adopted with the aim to include as many participants as possible, accepting that memory for events may have been adversely affected by time since the offence. However, due to the very small size of the population the 10 year period was adopted, however, all of the eventual participants had committed filicide within the preceding 5 years.

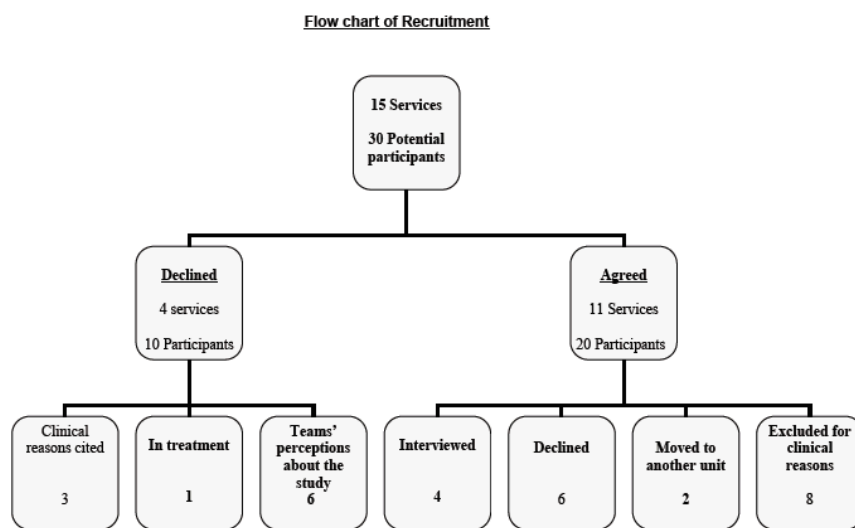
Due to possible communication problems and issues related to capacity, participants with a significant learning disability were excluded from the study.

**2.3.5 Recruitment.** I contacted 40 private and NHS hospital services in my efforts to locate potential participants to the study. In addition, and as a means to increase the number of potential participants I also emailed 78 community based consultant psychiatrists in two national healthcare trusts asking them to identify any potential participants to the study. I received only two responses – and neither of these respondents had mothers who fulfilled the inclusion criteria in their care. Because of the lack of responses I did not pursue recruitment from this source.

Twenty-five mothers were identified within 13 services in England, Scotland and Wales between 2010 and 2011. Due to the very small and difficult to access population a second phase of recruitment occurred in 2014 to try to identify any other

potential participants. An additional five participants were identified. Therefore, 30 potential participants were identified throughout England, Scotland and Wales.

Figure 2 shows the process of sampling and recruitment undertaken in this study. Four participants consented to participate in the study, and six potential participants declined. Eight potential participants were excluded for clinical reasons.



**Figure 2: Diagram of sampling for recruitment**

In the case of two potential participants, by the time that the various research governance processes had been completed, the service users had been transferred to another service. In accordance with the NHS confidentiality code of conduct (DOH, 2003), I was not allowed to know details of the ongoing placement and they were therefore lost to the study.

There were 10 potential participants who were never informed about the study due to services' reluctance to engage. During telephone and email contact with

clinical team members they expressed anxiety that engagement in the study would disrupt care for women in their services. Services gave varied reasons for not being involved in the study and these included both because the potential participant was about to be discharged, or had just been discharged (albeit still under the care of a community team) and fears that involvement in the study would be disturbing for them. A number of services considered that informing mothers in their care of the study would in some way damage the therapeutic relationship that they had either established or were in the process of trying to build. Another reason that services declined to participate was because services had their own research going on and judged that engagement in another study would be too much for the potential participants.

Approximately six potential participants were lost as a result of services perceptions of the merits of the study. Services indicated that they would have been willing to engage in a Department of Health funded, multi-site study but that they didn't consider the study appropriate as they thought of it as a 'learners project' (an allusion to the research being conducted as part of a doctoral training).

Three services declined to participate due to the clinical teams' evaluation that the potential participants in their care were too unwell to participate. One other service stated that the potential participant was reported to be in treatment and the service declined further other contact with myself. These difficulties in recruitment affected the study. However, the recruitment process garnered the optimum sample size available and was able to interview 40% of those informed about the study. However, two thirds of the available sample, were wholly inaccessible due to clinical

considerations, organisational difficulties or due to the influence of care-teams in deciding mothers' engagement in the study.

The way that services interpreted their role and responsibilities in terms of assessing participants for recruitment presented difficulties for the study. As can be seen in Figure 2, 20 potential participants were excluded from the study without ever having been offered the opportunity to take part. The Mental Capacity Act (HM Government, 2005) enshrines the rights of vulnerable adults to make their own decisions and stipulates that '*a person is assumed to have capacity unless it is established that (s)he lacks capacity*'. To my knowledge no team reported conducting a mental capacity assessment to determine whether potential participants could make that decision themselves. It is therefore likely that some participants with capacity to choose to participate in the study were unnecessarily excluded. However, in the interests of the safety, dignity, and wellbeing of potential study participants, it was necessary and desirable for clinical teams to have the role of making decisions about the participation of individuals for whom they had clinical responsibility.

**2.3.5.1 Initial survey of services.** In order to identify potential participants to the study, I made initial telephone and/or email contact with either consultant psychiatrists or more commonly with psychologists within services. I enquired whether there were any mothers who would potentially fulfil the inclusion criteria for the study. Gaining access to potential participants has been acknowledged as one of the most critical impediments to conducting research, and that this is even more the case with sensitive research (Johl & Renganathan, 2010). Relationships with gatekeepers, or those in organisations that can facilitate access to multiple potential



participants are of critical import to the success of research efforts (Feldman, Bell, & Berger, 2003). Both Johl and Renganathan (2010) and Feldman and colleagues (2003) articulate the painstaking, lengthy and delicate process of the researcher trying to gain entry to an organisation. This was certainly the case with regard to my experiences of communication with services. As Feldman et al., have suggested, engagement with services required a relational approach, where I had to make use of pre-existing contacts, but also to make strenuous efforts over months and years in order to establish good relationships with gatekeepers.

However, even despite these efforts at this preliminary stage some services were reluctant to divulge whether they had any potential participants in their care. The reluctance was understandable given the sensitivity of the subject of maternal filicide. I routinely needed to provide proof that I was employed by the NHS and was required to send evidence of my identity before services would speak further to me. This was understandable as high-profile mothers who had killed their child(ren) and were often the subject of intense media interest may have resided in that particular setting. However, even when services received confirmation of my identity they often refused to provide basic information such as the exact number of potential participants in their service, based on the inclusion and exclusion criteria for the study. As advocated by Feldman et al., (2003) I tried a variety of means of engaging the gatekeepers within organisations but was ultimately at times unable to get past some of them. However, this is not unusual in research and can be a major barrier to conducting research in sensitive areas (Johl & Renganathan, 2010).

Because of these difficulties it was not possible to identify exactly how many potential participants were in any given service. For example one service stated that it had 3-4 potential participants, but would not give any other basic (non-identifying) information. Therefore, I could not establish how many of these potential participants fulfilled the inclusion criteria for this study.

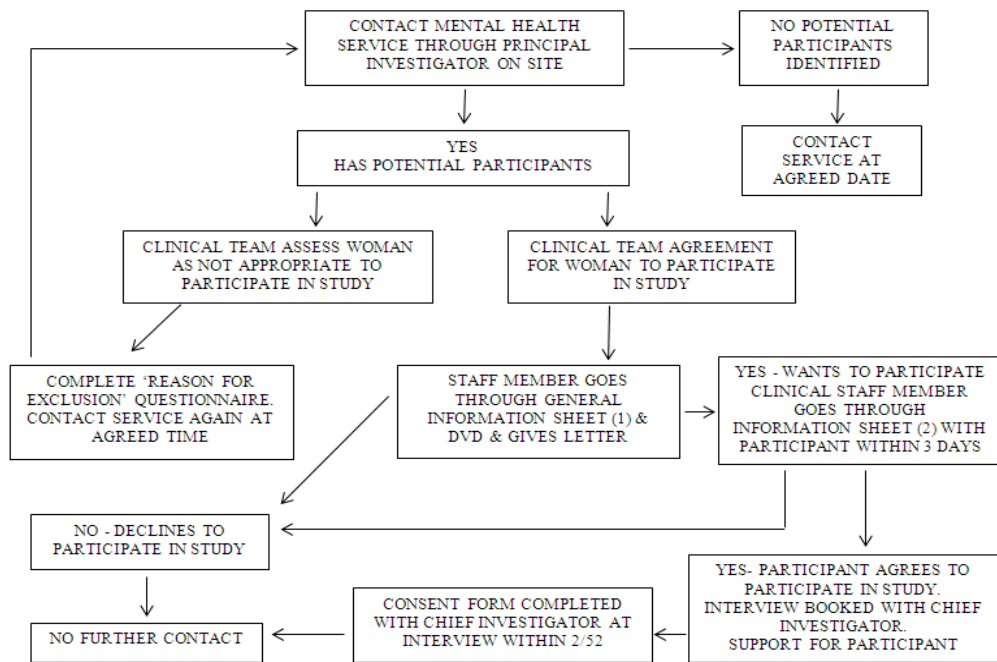
*Governance procedures and the impact on recruitment.* After obtaining ethical approval for the study there were still lengthy and complex processes to be undertaken in order to gain approval for the study from the different governance bodies of individual NHS trusts and privately run services. Mcdonach, Barbour and Williams (2009) have written about the unwieldy and cumbersome nature of the processes of obtaining approval from differing governance bodies. The authors report on how the processes differ between trusts and that replication of governance procedures introduce avoidable delays into the study implementation. Mcdonach et al's findings are consistent with my own experience of conducting this study in multiple healthcare sites. The local governance procedures differed between trusts and required me to fulfil differing requirements of each service. For example, I was required to complete an online training course in Information Governance for one trust and required to attend a one-day training on the same subject for another trust. Each trust required a 'Confirmation of NHS to NHS checks' from my employer that was necessary to allow me access to interview potential participants. These governance processes were lengthy and cumbersome and needed to be repeated for all services agreeing to participate in the study. The issue of the various trusts' different requirements and procedures introduced delays into the process of conducting the study that had specific and adverse effects on recruitment. For example, on a number

of occasions the mental well-being of a potential participant deteriorated during the time it took to get the team's agreement and to complete the various governance procedures of specific trusts. This resulted in potential participants who may have been willing to be involved in the study having to be excluded due to deteriorating mental health. Furthermore, and in relation to private healthcare establishments where the research and development governance arrangements seemed less clear, they were often dependent on the decision of a single manager. It occurred that two potential participants were transferred in the time that the clinical team took to agree to participate in the study and to complete the governance processes.

*Liaison with services.* Once I had obtained ethical approval to conduct the study I planned to obtain fuller, but still non-identifying, personal information about potential participants to the study. I had anticipated that life events or clinical issues might result in some potential participants being assessed by their teams as not appropriate and planned to re-contact the service at a later date (shown in Figure 3). The purpose of contacting the service again was to establish whether the potential participant's situation had changed and/or whether they were in a position to participate in the study or not.

Initially, I attempted to obtain limited and non-identifying information about potential participants that were not thought suitable for recruitment by asking team members to complete a sheet providing limited information about the potential participant (Appendix C (i)). However, invariably clinicians declined to complete the form but were usually willing to provide the relevant information over the phone (Appendix C (ii)). However, in general most clinical teams were reluctant to provide

information formally. Therefore, and in the interests of maintaining positive relationships with services at this stage in liaison with services I desisted from trying to obtain any additional information about potential participants, considering that I could obtain this information at a later stage of the study.



**Figure 3: A flow chart of the recruitment process.**

**2.3.5.2 Recruitment process.** After liaison with clinical teams and the identification of potential participants, the recruitment of participants followed four specific phases that are detailed below.

*Phase one: Engagement with services.* Because of the complexity of liaising with different personnel in teams and the time-consuming process of communication within clinical teams the process of engaging services was extremely lengthy. As suggested by Feldman et al. (2003), I worked hard to develop a rapport with services

through contact with the link person in order to facilitate access to the potential participants. This individual became an important resource and the only means of communicating with the wider clinical team. It was necessary to build-up trust with the link person in order to reassure them that as a researcher-clinician I had the necessary skills to ensure that their service user would not be unduly exposed to the risk of harm through involvement in the sensitive study. In this respect my professional role as a consultant clinical psychologist with experience and expertise of working with this particular clinical group, provided reassurance to services. My professional role may have helped to facilitate access to the study population. The process of engagement with the link person was consistent with what authors researching difficult to access populations describe (Feldman, et al., 2003; Johl & Renganathan, 2010). Communicating with the link person as gatekeeper to various services and clinical teams was a much more protracted, complicated and sensitive process than had been anticipated. It required me to make frequent email and phone contact in order to progress the study.

*Phase two: Engagement with clinical teams.* The link person in each service would liaise with their clinical teams to inform them about the study. I had initially planned to visit each service to present the research and build closer collaborative relationships with teams. However, all services declined the offer of a presentation of the study. Therefore, all of the communication between clinical teams and myself was conducted via the link person.

*Phase three: Recruitment of participants.* The recruitment process was overseen by the identified member of the clinical team and divided into two stages: 1)

**initial** information giving; and 2) **additional** information giving. Once clinical teams had agreed that the recruitment process could commence, limited and non-identifying information about potential participants to the study was obtained (see Appendix D: Inclusion Form). The information was limited to the age range of victims and perpetrators, method and year of filicide, diagnosis, and year of admission. Consistent with the NHS Confidentiality code of practice (Department of Health, 2003) no further personally identifying information was obtained about participants.

In order to ensure that the recruitment process adhered to ethical considerations I constructed a document providing guidance about the recruitment process (Appendix E: Guidance for staff) and this was given to the link person. The guidance included emphasizing the rights of the woman to choose whether to participate or not and the importance of the responsibility of the team member to provide support to the participant throughout the process. I provided a telephone consultation to the link person to inform them about the procedure for recruitment including going through the guidance documentation. It was important to emphasise the importance of informed consent, and the freedom of the woman to choose to participate or not. The clinician was also responsible for ensuring that the potential participant did not perceive herself as being coerced into participating in the study.

The recruitment process involved not only the preparation of the clinical team for the recruitment process, but also the provision of initial and additional information giving for the potential participants. The recruitment process is summarised below;-

### *1. Preparation of the clinical team.*

Prior to meeting with potential participants the clinical team would provide agreement for the recruitment process to be initiated. I provided a number of template letters detailing the recruitment process (Appendices F (i) (ii) and (iii)). Providing template letters ensured that the wider clinical team was fully aware of the stages of recruitment that the potential participant was at. The information ensured that all members of the clinical team were aware of their role in observing for any signs of distress in the potential participant and could provide any necessary support if required. This was an important feature in the ethical imperative to ensure the safety of participants. The use of the templates also ensured that the recruitment process was documented in the clinical records of the potential participant.

### *2. Initial information giving to the participant.*

The link person to the study would ensure that the clinical team member responsible for recruitment was fully informed about the recruitment procedure. The clinical team member would arrange to meet with the potential participant and provide them with a letter of introduction (Appendix G (i)). A DVD (Appendix G (ii)) detailing the study was also produced as an additional means of informing the potential participant about the study. Given the sensitivity of the study focus and the potential difficulties for any participants to engage in an interview about their experience of maternal filicide, the DVD was used to provide a user-friendly means of informing them about the study. The DVD also introduced the potential participant to myself as the person who would be interviewing them if they consented to participate in the study. It was hoped that

by '*meeting*' the researcher through the use of a visual medium, it would lessen any anxiety about the interview process and could improve the success of the recruitment process.

An information leaflet (Appendix G (iii)) was also provided for potential participants which outlined their rights to decline to take part in the study, and emphasised and made clear that their clinical care would be unaffected by their decision. The potential participant was encouraged to ask questions about any aspect of participation in the study.

### *3. Additional information giving to the participant.*

The potential participant would be given another information leaflet at a second meeting, held within seven days of the first (Appendix G (iv)). If the potential participant gave their informal consent to interview, then a research interview would be arranged within the following two weeks.

*Phase four: Gaining Consent.* Explicit and formal consent to participate in the study was obtained by myself prior to the interview (Appendix H). At the meeting with participants I ensured that consent was being given freely and that the participant was fully informed about the study. At this stage, when gaining consent I would repeat a number of points for the participant;- that the participant could withdraw consent at any time; that what they said would be reported (ensuring their anonymity); that participation was voluntary and would not affect their treatment; and that their clinical team would not know what they had said. This approach is consistent with the '*ethics as process*' framework proposed by Cutcliffe and Ramcharan (2002)



where the researcher ensures that consent is given freely and from a fully informed position.

**2.3.5.3 Participants to the study.** Four participants who had fulfilled the inclusion criteria to the study were eventually interviewed. All accessible participants were included in this study’s sample, providing informed consent and fully engaging with the interview process (as outlined in 2.4.5 below). Anonymised characteristics of the four participants are summarised in Table 7 below. Only very limited information was obtained about participants to ensure that they could not be identifiable. Anonymity of participants in this sensitive study was essential, as mothers who have killed their children have often received widespread media reporting. Also, the population of filicide mothers in the United Kingdom is extremely small and it would be easy to identify individual perpetrators from even very limited references to the age or gender of their victims or more specific personal identifiers of mothers such as their exact age. Therefore, and throughout the thesis only the age ranges of filicide mothers and their victims are included in the report.

**Table 7: Characteristics of participants**

<b>Participant</b>	<b>Age</b>	<b>MENTAL ILLNESS Diagnosis</b>	<b>Age of Victim</b>	<b>Method of filicide</b>
Louisa	31-45 years	Paranoid Schizophrenia	1-5 years	Strangulation and asphyxia
Sandra	18-30 years	Paranoid schizophrenia	1-5 years	Drowning
Marcia	31-45 years	Acute psychotic episode with depressive symptoms	1-5 years	Strangulation
Carol	46-55 years	Depression	11-15 years	Strangulation

## **2.4 Data Collection**

In GT method the collection and analyses of data is performed simultaneously and the processes are not independent of each other. However, for ease of reading the processes of data collection and analyses will be reported separately but should be accepted as having occurred simultaneously. That is, I conducted each interview and analysed the data iteratively, conducting each analysis following each interview.

**2.4.1 Interview method.** To obtain the data a semi-structured interview technique (Appendix I) was employed to guide the interview. Most authors writing about the uses of interview methods acknowledge the importance of building rapport with participants (Sieber & Stanley, 1992; Charmaz, 2006; Kvale & Brinkmann, 2009), a crucial consideration for the interviews conducted in this study, given the vulnerability of the study's participants and the sensitivity of the topic. Liamputtong (2007) has written about the importance of building trust and safety in relationships with vulnerable research participants, suggesting that qualitative research methodology offers a more flexible means of ensuring safety for study participants. In qualitative research questioning can be attuned to the needs of the individual and Liamputtong argues that this allows more vulnerable groups greater opportunity to speak about their experiences. This flexibility should allow for the participant to speak more freely but it was also something that I felt anxious about in terms of being able to conduct an interview that would be able to achieve its objectives. I was at times preoccupied with the risks that research participants would be distressed or upset from the interview process. I piloted the interview on volunteer colleagues in order to rehearse the interview process. The interview guide was also reviewed by the service user panel, which helped build my confidence in using it.

The importance of showing respect for study participants is an essential ingredient to data collection methods. It proved helpful that potential participants had seen me on the DVD and they often commented in the early stage of our meeting, that I looked different from when they had seen me on the DVD, which reflected the time since the DVD was made. For this informal stage I used my clinical experience with female forensic service users and let them know how long the interview may last, the importance of them taking breaks should they wish to do so and also the importance of them not feeling interrogated, but only saying what they felt comfortable to do so. The interviews therefore started informally, and within the interview process both a warm-up and wind-down phase were factored in. I also aimed to ensure that the interview process was consistent with Kvale and Brinkmans' (2009) recommendations that the interviewer should be aware of power differentials within the interview situation. I therefore sought to ensure that the potential participant was fully cognisant of her rights to terminate the interview, withdraw from the study and to only speak about what she would feel comfortable to disclose.

GT method suggests that the interview is not a static instrument, but a tool to be used flexibly to generate data (Charmaz, 2006). However, within this study, there was a tension between flexibility and the demands of the approval processes of both the ethic committee and the various research governance structures of each trust. The demands of institutional review boards to require detailed descriptions of research plans to be submitted has been criticised as inconsistent with qualitative research generally and GT in particular (Charmaz, 2006). However, in order to reassure both the ethics committee and the various governance bodies of trusts and clinical teams

the interview guide provided an important means to evaluate whether the potential participant could cope with the interview.

Interviews with participants typically lasted between 50 minutes to 1¼ hours and were audio recorded with the participants' consent.

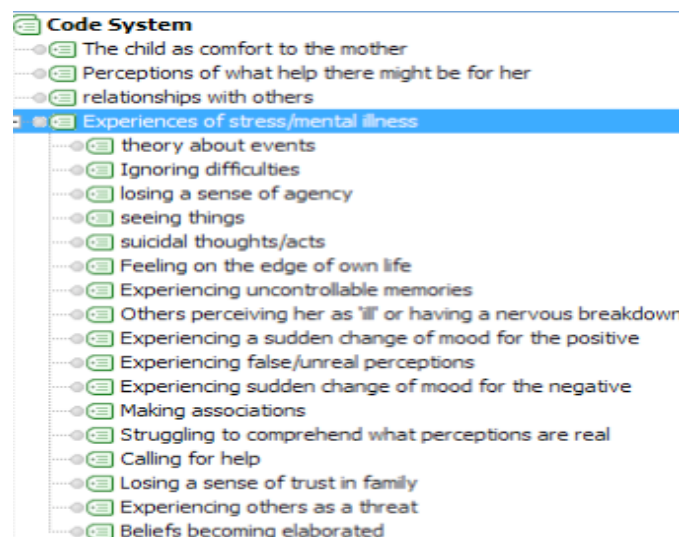
## **2.5 Data Analysis**

**2.5.1 Data management.** The interviews were digitally recorded and then transcribed. I transcribed the first two interviews and an administrator drafted transcriptions of the following two subsequent interviews. I checked the transcript against the recording. I listened repeatedly to all interviews.

I used MAXQDA (1989-2013), Qualitative Data Analytic Software, to manage and analyse the data. Transcriptions of the interviews were transferred from word documents to the software management package. Glaser (2002a) has suggested that computerised data analytic methods may be of limited use for conceptualising and thinking about the data. My own experience was that the MAXQDA software was a useful data management system, and especially in the early stages of coding. However, for later analytic procedures, such as developing categories and concepts, I found myself using the software less and less. Instead I made use of diagrammatical representations of the grounded theorising being produced.

**2.5.2 Initial coding.** One of the core methods used within GT is the analytical treatment of the data, which includes the coding and categorization of data. I adopted the method of line by line coding advocated by Charmaz (2006), remaining

open to the possibilities within the data. Charmaz (2006) recommends that codes are based on ‘gerunds’, forcing the analyst to try to see the action within each segment of data. I found that by coding with gerunds I was able to identify processes and to resist a tendency for descriptive labels (Mills, et al., 2006). However, not all of the data could be coded according to Charmaz’s (2006) recommendations and at times it was necessary to develop new codes specific to the data, as in the example of initial coding of a single interview shown in Figure 4.



**Figure 4: An example of initial codes of a single interview**

**Constant comparative method.** GT makes use of the constant comparative method as a main analytic technique (Glaser & Strauss, 1967). Constant comparative method is described by Charmaz (2006) as a:

*...method of analysis that generates, successively more abstract concepts...through inductive processes of comparing data with data, data with category, category with concept'. (p. 187)*

There is limited details about how to conduct the constant comparative method, but I adopted the strategies and used the advice from a number of sources (Glaser &

Strauss, 1967; Charmaz, 2006) and compared codes to each other in a constant iterative process. I found the process of comparing initial codes with each other and the data extremely time-consuming and confusing. The MAXQDA software programme was helpful in coding, and grouping some codes together, but this sometimes appeared to unnaturally group codes together, appearing to force the data. I therefore, used the coding programme in order to sift through the volume of data but made use of discussions with my supervisors to consider the theoretical possibilities within the data. Some data seemed to fit more than one code, although I opted for applying only single codes to lines of data. Glaser and Strauss (1967), provide a description of how the process of constant comparative method works:

*...different categories and their properties tend to become integrated through constant comparisons that force the analyst to make some related theoretical sense of each comparison'. (p. 109)*

The observation of Glaser and Strauss about the outcome of comparisons is that the analyst makes theoretical sense of the data as a result of constantly comparing it to other data and emergent codes. However, I found the process of making theoretical sense much more arduous and confusing than the quotation suggests. It was also not evident to me, at the initial coding level, how theoretical sense could be made from so many seemingly disparate codes. However, Charmaz (2006) suggests that conceptual understanding of the data develops through the use of the constant comparative method and the use of memo writing to develop thinking and conceptualisation of the data. Charmaz's advice is also clear, that within the constant comparison method the analyst is aiming to elevate the codes to a conceptual level.

