

Running head: FORENSIC MENTAL HEALTH PROFILE OF WOMEN OFFENDERS

**The forensic mental health profile of women offenders in the Eastern Cape, South
Africa**

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Abstract

Introduction

There is a dearth of research on mental health issues in women offenders in South Africa, especially regarding their socio-demographic backgrounds, offence characteristics, and forensic mental health profiles.

Objectives

This study examined the psychosocial and forensic mental health profile of women offenders referred by eastern Cape courts for forensic evaluation. A range of socio-demographic, criminological, clinical and forensic mental health variables were systematically explored.

Methods

A bi-phasic, mixed methods study design was adopted. The clinical and forensic records of all women referred for forensic evaluation to Fort England forensic psychiatric hospital in the Eastern Cape, South Africa were retrospectively reviewed, comprising 173 individual cases in the study period of 1993-2017. Inferential statistical analyses (chi-squared and multivariate logistic regression) were applied to explore relationships between variables and offending outcomes of interest. Detailed semi-structured interviews were subsequently conducted with a sub-sample of 8 women with mental disorder and violent offending backgrounds. Interview transcripts thematically analysed.

Results

Most women came from impoverished and disadvantaged backgrounds. Whilst the majority were first-offenders, a high proportion had violent index offences, with murder, attempted murder and assault with intent to do grievous bodily harm accounting for over half of cases. The majority of victims of violence were well known to the perpetrator, especially as biological children, intimate male partners or close family members. Biological children in their first year

of life were particularly vulnerable to being victims of homicidal violence. Disproportionately high rates of pre-offence mental illness, alcohol misuse, HIV infection and prior abuse of the offender (especially by intimate male partners) were present. High rates of severe mental disorders (especially psychiatric comorbidity and psychotic-spectrum disorders), and relatively low rates of personality disorders and substance disorders were diagnosed. The majority of women were declared to lack trial competence and criminal capacity, respectively, following forensic evaluation. Women who had backgrounds of prior abuse themselves had over three times the odds of subsequent violent offending in general, and almost six times the odds of homicidal offending in particular. Homicidal offences were significantly more commonly committed by women with no prior psychiatric history and no psychiatric comorbidity. Women who committed homicide had over eleven times of killing children as opposed to adults. Women over the age of 30 years, and those without psychiatric comorbidity, were significantly less likely to have killed children. Thematic analysis of interviews emphasized the important roles played by gender, self-image, and mental health in violent offending pathways.

Conclusions

A complex array of socio-demographic, criminological, clinical and forensic variables interact in women offenders of the Eastern Cape referred by courts for forensic evaluation. Exploration of these factors improves understanding of the broader psychosocial context of female offending, and of the personal experiences of the women themselves. This in turn provides an enhanced gender-focus to guide the progressive changes required in policy, legislative, clinical and research endeavours in this field.

Key words: female or women offenders; forensic mental health; offending behaviour; South Africa

Declaration

I, Mohammed Nagdee, hereby declare that this thesis is based on my original work, except where acknowledgements indicate otherwise. It is being submitted for the degree of PhD in Psychology at Rhodes University, and neither the whole work nor any part of it has been, is being or will be submitted for another degree at this or any other university.



Mohammed Nagdee

28/09/2020

Dedication

This thesis is dedicated to my parents, Rokeya and the late Ismail Nagdee, my wife Acacia, and my sons, Zak and Yusuf, to whom I am forever indebted.

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Chapter One: Introduction

The focus of this thesis is the forensic mental health profile of women offenders in the Eastern Cape of South Africa via the systematic exploration of a range of socio-demographic, offence-related, clinical and forensic variables. By utilizing a mixed methods approach, the quantitative and qualitative analyses of data provided insights into the complexity of the relationship between mental health and offending behaviour in the study population, and the centrality of the gendered context within which this is embedded. This introductory chapter serves to provide an overview of the thesis with respect to the: (a) broad research context; (b) significance and relevance of the study; (c) motivation and aims of the study; (d) the study setting; (e) the study design and methodology employed; (f) the strengths and limitations of the study; (g) the overall layout of the thesis; and (h) the key findings, conclusions and recommendations, respectively.

Research Context

Biological sex and gender are important predictors of criminal behaviour¹, with offending rates for males being significantly higher than those of females in all countries, communities and cultures, for all age groups, and for most types of crime (Janeksela, 1997). Globally, the number of women arrested and imprisoned has, however, increased significantly in recent decades and at a rate higher than for men (QUNO and Penal Reform International, 2011; de Vogel & Nicholls, 2016; de Vogel & de Spa, 2019). Research on the psychosocial aspects of female criminality has historically received less attention than its importance merits, with most

¹ This thesis uses the term “sex” when biological differences between males and females are being described or referred to, whilst “gender” is understood to be a broader social construct related to, and largely determined by, socio-cultural values, norms, attitudes, practices and belief systems.

studies confined to developed European and North American countries (Putkonen and Taylor, 2014). There is, however, growing interest on the changing patterns of female offending, the profile of female offenders, and the broader context in which their offences occur. Such information has potentially significant implications for crime prevention, practice and policy in a number of fields, including forensic mental health. Numerous factors may have contributed to these changing trends, including: female economic marginalization; expanded criminal “opportunities” with changing gender roles; increased substance abuse among women; and widening of the “arrest net” aimed at relatively non-violent or less serious crimes for which women are usually apprehended (e.g. property and substance-related offences) (QUNO and Penal Reform International, 2011; Schwartz and Steffensmeier, 2007). There are also a range of complex and interacting criminogenic risk factors associated with offending behaviour in women e.g. backgrounds of socio-economic adversity, early abuse experiences, childhood impulsivity and conduct disorder; poor levels of education; sub-optimal child-rearing practices, single parenthood; chaotic family settings; parental criminality; interpersonal conflict; substance abuse; and mental health variables (Andrews and Bonta, 2010; Bohle & de Vogel, 2017; Cloninger and Guze, 1970; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; Farrington, 2009; Liddell & Martinovic, 2013; Martin et al., 1978; Wang & Stamatel, 2019).

Traditional theories of criminogenesis, developed primarily by men to explain male offending, have been questioned in respect of their applicability to female offending. Earlier studies either failed to include females, or if they were included, have been criticised for being stereotyped or sexist in many respects (Belknap and Holsinger, 2006; Burman et al., 2001). Critics have contended that the gendered nature of criminogenic risk factors (e.g. family conflict, role stereotypes, early abuse, patriarchal social systems, psychosocial factors, etc.) are ignored by traditional, androcentric approaches. This has ramifications not only in

understanding female offending, but in the design and content of policies, legislation, interventions and responses to such offending.

There is substantial evidence in the research literature that many female offenders, particularly those who are incarcerated, display a range of mental health problems, including psychological needs that encompass self-concept, self-esteem, affect, cognition, executive function and behaviour (Fazel and Danesh, 2002; Hodgins, 1992; Hodgins et al., 1996; Hollin and Palmer, 2006; Palmer et al., 2010). Whilst psychological distress and mental ill-health are significant concerns for many female offenders, it is not always clear whether, under what circumstances or how this translates into offending behaviour. Women offenders are reportedly up to twice as likely to experience severe mental health problems as their male counterparts (Putkonen and Taylor, 2014; Singleton and Meltzer, 2002). A large national criminological and psychiatric survey of women prisoners in England and Wales found almost 60% of women offenders to have at least one clinically diagnosed mental disorder, as compared with less than 40% of men (Maden et al., 1994a; 1994b). In addition, one third of women had a history of deliberate self-harm (compared with under one-fifth of men); and over one-quarter of women had received psychotropic medication (compared with under 10% of men) respectively.

The broader psychosocial context of offending behaviour is essential to understanding the vulnerabilities of female offenders to mental disorders. Empirical work demonstrates a broad range of factors in this regard, including adverse early life experiences, social and economic impoverishment, poor educational and occupational attainment, and early abuse experiences (Bartlett, 2007; Bohle & de Vogel, 2017; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016). Women offenders represent a particularly disadvantaged and marginalized group in respect of their socio-demographic profile, as they are characteristically women of

colour who come from more impoverished communities, have low educational opportunities and attainment, with poor occupational histories, and are often single mothers with dependent children with relatively poor family or social support (Bloom and Covington, 2008; Derkzen et al., 2013; de Vogel & Nicholls, 2016; James and Glaze, 2006; Singer et al., 1995; Veysey, 1998). Approximately 70 - 75% of women prisoners have young, dependent children, and are the primary caretakers at the time of their arrest (Greenfeld and Snell, 2000; Martin and Hesselbrock, 2001). In addition, an estimated one-quarter of women offenders are reportedly pregnant upon entry into prison, or had delivered a baby in the preceding 12 months (Wooldredge and Masters, 1993). These family responsibilities are a source of significant distress, and may be associated with substantial mental health difficulties in many of the affected women (Hurley and Dunne, 1991; Martin and Hesselbrock, 2001). It has been proposed that unstable social, familial and interpersonal relationships also increase the risk that women will follow criminal family members and associates into criminal behaviour themselves, and in so doing, transfer their tendency to inter-personal nurturance and commitment into illegal activities as well (Gilfus, 1992; Schwartz and Steffensmeier, 2007). An appreciation of these multi-factorial layers of sociodemographic, offence-related and clinical variables, and their links to the broader offending context, has implications for the design and provision of more appropriate, effective and gender-focused mental health services for women offenders (Derkzen et al., 2013; de Vogel & Nicholls, 2016; Liddell & Martinovic, 2013; Putkonen and Taylor, 2014; Veysey, 1998).

The needs of incarcerated women (whether in prisons or other institutional settings such as forensic psychiatric hospitals) are hence complex and reflective of the broader gendered context which characterize their lives. Two of the most important needs in relation to incarcerated women are related to mother and child care, and mental health care, respectively,

with both of these exacerbated by the vulnerability of women offenders to victimization and abuse in male-dominated prisons (Thompson and Darjee, 2006).

Furthermore, there are also many socio-demographic, psychosocial and contextual factors that may precipitate, exacerbate or perpetuate the propensity of women to act violently, and which may also influence the risk, nature and severity of mental ill-health of the perpetrator. In comparison to violent men, women who are violent tend to be older, married with children, poorly educated, and to have been the victims of prior violence themselves (de Vogel & de Spa, 2019; Hollin and Palmer, 2006; Putkonen et al., 2008; Rossegger et al., 2009; Weizmann-Henelius, Viemerö et al., 2003). Violent women are also less likely to be foreign nationals, antisocial, recidivistic or have prior convictions in comparison to violent male offenders (Loucks and Zamble, 1999; Rossegger et al., 2009; Salekin et al., 1997; Vitale et al., 2002; Yourstone, Lindholm, Grann et al., 2008). Many studies have documented robust associations between more severe forms of mental disorder and violence in both men and women, but possibly more so in women (Putkonen and Taylor, 2014; Taylor and Bragado-Jimenez, 2009). Yet other studies have emphasized that the extent to which mental disorder moderates the relationship between gender and violence may depend on many complex and interacting factors e.g. the type of violent behaviour, the specific psychosocial antecedents of the violence; and the diagnostic profile of the individual perpetrator, and its unique psychopathological and behavioural manifestations (Hodgins, 1992; Swanson et al., 2002; Wessely et al., 1994). Female forensic psychiatric inpatients with violent offending backgrounds also represent a unique subgroup of offenders, with complex diagnostic presentations and treatment needs (de Vogel & de Spa, 2019; Nicholls et al., 2004; 2009; Skeem et al., 2005).

An emergent subgroup of female homicide offenders increasingly resemble their male counterparts, in a number of respects e.g. victims are more likely to be strangers; the perpetrators are poorly adjusted within her family and society; and alcohol abuse being a significant criminogenic factor (Putkonen et al., 2008; Putkonen, Weizmann-Henelius et al., 2011; Weizmann-Henelius et al., 2009; 2012). There is increasing public, media, political, academic and research focus on the relationship between mental disorder and homicidal violence. Empirical gender differences have been reported regarding the criminal background, location of offending, weapon usage, victim-offender relationships (and especially abusive ones), and the motivational aspects of homicidal behaviour, though conclusive explanations for gender differences remain largely elusive (de Vogel & Nicholls, 2016; Flynn et al., 2011; Jurik and Winn, 1990; Kellermann and Mercy, 1992; Liddell & Martinovic, 2013; Peterson, 1999; Putkonen and Taylor, 2014; Sanford et al., 2006; Yourstone, Lindholm and Kristiansson, 2008). There are complex interactions between female-perpetrated homicide and a number of broader contextual factors, including socio-economic adversity, interpersonal and family dynamics, psychosocial distress, mental ill-health, substance abuse, and numerous uniquely individual variables (such as coping, and social skills, temperament, personality structure, distress management, frustration tolerance, impulsivity, communication style, decision-making style, etc.) (Evans et al., 2013; Large et al., 2009; Silver, 2006). Nonetheless, it is estimated that up to one-third of homicidal offences are committed by people with documented mental disorder (Swinson et al., 2007; 2011; Swinson and Shaw, 2007).

Significance and Relevance

Gender-focused criminological data is not readily available in South Africa, with little to no mention made of the role of gender in most criminological surveys and statistical reports. There are no detailed reports focusing specifically on female offenders in South Africa, nor on

trends in the offending behaviour they engage in. This is despite the fact that South Africa has one of the highest per capita imprisonment rates in the world, and the ninth largest prison population worldwide (International Centre for Prison Studies, 2013). The proportion of women prisoners in South Africa is still relatively low (less than 3%) in comparison to developed countries, in which women account for 2 -10% of the total prison population (International Centre for Prison Studies, 2013). Data from 2016 reveals that there were over 161 000 incarcerated people, with 2.5% of South African inmates being adolescent girls or adult women, held in one of 22 correctional centres (only 9 of which are exclusively for women) (Judicial Inspectorate for Correctional Services, 2016). Almost half of South African female prisoners were incarcerated for economic crimes, over one-third for violent crimes, and approximately 10 % for substance-related crimes in 2011 (South African Correctional Services, 2012).

The mental health of South African women offenders has received scant research attention but a few studies have documented their pathways to imprisonment to be characterized by disproportionately high levels of prior abuse exposure, chaotic family settings, impoverished social backgrounds, and high rates of alcohol abuse and severe forms of mental illness (Africa, 2015; Artz et al., 2012; Haffejee et al., 2005; Luyt and Du Preez, 2010; Nagdee et al., 2018; 2019). The dire situation regarding the gross inadequacy of prison mental health care services in the Eastern Cape in particular has also been documented by Sukeri et al. (2016). The relative paucity of research attention on the forensic mental health of women offenders may be reflective of a number of variables, including: the small number, and relative invisibility, of such women in both prisons and forensic mental health systems; gender-sensitive treatment models in the criminal justice and forensic systems may be overridden by the perceived common priority of secure containment for all offenders with mental disorders

(i.e. policies and practices being designed primarily for men); and prevailing gender bias in structural approaches and ideological paradigms (Bland et al., 1999; de Vogel & Nicholls, 2016).

Many complexities and challenges face this area of forensic mental health research inquiry. Women comprise the minority of prison and forensic mental health populations; and many studies exclude women entirely, whilst others fail to report results or discuss their interpretation in a gender-focused manner (Putkonen and Taylor, 2014; de Vogel & Nicholls, 2016; Liddell & Martinovic, 2013). Furthermore, what is considered a criminal offence often changes with time and is not universal across jurisdictions or countries, and the same applies to psychiatric diagnostics (Taylor and Bragado-Jimenez, 2009; Wang & Stamatel, 2019). There has been relatively little academic, research or clinical interest on the profiles, characteristics and needs of mentally ill women offenders, with the vast majority of studies confined to the developed world (Bartlett, 1994; 2004; Bohle & de Vogel, 2017; de Vogel & Nicholls, 2016; Hodgins et al., 1986; Nicholls et al., 2009). Most research evidence on forensic mental health issues in women offenders comes from urban settings in Western, industrialized countries (especially in Europe and North America), raising questions about the generalizability of outcomes and conclusions to other settings. Whilst research on women offenders with mental illness is relatively rare to begin with, it is also heavily biased toward quantitative studies that seek to categorize such women, as opposed to understanding them, or studies that focus on motives as opposed to recovery (Stanton and Simpson, 2002; 2006). Qualitative studies which explore the unique, individual perspectives and personal experiences of women offenders (especially those who commit homicide) with mental illness are even more rare.

In South Africa, most research on forensic psychiatric populations have been limited by relatively small samples, and an almost exclusive focus on men (Barrett, et al., 2007; Calitz et al., 2006; 2007; Du Plessis et al., 2017; Marais et al., 2011; Strydom et al., 2011). There has been only one study recently published from Africa (or any other part of the developing world for that matter) that has examined forensic mental health issues in South African women offenders, though the study was a purely descriptive, quantitative one (Nagdee et al., 2019). There have been no published qualitative studies on forensic mental health issues in South African women offenders to date.

Motivation and Aims

South Africa is a country with extremely high endemic rates of crime in general, and disproportionately high rates of violent crime in particular (Berg and Schärf, 2004; Schönteich and Louw, 2001; South African Correctional Services, 2012). The profound social impact, gender stereotyping, public interest, media focus, and socio-political ramifications relating to crime and violence, and its relationship to mental health, calls for more in-depth exploration and understanding of these phenomena. As demonstrated in the preceding overview, most research on the mental health of offenders (both nationally and globally) has been conducted in industrialized, Western countries and has focused largely or exclusively on men. Analyses commonly “control for gender” rather than considering it interesting in itself. The historical gender bias of research in this field is particularly problematic in view of rapidly changing gender patterns in crime, and especially in light of the fact that women are increasingly engaging in violent offending. Understanding of the forensic mental health issues of women offenders, however, requires the consideration of a myriad of relevant, and influential, contextual variables, incorporating demographic, social, environmental, cultural, criminological, physiological, psychological and psychiatric dimensions. A forensic mental

health focus is especially pertinent because offending behaviour is, at its essence, the outcome of the mental processes that precede it, direct its execution and determine the nature of the aftermath or consequences for the individual offender, her associates and the systems entrusted with her management. As Yarvis (1990) has argued, other criminogenic and aetiological factors do influence mental function, but remain removed or detached from the final complex behavioural end-product constituting the offending act itself i.e. mental function mediates between all other important contextual factors and offending behaviour. Forensic mental health analysis considers the nature and health of an offender's baseline mental function, and how any specific mental health problems may impact on cognition, volition and/or emotion in a manner that influences offending behaviour and its psycholegal consequences (whether prior to or at the time of the offence, during criminal proceedings, during the period of forensic evaluation, or subsequently). The presence of a diagnosed mental disorder may impact on legally important behavioural end-points, which in turn may influence the competence of offenders to stand trial or their criminal capacity. Such considerations are unique to the individual offender i.e. the unique nature and context of their offences, and its relationship to their unique mental health (or illness) profile. Formal, court-ordered forensic mental health evaluation entails detailed clinical analysis and consideration of the role (if any) played by mental illness, intellectual disability, neurocognitive impairment, personality and/or substance-related factors in the commission of offending acts, and their impact on the psycholegal brief provided by courts upon referral. Inextricably intertwined with such forensic mental health considerations are a range of variables related to the individual background and context of each offender, in the form of predisposing, precipitating, perpetuating and inhibitory or protective factors that are unique to the woman concerned.

The forensic mental health profile of women offenders in South Africa remains largely unexplored and unknown, with only single descriptive, quantitative study on the matter recently published (Nagdee et al., 2019), and no detailed qualitative studies thus far. It is in this context that the present thesis focused on women offenders from the Eastern Cape of South Africa, via a holistic, mixed methods exploration of their socio-demographic, criminological, clinical and forensic mental health characteristics. The complexity of interacting variables highlights the importance of both the quantitative data contained within the criminological and forensic clinical records, and qualitative information embedded within the experiences, perspectives and attitudes of individual women offenders, especially those with mental health problems. A mixed methods study design was considered to be the most useful vehicle to gain more meaningful understandings of the research questions of interest. It was anticipated that such combined quantitative and qualitative data would shed important light on various pathways to offending behaviour in these women, and the broader bio-psycho-social and cultural context in which such offending occurs (especially in respect of violent offending). A more detailed rationale for the choice of the mixed methods approach is provided in the study design section that follows.

The primary aim of the study, therefore, was to systematically explore, analyse and document the forensic mental health profile of women offenders in the Eastern Cape of South Africa, who were court-referred for forensic psychiatric evaluation. It was anticipated that this would make an original contribution to expanding the body of knowledge in this under-researched field in a number of ways by: (a) providing a focus on the central importance of gender in respect of offending behaviour and mental health, and in moderating the relationship between these in South African women offenders with mental disorder; (b) improving the accuracy of gender-focused information on psychosocial context, criminogenic needs, risk

analyses and management, and the provision of mental health services (forensic and generic) in South Africa; (c) facilitating an appreciation of the complexity of forensic mental health issues in women offenders, with potentially important implications for improving the necessary gender-focus of criminological, mental health, criminal justice and political policies; and (d) stimulating further interest in this historically neglected area of academic and research endeavour in developing countries such as South Africa, as well as of the region and continent.

The specific aims of the study may be conveniently categorized into descriptive, comparative and qualitative components respectively. Firstly, the descriptive component of the study sought to provide a detailed description of the sample of women offenders in the Eastern Cape of South Africa with respect to their socio-demographic, criminological, clinical and forensic profile respectively. Secondly, the comparative component of the study sought to compare, via inferential statistical analyses, the characteristics and profiles of various sub-groups of women offenders categorized by: (a) typology of index offence (i.e. non-violent offenders; violent but non-homicidal offenders; and homicidal offenders); and (b) type of victim (i.e. child versus adult) respectively. The statistical comparisons of the numerous socio-demographic, offence-related, mental health and forensic variables sought to investigate whether there were any significant associations between variables of interest, as well as whether any specific variables could reliably be utilized for risk prediction of violent offending in particular. Finally, with respect to the qualitative component of the study, detailed individual interviews were conducted with a sub-sample of women offenders with severe mental disorder who had committed violent offences, and who were therefore managed within the forensic mental health system. This component of the study sought to explore the subjective perceptions, experiences and opinions, via thematic analysis of semi-structured interviews, of women who had the lived experience of both severe mental illness and violent offending.

Study Setting

South African Legislative Framework

Legislation guiding the process and management of offenders who are suspected to be, or actually are, mentally ill varies widely between countries. It is not a universal principle that the mental state of a criminal defendant necessarily influences the criminal justice process or alters the legal outcome (Flynn et al., 2011; Kaliski, 2006; Stone et al., 2000). Similarly, the circumstances under which offenders with mental disorder are diverted for treatment and rehabilitation to the mental health system, as opposed to the criminal justice system, varies as widely. The guiding principles and requirements of criminal liability in South Africa are based on an amalgam of common law and Roman Dutch law. Like many legal systems elsewhere, a defendant who is charged with an offence will only be held guilty if the State is able to prove beyond reasonable doubt that the defendant both (a) committed an unlawful act (*actus reus*) and (b) had simultaneous fault or culpability (*mens rea*, which translates from the Latin as “guilty mind”) (Snyman, 2014). In other words, prior to confirming that a defendant acted with culpability, she must be confirmed to have criminal capacity; and she has capacity if she has the mental abilities required by law to be held criminally responsible and liable for her unlawful conduct. In South African law, people with mental disorder (as is also the case for young children) may be acquitted from criminal liability if it can be demonstrated that they lack certain mental abilities i.e. by successful application of the so-called “insanity defence” (Kaliski, 2006; Snyman, 2014).