*Use of memos.* Proponents of GT suggest that the analyst makes use of memos to support the process of theory development and conceptualisation of the data. Charmaz (2006) defines memos as ‘*the pivotal intermediate step in GT between data collection and writing drafts*’ (p. 72). I constructed memos for each of the codes at the very earliest stage of analysis. The codes served to log the development of my theoretical sense of the data. In writing memos I was able to stop and think about my ideas in relation to the codes and categories that were being constructed from them. The early memos represented the beginning of the process of conceptualisation of the data, and reflected not only the data extracts, but thoughts and questions I had related to what the data was about (Charmaz, 2006). Memos ensured that I remained active in engagement with the analytical process, as the development of codes and categories required thinking and conceptualisation of the data. Memos both documented and detailed those processes, but were also used to facilitate thinking and analytical work. My memos from this time in the analytic process are instructive; they demonstrate that the final theorising have their origins in this first engagement with the analytic process, however, they do not betray the confusion and sense of being overwhelmed that I recall from this period. An example of an early memo is provided below:

*Memo for code ‘struggling to comprehend what perceptions are real’.  
Dated 23 October 2011*

*This code relates to the individual’s struggle to ascertain what is a real experience, or what is a memory or what is a perceived experience which did not happen. The individual may still be unsure what sense to make of her experience and may begin to believe that her experience can only be understood from an ‘illness’ perspective. What effect does this have on her confidence about what aspects of her experience are real and valid? How does the woman balance out the tensions between experiences that felt real but weren’t and those that feel unreal but are real?*

***Focused coding.*** Focused codes are described by Charmaz as the '*second major phase in coding*' (Charmaz, 2006, p. 57). They represent the initial efforts to '*sketch the content of your budding analysis*', (Charmaz, 2006, p. 91). Focused coding represents the forerunner to the process of developing categories. Focused codes are derived from grouping and synthesising the initial codes together. In synthesising codes I noted that I was forced to move from labelling and coding of data to a more active stance of engagement and conceptualisation of the codes. My memos reflected that my thoughts about the codes were starting to coalesce around particular themes and ideas, and this resulted in my comparing the focused codes with each other and also with other data.

Focused codes are not only those that are most frequent or significant in the data, but also codes that gain their significance as a result of the active analytical treatment of the data by the analyst. The transition from initial and open coding to focused coding did not occur in a linear way. I compared focused codes with data, and not all focused codes made their way into the analytical frame. Other focused codes underwent processes of change as I compared them with each other and I experienced new insights about the conceptual significance of some of the codes.

***Developing categories.*** The development of categories emerged from the constant comparison of focused codes with each other and the rest of the data as advocated by Charmaz (2006). In initial coding, memos are used to initiate the process of conceptualisation of the data. Memos became elaborated through conceptualisations that emerged from thinking and conceptualising the data. Decisions about which codes best represented what was constructed as happening in



the data were also incorporated into memos. These decisions formed narratives in memos about the categories that were beginning to be constructed within the analysis. Categories included inferences about the data, and were not just a classification process (Dey, 1999). I constantly interrogated the data by asking ‘*What is this data a study of?*’ and ‘*what does the data suggest? Or pronounce?*’ as advised by Glaser (1978, p. 57). Simultaneously to this interrogative relationship to the data I was comparing focused codes to each other and categorizing them at higher levels of abstraction. From this process, categories that had seemed promising often did not make their way into the analytic frame, as they could not be adequately developed from the data. This is true for an early code of ‘*Experiencing Powerlessness*’. The memo reproduced below demonstrates the conceptualisation of the data at that time:

**Memo about ‘experiencing powerlessness, April 2012**

What is this a study of?

Is this a study of the relationship of the state to children, and the degree to which that influences how empowered mothers feel in their role. The women see the state as a source of support for their role as mothers but are often frustrated in their interactions. The state in fact need her to solve this problem herself. So the woman may then find it hard to disclose she is struggling because to disclose means that she will come under a regime which demands she protects her child but does not provide the supportive structures necessary for her to achieve this. However, not all the women engage in the state in this way? Could the concept be related to dependency and lack of autonomy and feelings of powerlessness as a parent? Is the experience more related to experiencing others as determining how you bring up your children? Maybe the notion of mother is an internal one and full of expectations. When others interfere with your role or appear to have more power over you, or your life is that when you experience feelings of powerlessness? Is this what mothers are experiencing?

**2.5.3 Conceptualisation of the data.** The process of conceptualisation of the data was aided by the use of diagrammatical representations of the data (Appendix J). However, new insights and further conceptualisation of the data also occurred as a result of discussions with supervisors and other members of the study team. At times

I had the feeling that I was too close to the data, and would spend long periods of time thinking and asking myself ‘*what is really going on here?*’ Glaser (1998) is reassuring in advising that confusion and ambiguity will characterise this analytic phase of GT and he warns against forcing the data into premature categories. However, I experienced great anxiety about the possibility of ‘*forcing the data*’ (Glaser, 2002a) and constantly went through the interviews, coding and re-coding, comparing and conceptualising the data. At times I found it difficult to commit to defining particular labels to groups of codes. This difficulty was related to the demands of the analytic procedure to abandon some focused codes, that had seemed important, but which lacked sufficiency in the data or between participants.

***Theoretical sufficiency and theoretical sampling.*** Charmaz (2006) defines the process of saturation as occurring when no new theoretical insights are derived from gathering additional data, and when obtained data reveals no new properties of core theoretical categories. To achieve saturation of conceptual categories, a process of theoretical sampling is usually conducted that means the ‘*seeking and collecting (of) pertinent data to elaborate and refine categories in...emerging theory*’ (Charmaz, 2006, p. 96). Thus, the purpose of theoretical sampling is to obtain data that provides elaboration and development of categories to the point of saturation or theoretical sufficiency. In conducting the fourth interview in this study I did not know that four participants would represent the whole sample. At that time there were a further 4-6 other potential participants who were appropriate to participate in the study. However, in fact they either declined or were withdrawn due to clinical reasons or because they were transferred to other services. Therefore, a limited process of theoretical sampling was conducted in the third and fourth interview as questions and

probes sought to refine the theoretical categories that were emerging in the early stages of data collection and analysis. This approach to theoretical sampling is congruent with that espoused by Charmas (2006) who sees it as a strategy to be invoked where necessary and in response to the demands of the analytic processes. The small sample size of filicide mothers available for interview does not necessarily indicate that saturation has not been achieved, and Glaser (1978; 1992) has argued that categories can be saturated even with very small sample sizes.

**2.5.4 Developing theorising.** Constructivist GT privileges the practice of '*theorising*' over the original premise of Glaser and Strauss (1967) that a grounded *theory* would be discovered from the analysis of data. The use of theorising was adopted in this study, in preference to the term '*theory*' which suggests a single unitary phenomenon, not consistent with the constructivist perspective of this study. Theorising as advanced in this study is active, provisional and always located in the specifics of the context within which it was developed. The theorising will be limited to those mothers who were interviewed, and also the time that the theorising was produced.

Consistent with Charmaz's (2001) perspective the process of theorising continued from the initial planning stage of the study to the process of writing up. Theorising is the active engagement of the analyst with the data. In this study theorising about the data occurred when I conducted line by line analyses, and thought about the meanings that I invoked in engaging with the data (Clarke, 2005). Charmaz suggests that the practice of theorising occurs when the grounded theorist

*'...reach(es) down to fundamentals, up to abstractions, and probe into experience'*  
(Charmaz, 2006, p. 135).

Conceptual categories were produced from this constant comparison method of initial codes, focussed codes and categories each with the other, back and forth in an iterative process. The conceptual categories were produced from thinking about the processes at a greater level of abstraction and interrogative process on the data.

## **2.6 Summary**

This chapter has contextualised the present study within the philosophical assumptions that underpin it. I have aimed to demonstrate that a constructivist paradigm with relativist assumptions about the nature of reality and an interpretivist philosophy to ways of knowing are appropriate to the subject of this study. I have aimed to demonstrate that constructivist GT is an appropriate method for the research question related to the development of filicide in mothers with a diagnosis of mental illness. In this chapter I have provided a short and necessarily summarised account of both GT method and specifically constructivist methodology, including how I have applied those methods in conducting the study. I have tried to provide sufficient detail about how ethical considerations shaped and determined the implementation of the study design, and also provide a fair account of how these considerations have impacted on different aspects of the implementation of the study, specifically recruitment.

The following chapter provides an account and demonstration of how the methods of data analysis as explicated in this chapter were used to analyse interviews

with mothers. The grounded theory analysis of the data produced grounded theorising about the development of filicide in mothers with diagnosis of mental illness and will be presented in chapter three.

## **CHAPTER THREE**

### **FINDINGS OF ANALYSES OF DATA: CODES, CATEGORIES AND CONCEPTUAL CATEGORIES**

#### **3.1 Introduction**

The aim of this study was to theorise about the development of filicide in mothers with a diagnosis of mental illness. In this chapter the results of the analysis of data, using the method as explicated in chapter two, will be reported. The chapter demonstrates the analytical process that was applied to the data beginning with the initial coding and concluding with the grounded theorising of the development of maternal filicide that was constructed from interviews with mothers.

The data presented in this chapter has been modified for readability and to ensure the anonymity of study participants. I have removed any identifying names of places, towns or regions and have signified this change through the use of 'XXXX'. Participants names have been substituted with pseudonyms. I considered the use of false names for regions, but this approach appeared to me to be more prone to error. Maintaining anonymity was also ensured by referring to all victims in gender-neutral terms as '*my child*' so as not to reveal whether the victim or their siblings were male or female.

#### **3.2 The Development of Coding, Focused Codes, and Conceptual Categories**

The analyses of data resulted in the development of three main conceptual categories. The following section is structured to demonstrate the analytical processes involved in the formation of each of the categories. The reader is introduced to each

of the categories that emerged from the analytic treatment of the data and a description of how the conceptual categories developed from the analytical process. A summary of the conceptual categories and the codes from which they were built is in Table 12 (p105).

### **3.3 Constructing Conceptual Category One: *Being Left Holding the Baby***

I did not have a preconceived notion of the category of *Being Left Holding the Baby* prior to the initial interviews. However, I noticed early on that all the mothers were single parents at the time that they committed filicide and this turned out to be an important context for the development of maternal filicide. The following section details the analyses of the data and the formation of the conceptual category *Being Left Holding the Baby* as well as demonstrating how initial and focused codes were used to develop the category.

**3.3.1 Juggling Priorities.** From early in the analytical process, it was evident that mothers were engaged in a number of activities that competed with each other in terms of priorities. An initial early code was that of *Providing for the Family*. However, when the coded data was compared to other codes and data it was synthesised into the focused code of *Juggling Priorities*.

Early analysis of the data showed that mothers, whether single or not were engaged in activities directed towards their family life:

*It was the recession...so I kept the family together my husband started drinking more and more and more...so he would come home very late on weekends or sometimes not at all until the next day because he'd been to a party. I never got any rest, working full-time, and then looking after my child at the weekends.*  
(Marcia)

*My child used to go to my ex-partner's mums. I think my ex-partner went up to see our child a few times...I was dropping my child off, coming back, moving all the time. It was hard work! (Sandra)*

*I'd be planning out for the next day like, "have I got the uniforms ready?" "Right, if I do so many shirts tomorrow, who's running low on what sort of thing?" And that'd be going around my head, and like, "have I got to pull anything out of the freezer for tomorrow?" and it'd be just you know every day things that'd go on. (Carol)*

*I managed to decorate the children's bedrooms, but that was it, that was all I managed to decorate. I made myself physically ill by doing that, I lost my voice, I was absolutely shattered doing that. I did both the rooms in five days, and I was exhausted. (Louisa)*

Mothers also experienced compromises in their capacity to manage their priorities:

*Well, I suppose it started like not cook(ing) meals and things like that. I just gave my child a butty or something...and not cook dinners like I used to. I didn't play with them as much as I used to...I stopped taking my child to bed and stuff like that. If they fell asleep they would sleep on the couch. (Sandra)*

Through constant comparison of the early codes to the rest of the data, the codes underwent constant revision to account for variations in the data.

The code of *Juggling Priorities* was an activity that was not only directed towards and performed for the benefit of the mothers' children, it was an activity that was also focused on wider family members:

*(After getting children up for a school and dropping them at the school)...I'd get on the bus from the school, go down, get (her parent) up. The district nurse would come and give parent insulin and meds (medication). I'd give them breakfast, I'd do what I had to do. I'd go back up to mine and do what I had to do. I'd come back down to my parent's...give them their dinner, make sure that they had a meal there ready, which had to just be micro-waved...(Carol)*

*...I was doing my work and I found out my parent had (terminal illness). I was doing like quite a few doctors appointments with my parent at the time and taking time out of work so I was juggling my working life a little bit as well and as well as paying all the bills. (Marcia)*



The coded activity *Juggling Priorities* included not only practical and physical incidents but also activities of providing to others in emotional ways:

*I'd suggested to my husband that it would be a good idea to take our child to the swimming baths. I suggested that he do it during the week, before he started his afternoon shift at work because I thought he could have one to one contact, he didn't have the distraction of his mobile phone. And different things like that. Our child would enjoy it and they could have lunch together. I sent husband an e-mail...I just said 'you know it's all about you and our child having a relationship' and my husband didn't reply to that e-mail. (Marcia)*

**3.3.2 Resource Insecurity.** Much of the early analysis of the data related to financial concerns and mothers' activities in managing finances, which were initially coded as *Financing* and *Housing*. An example of data initially coded as *Financing* is produced below:

*I wasn't receiving benefits for myself because I wouldn't give my ex-partner's name and so for two years I lived on £8 a week, so that was a struggle as well. I didn't want him to have anything to do with my child because he had been violent. (Louisa)*

*My ex-husband wouldn't give us any money. And he knew...we'd already struggled. I wasn't falling deeper and deeper into debt but I was kinda like a month behind on everything. I just tried to get ahead with things, but I was still struggling. So I kinda paid some money off the Visa but I needed to spend it again really. My Child Support Agency (CSA) money started to arrive in about the month of XXXX. So it was quite a long time. (Marcia)*

*All my bills were high and stuff like, but I was tending just to not open them or anything, and they evicted me. So I was living in hotels off the housing benefit. (Sandra)*

*My parent had paid for a washing machine for me, about a year before, but my husband wouldn't pay for anybody to plumb it in. So it just sat there. (Carol)*

Another early, initial code was *Housing* and was built from specific concerns of mothers related to the inadequacy of *Housing*:

*(It was)..hectic really ...Travelling to different hotels with my child, the pram and all my stuff. I was living in hotels...in B&Bs...for a little bit so I mean, you know, it was hard....we went to one hotel twice, so it was three altogether...the*

*housing benefit was paying for it...and they said you gonna have to move out in a week and you have to go somewhere else. (Sandra)*

*Housing* was a concern and activity for all of the mothers in the study:

*...I'd been visiting houses, y'know rental houses...and the landlords wouldn't accept a written bond, you know when the council writes you out cos you can't afford the deposit. We'd trawl the internet, we'd go and see places but either when I found something...then I'd go back and the landlord wouldn't accept a written bond or the actual agency wouldn't accept a written bond. (Carol)*

*I've moved loads of times, because of the landlord or repairs need doing and the landlord won't do it, or they want us out then...when you complain. Or the electrician says it's not sound. I moved from there (women's refuge) to a hotel...and from there I had a flat, which was really dangerous, the windows were to the floor...so I moved to another flat which had a restaurant underneath and the fumes came up from the chip fryer and burnt all the inside of our noses and our throats. We had like scabs up our noses for about a year afterwards so we moved from there and slept on my friend's floor for a week and found a flat in XXXX. (Louisa)*

*We moved house and I became pregnant after a week of moving into this house. The house was upside down, it needed everything doing! The electricity, the gas, the roof, the walls...damp...everything. (Marica)*

In the analysis of the data I engaged in constant comparison, comparing the earlier codes of *Providing for the Family*, *Housing* and *Financing* both with each other and with the rest of the data. The focused codes of *Resource Insecurity* and *Juggling Priorities* developed from the comparisons of these coded data with each other.

**3.3.3 Experiencing Domestic Abuse.** All of the mothers in the study had experienced domestic abuse. The data was coded and incidences of abuse were labelled *Experiencing Domestic Abuse*:

*I couldn't trust him not to be violent. He (partner) had dragged me round the throat and tried strangling me, pushed my nose down when I was on the floor, he was on top of me, tried to throw me down the stairs. (Louisa)*

*He was quite violent. I put up with it for about two, two and a half years and he used to hit me and kick me, and spit on me, and stuff like that. (Sandra)*

*All he (former husband) did was hurl abuse at me at all times you know? He would even send us a text saying, 'Face – ugly. Body – average and you're not even good in bed! (Marcia)*

*The physical violence was minimal. It was more that, you know, the psychological had increased. I'd walk past and he'd punch out for nothing. It was just stupid. It was a crazy situation. For no reason he'd say "Look at you! Look at you! God, you know, you're a waste. What a waste of space you are!" (Carol)*

### **3.3.4 Integration of codes and conceptualising into category:**

*Disintegrating Security.* My memo reproduced as below, describes how I initially conceptualised the experiences of mothers at this time during the analytical process.

#### **Memo 1: Dated:15th of April 2012**

*What is this a study of? What is really going on here?*

#### **EXPERIENCING ABUSE**

Reports of physical abuse or psychological abuse. Participants talk about experiencing lots of abuse both physical and emotional, one reports that her husband makes all the decisions. Mothers describe relationship difficulties and violent assaults from their partners. The women's relationships with the fathers of their children seems insecure with experiences of infidelity, alcohol abuse, violence and conflict or needing police or social services' power to protect them.

Being left to look after a child, when the child wants to cement the relationship. Does this lead the woman to feel devalued? Angry? Alone and abandoned? How does it affect her feelings of security. How does this experience relate to being poor? Financially challenged. Left with the baby? Left with the bills? Marcia was left with a mortgage and her ex did not contribute to financially caring for the child. The mothers were left...in this case for another woman – to shoulder all the demands. What is it like if you want to be a 'good mum' to know that your child is suffering?

The early focused codes of *Juggling Priorities*, *Resource Insecurity*, and *Experiencing Domestic Abuse* were synthesised into the category of *Disintegrating Security*. The category *Disintegrating Security* was constructed as a category from

incidents in the data where mothers had been abandoned to care for their children, either within a relationship or as single mothers, in the context of *Resource Insecurity* and *Domestic Abuse*. The conceptual category included the concept of *Juggling Priorities*, where all priorities were seen as equal and resulted in compromises in care. Further conceptual development of the category resulted in the use of the conceptual category of *Being Left Holding the Baby*. In the following section, I will describe how the synthesis, integration and construction of the conceptual category *Being Left Holding the Baby* was conceptualised from the category, *Disintegrating Security*.

**3.3.5 Synthesis, integration and construction of the conceptual category: *Being Left Holding the Baby*.** The conceptual category of *Being Left Holding the Baby* emerged from the conceptualisation and integration of the focused codes of *Juggling Priorities*, *Resource Insecurity* and *Experiencing Domestic Abuse* into the category of *Disintegrating Security* and from noticing the condition of single motherhood for study participants:

*They both left me when I was pregnant...I was having problems with my partner, my child's father, but I still ended up getting pregnant, and he left when I was about 5 months pregnant, ... (talking of her older child)...had to go into foster care because I was going through pregnancy and in and out of hospital...(Louisa)*

*I'd felt let down by husband on a lot of occasions. He'd walked out on me when I was pregnant... but then he came back and walked out again and came back...and there were those occasions when I felt so let down by him. (Marcia)*

The label *Being Left Holding the Baby* appears to maintain credible 'fit' (Glaser, 1992) with the data as mothers were engaged in the majority of childcare (*Providing for The Family*). The category *Being Left Holding the Baby* also conformed to

Glaser’s demands that grounded theory analysis should produce conceptual handles that are both ‘*relevant*’ to the participants’ experiences and ‘*work*’. The category of *Being Left Holding the Baby* appeared to have ‘*conceptual grab*’ (Glaser, 2002a) in that it provided a simple and immediately recognisable label for the processes inherent within it. Table 8, shows a summary of the focused codes and the category and conceptual development of *Being Left Holding the Baby*.

<b>Table 8: <i>Being Left Holding The Baby</i></b>		
<b>FOCUSED CODES</b>	<b>CATEGORY</b>	<b>CONCEPTUAL CATEGORIES</b>
Juggling priorities Resource insecurity Experiencing domestic abuse	Disintegrating Security	<b>Being Left Holding The Baby</b>

### **3.4 Constructing Conceptual Category Two: *Developing a Siege Mentality***

The development of the category *Developing a Siege Mentality* was initially difficult, as early analyses seemed to produce seemingly disparate codes, which did not at first seem conceptually related. In addition one participant’s experience seemed qualitatively different from the others. I initially found it more difficult to move the analysis on to a conceptual level, frequently getting ‘*stuck*’ at the level of ‘*description*’ and ‘*person*’, (Glaser, 2002b). Only after a lengthy process of coding and re-coding, and considerable working to develop a level of conceptualising about the data, without ‘*forcing*’ it, was conceptual development possible. The following section describes the analytical process that occurred in the construction of the category *Developing a Siege Mentality*.

**3.4.1 Fearing.** Early coded items from the analysis of data were labeled *Fearing*. *Fearing* referred to general fears, but also mothers’ specific fears about

harm coming to their child:

*I was terrified because my child had been picked on, on the way home from school. So I used to pick my other child up, and then walk down to meet my child who was being picked on. (Louisa)*

The code of *Fearing* also related to mothers' fears that their child was going to be taken away:

*I just thought that somebody was going to try and take my child away. I don't know how I ever thought it now, but I believed that. (Louisa)*

*I didn't want them to take my child off me. I thought if I go to the doctor's and say I'm hearing voices, that they might not want my child to be around me. I was thinking of telling them once or twice, but I thought if I go in they're gonna call the social services that sort of thing. (Sandra)*

*Fearing* also related to fears that the child was going to be taken away by social services:

*The social worker said that I had to move out of XXXX (city) or they would take my child from me cos putting my child at risk (being close to a family member with whom the mother had once had a physical altercation). So I moved to XXXX (another part of the country)...And I went to a Women's Aid refuge there. (Louisa)*

*...because of domestic violence, social services had become involved, they'd told me that I had to leave my husband or they would take my children off me. (Carol)*

Other experiences of *Fearing* were more general and related to the emotional state of fearfulness:

*There was always an uneasy feeling that something bad was going to happen. (Louisa)*

*How did I feel? Horrible and very... well, frightened. (Marcia)*

**3.4.2 Feeling Suspicious of Others.** Another code, was labelled *Feeling Suspicious of Others* and appeared conceptually close to the code *Fearing*. However, the code *Feeling Suspicious of Others* was more specifically related to fearfulness in

relation to others. *Feeling Suspicious of Others*, included feelings of threat and fear in relationship as well as distrust in the motives and intentions of others:

*I was in that much of a state, I thought everybody in the street was going to come in and rape me...I rang the police and asked them to come back. I told them that I was frightened of my neighbours...and I told them that people were going to have a party and they were going to come to the house, take me and have me raped...I thought my friends and family were plotting against me to give my child to my (estranged) husband and his girlfriend and take my house away. (Marcia; brackets mine)*

*But I thought the whole time that they were against me. I kept thinking my dad was going to pick up the cup and throw it at me. I thought they were helping putting the children to bed because they were all going to give me a kicking in the kitchen ...I thought they could read my mind. I thought they knew what was going on. (Louisa)*

*I just started to kind of sort of withdraw and not answer the door or answer the phone and stuff like that. I just didn't want to go out I suppose. I didn't want them (friends) to come in either, you know into my home. (Sandra)*

*I cut off contact with everyone. (Carol)*

However, although the codes of *Fearing* and *Feeling Suspicious Of Others* appeared robust, I was yet to integrate and categorise them with the other codes constructed from the analysis and which seemed conceptually related.

### **3.4.3 Hearing Things/Seeing Things.** An early code was labelled *Hearing*

*Things:*

*...(Hearing voices of) people I knew which then made me think the devil was playing tricks on me because but I also thought people could read my mind. (Louisa; brackets mine)*

*I was still hearing voices and that but they weren't like as extreme as it was...(Sandra)*

However, other incidences in the data related to perceptual experiences, such as *Seeing Things:*

*What I seen in the house was quite scary...quite scary things really, like it's hard to describe it. Sort of people with disfigured faces, and things like that, you know? I was hearing things, like people gonna knock on your door wanting to come in and stuff like that. (Sandra)*

*And my child was crying because they whipped us and my child saw me being whipped. They come into our home in the middle of the night and dragged me out of bed and my child was crying. I've remembered all these things. (Marcia)*

So both coded incidences of *Seeing Things* and *Hearing Things*, were integrated into a single code of *Seeing/Hearing Things*. The task of the analysis was to sort and group these initial codes and synthesise and integrate them conceptually.

**3.4.4 Doubting Perceptions.** Mothers' difficulty in trusting their own evaluation of experiences or perception of events was evident in other parts of the data:

*Because one time when I was in church with friend they had this soup and I asked for a taste of her soup, and normally she would give me a taste of her food, or I would give her a taste and she's looking at another woman saying 'she wants to taste it'. And she said "no you can't, it's too peppery for you". Well, she knows I like pepper. She used to come for dinner with my child and there was always hot pepper sauce on the table. I said "what is it?" and she said, "pigs intestines" but she doesn't eat pork. So that played on my mind after I'd moved... and all these things going on in my mind. I don't know how I linked them up now, but I did. (Louisa)*

*I heard the next-door neighbour saying that they were going to move and I thought to myself that my ex-partner's parent's going to move in next door to me. And I thought...I can't cope if they turn up, sort of thing...but they weren't. (Sandra)*

*I believed I'd been raped, dragged round (local area), taken to work and raped down there and then taken to the Masonic hall (nearby) where I live and that I was put through an initiation. I'd been whipped, made to frighten my child with an evil mask on. That I'd signed the paperwork signing my child and the house over to my ex-husband. And I can remember my child screaming, and I can remember my insides falling out and I was just so scared. (Marcia)*

These incidences were coded and labelled as *Doubting Perceptions* and included difficulties trusting one's own evaluation of experiences and other people.