South African criminal law on mental illness evolved beyond the Victorian-era “M’Naghten Rules” following the acquittal of Demitrios Tsafendas, a mentally ill parliamentary messenger who assassinated the then Prime Minister of South Africa, Hendrick

Verwoerd, in 1964 (Kaliski, 2006). The subsequent Commission of Inquiry into “The Responsibility of Mentally Deranged Persons” conducted a detailed investigation into the issue of mental illness in the context of criminal behaviour (Rumpff, 1967). The Rumpff Commission recognized three aspects of mental function: (a) cognition (which included thinking, perceiving, reasoning, remembering, abstracting and having insight); (b) conation / volition (the ability to control behaviour by the voluntary exercising of free will); and (c) affect (feelings or emotions) respectively. The Commission held that mental illness (and by extension, intellectual disability) may cause “deterioration” of these functions, though in different ways and with different implications in respect of criminal law. Impairment in cognition (if sufficiently severe) may impair insight and the ability to differentiate between right and wrong; whereas, impairment in conation / volition (if sufficiently severe) may similarly impair the ability to exercise self-control over actions and behaviour. Although affective functions can, and do, influence goal-directed behaviour, the Commission contended that even intense emotions are ultimately subject to will power, and that mental illness does not necessarily impair affect to the point that this unavoidably leads to “blind impulses” and involuntary conduct. In other words, individuals who have impairments in affective function, ought nonetheless to be able to: (a) via their cognitive functions, appreciate right from wrong, set goals and make decisions; and (b) via their conative / volitional functions, pursue voluntarily selected behaviour and exercise sufficient self-control over the behavioural expression of their emotions. The so-called “insanity defence” in South African law hence came to rest on three key premises: (a) an act or omission which is unlawful i.e. an offence; (b) the presence of mental disorder (which includes severe mental illness and intellectual disability, but excludes substance-related and personality disorders); and (c) a consequent lack of criminal capacity (also called criminal responsibility) via significant impairment of cognition and/or volition at the time of the offence. The Rumpff Commission’s recommendations led to the

enactment of legislation outlining the key elements required for the defence of mental illness in criminal law, together with the associated procedural matters, and legal or forensic consequences in the Criminal Procedure Act (CPA) (Act No. 51 of 1977) and subsequent amendments (including the Criminal Procedure Amendment Act (CPAA) (Act No. 4 of 2017) respectively. The provisions that deal with these matters are contained in Chapter 13 of the CPA (1977) and CPAA (2017), comprising of three key sections regarding: (a) trial competence (section 77); (b) criminal responsibility / capacity (section 78); and (c) procedures for formal referral for forensic psychiatric evaluation (section 79) respectively, each of which are briefly reviewed below.

Trial Competence. South African criminal law is based on the premise of trial competence (referred to as “capacity to understand court proceedings” in section 77 of the CPA, but also referred to as “fitness to stand trial” or “trial capacity”) i.e. that a defendant must be able to understand trial proceedings and must be able to assist or instruct her defence counsel in order to make a proper defence. Section 77 deals with a criminal defendant’s trial competence: if at any stage of the trial it appears to the court that a defendant may be suffering from a mental disorder of a nature or severity that may impair trial competence, the court will order a formal forensic psychiatric enquiry into the matter in order to receive an expert opinion on trial competence, which relates to the defendant’s mental state at the time of trial. The enquiry into trial competence is viewed by the courts as a preliminary issue prior to the issue of criminal capacity for the alleged unlawful conduct is examined.

Criminal Responsibility. There is no formal definition of mental disorder, but the CPA (1977) specifies this to entail either “mental illness or intellectual disability”. If the “insanity defence” is raised, a formal forensic determination of the defendant’s criminal responsibility

(also referred to as criminal capacity) is required, with the burden of proof resting on the legal party who raised the issue. Criminal capacity rests on the ability of a defendant to both: (a) appreciate the wrongfulness of her act or omission (i.e. cognitive component related to insight); and (b) act in accordance with an appreciation of the wrongfulness of her act or omission (i.e. volitional component related to voluntary self-control) respectively. The basis of referral for formal forensic evaluation of capacity may be based on a number of factors e.g. unusual behaviour in court, previous mental health problems, testimony from the family of the defendant regarding their mental health, difficulties encountered by legal counsel to consult with the defendant, etc. (Kaliski, 2006). The evaluation of criminal capacity is expected by courts to be an informed, impartial and evidence-based clinical judgement by the assessing forensic mental health experts, which can be, and often is, tested under cross-examination during the trial. An individual defendant's capacity is determined by reference to the individual defendant and her alleged index offence only, and not by reference to any normative evaluation of reasonable standards of conduct (Snyman, 2014). The standard of proof applied by courts in these cases is therefore "on the balance of probabilities", as opposed to the higher threshold of "beyond reasonable doubt" that applies to all other criminal cases in which the mental health of defendants is not in question. Whilst there is a legal presumption that every person does not suffer from mental illness or intellectual disability so as not to be criminally responsible, whenever mental health becomes an issue in a criminal case, the matter is governed by the section 78 of the CPA.

Forensic Mental Health Evaluation. When the issue of mental disorder, and its potential influence on trial competence and/or criminal capacity, is formally raised in court, section 79 of the CPA (1977) and its subsequent amendments (including the CPAA, 2017) are invoked in order to trigger a formal forensic mental health evaluation of the defendant. In terms of section

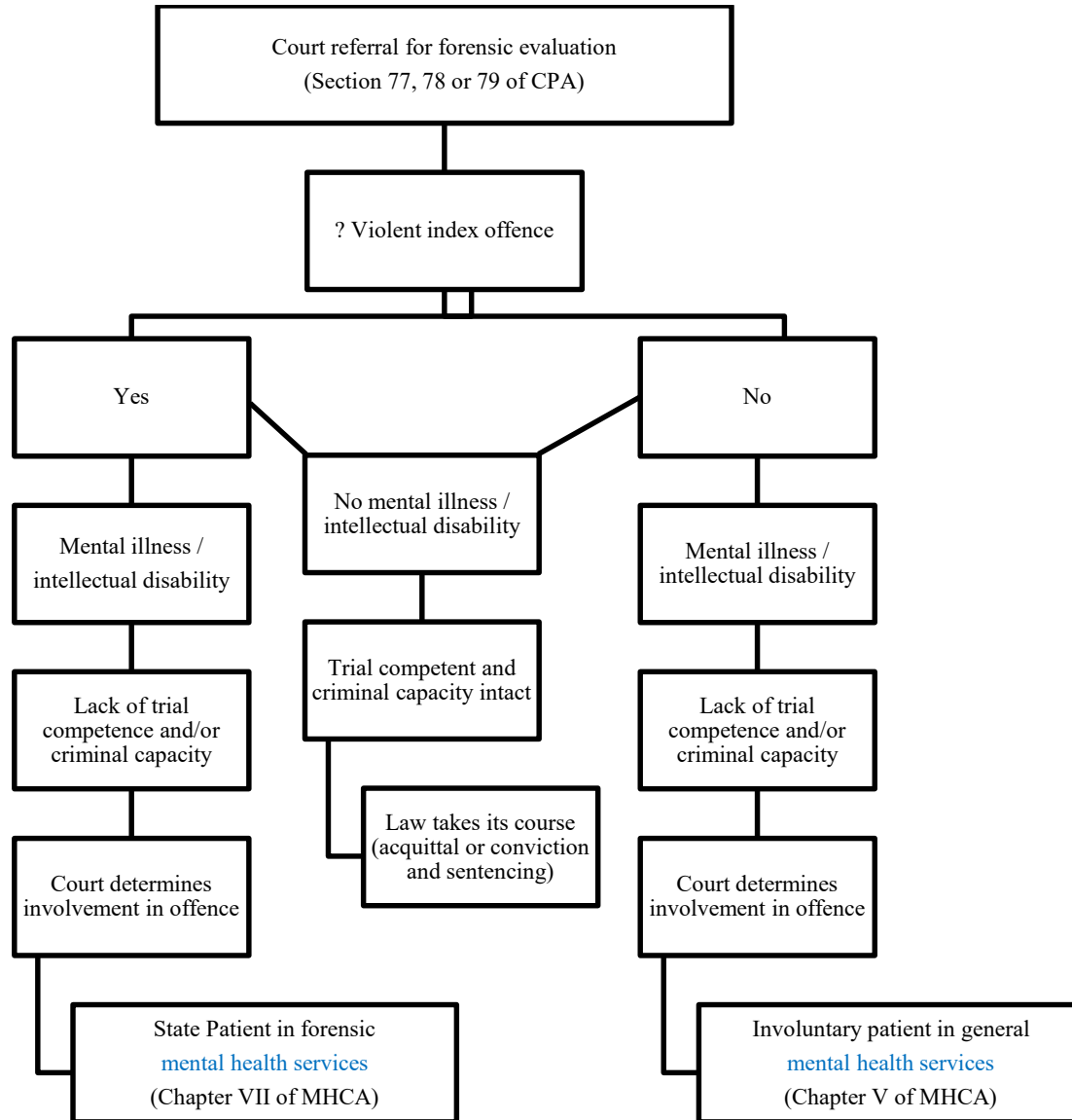
79, the court may refer a defendant at any stage of the trial for a forensic assessment and a formal expert opinion on: (a) whether a mental disorder (mental illness or intellectual disability) is present, and if so, its nature and severity; (b) whether the mental disorder has any impact on trial competence and/or criminal responsibility, and if so, to what degree; and (c) recommendations to the court on how to proceed as a result of these findings. Defendants are usually admitted for formal forensic evaluations to a designated public-sector forensic psychiatric hospital under a court order for a period of up to 30 days (renewable upon application to the court), though there is also an option for such assessments to be conducted on an out-patient basis or in a holding prison. The CPA distinguishes between offences that involve serious violence and non-violent offences: in cases involving serious violence, the CPAA (2017) directs the appointment of two psychiatrists for such forensic assessment (with a third psychiatrist appointed upon application by the defence counsel but only upon good cause). In addition, a clinical psychologist may, at the court's discretion, also be appointed to form part of the assessing forensic panel. In cases not involving serious violence, a single psychiatrist is considered sufficient to conduct and report upon the forensic evaluation. The specific terms and procedures for formal forensic evaluation are specified in section 79 of the CPA (1977).

Defendants may, as a result of the forensic evaluation described by the CPA, therefore be found not guilty by reason of mental disorder due to (a) being unfit to enter a plea, assist in their own defence, or for some other reason lacking trial competence; and/or (b) a lack of criminal capacity/responsibility. Such individuals may be referred, should the court be satisfied of their involvement in the offence, under the Mental Health Care Act (MHCA) (Act No. 17 of 2002), to mental health services for care, treatment and/or rehabilitation. The nature of the mental health care directed by the court depends largely on the nature of the mental disorder,

the index offence, findings on trial competence and/or criminal capacity, and the risk profile of the defendant concerned: for non-violent index offences and defendants considered a low risk for re-offending, court referrals will usually be in terms of Chapters V of the MHCA (2002) to general, non-forensic mental health services; whereas for violent index offences or defendants considered at high risk of serious violence (even in cases of non-violent index offences), referrals will be in terms of Chapter VI to specialized forensic mental health services respectively. An algorithm of these forensic evaluation and legal pathways is provided in Figure 1.

Figure 1

Forensic Evaluation and Legal Pathways as Regulated by the Criminal Procedure Act (1977) and Mental Health Care Act (2002)



Offence Classification. For the purposes of the present study, both prior and index offences categorized by an adaptation of Snyman's (2014) criminological classification, being the most widely used typology in the South African criminal justice system (Table 1 and Appendix 1).

Table 1***Classification of Offences (adapted from Snyman (2014))***

Category	Sub-category	Specific examples of crimes
Crimes against the State and the administration of justice	Crimes against the State	Treason, sedition, public violence
	Crimes against the administration of justice	Contempt of court, obstructing the course of justice, perjury, escape from custody
Crimes against the community	Sexual crimes	Any sexual assault under the Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act 32 of 2007)
	Crimes against the family	Bigamy, common-law abduction
	Crimes against public welfare	Corruption, extortion, drug offences, unlawful possession of firearms, concealment of births, public indecency, violating a grave or corpse
Crimes against a person	Crimes against life	Murder, attempted murder, culpable homicide, administering a noxious substance, exposing an infant

Category	Sub-category	Specific examples of crimes
	Crimes against bodily integrity	Common assault, assault with intent to do grievous bodily harm, intimidation, pointing a firearm
	Crimes against dignity and reputation	<i>Crimen iniuria</i> , criminal defamation
	Crimes against freedom of movement	Kidnapping
Crimes against property	Crimes related to appropriation of property	Theft, removal of property for use, robbery, receiving stolen property
	Fraud and related crimes	Fraud, forgery, theft by false pretences
	Crimes related to damage to property	Malicious injury to property, arson, housebreaking and related offences, trespass

The Eastern Cape

The study was conducted on women offenders referred by courts for formal forensic psychiatric evaluation to Fort England Hospital (FEH) in Makhanda (formerly Grahamstown), situated in the Eastern Cape province of South Africa, a region that is largely rural, impoverished, poorly resourced and under-developed. Data from the last national South African Census provides a contextual overview of the provincial profile of the Eastern Cape, with respect to its geography, population demographics, general health and functioning, and household statistics and services respectively (Lehohla, 2014) (Table 2).

Table 2

Eastern Cape (EC) Population Census Profile (adapted from Lehohla, 2014)*

Census item		EC census data
(SA national comparative data in parentheses)		
Geography	Area	168 966 km ² (13% of total area of SA)
Population	Population number	6 562 053 (12% of total SA population)
	demography	
	Population density and distribution	The two largest metropolitan areas are Port Elizabeth / Nelson Mandela Metropole and East London / Buffalo City Metropole, respectively; population density is highest in the rural, eastern half of the province

Census item	EC census data
	(SA national comparative data in parentheses)
Race**	Black African 86.3% (79.2%); Coloured 8.3% (8.9%); White 4.7% (8.9%); Indian/Asian 0.4% (2.5%); Other 0.3% (0.5%)
Gender	Male 47.1% (48.7%); female 52.9% (51.3%)
Age distribution	0-14 years 33.0% (29.2%); 15-64 years 60.2% (65.5%); over 65 years 6.7% (5.3%)
Language	Isi-Xhosa 77.6%; Afrikaans 10.4%; English 5.5%; Sesotho 2.4%; Other 4.1%
Highest level of education (for persons above 20 years of age)	No formal schooling 10.5%; some primary schooling 18.3%; completed primary school 6.2%; some secondary schooling 36.4%; completed secondary school 19.8%; tertiary education 8.7%
General health and functioning	Disability 9.6% of the population recorded as having a physical disability significant enough to cause activity/ functional limitation
Labour market	Unemployment rate 37.4% (majority are women)

Census item		EC census data
(SA national comparative data in parentheses)		
Household statistics and services	Type of dwelling	Formal 63.2% (concentrated in western half of EC); informal 7.7%; traditional 28.2% (concentrated in eastern half of EC); other 0.9%
	Type of toilet facilities	Flush toilet 45.9%; pit latrine 34.1%; bucket toilet 2.3%; none 12.7%
	Proportion of households with electricity for purpose indicated	Lighting 75%; cooking 62%; heating 31%
	Selected household goods ownership	Cellular phone 81.9%; television 63.2%; radio 61.1%; refrigerator 53.9%; computer 11.9%; terrestrial telephone 9.8%

Note. * Abbreviations: Eastern Cape (EC); South Africa (SA)

** It is recognized that “race” and “ethnicity” are complex terms, and often used interchangeably with little agreement on definitions or distinctions, including in the research setting. The term “race” is in general usage in the South African context (both past and present), and will hence be used throughout the thesis for the sake of consistency and simplicity. Such usage does not imply endorsement of the racist origin of this terminology.

A review of the Annual Reports of the Judicial Inspectorate for Correctional Services (2008 – 2016) provides an overview of prison services, and highlights the significant deficiencies within this system in South Africa, especially in catering for incarcerated women and their needs. The country had 236 operational prisons in 2016, housing a total prison population in excess of 160 000, the vast majority of whom were male (greater than 97%). Forty-five of these prisons are located with the Eastern Cape, which had a provincial prison population of approximately 20 000 prisoners in 2016 (12.5% of the national total). The Eastern Cape also has one of the highest prison bed occupancy rates in the country (above 142%), being considerably higher than the South African national average of 133% (Judicial Inspectorate for Correctional Services, 2008-2016). There was a total of 359 women prisoners in the Eastern Cape in 2016 (comprising 8.7% of the 4118 incarcerated women in South African prisons). At present, only twenty-two South African prisons cater for women in addition to men, and only 9 of these institutions are exclusively for women. Reliable gender-specific criminological data for the Eastern Cape is scarce. Nonetheless, the proportion of total crime contributed to by each category of Snyman's (2014) classification of offences (as described in Table 1 above) in the Eastern Cape are as follows: (a) crimes against the State and the administration of justice: 0.5%; (b) crimes against the community: 30%; (c) crimes against a person: 24%; and (d) crimes against property: 45.5% respectively (Crime Statistics South Africa, 2017).

Fort England Hospital (FEH)

Specialized forensic mental health services related to criminality in South Africa comprises three main areas of endeavour: (a) criminal defendants/offenders², as per Chapter 13 of the CPA (1977) and its amendments; (b) the care, treatment and rehabilitation of state patients, as per Chapter VI of the MHCA (2002) i.e. forensic patients who have committed serious or violent offences and, following formal forensic psychiatric evaluation, declared by courts to have been trial incompetent and/or lacking criminal capacity due to severe mental disorder; and (c) the care and treatment of mentally ill prisoners, as per Chapter VII of the MHCA (2002). Specialized forensic mental health services in the Eastern Cape are provided primarily by FEH, being the only tertiary-level forensic psychiatric hospital in the province which provides a full range of forensic mental health services with a dedicated, full-time multi-disciplinary team of forensic mental health professionals (including a number of registered forensic sub-specialist psychiatrists, general psychiatrists, psychiatric registrars, psychologists, occupational therapists, social workers, pharmacists and nursing personnel). In excess of 95% of court-ordered forensic evaluations in the Eastern Cape are conducted at FEH, including all offenders in the province charged with violent offences (comprising the majority of cases) requiring a panel of psychiatrists to compile the final court psychiatric report (Sukeri et al., 2016). Fort England Hospital is also the site of the national Maximum Security Unit (MSU), which receives forensic referrals from all other forensic mental health facilities in South Africa

² The term “offender” is used throughout this thesis for its simplicity, pragmatic value and universality of use in the literature. It is acknowledged, however, that the current study sample were technically criminal defendants (or remand detainees), who were charged with an offence, but not necessarily convicted, at the time of forensic assessment i.e. the trial process had not run to completion during the time of the forensic evaluation. The exception to this were the sub-sample of women who were interviewed for the purposes of detailed thematic analysis: these were women offenders with a diagnosed mental disorder, whom the courts had established had carried out the offences they were charged with, but on the basis of the so-called “insanity defence”, were declared State Patients and diverted into the forensic mental health system for treatment (as opposed to the prison system for punishment).

for patients who require intensive, specialized management in a high-secure setting as a result of risk profile, clinical complexity and/or extreme behavioural challenges posed. This unit is also the only accredited mental health unit in the province designated for the admission and in-patient management of mentally-ill prisoners (i.e. convicted prisoners who are serving sentences in prison, who subsequently develop severe forms of mental disorder requiring specialist in-patient mental health care). In addition, FEH is an accredited post-graduate training centre for forensic sub-specialty training, in accordance with the regulations of the Certificate in Forensic Psychiatry of the College of Psychiatrists of South Africa (College of Psychiatrists of South Africa, 2018).

Study Design and Methodology

The study adopted a mixed methods design, in which both quantitative and qualitative research approaches, techniques and data were utilized and combined, as this has been demonstrated to facilitate the benefits of each approach whilst minimizing their respective shortcomings (Fiorini et al., 2016). Quantitative methodologies, via standardization of the data collected, are better able to assess patterns across multiple variables, and in so doing make inferences about generalizability and causality; however, such standardization also limits the ability to manage unexpected information, as well as the reasons underlying quantitative data or respondents' answers (Pasick et al., 2009; Scott et al., 2011). The opposite is true for qualitative analyses, in which standardization is minimal and sample sizes typically small, but which are able to provide better insights into underlying reasons behind data, are more receptive to nuance and complexity, and more open to the identification and interpretation of unexpected processes or outcomes (Pasick et al., 2009; Scott et al., 2011). Generalizability of the findings of purely qualitative studies are, however, limited. Hence, by making use of both methodologies, mixed methods designs are potentially better at addressing broad,

multifactorial and complex research questions, such as those encountered in the health sciences, and in drawing more robust, rigorous and meaningful conclusions (Fiorini et al., 2016; Halcomb and Hickman, 2015). The pragmatism of mixed methods research design is an added advantage in the mental health sciences, as it allows a focus on applicability to real world problems, and values both objective and subjective knowledge (Johnson et al., 2007). As outlined by Fiorini et al. (2016), a number of attributes therefore supported the rationale for using the mixed methods approach for this study, including: complementarity of answers from both quantitative and qualitative components; completeness of understanding of complex, interacting variables; research question development and expansion; corroboration or confirmation of inferences or conclusions; compensation of limitations of one method by strengths of the other; and diversity in comparing and contrasting different perspectives on the same phenomena of interest. Whilst the advantages of mixed methods research designs seem clear, there are also some limitations to the methodology, such as the fact that it is relatively more time consuming, difficult, expensive and/or labour-intensive (Johnson and Onwuegbuzie, 2004; Zou et al., 2014).

Various types of mixed method research study designs have been described (Fiorini et al., 2016), including: (a) parallel type (in which quantitative and qualitative data are collected and analysed simultaneously, with findings subsequently compared in order to draw conclusions); (b) sequential type (which involves two different phases of data collection, in which the second phase of research questions, sampling, data and analysis is informed by the results of the first phase) e.g. an initial quantitative questionnaire / data collection tool is completed, the results of which then guides the design and focus of a qualitative interview schedule; (c) conversion type (in which the data from one approach (i.e. quantitative or qualitative) is converted to another); and (d) a fully integrated combination of the first three

types. The sequential mixed methods research design was selected for the present thesis i.e. the quantitative study phase was followed by, and informed, the qualitative study phase. This sought to optimize the opportunity to explore, expand on, and confirm the findings of the quantitative data from the first phase, and allowed more meaningful conclusions to be drawn by the addition of the second, qualitative phase of study. The results of each phase were anticipated to be convergent in some respects (i.e. where aspects of both phases lead to similar conclusions), and complementary in other respects (i.e. where the quantitative and qualitative results supplement each other), producing final, integrated study outcomes and conclusions which are potentially greater than the sum of their parts.

Hence, the forensic mental health profile of all women in the Eastern Cape who were charged with an offence, and subsequently referred by courts to Fort England Hospital (FEH) for formal forensic psychiatric evaluation (under the Criminal Procedure Act (CPA) (1977) and its amendments (CPAA, 2017), was systematically examined. A total of 173 such women underwent forensic evaluation at FEH between 1993 (the date from which archival records were available at FEH) and 2017 (the end of the study period). The mixed methods research design yielded data that was explored by both: (a) quantitative means (via descriptive and comparative inferential (χ^2 and logistic regression) statistical analyses); and (b) qualitative means (thematic analysis of semi-structured interview transcripts) respectively.

Study Strengths

Most studies of female offenders examine data from samples from large urban centres in developed, industrialized, Western countries, with similar research in developing countries and rural settings being relatively rare (Scott and Davies, 2002). Historically, many studies on the mental health of female offenders have been carried out on prison samples, have had relatively

small sample sizes, or contained little by way of inferential statistical analyses or qualitative data. Methodological limitations of some studies have also included unspecified diagnostic criteria, making comparisons with research results difficult; recording of only cross-sectional clinical observations, as opposed to more comprehensive, longitudinal clinical data; inadequate multi-disciplinary clinical evaluation data; differences in the nature and source of study samples; sample bias; and issues with respect to generalizability and representativeness (Putkonen and Taylor, 2014). Given this background, the current thesis has a number of strengths, each of which will be considered in turn below.

The most significant advantage of the present study design relates to the nature of the mixed methods research design, which integrated quantitative and qualitative approaches, optimizing the strengths of each whilst minimizing their respective shortcomings. The quantitative component of this study, via detailed analysis of offence-related, clinical and forensic records data held a number of benefits, including: (a) assessment of patterns and trends over multiple, complex variables; (b) identification of significant associations between variables; and (c) provision of the ability to potentially generalize certain outcomes, and infer significant associations, if not directly causal connections. The qualitative component of the study, via the thematic analysis of detailed interviews with women offenders, provided insights into some of the reasons behind the quantitative findings, and an appreciation of the broader, human and psychosocial research focus. In so doing, more meaningful and enriched understandings of the nuances and complexities of the study findings were enabled. Furthermore, the qualitative component of the study served as a reminder that each of the women interviewed is a unique human being, with unique life narratives, experiences, and opinions (as was also the case for all women offenders whose records contributed to the quantitative component of the study). Such qualitative insights provided benefits in realms

beyond the purely abstract and scholarly. In practice, the mixed methods research design was well suited to exploring the complex, multi-factorial and relatively poorly understood phenomena under study i.e. the forensic mental health of South African women who engage in offending behavior, especially of a violent nature. The pragmatic strength of the mixed methods approach was particularly helpful in efforts to more fully understand the nature and broader psychosocial backgrounds of the women included in the study. This enabled clarification of key study outcomes, and in proposing and prioritizing recommendations to address the challenges identified as a result.