### 3.4.5 Integration of codes and conceptualising into the category: *Trusting*

*No-One, Trusting Nothing.* The coded data from the interview with one of the participants, Carol did not at first appear to be consistent with those from the other interviews. I was yet to move the analysis of the data to the necessary conceptual level. The memo, as below, describes my thinking at the time:

**Memo 2: Dated 30.07.2012**

*What seems critical is that the mothers live with a sense of fear and begin to 'trust no-one' and maybe the condition is that of 'living in fear'. The women describe anxieties about the neighbourhood where they live and also either through a psychotic process or otherwise, begin to feel under threat and frightened about others. This is not true of the data obtained from the interview with Carol. What is really going on here?*

I had begun to 'work' and 'play' with the data, specifically comparing the codes and data from Carol's interview with those of other interviews. In working to discern what the coded data represented, I re-analysed the data and the codes and compared them to each other again. One incident in the data from the interview with Carol had initially been coded with the label *Living Under Social Services Regime*:

*There was no safety because if something happened to me, if the police got involved again and social services step up then they'd take my child off me.*  
(Carol)

However, the code did not have sufficiency in comparison with other data and codes. I began to use the conceptualised label of *Trusting No-One, Trusting Nothing* in integrating Carol's experience with the other codes of *Fearing, Feeling Suspicious Of Others, Hearing/Seeing Things*, and *Doubting Perceptions*. The category *Trusting No-One, Trusting Nothing* synthesised and integrated the experiences into a conceptually relevant category whereby relationships with others are frightening and

ones' own perceptions and feelings cannot be trusted as valid and reliable. The category *Trusting No-One, Trusting Nothing* appeared to 'work' in terms of explaining what was happening in the data. *Trusting No-One, Trusting Nothing*, was a category of experiences in which mothers experienced uncertainty in their relations with other, and in evaluating their own experiences. Further conceptualisation with the data occurred in constructing the data into a conceptual category.

#### **3.4.6 Synthesis, integration and construction of the conceptual category:**

***Developing a Siege Mentality.*** The conceptual category of *Developing a Siege Mentality* was built from the induced codes of *Fearing, Feeling Suspicious Of Others, Hearing/Seeing Things* and *Doubting Perceptions*. The codes had been integrated into the category *Trusting No-one, Trusting Nothing*. The conceptual category, of *Developing a Siege Mentality* appeared to have credible 'fit' with the data as there were incidences in the data where mothers were frightened of others and fearful of their motives and intentions:

*I thought that they were going to use me as a prostitute and then strip my skin and do whatever. (Louisa)*

*The council had nothing available. They took me around to a women's shelter and they said that they didn't have a house and they didn't reckon that the hostel that they had available...would be suitable. So the three of us, that's the lady from the women's abuse thing, my social worker and myself all agreed there was no option, I had to go back. I had to. The three of us agreed that I must not tell my husband what was going on in case the violence erupted. I was to continue looking independently for a place. (Carol)*

*I told my parent I was hearing voices. I think I upset them because my grandparent died quite a long time ago. I was saying to my parent that I could hear my grandparent and things which I thought was true. (Sandra)*

*And I rang the police and asked them to come back. I told them that I was frightened of my neighbours because my husband and his girlfriend knew some of our neighbours. I told them that people were going to have a party and they were going to come to the house, take me and have us raped again. (Marcia)*

Mothers feared that the intentions of others were malevolent and they also perceived themselves as vulnerable and defenceless. The conceptual category

*Developing a Siege Mentality* was ‘relevant’ to the concerns and activities of the women, as I constructed them. Table 9 presents the codes from which the conceptual category of *Developing a Siege Mentality* was built.

<b>Table 9: <i>Developing a Siege Mentality</i></b>		
<b>FOCUSED CODES</b>	<b>CATEGORIES</b>	<b>CONCEPTUAL CATEGORIES</b>
Fearing Feeling Suspicious of Others Hearing/Seeing Things Doubting Perceptions	Trusting No-one, Trusting Nothing	Developing a Siege Mentality

The label *Developing a Siege Mentality* describes an inward-looking approach to problem-solving and a lack of faith in the capacity of others to provide necessary support. However, critically, mothers’ attempts at problem-solving occurred whilst they are in an extreme state of fearfulness and distrust of others. The mothers also perceived threats to their relationship with their child. The conceptual category of *Developing a Siege Mentality* also implies being a victim of circumstance and being surrounded by hostile forces. As such the label has conceptual ‘grab’ as a descriptor of the mothers’ perceptions of the outside, social world. Within the siege mentality, however, resides not just the mother, but the mother and her child(ren). This has significant implications for the development of maternal filicide, as will be demonstrated in the following section.

### 3.5 Constructing Conceptual Category Three: *Resolving*

None of the mothers in the study were asked to talk about the act of killing their children (see interview guide Appendix I), although all of them described the event, and some in quite a lot of detail.

**3.5.1 Hopelessness.** From early, initial coding, experiences of *Hopelessness* were evident in the data:

*I felt like I couldn't live, carry on like that no more. Being poor, no joy in anything really. I'd go in the shop and I'd look around and people would just be like, you know, 'drappy' clothes and things. I'd think to myself "Why's it like this all the time?" Do you know what I mean? "Why's it so like, people are poor and stuff?" It was nearly Christmas. I felt horrible around that time. Thinking that a lot of people didn't have money and stuff. (Sandra)*

*The situation was impossible. You think it can't get worse but it does...because there was no option, I was physically tired, I was emotionally tired, the emotional grinding down over sort of like 15 years. (Carol)*

*Yeah, I was lying in bed the night before it had happened (killing her child) and I couldn't sleep and I was rigid. I can remember being so tense, my whole body was rigid and I'd heard of a lady who jumped in front of a train with her two children. That thought went through my mind and it was like I could completely understand why. Cos she couldn't cope no more. (Louisa; brackets mine)*

However, not all of the mothers reported feelings of *Hopelessness* prior to deciding to kill their children, although they all described *Suicidal* thoughts and feelings.

**3.5.2 Suicidality.** All of the mothers in the study reported that immediately prior to the filicide they had wanted to kill themselves. All of the mothers also reported that they had harmed themselves after having killed their children. In the data, incidences of feelings and thoughts of *Suicide* were labeled *Suicidality*:

*I couldn't concentrate. Then I thought "well I'm useless". That's why I wanted to end my own life. Cos, I was stuck. I couldn't do anything. I couldn't do what I thought I could do. (Sandra)*

*When I decided to kill myself, you know, it felt a relief. I knew what I was going to do. I knew that it was going to happen. I knew that there'd be no more hurting, no more panicking, no more fright, no more physical abuse, no more mental abuse, it was going to end, it was "phew! Thank goodness for that". I guess it was just a massive relief that I'd actually made a decision for myself. (Carol)*

However, whilst some of the data was clearly linked to *Suicidality*, other data was more difficult to differentiate from other feelings and thoughts that were filicidal in intent.

**3.5.3 Suicide-Filicide.** Incidences of *Suicidal* and *Filicidal* thoughts and plans often occurred simultaneously:

*...and that's when I thought, "what are my options?" My only option is to take my child with me. It would be cruel not to. It would be cruel to leave my child in the situation. (Carol)*

*And that was it. I felt I was on the edge of my life and what about my child? (Marcia)*

*And I wanted us all to go together, I didn't want anybody left. (Louisa)*

*I decided to do what I was going to do. To end it for both of us, both of us at the same time. I wasn't planning on sticking around after that ... (Sandra)*

The coding difficulties related to *Suicide* were resolved by integrating them into a focused code of *Suicide-Filicide*.

What the above data segments reveal is that the killing of the child is being considered as a course of action. Thoughts of *Suicide* appeared inextricably linked to thoughts of *Filicide*.

**3.5.4 Saving.** *Saving* was an in-vivo code related to mothers' beliefs that they were *Saving* their children through filicide. *Saving* was the motivation for the actions of mothers. The focused code of *Saving* related to *Saving* the child from perceived threat or harm:

*Something just made me think that I had to suffocate my child, because they were going to be cut open and slowly killed. I believe in God so I was praying that God would take them home as I was doing it. (Louisa)*

*But nobody could have ever envisaged this. Nobody. Because everybody knows I was a fantastic mum. But that morning I was petrified for my child. Absolutely petrified. And I thought I was **saving** my child. (Marcia; emphasis mine)*

*I knew my child would be safe. Nobody could hurt them ever again in their life. Never at any time would they have anything bad happen to them. Nothing bad, nobody could touch them. My child's safe, safe. I know they are safe. I know they are with God. I know that they're being looked after. I pray for that every night. (Carol)*

The code of *Saving* was also conceptually related to fears that the child was going to be taken away:

*I thought it was the best for both of us, really. Coz I didn't want my child taken off me. I decided to do what I was going to do. I thought to myself, "yeah I'm gonna do it, I'm gonna do it". But I kept backing out of it really, I'd think, "No, I can't do that." (Sandra)*

*...social services told me that I had to leave my husband or they would take my children off me. (Carol)*

*I thought he (relative) wanted to separate my child and I...and that they were going to section me and separate us forever. (Marcia)*

**3.5.5 Auto-Pilot.** Another in-vivo code was *Auto-Pilot* which was a term that one of the (non-victim) children had used to describe their mother immediately prior to her committing the filicide:

*But it was almost like, my eldest child said to me, they said, "What's the matter with you Mum? You're really calm" so it was just like I was on autopilot. I didn't have any energy. My emotions were quite flat. (Louisa)*

This seemed an important process in the development of maternal filicide, and other coded data, densified the focused code of *Auto-Pilot*:

*I felt at peace...something clicked and I thought good idea and I actually felt calm about it (suicide). I felt really calm about it. (Carol; brackets mine)*

Other processes were initially coded as *Lack of Agency*, but were then integrated into the induced concept of *Auto-Pilot*, as the codes seemed conceptually linked, integrating experiences in which the mothers felt disconnected from their actions:

*Yeah, but in all that time I just remember things, evil face kind of in our bedroom in the house. And I sometimes think "was there something in the house made me do it?" (Marcia)*

*I felt like I was somebody else. Somebody else, it was like moving me and touching me and things. Just felt like I was sort of, not possessed, taken over. As if someone was moving me, and stuff like that and making me do it. I felt like I was being walked to the room where I did the thing. (Sandra)*

The processes inherent in the in-vivo code *Auto-Pilot* appeared to be related to the development of maternal filicide. However, it was necessary to integrate and synthesise the code with other codes of *Hopelessness*, *Filicide-Suicide*, and *Saving* into a conceptual category.

### **3.5.6 Integration of codes and conceptualising into the category:**

*Resolving*. Comparison of the codes *Hopelessness*, *Filicide-Suicide*, *Saving* and *Auto-Pilot*, with each other and the rest of the data, produced a conceptual frame for understanding the process of decision-making in determining to kill the child. The mothers experienced profound feelings of *Hopelessness* and *Suicidality* but these feelings needed to be reconciled with the responsibilities that they had for their children.

A category labeled *Resolving* was built after sorting and grouping codes and

integrating the codes of *Hopelessness*, *Suicide-Filicide*, *Saving* and *Auto-Pilot*. *Auto-pilot* was constructed as conceptually related to the category *Resolving* as the mothers appeared to undergo a catastrophic disconnection from their emotional worlds. *Resolving* is a category that integrates the experiences of *Hopelessness* and *Suicidality* reported by mothers. Within the conceptual category of *Resolving* is the process of *Saving* reported by mothers as their motivation for killing their children. The act of killing the child appears to be understood by the mothers as a means of keeping their children close to them (*Uniting*).

### **3.5.7 Synthesis, integration and construction of the conceptual category:**

*Resolving*. Maternal filicide appeared to offer the mothers a means of maintaining a bond with their child. In the minds of mothers, following the filicide, she and her child would be united together in death. The conceptual category of *Resolving* emerged from the analytical frame in which anxieties about separation from the child, in the context of the mothers' sense of *Hopelessness* and *Suicidality*, were *Resolved* by deciding to kill the child as well as herself. The filicide was conducted in part to avoid separation and to achieve a permanent state of *Uniting* with the child. *Resolving* as a conceptual category seemed to involve a failure to differentiate the separateness of the mother and the child and a distorted belief that killing the child was an act of love:

*Well, I realised that there was nobody that could look after my child. As I said, my husband was incapable. So if he was incapable and I was dead, my child would be in put into an institution. I couldn't let that happen to my child. (Carol)*

*So, I decided that we both had to die together. I was remembering all these awful, awful things (crying). And just the pain for my child, and I thought 'I can't believe we've got this far (crying). We've come all the way through (crying), for it to end like this'. I just knew my child and I had to be together so ... I took my child's life and I hate myself for it but I did do it. (Marcia)*



*Yeah, the most desolate, desolate feeling in the world. And you love that child so much, and it's not done with malice or hatred or evil. You do it because you love that child. I know it's hard for people to understand. (Carol)*

Table 10 presents the codes from which the conceptual category of **Resolving** was developed. The GT method of analysis had also produced a focussed code for the experiences and processes related to pregnancy and becoming a mother. This was labelled *Transitioning into Motherhood*.

<b>Table 10: Resolving</b>		
<b>FOCUSED CODES</b>	<b>CATEGORY</b>	<b>CONCEPTUAL CATEGORY</b>
Hopelessness Suicide-filicide Saving Uniting Auto-pilot	Resolving	Resolving

### **3.6 Focused Code: *Transitioning into Motherhood***

Mothers had not been asked directly about pregnancy and becoming a mother, but both featured as early codes, although the quantity of data about both was limited. Therefore, the level of conceptualisation and analysis did not proceed further than the development of a focused code of *Transitioning into Motherhood*. However, all of the mothers described their experiences of becoming a mother. The following section details the limited development of the category *Transitioning into Motherhood* that was constructed from the analysis of the data. The code appeared to capture and conceptualise the process or activity that mothers were engaged in during the transformation from childless/childfree woman to becoming a mother:

*I just remember being a new mum and you get that emotional you know, you do. Your baby's everything to you... and the love, where the love comes from it just blows you away. (Marcia)*

The focused code of *Transitioning into Motherhood* included experiences of emotional changes as well as feelings of love and bonding. However, it also included changes to the mothers' identity, feelings of anxiety and changes to their social lives:

*But I changed as a person when my child was born. I didn't expect to kind of change that much but I did...I didn't want to go out anymore, I would get anxious if, you know, if my husband suggested going somewhere. On the evening I would become anxious, I didn't want to go, I wanted to be in the house and I was happy doing that because previous to me becoming pregnant I'd had a really full life, a good social life. I didn't expect to go from you know being, a little bit of a socialite to, I just... didn't want to be anywhere else...(Marcia)*

*Yeah, I loved being a mother. I couldn't wait to have a second child so I'd feel like a proper mother. (Louisa)*

The code *Transitioning into Motherhood* also included negative changes such as post-natal depression and latent suicidal (and filicidal) wishes:

*When my first child was a baby...I would wake up in the morning thinking it would be so much easier if neither of us woke up...just too much to cope with. I don't know what was too much to cope with, I just didn't feel right. (Louisa)*

*I mean after I had my child they thought it was post-natal depression and they put me on Prozac. They took me off that, (then) they put me on valium. They put me on this, they put me on that, you know. (Carol)*

Other negative feelings, such as social withdrawal were also evident in the code *Transitioning into Motherhood*:

*I just started to kind of sort of withdraw and not answer the door or answer the phone and stuff like that. I just didn't want to go out I suppose. (Sandra)*

Anxiety appeared to be conceptually important to the process of *Transitioning into Motherhood* and to have relevance to the data:

*I worried endlessly even with driving...all of a sudden I started to think "I hope that truck doesn't pull out, I can't be in an accident, I'm a mum you know!" (Marcia)*

*(The flat had)...floor to ceiling windows and it used to frighten me that my child would go through a window. Yeah, I felt I had to stay awake to look after the children...even though they were asleep. I've always had a fear of fire...I just couldn't relax at all. (Louisa; brackets mine)*

In addition *Transitioning into Motherhood*, could include the significance of the event due to the impact on the relationship with the child's father:

*I didn't tell them (parents) till the day after, I don't know why, it's just sort of, things were going on. XXXX (ex-partner) was coming up to the hospital and stuff like that. Suppose I just wanted XXXX (ex-partner) there, just wanted to sort of not try again, but just get closer to him if you know what I mean. (Sandra)*

Table 11 presents the focused code of *Transitioning into Motherhood*

<b>Table 11: <i>Transitioning into Motherhood</i></b>
FOCUSED CODE
Transitioning into Motherhood

### **3.7 The Construction of Grounded Theorising in the Development of Maternal Filicide**

In the previous section I have reported on the development of coding and the formation of categories and conceptual categories.

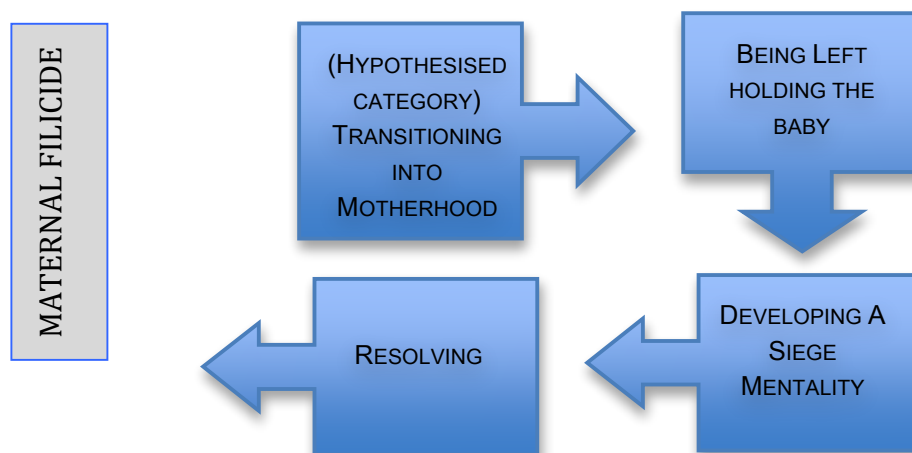
In the next section I will report on the further conceptualisation of the data that originated in the early analyses and concluded in the development of the final grounded theorising about the development of maternal filicide. The conceptual categories and the induced concepts and categories from which they were built are shown in Table 12.

FOCUSED CODES	CATEGORIES	CONCEPTUAL CATEGORIES
JUGGLING PRIORITIES RESOURCE INSECURITY EXPERIENCING DOMESTIC ABUSE	DISINTEGRATING SECURITY	BEING LEFT HOLDING THE BABY
FEARING SEEING/HEARING THINGS FEELING SUSPICIOUS OF OTHERS DOUBTING PERCEPTIONS	TRUSTING NO-ONE, TRUSTING NOTHING	DEVELOPING A SIEGE MENTALITY
HOPELESSNESS SUICIDE-FILICIDE SAVING UNITING AUTO-PILOT	RESOLVING	RESOLVING
TRANSITIONING INTO MOTHERHOOD		

**Table 12: Codes, categories and conceptual categories from analysis of data**

I had by this point in the analysis, begun to look at the conceptual categories; *Being Left Holding the Baby* and *Developing a Siege Mentality* and *Resolving* and to think about the relationships between them. I hypothesised that the category *Transitioning into Motherhood* was related to the more developed conceptual categories of *Being Left Holding the Baby*, *Developing a Siege Mentality* and *Resolving* as part of a sequence of processes as shown in Figure 5.

**Figure 5: A Diagram of Initial Theorising of Maternal Filicide in Mentally Ill Mothers (Constructed in December 2012)**



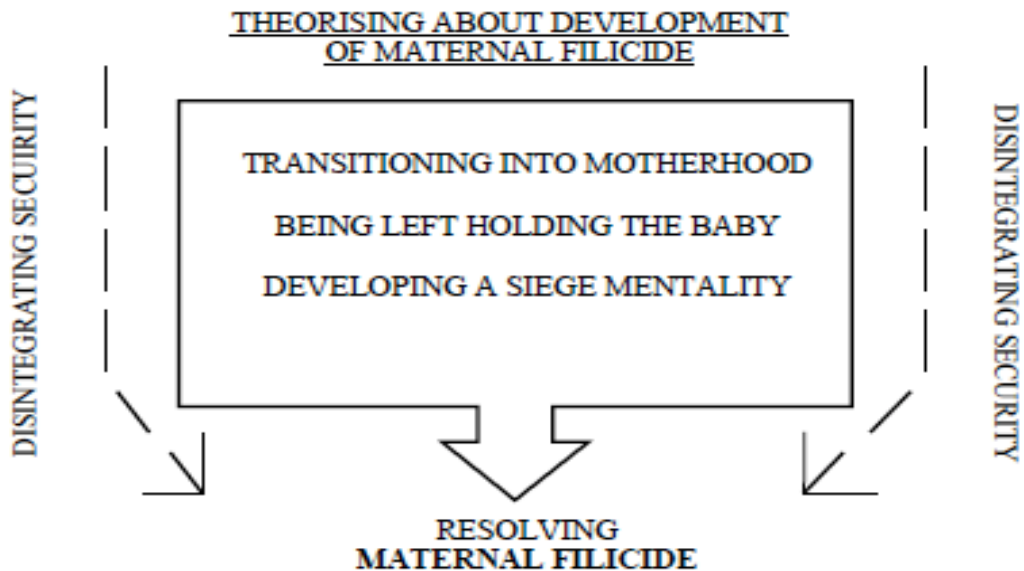
**3.7.1 Initial theorising about the development of maternal filicide.** The initial theorising as depicted in Figure 5 appeared to be an adequate representation of the theorising of the development of maternal filicide and seemed to have a good *'fit'* with the data. However, I had yet to feel satisfied with the *'workability'* of the model, or how well it accounted for how the mothers had solved the concerns that they had reported at interview. I continued to question whether I had forced the data into a chronological account to the detriment of greater conceptual development. These concerns were brought into sharper focus whilst writing the thesis. The process of writing became an extension of the analytical and conceptualising processes (Charmaz, 2006) and resulted in a continuation of category development and conceptualisation.

**3.7.2 Grounded theorising about the development of maternal filicide.** As a result of the aforementioned dissatisfaction with the initial theorising a second model (Figure 6) began to take shape during the analytical processes of conceptualising and theorising about the development of maternal filicide. In comparing the categories; *Transitioning into Motherhood*, *Being Left Holding the Baby*, *Developing a Siege Mentality* and *Resolving*, I had been constantly thinking about possible conceptual links between them and also conceptualising a more abstract process that accounted for the development of maternal filicide. I continually applied the question 'what is really going on here' to the analyses.

Glaser (1978; p. 72) suggests the use of theoretical codes as a means to develop hypotheses that demonstrate the relationships between conceptual categories. The concept of *Disintegrating Security* began to develop in my mind as not only a

category that had grouped together and synthesised conceptually related concerns and activities but also as conceptually related and underpinning the processes of *Transitioning into Motherhood, Being Left Holding the Baby and Developing a Siege Mentality*. In Figure 6 the centrality of the process of *Disintegrating Security* is evident. Importantly, in terms of ‘credibility’ the use of the theoretical code *Disintegrating security*, also fulfilled the criterion of ‘workability’ in providing a theory about what study participants were attempting to resolve by the action of filicide. The conceptualisation of the process of maternal filicide theorised that the act represented the attempts of mothers at *Resolving* the experiences of *Disintegrating Security* that had begun in *Transitioning into Motherhood* and intensified and accreted in the process of *Developing a Siege Mentality*.

**Figure 6:** *Final Model Theorising The Development Of Maternal Filicide (developed in April 2013)*



### 3.8 Disintegrating Security; Inter-Related Propositions

The process of *Disintegrating Security* is proposed as both a theoretical code that explicates the relationship between the four concepts and also as a process in its own right. Any summary of grounded theorising might also include how the theorising can be expressed as a series of propositions (Strauss & Corbin, 1990). The theorising of *Disintegrating Security* is presented as a series of inter-related propositions as set out below.

#### **Propositions**

The main proposition of the present study is that there is a central process of *Disintegrating Security* in the development of maternal filicide in mothers with a diagnosis of mental illness. The process of *Disintegrating Security* is conceptually related to a number of specific conceptualised conditions, activities and processes. These include;

1. A process of *Transitioning into Motherhood* is associated with anxiety, changes to mood and identity for mothers. These changes are theorised as marking the ontogenesis of the process of *Disintegrating Security* for mothers in the development of filicide.
2. A condition of *Being Left Holding The Baby*. Mothers are engaged in prioritizing and managing demands within the context of inadequate support and resources. *Experiencing Domestic Abuse* is also relevant. The condition of *Being Left Holding the Baby* is theoretically linked to loss of relationships particularly losses and breaks in relationship to the child's father.
3. Uncertainty for mothers in their relationships with others and the reliability of their perceptions of reality are conceptualised as critical to the process of *Developing A Siege Mentality*. Within this process mothers perceived a threat to the relationship with their child.
4. The process of *Filicide-Suicide* is conceptualised within the theorising of this study as the final process in the development of maternal filicide.