A second strength of the study is related to the relatively good sample size. There are two crucial pre-requisites to obtain reasonable sample case-loads in studies on the forensic mental health of female offenders: (a) the time period under study, with the more robust and widely-cited studies covering in excess of 5-10 years; and (b) the catchment area size, with a threshold in excess of around 5 million people considered favourable (Schanda et al., 2004). The current study met both these criteria, covering a period in excess of 20 years (1993 – 2017), with the catchment area being the entire Eastern Cape, a province with a population in excess of 7 million people. In other words, this research examined the entire population of all female offenders referred by courts for formal forensic psychiatric evaluation to FEH, for the whole provincial legislative jurisdiction, over a period exceeding two decades. This optimized the study sample size (a sample of 173 women offenders was substantially larger than most other studies of this nature in the research literature) and minimized some of the sample bias issues associated with smaller study samples.

Thirdly, the present study also focused on the forensic mental health of female offenders from a largely rural, impoverished province of a developing, sub-Saharan African country. As far as the author-researcher is aware, no equivalent, large mixed methods study of this nature has been previously conducted provincially, nationally or continentally. The only other research study in South Africa (or the African continent) in this field was the recently published national collaboration on female offenders which arose as an extension of the present study, and drew on the forensic clinical records of almost 600 female offenders from six forensic institutions in the country, but was limited to a descriptive quantitative analysis (Nagdee et al., 2019). This again emphasizes the value of the present mixed methods research approach, and its extension beyond basic descriptive information to a more detailed inferential statistical analysis, as well as the inclusion of thematic analysis of qualitative data obtained by semi-structured interviews.

In the fourth instance, data for the present study were drawn from detailed individual clinical and forensic mental health records (as opposed to large, generic, prison, criminological or other non-clinical databases) held at Fort England Hospital, which is a large, tertiary, academic forensic mental health facility with an established and sound records archive system. The information contained within the forensic mental health records covered a wide set of domains of interest. These included details of socio-demographic variables and pre-offence background; offence-related and court-referral data; victim-offender relationships; prior mental health history; circumstances of the index offence(s); detailed narratives of offender versions of the offence (providing further information on the unique background, context, motivation and mental state of individual offenders at the time of the offence); detailed, clinical data on longitudinal forensic assessment conducted by multi-disciplinary forensic teams throughout

the formal period of evaluation (typically of at least 3 – 4 weeks in duration), during which comprehensive clinical observations, interviews, assessments and investigations were carried out and documented in each case); access to psychiatric court reports and forensic mental health summaries providing details of each forensic case assessment and the forensic outcomes (including final clinical diagnoses using the structured DSM classification system; as well as formal statements on trial competence, criminal responsibility and recommendations made to court); and access to all subsequent clinical, administrative and legal records of violent women offenders with confirmed severe mental disorder, who were declared by courts as State Patients and admitted to FEH for institutional forensic management.

Finally, the study design facilitated access to a selected sub-sample of violent women offenders with severe forms of mental disorder who consented to detailed semi-structured, exploratory interviews on pertinent issues for subsequent thematic analysis. In respect of the latter, the interviews provided individualized, qualitative information which was especially valuable in shedding further light on the unique life stories of women with the lived experience of both severe mental disorder and violent offending, and in documenting their personal experiences and perspectives on research questions of interest preceding, during and following the commission of those offences. The thematic analysis had a number of further advantages in view of the fact that it is an approach that is scientifically rigorous, well established, and widely used, whilst also being flexible enough to produce insightful interpretation of the complex, sensitive and potentially stigmatised themes under discussion. This facilitated a richer understanding of the complexity of female offending in the relatively unexplored setting of the Eastern Cape of South Africa, and the associated gender, social-cultural and forensic mental health issues, than would have been possible otherwise.

Study Limitations

There are a few key limitations to the current study which require consideration and placing into perspective. Firstly, the cross-sectional retrospective design of the quantitative component of the study (i.e. sampling of historical clinical records) produced some limitations regarding generalizability, data inaccuracy or omissions in some cases, and possible sources of bias. Inherent in retrospective records-based studies of this nature is the difficulty in completely controlling for all confounding variables. In addition, a degree of case-inclusion bias would also have been introduced following the purposive sampling technique used (i.e. inclusion of all cases referred by courts for forensic evaluation within the study area and period). Due to the nature of historical clinical records, some information bias was also inevitable e.g. some of the required data was not available; some data required cross-checking between multiple sources to confirm accuracy; and in some cases, the documented data was insufficiently detailed, especially in respect of older records. In a few cases, the unequivocal coding of the required information was not possible, necessitating these data items to be recorded as “unknown” or “unspecified”. This is reflected in the relatively high frequency of missing data in some aspects of the quantitative analysis, though this was made explicit in all instances in the presentation of results where appropriate.

Secondly, the study was limited to women offenders who were deemed by courts, as a result of concerns regarding their mental health, to require formal forensic evaluation in a specialized forensic hospital. This study hence focused on a very specific set of women offenders, and this naturally limits the generalizability and applicability of findings to other population’s e.g. male offenders, female offenders without mental health problems, female offenders from urban, industrialized settings, and other non-forensic psychiatric populations irrespective of gender.

Thirdly, the absence of comparative data on male offenders limited conclusions that could otherwise have been drawn from gender comparisons in respect of socio-demographic, offence-related, clinical and forensic profiles. This is an important aspect which should be the focus of future research endeavours in efforts to obtain more robust and comprehensive data on gender-related forensic mental health issues in developing countries.

Finally, there were a few generic limitations to the qualitative research methodology employed. Cross-sectional interviews of a relatively small number of women, the inevitable power-dynamic that exists between clinician-researchers and patient-participants, ethical questions regarding research on vulnerable populations, and the possibility of language or cultural bias in interpreting information (especially qualitative information obtained by interview) are all issues that cannot be ignored. There was, however, an acute awareness of these issues at the outset, and efforts to minimize their influence were incorporated into the choice of study design and methodology, data collection and analysis, as previously described. In addition, the relatively limited interpretative power of thematic analysis meant that analytic claims beyond careful description within clear theoretical frameworks, and the generalizability of findings, were similarly limited. Thematic analysis of interview transcripts also does not always provide easily accessible information on language use, non-verbal behaviour, and the fine-grained functionality of inter-personal engagement and talk (Braun and Clarke, 2006). This did not, however, detract from the utility of the information obtained, nor from the validity of the findings of the qualitative components of the study.

Layout of Thesis

The extent of the research literature review and the complexity of the forensic mental health research field guided the layout of the thesis, which follows a systematic, funneled approach (both within individual chapters, and across the thesis as a whole) i.e. issues of broad, general interest are reviewed initially to set the context, prior to increasingly specific and detailed focus on issues pertinent to the study itself.

Chapter Two sets out the broader context of the research territory of the thesis by first examining overall trends and patterns of female offending, then outlines general (i.e. gender-neutral) criminogenic theories, followed by a detailed appraisal of gender-focused theories of female offending in particular.

Chapter Three initially examines the mental health of women offenders by reviewing important aspects of psychological distress caused by prior abuse experiences, and specific mental disorders associated with female offending. This is followed by a review of research evidence of mental health issues affecting women within the criminal justice and forensic mental health systems respectively.

These themes are developed further in Chapter Four by an exploration of the complex associations between gender, mental health and violent offending in particular. A detailed review of forensic mental health issues in violent women is provided, including their offence profile, psychosocial issues, developmental pathways to violence, as well as an examination of violent women within forensic mental health services, and the associated mental disorders in this population.

The focus of Chapter Five is on the unique forensic mental health issues of homicidal women, via an examination of their offence profile, psychosocial and situational context, and specific mental disorders in this population of women offenders. The literature review then provides a more detailed appraisal of mental health issues in women who murder versus children respectively. The extensive research literature on female-perpetrated child homicide is then reviewed in terms of the unique issues around: epidemiology; peri-partum mental health; mental health of filicidal, infanticidal and neonaticidal women; and typologies of child homicide, respectively. The chapter then examines the literature on qualitative studies around the mental health of homicidal women, before concluding with a review of recidivism in this population.

Chapter Six provides a comprehensive description of the methodology employed in the study, including the aims of the study, procedures employed, data collection measures, as well as the details of the quantitative analyses (descriptive and inferential) and qualitative, thematic analysis, respectively. An appraisal of pertinent ethical considerations and safeguards concludes the chapter.

The results in Chapter Seven are arranged in a similarly structured, sequential manner: (a) *descriptive* results; followed by (b) results of *inferential* statistical analyses; and finally (c) *qualitative* analytical results respectively. In the first instance, *descriptive* results are provided with respect to the general socio-demographic, offence-related, clinical and forensic profile of the study sample as a whole. More focused descriptive results are then provided for sub-samples of: (a) violent women offenders in general; (b) women who acted violently against adults versus children; and (3) homicidal women respectively. Secondly, outcomes of the *inferential* statistical analyses are arranged by presenting results on the associations between

variables of interest (via χ^2 analysis), followed by those regarding risk predictors of violence (via logistic regression analysis). Finally, *qualitative* results of interviews of violent women with severe mental disorder (via thematic analysis of interview transcripts) are described in terms of the key themes of interest i.e. related to self-image, mental health, the index offence itself the aftermath of the offence, and the views of the future respectively.

The discussion in Chapter Eight commences with an overview of the sociodemographic, offence-related, clinical and forensic mental health profile of the women offenders under study. This is followed by more focused and detailed appraisals of the profiles of women who committed violent offences, and homicidal offences, respectively. The findings of the qualitative thematic analysis are then brought under discussion, providing further context and enriching understanding of the findings.

The final chapter provides an integrated, narrative summary of key study outcomes and conclusions. This is followed by a set of pragmatic recommendations, with an emphasis on the South African context, around issues related to: (a) family, social and community support for women offenders; (b) gender-focused mental health care; (c) violent women offenders; and (d) future research directions in the field respectively.

Conclusions and Recommendations

Despite the limitations to the current research outlined above, this was the most comprehensive survey of the socio-demographic, offence-related, clinical and forensic profiles of women offenders in the Eastern Cape of South Africa. It was also the most detailed mixed methods study (incorporating descriptive and inferential quantitative analyses, and qualitative

thematic analysis) of these issues in the South African context to date. The key findings from the quantitative and qualitative components, respectively, of the study are outlined below.

Quantitative outcomes

The majority of women were young to middle-aged, black African, single mothers, with poor educational and occupational attainment, and financially dependent on families and/or state social grants. Whilst the majority were first-offenders, a high proportion of women had violent index offences, with murder, attempted murder and assault with intent to do grievous bodily harm accounting for over half of all cases. The majority of victims of violence were well known to the perpetrator, especially as biological children, intimate male partners or close family members, respectively. Biological children in their first year of life (especially the first month) were particularly vulnerable to being victims of homicidal violence. Disproportionately high rates of pre-offence mental illness, alcohol misuse, HIV infection and prior abuse of the offender (especially by intimate male partners) were present. Relatively high rates of severe mental disorders (especially women with psychiatric comorbidity and psychotic-spectrum disorders), and relatively low rates of personality and substance-related disorders were diagnosed following formal forensic evaluation. The majority of women offenders were declared to lack trial competence and criminal capacity, respectively, in psychiatric court reports.

Inferential statistical analyses revealed four key findings. Firstly, women who had backgrounds of prior abuse themselves had over three times the odds of subsequent violent offending in general, and almost six times the odds of homicidal offending in particular. Secondly, homicidal offences were significantly more commonly committed by women with no prior psychiatric history and no psychiatric comorbidity. Thirdly, women who committed

homicide had over eleven times the odds of killing children as opposed to adults. Finally, women over the age of 30 years, and those without psychiatric comorbidity, were significantly less likely to have been violent toward children.

Qualitative outcomes

The qualitative thematic analysis of interviews with violent women with mental ill-health further highlighted the complexity and heterogeneity of influential variables, and the broader context within which their offending pathways were embedded. These include multiple, interacting criminogenic risks and needs relating, but not limited, to factors such as adverse life circumstances (especially pre-offence abuse experiences); interpersonal conflict, social and family dysfunction; socio-economic impoverishment; unemployment; single parenthood; substance misuse; and persistent psychological distress and mental ill-health. A number of important recurring issues emerged from the thematic analysis in this regard, including: (a) the centrality of gendered social and family roles; (b) the importance women attached to their personal roles as mother, partner and carer of those close to them in forging self-identity; (c) the complex relationship between self-image and behaviour on the one hand, and mental ill-health on the other; (d) variation in perceptions regarding the connections between gender, mental illness and offending behaviour; (e) the broader, gendered psychosocial context of violent offending; and (f) the stark contrast in their experiences and perceptions of the punitive criminal justice system on the one hand, and therapeutic forensic mental health system on the other.

Conclusions

This study highlighted the complexity of the relationship between a trio of key factors which impact on forensic mental health in women offenders in the Eastern Cape: (a) offending

behaviour, influenced by variables such as socio-economic adversity, low educational attainment, unemployment, prior abuse experiences, interpersonal conflict, home circumstances, etc.; (b) mental health problems, increased by backgrounds of prior abuse, poor social and family support systems, pre-offence psychological distress, being a single mother of dependent children, alcohol abuse, etc.; and (c) individual and contextual factors, such as resilience, personality structure, attitudes, motivation, social judgement, relationship with significant others, adherence to treatment programmes, etc.. All these are embedded within a gendered context, and individual factors potentially exacerbate, mitigate or otherwise moderate both the associated risk and nature of the first two factors. In other words, the uniquely personal traits of individual women, as well as their gendered psychosocial and environmental context, are inextricably related to their vulnerability to psychological distress and mental ill-health, as well as their risk of engaging in offending behaviour. All these areas need to be proactively engaged by criminal justice, mental health, social and family systems for progress to be made in assisting women offenders with mental illness in achieving, and sustaining, recovery.

Recommendations

Specific recommendations that emerged from the findings of the present study related to: (a) family, social and community support services; (b) gender-focused mental health services; (c) recommendations regarding violent women offenders; and (d) directions for future research in this field, respectively.

Chapter Two: Offending Behaviour in Women

Whilst men are responsible for the vast majority of crimes in all settings, the role of sex and gender in the offending behaviour pathways of women has come under increasing focus in the criminological and forensic mental health literature (de Vogel & Nicholls, 2016). This chapter will establish the broader research context of the thesis, by outlining, in the first instance, the overall patterns and trends of female offending, and how these are changing with time. A contextual summary of the “traditional” theories of offending behaviour, and how they may (or may not) approach the issue of gender is then provided. These theories include psychodynamic, social and cognitive-behavioural models of criminogenesis. The androcentric nature of many traditional theories has led to the development and promotion of a range of more gender-focused criminogenic theories to understand female offending in particular. A detailed review of the most important of these is then undertaken, encompassing biological, criminological, social and psycholegal paradigms.

Female Offending Patterns and Trends

Whilst the absolute rate of crime is considerably lower for females, the incidence of crime in both males and females progressively rises throughout childhood to a peak in mid- to late adolescence, falling throughout adulthood thereafter (Janeksela, 1997). This age-gender-crime relationship seems to be consistent over time and across most crime categories. A small secondary peak in the mid-forties to mid-fifties (possibly associated with the menopausal period in women) has been reported by some authors (Stone et al., 2000). Men more likely to commit violent or serious property offences (e.g. housebreaking or armed robbery), and are more likely to have prior convictions, than women (Greenfeld and Snell, 2000; Schwartz and Steffensmeier, 2007). In both the USA and UK, whilst approximately 20-25% of arrests

recorded by police are of females, only approximately 5% of convictions are of female defendants (Putkonen and Taylor, 2014). The most common female-perpetrated crimes in the USA and Europe, for example, are non-violent property-related crimes (e.g. theft and shoplifting), followed by economic and sex-industry related crimes (e.g. fraud, forgery and prostitution), and substance-related crimes respectively (d'Orban, 1971; Farrington and Morris, 1983; Greenfeld and Snell, 2000; Home Office, 2012; Janeksela, 1997; McKeown, 2010; Schwartz and Steffensmeier, 2007; Staton-Tindall et al., 2007). Female offenders in general are also less likely to be involved in gang-associated crime or recidivism, as compared to men (Greenfeld and Snell, 2000; Janeksela, 1997; Schwartz and Steffensmeier, 2007).

Nonetheless, there is growing evidence that juvenile females are becoming more involved in gang-related offending, and more likely to engage in weapon use than previously (McKeown, 2010). Women involved in violent offences are also more likely to be young, and more likely to be intimate partners of their victims, in comparison to men (Janeksela, 1997). Female participation in violent crimes is steadily increasing, with a reduction in the gender gap for assaultive offences (de Vogel & Nicholls, 2016; Greenfeld and Snell, 2000; Schwartz and Steffensmeier, 2007; Putkonen and Taylor, 2014). In the USA, for example, conviction rates of female felons have increased at over twice the rates of male defendants (Greenfeld and Snell, 2000). Similarly, in England and Wales, whilst the most common female-perpetrated offences are property-related and acquisitive offences (45% of all female offences, compared to 28% for men), these were followed by violence against the person (13% of all female offences, compared to 17% for men) (Home Office, 2012). Furthermore, whilst an estimated 2% to 9% of national prison populations are female, there has been a decrease of the male to female ratio for convicted offenders globally (Greenfeld and Snell, 2000; Home Office, 2012; QUNO and Penal Reform International, 2011; Schwartz and Steffensmeier, 2007). The overall male to

female ratio for offenders convicted or cautioned for indictable offences in Great Britain, for example, was 4.67:1 in 1991, compared to 11:1 in 1949 (Home Office, 1992). Whilst male arrest rates for all crimes (including violent ones) have markedly declined since the mid-1990's, female rates appear to have either levelled off or declined less precipitously, and the female contribution to total arrests has more than doubled between the 1960's and the mid-2000's (Schwartz and Steffensmeier, 2007). Most of this rise has, however, been in connection to minor property, substance-related and less serious assaultive offences respectively. Greenfeld and Snell (2000) reported that women accounted for around 15% of those arrested for violent crimes (homicide and aggravated assault in particular), 20% of substance-related arrests, and almost one-third property-crime arrests. Young adult female arrest rates for violence, however, has risen significantly in recent decades e.g. the female arrest rate for simple assault increased nearly 300% between 1980 and 2010, with similar patterns reported for aggravated assault arrests over this time (Greenfeld and Snell, 2000; Snyder, 2011).

General Theories of Offending Behaviour

Early criminological theories of offending behaviour were largely developed from studies on boys and men, primarily due to the fact that antisocial behaviour is predominantly a male phenomenon. Female offenders have historically been considered to be more “mad” than “bad”, and early single gender studies assumed that women were necessarily and inherently different to men (Putkonen and Taylor, 2014). Whilst it is beyond the scope of this thesis to review the details of this complex field of applied criminology, a contextual summary of the main “traditional” theories of criminal behaviour, and how they deal with the issue of gender, is provided below. These can be conveniently arranged into four groups: (a) psychodynamic and social control theories, (b) social location theories, (c) social process theories, and (d) social-cognitive-behavioural theories respectively (Andrews and Bonta, 2010; de Vogel &

Nicholls, 2016; Schwartz and Steffensmeier, 2007), each of which is considered in turn below. This is followed by an exploration of the more prominent gender-focused approaches to female offending in particular.

Psychodynamic and Social Control Theories

These theories, with their roots in the psychoanalytic perspectives of Freud (1922), hold that a strong superego is the psychological reflection of adherence to societal rules, with a strong ego being a set of coping and defence skills by which the demands of immediate gratification may be delayed for longer term gain (Andrews and Bonta, 2010). Criminal behaviour is then seen as one of the consequences of psychological immaturity in the context of a weak superego, compromised ego structure, impaired self-control and poor coping skills in challenging situations. As a result, the routes to criminal conduct are linked to parental influences, family processes, social context and personality structure (particularly associated with antisocial traits e.g. lack of guilt or empathy, and disregard for conventional rules). Psychodynamic theories in context of criminality were further adapted into the multi-factorial theories of Glueck and Glueck (1950) (as cited in Andrews and Bonta, 2010), and subsequently into the social control theories of Hirschi and Gottfredson (2000). Glueck and Glueck proposed that the major correlates of persistent and serious delinquency were: antisocial attitudes and associates; a complex set of antisocial personality variables (e.g. restless energy, aggression, impulsivity, callousness); problematic family conditions (e.g. “psychologically disadvantaged” parents, weak parent-child affection, poor parenting styles, family instability); and unfavourable social situations (e.g. impoverished socio-economic situation, scholastic or occupational instability) respectively. The combination of such factors manifests as personal and interpersonal distress, and facilitate the development of conflict, helplessness, and ultimately, criminal behaviour. Hirschi and Gottfredson placed greater emphasis on ties to

convention, with criminal behaviour being a reflection of weak attachment to conventional pro-social values, attitudes and institutions. The presence of antisocial attitudes and impairments in self-control, in association with weak attachments to convention, lead to the development of criminal conduct by offending individuals.

The psychodynamic perspective is also present in theories linking aggression and criminality, such as the frustration-aggression hypothesis of Dollard et al. (1939) (as cited in Andrews and Bonta, 2010). This proposed that frustration interferes with behaviour that has pro-social value, and that aggression is always a consequence of frustration. Dollard and colleagues hence viewed correlates of criminality to be indicators of frustration, which accounted for the motives behind criminal behaviour. Berkowitz (1989) reformulated the frustration-aggression hypothesis by introducing more sophisticated social learning principles and cognitive-emotional mediators. Berkowitz distinguished between “instrumental” and “angry” aggression. The former is learnt following operant conditioning principles, and is viewed as primarily oriented toward some other non-violent goal (e.g. acquisition of property or money as the primary goal in the aggressive act of armed robbery). “Angry” aggression, by contrast, is seen as an impulsive response to specific frustrations, with the primary goal being to inflict injury on others. Violence is therefore a consequence of frustration arousing high levels of anger, especially in individuals with “aggressive personalities” and limited capacity for self-control. Support for the potentially important links between interpersonal bonds and offending behaviour comes from the finding that juvenile delinquents, of either gender, tend to come from dysfunctional family and social systems, and have histories of relatively unstable interpersonal relationships (Andrews and Bonta, 2010; Schwartz and Steffensmeier, 2007). In addition, these approaches suggest that women in traditional family roles engage in behaviour that, to a greater extent than men, promotes greater interpersonal stability, and consequently

better family and social cohesion i.e. traditional female roles are considered to afford women some measure of protection against criminal involvement.

Social Location Theories

These theories hold that criminal behaviour is reflective of one's location in the social system, which in turn is based on inequalities in the distribution of wealth, social status and power (Andrews and Bonta, 2010). Indicators of such social location include social "class", age, gender and racial or ethnic background. Risk factors for criminality are embodied in poor educational and occupational attainment, social alienation, gang membership, and limited social opportunities, in combination with the desire for material "success" and uplifting of one's location in the social milieu. Those who are socio-economically deprived, young, male and historically disadvantaged are therefore more prone to criminal behaviour. Being female, a position of disadvantage in a patriarchal society, however, is not in itself considered significantly influential as a motivation for crime (Andrews and Bonta, 2010).

One of the important earlier proponents of this type of approach was Merton (1938), who developed the anomie theory of criminality. This asserted that crime was not an expression of impulsivity, immaturity, weak ego strength or poor self-control (as in psychodynamic and social control theories above), but rather reflects the personal distress ("strain") linked with socially structured inequality in wealth and power distribution. Criminal behaviour is hence viewed as an innovative and adaptive route to conventional social success for those whose have disadvantaged social location i.e. social systems exert pressure on vulnerable people to engage in criminal behaviour. Such social location theories have been criticized because the magnitude of association between measures of social inequality and criminal conduct (as a result of numerous confounding variables) is considered tenuous (Andrews and Bonta, 2010). In

addition, the focus on economic strain tends to negate important gender-related issues in the lives of women who subsequently offend, such as sexism, abuse, racism and other traumatic experiences (Belknap and Holsinger, 2006).

Agnew (1992) and Agnew et al. (2002) challenged the links of anomie theory to socio-political ideology, especially around social class and status, and proposed instead a more general social psychology perspective. These authors replaced the structural anomie-alienation-innovation pathway with the more social learning pathway of frustration-anger-aggression leading to offending behaviour. They called this the general strain theory and proposed multiple potential motives for criminal behaviour as contributing to offending choices and behaviour. These include: moral evaluations of crime being justified by social context; reviews of the potential rewards versus the potential costs of criminal behaviour that is contemplated; negative affect and cognitive-emotional states with an emphasis on anger; and the personality structure and temperament of individual offenders respectively. A further revision of the general strain theory approach acknowledged a wider range to potential strains (beyond the economic) such as failure to achieve healthy goals, and the loss of more positive stimuli in favour of more negative ones (Broidy, 2001; Broidy and Agnew, 1997; Hoffmann and Su, 1997). These revisions emphasize that structural factors such as inequality and poverty underlie much of the motivation for conventional offending in both males and females. The gender gap in crime is viewed to be the result of the strains of a gendered society, with women placing relatively less value on materialistic goals than men (primarily due to women fulfilling traditional, domestic roles, rather than the occupational roles of men which emphasize material gains). This would suggest that female victimization is a major underlying cause of female crime, mediated through frustration-anger-aggression pathways that many women offenders experience in their daily lives (Andrews and Bonta, 2010). Broidy and Agnew (1997) argued

that support for the revised general strain theory came from observations that girls are more likely to be victims of prior abuse, and are more concerned with maintaining healthy interpersonal relationships (as opposed to boys being more focused, and strained, than girls about materialistic achievements). Similarly, Sharp et al. (2005) documented a complex interaction of variables response to these strains: although both men and women in their study responded to significant strain with externalized anger, women seemed more likely to display internalised and negative affective responses. This was proposed to partly explain how such gender differences may mediate the likelihood of subsequent offending behaviour, especially in the context of interpersonal conflict.

Social Process Theories

The most prominent theory in this group is the differential association theory which suggests that criminal attitudes, values, beliefs, rationalizations and skills are learned through differential exposure to pro-criminal versus pro-social patterns respectively (Sutherland et al., 1992). Such learning is said to occur within intimate personal and social groups, with offending behaviour being an expression of differentials in the reinforcement and punishment of criminal and non-criminal behavioural alternatives. Differential association theory focuses on antisocial attitudes and antisocial associates as being particularly strongly correlated to both histories of a criminal past and predictors of a criminal future in individual offenders (Andrews and Bonta, 2010). A central causal assumption is that criminality reflects cognitions that favour pro-criminal behaviour: delinquency results from a differential excess of cognitions favourable to rule violations, over those unfavourable to such violations. The causal offending behaviour chain extends from the influence of antisocial associates to the assumption of antisocial attitudes and behaviour in particular situations. Theorists in this field also strengthened classical differential association theory by introducing operant conditioning principles into the

social learning process of offending behaviour (Andrews, 1980; Burgess and Akers, 1966). These models allow antisocial associates a more direct causal influence, even unmediated by antisocial attitudes. Antisocial attitudes and associates not only influence and reinforce each other, but facilitate situations that are favourable to criminal activity. Furthermore, it is proposed that in situations of interpersonal influence, the strength of influence increases with the quality of the interpersonal relationship. High-quality relationships tend to be characterized by mutual respect, caring and positive regard, as opposed to relationships which are cold, uncaring and disrespectful. The direction of influence depends on which attitudes and behaviours are being modelled and reinforced: hence pro-social / anti-criminal learning depends on exposure to pro-social / anti-criminal patterns under sustained high-quality relationship conditions within intimate personal groups. Social process perspectives therefore place emphasis on the differential learning of criminal values, attitudes and skills in explaining offending behaviour. Gender differences in offending patterns are suggested to be a consequence of limited female access to criminal learning opportunities, as evidenced by, for example, the lesser involvement of women in gang networks and organized criminal cultures.

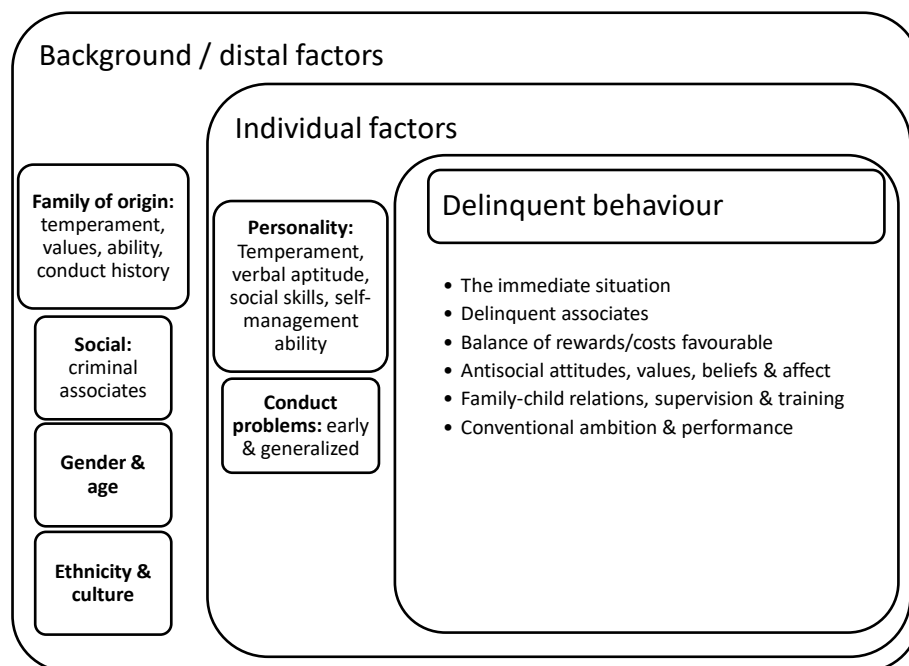
Social-cognitive-behavioural Theories

These models are based on the premise that the chances of an offence being committed increases with the density of rewards for criminal behaviour, and decrease with the density of the costs (Andrews and Bonta, 2010). These signalled rewards reflect degrees of personal control over one's behaviour, which is influenced by a combination of many psychosocial variables in the offender and his or her individual context. A combination of antisocial attitudes, interpersonal control by antisocial associates, a context that reinforces criminal behaviour, and personal predisposition contribute to the commission of offences (Ajzen and Fishbein, 2005; Andrews and Bonta, 2010; Bandura, 2001; Digman, 1990; Mischel, 2004). As

illustrated in Figure 2, this integrative social-cognitive-behavioural model proposed multiple pathways to offending, but emphasize antisocial attitudes and associates, behavioural history and personality structure as being particularly influential. These core variables may be influenced or moderated by conditions in an individual's major domains of interaction or function e.g. in domestic, school, work, leisure or social domains. The final common pathway to offending behaviour, whilst based on the interplay between these complex variables, is via the balance of perceived rewards versus costs i.e. a social cognitive analysis that favours such behaviour.

Figure 2

A Social-cognitive-behavioural Model of Criminal Conduct (adapted from Andrews and Bonta, 2010)



A related model sought to examine the relationships between cognitive and affective empathy on social behaviour (both prosocial and offending behaviour), and the role of cognitive distortions in mediating these relationships (van Langen et al., 2014). A sample of

264 adolescent girls in the Netherlands were included in a study which utilised a series of structured questionnaires and rating scales. Both cognitive and affective empathy were positively related to prosocial behaviour, but no support was found for the hypothesis that cognitive distortions played a role in mediating the relationship between empathy and offending.

These models emphasize the importance of interactions between personal and broader contextual psychosocial factors (criminogenic needs) in increasing the likelihood (risk) of criminal behaviour (Hollin and Palmer, 2006). A distinction is drawn between static, historical factors and more fluid, changeable dynamic factors respectively. Dynamic variables (e.g. socioeconomic status, substance abuse and mental ill-health) are criminogenic needs that may predict the risk of future offending. Such models incorporate the background dispositional variables that shape the individual and the immediate context of behaviour. These models also attempt to avoid the assumption that, for example, all young offenders are temperamentally aggressive, conduct-disordered, or have weak bonds to family and social systems i.e. attempts to avoid assumptions about gender profiles, roles, goals and attitudes. Instead, it is suggested that the chances of criminal conduct for both males and females increase with increasing numbers of predisposing variables (Andrews and Bonta, 2010; Hollin and Palmer, 2006).

Gender-focused Theories of Female Offending

A number of studies sought to explore and understand the criminogenic role of gender in respect of female offending in particular. Cloninger and Guze (1970) showed that recidivist female prisoners had strong family histories of psychiatric disorder (especially alcohol and other substance-related disorders, “sociopathy” in male relatives and “hysteria” in female relatives). These women also displayed high levels of conduct disorder at school, poor

occupational records and interpersonal conflict in family relationships. Cloninger and Guze suggested that although these historical factors were similar to those of recidivistic male prisoners, they seemed more prominent in women. They hypothesized that females had a higher threshold for delinquency, but that once this threshold was crossed the psychosocial repercussions were potentially more severe than for males i.e. more aspects of the lives and functionality of such women were disturbed, with offending behaviour being one expression of disturbance. A robust, population-based, prospective study which included both females and males as primary participants, was the Dunedin Birth Cohort study (Moffitt et al., 2001). On the one hand, the outcomes confirmed some of the accepted earlier understandings of antisocial behaviour (e.g. the substantially lower rate of violent offending by females), but a number of findings were surprising. Whilst female offenders displayed less physical aggression at every age compared to male offenders, two exceptions emerged: violence directed at intimate partners, in which the violence of young women matched offending rates of young men; and self-reported rates of alcohol and drug-offences in middle adolescence being the same for boys and girls respectively. A range of explanatory models have been proposed for these gender similarities and disparities in crime rates and patterns, and which emphasize the centrality of the broader psychosocial context in which female offending occurs. Two of the more prominent gendered models of offending behaviour in women are: (a) the model proposed by Steffensmeier and colleagues (Schwartz and Steffensmeier, 2007; Steffensmeier, 1983; Steffensmeier and Allan, 1996; Steffensmeier and Haynie, 2000); and (b) the gendered risk/criminogenic needs model (Andrews and Bonta, 2010; Hollin and Palmer, 2006; Palmer et al., 2010). These models suggest that both male and female crime would be better understood by an appreciation of the influence of the daily life experiences of men and women on gendered offending patterns.

In an extensive review of these debates, Schwartz and Steffensmeier (2007) argued that, despite the androcentric origins of the traditional theories, they may be sufficiently gender-neutral in offering some understanding of the overall context and origin of offending behaviour. These authors proposed that the significant overlap in the causes of both male and female crime lends some support to the traditional theories. Firstly, the majority of female and male offenders come from backgrounds of socioeconomic strain, poor educational attainment and minority-group communities, with female offenders also more likely to have dependent children. Secondly, there are parallels in the rates of male and female offending rates over time, across offence types, and in different social settings and areas i.e. female offending rates are low when those of males in the same setting are low, and vice versa. Thirdly, causal factors identified by the traditional theories (e.g. criminal associations, measures of family and social bonds, learning opportunities, parental controls, risks versus rewards perceptions, etc.) appear equally applicable and have comparable effects across gender. Whilst the traditional theories assist with a general understanding of male and female crime, Schwartz and Steffensmeier also suggested that they are less adept at accounting for distinct and persistent gender differences in offending patterns e.g. women being significantly less likely to commit violent or gang-related offences. Women are supposedly more motivated by relational and family-orientated concerns and goals (as opposed to the more self-focused modus operandi of male offenders), and appear to have a higher threshold of tolerance to provocation before turning to crime or violence (Schwartz and Steffensmeier, 2007; Steffensmeier, 1983).

In respect of the risk/criminogenic needs model, “criminogenic needs” refer to risk factors for offending that are dynamic (hence potentially changeable and/or amendable to interventions), in contrast to non-criminogenic needs which are issues that may require treatment or attention (e.g. a medical condition) but that are unrelated to offending risk and

behaviour (Andrews and Bonta, 2010; Hollin and Palmer, 2006; Palmer et al., 2010). Hollin and Palmer (2006) emphasized that whilst there are multiple, common needs for offenders of either gender, this does not necessarily imply that the aetiology, nature, or importance of these needs are the same for women and men. Hollin and Palmer expressed concern that conclusions of risk-needs models based primarily on male offenders may not accurately reflect certain women-specific variables. Furthermore, the nature of the relationship between criminogenic needs and offending risk is also unlikely to be the same for men and women. Risk-need analyses of incarcerated women prisoners, for example, suggests that violent offences by women are likely to be both contextually and qualitatively different to male-perpetrated violence (Blanchette, 1997; Hollin and Palmer, 2006).

Suter et al. (2002) conducted gender-focused comparisons of Australian prisoners regarding the expression and experience of anger. Their study found gender differences not only in the overall levels of anger, but also in the triggers and control of anger. This suggested that risk assessment instruments need to be recalibrated, and risk management approaches modified, for female offenders. Similarly, Clark and Howden-Windell (2000) studied a group of British female prisoners to identify predictive criminogenic factors, and found the main predictors of recidivism to be criminal history, substance abuse, poor educational attainment, disrupted family life, and attitudes/behaviour within prison. Van Voorhis et al. (1992) explored the risks and needs of women prisoners via a survey of their supervising correctional workers. A number of unique needs were identified, including matters such as coping with abuse and trauma; self-esteem; assertiveness; access to health care; mother and child care; substance use; and interpersonal relationship problems. Other authors have similarly identified women-specific criminogenic needs related to mental health particularly around issues of poor self-esteem, abuse and victimization, deliberate self-harm and depression, interpersonal difficulties

and substance abuse respectively (Blanchette, 2002; Byrne and Howells, 2000; 2002; Phillips and Harm, 1998). This notwithstanding, some authors have questioned the degree to which prior experiences (such as pre-offence abuse exposure) have predictive power with regard to future offending i.e. whether they could be considered truly criminogenic (Fagan, 2001; Lowenkamp et al., 2001). Whilst many retrospective studies document a history of prior abuse in the majority of female offenders, most prospective studies report that the minority of victims (30-50%) become offenders (Fagan, 2001). Lowenkamp et al. (2001) argued that prior abuse may not, by itself, be a sufficiently powerful dynamic risk factor for subsequent offending, but that it may interact with other criminogenic needs in lowering the offending threshold. Hence, multiple criminogenic risk factors, interacting with individual psychosocial and contextual variables, influence the progression from abuse to offending, but the exact circumstances and mechanisms remain unclear (Hollin and Palmer, 2006). A detailed review of the more specific and well-known theories focusing on female offending in particular will be undertaken below.

Biological Theories

Constitutional and Genetic Factors. Historically, it was suggested that girls and women have a greater constitutional resistance to offending behaviour, and typically only do so in the presence of extreme and adverse psychological distress or environmental influences (Putkonen and Taylor, 2014). Gender discrepancies in the rate and nature of brain maturation during infancy and childhood have also proposed to bestow a greater vulnerability to cerebral insults and subsequent behavioural disturbances (Putkonen and Taylor, 2014). In support of this approach, criminogenic risk factors leading to behavioural misconduct and criminality include higher rates of neurocognitive compromise amongst delinquent boys than girls, especially if associated with early onset hyperactivity (Moffit et al., 2001). Many studies of the developmental pathways and characteristics of delinquent youth, however, show more

gender similarities than differences (Miller et al., 2010; Odgers et al., 2008), and this debate remains unresolved.

The evidence remains inconclusive regarding gender differences in the heritability of antisocial conduct, and associated problems such as substance misuse (Putkonen and Taylor, 2014). Differences were demonstrated, for example, in the Dunedin birth cohort study regarding the relative frequency of childhood-onset, lifelong versus later-onset, self-limiting antisocial behaviour respectively, with the former variety mostly confined to males (also being the pattern closely correlated to neuropsychological impairments) (Moffit et al., 2001). This suggests not only that girls may be relatively protected from early cerebral insults, but that there may be gender differences in the genetic predisposition to antisocial behaviour itself. Miller et al. (2010) similarly concluded that boys (especially those that displayed early-onset conduct disorder) were more likely to follow pathways of chronic delinquency, than was the case with girls.

Physique and Physiology. Whilst d'Orban (1971) noted early studies that postulated delinquent girls tended to be physically "over-developed", taller and heavier (i.e. more masculine) than the average, there is no good evidence to support this. Nonetheless, physical strength has been proposed to be a beneficial attribute for committing violent crimes (especially those in gang-related settings), and in the interactions between criminal associates (Schwartz and Steffensmeier, 2007). These approaches theorise also propose that women perceive themselves (as they are generally perceived by others), as having less violent goals and potential than men, partly due to the relative physicality of men in comparison. This may help account for female crime tending to be both less frequent and less violent in nature. Perceived vulnerability may also help explain the greater tendency of women to play more dependent

roles as criminal accomplices, as opposed to solo career criminals. In addition, for reasons that remain unclear, the reported association between violence and blood serotonin levels in men has also not been demonstrated in women (Moffit et al., 1998).

Historically, it has also been suggested that female hormonal changes result in periods of stress which may be associated with crime. It was widely, and erroneously, believed in the 19th century, for example, that menstruation had an influence on female criminality (Putkonen and Taylor, 2014). Dalton (1961) claimed that up to 50% of women prisoners offended in their premenstrual week, and further asserted that the premenstrual phase also commonly coincided with behavioural disturbances, rule violations in prison, poor examination results and motoring offences. Hands et al. (1974) (as cited in Stone et al., 2000) similarly reported a link between disturbed behaviour and the menstrual cycle in a small group of behaviourally disturbed special hospital patients. D'Orban and Dalton (1980) studied a group of violent women offenders, and concluded that their offences were more likely to have occurred in the peri-menstrual period than in the rest of the cycle. They reported that these women's awareness of their premenstrual symptoms did not seem to correlate with the violence they displayed i.e. the majority of women seemed unaware of their cyclical pattern of symptoms and associated behavioural changes. Gibbons and Prince (1962) (as cited in Stone et al., 2000) challenged the supposed links between shoplifting and hormonal fluctuations. Attempts at invoking the so-called premenstrual syndrome into criminal defences have also had limited success (d'Orban, 1983; Downs, 2002; Lewis, 1990; McSherry, 1994). The evidence suggests that whilst there may be some risk of psychological or behavioural changes in some women during peri-menstrual or peri-menopausal phases, it is likely that the effect is relatively small, and may only occur in a small subset of women who are prone to mental health problems at other times as well (Putkonen and Taylor, 2014). In addition, whilst this may have sentencing or treatment

implications, it does not by itself negate trial competence nor criminal responsibility, unless there is associated clinical evidence of sufficiently severe mental disorder (active at the time of trial and/or offence respectively). For women who already suffer from a psychotic-spectrum or mood disorders, the intensity of psychiatric symptoms can vary over the course of the menstrual cycle (Hallonquist et al., 1993). There is also, independently of the premenstrual syndrome, a group of women who are vulnerable to mental health problems (especially mood and psychotic disorders) during the peri-partum period, and to a lesser extent, peri-menopausal phases of their lives (Häfner et al., 1998; Spinelli, 2004).

Evolutionary Psychology. Campbell et al. (2001), arguing from an evolutionary psychology perspective, proposed that scarcity of resources may increase the risk of offending in women e.g. property offences may be related to attempts by women to provide for themselves and their dependent children, whilst violence may result from competition between females for males who are able to provide requisite resources. These theories also suggest that evolutionary pressure may have differentially reduced the female threshold related to fear of physical danger, which in turn is proposed to inhibit women's propensity to behave violently. Furthermore, when faced with direct inter-personal confrontation, women tend to utilise low-risk strategies (e.g. shunning, stigmatising or verbal aggression) rather than physical violence. The commission of violence by women is hence viewed as a form of resource competition, agreeing in a sense with theories that highlight the role of economic marginality and poverty in female offending pathways. This is in contrast to earlier androcentric bias in evolutionary thinking and to the paternalism of traditional criminological theories which viewed female crime as either wayward (a rejection of patriarchal dominance) or pathological (Campbell et al., 2001; Chesney-Lind, 1989). In summary, Campbell and co-workers suggested that female crime is a function of the motivational effects of resource scarcity (and the competition this

generates) interacting with the gender-differentiated inhibitory effects of fear. They argue that this may partly account for the fact that gender differences generally increase with the level of violence used in the commission of offences. Such evolutionary psychological approaches also concur with theories that emphasize the greater social control of girls and women being internalised more effectively (in comparison to males) as self-control and restraint (Campbell et al., 2001; Hagan et al., 1987).

Criminological Theories

Female Offending Patterns. Schwartz and Steffensmeier (2007) and Steffensmeier and Allan (1996) argued that a gender focus may predict many female offending patterns. Female involvement tends to be higher for crimes associated with traditional gender roles, which may be related to criminal opportunity. These authors illustrate the utility of this approach by applying it to examples of property, violent, public order and substance-related crimes respectively. Offences associated with “traditional” female roles of housekeeping and family-related shopping (e.g. shoplifting or forgery), for example, have disproportionately high female arrest rates. Similarly, the relatively high proportion of women in office and administrative positions (e.g. as book-keepers, bank tellers or secretaries) accounts in part for the relatively high female-perpetrated rates for economic crimes (e.g. small-scale fraud). This model also predicts differences in motives between men and women in such crimes e.g. women tending to act fraudulently to support families or protect relationships, whilst men being more likely to be motivated by material gains, social status and/or to protect themselves. In addition, such approaches also explain that the reasons fewer women commit serious acquisitive offences (e.g. large-scale burglaries, or high-level corruption) are related to the fact that such crimes are incongruent with traditional female roles, hence limiting criminal opportunity (Steffensmeier and Terry, 1986). With respect to violent offences, it has been suggested that female motives

for violence are primarily connected to issues around personal relationships, self-defence under threat, mental ill-health, or as a result of provocation or abuse (Dobash and Dobash, 1984; Dobash et al., 1992; Schwartz and Steffensmeier, 2007). This perspective emphasizes that this is supported by the fact that violent women mostly target people well known to them (especially intimate male partners, close family members or biological children), as opposed to men who are more likely to act violently against strangers. In addition, these models correctly predict that violent women more commonly commit their offences within, or close to, their homes, with a generally higher threshold of provocation required (as compared to men) to act violently in the first instance (Dobash et al., 1992). In the context of abusive relationships, however, women are at increased risk of being violent in retaliation or self-defence against their abusers (Schwartz and Steffensmeier, 2007). A gender focus also predicts with some accuracy patterns of “public order” offences, such as prostitution, an offence category in which female rates far exceeds that of males. Schwartz and Steffensmeier (2007) point out that gender differences in convictions for prostitution are primarily related to the high demand for female sexual services by men, and the patriarchal double-standards associated with this. Gender issues similarly influence differences in patterns of substance-related offending e.g. women are often introduced to substance abuse by male associates; and female substance-related offences are less likely to be associated with violence (Anglin and Hser, 1987; Pettitway, 1987; Schwartz and Steffensmeier, 2007).

There is little evidence to support claims that women engage in offending behaviour as much as men do, but that this does not reflect in official criminal statistics (Putkonen and Taylor, 2014). There are some studies that do suggest gender parity in the perpetration of certain offences e.g. rates of offending against intimate partners by younger women were

approximately equivalent to those of younger men in the Dunedin Birth Cohort study (Moffitt et al., 2001). So-called “hidden criminality”, however, is difficult to identify and quantify.

Criminal Opportunity. Prevailing gender roles, norms and stereotypes are generally thought to contribute to limit female access to criminal opportunity. Schwartz and Steffensmeier (2007) suggest that stereotyped value systems mean that women have relatively limited access to legitimate, non-criminal social and occupational opportunities, and especially in engaging in certain types of work (e.g. as truck-drivers or dockyard workers). Opportunities for certain types of crime associated with such occupational roles (e.g. drug dealing or smuggling) may therefore also be limited. Similarly, women’s relative scarcity in the upper echelons of political or business hierarchies may limit their involvement in large-scale economic, financial or politically-motivated crimes (e.g. corruption, international crime syndicates, arms smuggling, etc.). In contrast, women falling into more traditional, lower paid roles (e.g. as office workers or housekeepers) facilitates exposure and opportunity for petty, less serious forms of crime (e.g. small-scale shoplifting or low-level fraud). Schwartz and Steffensmeier further contended that increases in property and minor assault crimes amongst women are unlikely to be due to occupational gains, or changing gender roles. On the contrary, these authors suggest that adverse economic pressures, heightened rates of divorce, single-mother households, and the perpetuation of male-dominance in the social milieu may aggravate criminal involvement in female-perpetrated property and economically motivated crimes i.e. crimes that require little criminal “skill”, and are relatively more accessible to women in traditional gender roles e.g. as working mothers who are also caring for dependent children.

Motivation and Criminal Attitudes. The same factors that limit access to criminal opportunity for women, may also inhibit their criminal volition i.e. gender roles, relational

concerns, physical strength, attitudes to sexuality, issues around socio-cultural control, etc. may all influence individual criminal motivation (Schwartz and Steffensmeier, 2007). Hence, risk-seeking versus risk-averse temperament, empathy, response to being caught or humiliated, levels of self-control, impulsivity, social judgment, and perceived costs versus benefits of criminal behaviour may all have an influence on individual criminal motivation. Women may also have risk versus reward preferences, motivations and styles that are different to those of men: whilst men tend to take criminal risks in order to improve their social, occupational and/or financial status (i.e. to gain individual advantage), women may take criminal risks more in an effort to protect loved ones, sustain relationships, or to extricate themselves from threatening, abusive or distressing personal situations (Schwartz and Steffensmeier, 2007; Steffensmeier, 1980; Steffensmeier and Allan, 1996). Research on the role of “criminal attitudes” in women (the target of many programmes designed to reduce offending behaviour and recidivism) is limited. There are, however, suggestions that gender is likely to influence social and cognitive skills relating to the development of criminal attitudes and outcomes (Bennett et al., 2005; Blanchette, 2002; Hollin and Palmer, 2006).