Maternal filicide is conceptualised as 'working' in *Resolving* two central dilemmas for mothers;

- a) fears of harm to the child
- b) the unwanted consequences of the mothers' suicide for their children

*Saving/Uniting* are the motivations that mothers gave for killing their children

*Autopilot* may be a necessary precondition in the completion of filicide.

## CHAPTER FOUR

### DISCUSSION

#### 4.1 Introduction

The aim of the present study was to advance a grounded theorising of the development of maternal filicide from interviews with mothers who had received a diagnosis of mental illness. The objective was to interview between 6-8 mothers who had been convicted of having killed their children. The aims of producing grounded theorizing of maternal filicide have been achieved however, there are limitations to the study, primarily due to the small number of participants eventually recruited. However, no claims are made about the development of maternal filicide beyond what was produced from the analysis of interviews with these particular mothers. The study has produced a rich and in-depth account of the development of maternal filicide that provides a theoretical lens for clinicians to use when working with filicide mothers. Furthermore, the study contributes to understanding of the process of filicide a seemingly incomprehensible act.

The present study conceptualises the act of maternal filicide as a response and an attempt to manage *Disintegrating Security* in a number of social, economic, relational and psychological spheres. The proposed grounded theorising suggests that a number of processes accrete and interact sequentially with each other. The development of maternal filicide is not limited to the influence of any one single process, but results from a process of *Disintegrating Security* in a number of domains. A conceptualised account of the development of maternal filicide is proposed and includes the process of decision-making that mothers undertake in the act of filicide.



## 4.2 Discussion of Study Findings

During the analysis of the data and the subsequent writing up process, I had begun to consider the study findings in relation to psychological theories. As a practicing clinician, I came to the research process with a number of sensitising concepts so I could not help but notice the theoretical possibilities evident to me within the data. The first of these was attachment theory (Bowlby, 1969) which explores the emotional bond between the child and significant primary carers. A number of attachment related studies have investigated the role of early attachments on later adult functioning (Dozier, Stovall-McClough, & Albus, 2008; Bifulco & Thomas, 2012). These findings have relevance to maternal filicide as they indicate the importance of early childhood experiences for mothers and are also relevant to considering the relationships between mothers and their victims. The second sensitising concept was the social construction of gender and motherhood (Ussher, 1991). These theories are useful in providing a context to interpreting the findings of this study. Within the following section I aim to discuss the study findings and to consider them alongside existing theories and research about maternal filicide.

In concluding this chapter, I will discuss the implications, limitations and recommendations of the study. I will make use of Charmaz's (2006, p. 182) criteria for evaluating the quality of grounded theory studies; *Credibility*, *Originality*, *Resonance* and *Usefulness*. The final section of this chapter provides an account of my reflections about the process of investigating the topic of maternal filicide (Frost, 2011).

**4.2.1 The influence of socioeconomic factors on violence.** A number of studies and theorists have provided evidence that socioeconomic factors are widely implicated in violence generally, for both men and women, parents and non-parents and so the relevance of economic adversity for incidences of violence has already been well established (Loftin & Parker, 1985; as cited by Smithey, 1997). However, poverty has also been found to have a direct impact upon rates of child homicide and salient to the focus of the present study, has also been found to be related to filicide, including maternal filicide (Smithey, 1997). Alder and Baker (1997) claim that the links between socioeconomic deprivation and violence for women are complicated as the significance of socioeconomic difficulties is on the subsequent limit of availability of choices and opportunities for dealing with a range of problems. Alder and Baker cite the work of Carlen (1988) who reported that:

*‘...women’s stories reveal the reality of the everyday life of poverty, the feeling of powerlessness, the boredom, the futility and the dependence’ (p. 20).*

The quotation is relevant when considering the findings produced in this study and they suggest that they have specific psychological correlates.

**4.2.2 Social and economic adversity in the lives of filicide mothers.** Filicide mothers in this study were actively engaged in performing the majority of domestic and childcare tasks (*Being Left Holding The Baby*). The mothers perceived the fathers of their children as not making adequate contributions (if any) to domestic and childcare tasks. In studies of the division of childcare responsibilities in families, mothers have generally been found to invest a disproportionately high level of care and to engage in a greater number of domestic labour tasks when compared to fathers

(Kimmel, 2008). Therefore mothers in this study could be said to be no different from other mothers in the general population. However, once fathers had left the family home, mothers considered their practical and financial contributions as inadequate. The contact fathers had with their children and the lack of provision of practical and economic support became sources of uncertainty and insecurity for mothers. Importantly, the uncertainties and deficits in financial contributions from fathers had specific and adverse impacts on the activities and capacities of mothers to provide for their children. These deficits also impacted on mothers' abilities to access necessary housing and financial support.

For mothers in this study socioeconomic adversity presents a source of stress that contributes to the development of filicide. This formulation is consistent with the maternal filicide theoretical framework (Mugavin, 2005) that suggests that it is necessary to broaden the explanations of filicide from the narrow psychopathologic to include the multitude of psychosocial factors. Mugavin's theoretical framework suggests that for filicide mothers' economic deprivation and lack of interpersonal support contribute to filicidal acts. Mugavin suggests that:

*'...severe psychosocial stressors often plague women who commit filicide. The include financial and housing problems; domestic abuse; deteriorating mental health, limited social support; conflict with family members and sexual partners; and serving as primary care-giver for at least one child.'* (Mugavin, 2005; p.70)

Accounts from mothers in this study, are consistent with the framework proposed by Mugavin and consistent with studies that financial hardship, housing difficulties and social isolation were features in the lives of filicide mothers, in both clinical and non-clinical populations (d'Orban, 1979; Smithey, 1997; Meszaros & Fischer-Danzinger,

2000; Lewis & Bunce, 2003; Mugavin, 2005). However, the present study provides important indepth details of the processes of care which mothers were engaged in and which elaborate on existing knowledge.

Taken at face value, filicide committed in a context of inadequate resources in the environment is consistent with evolutionary theory. Stressed female carers of offspring in both non-human and human species have been found to adapt to threat by the use of infanticide (Hrdy, 1999). However, it is also clear that mothers were engaged in activities of care towards their children, until such time as they became depressed and suicidal. It is also important to consider that not all mothers kill their offspring in the context of socioeconomic adversity. It is therefore necessary for any theorising about maternal filicide to move beyond such a broad view and begin to establish a greater level of detail about the psychological and cultural factors that contribute to the development of maternal filicide.

Mothers in this study are conceptualised as concerned and preoccupied with managing a number of competing demands within their role as main care-giver and provider to their family. The grounded theorising did not produce accounts or processes of maternal neglect of children. Conversely, the co-produced account from this study shows that mothers were significantly engaged in a range of activities which included securing housing and financial support for the family, alongside the everyday activities of childcare. These findings are consistent with other studies of filicide mothers with a diagnosis of mental illness:

*...before the homicidal act quite unexpectedly occurred, most of these mothers were reported to have been "perfect mothers" who took good, even meticulous*

*care of their children, were well controlled and restrained in their relations with others. (Haapasalo & Petäjä, 1999; p. 233)(p. 233)*

Haapasalo and Petäjä concluded that many of the mothers in their study had tried to excel at motherhood and may have tried to suppress any negative feelings and impulses towards their children. However, according to Haapasalo and Petäjä when mothers experienced increased stress in their lives then they may have been more vulnerable to a 'psychotic breakdown' and depression.

**4.2.3 Women as society's unpaid and undervalued carers.** At the same time as being primary providers of care to their children, mothers were also concerned about the needs of other members of their family and were engaged in providing care for them as well. The 2011 consensus showed that unpaid caring activities rose between 2001-2011 and that the burden of care had fallen disproportionately upon women (ONS; Families and Households, 2014 ). Being an unpaid carer (either as a mother or providing support to wider family members) is likely to make a woman more vulnerable to poverty and experiences of being economically disadvantaged have negative implications for mental health. The DOH document '*Into The Mainstream: Strategic Development of Mental Health Care for Women*' (DOH, 2002) suggests that there is also a low societal status and value placed upon women's roles in the family and in the workforce. It is contended that the low societal status could have negative implications for mothers' sense of self-worth. The document raises concerns about the negative impact of the burden of care and the low status of that role for women in terms of their mental health and well-being, noting that poverty is also associated with mental ill-health. It is conceptualised within this study, that mothers were more vulnerable to higher levels of poverty. As such it is likely that

mothers were experienced greater levels of tension and stress from having a number of competing and often unsupported roles and responsibilities.

**4.2.4 Single motherhood and socioeconomic difficulties.** A significant part of the mothers' socioeconomic difficulties appeared to be related to their status as single mothers. Women account for approximately 91% of lone parent households with dependent children in the UK. The number of single parent households has tripled over the last 40 years, representing 25% of all families (ONS; Families and Households, 2014). Single mothers have generally been found to be poorer than both married and childfree women and this is thought to be partly due to lack of employment for women. Only 39% of mothers with children under the age of 3 years old in the UK are in any form of employment, and women are more often in lower paid and part-time work compared to men (ONS; Families and Households 2014).

Socioeconomic adversity results in two major influences for those experiencing it; firstly resulting in higher rates of violence generally and secondly resulting in an adverse effect on mental health and wellbeing. Alder and Baker (1997) also raise the possibility that adverse social status and living in adverse contexts could have specific psychological consequences for a woman's sense of self, her worth, the future and her relationship with others. It is Alder and Baker's contention that the psychological consequences are relevant to female violence.

**4.2.5 Domestic abuse and relationship difficulties.** In addition to the impact of socioeconomic factors impacting on mothers and co-constructed as contributing to the development of maternal filicide in this study was the presence of domestic abuse. Experiences of domestic abuse for filicide mothers have been

reported in a number of studies (d'Orban, 1979; Lewis, et al., 1991; Crimmins, et al., 1997; Mugavin, 2005; McKee & Egan, 2013). Experiences of abuse, both in childhood and particularly for women, in adulthood have been found to be risk factors for violence for mothers with a history of mental illness (de Vogel, et al., 2012) and were therefore present for mothers in this study.

The loss of an intimate relationship or the presence of abusive partners as conceptualised within this study represented a specific type of insecurity for mothers and contributed to a process of *Disintegrating Security* for them. Mugavin (2005) argues that the presence of multiple-stressors act to predispose mothers to acts of violence:

*“A multitude of psychosocial factors predispose a mother to acts of violence...in general, the biological fathers of the children are abusive and antagonistic, providing minimal economic support. As a result, many of the mothers are left to “garner their own resources for survival whilst simultaneously raising children” (Mugavin, 2008; p.69).*

Relationships with others have been postulated as having an important and very particular influence on women's sense of identity (Baker Miller, 1991). In addition relational connectedness to others has previously been defined as important for women's general psychological wellbeing (Gilligan, 1982). Baker-Miller argues that women are sensitive to losses and changes in social relations and have a greater need to feel emotionally connected to others, than men. Therefore, the difficulties in relationships, including abuse, the experience of relationship conflict are conceptualised in this study as sources of psychological stress for mothers.

**4.2.6 The social construction of motherhood: The dark side.** A number of authors have considered the social construction of motherhood to be a significant aspect of filicide (Morris & Wilczynski, 1993; Alder & Baker, 1997). Morris and Wilczynski (1993) suggest that there is a *'myth of motherhood'* and identify societal expectations of what being a woman or a mother should be like. The authors suggest that there is an expectations on women:

*...to want to have children; to love them immediately, dearly and always; to put their interests first at all times; to enjoy every aspect of childcare and domestic responsibilities; and to be ever smiling, ever cheerful, all perfect.* (p199)

In the conceptual category of *Being Left Holding the Baby* mothers were conceptualised as working to provide for their children and trying to put their children's interests ahead of their own. However, in the context of severe social and economic adversity any idealised notion of motherhood would have been difficult to achieve. Alder and Polk (2001) consider these idealised stereotypes of woman and mothers alongside an alternative construction which they term the *'dark side of motherhood'* in which the burden of responsibility for child-rearing falls disproportionately upon mothers. This viewpoint is relevant to the assertion made by Morris and Wilczynski, (1993) that mothers:

*...learn that the reality is nothing like (the stereotypical representation). They (mothers) are quite unprepared for the hard, selfless, exhausting and isolating work involved in looking after a child'. (p. 209; brackets mine)*

In Mugavin's (2005) maternal filicide theoretical framework one of the triggers to maternal filicide is *'good mother stress'*. Good mother stress is related to the pressure of trying to be a good mother, although lacking sufficient validation for the role. Mugavin, also considers that filicide mothers experience feelings of social



devaluation in their role and are lacking in an appropriate maternal role model due to the failures of their own mothers. Mugavin, like Alder and Polk (2001) considers that motherhood is often central to the way that many women define themselves and also to how they are perceived by others. The authors suggest that some mothers idealise motherhood as the ultimate physical and emotional achievement of their lives. Drawing on the work of Smithey (1997) Mugavin (2005) contends that for women who assume the role of a mothers they may find that fulfilling it in the prescribed way is an extremely difficult undertaking.

Related to any cultural idealization of motherhood is an alternative perspective in which motherhood is based on a naturally occurring maternal instinct in all women (Motz, 2009). In her book *From Here to Maternity*, Oakley (1981) argues that an assumption about natural motherhood is in reality a myth. Within such a construction the capacity of a mother is assumed to be innate and women who struggle in their relationship with their child or with more complicated feelings about motherhood, would be considered as deviating from the norm. If the concept of what it is to be feminine is also predicated upon women's ability to both become a mother and succeed in the role then it is self-evident that problems in this role will have wide-reaching implications for mothers evaluation of themselves. When women fail to live up to maternal stereotypes, questions are raised about their 'true' femininity (Oakley, 1981; Smithey, 1997). Failures to live up to stereotypes, or to have widely dissonant reactions and responses to motherhood than those valued in society could be sources of isolation and stress to mothers and potentially have implications for the psychological well-being of mothers in this study.

In addition to the social constructions of women that idealise mothers, the representation of children has also been criticised as being unrealistic and idealistic. Morris and Wilczynski cite Ann Oakley (1981), who argues that within the myth of motherhood children are represented as ‘...wonderful repositories of nothing but joy for those who bear them’ (p. 209). It is apparent from the co-constructions from this study that the reality of the experience of mothering is very different from the culturally produced stereotype. The co-construction produced in this study conceptualises the role of mother as a demanding one and as occurring in the context of socioeconomic adversity and inadequate support. Mothers’ perceptions of failing in their role as mothers may have particular psychological significance for them.

**4.2.7 Mental health factors in filicide.** The conceptual category of *Developing a Siege Mentality* was developed from the conceptualisation of mothers’ experiences, of *Fearing*, *Hearing/Seeing Things*, *Feeling Suspicious of Others* and *Doubting Perceptions*. A number of the experiences described by mothers in this study can be understood within a psychiatric classification system. All of the mothers in this study had been diagnosed as suffering from a mental illness at the time that they committed filicide. However, as a clinical psychologist trained in psychiatric systems it was important to me, and to the integrity of the analytical process not to unwittingly reproduce untested and unexamined assumptions (Charmaz, 2006). Instead it was imperative to keep an open mind in theory building from the actions and processes in the data. Because of my theoretical sensitivity to psychiatric terms and their meaning I had to make a conscious effort to eschew the use of psychiatric diagnoses as a means to define and categorise study participants’ experiences. However, the fact that all of the mothers in the study had been diagnosed as having a

mental illness at the time of the filicide, and were receiving psychiatric treatment suggests that they were mentally ill at the time of the offence. This is consistent with Mugavin's maternal filicide theoretical framework (2008) that identifies a vulnerability to mental illness as a factor related to maternal filicide.

**4.2.8 Experiences of terror, vulnerability and the presence of delusional thought processes.** The accounts given by mothers in the present study are similar to a description of filicide mothers by Mugavin (2005) who describes the '*profound delusional anxiety*' involving '*perceptions of imminent, cataclysmic danger*' (p. 69) that characterised the mental state of '*mentally ill, psychotic mothers*' who kill their children. In her theoretical model of maternal filicide, Mugavin (2008) suggests that a trigger for filicide mothers is a sense of desperation. Consistent with Mugavin's description of the mental state of mothers at the time of filicide is Kunst's (2002) view that the filicidal act of a mother is;

*...not provoked by feelings of hatred or contempt for their (sic) own children, but is the result of preoccupation with their own vulnerability and terror'. (p. 69)*

The description of terror and vulnerability suggested by Kunst is consistent with the re-constructed accounts within the present study where mothers are theorised as experiencing *Disintegrating Security* in their perceptions of the world around them. Mothers did not describe relationships with others as providing support, nurturance and comfort, but instead as interactions that appeared to pose the threat of risk of harm. The co-constructed account of the mothers' experiences presents mothers as in an extreme state of fearfulness, and terror. Under these psychological conditions, mothers' capacity for organization, problem-solving, and making decisions is likely to have been adversely affected. Bad social conditions, poor relationships, threat and

shame have been found to compound the experience of underlying mental health conditions, hindering effective problem-solving and the capacity to see other solutions (McMurran, Egan, Richardson, & Ahmadi, 1999; as cited in Mckee & Egan 2013, p7). These psychological difficulties are likely to have contributed to mothers withdrawing from their social relationships and compounded their difficulties identifying solutions to their life problems. This is consistent with the conclusions drawn by Alder and Baker (1997) who suggest that the filicide-suicide mothers in their study had been attempting to deal with their problems themselves, believing that they did not have anyone else to turn to;

*The overwhelming image that emerges across the cases is of women who feel pushed up against a wall, who perceive they have few other options, that is they are acting from a position of relative powerlessness' (1997; p36).*

This quotation exemplifies the context within which maternal filicide is co-constructed as occurring in the present study and is consistent with what other authors have suggested characterises the lives of mothers who go on to kill their children.

**4.2.9 Social withdrawal.** The rendered accounts of mothers in this study also demonstrate a degree of withdrawal from the social world and detail the increasing isolation of mothers. The lack of available social support has been found to be associated with maternal experiences of depression (Brown & Harris, 1979), and this may be relevant to contextualising the development of maternal filicide. Social isolation is associated with mental ill health, and women are considered to be more vulnerable to social isolation than men (Gilligan, 1982) due to lone parenthood, reduced mobility as a result of greater dependence on public transport and fear of going out alone at night (DOH; Women's Mental Health: Into the Mainstream.

Strategic development of mental health care for women. 2002). These issues are relevant to understanding the development of maternal filicide for mothers in this study.

**4.2.10 Mothers' fears of being separated from their children.** Mothers in this study were conceptualised as experiencing profound feelings of fear and insecurity. Within the context of a number of adverse socioeconomic stressors, experiencing victimisation from abuse and loss of the relationships with the father of their children, the emotional and psychological states of mothers are salient in understanding the development of maternal filicide. The accounts rendered from the analysis of the data indicated that mothers felt extremely fearful in their day-to-day lives. Whilst fearfulness was experienced as a general, pervading feeling the experience was also co-constructed as concerning fears of potential harm to their children and/or fears that their child would be taken away from them by social services or family members. Mothers were conceptualised as *Developing a Siege Mentality*, where the wider social world was defended against and where increasingly the mother and her child lived together, but separate from others.

The conceptualisation of the accounts of mothers in the study was that fearfulness began to coalesce around having their children taken away from them. It may be for that for filicide mothers there is a particular sensitivity to separation from loved ones that extends beyond relationships to children. In Mugavin's (2008) theoretical model of maternal filicide the early experiences of mothers are posited as vulnerability factors. The vulnerability occurs as a result of both a history of exposure to abuse and also from inadequate maternal role development. The literature

related to filicide contends that the relationship of filicide mothers to their own mother is significantly linked to their capacity to assume the maternal role as adults. The study by Crimmins, et al. (1997) showed that mothers that they interviewed had all experienced '*various kinds of losses that were followed immediately by gross insensitivity to their emotional needs*' (p65). These early events and a lack of any social support are held by the study authors to have been traumas that acted in eroding the sense of self of the filicide mothers. Crimmins et al., suggest that the women in their study were 'motherless mothers' as their own mothers had been unavailable to them in childhood. Crimmins et al., suggest that from a self-psychological perspective:

*..the women's sense of self is too damaged for her to care about another human being. (p. 51)*

Mugavin (2008) considers that difficulties in attachment relationships with their own mothers, give rise to second-generation effects of unresolved loss or trauma with concomitant effects upon the capacity to cope with the maternal role. The theory of attachment provides a useful context for considering the grounded theorising proposed in this study: mothers were found to be experiencing *Disintegrating Security* in a number of the discussed domains.

**4.2.11 Insecurity and attachment theory.** The theory of attachment (Bowlby, 1969) may be relevant not only to understanding mothers' own capacity for parenting but also to understanding their anxiety about being separated from their children. Attachment is theorised as a basic innate need, required for optimal development of the child (Ainsworth, 1978). Attachment theory posits that for some mothers separation from their children would be associated with extremely

high levels of anxiety. A particular style of attachment has been variously labelled as ‘enmeshed’ or ‘preoccupied’ (Ainsworth, 1978), which is characterised by overcloseness and much anxiety and distress in response to separation (Rothbaum, Rosen, Ujiie, & Uchida, 2002). The issue of over-closeness and attachment anxiety in filicide mothers has been suggested by McKee and Egan (2013) who considered that in cases of filicide-suicide there was likely an enmeshed mother-child relationship.

Related to attachment styles of filicide mothers is the suggestion by Porter and Gavin (2010) that in cases of infanticide there is an unwillingness on the part of the mother to see the victim as an autonomous and independent individual with their own rights and identity. This theoretical conceptualisation is consistent with psychoanalytic theories (Welldon, 1992; Pines, 1993; Motz, 2009). The suggestion by these authors is that in filicide mother-child enmeshment results from the insecure attachment style of the mother. Attachment theory provides a useful context for considering the grounded theorising proposed in this study; that mothers are experiencing *Disintegrating Security* in a number of domains and this includes relationships with their children.

**4.2.12 Suspiciousness and contact with services.** Concerns from mothers that they were not coping with the demands of providing for their children potentially occurred alongside insights that they were struggling to cope with life events and parenting responsibilities. This sense of not coping may have been a realistic appraisal of their parenting capacity given their feelings of profound fearfulness and suspiciousness about others. These concerns may have negatively influenced mothers’ decisions about whether to seek help or not.

There is a public perception that social services have become more instrumental in the lives of families and official statistics suggest that there has been a 12% increase in the number of children that have been placed into local authority care since 2009 (Harker & Heath, 2013). Therefore, filicide mothers in this study may have been well placed in judging that child protection services would prioritise the child's perceived safety over the mothers' wellbeing. Understandably given the vulnerability of infants and children, services should consider removing the child if the mother's capacity to care for them was in question and where there is a concern about risk of harm. Two risk factors for female violence generally have been found to be problematic relationships with children and difficulties in the parenting role (de Vogel, et al., 2012) so it is conceivable that filicide mothers were experiencing difficulties in their role. However, asking for support may be particularly difficult for mothers with limited economic and social resources at their disposal. In their social analysis of maternal filicide Alder and Baker (1997) acknowledge that those with limited resources would be likely to seek out social welfare agencies to support them. However, they go on to suggest that in doing so mothers would be asking for support from the exact same agencies with the power to invoke 'coercive responses' (p21), making it unlikely that such mothers would seek necessary help. This tension in the relationship between mothers and child protection services, is conceptualised within this study as contributing to mothers' experiences of *Disintegrating Security*.

**4.2.13 Suicide as a motivation for filicide.** All mothers in this study contemplated suicide and had concomitantly considered killing their children. The mothers all reported that they had harmed themselves after having killed their



children and had wanted to kill themselves prior to the filicide. This finding is consistent with a well-established body of work that has established a relationship between maternal filicide and suicide (Bourget & Bradford, 1990; Alder & Polk, 2001; Hatters Friedman, et al., 2005c).

Collins, et al's., (2001) review of the literature on filicide-suicide identified two primary motives for a parent to commit the act. In the first motive suicide follows where accidental, and unintended death has occurred as a result of child abuse or following a primary filicide attempt. The parent may then commit suicide in the aftermath of their actions, filled with despair and remorse. The second motive where the killing of the child and the parent's subsequent suicide are premeditated are often called '*mercy killings*' in reference to the perpetrators intention to relieve the current or future suffering of their offspring as they see it. The concept of mercy killings is also identified as a trigger in Mugavin's (2008) theoretical framework of maternal filicide; the parent's perception of the need to kill the child is an important cognitive component of decisions to commit filicide. The conceptualised account produced in this study is consistent with the second motive as posited by Collins et al., and is consistent with a '*mercy killing*' or altruistic type of filicide. The typology of *extended suicide* advanced by Bourget and Bradford (1990) is relevant to the conceptualisation in this study and consistent with the filicide-suicide motive delineated by Collins, et al., (2001). In such filicide-suicide cases, parents have been found to feel depressed and hopeless and to see suicide as their only option. Under such conditions the parent is thought to worry about the impact of their suicide upon their surviving child(ren).

Mugavin's maternal filicide theoretical framework (2008) identifies a trigger to filicide as the degree of desperation of the mother. Mugavin describes a loss of hope and a surrender to despair as significant psychological processes that precipitate the filicide. A number of studies of maternal filicide have identified the presence of depression as a significant risk factor for mothers who kill their children (Resnick, 1969; Haapasalo & Petäjä, 1999; Lewis & Bunce, 2003; Hatters Friedman, et al., 2005a; Flynn, et al., 2013). The present study's conceptualisation of mothers' hopelessness and suicidality is consistent with existing research, but adds to the knowledge base by providing more in-depth understanding of 'taken for granted meanings' (Charmaz, 2006).