Systemic Gender Bias. Gendered paradigms are also considered useful in understanding the apparent increases in less serious, non-confrontational offences (e.g. minor property offences, fraud, theft, etc.). Schwartz and Steffensmeier (2007) contended that this is not the result of any real change in the aggressive nature of modern women, nor has there been any significant change in the gender norms governing behaviour in patriarchal societies. They proposed that the evidence points rather to criminal justice systems increasingly focusing on less serious crimes, which are more commonly associated with women. In other words, the widening of the “arrest net” by law enforcement agencies in many countries has led to an artificial escalation of female arrest rates. Women may also be treated differently by criminal

justice and forensic mental health personnel, ranging from chauvinistic/paternalistic leniency, on the one hand, to gender-based discrimination (possibly systematized in some settings) on the other (Franklin and Fearn, 2008; Putkonen and Taylor, 2014). In the UK, for example, women charged with indictable offences were about half as likely as men to be handed custodial sentences, and also tended to receive significantly shorter sentences (Home Office, 2012). Similarly, infanticidal British mothers are reported to have received less severe sentences than infanticidal fathers (Marks and Kumar, 1993). This kind of gender bias is not, however, restricted to the criminal justice system. A Swedish study devised a series of homicide case vignettes, in which the gender of offenders was varied, and found that forensic mental health professionals were more likely to assess female offenders as being mentally ill and requiring treatment; whereas judges tended to be influenced by their own gender in making disposal decisions i.e. female judges were more likely to recommend psychiatric treatment for female offenders, and male judges for male offenders respectively (Yourstone, Lindholm, Grann et al., 2008). Oberman (1996) commented on the polarization of the views of many (within the criminal justice and other systems) with respect to offending women, as necessarily either being insane and deserving of significant leniency, or as evil and deserving particularly harsh punishment.

Context of Offending. Gendered offence patterns are also influenced on numerous factors related to the broader context in which offences occur (Schwartz and Steffensmeier, 2007; Triplett and Myers, 1995). These contextual factors include variables such as the specific setting, characteristics and circumstances of the offence; victim-offender relationships and roles in the offence; weapons and levels of violence used; and so forth. Violence against intimate partners provides an illustrative example of the importance of offending context: female offenders are more likely than both non-offenders and male offenders to have

experienced prior abuse themselves (often at the hands of their own victims) (Dobash and Dobash, 1984; Dobash et al., 1992; Schwartz and Steffensmeier, 2007). The type of offence committed may also itself be influenced by gendered contextual factors e.g. females are consistently demonstrated as being less likely than men to use weapons, seriously injure others, break into buildings or steal items that they do not need (Greenfeld and Snell, 2000; Schwartz and Steffensmeier, 2007). Similarly, when women commit traditionally male-dominated crimes (such as burglary or robbery), these are less likely to be pre-planned, solitary, or violent in nature (Steffensmeier and Terry, 1986). Whilst women are also significantly more likely than men to be first-time offenders (Hollin and Palmer, 2006), there are still differences between different groups within the female offender population with respect to criminal history. Blanchette (1997; 2002), reported that violent Canadian women offenders were less likely than non-violent women offenders to be first-time offenders, but showed higher rates of substance-related and mental health problems.

Social Theories

The Organization of Gender. Schwartz and Steffensmeier (2007) used the phrase “the organization of gender” to refer to various aspects of social life that tend to reduce the probability of crime for women and enhance the probability for men, especially with respect to gender roles, norms, stereotypes and practices within patriarchal socio-cultural systems. Female criminality is then, for example, inhibited by gendered issues such as the tendency of women to be nurturing toward others and their concern with maintaining interpersonal relationships. These concerns were proposed to not only constrain female offending but to affect female self-identity itself, particularly in societies in which such identity is derived from, and defined by, men (as intimate partners, fathers, brothers, etc.). If these men are conventional, pro-social and law-abiding, then female criminality is also restrained. However, such derivative

identity may also draw women into offending behaviour (usually as accomplices) if their male associates are offenders themselves.

Klein (1973) has argued that female vulnerability to offending increases when the protective effect of the traditional family unit is disrupted by family and social conflict or upheaval. This concept has been controversially extended, with seemingly little evidence, to suggest that increases in female offending rates are related to the abandonment of traditional gender roles as a result of increased gender equality. Downes and Rock (1995) (as cited in Bartlett, 2006) contended that there is little evidence that any economic empowerment or social emancipation of women in some societies has led to increased female-perpetrated crime. Whilst it may be plausible that greater gender equality may have resulted in greater female participation in public sphere activities (e.g. working, shopping, banking, driving, etc.), and that this may account for small increases in minor offences, it is also an assumption that this is evidence of true female equality and emancipation (Schwartz and Steffensmeier, 2007). The offences that have demonstrated the most consistent increases, in fact, tend to be the relatively minor offences committed mostly by socio-economically deprived and marginalized women (Daly, 1989). Similarly, the majority of violent offences by women tend to be of relatively lower severity compared to those by men, and tend to be in response to relational concerns e.g. domestic conflict with a family member or abusive intimate partner (Schwartz and Steffensmeier, 2007).

Feminist perspectives propose that not only are the daily experiences of men and women profoundly different, but the role of patriarchy is central to any understanding of female offending especially as it relates to issues such as the effects of gender-based social and occupational disadvantage, economic marginalization, abuse of girls and women, and female

responses to all other aspects of structural oppression (Belknap and Holsinger, 2006; Chesney-Lind, 1986; 1989; Daly and Chesney-Lind, 1988; Holsinger, 2000). In addition, it is problematic that the focus on female crime is in itself gendered i.e. viewed as either “masculine” because the behaviours are construed as conflicting with traditional female gender roles, or “feminine” because criminal women are viewed as socially “deviant” (Klein, 1973). The trajectories into criminality are therefore considered at least partially gender-specific, with developmental processes, resultant “problem” behaviours, entrenched socio-cultural prejudices, and biased systemic responses to females who engage in such behaviours (Holsinger, 2000).

An additional gender issue related to gender organization concerns the extent to which women play either primary/dominant roles or secondary/follower roles in the commission of crime. Alard et al. (1996), for example, explored the perceptions of 104 American female felons with respect to their degree of criminal involvement with male accomplices. A larger proportion of African-American women were members of all-woman criminal groups, than was the case for other racial groups. The most common crimes with women as sole offenders were assault, theft, forgery, and driving whilst under the influence of substances. Crimes such as robbery, burglary, and drug-related offences, however, were more often carried out with male accomplices i.e. men facilitated the criminal opportunity for these women by providing access to the acquisition of criminal skills, values and roles. In addition, gang-related criminal networks incorporate women into highly gendered, hierarchical division of labour in a chauvinistic world, further entrenching their social disadvantage (Romenesko and Miller, 1989).

Social Controls. Regardless of debates in respect of female emancipation and its effects on female criminality, girls remain more likely to experience more family and social controls than boys in most settings, cultures and countries, primarily because of patriarchal paradigms and associated fears of female vulnerability (Crockett et al., 1996). Similarly, behaviours that border on delinquency remain more likely to be tolerated for boys than is the case for girls (Putkonen and Taylor, 2014). Such gendered social values and controls may change over time, though not always in a progressive direction. Female involvement in serious crime in England between 1687 – 1912 was examined by Feeley and Little (1991), who showed relatively high proportions of female defendants in the early 18th century, followed by a slow decline into the early 20th century and beyond. Feeley and Little suggested that the decline could be attributed to a combination of social factors (e.g. changes in social attitudes, industrialization and the relative emancipation of women) that altered the nature of social control of women over this period. Simon and Baxter (1989) conducted a survey of nine cross-sectional studies of serious female offending between 1950-1980, which tested the so-called emancipation hypothesis of female offending over this period. The results provided little evidence that increasing economic emancipation and improvements in gender equality increased female offending rates. Female arrest rates for homicide have also not been shown to be related in any significant way to a country's level of development or degree of industrialization (Kruttschnitt, 1993; Steffensmeier et al., 1989).

Schwartz and Steffensmeier (2007) suggested that male acceptance and enforcement of gender stereotypes subject females to relatively greater social control in the form of parental and/or partner “supervision”. Young girls and female adolescents in particular tend to be more closely supervised and monitored than is the case for boys, with risk-taking behaviour more actively discouraged in girls. Even as adults, social controls imposed by patriarchal family,

social and cultural systems serve to constrain the ability and willingness of women to engage in crime (Giordano et al., 1986; Schwartz and Steffensmeier, 2007; Steffensmeier, 1983). Criminal devaluation, stigmatization and control of women may further restrict female access to criminal opportunities. It has also been suggested that gender differences in “moral development”, as a consequence of social controls, may result in females being socialized toward greater empathy, nurturance and cultivation of interpersonal skills (Beutel and Marini, 1995; Brody, 1985). This tends to restrain women’s willingness to access and engage in crime, especially when it involves violence. Those women who do offend tend to engage in relatively minor crimes, with lower risks of injuring or endangering the lives of others, with the offending women often being vulnerable to injury themselves (Schwartz and Steffensmeier, 2007).

Developmental Perspectives. These models consider behavioural challenges, including delinquency and offending, to be age- and gender-associated because of patterns in developmental stages (de Vogel & Nicholls, 2016). The role of developmental transitions in offending behaviour is emphasized, with a number of differences reported in outcomes for delinquent girls versus boys (Kjelsberg and Friestad, 2009; Laub and Lauritsen, 1993). In their study of female delinquents, Lewis et al. (1991) reported that whilst early “organic” problems did not necessarily predict subsequent offending, there were relatively high rates of morbidity, mortality (especially from suicide), substance abuse and poor longer term functionality. These authors asserted that incarceration of delinquent girls with such care and support needs possibly contributed to ongoing dysfunctional, criminal and/or violent lifestyles. Kjelsberg and Dahl (1999) conducted a Norwegian study of almost 900 adolescent psychiatric inpatients, followed up for two decades. The main factors that independently and significantly contributed to subsequent offending were: behavioural problems, personality disorder, substance abuse, verbal abuse in the home, and disciplinary issues at school. Furthermore, Miller et al. (2010)

reported early-onset delinquency to also be a robust predictor of criminality beyond adolescence. Johnson et al. (1995), in a longitudinal study of over six-hundred families, compared the effects of parental mental health and parent-child communication on adolescent delinquency. Poor levels of parental support were more prominent risk factors for boys than girls, and this effect was amplified when one or more parents had a chronic psychiatric illness. The combination of parental mental illness and the lack of consistent parental support, however, had a more marked effect on offending risk in girls.

Socio-economic Vulnerability. A number of investigators have challenged assumptions that improvement in the economic standing of women has led to the observed increases in female criminality, as the evidence actually emphasizes the important role of gender discrimination, socio-economic distress and unemployment in the context of patriarchal power relations in the backgrounds of most women offenders (Chesney-Lind, 1986; 1988; 1989; Daly, 1989; Schwartz and Steffensmeier, 2007; Steffensmeier, 1980). Schwartz and Steffensmeier (2007) noted that involvement in crime over the longer term (i.e. as a “career criminal”) is extremely rare amongst female offenders (even amongst violent offenders), unlike the case for male offender populations. The offending pathways of female delinquents are also typically shaped by chaotic and impoverished home environments, in which property, drug and sex-worker related crimes can be seen to reflect survival or coping strategies (Anglin and Hser, 1987; Gilfus, 1992).

Related to socio-economic vulnerability, are criminogenic issues related to education, occupation, income, and housing. The educational and occupational attainment of women prisoners is generally lower than is the case in the non-offending population, with only around one-quarter of women being in actively employment in the year leading up to imprisonment

(Blanchette, 2002; Home Office, 2007). In addition, the Home Office (2012) report noted that most women serving custodial sentences in the UK were living in rented accommodation at the time of arrest, and a substantial proportion of these women anticipated being homeless upon release. The socioeconomic vulnerability of female offenders was further highlighted in a review by Sorbello et al. (2002), as most women who were held in custody faced significant financial problems, and became dependent on family members or partners to meet their daily living expenses (as well as those of their dependent children). Financial difficulties, socioeconomic vulnerability, and housing insecurity are hence considered significant, and independent, criminogenic needs for women (Hollin and Palmer, 2006).

Psycholegal Theories

Family and Interpersonal Dynamics. There is much literature on associations between adverse interpersonal and family relationships and offending behaviour (especially of a violent nature) in both males and females (Hollin and Palmer, 2006). Women offenders are more likely than not to come from families with high levels of conflict, and to have parents who are more frequently absent, substance abusing, criminal or mentally ill (Hollin and Palmer, 2006; Putkonen and Taylor, 2014). A large Finnish, prospective birth cohort study found that women who grew up in families with absentee fathers were more than twice as likely to become offenders, in comparison to those with consistent paternal involvement during their childhood years (Kemppainen et al., 2002). This study also reported childhood-onset smoking and being the first-born child to be factors associated with subsequent criminality. Similarly, Putkonen, Weizmann-Henelius et al. (2011) reported Finnish homicidal women offenders to be significantly more likely than their male counterparts to report prior childhood abuse, high levels of pre-offence family conflict, and poor educational attainment. In the UK, the Cambridge Study of Delinquent Development compared risk factors for criminality in male

and female siblings, and found certain familial (especially parental) factors were stronger predictors of offending in brothers, whilst socio-economic and child-rearing factors were stronger predictors in sisters respectively (Farrington and Painter, 2004), as illustrated in Table 3.

Table 3

Risk Factors for Offending in Male and Female Siblings (adapted from Farrington and Painter, 2004)

Variable	Risk factor*
Family	Delinquent sibling* Convicted father or mother Teenage mother Nervous father or mother Poorly educated father
Socioeconomic	Low social class* Low family income* Poor housing* Large family size* High-delinquency school*
Child-rearing	Low paternal interest in children* Low parental interest in education* Parental conflict* Harsh discipline* Poor supervision* Low levels of praise* Separated from parent

Note. * Risk factors that are reported to be stronger predictors of criminality for sisters than for brothers.

Bartlett (2006) noted, however, that whilst findings of differential risk factors for brothers and sisters are helpful, they do not explain why women offend relatively rarely, nor do they shed much light on other gender differences in offending patterns. Hackler (1991), in an exploration of the links between social policy, gender inequality and violence in women, found that the focus of policies and interventions with violent offenders are unlikely to have much effect on reducing future violence nor on the conditions that gave rise to it. Hackler noted that

there was no direct relationship between the frequency and severity of violent offences, and suggested that a focus on less violent offending (especially within family settings) would lead to a reduction in violence. Since socioeconomic factors prevent many women from leaving violent domestic settings, greater economic equality should (theoretically at least) improve their ability to extricate and empower themselves, and reduce the risk of violence in this context (Hackler, 1991).

Women prisoners similarly have complex pre-offending family and interpersonal variables that contribute to offending risk. Convicted women are more likely than non-offending women to have come from single parent homes (with the majority raised only by their mothers) (Bloom and Covington, 2008). The majority of convicted female offenders also tend to come from dysfunctional backgrounds, characterized by high levels of abuse, lack of adequate and consistent parental care, limited family support, inappropriate role models, inconsistent use of discipline, poor supervision, poor attachments, and social environments that support criminal values (Zaplin, 1998). The systems perspective provided by the analysis by Zaplin also highlighted the fact that girls growing up in such environments, unsurprisingly, attain poor school or occupational performance, have relatively low educational or work-related aspirations, fail to develop healthy and sustainable peer relationships, and often gravitate to economic and social instability as adults. It was suggested that the associated emotional deprivation experienced by many female offenders in their interactions with others, coupled with distorted views of empathy, caring and self-worth, leads to mental health and behavioural problems, one manifestation of which is delinquency and offending behaviour. In considering the social and health needs of women released from UK prisons, Williamson (2006) found most of these women to have histories of poor educational and occupational attainment, significant challenges in accessing primary health care facilities, and to be at risk

of homelessness upon release. In addition, significant numbers of female prisoners had child care responsibilities prior to, during and following incarceration. The Home Office (2012) similarly indicated that over half of women prisoners had at least one dependent child (under 16 years of age), with over one-third having more than one dependent child. Greenfeld and Snell (2000) noted even higher rates (70%) of dependent children of American women prisoners. The imprisonment of women who are mothers often leads to their dependent children being left in the care of dysfunctional relatives, disruption of mother-child attachments, and negative mental health sequelae in both mother and children (Hollin and Palmer, 2006; Sorbello et al., 2002). This is postulated to further negatively impact on family and community re-integration following the release of these women from prison, and possibly to perpetuate subsequent offending risk.

Abuse and Trauma Experiences. It has been extensively demonstrated in the research literature that women offenders (especially those who act violently) are more likely to have been victims of abuse than male offenders and non-offending women (Belknap and Holsinger, 2006; Bloom and Covington, 2008; Browne and Finkelhor, 1986; Browne et al., 1999; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; Gaarder and Belknap, 2002; Gilfus, 1992; Greenfeld and Snell, 2000; Holsinger, 2000; Janeksela, 1997; Jordan et al., 1996; López and Emler, 2011; Lowenkamp et al., 2001; McClellan et al., 1997; McKeown, 2010; Palmer et al., 2010; Rivera and Widom, 1990; Rodríguez et al., 2006; Roe-Sepowitz, 2009; Rossegger et al., 2009; Schwartz and Steffensmeier, 2007; Siegel and Williams, 2003; Singer et al., 1995; Smith and Thornberry, 1995; Snell and Morton, 1994; Sung et al., 2010; Widom, 1989a; 1989b; Yourstone, Lindholm and Kristiansson, 2008). Illustrative evidence from some of the more robust and pertinent study outcomes in this regard is reviewed below.

Gender-focused research studies on childhood abuse (including neglect) find that not only is abuse more common in delinquent girls than boys, but that it tends to start earlier, persist for longer and is a stronger predictor of subsequent criminality in girls (Chesney-Lind, 1989; Belknap and Holsinger, 2006; McClellan et al., 1997). In a prospective study of female delinquents, Siegel and Williams (2003) explored the relative importance of sexual abuse in subsequent criminal pathways. They found that women who were victims of sexual abuse were significantly more likely to be arrested for violent offences. Similarly, a study of 2452 British adolescents and young adults found those with backgrounds of childhood abuse to be at significantly higher risk for delinquency and future adult offending (Rivera and Widom, 1990; Widom, 1989a; 1989b). Girls who were abused were at much higher risk of subsequent violent offending than those without abusive backgrounds (abused boys were no more likely than boys with no history of abuse go on to violent offending). Belknap and Holsinger (2006), in a study comparing 163 incarcerated adolescent girls and 281 incarcerated boys, similarly found the majority of girls (60%), as compared to the minority of boys, reported significantly higher levels of all forms of abuse (especially sexual and physical abuse). In addition, half the girls (but less than 20% of boys) reported more than one sexual abuser, whilst 12% of girls (and 3% of boys) reported at least three abusers. The response of girls to abuse was also considered an important factor in elevating the risk of subsequent offending behaviour. Over 50% of their sample believed the abuse to be directly related to their delinquency, with girls being significantly more likely than boys in reporting this. Belknap and Holsinger emphasized the importance of broadening the understanding of risk factors for subsequent offending if gender-specific needs are to be understood. For girls in particular, these include factors such as abusive experiences, mental health reports, sexual identity, significant “life events”, and persistent, patriarchal value systems as crucial to the understanding of female offending pathways.

Browne and colleagues (Browne and Finkelhor, 1986; Browne et al., 1999) explored contextual factors that characterise the abuse of females, and found that women are significantly more likely to be abused by someone well known to them, with the abuse likely to occur over a protracted period of time. Browne et al. (1999) explored the life-time abuse experiences of 150 convicted women prisoners: almost 60% reported sexual abuse; 70% reported severe physical abuse during childhood or adolescence; 25% reported severe physical abuse during adolescence by an intimate partner; and 75% reported violence at the hands of a non-intimate person known to them. Only 6% did not report being the victim of any form of abuse during their lives. Women who reported physical or sexual abuse were also significantly more likely to report similar victimization to persist into adulthood. Gilfus (1992) conducted detailed interviews with a sample of incarcerated women, and documented backgrounds of childhood sexual abuse in 65% of the women (with an average of two different abusers each, with half reporting the perpetrator to be a close family member); and chronic, recurrent physical abuse by a family member was reported by three-quarters of women interviewed. Lowenkamp et al. (2001) examined the impact of childhood abuse on their American sample of 442 male and female offenders. Whilst approximately 11% of the sample reported childhood-onset abuse (17% of females versus 9% of males), prior abuse was not by itself a consistent predictor of subsequent offending for either gender. Snell and Morton (1994), surveyed a sample of incarcerated American women, and found 43% had a history of childhood abuse (compared with an estimated 12% of male prisoners), whilst Jordan et al. (1996) found an even higher proportion (80%) of their sample of incarcerated women to have reported “child-adult victimization”. Greenfeld and Snell (2000), summarizing data from American criminological databases, documented that nearly 6 in 10 women offenders reported having experienced physical and/or sexual abuse in the past (over one-third were abused by an intimate partner, and around one-quarter by a family member). In summary, the research evidence suggest that

not only is the experience of abuse (most often at the hands intimate partners or close family members) disproportionately common amongst women offenders, but that it may be an independent predictor of subsequent violent offending.

Mental Health Problems. A large systematic review of Fazel and Danesh (2002), encompassing almost 23 000 prisoners (nearly 20% of whom were women), concluded that there was little evidence that mental illness per se is more prevalent among incarcerated women as compared to men. Furthermore, a meta-analysis of recidivism amongst offenders with and without mental disorder conducted by Bonta et al. (1998) concluded that the main predictors of recidivism appear comparable for both groups. In addition, indicators of mental illness appeared unrelated to subsequent offending, or in some cases were even negatively correlated with recidivism. The majority of studies in this meta-analysis were, however, of male offenders, and the generalization of its conclusions to female offenders has been questioned (Hollin and Palmer, 2006). Nonetheless, Fazel and Grann (2006), in their study of the population impact of serious mental disorder on violent crime, calculated the proportion of community violence attributable to psychosis to have been almost equivalent for younger men and women (between ages 15 – 24 years). For older ages, however, only about 5% of male perpetrators of violent crime were psychotic at the time of offending, compared to approximately 20% of women. In a subsequent meta-analysis, Fazel, Gulati et al. (2009) reported that moderation of the relationship between psychosis (particular schizophrenia) and criminal risk by substance misuse comorbidity was pronounced among many women. The population-attributable risk of homicide to psychosis has also consistently been reported to be elevated for women in a series of Finnish studies, and disproportionately raised with co-morbid alcohol misuse (Eronen, 1995; Eronen et al., 1996b; Eronen et al., 1996; Schanda et al., 2004).

Another Finnish study, however, found no such gender differences in a 1995 – 2004 cohort of convicted homicide offenders (Putkonen, Weizmann-Henelius et al., 2011).

There is also growing body of literature that implicates substance abuse as significant criminogenic factor in women offenders. Greenfeld and Snell (2000), in their extensive survey of American female offender data, reported the association to be stronger in women: an estimated 40% of violent women offenders (as opposed to 30% of men) were reported by victims to have been intoxicated (with alcohol and/or other substances) at the time of the offence; and almost 90% of women offenders (compared to 75% of men), reported regular substance abuse. Palmer and Hollin (2007) similarly reported significantly high levels of substance use problems amongst English female prisoners, as compared to their male counterparts. In addition, the reasons for drug abuse may be qualitatively different for male and female offenders. Langan and Pelissier (2001), for example, surveyed prisoners in a drug treatment programme, and found female prisoners to be more likely to: have more severe patterns of substance abuse; come from homes in which substance abuse was present; have experienced childhood abuse; and have higher rates of mental illness (primary mental disorders co-occurring with substance-related disorders). In addition, there were significant gender differences in the motivations for substance abuse: men tended to use substances hedonistically, whilst women used substances as self-help for psychological distress.