**4.2.14 The Concepts of Saving and Uniting.** The conceptualised account produced from the analyses of data in this study, are consistent with existing literature on maternal filicide. Mothers are conceptualised as having killed their children either to save them from being motherless and/or to protect them from perceived harm. Mothers' decisions to commit filicide were modulated by simultaneous beliefs about both *Saving* and *Uniting* with their child. The process of *Saving* was posited in the theorising about maternal filicide as conceptually related to two areas of concern for mothers; firstly, that separation following parental suicide would effectively be an unacceptable abandonment of the child; and secondly, that killing the child was a way of ensuring that the child was safe from perceived harm. It is likely that some of these negative beliefs about the world were related to mental illness factors, particularly depression and the presence of psychoses.

The co-constructed accounts of the development of maternal filicide included the mothers' beliefs that the child was in imminent danger. Some of those beliefs did not appear to be related to reality and could therefore be an artefact of having a mental illness, particularly psychosis. For example Louisa claimed that she suffocated her child, as she believed that the child was going to be '*cut open, and slowly killed*' and so the filicide also represented a '*mercy killing*' in that it was commissioned to avoid a feared outcome. However, this filicide was motivated more as a result of fear that the child was in imminent danger, than fears about the child's well-being after the planned suicide of the mother. This account of the development of maternal filicide is consistent with other research that has commented on the beliefs that filicide mothers have reported in explaining their motivations for the act. In a content analysis of 21 maternal filicide cases McKee and Egan (2013) found that mothers had shown clear evidence of holding delusional beliefs in which they believed that their child had to die. The reported beliefs included that the child was possessed by a devil. Likewise Haapasalo and Petäjä (1999) reported a psychotic belief of one of the mothers in their study, that the victim was a '*changeling*'.

**4.2.15 Uniting: a means of mothers' avoiding separation from their children?** Mothers in the study are conceptualised as believing that separation from their child could be avoided through a process of uniting that they envisaged would follow death. The concept of *Uniting* with children (following filicide-suicide) is conceptualised as a means of *Resolving* for mothers the issue of the separation from their children. The belief of mothers in the concept of *Uniting* is consistent with a case quoted by Adler & Baker (1997) of a mother who survived her attempt at suicide:

*I didn't consider what I was doing was wrong. I just felt I was **uniting** a family that had suffered a lot...I just felt that I have been driven to an absolutely agonising point where I just couldn't see my way out. (p. 27; emphasis mine)*

**4.2.16 Emotional detachment and the influence of auto-pilot.** McKee and Egan (2013) identified a process of emotional detachment of the mother from their child and postulated that this process facilitated filicide. They further contended that in mothers with delusions, the child becomes incorporated into the mother's abnormal belief system potentiating an emotional detachment from the child. In this study, a process of *Auto-Pilot* was identified as relevant to this phase in the development of maternal filicide. Mothers are co-constructed in the study as feeling disassociated from their feelings. Phenomena such as disassociation and depersonalisation have been theorised as occurring when an individual is in an extreme emotional state (Herman, 1992) and this would be relevant to the process of maternal filicide produced in this study. In the process of *Auto-Pilot* mothers are conceptualised as experiencing a sense of calmness and detachment both from their sense of themselves and from their emotions. *Auto-pilot* may be a necessary precondition or state in the commission of maternal filicide. In order that a loving, previously very engaged mother kills her child a process of disengagement or detachment may be necessary.

**4.2.17 Transitioning into motherhood.** The process of transitioning into motherhood was the least developed of the categories produced in the grounded theory analysis of the data and was not elaborated beyond the form of a focused code. This code was induced from a limited data set and therefore caution must be used in considering the importance of this process. For that reason only very limited claims can be made about its place in the process of the development of maternal filicide.

However, the focused code is suggested as a potential distal factor in the development of maternal filicide and worthy of further investigation.

Previous research suggests that post-natal depression has been found to be associated with mothers who have committed filicide (Spinelli, 2004). Pregnancy and childbirth are regarded as a time of significant biological, social and psychological adjustment, related to an increased risk of psychiatric disorder (Spinelli, 2004). Changes in the mothers' identity at the time of the birth of their child have also been noted previously for mothers. Pines (1993) considers that the birth of a child can be a crisis point for mothers in their search for an identity the beginning of '*an unalterable (sic) and irrevocable mother-child relationship*' (p. 60). The degree to which this process of transition into motherhood is related to the development of filicide will need further investigation.

#### **4.3 Mothers Who Kill Their Children; Mad, Bad or Sad?**

The present grounded theorising offers both psychological and socially derived concepts as salient to understanding the development of filicide. The central process of *Disintegrating Security* is posited as providing the what of a grounded theorising account of maternal filicide and also goes some way to exploring the why and how. The grounded theorising has established that mothers acted with a degree of agentive power in *Resolving* the difficulties in their situation as they saw them. This conceptualisation of maternal filicide is inconsistent with how in the past female violence has typically been constructed, where perpetrators of filicide have been viewed as either pathological (mad), victims (sad) or deviant (bad) (Ussher, 2006). Such conceptualisations of mothers who have killed their children tend to posit that

mothers' were devoid of agency and committed filicide as a result of circumstance or aberration (Africa, 2010). Directly opposing this view is the grounded theorising produced in this study, which is conceptualised as broadly consistent with the assertion of Morris and Wilczynski (1993) that there are:

*...direct connections between the social circumstances of many mothers, society's expectations of mothers, and maternal child-killing. In many ways, mothers who kill their children can be seen to be responding rationally – an understandable response to particular sets of situations. (p. 200)*

However, whilst there appears to be a degree of 'logic' in the reasoning deployed by mothers in killing their children, it is necessary to advance the theorising about the development of maternal filicide beyond the argument that it occurs as a result of social and cultural determinants. This study has identified processes that contribute to the development of maternal filicide, but which exclude notions of 'madness, sadness and badness' as adequate explanatory concepts. Instead the present study renders mothers as having been active in *Resolving Disintegrating Security*. Therefore, an arguable degree of agency by mothers is assumed within the grounded theorising in this study.

#### **4.4 What this Study Adds to the Current Understanding of Maternal Filicide by Mothers with a Diagnosis of Mental Illness**

**4.4.1 The development of filicide.** This study proposes substantive theorising about the processes relevant to the development of maternal filicide from the perspective of mothers with a diagnosis of mental illness. Resnick (1969) suggested that filicide mothers with a diagnosis of mental illness have been acting without any discernible motive. The present study's account of the development of

filicide has produced a conceptualisation of filicide mothers' as acting with 'rationality-within-irrationality' (Stanton, et al., 2000; p1459). The act of filicide is conceptualised as a rational action based on the beliefs of mothers at a particular time. This is not to suggest that there is an excuse for the filicide but that the study has been able to elucidate the reasoning of mothers.

**4.4.2 The influence of mental illness factors.** The findings from the present study accept the material reality of mental illness as a construct, although not uncritically. The findings have added to existing knowledge about filicide by mothers with a diagnosis of mental illness. A conceptualised account of mothers' experiences has been proposed as understandable within a psychiatric framework of mental illness. However, this study has additionally provided a detailed account of the processes co-constructed from the analyses of the data that provide more description about the phenomenological experiences of filicide mothers.

**4.4.3 The impact of depression, hopelessness and suicidal intentions of mothers in the development of filicide.** One of the most important findings produced in this study is the critical importance of the psychological processes of hopelessness, depression and suicidal intentions in mothers who committed filicide. The grounded theorising has elucidated the process of depression and hopelessness that appear to be the psychological response to a number of social, economic, and relational stressors that acted to overwhelm the mothers in this study. It is these key processes that have been identified as contributing to the decision-making processes of mothers for both suicide and filicide. Consistent with the findings of Stanton et al.,

(2000) the present study findings suggest that there is a process of thinking about and planning the filicide.

#### **4.4.4 Positive relationships with children as a potential risk factor.**

Previous studies have found important distinctions between mothers with a mental illness and those mothers that kill their children through fatal maltreatment or prolonged abuse and who do not have a mental illness. This study adds to existing knowledge that suggests that filicide mothers with a diagnosis of mental illness are conceptualised as active in their role as mothers, displaying caring behaviours towards their children. Paradoxically, the importance of the caring role could increase the risk of filicide through increases in maternal stress. Traditionally, theorists have thought that a protective factor against the risk of violence for women (and to certain extent men) has been the presence of a positive relationship with their children (Kreager, Matsueda, & Erosheva, 2010). Therefore, the findings of the present study are important for clinicians who need to assess for risk of harm to children to be aware of. Whilst no direct causal associations have been established, one interpretation of the filicides in this study is that it was mothers' emotional attachment to their offspring that increased the risk that the child would be a victim.

### **4.5 Implications and Recommendations**

**4.5.1 Raising public awareness.** One of most important implications of the present study is that it has the potential to increase the public understanding of an act which has understandably been described as '*...perhaps one of the most emotive and tragic acts in the human behavioural repertoire*' (p781; Hatters Friedman, et al., 2012). The killing of children by their parents has previously, and with legitimacy,



been considered a heinous act. Children are dependent upon their parents for nurturance and protection and their vulnerability and dependence make them defenceless against threat and aggression. Therefore, parents who have killed their children have previously been thought of with understandable horror and revulsion.

An account has been produced in this study which theorises that mothers with a diagnosis of mental illness were highly engaged in the care and provision of their children. Mothers in this study are therefore conceptualised as distinct from those mothers who engage in fatal maltreatment and prolonged child abuse and who have been previously found to engage in neglecting and abusive behaviours. Therefore, dissemination of the present study findings could be useful in helping to reduce stigmatisation for filicide mothers by making visible the contexts, conditions and processes they experience.

#### **4.5.2 Enhancing knowledge and understanding of mental health staff.**

Another implication of the present study is that clinicians charged with the care and psychological rehabilitation of filicide perpetrators can make use of the grounded theorising developed in this study as a theoretical lens with which to view the act. The study makes explicit a number of social, economic, relational and psychological factors that are conceptualised as contributing to maternal filicide for mothers who participated in this study. The study provides a conceptualisation of filicide that emphasises the mothers' care for their children and the contributing effects of hopelessness, depression and suicidality in the development of filicide.

Mental health staff are often emotionally challenged when working with such emotionally distressing cases as filicide. Increased empathy for mothers and enhanced understanding of them could benefit the potential for successful therapeutic outcomes. In addition an increased awareness and understanding about the development of maternal filicide has the potential to reduce emotional burnout for staff members: therefore, presentations of the research to clinical staff will ensure that they are informed of the findings.

**4.5.3 Supporting families of filicide victims and perpetrators.** The grounded theorising of the development of maternal filicide produced in this study may also be useful to family members of perpetrating mothers who feel traumatised in the aftermath of the filicide act. Immediate and wider family members, including the victim's siblings, and father are all indirect victims of filicide. Filicide mothers often have surviving children who will also have been traumatically affected by the event. One implication of the findings is that they provide an opportunity for indirect victims to have a means of making sense of the act. Making sense of life experience is a critical function in human experience and has been associated with reduced psychological distress for those affected by trauma (De Zulueta, 2006). If disseminated to those who work with families of filicide perpetrators the findings from this study could contribute to reducing the risk of traumatic sequelae.

**4.5.4 Enhancing therapeutic support for perpetrators.** Increased understanding of the contexts and conditions within which filicide occurs and the psychological processes that contribute to the occurrence of filicide could provide important self-understanding for perpetrators. Risk of suicide has been found to be a

real issue affecting over 17% of surviving mothers in an eight year period following filicide (NCI data as cited by Flynn, et al., 2009b). Therapeutic approaches that provide an alternative perspective to that adopted in the popular media could have an impact on reducing the risk of psychological trauma and suicide in the lives of surviving filicide-suicide mothers. Filicide mothers often have other children (Lewis & Bunce, 2003) and so the ramifications of an improvement in their mental health of filicide mothers can be seen as related to their potential influence on their surviving children.

**4.5.5 Detection of filicide-suicide risk.** All of the mothers in the present study described suicidal feelings prior to committing filicide. The grounded theorising of *Resolving Disintegrating Security* suggests that the presence of social, economic, relational and psychological factors, including hopelessness and depression are relevant to the development of maternal filicide. Maternal filicide is such a rare event that the difficulties of prediction are immense.

The present study however, found that filicide mothers engaged in a degree of planning in the context of an extremely low mood, sense of hopelessness and suicidality. Although none of the mothers in this study reported any contact with mental health professionals, the findings suggest that there may be a small window of opportunity to detect at-risk mothers. Hatters Friedman et al., (2005c) in their study of filicide-suicide parents recommend that those who are depressed and suicidal should be directly questioned about their thoughts regarding the fate of their child in the event of parental suicide. The identification of at-risk mothers is not without its

problems, as filicide mothers in this study appeared suspicious and fearful of others and preoccupied with fears of being separated from their children.

The grounded theorising produced in this study provides confirmation that filicide mothers suffering from mental illness would likely present very differently than professionals may expect. Popular beliefs about children at risk of filicide tend to be influenced by the more common and publicised child abuse/fatal maltreatment types of filicide. However, the usual indicators of child neglect or mistreatment such as low weight, social withdrawal or signs of bruising and fearfulness (Reder, Duncan, & Lucey, 2003) could be absent in children of filicide mothers with mental illness. Instead, in order to increase the opportunities to detect at risk mothers, professionals could focus their assessments on the degree of hopelessness, depression and suicidality in mothers. In addition the study findings could be useful to clinicians and other professionals in highlighting that heightened concerns and irrational fears expressed by mothers should be further assessed. Increasing clinician's knowledge that mothers' fears about potential separation from their children would not necessarily exclude the risk of filicide could be helpful to clinicians responsible for assessing mothers with mental health problems. In addition clinicians need to be aware that the presence of multiple stressors, relationship losses and the fear of separation from their child would also be indications that a closer assessment of risk of filicide would be warranted. The grounded theorising advanced in this study suggests that those involved with mothers and their families should not rely exclusively on signs of positive attachment and parenting abilities as evidence of protective factors against risk of harm. Instead a recommendation of the present study is that professionals could use the findings as a means to understand that

positive attachment and high levels of care towards children do not act to exclude the risk of filicide.

#### **4.6 Limitations of the Study**

*'A theorist attempts to convince readers that certain conclusions flow from a set of premises'* (Markovsky, 2004 as quoted by Charmaz, 2006, p. 128). I have aimed to present the conclusions arising from the grounded theorising of maternal filicide so as to convince the reader that they are consistent with the data. However, within any research inquiry there will be both strengths and limitations of the study in achieving its research aims. The presence of limitations does not decrease the value of the study, but it is necessary to provide a summary of the limitations to aid the reader in evaluating the merits and value of the study overall.

**4.6.1 Methodological limitations.** One limitation of this study is the small sample size. Accessing a difficult to reach and very small population in such a sensitive study meant that the size of the sample was always going to be small. I therefore turned to the literature for guidance about the implications of undertaking qualitative research with small populations. I found that there were no clear and unequivocal guidelines about sample size and instead there were contrasting perspectives on what constitutes adequacy within qualitative research generally and within GT specifically (Morse, 1995; Mason, 2010; O'Reilly & Parker, 2012). On the one hand it has been pointed out that sample size is less important than the depth and quality of information obtained (Guest, Bunce, & Johnson, 2006; Mason, 2010). Further, that adequacy of sample size is also determined by the initial research questions and aims (Baker & Edwards, 2012), the heterogeneity of the sample

(O'Reilly & Parker, 2012), the budgets and resources available (Charmaz, 2006) and the demands of academic supervisors and institutions (Mason, 2010). Whilst on the other hand there have been assertions that the size of the sample is an essential prerequisite for judging quality in qualitative research (Morse, Barrett, Mayan, Olson, & Spiers, 2002) and that there are legitimate concerns about the quality of conceptual and theory development in studies with small sample sizes or data sources (Ritchie & Spencer, 2004).

The question of sample size has been a troubling issue in the literature of qualitative methods because of concerns about quality. O'Reilly and Parker (2012) have argued cogently that quality within qualitative research has been inappropriately evaluated through the 'unquestioned acceptance of the concept of saturation' (p190). They also point out that there have been no published guidelines or tests of adequacy for estimating the sample size required to reach saturation. Charmaz (2006) has made the same point and in addition argued that there have not been any guidelines for determining a priori estimates of the amount of data required in each category. Therefore, there is disagreement about what constitutes saturation and a lack of clarity about when it has been reached. However, it is also broadly accepted that many authors claim saturation without providing transparency in how this has been achieved (Morse, 1995; Bryman, 2008; O'Reilly & Parker, 2012). In that respect it is important to make modest claims in respect of study findings and to be transparent about the process. Transparency about not reaching saturation does not necessarily invalidate the study findings (O'Reilly & Parker, 2012). If saturation has not been reached then it only means that the phenomenon has not yet been fully explored rather

than that the findings are invalid (Morse, 1995; as cited by O'Reilly and Parker, 2012, p194).

In this study I make modest claims about theoretical saturation using the advice of (Morse, 1995); that small numbers in research populations should not pose problems for a grounded theorist; and that the GT researcher should be focused on developing conceptual categories and illuminating the properties of that category. The size of a study sample should not necessarily indicate that saturation has not been achieved, as categories can be saturated even with very small sample sizes (Charmaz, 2006). The grounded theorist is advised that it is not the quantity of data in any category, but the richness derived from detailed description that is theoretically important (Glaser, 1978; 1992).

Determining the actual sample size of any study is dependent upon the availability of research participants (Flick, 2008), the demands of review bodies and ethical committees who require the size of the sample to be identified prior to the start of the study (Mason, 2010) and the arbitrary point where the researcher decides that enough data has been collected. Irrespective of arguments about saturation, a greater number of participants or more interviews with the same participants may have added to the conceptual development and theoretical rendering of maternal filicide developed in this study. More interviews or data sources (subject to ethical approval) would have allowed for greater opportunity to follow up on promising directions suggested in the data, particularly in relation to the transition into motherhood. However, it is likely that clinical teams, the ethical committee and trust governance

boards may have rejected the study completely if the study design had included a second follow-up interview.

I have taken comfort from Strauss & Corbin (Morse, 1995) who reassuringly suggest that:

*Sometimes the researcher has no choice and must settle for a theoretical scheme that is less developed than desired. (p. 292)*

There are also a number of published qualitative studies using only four participants (Wellard, Rennie, & King, 2008; Sodi, et al., 2011; Crizzle & Newhouse, 2012) and at least one precedent of a GT study with four participants (Pal, 2012). The presence of these studies suggests that other authors have also had to manage the issue of small sample sizes.

#### **4.6.2 Limitations of the study design.**

*The role of clinical teams.* The role of clinical teams in selecting patients for admission to the study was an essential aspect of gaining ethical approval for such a sensitive study. It was also an essential element in the provision of safety for the vulnerable population used in this study. However, the way that services interpreted their roles as gatekeepers resulted in the exclusion of the majority of the population from participation in the study. Gummerson (2000) has written about how gatekeepers to organisations can effectively block access to potential study participants, and this was the case in this study. Services' perception of the study and fears about mothers being upset or distressed by the research resulted in the exclusion of two thirds of a very small national population.



*What mothers didn't say.* The study method relied upon self-reports from interviews. Absent from the accounts given by mothers were any descriptions of anger, frustration or violent urges. Kitzinger (1990) has described a number of potential barriers for study participants to give accurate accounts of their actual experiences. Firstly, Kitzinger describes the objections to relying on what people say about their experience, based on the consistent findings from a range of studies that show variance between self-report and objective measures. Secondly, Kitzinger describes specific limitations of qualitative research methodology in which '*facts*' can never be unequivocally identified from individual accounts. What mothers said about their experiences is at best only one account from a repertoire of many possible accounts and discourses and '*represents a culturally available way of packaging experience*' (p128). These points have relevance for why mothers may not have been able to put into words less socially acceptable aspects of their experiences.

**4.6.3 Limitations of the study findings.** Perhaps one of the major limitations of the present study is that it does not provide a grounded theorising account of maternal filicide which would successfully differentiate the experiences of *Disintegrating Security* in filicide mothers from non-filicide mothers (with or without a diagnosis of mental illness). However, this was not a specific aim of the study. The processes and conditions identified in this study and conceptualised as relevant to the development of maternal filicide, could be considered as applicable to many mothers who experience socioeconomic adversity, single parenthood, and feelings of depression and suicidality. However, what the study does do is provide a detailed account of the development and relationship of suicidal thoughts and intentions to kill the child. Such an account has not been produced before. No claims are made for the

generalisability of the study findings to other filicide mothers, but there is a claim that the knowledge derived from the grounded theorising in this study has credibility and worth in the field of maternal filicide.

#### **4.7 Recommendations for Future Research**

Research inquiry is urgently required to differentiate between those mothers who kill their children and those that don't. The findings from the present study suggest that further investigation of mothers' particular psychology would be a useful direction for future research. Recommendations for further research include;

- An investigation into the relationship between the mother and her victim.
- Interviews with family members may be a useful method of assessing the quality of the mother-child relationship
- Research that explores the early lives of filicide mothers from an attachment perspective could provide more information about the impact of early experience on filicide mothers.

#### **4.8 Meeting the Criteria for Quality in a Grounded Theory Study**

The findings of the present study need to be put in the context of a critical evaluation about the various merits, quality evaluation and limitations of the study. I have used Charmaz's (2004) criteria for evaluating quality of the study; *credibility*, *originality*, *resonance* and *usefulness*.

**4.8.1 Credibility.** Credibility is defined by Charmaz (2006) as how well the claims made in any study are supported by the evidence. The credibility of the study primarily relates to the extent to which the conceptualised concepts and categories

'fit' the data from which they were developed (2006). Consistent with the urgings of Guba and Lincoln (Glaser, 1998) I sought to be rigorous in all aspects of the study implementation and to produce results that under scrutiny would be evaluated as trustworthy. However, I have constructed the grounded theorising of *Resolving Disintegrating Security* according to my own subjectivity. The theorising is not advanced as fact, but as inextricably linked to my values (1985). The process of collecting and analysing data and conceptualising and constructing theory are a result of my interaction and interpretation of both the meanings the study participants tried to convey and my own interpretive lens.

**4.8.2 Originality.** The second criterion for evaluating the quality of a grounded theory study is in terms of its *originality* and whether it offers new insights to an existing phenomenon. The study is original in offering a conceptualised rendering of the development of filicide from interviews with mothers with a diagnosis of mental illness. No previous studies have interviewed mothers specifically about the development of filicide. The study adds to the existing but limited knowledge about maternal filicide offering new insights into the conditions and processes that contribute to its occurrence. The study offers a unique, novel and not previously produced exploration of the development of filicide-suicide in mothers providing a rich and detailed account of the decision-making and reasoning as co-constructed from accounts of filicide from interviews with mothers.

**4.8.3 Resonance.** Another criteria for checking quality in grounded theory is resonance, which is the degree to which the theorising makes sense and has 'grab' for participants and practitioners in the substantive field (Charmaz, 2006, p. 127).

Resonance should also be evident in how well the theorising reveals both the ‘liminal and unstable taken-for-granted-meanings’ (Glaser, 2002b). The study makes explicit the social constructions of motherhood and the implications they have for mothers in this study. Further the study reveals the taken-for-granted meanings about mental illness so that a fuller description and a number of useful insights about mothers’ experience can be identified. This study can also claim to have contributed to making visible the agentive power used by mothers in *Resolving* their concerns.

**4.8.4 Usefulness.** The criterion of *usefulness*, according to Charmaz (Charmaz, 2006, p. 182) must offer interpretations that people can use in everyday life. The processes and conditions identified in the grounded theorising should contribute to knowledge and also lead to future research in substantive areas. Usefulness is also held by Charmaz to have more lofty aims in that the study should contribute to making a better world. In terms of contributing to making a better world it is feasible that by presenting a credible, and original grounded theorising about the development of filicide the study may be useful to both care staff and surviving family members who struggle to understand how a mother could kill her own child.

The present study aimed to provide an in-depth account of maternal filicide to increase understanding of an incomprehensible act. It is my contention that the thesis presented here provides grounded theorising of the development of maternal filicide as co-constructed from four in-depth interviews with filicide mothers with a diagnosis of mental illness.

#### 4.9 Reflexive Summary of the Study

*I began the process of investigating maternal filicide, over 10 years ago when I worked clinically with a mother who had killed her seven-year old child by drowning. I was aware at the time that the literature that I read to inform my clinical work, was inadequate in helping me to understand mothers' experiences. This gap in the literature was the main inspiration for me to want to conduct the research. By the time I began the research project I had had many conversations with a number of mothers who had killed or attempted to kill their child(ren). I believed that my previous clinical experience of interviewing mothers who had killed their children would be a valuable asset to use in such a sensitive area of research inquiry.*

*In the early stages of the research process my ambition was somewhat grandiose in that I aimed to advance a grand, grounded theory of maternal filicide. In my naivety I thought that my research efforts would 'uncover' a groundbreaking theory that could account for filicidal acts. However, in the six years since starting my study the loftiness of these aims has been replaced with a more realistic recognition that knowledge is built through slow progressions and is always relative in its perspective. I have long since lost the enchantment with the 'fool's gold' of the 'theory'.*

*In conducting this study I have wrestled with the philosophical and methodological underpinnings of grounded theory including an examination of my own ontological and epistemological perspectives. Further, during the study I wrestled constantly with the tension between the 'objectivist' tenets of grounded theory as advocated by Glaser and the constructivist theorising of Charmaz. I found that although my epistemological leanings are interpretivistic, I longed for the simplicity of the positivism retained by Glaser.*

*I stayed true to the GT directive of not comprehensively reviewing the literature until the results had been analysed and written, and the discussion of results had been documented. However, after I had written the introduction to the study, I then felt dissatisfied with the discussion, as new insights and interpretations of the data struck me in different and novel ways. GT proved to be really iterative as just when I thought the write up was over, I revised my conclusions about some of the implications of the study, seeing these in a new light, as if for the first time. I have concluded that the iterative process in qualitative research has to have an enforced ending, as the desire to keep searching and thinking about the data could lead to a never-ending process of conceptualising.*

*The process of research inquiry over this period has changed me. To embark on a project, about which I was passionate, and to encounter so many barriers and yet not be willing to give it up has taught me much. I can't help but reflect on what the process of the research activity has meant to me. Some time, mid-way through the research process, after having interviewed all the mothers, I grieved for the loss of the hope to have interviewed more participants. I grieved for dead children. I wrestled with questions about the value of the study, given the small number of interviewees. However, I continued to tell myself 'it's four more than anyone else!' and to remind myself of the mothers who had thanked me for interviews and encouraged me to do the research. I lived with the images of the mothers, their experiences, their children, both dead and alive, and their stated wishes for their*

*experiences to be described. This time was a difficult time, laden with the material of the interviews, overwhelmed and confused by the data and engaged in the painstaking work of the coding and analytic processes. There were personal reflections for me about my motivation for the subject area; I am not a mother.*

*Both myself and the study emerged from this period somewhat changed! I had survived the analytical processes and somewhere during the process the research had become mine. I am not sure if I claimed the research, or somewhere in the minutes, hours and days, weeks and months, and then years the study claimed me! But I had emerged with a grounded theorising of maternal filicide. I had also learnt skills of academic research.*

*At this point the submission of the doctoral thesis feels like the beginning. I know that the value of the research is in being able to disseminate the findings and to make a difference to victims of filicide. I have not forgotten the interviews with women, the images that their stories evoked or the dark time I experienced going through such painfully sad and tragic data word-by-word and line-by-line.*

*I am grateful for all that I have learnt, academically, emotionally and practically in the process of completing this doctoral thesis.*

*Geraldine Holloway  
6<sup>th</sup> of September 2015*

## CHAPTER FIVE

### A CONSIDERATION OF ALTERNATIVE METHODOLOGICAL APPROACHES

#### 5.1 Introduction

The present study has advanced a theorising perspective about the development of the process of maternal filicide using a qualitative approach and GT methodology. However, the objective of the study to interview between 6-8 mothers was not achieved, despite extensive efforts to do so, interviewing only 4 participants. One criticism of the study is that only limited data was used to develop theorising about filicide. Therefore, it is useful to consider what potentialities there are in the data from the use of alternative methodological stances. Alternative qualitative methodologies may have focused on alternative positions. Interpretative Phenomenological Analysis (IPA; Smith, 1991) would provide a conceptual interpretive account of the individuals' lived experiences without the emphasis on theory development; Discourse Analysis (DA; Foucault, 1977; Fairclough, 2003) would provide a critical lens through which participants' language would provide analytic insights into the production of power between child, mother and society; or Single Case Study (SCS; Yin, 1994) where in-depth thick description can provide specific conclusions relevant to each participant's unique circumstance. In this chapter I will review selected alternative methodologies to consider how the data might otherwise have been interpreted through the prisms of interpretive, discursive and emic perspectival frames. Each of the following summaries provides insights of alternative postionalities within the data.

## **5.2 Alternative methodologies**

**5.2.1 An overview of Interpretative Phenomenological Analysis.** The IPA approach was first used by Smith (1991) who drew on the theoretical ideas from phenomenology (Giorgi, 1995), hermeneutics (Palmer, 1969) and from ‘an engagement with subjective experience and personal accounts’ (Smith, Harre, & Van Langenhove, 1995). Phenomenology is concerned with how things appear to individuals and utilises the philosophical perspective of a person as ‘embedded, embodied and immersed in the world in a particular historical, social and cultural context’ (Frost, 2011; p. 46). IPA is theoretically underpinned by hermeneutics or the theory of interpretation where the subjective interpretation of reality is held as a process inherent within human experience. As such interpretation in IPA, as with the particular methodology of GT adopted in this study, is conceptualised as implicit in how individuals may describe their experiences but also in how the researcher makes sense of and interprets descriptions of events. In effect, similar to GT method, IPA can be described as a dynamic process, with the researcher making interpretations of the data representing a ‘double hermeneutic’ (Giddens, 1987) where the interpretations of participant and researcher are acknowledged factors in the analytical process. Proponents of IPA as a research method emphasise that the interpretive process of the researcher is central to the IPA method and should be as transparent as possible (Shaw, Dallos, & Shoebridge, 2009). It is interesting to note that the need to make explicit the processes of research activity using a reflexive style is a feature of most qualitative methodologies (Silverman, 2005), including the GT method as advocated by Charmaz (2006).



The third theoretical underpinning of IPA is the emphasis on idiography. Idiographic approaches aim for an in-depth focus on the uniqueness of an individual's experience with the aim of developing a detailed analysis of both the lived experience and how these experiences are made meaningful (Frost, 2011).

**5.2.2 IPA method in comparison to GT** There are a number of differences in the IPA method when compared to that of GT in respect of data collection and analytical processes. Firstly, prior to the data collection phase of IPA the researcher can make use of available theoretical literature on the subject and this knowledge can inform data collection. In contrast in GT method the researcher should collect data without first making use of theoretical knowledge about the process under examination. The mode of data collection in GT would be relatively unstructured with an emphasis on the participant providing accounts without the use of predetermined questions, as far as possible. In the IPA method, theoretical and other sources of knowledge can be used to influence the inquiry as long as these are acknowledged and made explicit.

In the first stage of data analysis in IPA the researcher is required to read the whole transcript a number of times and make detailed reflexive notes on the data. The researcher focuses on content, use of language, context and interpretive comments (Frost, 2011). In the second stage of analysis the notes are organised into themes (rather than codes as in GT method). The third stage of analysis involves the examination of emerging themes that are then clustered together according to conceptual similarities. The emphasis in IPA is clearly on conceptual development as opposed to that of theory, and as in GT makes use of an inductive approach rather

than a deductive approach to generating knowledge. In the final stage of analysis of data from an individual the researcher should look for patterns in the clustered themes and organise a structure to present them in a table. The table shows both main themes and sub-themes and is further developed as the iterative process is repeated for each of the data sets from participants. As in GT the analytical procedures in IPA are iterative and the researcher uses themes from earlier analyses to interpret the meanings of later interviews or texts. In IPA the researcher is more engaged in a reflective process of the meanings and narratives of study respondents than in GT that seeks to construct from the data theories about a process. In GT analytical processes theory is developed from abstractions made at every level of the analysis as codes and concepts are compared to each other. The IPA method produces an interpretive account of the important meanings individuals ascribe to common experiences.

**5.2.3 How the use of IPA methodology could have been used with the data set in this study** Given the issue of the very small number of convicted filicide mothers with a diagnosis of mental illness in the UK, IPA would have been a useful methodology to use. The sample size in IPA can be between 1-30 participants, depending on the amount of detail in the data and it has been argued that even single cases can produce sufficient material to develop conceptual understanding about the meanings ((Brocki & Wearden, 2006). Smith, Harre & Langenhove (1995) suggest a sample size of between 3-6 participants for undergraduate and masters-level IPA projects, although this maxim does not appear to be based on methodological issues and no such parameters are suggested for doctoral level projects.

Should IPA have been used as the methodology in this study it would have potentially resulted in a more in-depth and detailed account of maternal filicide at a conceptual level. For example certain themes related to how mothers feared being separated from their children were constructed from the data using the GT method. This theme could have been more conceptually developed to provide an in-depth understanding of that experience as mothers had lived it than was possible with the GT method, which is focussed more on an account that elucidates processes. In IPA not only is there development of the main themes into concepts but concepts are organised hierarchically to include super and sub-ordinate relationships. It is evident that such an approach not only allows for concept formation but also allows the relationship between concepts of greater and lesser importance to be elucidated.

The use of the IPA method would also have allowed for a greater inclusion of the reflections of the researcher within the analysis of the data. When immersing myself in the data, using the GT method I had had a number of reflections about the relationship of social and other care services to mothers. Three out of the four mothers in the study complained about unhelpful and coercive experiences they had had with their social workers. In IPA my reflections as researcher would have been included in the analytical and interpretive frame used in the analysis of the data, to a much greater degree than would be the case in GT where the emphasis is on constructing theory from data.

The aim of the study using a GT method was to explore the development of maternal filicide as a process from interviews with mothers with a diagnosis of mental illness. Should the IPA method have been adopted it is possible that more detailed

information about themes and concepts of importance for mothers would have been included in the final analysis. This approach would have provided a fuller account of the details of the lived experience of maternal filicide in mothers with a diagnosis of mental illness than could be obtained using GT method with its emphasis on theory development about specific processes.

### **5.3 An overview of Discourse Analysis**

Fundamentally, DA is a methodological approach that assumes that all knowledge is 'socially constructed' (Starks & Brown Trinidad, 2007). The DA approach aims to explore and examine the values that are often hidden in 'taken for granted' knowledge. It is evident that DA is underpinned by a constructionist ontology that rejects the notion that pre-existing structures determine social life. Interestingly in respect of the use of DA in psychology DA also rejects the internal or psychological structure as something that truly exists. Instead DA holds that such structures can be 'talked or practiced into being' (Frost, 2011). DA aims to expose the way versions of the world of society, events and inner psychological worlds are produced in discourses (Bryman, 2008) So, using filicide mothers with a diagnosis of mental illness as an example, DA would be a useful approach to uncover the taken for granted meanings such as questioning the practice of constructing a mental illness diagnosis as an explanatory concept with which to consider the filicide act.

In DA, language is viewed as a constitutive truth and as a means to negotiate meanings and 'realities'. Epistemologically, DA suggests that our knowledge of the world is produced through our organisation of language and behavioural practices. A form of DA can be found in Discursive Psychology and is associated with the work of

Jonathan Potter and Margaret Wetherell in which there is a particular interest '*in the role of accounts of explanations of behaviours which might be unusual, bizarre or in some way reprehensible*' (1987; p. 74: as cited by Frost 2011).

The DA approach in Discursive Psychology makes use of rhetorical devices that may enable the examination of both verbal and non-verbal excuses and justifications used in any given account. This approach would have obvious utility in identifying and exploring potential motivations of filicide by mothers where those motivations may be socially or culturally unacceptable.

There is a critical distinction of DA from both IPA and GT; whereas in IPA and GT the researcher immerses themselves in the data with the analytic goal of attending to the participants account with an open mind, in DA the researcher uses their knowledge to situate the analysis and to consider how what is said may be related to other discourses (Starks & Brown Trinidad, 2007). In a sense DA exposes the ways people use language whereas IPA provides rich, detailed and thematic information about the lived experience of participants and GT provides an in-depth account of a theorised process.

An important feature of DA as an approach is that it can focus on (group) relations of power, dominance and inequality (Van Dijk, 1995) and this is especially true if the type of DA used is based upon the work of Michel Foucault (1977). Using a DA approach allows texts, photographs and videos to be studied and offers a means to analyse how filicide in mothers with diagnosis of mental illness is being written and/or represented in popular media. The alternative positioning of the research,

studying discourses about filicide mothers may have revealed some of the taken for granted meanings about violent women, particularly how such women can be constructed as ‘mad, bad or sad’. Through analysis of discourses some of the socio-cultural forces inherent in medicalising female violence could also have been identified.

**5.3.1 Discourse Analysis Method in comparison to GT** The use of a DA method would have allowed an in-depth exploration, providing a detailed account, rather than the theorising account as produced in GT method. As with the development of themes in IPA and the coding and conceptual development achieved in GT, the analytical process in DA involves careful reading of transcriptions. An acknowledgement of the researchers own cultural, historical and social influences upon the process of the research is also made explicit in both GT and IPA method (Frost, 2011). As in GT where the constructions of memos is an important aspect of making sense of the data, and in IPA where researcher reflections are an important part of the analysis of the data, in DA the researcher should also make notes as an integral part of engaging with the data. The use of reflexivity as utilised in both IPA and GT is also a part of the DA method (Starks & Brown Trinidad, 2007). Researcher reflexivity is used in DA to facilitate greater understanding of the qualities and characteristics of the discourse.

The researcher should aim to get a feel for the whole of the text when first reading the transcripts and to engage with the data, making decisions about what is important and what can be omitted. The researcher should identify words and phrases that taken together constitute wider discourses. These wider discourses can be coded together

under an appropriate label. Using the DA methodology is complex and time-consuming and as the analysis progresses the themes and codes shift to accommodate new ways of structuring. A useful aspect of the DA approach is that the researcher is required to interrogate themselves about their relationship to the data. Within the analytical frame the researcher questions how the setting and relationship of the researcher to the participant may have had an impact on what account was given at any particular time. However, this should also be a tenet of all qualitative methodologies and this includes IPA and GT approaches.

**5.3.2 How the use of DA methodology could have been used with the data set in this study** One of the key benefits of using a DA method to investigate the subject of maternal filicide in mothers with a diagnosis of mental illness would be the diversity of information that could be included in the investigation. For example, legal, medical and nursing reports; newspaper and social media material; and television or film depictions could all be admissible as means to explore the subject. The breadth and diversity of material to be included in the analysis would allow for other perspectives and positions to be taken in relation to maternal filicide; that of the general public, the medical institution, and the legal profession. The use of DA would have provided important and currently unexplored knowledge about views and practices in relation to filicide mothers. For example using the DA method with medical reports would have allowed for the use of medical practices in diagnosis of filicide mothers to be analysed.

A DA approach could potentially have provided an analysis of the power relations within the relationship between society, the medical profession and filicide mothers.

The nature of the practices and ways of talking and understanding filicide mothers used by the medical profession would have been revealed through the use of a DA approach. The approach would have provided an alternative position to the one adopted in this study; the position of the medical profession.

In addition, in the GT study a 'siege mentality' was theorised as relevant to the development of maternal filicide. DA method would allow a consideration of the elements of power expressed through formal social practices such as child protection agencies, housing providers and social care systems. Given how much of what mothers in this study were concerned with housing, finances and losing their children, the use of a DA approach would have potentially revealed key power relations which were impacting upon mothers access to financial resources, support from benefits agencies, housing providers and social and child protection services. The methodological approach taken by DA could have provided in-depth understanding about how these key power relations worked in very specific ways for filicide mothers. The DA approach, then, could have potentially provided an understanding about how services might need to modify, change or redesign their approaches to mothers with mental health problems.

An analysis of discourses produced by filicide mothers, and which could have included information from their family members or medical teams could elucidate some of the key personal and individual motivations about filicide that are hidden by the social-cultural structures and practices related to mothering, gender stereotyping and female violence.



#### **5.4 An overview of Single Case Study method**

The basic case study entails the detailed and intensive analysis of a single case (Bryman, 2008) and is concerned with the complexity and particular nature of the case in question (Stake, 1995). However, there is also a case study research method which makes use of a number of case studies in order to build theory and develop theoretical propositions (Eisenhardt & Graebner, 2007). However, the selected methodology being reviewed here is that of the SCS method. The two earlier proponents of case study paradigms were Yin (1994) and Stake (1995) who have both adopted a constructivist methodology which is closer to pluralism than relativism (Baxter & Jack, 2008).

Case studies have been used to investigate both individuals and communities and more controversially have been used to study specific phenomenon (Bryman, 2008). Case studies tend to take an idiographic approach, concerned with exploring in great detail a particular case and elucidating the specifics of it. Case studies can make use of both qualitative and quantitative methods, depending on the size of the data and the ontological and epistemological underpinnings adopted. Case study research can be retrospective or prospective and use differing sources of data; observations, reports, notes, interviews and material objects are all admissible (Yin, 2003). Knowledge derived from single case studies has been considered as neither representative nor generalisable (Bryman, 2008), although others have argued that a SCS should aim to generalise across other cases (Gerring, 2006).

The SCS method can be used to study a single case in considerable depth and Bennett (2004) has suggested that it can identify new variables and hypotheses through both

inductive and deductive means. Bennett (ibid) has also suggested that SCS method is a useful means to develop historical explanations of particular cases. The SCS method can also achieve high levels of construct validity. However, disadvantages of the method have also been cited such as problems with case selection and case bias and the limitations on how much SCS can be thought of as generalising and representative of other cases (Gerring, 2006).

Different types of cases have been suggested for SCS (Bryman, 2008). These can be delineated into either critical cases, where the researcher chooses a case to test a hypothesis and where the researcher has a well-developed theory; extreme or unique cases; representative or typical cases, where the 'objective is to capture the circumstances and conditions of an everyday or commonplace situation' (Yin, 2003; p41); and revelatory cases where the researcher has the opportunity to observe and analyse a phenomenon not previously accessible. A case study design of a filicide mother with a diagnosis of mental illness would represent a revelatory case, according to Yin's definition.

**5.4.1 SCS method in comparison to GT** In conducting case study research it has been recommended that a number of propositions should be made prior to beginning the investigation (Baxter & Jack, 2008). The propositions act as parameters to the research, necessarily limiting the scope of the inquiry and ensuring its feasibility (Morley & Adams, 1991). This is clearly distinct from the approach to data analysis taken in GT that aims to obtain data and to be as open as possible throughout the coding phase of analysis and to avoid imposing limitations or constraints upon the data.

In SCS method the initial data analysis starts at a basic level, organising key words or themes or ideas which are then organised into a conceptual framework (Miles & Huberman, 1994). In a sense this is similar to the coding operations in GT but with specific and important differences. In SCS method the conceptual framework focuses on concepts and does not seek to identify relationships between them. As in GT (and both IPA and DA) the researcher is encouraged to keep notes and to scrutinise the concepts identified in the analysis. However, specific to the SCS method the researcher compares the concepts to propositions and to existing theory. In elucidating the method thus, it is clear that GT makes use of existing theoretical material in a very different way to that advocated in the SCS method (and that proposed by both IPA and DA). In GT, knowledge about existing theory is not utilised until there has been theory generation from the data.

In SCS method the use of differing sources of data, such as interviews and newspaper reports are not handled separately. The analysis will treat all sources equally and the concepts from the analysis converge within the developing frame. The analytic process has been articulated by Yin (1994) as including pattern matching; linking data to propositions and time-series analysis. The SCS method seeks to develop a full description but also to go beyond description to include conceptual development of data from the study of a single case.

**5.4.2 How the use of single case study methodology could have been used with the data set in this study.** The use of SCS design in the investigation of filicide in mothers with a diagnosis of mental illness would have allowed for an

individual case to be explored in considerable depth. Likely using the revelatory approach as defined by Yin (2003) the SCS method would have aimed to develop detailed and in-depth information about a single case. Such an approach could have utilised a different design that made use of a series of interviews with one mother, although this design could also have been used in GT, IPA and DA approaches to good effect as well. Another advantage of the use of the SCS methodology would be that data from questionnaires, nursing observations, medical and legal reports and the popular media could have been included in the study of a single case, allowing for greater development of detailed understanding. The use of different data sources obtained from the natural environment of the participant can be seen as a distinct advantage of SCS qualitative methodology giving it strong ecological validity (Zainal, 2007).

Some authors have been critical of the degree to which a single case study can move beyond the descriptive level to a more conceptual level (Gerring, 2006). However, research based on the study of single cases has been acknowledged as a source of detailed understanding of phenomena that had previously been unknown (Yin, 2003). Therefore, although there is often considerable criticism about how SCS methodology has been reported and defined, there is agreement that case study research paradigms can make a contribution to both knowledge and theory (Yin, 2003; Bennett, 2004).

## **5.5 Conclusion**

Having adopted a GT method to investigate the individual lived experience of filicide from interviews with mothers with a diagnosis of mental illness the small numbers of women eventually recruited to the study presented limitations. In this chapter I have

aimed to present potential alternative methodologies and to consider how these would allow for differing emphases and findings had they been the chosen methodology for this study. In the main I have continued to consider qualitative methodology as an appropriate approach to the study of filicide as opposed to quantitative methodology primarily due to the very small numbers of potential participants. In addition qualitative methodology is advocated in subject areas where little is known or which are under-researched (Silverman, 2005). The subject area of filicide for mothers with a diagnosis of mental illness, specifically using an interview design, is both under-researched and poorly understood (Hatters Friedman, et al., 2005a) suggesting that qualitative methodology would be the preferred mode of investigation.

In considering alternative methodologies I have attempted to consider the alternative positions that different methodologies would have afforded in this study and to consider the relative advantages and disadvantages of each approach. In conclusion the IPA method seems to provide a very useful approach, appropriate for use with small numbers of potential participants, to research the subject of maternal filicide. The use of an interview design in an IPA study would allow for an in-depth and detailed understanding of maternal filicide in mothers with a diagnosis of mental illness to be produced from an experiential and conceptual, interpretive level. Using IPA in this way would preserve one of the central ambitions of the study: to explore the process of maternal filicide from the perspective of filicide mothers.

One of the other key merits in the use of IPA as a methodology is that it would allow for conceptual development of the experience of filicide from the perspective of the lived experience. In GT there is a priority to develop theory, which is clearly an

important aim for gaining understanding about the development of processes under investigation. However, with such limited numbers the study is open to the criticism that the theory was developed with insufficient data. The use of IPA methodology would allow for conceptual development without the need to construct theory from the data. Instead IPA methodology would be aimed at developing a clear and conceptual account of the lived experience of maternal filicide.

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APPENDIX	PAGE	NAME
A	i	ii - South West Research Ethics Committee: Request for Further Information or Clarification (17.02.11)
	ii	vi - South West Ethics Committee Ethical Approval (07.04.11)
B		xi - Summary of Service User Feedback
C	i	xiv - <b>Reasons for Exclusion Questionnaire</b>
	ii	xv - <b>Reasons for Exclusion Telephone Interview Form</b>
D		xvi - <b>Inclusion form</b>
E		xix - <b>Guidance to Staff</b>
F	i	xxi - Letter to Responsible Clinician: <b>Recruitment</b>
	ii	xxii - Letter to Responsible Clinician: <b>Approach for Interview</b>
	iii	xxiii - Letter of Confirmation of Research Interview
G	i	xxiv - <b>Introduction Letter (to Service Users)</b>
	ii	xxvi - Introductory DVD for Service Users
	iii	xxvii - Participant Information <b>Part One</b>
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H		xxix - <b>Consent Form</b>
I		xxx - <b>Interview Guide</b>
J		xxxiii - Diagrammatical Representation of Data
K		xxxiv - Initial Introduction Letter to Clinician
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N		xxxviii - Consent Form

# Appendix A (i): An Exploration from the Perspective of Mothers: South West Research Ethics Committee: Request for Further Information or Clarification (17.02.11)

## South West 4 REC

Whitefriars  
Level 3, Block B  
Lewin's Mead  
Bristol BS1 2NT

Email: ubh-tr.SouthWest4@nhs.net  
Telephone: 0117 342 1335  
Facsimile: 0117 342 0445

17 February 2011

Ms Gerrie Holloway  
Consultant Clinical Psychologist  
West of England Forensic Service  
Blackberry Hill, Stapleton  
Bristol BS16 1EG

Dear Ms Holloway

**Study Title:** A Grounded Theory exploration of the development and meaning of filicide as constructed by mothers with mental illness.

**REC reference number:** 11/SW/0009

**Protocol Version number:** 1

The Research Ethics Committee reviewed the above application at the meeting held on 16 February 2011. Thank you for attending to discuss the study.

### Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Protocol	1	11 February 2011
Participant Information Sheet	1. Part Two	11 February 2011
Letter of invitation to participant	1	11 February 2011
Letter of invitation to participant	1. Letter to Teams	11 February 2011
GP/Consultant Information Sheets		11 February 2011
Investigator CV	G. Holloway	17 January 2007
Participant Consent Form	1	11 February 2011
Questionnaire: Inclusion Form	1	11 February 2011
Flow Chart	1. (Recruitment)	11 February 2011
Pre Interview Guide	1	11 February 2011
DVD		
Participant Information Sheet	1. Part one	11 February 2011
Research Proposal	1	11 February 2011
Service User Feedback		



## Appendix A (i): An Exploration from the Perspective of Mothers: South West Research Ethics Committee: Request for Further Information or Clarification (17.02.11) [contd]

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Telephone Survey of No. of Women in Services	1	11 February 2011
CV- Dr Frances Blumenfeld	2	01 January 2007
Guidance to staff	1	11 February 2011
Questionnaire: Exclusion Questionnaire	1	11 January 2011
Questionnaire	1	11 February 2011
Evidence of insurance or indemnity		09 August 2010
Referees or other scientific critique report		11 February 2011
REC application	3.1	24 January 2011
Covering Letter		24 January 2011
Summary/Synopsis	1 (flow chart)	11 February 2011
Letter from Sponsor		09 August 2010
Interview Guide	1	11 February 2011
CV- Dr Charles King		22 January 2010

The Committee thought this research was well-thought through given the sensitive nature of the topic. The Committee was pleased to note that this project was very inclusive; translation would be provided if necessary and introductory information was available on CD as well as DVD.