Males and female offenders also differ in their patterns of substance abuse. Singleton et al. (2003) found that 63% of English male prisoners self-reported high levels of alcohol abuse prior to imprisonment, in contrast to 39% of female prisoners, with similar patterns reported in North American arrestee surveys (Lo, 2004; Nunes-Dinis and Weisner, 1997). A few studies report that female offenders tend to preferentially abuse substances other than alcohol. Butler

et al. (2003), for example, examined a sample of Australian prisoners, and found the majority (62% of males and 71% of females) to have a substance abuse history. Whilst almost half their sample used intravenous routes of illicit substance administration, this was more prevalent in women. In addition, 32% of females (compared to 20% of males) reported being intoxicated at the time of their offence. These confirmed the findings of McClellan et al. (1997) who also found higher illicit substance misuse amongst female offenders in comparison to males. Their regression analysis demonstrated that substance abuse predicted future offending even when other sociodemographic variables were controlled for. Alcohol and other substance misuse have also found to be particularly high amongst female offenders serving community sentences, with over 42% of females registered with the Offender Assessment System in the UK having problematic drug use, as compared to just 33% of males (Hollin and Palmer, 2006; Palmer et al., 2010). It has further been proposed that whilst substance dependence is often the motivating drive for offending in both males and females, this may be more so for females who face greater constraints against offending in general, and who additionally may require more powerful motivations to offend in the first instance (Schwartz and Steffensmeier, 2007). Female-perpetrated burglary and robbery, for example, typically occurs in the context of substance dependence, and is more likely to be abandoned following cessation of substance abuse (Anglin and Hser, 1987). Substance abuse is also more likely to facilitate women's initiation into crime, with its associated exposure to violence, offending opportunities and exploitation by substance-dependent men (Pettitway, 1987; Steffensmeier and Terry, 1986). Whilst rates of substance-related disorder are historically lower amongst women than men, for violent offending categories women offenders may have caught up with rates documented for males, and to have probably exceeded them in some settings (Häkkinen-Nyholm et al., 2009; McMahon et al., 2003).

Widom (1978) also identified a number of disordered personality traits, independent of co-morbid mental disorder, that may be related to violent offending behaviour in both men and women. Three criminogenic personality types were proposed: “primary psychopathy” (low levels of anxiety, but high levels of aggression and impulsivity); “secondary or neurotic psychopathy” (high levels of anxiety, aggression and impulsivity), and “over-controlled” personalities, respectively. Traumatic childhood experiences in women are also possibly correlated to the interpersonal, affective and lifestyle characteristics of psychopathy, whereas in men they are reportedly only related to antisocial behaviour (Weizmann-Henelius, Grönroos et al., 2010; Weizmann-Henelius, Putkonen et al., 2010). The validity of applying the concept of psychopathy to women offenders, however, remains the subject of much debate. The many complex issues and dimensions in respect of the forensic mental health of women offenders, especially those who commit violent offences, will be reviewed in further detail in subsequent chapters.

Interacting Criminogenic Needs

Most research evidence suggests that female offenders are likely to have multiple, complex and mutually interacting criminogenic needs e.g. relating to adverse life events, substance misuse, mental ill-health and interpersonal relationships (Andrews and Bonta, 2010; Hollin and Palmer, 2006; Palmer et al., 2010; Putkonen and Taylor, 2014; Schwartz and Steffensmeier, 2007). A number of individual and structural factors have been proposed that combine to obstruct the pro-social participation of female offender’s e.g. prior victimization, abuse and trauma, low employability skills, poor socioeconomic circumstances, poor interpersonal relationship experiences (Taylor et al., 2013). There are a number of multivariate analytical studies that have emphasized the importance of appreciating the complexity of the interaction between such needs and the risks of subsequent offending by women; the key

outcomes of the more robust of these studies are summarized below in order to illustrate this. Walrath et al. (2003), for example, found convicted young women offenders to have experienced a significantly higher number of prior adverse life events as compared to non-convicted women. The strongest discriminating variables between women with and without conviction histories were backgrounds of substance abuse and fleeing difficult home circumstances. In addition, convicted female adolescents were also significantly more likely to report prior sexual abuse, suicidal behaviour and severe mental ill-health requiring psychiatric hospitalization. Similarly, McClellan et al. (1997), in their study comparing American male and female prisoners, examined the relationships between prior abuse experiences, substance use, and mental health problems, and offending behaviour. In comparison to men, significantly more women had experienced abuse during their childhood years, with abuse also more likely to persist into adulthood for women. In addition, women were more likely to be suffer from depressive disorders and to be abusing illicit substances (as opposed to alcohol, which men abused more frequently). Multiple regression analysis demonstrated that substance-related disorders, alongside certain sociodemographic variables (e.g. young age), were particularly strong predictors of property and violent crime. Messina et al. (2007) examined the effects of childhood adversity, traumatic distress and relationship difficulties in drug-dependant prisoners and reported similar results: female offenders had higher rates of prior abuse experiences than their male counterparts, and also that this victimization was more likely to have continued into adulthood. Abuse was also found to have had a significantly deleterious effect on their mental health, and to have been associated with early-onset substance misuse, particularly for women. Browne et al. (1999) also documented strong associations between substance abuse, offending behaviour and prior abuse. Women prisoners who had substance use problems prior to custodial sentences are also reported to be at significantly higher risk of being victims of intimate male partner violence, and mental ill-health (Staton et al., 2003; Wilson-Cohn et al.,

2002). Greene et al. (2000) used qualitative analysis of interviews of convicted and imprisoned American mothers, and found high rates of prior abuse, family dysfunction, socioeconomic deprivation, and substance abuse (with similar problems documented in their children). Martin and Hesselbrock (2001) reported significantly higher rates of mental disorder (especially severe depressive syndromes) amongst American women prisoners, again most often in the context of prior physical and/or sexual abuse and substance abuse. Similarly, Anderson et al. (2002) conducted logistic regression analysis on a sample of female drug offenders and found that certain sociodemographic variables (e.g. age, socio-economic status, educational attainment and race) were better predictors of mental health problems than involvement in crime per se. Palmer et al. (2010) examined criminogenic needs in a sample of over 6500 male and over 1000 females registered on the Offender Assessment System in the UK: the criminogenic needs of women were confirmed to be significantly higher and more complex than those of men, especially regarding factors related to mental health and interpersonal relationships respectively. More recently, Wang & Stamatel (2019) analysed pooled data for 27 highly developed and 38 less developed countries to assess whether four key theoretical perspectives on female criminality – emancipation, economic marginalization, arrest net widening, and modernization – explain female representation in the criminal justice system. The results provided support for modernization, emancipation and net-widening theories of female offending but not for economic marginalization theory.

Conclusion

It is apparent that changes in female offending patterns and trends have accelerated in the past few decades, with women offenders increasing resembling their male counterparts in the rates, circumstances and nature of offences committed. The “traditional” theories of offending behaviour have been criticised for their androcentric nature. Understandings of the nature and

context of female offending has been enhanced by the proliferation of more gender-focused criminogenic theoretical approaches. The most important of these relate to the fundamentally gendered context of female offending with respect to a range of complex, interacting, historical and dynamic criminogenic needs, including: (a) criminological factors (e.g. criminal opportunities, motivations and attitudes); (b) social factors (e.g. gender roles, norms and practices within patriarchal settings; differential, gender-based social controls; socioeconomic vulnerability of women, etc.); and (c) psycholegal and individual factors (e.g. the role of interpersonal, family and social dynamics; prior abuse and traumatic experiences; individual temperament, personality and psychological distress; substance abuse; mental health problems encountered by girls and women, etc.) respectively.

Chapter Three: Mental Health of Women Offenders

The mental health of women who offend has received increased research attention in recent decades. This chapter undertakes a detailed review of the evidence in this regard, including appraisals of the associations between female offending and prior abuse experiences, as well as specific groups of mental disorders respectively. The latter includes focus on developmental, psychotic, mood, substance-related, personality and posttraumatic stress disorders; self-harming and suicidal behaviour; and psychiatric comorbidity in female offenders. A comprehensive review of mental health issues affecting women within the criminal justice system follows, including an overview of female prisoners, prison-based mental health surveys and the mental health needs of, and care services available to, incarcerated women (including those in the South African setting). The literature review then progresses to an evaluation of women within forensic mental health systems, and specific issues regarding the provision of gender-focused forensic mental health services.

Mental Disorder in Women Offenders

Whilst some debates historically have centred on the issue of whether women offenders are primarily “mad” or “bad”, Comack and Brickey (2007), for example, suggested that this binary conceptualisation of female offenders is complicated by the addition of a third category: the “victim”. Rather than viewing these concepts as mutually exclusive, they suggested interconnectedness between them and noted that their application to violent female offenders in particular remains largely unknown. Abuse-victimization, substance abuse and mental health are important variables not only when considering female offending pathways, but also in respect of the needs of incarcerated women, and how these should be met (Bohle & de Vogel, 2017; de Vogel & Nicholls, 2016; McKeown, 2010). Bartlett (2006; 2007) pointed out that the

fact that women's offending profiles of less serious crimes lead to shorter custodial sentences, makes delivery of effective interventions (medical, mental health, criminal justice and/or social welfare) more difficult. In addition, the relatively small number of women's prisons and forensic mental health units exacerbates this problem as women tend to be incarcerated / admitted to facilities far from their homes, areas of origin and dependent children. This poses further challenges for continuity of care, monitoring and support following parole, release or discharge from these facilities. Putkonen and Taylor (2014) raised a number of important questions around the relationship between mental disorder and female offending, with respect to gender differences around issues such as: (a) the nature and rates of specific mental disorders; (b) social and systemic attitudes toward, and handling of, offenders with and without mental disorder; (c) offence profiles and characteristics of those with and without mental disorder; and (d) how these issues are linked in male and female offenders respectively.

Whilst race, ethnicity and cultural background are important issues to consider in female offender research, there is a dearth of research information globally in respect of how these factors impact on the mental health needs (especially in the forensic context) and services for incarcerated women. Nonetheless, Derkzen et al. (2013), for example, reported that the number of Aboriginal Canadian federal female offenders had increased by almost 90% in the previous decade, and were disproportionately over-represented in the correctional system, comprising around one-third of the imprisoned female offender population but less than 5% of the Canadian population. These women also tended to be single parents living in over-crowded, impoverished communities, had higher rates of unemployment, poorer educational attainment, and were more likely to be abused and/or to have been the victims of violent crime themselves. Derkzen and colleagues documented further that disadvantaged racial minority groups are likely to have unique mental health needs, requiring culturally sensitive and appropriate

services to meet these needs. Rates of mental health problems had indeed steadily increased in this population, with higher prevalence of both prior (14-27%) and current mental disorder diagnoses (7-22%), more psychotropic medication prescriptions issued (33-44%), and consistently high levels of substance abuse (averaging 75%). Diamond et al. (2001) also documented numerous risk factors for mental illness in women prisoners, besides gender, which serve to substantially increase the vulnerability of women, including those of African-American or Hispanic background, socio-economic deprivation, poor educational attainment, and complex clinical comorbidity. The research evidence around specific mental health issues and disorders in women offenders is reviewed in further detail in the sections that follow.

Prior Abuse

As alluded to previously, it is well established that a high proportion of women offenders (especially those convicted of violent offences) report prior abuse experiences (physical, sexual and/or emotional), with estimates ranging from 45 – 98% of study samples (Acoca and Dedel, 1998; Belknap and Holsinger, 2006; Bloom and Covington, 2008; Bohle & de Vogel, 2017; Browne and Finkelhor, 1986; Browne et al., 1999; Chesney-Lind; 1986; 1988; de Vogel & Nicholls, 2016; Fickenscher et al., 2001; Gaarder and Belknap, 2002; Gilfus, 1992; Greenfeld and Snell, 2000; Holsinger, 2000; Janeksela, 1997; McClellan et al., 1997; McKeown, 2010; Messina et al., 2007; Rodríguez et al., 2006; Roe-Sepowitz, 2009; Rossegger et al., 2009; Schwartz and Steffensmeier, 2007; Singer et al., 1995; Sung et al., 2010; Widom, 1989a; Young, 1998; Yourstone, Lindholm and Kristiansson, 2008). A history of abuse (especially sexual abuse) is also independently linked to increased incidence of a range of mental disorders in women prisoners, including mood disorders (especially major depressive disorder), trauma and other stressor-related disorders, anxiety disorders, psychotic-spectrum disorders, substance-related disorders, and personality disorders (especially of the borderline type)

respectively (Bryer et al., 1987; Green et al., 2005; Jordan et al., 1996; Martin and Hesselbrock, 2001; Messina and Grella, 2006; Saunders et al., 1992; Surrey et al., 1990). These studies concur that convicted women are less likely to achieve social, personal and economic independence, abstinence from substance abuse, or to refrain from subsequent criminality without their mental health needs, and its underlying correlates, being adequately addressed. This includes prioritising gender-focused mental health interventions such as addressing prior abuse and victimization experiences, treating symptoms of mental disorder, improving functional outcomes, and attending to comorbidity (e.g. substance misuse and physical ill-health) (Bloom and Covington, 2008). Despite the significant influence of traumatic experiences on the evolution of mental and physical health problems in female offenders now being so well documented, many criminal justice, correctional and mental health care systems do not routinely, or adequately, enquire about abuse experiences when assessing health needs, leading to inadequate and/or inappropriate therapeutic interventions (Bloom and Covington, 2008; Jordan et al., 2002; Morash et al., 1998; Young, 1998).

Developmental Disorders

Early-onset attention deficit hyperactivity and conduct disorder in children and adolescents have both been associated with an increased risk of subsequent delinquency in both boys and girls (although girls are more likely to suffer depressive disorders, as opposed to ADHD or conduct disorder) (Babinski et al., 1999; Barkley et al., 2004). There is also, however, research evidence that the relative impact of offending on mental health in adolescence could also have a gender differential. Fazel, Doll et al. (2008) conducted a systematic review and meta-analysis of studies of adolescents within juvenile detention centres (comprising a collective sample of almost 3000 girls and 14 000 boys respectively), and found that almost 20% of girls had a diagnosis of ADHD, compared with just 12% of boys. Both girls

and boys exhibited similarly high average rates of conduct disorder (around 50%), and relatively low rates of psychotic disorders (under 5%). The girls, however, had almost triple the rate of depression compared to boys (30% for girls versus 11% for boys). Gender patterns in Swedish adolescents who underwent formal forensic assessment in Sweden yielded similar conclusions (Fazel, Långström et al., 2008). In addition, there is some evidence that when hyperactivity is atypically prominent in girls with ADHD (being usually more common in boys with ADHD), this may be more predictive of subsequent substance misuse, poor academic achievement, problematic peer and social relationships, and possible delinquency, than is the case with boys (though the strength of these associations were unclear) (Elkins et al. 2007; Sihvola et al., 2011).

Psychotic and Mood Disorders

Whilst there are no significant gender differences in the overall lifetime risk of schizophrenia (the psychotic-spectrum disorder most strongly associated with offending behaviour, and especially violent offending), women tend to develop the disorder later, and possibly have a more benign course of illness, than is the case for men (Häfner et al., 1998; Putkonen and Taylor, 2014). Gender differences in onset and course of schizophrenia (and possibly other psychotic-spectrum disorders as well) has been proposed to possibly offer a measure of protection for some schizophrenic women from the more severe social consequences of the disease, including offending vulnerability (Häfner et al., 2003). The evidence is inconclusive with respect to whether psychotic female offenders differ in the nature or clinical characteristics of their psychotic presentations (or their responses to these) (Putkonen and Taylor, 2014). Women with psychosis within forensic mental health services in England appear to have a generally younger age of psychotic onset than men, and are more likely to have experienced sexual abuse during childhood (Hads et al., 1997). It has also been

documented that whilst women are at least as likely as men to respond to passivity phenomena (such as thought insertion, deletion or control), they may not be as prone to respond to command hallucinations or persecutory delusions (Teasdale et al., 2006). McMahon et al. (2003) report that women offenders with psychosis are, however, increasingly approaching rates of co-morbid substance abuse seen in male offenders, with such dual diagnostic comorbidity increasing the risk of violent offending in particular. Nonetheless, women offenders with psychosis generally tend to have better longer term outcomes, are more often successfully returned to community settings (despite their tendency to violence as in-patients), and are at lower risk of re-offending than their male counterparts (Jamieson and Taylor, 2002; Lindqvist and Allebeck, 1990; Soyka et al., 2007; Wessely et al., 1994). There is surprisingly little research literature in respect of mood disorders in offending women. In women with severe presentations of mood disorder (especially if associated with psychotic features and/or suicidal tendencies), both bipolar and depressive disorders have been linked to offending risk (Loucks and Zamble, 1999; 2000). Most of the research evidence in this field, however, relates to violent offending in women (especially focused on homicide). These issues will be considered in further detail in subsequent chapters on the mental health of violent and homicidal women respectively.

Substance-related Disorders

The abuse of substances, either independently or concurrently with other mental disorders, is well documented as a significant criminogenic factor in female offenders, who are consistently reported to have more severe substance related problems than male offenders (Byrne and Howells, 2000; Fazel et al., 2006; Gorsuch, 1998; Greenfield and Snell, 2000; Henderson, 1998; Hollin and Palmer, 2006; Home Office, 2012; Johnson, 2006; Lanz et al., 2008; Lopes and Mello, 2010; Maden et al., 1994a; Martin and Hesselbrock, 2001; Putkonen

and Taylor, 2014; Sorbello et al., 2002; Staton-Tindall et al., 2007; Teplin et al., 1996). Substance misuse also places women at higher risk of arrest in the first place, with 25% of arrested women citing a motivation for her index offence to be related to sourcing money for substances of abuse (Martin and Hesselbrock, 2001). Women offenders who abuse substance tend to be younger, less likely to generate income, and socially and occupationally marginalized, in comparison to their male counterparts (Byqvist, 1999). Blount et al. (1991) reviewed the case records of 1076 women incarcerated in the Florida prison system, and found the extent of substance abuse to be inversely related to age and employment status at the time of arrest. The severity of substance abuse was directly related to the extent of prior offences, and was also correlated with dysfunctionality and criminality in the families of offenders. The same study reported so-called “recreational” substance users to have committed more violent crimes (though non-substance users were overall more likely to have been convicted of murder).

James and Glaze (2006) reported the most common substances of abuse prior to arrest of American female offenders to be crystalline cocaine (34%) and methamphetamine (17%). In the same sample, 68% had experienced prior abuse, 17% had been homeless and 47% had a substance-abusing parent. There is also evidence of robust associations between the use of substances and the experience of abuse among female offenders (Browne et al., 1999; Harlow, 1999; Marcus-Mendoza et al., 1994). Substance-related problems are significantly more prevalent in incarcerated women with backgrounds of physical and/or sexual abuse, who are likely to report the primary motivation for substance use as alleviation of the associated psychological distress (Bartlett, 2007; Langan and Pelissier, 2001). Since there are relatively limited community treatment alternatives for women who abuse substances (especially those with co-morbid mental illness and dependent children), this has been shown to further increase

the risk of offending behavior, in a cycle that is difficult to break (Martin and Hesselbrock, 2001; Wellisch et al., 1996). Similarly, Jordan et al. (2002), examined patterns of use of mental health and substance abuse services by female offenders, and confirmed that despite receiving such treatment many women continue to suffer serious mental health difficulties in the longer term, and continue to engage in high-risk behaviours that lead to repeated incarceration.

There are a number of studies that indicate that female offenders have higher rates of alcohol dependence in comparison to male offenders (Birecree et al., 1994; Blount et al., 1991; Hurley and Dunne, 1991; Jordan et al., 1996; Martin and Hesselbrock, 2001). Greenfeld and Snell (2000) reported different findings in their extensive survey of American State prisons: whilst the majority of women offenders had been using substances at the time of their offence, women tended to mostly use illicit substances whereas men tended to use alcohol relatively more commonly. Whilst more women than men (38% versus 29%) were intoxicated at the time of the offence, the intoxication was more commonly due to alcohol in men than women (38% versus 29%). Furthermore, whilst over half the women prisoners reported abusing alcohol in the year prior to the offence, the pre-offence alcohol abuse rate was also higher in men (reported in two-thirds of male prisoners) in Greenfeld and Snell's survey. Similarly, Fazel et al. (2006), in their systematic review of substance abuse patterns among prisoners (across 13 studies with a collective sample of 3270 women and 4293 men), reported that the prevalence of alcohol-related disorders was similar (or lower) for women (10-24% versus 18-30% for men), whilst the prevalence of illicit substance-related disorders was significantly higher among women (30-60% versus 10-48% for men) respectively. Substance dependence in women with criminal histories have been suggested to follow two distinct patterns, following the study of Modestin and Rigoni (2000): women dependent on illicit-substances tended to have more criminal convictions (excluding drug-related offences) than those who were alcohol-dependent. In

addition, women who abused illicit substances tended to be younger, of lower socio-economic status, unemployed, had earlier onset of offending behaviour, and to have required mental health care earlier, than those who abused alcohol.

Personality Disorders

Certain personality disorders, especially of the Cluster B type (and antisocial and borderline personality disorders in particular) are known to increase the risk of offending behaviour in general, though the nature of this relationship is uncertain (Bohle & de Vogel, 2017; de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014). In addition, there are significant differences in personality disorder prevalence rates between men and women, but relatively little data on these in offender populations. Lifetime prevalence rates for antisocial personality disorder are significantly higher amongst men (irrespective of offending background) in all countries and settings (Golomb et al., 1995). Furthermore, although borderline personality disorder is often cited as having a female preponderance, the evidence for this, especially in women offenders, is equivocal. A large epidemiological survey of over 34 000 people in the US by Grant et al. (2008), for example, found gender parity in the prevalence of borderline personality disorder, although women in the sample were also reported to suffer more disability as a result of the diagnosis. In a national survey of psychiatric morbidity among prisoners in the UK, Singleton et al. (1998) (as cited in Putkonen and Taylor, 2014) reported fewer women to have antisocial personality disorder (less than one-third of women compared with over two-thirds of the men), whilst borderline personality disorder rates were similar in both women and men (about 20% for each). A British prison survey by Gunn et al. (1991) (as cited in Putkonen and Taylor, 2014) also found similar rates of personality disorder among female and male prisoners. Yet other surveys have reported significantly higher rates of personality disorder amongst women offenders on certain personality disorders (borderline, dependent, depressive,

histrionic, obsessive-compulsive, and schizotypal types) (Coolidge et al., 2011; Maden et al., 1994b).

Warren and colleagues (Warren and Burnette, 2012; Warren et al., 2002; 2003; 2005; Warren and South, 2009) studied over 800 imprisoned women and found disproportionately high levels of psychological distress and Cluster B personality disorders. The most common personality traits were in relation to interpersonal instability, impulsivity, recklessness, substance abuse, suspicion of others, social awkwardness, and dependent attitudes and behaviour. These personality traits preceded incarceration and were considered to inevitably contribute to the behaviours and circumstances that led to incarceration. There was a particular correlation between cluster B psychopathology and impulsive and violent behaviour.

It is also been postulated that the presence of personality disorder (especially if co-morbid with Axis I mental disorders) in women offenders has potentially important implications with respect to access to mental health care. Rutherford and Taylor (2004) looked at 3309 new receptions at Holloway Prison in the UK, and identified prisoners who were subsequently referred to in-patient psychiatric services. Only 60 such women were identified: 26 were referred, in terms of British mental health legislation, under the category of “personality disorder”, and 34 under the category of “mental illness” respectively). The women in the “personality disorder” group were significantly more likely to have had a history of prior self-harming behaviour and being victims of childhood sexual abuse, but they waited for a psychiatric hospital bed for a significantly longer time than those in the “mental illness” group. The authors concluded that despite the intense mental health needs of women with personality disorder, they received a poor and inadequate response from mental health care services and were relatively disadvantaged as a result.

Psychopathy in women remains a controversial construct with respect to its validity and clinical presentation in both men and women (it is included in neither the ICD-10 nor the DSM5 classification systems as a specific personality disorder), though it has been increasingly applied to women offenders, especially as it applies to violence risk assessment (Berardino et al., 2005; Dolan and Völlm, 2009; Forouzan and Cooke, 2005; Forth et al., 1996; Logan and Blackburn, 2009; Nicholls et al., 2005; Nicholls and Petrila, 2005; Strand and Belfrage, 2001; 2005; Warren and Burnette, 2012; Warren et al., 2003; 2005; Weizmann-Henelius, Grönroos, et al., 2010; Weizmann-Henelius, Putkonen, et al., 2010). There is also little empirical guidance for women on the diagnostic cut-off for psychopathy as described and determined by the Hare Psychopathy Checklist – Revised (Hare, 1999; 2003). As offending generally tends to have a later onset in women, some of the Hare Psychopathy Checklist items may not be as relevant to women e.g. the antisocial behaviour items, or those related to glibness and inflated self-worth (Forouzan and Cooke, 2005). Furthermore, the relationship between psychopathy and other mental disorders in both men and women remains unclear, nor are there any violence risk assessment tools based on research that includes sufficient numbers of women in the study samples (Logan and Blackburn, 2009). Some authorities have urged further caution in the use of the controversial descriptive terms in this field (e.g. “glib, cunning, manipulative, sensation-seeking, irresponsible, promiscuous, pathological liar, lack of remorse, failing to take responsibility”, etc.) which may reinforce stigmatization of otherwise vulnerable, even if antisocial, women (Maier, 1990).