### Issues discussed:

1. It was noted that a couple of pilot interviews would be undertaken, which might result in changes being made to the interview schedule. Should this be the case, the revised schedule should be submitted to the Ethics Committee for further review and approval.
2. Upon query, you confirmed that "killing" meant murder in the context of this research.
3. There might be a risk of disturbing disclosure occurring during interview, which would necessitate breach of confidentiality. This needs to be stated explicitly in the participant information sheet and specific consent gained for this. This was agreed by you.
4. There was some concern that questioning participants might provoke adverse reactions. Would there be any support/protection available? Members were reassured that the majority of participants would be in-patients except for one outpatient. The interview for this participant would be timed when the designated Principal Investigator was available to provide support (if necessary) before the participant went home.
5. What would happen should the clinical team fail to identify any women to put forward for this study or in case of poor recruitment numbers? Members were informed that an application would be made to recruit from elsewhere.
6. The brief participant information sheet states that agreeing (or refusing) to take part will not be noted in their record but the consent form says a copy of the consent will be placed in the medical record. You confirmed that a copy of the consent form would be placed in the medical record and participants will be advised accordingly. Wording in the PIS will need to be changed to reflect this.

## **Appendix A (i): An Exploration from the Perspective of Mothers: South West Research Ethics Committee: Request for Further Information or Clarification (17.02.11) [contd]**

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In answer your queries, the committee advised as follows:

- (a) Application for the non-NHS SSI should be lodged with the Research Ethics Committee responsible for that area.
- (b) A principal investigator would be required rather than local collaborator.
- (c) Any proposed changes to the application should be made via a substantial amendment once a final decision for the research had been given.

### **Provisional opinion**

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the above points and request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

### **Further information or clarification required**

- The initial letter of introduction and the participant information sheet (PIS) should be signed by you as PhD student at the University of Essex, in addition to your role and place of employment.
- Under the paragraph headed "What will happen if I don't want to carry on with the study", in Part 2 of the Information sheet, wording is difficult to understand and should be simplified.
- Under the paragraph entitled "Who has reviewed the study", the name of our committee needs to be inserted.
- Exactly how will interview recordings be destroyed?
- On page 9 of the application form, use of a laptop is mentioned, however, at A36 the appropriate box has not been ticked. It is stated that the laptop will be kept in secure and locked accommodation, but does not specify where. How long before the transcript on the laptop is transferred to the University M drive?

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 17 June 2011.

### **Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

## Appendix A (i): An Exploration from the Perspective of Mothers: South West Research Ethics Committee: Request for Further Information or Clarification (17.02.11) [contd]

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### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

<b>11/SW/0009</b>	<b>Please quote this number on all correspondence</b>
-------------------	---

Yours sincerely

**Dr David Evans**  
**Chair**

Copy to: *Ms Sarah Manning-Press, University of Essex*  
[sarahm@essex.ac.uk](mailto:sarahm@essex.ac.uk)

*Dr Frances Blumenfield*  
[fblume@essex.ac.uk](mailto:fblume@essex.ac.uk)

*R&D Department for AWP*  
[CHARLOTTE.HOOK@AWP.NHS.UK](mailto:CHARLOTTE.HOOK@AWP.NHS.UK)

.....

### South West 4 REC

#### Attendance at Committee meeting on 16 February 2011

#### Committee Members:

Name	Profession	Present	Notes
Rev Alastair Davies	Clergy - Snr. Chaplain	Yes	
Dr David Evans	Consultant Neonatologist	Yes	
Mrs Rachel Fielding	Deputy Director of Midwifery	Yes	
Mrs Christine Fowler	Lay member	Yes	
Miss Mumtaz Goolam	NHS LARMS	No	
Mr Daniel Hajjoff	Consultant ENT Surgeon	Yes	
Mr Geoffrey Jones	Lay member	Yes	
Dr Ronelle Mouton	Consultant Anaesthetist	No	
Miss Sylvia Pearson	Senior trial Co-ordinator	Yes	
Dr Lucy Swithinbank	Associate Specialist - Urodynamic Unit	Yes	
Mrs Joan Wadsley	Lay member	Yes	

#### Also in attendance:

Name	Position (or reason for attending)
Mrs Naazneen Nathoo	REC Coordinator

**Appendix A (ii): South West Ethics Committee Ethical Approval  
(07.04.11)**



**National Patient Safety Agency**

National Research Ethics Service

**NRES Committee South West - Southmead**

Whitefriars  
Level 3, Block B  
Lewin's Mead  
Bristol  
BS1 2NT

Telephone:  
Facsimile:

07 April 2011

Ms Gerrie Holloway  
West of England Forensic Service  
Blackberry Hill, Stapleton  
Bristol  
BS16 1EG

Dear Ms Holloway

**Study title:** **A Grounded Theory exploration of the development and meaning of filicide as constructed by mothers with mental illness.**  
**REC reference:** **11/SW/0009**

Thank you for responding to the Committee's request for further information on the above research.

The further information was considered by a sub-committee of the REC. A list of the sub-committee members is attached.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

**Ethical review of research sites**

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**

## Appendix A (ii): South West Ethics Committee Ethical Approval (17.04.11) [contd]

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Questionnaire: Exclusion Questionnaire	1	11 January 2011
Questionnaire	1	11 February 2011
Letter of invitation to participant	1. Letter to Teams	11 February 2011
Letter of invitation to participant	2	11 March 2011
GP/Consultant Information Sheets		11 February 2011
Flow Chart	1. (Recruitment)	11 February 2011
Pre Interview Guide	1	11 February 2011
DVD		
Research Proposal	1	11 February 2011
Service User Feedback		
Telephone Survey of No. of Women in Services	1	11 February 2011
CV- Dr Frances Blumenfeld	2	01 January 2007
Guidance to staff	1	11 February 2011
Participant Information Sheet: Part 2	2	11 March 2011
REC application	3.1	24 January 2011
Questionnaire: Inclusion Form	1	11 February 2011
Participant Information Sheet: Part 1	2	11 March 2011
Investigator CV	G. Holloway	17 January 2007
Participant Consent Form	2	11 March 2011
Covering Letter		24 January 2011

Covering Letter		12 March 2011
Summary/Synopsis	1 (flow chart)	11 February 2011
Letter from Sponsor		09 August 2010
Interview Guide	1	11 February 2011
CV- Dr Charles King		22 January 2010
Protocol	1	11 February 2011
Evidence of insurance or indemnity		09 August 2010
Referees or other scientific critique report		11 February 2011

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

<b>11/SW/0009</b>	<b>Please quote this number on all correspondence</b>
-------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely



**Dr David Evans**  
Chair

Email: [mindy.kaur@nhs.net](mailto:mindy.kaur@nhs.net)

Enclosures: *List of names and professions of members who were present at the*

**Appendix A (ii): South West Ethics Committee Ethical Approval (17.04.11)  
[contd]**

*meeting.*

Copy to: *Ms Sarah Manning-Press, University of Essex*

**NRES Committee South West - Southmead**

**Attendance at Sub-Committee of the REC meeting on 01 April 2011**

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Pamela Cairns	Consultant Neonatologist	Yes	
Mr Trevor Beswick	Pharmacist	Yes	

## **Appendix B: Summary of Service User Feedback**

### **SERVICE USER FEEDBACK**

Could the participants be given a letter outlining the information in Part One leaflet? Feel the leaflet is good – kind, caring tone and easy read language but confused who would see the different leaflets, when.

Could have some of the more basic, details in letter and info on complaints, confidentiality in one leaflet?

Some people might respond better to a letter rather than just a leaflet.

#### **Participant Information Part 1:**

- Does Dr Frances Blumenfeld etc address need to be on there?
- Names of Gerrie Holloway and Dr Frances Blumenfeld not in line.
- Take heading up to text.

#### **Participant Information Part 2:**

- Names of Gerrie Holloway and Dr Frances Blumenfeld not in line.

Consent Form – replace patient with service user.

Pre Interview Script - insert sentence to explain keeping unsent form in medical records.

Interview Questions - typo in number 5.

### **Service User Feedback 2**

#### **Participant Information Part One**

- Language works well and has a caring feel to it.
- ‘Part 2’ – attached or issued with Part 1?
- Question mark by Dr Frances Blumenfeld etc.
- ‘5 minute DVD’ – available from?
- ‘Why have I been chosen’ – replace people with women and put at each centre after ‘taking part altogether’.

#### **Participant Information Part Two**

- Good to include information about ethics.
- Second page, ‘Complaints’, ‘please address them to me’ – put in Gerrie’s details. Last paragraph under ‘Complaints’ replace contact details supplied below with overleaf.



## **Appendix B: Summary of Service User Feedback (contd)**

### Consent Form

- Point 1 – these documents would be helpful if cross-referenced to actual issued documents.
- ‘medical notes’ – explanation as to why their medical notes would be useful.

Pre Interview Script – perhaps include your name with instructions.

### Interview Questions

- No 4 – maybe this would read better if it was worded slightly differently as I think it may be upsetting.
- No 5 – typo.

### **Service User Feedback - 3**

#### Participant Information Part One and Part Two

- Add e.g. ‘A research study conducted by Ms G Holloway’.
- The following is ticked meaning it’s helpful and inclusive:
  - ‘I am completing the research as part of a Doctorate etc....’
  - I have added to the titles to make it clear from the beginnings of the leaflets that this will be a one to one work and interview. That no other organizations or people will be involved with the service users, e.g. it is/will be safe and no one else will be ‘sprung’ on them.
  - What happens after the interview? Etc.
  - What will happen to the results of the research study? Etc.
  - Who is organising and funding the research? Etc.
  - The interview will be digitally audio-recorded etc.
  - The data will be analysed etc.
  - You have the right to check the accuracy of data held about you and to correct any errors.

Interview Questions - felt uncomfortable with question 4. Needs to be rethought, ‘seemed important’ and ‘child dying’ do not fit well together.

---

#### Notes from the DVD

- Professional
- Clear
- Opening statement and closing thank you should be with Gerrie speaking to the camera to make it more personal
- Length about right
- Making a cup of tea a good idea
- The focus on Gerrie physically what she looks like how she is, was good
- I felt safe, felt I was getting to know her from a safe distance
- Verbal content was clear, calm and soft

## **Appendix B: Summary of Service User Feedback (contd)**

- Film clear calm and soft in tone
- Explained the motives for the project which I think is important
- Appropriate length
- Very good.

# Appendix C (i): Reasons for Exclusion Questionnaire

Maternal Filicide: An Exploration from the perspective of mothers. Reasons For Exclusion Questionnaire. VI. 11.02.2011

## Reasons for Exclusion Questionnaire

Please fill out the questionnaire to let me know the reasons why this service user is excluded from participating in the study. Answering this questionnaire does not involve providing any personally identifiable information about your service user. Should you be concerned that by providing any of the requested information this will risk the identity of the service user being detectable then please complete only the information which you feel comfortable with. This information will be used to provide basic details about the service users who are excluded from this study and to provide information about the reasons why they have not participated. Any information which you provide will only be reported within group statistics to ensure anonymity.

Please fill out one questionnaire per service user.

### LIMITED PERSONAL DETAILS

Participant's age: 18 – 30yrs  31 – 45 yrs  46 – 55 yrs  55 yrs or over

How long is this admission, (since the offence)? 0 – 5yrs  6-10yrs  11-15 yrs   
16 yrs or over

ICD-10 Diagnosis: .....

### INFORMATION ABOUT OFFENCE

Year of Filicide: .....

Year of Conviction: .....

Multiple Victims?: Yes  No

Age of Victim (1): 1- 5 yrs  6 – 10yrs  11 – 15yrs  16 yrs or over

1

Maternal Filicide: An Exploration from the perspective of mothers. Reasons For Exclusion Questionnaire. VI. 11.02.2011

Age of Victim (2): 1- 5yrs  6 – 10yrs  11 – 15 yrs  16 yrs or over

Age of Victim (3): 1- 5 yrs  6 – 10yrs  11 – 15 yrs  16 yrs or over

Method of killing: Stabbing  Asphyxiation  Drowning   
Shooting  Fire-setting  Overdosing   
Other.....

### REASONS FOR EXCLUSION FROM RESEARCH AT THIS POINT:

Perception of the study

Risk of harm to participant

Mental Illness Symptoms

Care Pathway issues (near discharge)

Significant Life Events

Physical Problems/illness

Concern about effect of recruitment on  
relationship with team

Other

(Please Specify): .....

Any other comments regarding exclusion from research at this point:  
.....  
.....

Can I contact you in the future to enquire  
whether the situation has changed? Yes  No

2

## Appendix C (ii): Reason for Exclusion Telephone Interview Form

Maternal Filicide: An Exploration from the perspective of mothers. Reasons For Exclusion Questionnaire, V1, 11.02.2011

### Reasons for Exclusion Telephone Interview Form

#### Stage of Study

- a) First contact  (Pink Form)  
 b) Information leaflet 1 (DVD has been sent)  (Green Form)  
 c) Information leaflet 2  (Blue Form)  
 d) Consent & Interview Stage  (Yellow Form)

#### SERVICE CONTACT DETAILS

Name of Service: .....  
 Address: .....  
 .....

Name of Service Contact .....  
 Profession: .....  
 Contact Telephone Number: .....  
 Contact Email Address: .....

Date & Time Contacted: .....

Plans to Enquire again? Yes  No

If Yes, Date (and time) of next contact: .....

#### LIMITED PERSONAL DETAILS

Participant Study Number: SITE NO.....STUDY PARTICIPANT NO.....

Participant's age: 18-30 yrs  31-45 yrs  46-55 yrs  55 yrs or over

Year of Admission following Filicide: .....

ICD-10 Diagnosis: .....

Maternal Filicide: An Exploration from the perspective of mothers. Reasons For Exclusion Questionnaire, V1, 11.02.2011

#### INFORMATION ABOUT OFFENCE

Year of Filicide: .....

Year of conviction: .....

Multiple Victims?: Yes  No

Age of Victim (1): 1-5  6-10  11-15  16 or over

Age of Victim (2): 1-5  6-10  11-15  16 or over

Age of Victim (3): 1-5  6-10  11-15  16 or over

#### REASONS FOR EXCLUSION FROM RESEARCH AT THIS POINT:

- Perception of the study   
 Risk Issues   
 Mental illness symptoms   
 Care Pathway issues (near discharge)   
 Significant life events   
 Physical problems/illness   
 Concern about effect of recruitment on relationship with team   
 Other

(Please Specify): .....

Any other comments regarding exclusion from research at this point:

.....  
 .....

Appendix D: Inclusion Form

**INCLUSION FORM**

**Stage of Study**

- |   |                          |         |
|---|--------------------------|---------|
| a) First contact<br>Form)                             | <input type="checkbox"/> | (Pink   |
| b) Information leaflet 1 (DVD has been sent)<br>Form) | <input type="checkbox"/> | (Green  |
| c) Information leaflet 2<br>Form)                     | <input type="checkbox"/> | (Blue   |
| d) Consent & Interview Stage<br>Form)                 | <input type="checkbox"/> | (Yellow |

**SERVICE CONTACT DETAILS**

**Name of Service:**

.....

**Address:**

.....

.....

.....

**Name of Service Contact**

.....

**Profession:**

.....

**Contact Telephone Number:**

.....

**Appendix D: Inclusion Form (contd)**

**Contact Email Address:**

.....

**Date & Time Contacted:**

.....

**Plans to Enquire again?      Yes            No**

**If Yes, Date (and time) of next contact:**

.....

**LIMITED PERSONAL DETAILS**

**Name of Service User: (if at interview stage).....**

**Participant Study Number: SITE NO..... STUDY PARTICIPANT NO.....**

**Participant age: 18 – 30yrs       31 – 45yrs       46 – 55yrs       55yrs or over**

**Year of Admission following Filicide:**  
.....

**ICD-10 Diagnosis: .....**

**Has the service user been an Inpatient at Fromeside?      Yes**   
**No**

**(IF YES EXCLUDE FROM STUDY )**

Appendix D: Inclusion Form (contd)

**INFORMATION ABOUT OFFENCE**

**Year of Filicide:** .....

**Multiple Victims?:**            **Yes**                        **No**           

**Age of Victim (1):**            **1- 5 yrs**             **6 - 10 yrs**             **11 – 15 yrs**   
**16yrs or over**

**Age of Victim (2):**            **1- 5 yrs**             **6 – 10 yrs**             **11 – 15 yrs**   
**16yrs or over**

**Age of Victim (3):**            **1- 5 yrs**             **6 – 10 yrs**             **11 – 15 yrs**             **16**  
**yrs or over**

**Method of Killing Victim**

**(1)**.....

**Method of Killing Victim**

**(2)**.....

**Method of Killing Victim**

**(3)**.....

## Appendix E: Guidance to Staff



### Secure Services Strategic Business Unit

ADDRESS OF SITE

West of England Forensic Mental Health Servi  
Fromesi  
Blackberry H  
Staplet  
Bris  
BS16 1E

Tel:(0117) 958 36  
Direct Dial: (0117) 378 4168/41  
Fax:(0117) 958 54

Our Ref: GH/RS  
29 September 2016

### GUIDANCE TO STAFF

**Study Title: Maternal Filicide; An exploration from the perspective of mothers.**

Dear colleague,

Thank you for agreeing to provide information to your service user regarding this study. Please ensure that you have received the following materials (which are to be shown in the order given):

- DVD – Introduction to researcher and rationale for the study.
- Introduction Letter for service user
- Information Leaflet Part 1
- Information Leaflet Part 2

Prior to meeting with the service user please ensure that you are able to make use of a DVD player, you should let the service user know that the DVD is about a study for women who have similar experiences to herself and is only 90 seconds long. You can then give the women the Introduction letter and the Information Leaflet part 1.

In carrying out this study we wish to ensure that the best interests of participants are safeguarded. For this reason we ask that in discussing the research with individuals that you emphasize the following key points:



## Appendix E: Guidance to Staff (contd)

- The research is part of a research doctorate.
- Participation is completely voluntary.
- Agreeing or refusing to take part in the study will have no bearing whatsoever on their treatment or any decisions made about their detention.
- At this point, individuals are not required to make a final decision about participation in the study.
- If your service user is interested in the study please arrange to go through Information Leaflet 2 with them within 3 days.
- If the service user would like to participate in the study ..... will contact me and I will come to the service and interview the service user with her consent within 2 weeks.

Thank you very much for your assistance with this study. Please do not hesitate to contact me if you have any concerns.

Yours sincerely,



Ms Gerrie Holloway  
Clinical Psychologist, Chief Investigator  
West of England Forensic Service for  
Women  
Fromeside  
Blackberry Hill  
Stapleton  
Bristol BS16 1 EG.  
Telephone: 0117 378 4167/8 or 4173  
(direct line)

Dr Frances Blumenfeld, Academic  
Supervisor &  
Ms Gerrie Holloway, Doctoral Student  
University of Essex  
Colchester Campus  
Wivenhoe Park  
Colchester CO4 3SQ.  
Telephone 01206 873125

Appendix F (i): Letter to Responsible Clinician: Recruitment



University of Essex

Avon and Wiltshire  
Mental Health Partnership NHS Trust



Secure Services Strategic Business Unit

West of England Forensic Mental Health Service  
Fromeside  
Blackberry Hill  
Stapleton  
Bristol  
BS16 1EG

Tel:(0117) 958 36  
Direct Dial: (0117) 378 4168/41  
Fax:(0117) 958 54

Our Ref: GH/FS  
29 September 2016

Dear RC Re A Grounded Theory exploration of the development and meaning of  
filicide as constructed by mothers with mental illness.

I am writing to confirm that following the agreement of the clinical team that NAME OF  
PARTICIPANT .....can be approached to be informed about the above study she will  
receive information about the study (Introduction Letter, 90-second DVD and  
Information Leaflet 1) on ...DATE..... by .....

Please do not hesitate to contact either me should you require any further information,  
and thank you again for your support for this important study.

Yours sincerely,

Ms Gerrie Holloway  
Clinical Psychologist, Chief Investigator  
West of England Forensic Service for Women  
Fromeside  
Blackberry Hill  
Stapleton  
Bristol BS16 1 EG. Telephone: 0117 378  
4167/8 (secretary)

Mrs Frances Blumenfeld, Academic Supervisor  
Ms Gerrie Holloway, Doctoral Student  
University of Essex  
Colchester Campus  
Wivenhoe Park  
Colchester CO4 3SQ. Telephone 01206  
873125/8741443



Secure Services Strategic Business Unit

West of England Forensic Mental Health Servi  
Fromesi  
Blackberry H  
Staplet  
Bris  
BS16 1E

Tel:(0117) 958 36  
Direct Dial: (0117) 378 4168/41  
Fax:(0117) 958 54

Our Ref: GH/FS  
29 September 2016

Dear ..... Re A Grounded Theory exploration of the development and meaning of  
ficide as constructed by mothers with mental illness.

I am writing to confirm that following the agreement of the clinical team .....has  
agreed to meet with Ms Gerrie Holloway chief investigator of the above study.  
Therefore, an appointment has been made for Gerrie, to meet with..... on.....and go  
through the consent process before potentially participating in the research interview.  
Should there be any change in the clinical presentation of .....and you consider it  
necessary to reschedule the appointment, please contact..... on telephone  
number.....so that an alternative date for the interview can be made.

Please do not hesitate to contact me should you require any further information, and  
thank you again for your support for this important study.

Yours sincerely,

Ms Gerrie Holloway  
Clinical Psychologist, Chief  
Investigator  
West of England Forensic Service for  
Women  
Fromeside  
Blackberry Hill  
Stapleton  
Bristol BS16 1 EG. Telephone: 0117  
378 4167/8 (secretary)

Mrs Frances Blumenfeld, Academic  
Supervisor &  
Ms Gerrie Holloway, Doctoral Student  
University of Essex  
Colchester Campus  
Wivenhoe Park  
Colchester CO4 3SQ. Telephone 01206  
873125/8741443

**Appendix F (iii): Letter to Responsible Clinician: Confirmation of Research Interview**



University of Essex

**Avon and Wiltshire**  
Mental Health Partnership NHS Trust



**Secure Services Strategic Business Unit**

West of England Forensic Mental Health Service  
Fromeside  
Blackberry Hill  
Stapleford  
Bristol  
BS16 1E

Tel:(0117) 958 36  
Direct Dial: (0117) 378 4168/41  
Fax:(0117) 958 54

Our Ref: GH/FS  
29 September 2016

*DEAR.....* Re A Grounded Theory exploration of the development and meaning of filicide as constructed by mothers with mental illness.

I am writing to confirm that .....consented to participate in the above study and was interviewed on.....

Please do not hesitate to contact me should you require any further information, and thank you again for your support for this important study.

Yours sincerely,

Appendix G (i): Introduction Letter (to Service Users)



University of Essex

Avon and Wiltshire  
Mental Health Partnership NHS Trust



Secure Services Strategic  
Business Unit

West of England Forensic Mental Health Servi  
Fromesi  
Blackberry H  
Staplet  
Bris  
BS16 1E

Tel:(0117) 958 36  
Direct Dial: (0117) 378 4168/41  
Fax:(0117) 958 54

Our Ref: GH/FS  
29 September 2016

**Dear service user, re: participation in study 'Maternal Filicide: An Exploration from the Perspective of Mothers'**

Thank you for taking the time to read this letter. To introduce myself I am a Consultant Clinical Psychologist who has worked with women who have killed their children. As part of my doctoral research studies at the University of Essex I am conducting a study interviewing women who have had this experience to find out more about it. I have also made a 90 second-long DVD to introduce myself and to explain a bit more about the study. More detailed information is available in the attached Information Leaflet Part (1) and your clinical team member can answer any questions you might have about the study.

I do not know your identity. Your clinical team has agreed to approach you on my behalf and invite you to take part in the study. For now, please allow me to give you some information about the study and why I would like to invite you to take part. There are some good reasons why such a study is needed, even though it might be difficult for you to talk about your experiences. The reasons include:

**Developing an understanding of the experience of women who have killed their children.**

Very little is known about the experiences of mothers who have killed their children. This study aims to increase knowledge about the experience by interviewing a number of mothers (6-8). Findings from the study could help

**Appendix G (i): Introduction Letter (to Service Users (contd))**

psychologists, nurses and doctors to understand how best to help mothers who have had this and could improve treatment for yourselves and others.

Learning about the experience from the perspective of women themselves. The study will explore what mothers themselves say about their experience. This will increase knowledge about the experience, which could be useful in helping mothers and children in the future and to reduce the risk of the same thing happening to them.

#### Invitation to participate in the study

If you are interested in participating in the study then please read the Information Leaflet. Further information is available in Information Leaflet Part (2), which you can read if you think you would like to participate in the study. If you agree to participate I will meet with you, at a time and date convenient to you, within the next two weeks, so that with your consent I can interview you about your experience.

#### Important points

It is important that you understand that:

- Participation is completely voluntary. Agreeing or refusing to take part in the study will have no bearing whatsoever on your treatment or any decisions made about your detention.
- At this point, individuals are not required to make a final decision about participation in the study. If you agree to meet with me, you can still decline to proceed any further.

I hope that this letter has been helpful in introducing myself and giving you some brief details about the study. Please ask your staff member if you require any further information.

Yours Sincerely,



Ms Gerrie Holloway  
Consultant Clinical Psychologist, Chief  
Investigator  
West of England Forensic Service for  
Women  
Fromeside  
Blackberry Hill  
Stapleton  
Bristol BS16 1 EG.  
Telephone: 0117 378 4167/8 or 4173  
(direct line)

Dr Frances Blumenfeld Academic  
Supervisor &  
Ms Gerrie Holloway, Doctoral Student  
University of Essex  
Colchester Campus  
Wivenhoe Park  
Colchester CO4 3SQ.  
Telephone 01206 873125/8741443

## **Appendix G (ii): Introductory DVD for Service Users**

## Appendix G (iii): Participant Information Part One

### Will the interview data go on my record or be shared with staff on the unit?

The content of the interview will not form part of your clinical record and will not be shared with the clinical team. However, a record of an invitation to take part and a note that you have been interviewed will be recorded in your healthcare record. However, if I have reason to believe that you, or someone else, are at risk of harm, or if you tell me about a criminal act that you have not previously disclosed, I may need to inform a member of the clinical team but I will tell you if I intend to do so.

### Are there possible disadvantages/risks in taking part?

It's possible that some of what is discussed in the interview may be sensitive for you and may cause you to become upset. I will be checking for signs of this and you can change the subject or finish the interview at any time. A member of staff will be available to provide you with support afterwards if necessary.

### What are the possible benefits of taking part?

Although there may be no direct benefit to you, you may find it helpful to talk about your experiences. However, the results of the study may increase understanding of mothers, which may improve the help that other women receive in the future and help prevent these things happening to them and their families.

### What if there is a problem?

Any complaint about the study would be taken very seriously. Part 2 of the Participant Information leaflet contains details of the complaints procedure.

Thank you for reading this leaflet. If are interested in taking part in the study, please see Part 2 of the Participant Information for further details of complaints and confidentiality procedures.

With thanks – Gerrie Holloway

### CONTACT DETAILS:

- |  |  |
|--|--|
| 1. Ms Gerrie Holloway<br>Clinical Psychologist<br>Fromside Forensic Service<br>Blackberry Hill<br>Bristol BS16 2EW<br>Tel. 0117 378 4012 | 2. Dr Frances Blumenfeld<br>(Academic Supervisor)<br>Ms Gerrie Holloway<br>(Doctoral Student)<br>University of Essex<br>Colchester, CO4 3SQ<br>Tel. 01206 873765 |
|--|--|



## PARTICIPANT INFORMATION

### PART ONE

### Maternal Filicide: An Exploration from the Perspective of mothers

A Research Study conducted by Ms Gerrie Holloway

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please watch the 90 second DVD which introduces me and explains a bit about the study. Please take time to read this leaflet carefully. This information is also available on CD in spoken form.

Maternal Filicide: An Exploration from the perspective of mothers: INFORMATION LEAFLET 1 - V.2 11.03. 2011

### What is the purpose of the study?

I am completing the research as part of a Doctoral qualification in Clinical Psychology with the University of Essex.

The purpose of the study is to gain an understanding about what was going on in the life of a mother who has killed her own child. This could help to improve the support that is provided to women who have had this experience. In particular, the aim is to understand:

- what mothers themselves say about their experience.
- To learn about potential factors which could be useful in identifying mothers and children at risk in the future and could improve treatment for yourself and others.

### Why have I been chosen?

I do not know your identity but I have spoken to your clinical team who have suggested that you can receive information and an invitation to participate in this study. I am also contacting other services as between 6-8 participants in the study will be interviewed in different sites around England.

### Do I have to take part?

No. Participation is completely voluntary. Your decision will have no impact on any decisions made about your detention or any aspect of your treatment.

### What will happen to me if I agree to take part?

Basically, it is a one-off interview.

- If you are interested in participating in the study then please let your clinical team staff member know and they will give you further information.
- If you consent to participate in the study your clinical team member will arrange for me to meet with you at a convenient time for interview.
- On the day of the interview I will check again that you understand the study and are happy to take part. You can still withdraw at this point.
- The interview will be quite informal and there will be no other forms or questionnaires to complete.
- It will be held in a private room in the unit and will take about an hour.

(continued overleaf)

- I will be interested in hearing your views about your experience, including:

Your understanding about the reasons for what happened.

The experiences you have had in life both at the time and before, that may have led to what happened.

You can refuse to answer any of the particular questions asked or you can say as much or as little as you want to. You can end the interview at any time and you can take breaks if you need to.

### What happens after the interview?

The interview will be recorded and typed up. Any personal information that could identify you or the unit will be removed. I will be analysing all the interviews together and picking out themes and patterns in the information. I will be writing up the study as a journal article, which may be submitted to an academic journal to be published.

Maternal Filicide: An Exploration from the perspective of mothers: INFORMATION LEAFLET 1 - V.2 11.03. 2011



## Appendix G (iv): Participant Information Part Two

### What will happen to the results of the research study?

It is intended that the research be published. You will not be identified in any publication. A summary of the findings will be sent to you, unless you would prefer not to receive it. The findings will also be presented to professionals working with mothers to improve their knowledge and understanding of mothers who have killed their children.

### Who is organizing and funding the research?

The research is funded by the University of Essex and Avon and Wiltshire Mental Health Partnership Trust. Neither (the unit), nor any clinician responsible for your care, will receive any payment for your participation in the study. The researcher is undertaking the research as part of a Doctoral Research Study, but is not being paid specifically to conduct the study.

### Who has reviewed the study?

The study has been reviewed by South West (4) Regional Ethics Committee, which provided approval for the study to be carried out at a number of specified sites.

Thank you very much for taking the time to read these information leaflets. Please keep them for your own records.

– With thanks – Ms Gerrie Holloway



## PARTICIPANT INFORMATION

### PART TWO

### Maternal Filicide: An Exploration from the Perspective of Mothers

A Research Study conducted by Ms Gerrie Holloway

This leaflet provides further information about the study's complaints and confidentiality procedures. It should be read following the leaflet entitled *Participant Information – Part One*.

#### CONTACT DETAILS:

1. Ms Gerrie Holloway  
Clinical Psychologist  
Fromside Forensic Service  
Blackberry Hill  
Bristol BS16 2EW  
Tel. 0117 9583678
2. Dr Frances Blumenfeld  
(Academic Supervisor)  
Ms Gerrie Holloway  
(Doctoral Student)  
University of Essex  
Wivenhoe Park  
Colchester, CO4 3SQ  
Tel. 01206 873765

Maternal Filicide: An Exploration from the perspective of mothers. Information leaflet 2- V.2 11.03.2011.

### What if there is a problem?

Any complaint about the way you have been dealt with during the study will be treated very seriously.

### Complaints:

If you have a concern about any aspect of this study, please address them to me (details overleaf) and I will do my best to answer them. If you are still unhappy and wish to complain formally, or you want to complain about something I have done or said, you can do any of the following:

- Tell the staff member who initially approached you about participating in the study. He/she will support you in following the NHS complaints procedures.
- Directly contact Helen Pike, the Complaints' Administrator for AWP (Helen.Pike@awp.nhs.uk / 01249 468217) or the Complaints' Administrator for your service.
- Contact either my research supervisor, who is based at the University of Essex, (contact details supplied overleaf).

### Harm:

In the unlikely event that something does go wrong and you are emotionally or psychologically harmed during the research study then you may have grounds for a legal action for compensation against myself or the University but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

### Will my taking part in this study be kept confidential?

All your information will be treated as confidential.

I will not need access to your medical, or other, records, for the purposes of this study.

As outlined in the first information leaflet, the content of the interview will not form part of your clinical record and will not be shared with the clinical team. The exceptions to this are if I believe that you, or someone else, are at risk of harm, or if you tell me about a criminal act that you have not previously disclosed to the clinical team. In these cases, I may need to inform a member of the clinical team but I will tell you if I intend to do so.

The interview will be digitally audio-recorded, with your consent. After the interview, I will type out the content of the interview and the audio recording will be deleted. A copy of the recording can be provided to you, on request.

Any personal information that could identify you or the unit will be removed from the typed data. The data will be stored securely while the study is written up. After the study is completed, and the doctoral thesis has been examined the data will be stored securely for 10 years within AWP Trust.

The data will be analysed by the researchers together with data from other participants' interviews. Approximately six to eight individuals will be interviewed in total. With your consent, some direct quotations may be included in the final report, but you will not be identifiable as the speaker.

You have the right to check the accuracy of data held about you and to correct any errors.

The procedures for handling, processing, storage and destruction of your data will comply with the Data Protection Act 1998 a copy of which is available to you if you so wish.

Maternal Filicide: An Exploration from the perspective of mothers. Information leaflet 2- V.2 11.03.2011.

**Appendix H: Consent form**



Participant Number:

**CONSENT FORM**

**Title of Project: Maternal Filicide: An Exploration from the Perspective of Mothers**

**Name of Researcher: Gerrie Holloway**

**PLEASE SIGN INITIALS IN BOX**

- 1. I confirm that I have read and understand the Information Leaflets Parts 1 & 2 dated 11 March 2011 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my treatment or other legal rights being affected.
- 3. I give permission for the interview to be audio-recorded.
- 4. I give permission for possible use of anonymous quotes of the interview to be written down and included in any publication.
- 5. I understand that if I disclose information regarding criminal activity or risks to myself or others that this information will be reported to my clinical team.
- 6. I agree to take part in the above study.

\_\_\_\_\_  
Name of Service User      Date      Signature

\_\_\_\_\_  
Researcher      Date      Signature

When completed: 1 for service user; 1 (original) to be kept in healthcare records; 1 for researcher site file.

## **Appendix I: Interview Guide**

### **INTERVIEW GUIDE**

As you know I am interviewing women who have had your experience to try to get information which will help us to understand and prevent the same thing happening to other mothers and their children.

I will ask you questions and I may ask you to repeat things if I have not understood. I am interested in hearing in your own words what your experience has been although I not be asking you to talk about what actually happened, I am interested in your experiences leading up to what happened.

You are welcome to take a break at any time.

So could you start by telling me where you were living at that time?

And who was living with you?

Did you work?

Were you in contact with any health or social services?

#### **1 EXTERNAL CONTEXT**

**What was going on for you around the time when your child died?**

*Events, problems, finances, family issues, contact with mental health or social care services?  
Can you say something more about that? Can you describe in as much detail as you can what was going on for you?*

*Do you have any examples of 'x' that you can describe for me?*

*Anything unusual?*

**HOW DO YOU THINK THAT XXX CONTRIBUTED TO WHAT EVENTUALLY HAPPENED TO YOUR CHILD?**

## **2. INTERNAL EXPERIENCES**

### **Appendix I: Interview Guide (contd)**

**Can you tell me what was going on in your mind or how you were feeling before you did what you did? Take your time and try to describe in as much detail as possible what you were experiencing.**

*Did something happen that triggered things for you at that time?*

*Was there something unusual that you were feeling, thinking experiencing?*

*What did you believe at that time?*

*How were you feeling?*

*Can you describe for me how you think you were at that time.*

*Was this different to your previous experiences?*

**HOW DO YOU THINK THOSE THINGS THAT YOU HAVE MENTIONED CONTRIBUTED TO WHAT HAPPENED?**

## **3. INTENTION**

What did you intend to do? What were your intentions at that time?

Had you a plan in your head? Had you had these thoughts before? So why do you think it was different this time?

What did you think might be the consequences of doing it?

Can you remember what you were thinking about before it happened?

**AND HOW DO YOU THINK THAT MIGHT HAVE INFLUENCED YOU AT THE TIME?**

## **4. HELP AND SUPPORT**

**Were there occasions that you tried to get help or support at that time?**

*Did you see your GP? Can you describe in detail an occasion when you tried to get help?*

*Were you in contact with mental health teams?*

*Did you have friends or family that you turned to?*

**DO YOU THINK THAT THESE THINGS THAT WE HAVE TALKED ABOUT CONTRIBUTED TO WHAT HAPPENED? AND IN WHAT WAY?**

**Appendix I: Interview Guide (contd)**

**5. CURRENT PERSPECTIVE**

LINK TO SOMETHING THAT THE PARTICIPANT HAS SAID.

Looking back what is your theory about why what happened happened?

*Interview de-brief/wind-down to include questions about what they will do next, what activities planned for the day, small talk about weather etc.*

*Remind participant that a summary of the study findings will be sent to them in beginning of 2013, unless they would prefer not to see it.*

## Appendix J: Diagrammatical Representation of Data

### Entering Motherhood

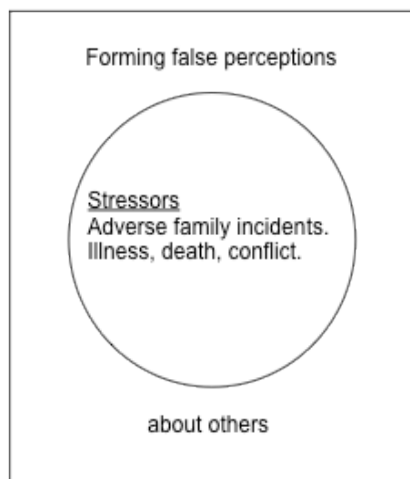
#### Becoming a Mother

Loss of identity  
Merging with child symbolically  
Separation anxiety

#### "Left Holding the Baby"

Money problems  
Inadequate housing  
Insecure housing  
Financial insecurity  
Living under Social Services regime

Privatising  
Publicising



QS Is it own feelings put on child  
What about women not involved

### Siege mentality

- Feeling threatened by others/suspicious
- Feeling anxious and depressed
- Begins to fear that child is going to be taken away

### Building up Phase

- Believes can't go on
- Believes death is the answer
- "autopilot"
- Believes child would be better off dead than alone



Kills child  
Kills self

Constructed on the 12<sup>th</sup> of July 2012

## Appendix K: Initial Introduction Letter to Clinician



Avon and Wiltshire   
Mental Health Partnership NHS Trust

Secure Services Strategic Business Unit

Address of Site

West of England Forensic Mental Health Service  
Fromside  
Blackberry Hill  
Stapleton  
Bristol  
BS16 1EG

Tel:(0117) 958 3678  
Direct Dial: (0117) 378 4168/4167  
Fax:(0117) 958 5477

Our Ref: GH/FS  
12 January 2014

**Dear (previous contact) re: participation in study 'Maternal Filicide: An Exploration from the Perspective of Mothers'**

You may recall that we have previously had contact regarding the above study which is a Grounded Theory interview study exploring the development of filicide from the perspective of mentally ill mothers. I am a practicing Consultant Clinical Psychologist who is conducting the study as part of my doctoral research at the University of Essex.

I have completed and analysed a number of interviews with mothers and am now looking to interview **clinicians** who have experience of working with women who have killed one (or more) of their children. The additional interviews with clinicians, aim to increase the understanding of maternal filicide by exploring the formulations that clinicians make about the development of the act in mentally ill mothers. The interview would explore clinicians' views about what contributed to the development of the filicide(s) in cases that they had worked with. The interview will not last longer than an hour and will not include any identifying information about specific casework. The interview will also explore the clinicians' responses to the concepts and categories that have emerged from the analysis of the interviews with mothers. Interviews with clinicians who wish to take part will occur at their place of work and will be recorded.

No studies have previously interviewed women who have killed their children so the present study represents an original research project. Very little is known about the experiences of mentally ill mothers who have killed their children and this study aims to increase knowledge about the experience from the perspective of mothers themselves, including what clinicians say about the development of maternal filicide. The study has been discussed within the Mental Health and Disability Division at the Department of Health and will potentially contribute to a range of policy developments. Findings from the study could also help psychologists, nurses and doctors to understand how best to help mothers who have had this experience and could improve risk assessment, management and treatment of mothers in the future.

Please find enclosed additional information leaflets about the study and also a reply slip. Please would you complete and return the slip in the stamped addressed envelope provided, within 10 working days, indicating whether you would be interested in participating in the study or not.

Approval for participation in the study will need to be obtained from your local trust R&D office prior to any interview, but they are aware of the study and I am liaising with them to obtain agreement.

## Appendix K: Initial Introduction Letter to Clinician (contd)

Thanking you in anticipation

Kind regards,



Ms Gerrie Holloway  
Consultant Clinical Psychologist, Chief Investigator  
West of England Forensic Service for Women  
Fromeside  
Blackberry Hill  
Stapleton  
Bristol BS16 1 EG.  
Telephone: 0117 378 4167/8 or 4173 (direct line)

Dr Frances Blumenfeld Academic Supervisor &  
Ms Gerrie Holloway, Doctoral Student  
University of Essex  
Colchester Campus  
Wivenhoe Park  
Colchester CO4 3SQ.  
Telephone 01206 873125/8741443

Tear off slip here-----

### Reply Slip

Name..... Post.....

Work Address..... Work email.....

..... Work Telephone number.....

.....

.....

**Please delete**

**I wish/do not wish to participate in an interview about my clinical work with women who have killed their children.**

**Signature**..... **Date**.....



# Appendix L: Participant Information Part One

## Will the interview data be confidential?

The content of the interview will be confidential and anonymised. However, if you disclose anything that suggests that you or anyone close to you is at risk of harm then I am duty bound to report this.

## Are there possible disadvantages/risks in taking part?

It's possible that some of what is discussed in the interview may be sensitive for you. I will be checking for signs of this and you can change the subject or finish the interview at any time.

## What are the possible benefits of taking part?

Although there may be no direct benefit to you, you may find it helpful to talk about your experiences and to participate in the study. The results of the study may increase understanding of mothers who have killed their children, which may improve the help that they receive in the future. The results of the study may also help prevent these things happening to mothers and their families in future.

## What if there is a problem?

Any complaint about the study would be taken very seriously. Part 2 of the Participant Information leaflet contains details of the complaints procedure.

**Thank you for reading this leaflet. If are interested in taking part in the study, please see Part 2 of the Participant Information for further details of complaints and confidentiality procedures.**

With thanks – Gerrie Holloway

### CONTACT DETAILS:

1. Ms Gerrie Holloway Consultant Psychologist Fromeside Forensic Service Blackberry Hill Bristol BS16 2EW Tel. 0117 378 4012	2. Dr Frances Blumenfeld (Academic Supervisor) Ms Gerrie Holloway (Doctoral Student) University of Essex Colchester, CO4 3SQ Tel: 01206 873765
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### APPENDIX II

## PARTICIPANT INFORMATION

### PART ONE

### Maternal Filicide: An Exploration from the Perspective of mothers

A Research Study conducted by Ms Gerrie Holloway

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please read this leaflet which sets out what participation involves.

Maternal Filicide: An Exploration from the perspective of mothers: INFORMATION LEAFLET 1 Clinician version - V.1 25.05. 2012

## What is the purpose of the study?

I am completing the research as part of a Doctoral qualification in Clinical Psychology with the University of Essex.

The purpose of the study is to gain an understanding about the contexts and experiences of a mentally ill mother who has killed her child from the mothers' viewpoint. I have interviewed a number of women nationally and analysed what they had to say. The views of clinicians with experience of working with women are now sought to compare and contrast with what women have said.

Participating clinicians will be asked to describe their formulations as to the development of filicidal behaviour in the women that they have worked with. Part of the study will also be to analyse previous media reports of women who have killed their children.

No studies have previously interviewed mentally ill mothers and so very little is known about the area. The findings of this study could help to improve the support that is provided to women who have had this experience and to prevent it happening in future.

## Why have I been approached?

I have approached a number of clinicians working in secure services to invite them to take part in the study. I have also circulated information about the study to a professional email discussion group that was sent to all members.

## Do I have to take part?

No. Participation is completely voluntary.

## What will happen to me if I agree to take part?

Basically, it is a one-off interview.

- If you are interested in participating in the study then please contact me on 0117 378 4167/8 (secretary's number) and I will arrange an interview with you at your place of work which will last about an hour.
- On the day of the interview I will check again that you understand the study and are happy to take part. You can still withdraw at any time.
- The interview will be audio recorded but quite informal and there will be no other forms or questionnaires to complete.

Contd. overleaf

- I will be interested in hearing about your understanding and formulation about what lead up to maternal filicide in the women you have worked with. The experiences you think that the mother had had in her life both at the time and before, that may have led to what happened.
- I will not need to know (and nor should you tell me) any identifying information about any of the people you have worked with.

You can refuse to answer any of the particular questions asked or you can say as much or as little as you want to. You can end the interview at any time and you can take breaks if you need to.

## What happens after the interview?

The interview will be recorded and typed up. Any personal information that could identify you or the unit will be removed. I will be analysing all the interviews together and picking out themes and patterns in the information. I will be writing up the study as a journal article, which may be submitted to an academic journal to be published.

Maternal Filicide: An Exploration from the perspective of mothers: INFORMATION LEAFLET 1 – Clinicians - V.1 25.05. 2012

## Appendix M: Participant Information Part Two

### What will happen to the results of the research study?

It is intended that the research be published. You will not be identified in any publication. A summary of the findings will be sent to you, unless you would prefer not to receive it. The findings will also be presented to professionals working with mothers to improve their knowledge and understanding of mothers who have killed their children.

The research has been discussed with the Mental Health and Disability Division at the Department of Health and will potentially contribute to a range of policy developments.

### Who is organising and funding the research?

The research is funded by the University of Essex and Avon and Wiltshire Mental Health Partnership Trust. The researcher is undertaking the research as part of a Doctoral Research Study, but is not being paid specifically to conduct the study.

### Who has reviewed the study?

The study has been reviewed by NRES South West (4) Research Ethics Committee, which gave a favourable ethical opinion.

**Thank you very much for taking the time to read these information leaflets. Please keep them for your own records.**

**– With thanks – Ms Gerrie Holloway**

### CONTACT DETAILS:

1. Ms Gerrie Holloway Consultant Psychologist Fromeside Forensic Service Blackberry Hill Bristol BS16 2EW Tel. 0117 9583678	2. Dr Frances Blumenfeld (Academic Supervisor) Ms Gerrie Holloway (Doctoral Student) University of Essex Wivenhoe Park Colchester, CO4 3SQ Tel: 01206 873765
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Appendix III

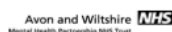
## PARTICIPANT INFORMATION

PART TWO

### Maternal Filicide: An Exploration from the Perspective of Mothers

A Research Study conducted by Ms Gerrie Holloway

This leaflet provides further information about the study's complaints and confidentiality procedures. It should be read following the leaflet entitled *Participant Information – Part One*.



Maternal Filicide: An Exploration from the perspective of mothers. Information leaflet 2 - Clinician version- V.1 25.5.2012.

### What if there is a problem?

Any complaint about the way you have been dealt with during the study will be treated very seriously.

#### Complaints:

If you have a concern about any aspect of this study, please address them to me (details overleaf) and I will do my best to answer them. If you are still unhappy and wish to complain formally, or you want to complain about something I have done or said, you can do any of the following:

- Directly contact Helen Pike, the Complaints Administrator for AWP (Helen.Pike@awp.nhs.uk / 01249 468217) or the Complaints Administrator for your service.
- Contact either my research supervisor, who is based at the University of Essex, (contact details supplied overleaf).

#### Harm:

In the unlikely event that something does go wrong and you are emotionally or psychologically harmed during the research study then you may have grounds for a legal action for compensation against myself or The University, but you may have to pay your legal costs.

#### Will my taking part in this study be kept confidential?

All your information will be treated as confidential.

I will not need access to any personal records for the purposes of this study.

As outlined in the first information leaflet, the content of the interview is confidential. The exceptions to this are if I believe that you, or someone else, are at risk of harm, or if you tell me about a criminal act that you have not previously disclosed. In these cases, I may need to inform a member of your organisation but I will tell you if I intend to do so.

The interview will be digitally audio-recorded, with your consent. After the interview, I will type out the content of the interview and the audio recording will be deleted. A copy of the recording can be provided to you, on request.

Any personal information that could identify you or the unit you work in will be removed from the typed data. The data will be stored securely while the study is written up. After the study is completed, and the doctoral thesis has been examined the data will be stored securely for 10 years within AWP Trust.

The data will be analysed by the researchers together with data from other participants interviews. Approximately four to six individuals will be interviewed in total. With your consent, some direct quotations may be included in the final report, but you will not be identifiable as the speaker.

You have the right to check the accuracy of data held about you and to correct any errors.

The procedures for handling, processing, storage and destruction of your data will comply with the Data Protection Act 1998 a copy of which is available to you if you so wish.

Maternal Filicide: An Exploration from the perspective of mothers. Information leaflet 2 - Clinicians V1 25.5.2012.

## Appendix N: Consent Form

Maternal Filicide: An Exploration from the perspective of mothers. (Clinician Consent Form) V.1 . 25.5.2012



Participant Number:

APPENDIX IV

### CONSENT FORM

**Title of Project: Maternal Filicide: An Exploration from the Perspective of Mothers**

**Name of Researcher: Gerrie Holloway**

#### PLEASE SIGN INITIALS IN BOX

1. I confirm that I have read and understand the Information Leaflets Parts 1 & 2 dated 25.5.2012 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my treatment or other legal rights being affected.
3. I give permission for the interview to be audio-recorded.
4. I give permission for possible use of anonymous quotes of the interview to be written down and included in any publication.
5. I understand that if I disclose information regarding criminal activity or risks to myself or others that this information will be reported to my employers.
6. I agree to take part in the above study.

\_\_\_\_\_  
Name of Service User      Date      Signature

\_\_\_\_\_  
Researcher      Date      Signature

When completed: 1 for participant (original); 1 to be kept in study file