These issues notwithstanding, estimates of psychopathy in women vary across studies, with rates of between 9 – 31% reported in North America and Europe (Salekin et al., 1997; 1998; Vitale et al., 2002; Warren et al., 2003; Weizmann-Henelius et al., 2004a; 2004b).

Salekin et al. (1998) reported lower prevalence rates of psychopathy in imprisoned women than men, and also that women with psychopathy were substantially less likely than men to become recidivists. Poor behavioural control, however, has been noted to be more common in women with psychopathy, in comparison to those women deemed not to have psychopathy (Strand and Belfrage, 2005). The importance of certain traits, especially emotional instability and impulsivity, in women offenders who are supposedly psychopathic (whether or not linked with recidivism), has been the focus of interest in a few studies (Komarovskaya et al., 2007; Kreis and Cooke, 2011). There is some evidence that suggests that the antecedents and comorbidities of psychopathy and borderline personality disorder may be similar in women. Hicks et al. (2010) described “secondary psychopathy” amongst female offenders which presents with behavioural patterns very similar to borderline personality disorder. A number of Finnish studies have reported that the impact of distressing childhood experiences (e.g. sexual abuse, early loss of a parent, maternal mental ill-health) on Hare Psychopathy Checklist scores may be stronger in women (Putkonen and Taylor, 2014). In addition, in their study of female prisoners, Verona et al. (2005) concluded that childhood abuse (especially physical and sexual) was strongly associated with the social and antisocial behavioural factors of the Hare Psychopathy Checklist, but not with the interpersonal or emotional ones.

Posttraumatic Stress Disorder

A UK Home Office survey of 234 female prisoners demonstrated high rates of prior traumatic life experiences: one-third of women were sexually abused in childhood sexual abuse; one-fifth had been abused throughout their lives; and one-third were adult victims of abuse and harassment in prison (Home Office (2007) (as cited in Bartlett, 2007). Several studies have concluded that posttraumatic stress disorder (PTSD) is particularly prevalent among incarcerated women, occurring in up to one-half of samples (Henderson et al., 1998;

Home Office, 2007; Karatzias et al., 2018; McClellan et al., 1997; Teplin et al., 1996; Tye and Mullen, 2006; Zlotnick, 1997). Diagnostic criteria for PTSD were met in almost twice as many female than male offenders, whether as pre-trial defendants (9% of women versus 5% of men) or convicted prisoners (5% of women versus 3% of men) in a survey by Singleton and Meltzer (2002). PTSD is also disproportionately common among female juvenile offenders (Cauffmann et al., 1998; Dixon et al., 2005). In a study of PTSD and associated comorbidity in 85 convicted female prisoners, Zlotnick (1997) found almost 50% of participants to have met the diagnostic criteria for current PTSD, and 20% for lifetime PTSD, respectively. Incarcerated women with PTSD, in comparison to those without, also had a greater likelihood of co-morbid major depressive disorder, substance-related disorders and borderline personality disorder in this study. In addition, Zlotnick found women with PTSD to be more likely to report prior childhood abuse, and to present with emotional dysregulation, dissociative experiences, and psychosomatic symptoms. In the United States, PTSD was reportedly the second most common psychiatric disorder in imprisoned women, following substance-related disorders (Teplin et al., 1996). McClellan et al. (1997) reported a significant correlation between PTSD and substance abuse, and contended that substance abuse in this context may be considered a self-medicating response to earlier traumatic events in many women offenders. A more recent study by Karatzias et al. (2018) hypothesized that the experience of trauma in adulthood, PTSD and emotional dysregulation would mediate the relationship between childhood traumatic events and subsequent criminal behaviour. Eight-nine Scottish female prisoners were interviewed using standardized scales, with a series of regression and mediation analyses undertaken on the data. Almost all (91%) of the women reported both childhood and adulthood trauma. Over half (58%) met the criteria for PTSD, and multiple traumas were significantly associated with the seriousness of offence.

Self-harm, Suicidality and Mortality

Disproportionately increased mortality rates (from all causes, including suicide, and irrespective of gender) are reported in both criminal and psychiatric populations (Joukamaa et al., 2001; Martin et al., 1985). In their study of 500 psychiatric outpatients, Martin et al. (1985) reported substance related disorders (particularly alcoholism) and antisocial personality disorder to be especially predictive of unnatural death, especially suicide, a pattern confirmed in other studies (Baxter, 1996; Baxter and Appleby, 1999). Schizophrenia and depressive disorders (especially major depression) are also associated with significantly elevated death rates (Joukamaa et al., 2001). Incarcerated women offenders, however, are more vulnerable than men to self-mutilation, self-harming and suicidal behaviour (Bartlett, 2007; Corston and Britain, 2007; Liebling, 1994). In the UK, for example, there were 24 468 incidents of self-harm amongst female prisoners in 2011 (a rate of 2104 incidents per 1000 women), which was reportedly the lowest rate in the five preceding years; despite this, it was still over ten times higher than the self-harming rate for male prisoners (194 incidents per 1000) for the same period (Home Office, 2012).

The self-harm and mortality risk remain high for offenders even following their release from incarceration, or discharge from mental health facilities. Harding-Pink (1990) found that the mortality rate of released prisoners in Switzerland to be over 4 times the age-adjusted rate in the community, with the majority of these deaths related to substance overdose. A study amongst discharged Finnish psychiatric patients, for example, found that women had higher overall mortality rates than men, but especially higher rates of both attempted and completed suicide (Sohlman and Lehtinen, 1999). Similarly, numerous studies have documented disproportionately high death rates of former inmates, especially women, following their release from prison (Binswanger et al., 2007; Freudenberg et al., 2007; Pratt et al., 2006; Verger

et al., 2003), although these studies did not necessarily account for all potential confounding variables (e.g. age, race, education, socio-economic status, etc.).

Comorbidity

There is good evidence that the majority of offenders diagnosed with a mental disorder, irrespective of gender, suffer from at least one other disorder i.e. comorbidity is the norm in these populations (Abram and Teplin, 1991; Derkzen et al., 2013; Messina et al., 2004). In the custodial setting, women prisoners are significantly more likely than men to have psychiatric comorbidity (i.e. two or more mental disorders co-occurring in one individual), especially in the form of dual diagnoses (i.e. a mental disorder co-occurring with a substance-related disorder in one individual) (Abram et al., 2003; Acoca, 1998; Birecree et al., 1994; Hurley and Dunne, 1991; Johnson, 2006; Messina et al., 2004; Singleton and Meltzer, 2002; Sung et al., 2010; Trestman et al., 2007; Zlotnick et al., 2008). Rates of psychiatric comorbidity for women offenders are estimated to range from 50 – 90% (Diamond et al., 2001). The severity of substance use in women offenders also increases the likelihood of co-morbid mental health and medical problems; and conversely those with severe primary mental disorders are at also high risk of developing co-morbid substance-related disorders (Abram et al., 2003; Anderson et al., 2002; Mumola, 1999; Putkonen and Taylor, 2014; Veysey, 1998). Abram et al. (2003), for example, studied a large, randomly selected sample of 1272 awaiting-trial female arrestees in Chicago, and found that almost three-quarters of those with a primary mental disorder also met the diagnostic criteria for a substance-related disorder at some earlier point in the lives (with almost a quarter of women abusing two or more substances). In addition, this study also found that almost 20% of women had both current severe mental disorder and a current substance-related disorder at the time of evaluation.

In comparison to the non-offending population and to male offenders, women offenders also suffer significantly more frequent and severe medical comorbidity, for both acute and chronic medical conditions (Anderson et al., 2002; Binswanger et al., 2010; Bloom and Covington, 2008; Maruschak, 2006; Staton-Tindall et al., 2007). It is estimated that women inmates are thrice as likely to have medical health problems than women as compared to women in the community, including sexually transmitted infections (especially HIV), obstetric and gynaecological problems, urinary tract infections, and a range of chronic medical problems (such as hepatic and renal disease, cardiovascular disease, diabetes, and respiratory illness) (Marquart et al., 1999; Maruschak, 2004; Ross and Lawrence, 1998; Young, 1998). Similarly, a survey of Australian correctional facilities found the majority of prisoners (over 80% of women and 65% of men) were diagnosed with at least one chronic medical condition (Butler et al., 2004). Furthermore, in a study of prisoners being released from a New York correctional facility, Freudenberg et al. (2007) reported women prisoners to be more likely to have had an emergency room visit during their incarceration, in addition to more frequently seeking medical help following their release (especially related to depressive, anxiety and respiratory symptoms), in comparison to men. This same study found female inmates to have a higher risk of death (especially following release from prison) from substance abuse, suicide, cardiovascular disease and hepatic disease in particular.

The complex inter-relatedness and importance of comorbidity was demonstrated by Binswanger et al. (2010) in a survey of almost 7000 prisoners in the US which investigated gender differences in medical, psychiatric and substance dependence disorder that were present. After controlling for important confounders (e.g. sociodemographic factors), women had a significantly higher rates for both medical conditions (especially HIV-infection and a range of cardiovascular, respiratory, endocrine and oncological conditions) and mental

disorders (especially mood, psychotic, anxiety, personality and substance-related disorders). Whilst higher rates of morbidity amongst women offenders are partly explained by poverty, poor access to health care services and poor nutrition, Anderson et al. (2002) highlighted the adverse effects of mental ill-health and substance abuse on outcomes from medical illness (especially HIV) in a study of 848 women prisoners in Florida.

In relation to HIV-AIDS in particular, women prisoners do have higher rates of HIV-infection than their male counterparts, with approximately 3 – 3.5% being sero-positive (as opposed to under 2% of men) reported in surveys abroad (Franklin et al., 2005; Greenfeld and Snell, 2000; Maruschak, 2004; Martin and Hesselbrock, 2001; Waring and Smith, 1991). While the high prevalence of HIV/AIDS poses a significant health problem in all prisons, it poses a particularly serious threat to female prisoners in particular (Waring and Smith, 1991). The estimated overall prevalence rate in South Africa is estimated to be around 12% (14% in females, and 10% in males) (Shisana et al., 2014), but the HIV-infection rate in women of reproductive age is much higher: the national average HIV-positivity rate in this cohort was closer to 20% for the period 2002 – 2018 (Statistics SA, 2018). There is also good evidence of relatively high rates of co-morbid mental disorder in HIV-positive South African samples. Olley et al. (2006) reported, for example, that the prevalence of psychiatric disorders in recently diagnosed HIV-positive patients was around 56% at baseline and almost 50% at 6-month follow-up (with depression disorders and PTSD being particularly common). The morbidity and mortality rates related to HIV amongst women offenders in developing countries, especially in sub-Saharan Africa, is expectedly higher as a result of the higher baseline HIV rate in these countries, but there is a paucity of reliable data in this regard. A recent survey of 573 women offenders referred by South African courts for forensic assessment to large forensic

hospitals in the country over a 12-year study period, however, reported a relatively low HIV-positive rate of 5% (Nagdee et al., 2019).

Women in the Criminal Justice System

Globally, female prisoners comprise less than 10% of total prison populations (Putkonen and Taylor, 2014). The percentage of women incarcerated in prisons in various English-speaking countries, for example, is shown in Table 4 (International Centre for Prison Studies, 2013).

Table 4

Female Prisoners in English-speaking Countries (International Centre for Prison Studies, 2013)

Country	Female prisoners (% of total)	Total number of prisoners
Australia	7.6	30 775
England and Wales	4.6	85 158
Canada	5.1	40 544
New Zealand	6.3	8 520
United States	9.0	2 228 424

Whilst women continue to make a small contribution to the total offending rate (and to violent crime in particular), the female contribution to offending (hence the relative proportion of female prisoners) has changed in recent decades (de Vogel & Nicholls, 2016; International Centre for Prison Studies, 2013). Sixty-percent of women on remand do not receive custodial sentences, but the chances of women receiving custodial sentences are also increasing in the UK (Corston and Britain, 2007). Whilst absolute numbers of women in prison remain relatively small (with the exception of the United States, where women also comprise a disproportionately large proportion of a large prisoner population), the percentage of prisoners who are female is increasing (Bartlett, 2006; 2007). In the UK Bartlett documented that the

female sentenced prisoner population increased by 184% (compared with an increase of 57% of male sentenced prisoners) in the decade of the 1990's, with the majority of the increase being on account of substance-related and property offences. The female percentage of the US total prison population has also increased steadily from 3% in the 1960's, to 7% in 2005, and to 9% in 2013 (International Centre for Prison Studies, 2013). Similarly, Greenfeld and Snell (2000) reported that between 1990–1996 the number of substance-related convictions of women has grown by approximately 40%. In addition, Greenfeld and Snell found that the number of female felony convictions in US State Courts between 1990 – 1996 grew at more than twice the male conviction rate for every category of crime (including property, substance-related and violent offences). Greenfeld and Snell also summarised the profile of incarcerated women in the US State prison system, noting a number of important trends: (a) two-thirds of women were black, Hispanic or another racial minority; (b) in excess of 50% were unmarried, with 70% having minor children; (c) the majority were high-school graduates; (d) female prisoners mostly came from impoverished backgrounds; (e) nearly 60% of women had been abused previously, with over one-third by an intimate partner, and around one-quarter by a family member; (f) women were more frequently intoxicated (especially with illicit substances) during the commission of the offence than were men (40% of women versus 32% of men); (g) approximately 65% of female prisoners had prior offending backgrounds (compared to 77% of men); (h) the average duration of imprisonment was shorter for women than for men with equivalent offences; (i) approximately 3.5% of female prisoners were diagnosed with HIV-infection (compared to 2.2% of male prisoners); and (j) approximately one-fifth of women prisoners were on psychotropic medication for mental illness.

In line with these findings, many other studies report that women prisoners are more likely than imprisoned men to have been victims of prior abuse, come from unstable social and

family backgrounds, have poorer socio-economic circumstances, and suffer from higher rates of mental ill-health (especially disorders associated with substances, self-harming and suicidal behaviour) (DeHart et al., 2014; Hawton et al., 2014; Janeksela, 1997; Schwartz and Steffensmeier, 2007; Singleton et al., 2003; Singleton and Meltzer, 2002). In addition, possible gender bias within the criminal justice system also remains an issue under debate in many countries (Wang & Stamatel, 2019). Fenster (1981) (as cited in Janeksela, 1997) found that gender of defendants seemed to influence final court dispositions in a study of 105 American felony case: males were thrice as likely to receive prison sentences, as well as longer sentences, than females convicted of similar offences. Harvey et al. (1992), in an analysis of United Nations Crime Surveys of its member states for the period 1970 to 1985, found that men disproportionately outnumbered women at every stage in the criminal justice process (as suspects, arrestees, and amongst those convicted and imprisoned), whereas the opposite was true for women, who were especially disproportionately under-represented in the latter stages of the legal process (i.e. conviction and imprisonment). Greenfeld and Snell (2000) similarly found that American women were less likely than men to be imprisoned when culpability, mitigating factors and degree of harm incurred by the offence are considered by courts. Similarly, Simmonds and Dodd (2003) reported that whilst men and women in the UK were equally likely to be found guilty by courts, men were more likely to be imprisoned, whereas women were more likely to receive community disposals. Another UK study, however, showed that the apparent leniency of the courts to women reflect that women commit less serious offences and have fewer previous conviction than men, as opposed to systemic gender bias in sentencing practices (Farrington and Morris, 1983). Within prison, women are reportedly also involved in more adverse events than men (including restrictions following self-harming behaviour and disciplinary punishments for rule violations), leading some to question the role

of gender bias in prison services (de Vogel & Nicholls, 2016; DeHart et al., 2014; Home Office, 2012; Putkonen and Taylor, 2014; Wang & Stamatel, 2019).

There is a dearth of reliable criminological data in South Africa, in part due to relatively stringent governmental regulations on their availability in the public domain. A moratorium on the publication of crime statistics was declared in 2000, and although this was eased in 2003, the availability of reliable criminal statistics in general remains poor. This notwithstanding, a summary of two key criminological reports by Berg and Schärf (2004) and Schönteich and Louw (2001), respectively, which have summarised crime trends in South Africa, is provided below.

Schönteich and Louw (2001) reported that crime rates have steadily increased in South Africa over the past few decades, especially violent crimes. Specific criminological data in the 1990's reflected the following: (a) after 1996, levels of all recorded crimes have increased at an escalating rate; (b) South Africa had disproportionately high levels of violent crime by international standards: in 1999 (over one-third of all reported crimes were violent in nature, compared to approximately 15% in the US and just 6% in the UK respectively); (c) violent crimes increased by over 22% between 1994-1999, especially those involving severe forms of violence such as aggravated assault; sexual assault; attempted murder and murder; and (d) in comparison to 110 other countries surveyed between 1994 – 1999, South Africa had the highest per capita rate of murder and rape in the world, the second highest rates of robbery and violent theft, and the fourth highest rate of aggravated assault respectively.

Berg and Schärf (2004) assessed South African crime statistics and trends over the decade from the mid-1990's to the mid-2000's, and drew broadly similar conclusions to those

of Schönreich and Louw (2001): (a) the overall rate of violent crime showed a steady increase from 1994-2003, a pattern that was consistent across all provinces, including the Eastern Cape; (b) whereas violent crime statistics constituted an average of 29% of all reported crimes in South Africa during this time, property-related crimes constituted the largest single category (55% of all reported crimes);(c) death due to homicide was the leading cause of non-natural deaths in South Africa, comprising 45% of all non-natural deaths; and (d) there were particularly robust associations (though not necessarily causal) between violent offending in South Africa and both substance abuse and firearm availability, respectively.

Other comparative international criminological surveys have revealed similar contrasts regarding the disproportionately high violent offending rates (especially for murder) for South Africa. A survey of comparison with 38 other countries (the majority of them European, but also including Australia, Japan, Canada, United States and New Zealand), for example, revealed an average murder rate of 1.05 – 5.56 per 100 000 people for the period 1999 – 2001; South Africa, in comparison, had an average rate of 55.86 per 100 000 for a similar period (1998 – 2000) (Barclay et al., 2003). There is much speculation about the reasons why South Africa has such disproportionately high levels of violent crime in particular. Whilst it is beyond the scope of this thesis to explore these in detail, Berg and Schärf (2004) and Schönreich and Louw (2001) both offered similar, multi-factorial hypotheses in this regard including: the impact of South Africa's ongoing socioeconomic and socio-political transitional problems; links between the country's violent past and contemporary offending; proliferation in firearms; increasing levels of substance abuse; growth in organized crime; demographic shifts to a more youthful, but also poorly educated and unemployed population; rapid, uncontrolled urbanization with associated socio-economic deprivation and housing insecurity; and a poorly performing law enforcement and

criminal justice system, to mention a few. These authors suggest further that the likelihood of people falling victim to crime is further influenced by age, level of income, place of residence and social context. The greatest risk of falling victim to interpersonal violence, for example, is amongst young, poor, previously disadvantaged township residents; whereas serious property crime tends to target middle-aged, wealthier, suburban residents; and victims of violent property crimes are seemingly less clearly defined in terms of their characteristic profile.

Prison Mental Health Surveys

The number of prisoners with mental illness has increased over the past few decades at rates greater than anticipated, with the majority of prevalence studies documenting severe mental disorder rates in prisoners greatly exceeding those in the community (de Vogel & Nicholls, 2016; Fazel and Danesh, 2002). The Human Rights Watch (2006) estimated there to be thrice as many mentally ill patients in US prisons as in psychiatric hospitals. Up to 80% of imprisoned women meet the diagnostic criteria for at least one lifetime mental disorder (Bloom and Covington, 2008; Derkzen et al., 2013; Jordan et al., 1996; 2002; Teplin et al., 1996). Female prisoners are also up to twice as likely as their male counterparts to have a pre-offence mental disorder diagnosis, and twice as likely to be suffering from active psychiatric symptoms upon entry to prison (Derkzen et al., 2013; de Vogel & Nicholls, 2016; DeHart et al., 2014; Guy et al., 1985; Martin and Hesselbrock, 2001; Thompson and Darjee, 2006).

In a survey of prison mental health in the US prison system, James and Glaze (2006) found approximately 75% of women prisoners to have active symptoms of mental disorder (and approximately 60% of male prisoners). In the past year, approximately 23% of female offenders in this study were diagnosed with a mental health disorder (nearly thrice the male

rate); almost 10% had required an overnight admission to a psychiatric facility; and twice as many females than males received psychotropic medication or psychotherapy. In addition, the prevalence of mental health disorder varied by race (in 62% of white, 55% of black and 46% of Hispanic prisoners respectively), as well as by age (with highest rates for inmates 24 years or younger, and lowest for those 55 years or older respectively).

There is much debate regarding reasons for the over-representation of mentally ill women in prisons. Factors which are likely to contribute stem from the vulnerability of people who are mentally unwell, irrespective of gender, to being arrested in the first instance, having their parole revoked more often for technical or relatively minor infringements, and poor social and family support upon discharge into the community (Cloyes et al., 2010; Lamb and Weinberger, 1998; Lamb et al., 2004; Lovell et al., 2002; Solomon et al., 2002; Teplin, 1984; 2000). Psychological distress is also likely to present in female offenders in ways that are different to their male counterparts, in respect of the gender-specific nature and severity of psychopathological symptom expression, responses to the situational stressors of the prison environment, the deleterious effects of separation from their dependent children, and levels of engagement with prison mental health services (Blitz et al., 2005; Derkzen et al., 2013; Drapalski et al., 2009; Lindquist and Lindquist, 1997).

The most commonly encountered mental health problems in prison range from mood disorders (both depressive and bipolar syndromes), schizophrenia and other psychoses, anxiety disorders, trauma and stressor-related disorders (especially PTSD), substance-related disorders and personality disorders, respectively (with the latter two categories being disproportionately elevated in prisoners). The majority of prison prevalence studies, however, have focused on men, with relatively few studying the female prison population (Birecree et al., 1994;

Blanchette and Motiuk, 1996; Daniel et al., 1988; Diamond et al., 2001; Hurley and Dunne, 1991; Lamb and Grant, 1983; Maden et al., 1994a; 1994b; Singer et al., 1995). Nonetheless, there are many epidemiological prison mental health surveys which have included women. Table 5 below is a summary of the key mental health outcomes of the larger, more robust studies, and illustrates two key trends: (a) prisoners of either gender have a high burden of mental health problems, both prior to and during their incarceration; and (b) women prisoners have disproportionately high rates of mental disorders, especially psychotic, mood, posttraumatic, substance-related and personality disorders.

Table 5

Summary of Key Mental Health Surveys of Women Prisoners

Continent*	Study*	Study sample and setting	Key mental health outcomes
Europe	Coid et al. (2009)	Male (n = 1353) and female (n = 304) prisoners in England and Wales	Significantly higher rates in women compared to men of schizophrenia (19% vs 8%), depressive (68% vs 30%), alcohol (28% vs 20%) and other substance-related disorders (60% vs 39%)
	Gibbens (1971)	Women prisoners (n = 638) in HMS Holloway Prison (UK)	Prior psychiatric history in 25%; psychiatric diagnosis in prison in 44%, especially psychotic (5%), neurotic (5%), personality (8%) and alcohol-related (8%) disorders
	Loughran and Seewoonarain (2005)	Women prisoners (n = 318) referred to in-reach mental health services in HMS Bullwood Prison (UK)	High rates of depressive (80%) and substance-related (80%) disorders, and deliberate self-harm (50%)
	Maden et al. (1994a; 1994b)	Women prisoners (n = 301) in England and Wales	Psychiatric history: prior out-patient treatment in 22% and in-patient treatment in 5%; higher rates in women compared to men of substance misuse (26% vs 2%), personality disorder (18% vs 10%), neuroses (18% vs 10%) and intellectual disability (6% vs 2%); psychosis present in 2% irrespective of gender

Continent*	Study*	Study sample and setting	Key mental health outcomes
	O'Brien et al. (2003)	Women prisoners (n = 771) in England and Wales	High rates of personality (50%), substance-related (38%) and psychotic disorders (14%)
	Parsons et al. (2001)	Women remand detainees (n = 382) in UK	High lifetime prevalence of mental disorder (81%); high rates of current mental disorder (76%), especially psychotic disorders (11%)
	Rutherford and Taylor (2004)	Women prisoners (n = 60) in HMS Holloway Prison (UK) referred to in-patient mental health services	High rates of personality (43%), psychotic (38%), bipolar (12%) and depressive disorders (7%)
	Turner and Tofler (1986)	Women prisoners (n = 708) in HMS Holloway Prison (UK)	High rates of prior psychiatric treatment history (18%) and deliberate self-harm (30%); high rates of mental disorder (> 50%), substance related disorders (16%) and psychotropic medication use (13%)
	Watzke et al. (2006)	Male (n = 366) and female (n = 49) prisoners in Germany	High rates in women compared to men of neurotic (33% vs 12%) and affective disorders (12% vs 5.5%), but lower rates of alcohol misuse (27% vs 47%)
North America	Binswanger et al. (2010)	Male (n = 4994) and female (n = 1988) prisoners in the US	Higher rates in women compared to men of illicit substance misuse (46% vs 35%), mood (21% vs 9%), post-traumatic stress (11% vs 5%) and personality (9 vs 5%) disorders
	Birecree et al., (1994)	Women prisoners (n = 91) in Oregon (US)	High rates of substance related (91%) and mood disorders (42%)
	Blanchette and Motiuk (1996)	Women prisoners (n = 76) in Ontario (Canada)	High rates of alcohol related (63%), antisocial personality (37%), psychosexual (34%), depressive (33%), and generalized anxiety (20%) disorders
	Cloninger and Guze (1970)	Women prisoners (n = 66) in the US	Majority had a history of parental deprivation, poor functionality and psychiatric disorder prior to imprisonment; high rates of mental disorder (88%), especially "sociopathy" (65%), alcohol abuse (47%), "hysteria" (41%), other drug abuse (26%), "anxiety neurosis" (11%), depression (6%) and "mental deficiency" (6%)

Continent*	Study*	Study sample and setting	Key mental health outcomes
	Derkzen et al. (2013)	Federal female prisoners (n = 88) in Canada	High rates of antisocial personality (83%), substance-related (80%), major depressive (69%) and post-traumatic stress (52%) disorders
	Dixon et al. (2004)	Juvenile female offenders (n = 100) and female controls (n = 100)	Significantly higher rates in juvenile female offenders compared to juvenile female controls of conduct (91% vs 1%), substance-related (85% vs 5%), depressive (55% vs 25%) and post-traumatic (37% vs 4%) disorders
	Jordan et al. (2002)	Women prisoners (n = 805) in Carolina (US)	High rates of prior mental disorder (64%); high rates of ongoing substance-related (43%) and mood (26%) disorders
	Kane and DiBartolo (2002)	Women prisoners (n = 30) in rural Maryland (US)	High rates of prior abuse and victimization (84%); high rates of serious mental illness (70%) and substance abuse (alcohol in 80%; illicit substances in 63%)
	Lamb and Grant (1983)	Women inmates (n = 101) referred for pre-trial psychiatric evaluation in US	High rates of prior psychiatric hospitalization (86%), prior arrest (94%) and prior violence (70%)
	Singer et al. (1995)	Women prisoners (n = 201) in Cleveland (US)	High rates of prior sexual abuse (81%); high rates of substance-related disorders (83%) and "clinically distress due mental illness" (64%)
	Teplin et al. (1996)	Women prisoners and community controls (n = 1272) in the US	High lifetime prevalence of any mental disorder (80%); higher rates in women prisoners (compared to women in community) of substance-related, personality and post-traumatic stress disorder, but similar rates of schizophrenia
Other continents	Butler et al. (2005)	Male (n = 777) and female (n = 176) prisoners in New South Wales (Australia)	Higher rates in women (compared to men) of any mental disorder (61% vs 39%), especially post-traumatic stress (44% vs 20%), depressive (20% vs 14%), generalized anxiety (20% vs 13%), panic (17% vs 7%) and bipolar (6% vs 2%) disorders
	Hurley and Dunne (1991)	Women prisoners (n = 92) in Australia	High lifetime prevalence of substance-related disorders (54%); high rates of current mental disorder (53%), especially adjustment disorder

Continent*	Study*	Study sample and setting	Key mental health outcomes
			with depressed mood, substance-related and personality disorders

Note. * Alphabetical order of reference per continent

Furthermore, Fazel and Danesh (2002) published an extensive systematic review of 62 surveys of “serious mental disorder” (defined as a psychotic disorder, major depressive disorder and/or personality disorder) in 12 different countries and included almost 23 000 prisoners (male and female). These researchers only included surveys in which validated diagnostic instruments were used, but excluded substance-related disorders from the analysis. Approximately 81% of those surveyed in these studies were men. In studies that included female detainees or sentenced female offenders, the results of a comparison to male prisoners for the most common mental disorders (at the time of or within 6 months of assessment) is summarised in Table 6.

Table 6

Prevalence of “Serious Mental Disorder” in Prisoners (adapted from Fazel and Danesh, 2002)

Mental disorders	Females (%)	Males (%)
Psychotic disorders	4	3.7
Major depressive disorder	12	10
Personality disorder (all types)	42	65
Antisocial personality disorder	21	47

Fazel and Danesh (2002) drew a number of important conclusions from their systematic review. Firstly, the risks of having a “serious mental disorder” is significantly higher in prisoners as compared to the general population, with a two to four-fold higher risk of psychotic and depressive spectrum illnesses, and a ten-fold higher risk of antisocial personality disorder, respectively. More research is, however, still required to clarify the extent to which such

excesses are causes, consequences, or both, of imprisonment. In the second instance, the treatment burden of severe mental disorder in prisoners is therefore also substantial, especially with respect to psychotic and mood disorders. Given the relatively limited resources allocated to prison mental health care (even in developed, industrialized countries), most prisoners with mental illness are unlikely to receive adequate or appropriate care. Thirdly, male and female offenders differ in their mental health profiles, with females tending to display more depressive and psychotic syndromes, and males having more difficulties as a result of personality disorder (especially of the antisocial type). Finally, although only one-third of the world's prison population are in Western countries, approximately 99% of available epidemiological research data from prison surveys are derived from these countries, highlighting the need for forensic mental health research in developing, non-Western populations.

Overall though, Fazel and Danesh concluded that there are greater gender similarities than differences in rates of "serious mental disorder" in prisons, with the lower rates of personality disorder among women being the main distinction. In a subsequent review of prison health surveys across Western countries, Fazel and Baillargeon (2011) confirmed these gendered trends in rates of most mental disorders, but also documented much higher rates of both substance-related disorders and PTSD in women prisoners in particular. DeHart et al. (2014) used a mixed methods study design to examine the life history interviews of 115 American women prisoners. The majority met lifetime diagnostic criteria for a severe mental disorder, with particularly high rates of PTSD (51%) and substance use disorders (85%). Cox regression analyses examined the associations between life experiences and offending risk. Serious mental illness was associated with substance use, running away from home during adolescence and drug offences. Substance use disorder was related to earlier onset of substance use and driving under the influence. Intimate partner violence increased women's risk for

property crimes and violent offending (especially with weapon use). The findings of such studies demonstrate the need for gender-responsive and trauma-informed practices to address mental disorders and victimization among female offenders.

Needs of Women Prisoners

Two of the most important areas of need in women prisoners relate to mother and child care, and mental health care, respectively, both being exacerbated by the vulnerability of women offenders to victimization and abuse in male-dominated prisons (Thompson and Darjee, 2006). Each of these areas is considered in further detail below.

Mother and Child Care. Approximately two-thirds of women imprisoned in the UK were living with their dependent children prior to their imprisonment, with almost 20 000 children separated from their primary care-givers due to maternal imprisonment annually (Corston and Britain, 2007). In South Africa, Nagdee et al. (2019), in a survey of 573 women offenders referred for forensic psychiatric assessment, found the majority (68%) of women to have been mothers of dependent children at the time of arrest (with almost half having more than one child, and almost one-fifth having more than three children). Even these figures may underestimate the extent of the problem, as many incarcerated women tend to avoid declaring their dependent children upon arrest, for fear of care disruption or that their children would be removed by social services (Putkonen and Taylor, 2014). Many women are also pregnant at the time of their entry into prison, though reliable estimates on this are rare (Caddle and Eaton, 1997; Putkonen and Taylor, 2014). In England and Wales, Caddle and Eaton reported that almost two-thirds of women prisoners were mothers of minor children, who between them had 2168 children, nearly a third of whom were under 5 years of age. In addition, approximately 100 women were pregnant at some point during their imprisonment. Whilst some of these

women would leave prison prior to delivery, the level of antenatal, perinatal and postnatal health care they receive whilst incarcerated and following release is often uncertain or less than adequate (Edge, 2006). Unsurprisingly, the risk of premature delivery, low birthweight babies, and other poor birth outcomes, is reported to be significantly elevated in prison (Knight and Plugge, 2005).

Putkonen and Taylor (2014) reported that in the UK, as in many other European countries, women who give birth in prison, or those with a child less than 1.5 years old, may be eligible for placement in a mother and baby unit (MBU) located within prisons or another secure facility. An international survey of prison MBU's, however, found a range of approaches to the management of imprisoned women and their dependent children, many examples of which were inadequate and/or inappropriate to meeting both maternal and child needs (Aynsley-Green, 2008). These varied, for example, from arrangements that allowed the mother and baby to be together all day, to systems which dispatched children to extra-curricular nurseries (allowing the mother to work and the child to learn by day), to more progressive mother and child-centred systems which allowed mothers to live with their children in self-catering apartments until the child attains school-going age. South Africa has 22 prisons that house women prisoners, with a total of 16 designated MBU's catering for women with children under two years of age, though these are grossly under-resourced and inadequate (Judicial Inspectorate for Correctional Services, 2008-2016).

It has further been documented though that mental health morbidity of both mothers and children in MBU's is disproportionately high. Birmingham et al. (2006) found in a mental health survey of MBU's in the UK that nearly two-thirds of mothers had a diagnosed mental disorder (most commonly substance-related, personality, and depressive disorders). The

mothers in MBU's, in comparison to other imprisoned women, tended to come from more stable family and social backgrounds, but with a higher frequency of index offences that were substance-related. Catan (1989) surveyed children who had spent at least 4 months in MBU's, and found them to have relatively poor cognitive and motor abilities for their age, raising speculation that this may be partly due to insufficient stimulation in these environments. Poehlmann (2005), studied attachment relationships between children and their imprisoned mothers, emphasized the importance of providing adequate support for affected families, including mental health care and the appropriate placement of children. Newman et al. (2011) reviewed prison-based parenting programmes for incarcerated mothers in Australia, and found these to have the potential, if sufficiently resourced and appropriately structured, to improve parenting skills, knowledge and confidence, and in so doing improve mother and child outcomes.

Mental Health Care. Both male and female offenders commonly experience psychological distress upon entry into prison, which is likely to persist or escalate following incarceration, and may precipitate or exacerbate a range of mental disorders (de Vogel & Nicholls, 2016; Hurley and Dunne, 1991). A range of mental disorders (including personality and substance-related disorders), individually and co-occurring, may themselves heighten the risk of law violations; and the experiences of the consequent arrest, trial, conviction, sentencing and incarceration may in turn exacerbate symptoms of mental illness (Lord, 2008; Martin and Hesselbrock, 2001; Teplin, 1984). Whilst the physical prison environment can exacerbate the mental health vulnerabilities of incarcerated women, its gender-specific effects have received scant attention in the literature (Bartlett, 2007). Although prisons are necessarily hierarchical and custodial, they also remain intrinsically authoritarian and patriarchal; and for women who have been abused in the past, especially within patriarchal and highly gendered settings, such

systems can be particularly distressing (Henderson et al., 1998; Heney and Kristiansen, 1997). Mentally ill female prisoners experience greater difficulty negotiating the prison environment, and may present significant management challenges, including self-harming behaviour, serious rule breaking, and assaultive acts (Lord, 2008). It is further reported that women in prison, especially those with mental health problems, are at significantly increased risk of harassment and abuse within prison, in comparison to both male offenders, and other female offenders with no mental illness, respectively (Blitz et al., 2008; Wolff and Shi, 2009).

Health services, including mental health care, are often accessed by women offenders for the first time in prison (Staton-Tindall et al., 2007). Despite this, female offenders may use the services more frequently than men in some settings. Ingram-Fogel (1991), for example, found that female offenders made a relatively high number of visits to prison health services during the first 6 months of imprisonment (with an average of over 12 visits in this time). Similarly, Young (1998) studied a sample of 129 incarcerated women and found a high number (2869) of specific prison health service visits during a 4-month period, which was significantly higher than male prisoners. Although relatively more female prisoners seek health care during their incarceration than men, the adequacy, appropriateness, efficacy, purpose and outcomes of such treatment has been questioned, especially in respect of mental health care (Baskin et al., 1989; Maden et al., 1994a; 1994b; Martin and Hesselbrock, 2001; Morash et al., 1994; Teplin et al., 1997). Limited mental health service utilization has been especially associated with women offenders who have dependent children, and who come from backgrounds of socioeconomic disadvantage, housing insecurity, and have limited access to community health services (Ingram-Fogel, 1991; Ross and Lawrence, 1998; Staton-Tindall et al., 2007). In addition, Staton-Tindall et al. found that service utilization profiles for general medical and substance-related did not differ significantly among women from urban versus rural backgrounds

respectively; but there were differences in mental health service utilization patterns, with urban women reporting greater usage than women with from rural backgrounds. Rural women who had access to community health services prior to arrest, also reported fewer health problems whilst in prison.

Furthermore, whilst many women's prisons may conduct mental health assessments of prisoners, the techniques are often inadequate or inappropriate (Martin and Hesselbrock, 2001). This is because assessment and diagnostic instruments are usually designed for male prisoners, tend to be unreliable (e.g. inaccurate estimates of mental health needs), focus on risk management rather than mental health, and /or clinical assessment systems are often compromised by resource and skills deficiencies (Birecree et al., 1994; Martin and Hesselbrock, 2001; Teplin et al., 1997; Wellisch et al., 1996). Treatment decisions in prison facilities may also be shaped less by current need than by other variables e.g. prior treatment history, criminal history, and assessments by non-clinical prison personnel (Teplin, 1990; Teplin et al., 1997). Only a quarter of women prisoners with severe mental disorder actually received the required mental health service in the study by Teplin and co-workers. The same study reported that the groups of women who were most likely to receive prison mental health care were those with schizophrenia or bipolar disorder; those with prior psychiatric histories; and white high school graduates. In addition, women with at least two prior arrests were about 40% less likely to receive mental health services in prison. A further consideration is that since health care resources are generally scarce in prisons, mental health care treatment options are usually limited in scope, and sometimes limited to sentenced prisoners only (and excluding those awaiting trial or on remand) (Putkonen and Taylor, 2014). Conventional prison mental health treatment programmes have received a range of further criticisms related to issues as: tending to focus on crisis management and harm reduction, as opposed to supportive care and

recovery; following rigid programmatic designs that are mostly developed by and for men; not recognizing or meeting the unique needs of women; and consolidating, rather than addressing, the cycles of disadvantage that many women offenders face (Putkonen and Taylor, 2014). Sorbello et al. (2002) similarly highlighted the importance of prison programmes addressing the specific educational, social and employment disadvantages of women offenders, with these being crucial criminogenic factors in themselves.

Baskin et al. (1989) argued that women are often disproportionately engaged with prison mental health services as a result of not only their mental health needs, but also due to gender-prejudiced responses to “role-incongruent” behaviour in the prison setting i.e. in comparison to men, women prisoners are more likely than men to receive psychiatric interventions for equivalent displays of aggression, challenging behaviour or violence in prison. In support of this, Morash et al. (1994) found that women prisoners received between 2 to 10 times the amount of psychiatric medication than their male counterparts. They suggested that whilst this may be due to women’s greater need and use of prison mental health services, and/or their greater psychological distress, it may also reflect attempts by prison systems to control perceived “role-incongruent” behaviour by women. A further consideration is that women may not utilise available prison mental health resources because they perceive them to be inappropriate, insufficient, punitive, untrustworthy or unacceptable in some way (Martin and Hesselbrock, 2001). Bartlett (2007) indicated that although the absolute numbers of women needing mental health services in most countries is relatively low, the capacity of service provision is often a problem. Bartlett noted that whilst only approximately 70 incarcerated women per year in the UK, for example, actually receive Hospital Orders for transfer from prison to a psychiatric hospital, women are also more likely than men to receive such Orders by virtue of their higher baseline rates of mental ill-health. The UK Government has, however,

introduced within its policy frameworks a number of gender-focused concepts, such as “equivalence of care”, “gender-sensitive care” and holistic approaches” in prisons: “equivalence” refers to women prisoners deserving the same level of care as that provided by outside prison; “gender-sensitive care” incorporates an understanding of women’s experiences and how care planning and delivery should be designed accordingly; and “holistic approaches” considers the range, complexity and totality of health, criminal justice and social care needs of female offenders respectively (Bartlett, 2006; 2007).

The specific issue of unresolved substance abuse among women prisoners has received much research attention, especially given that it is amongst the needs most strongly correlated with recidivism. There have been suggestions that shifting from traditionally punitive and rigid substance programmes to more recovery-oriented, rehabilitative models would be more effective (Van Voorhis et al., 2010). In an evaluation of an American prison-based substance misuse programme, Pelissier et al. (2003) found that despite the greater degree of life stressors and adversity faced by women compared with men in the study, women had significantly lower recidivism and substance abuse rates following their release, with similar outcomes were reported in Canada by Dowden and Blanchette (2002). Three main approaches to more gender-sensitive substance abuse treatment programmes for women offenders were offered by Welle et al. (1998): (a) recognition that addressing substance abuse reduces re-offending risk; (b) viewing substance use and criminality as separate issues, but with a number of common elements; and (c) prioritizing therapeutic attention on the psychological distress from traumatic stressors (which are known to trigger, complicate and/or protract substance abuse and offending behaviour). Putkonen and Taylor (2014) further emphasized the importance of recognizing that many women may commit crimes not only to support their own substance

abuse, but also that of their intimate partners, who may coerce women into declining participation in substance programmes.

Mental Health Care for Women Prisoners in South Africa

The Government of South Africa has an obligation to meet all the minimum standards of health care for women offenders, as outlined in both its own legislative frameworks and the policy documents of various international agencies to which it is formally affiliated (Judicial Inspectorate for Correctional Services, 2008-2016). Section 35 of Chapter Two of the Constitution of the Republic of South Africa (1996) outlines the constitutional obligations that provide for, inter alia, adequate health care, together with the provisions of various legislative regimes, including: the Correctional Services Act (Act 111 of 1998), the Health Act (Act 63 of 2003) and the Mental Health Care Act (Act 17 of 2002). The Correctional Services Act in particular has a number of gender-focused references related to the treatment of female prisoners, including the obligation of the state to: accommodate the “nutritional rights of pregnant women”; “create a gender-sensitive environment”; the rights of women to have “children up to the age of two years live with imprisoned mothers; “same-sex searches”; and “non-discriminatory and gender-responsive programs” respectively.

South Africa is also bound by the “United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules)” (United Nations, 2010), which were formulated in response to the growing global population of incarcerated women and to focus specific attention on their rights and needs. The Bangkok Rules include the gender-specific rights of women prisoners to: (a) meeting of female hygiene needs; (b) psychological services (especially for women with backgrounds of prior abuse); (c) female health care services (including during pregnancy); (d) specialized treatment

programmes, including those related to mental health and substance rehabilitation; (e) culturally-sensitive services; (f) alternative screening methods to replace invasive body searches; (g) never have physical restraints used during labour and childbirth; and (h) regular family and child visits.

The Bangkok Rules were subsequently revised in the “United Nations Standard Minimum Rules for the Treatment of Prisoners” (the Nelson Mandela Rules)” to contain new provisions specific to the treatment of women prisoners (United Nations, 2015), including gender-specific rights to: (a) detention in facilities that are separate from male prisoners; (b) all necessary pre- and post-natal care and treatment; (c) having children stay with mothers in prison wherever possible (including provision of child care services), in the best interests of the child; (d) access to qualified health professionals, and adequate, appropriate health care services (including mental health care); (e) conjugal visits wherever appropriate and possible; (f) contact with female-only prison staff wherever possible; and (g) provision of psychiatric treatment whenever needed, both during imprisonment and after release.

Despite these specific obligations, the South African Judicial Inspectorate for Correctional Service Annual Reports (2008 – 2016) makes repeated reference to the inadequacy of prison health care facilities, services, medication, and to the significant shortages of essential health professionals, (including mental health care services and personnel) within South African prisons. This is also despite the fact that the most common severe mental disorders encountered in South African prisons (schizophrenia, substance-induced psychoses, depression, and PTSD in particular) are reported as requiring urgent, specialized mental health care in many, if not most, cases (Judicial Inspectorate for Correctional Service Annual Reports, 2008 – 2016).

The dire situation regarding the gross inadequacy of prison mental health care services in the Eastern Cape in particular has also been documented by Sukeri et al. (2016). During the period of January to December 2010, a total of 403 patients were admitted to FEH (under both the CPA (1977) for formal forensic evaluation, and the MHCA (2002 as state patients or mentally-ill prisoners for forensic care and rehabilitation), which is the only tertiary-level, specialized forensic psychiatric hospital in the Eastern Cape. With an average bed utilisation rate in excess of 200% at FEH over the study period, as a result of the unavailability of sufficient forensic beds elsewhere in the province, it was concluded that forensic mental health service provision in the Eastern Cape was grossly inadequate. Furthermore, there were profound additional and associated systemic deficiencies, including the fact that: the EC does not have any structured prison mental health service at all (and especially no gender-sensitive mental health services for women); there are no mental health services for children and adolescents in the youth justice system; and no prison facility in the EC has a resident psychiatrist. In addition, no community-based, forensic mental health services or support exist for forensic psychiatric patients on leave of absence, nor for mentally ill prisoners on parole, irrespective of gender. Sukeri et al. recommended the urgent establishment of a multi-sectoral provincial public sector task team (including the South African Departments of Health, Justice and Constitutional Development, Correctional Services, Police Services and Social Development,), to lead the development and implementation of more adequate, accessible, appropriate, and effective forensic and prison mental health services in the province.

The mental health of South African women offenders in particular has received scant research attention but a few studies have documented their pathways to imprisonment to be characterized by disproportionately high levels of prior abuse exposure, chaotic family settings,

impoverished social backgrounds, and high rates of alcohol abuse and severe forms of mental illness (Africa, 2015; Artz et al., 2012; Haffejee et al., 2005; Luyt and Du Preez, 2010; Nagdee et al., 2018; 2019).

Women in the Forensic Mental Health System

Biological sex and psychosocial gender roles are known to exert potentially powerful influences on the expression of psychopathology and associated behaviours, including offending. In particular, there are numerous facets of mental illness that are universally known to exhibit important gender differences, including: the risk of development of mental illness; the prevalence of individual mental disorders; age of illness onset; nature of symptoms and presentations of mental illness; course and severity of illness; relative response to clinical treatment; and prognosis to name a few (American Psychiatric Association, 2013; World Health Organization, 1992). Women offenders also have a higher risk for developing mental illness, especially associated with vulnerabilities related to gendered psychosocial factors within patriarchal settings e.g. prior abuse experiences, social disadvantage, etc. (Bohle & de Vogel, 2017; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Long et al., 2008; Mullen et al., 1993; Thomas et al., 2005). In developed countries such as the UK, female patients generally outnumber males in general psychiatric hospitals by a ratio of up to 3:1 (Bartlett and Hassell, 2001).

Whilst there have been relatively few studies focusing on female offenders within forensic mental health services, a few studies have documented concern regarding the patterns and distributions of women, and potential gender bias, within forensic mental health systems. Women comprise a slightly larger proportion of the in-patient forensic population than is the case in prisons, but they are still in the significant minority (up to one-fifth, and often

significantly less than this, of forensic in-patients are women) (Bartlett and Hassell, 2001; Putkonen and Taylor, 2014). In the UK example, mental health service provision for female offenders outside the prison or correctional services system was historically provided in so-called special or high-secure forensic hospitals; medium-secure care provision developed later but were mostly mixed gender facilities catering primarily for women with intellectual impairment or personality disorder (rather than other forms of severe mental disorder), and did not include community-based forensic care (Bartlett, 2004; Bartlett and Hassell, 2001; Hassell and Bartlett, 2001; Kaye, 1998; Sarkar and Di Lustro, 2011; Warner and Ford, 1998). Women who had committed violent offences, whose anticipated length of incarceration extended beyond 2 years and/or whose behaviour was deemed to be particularly challenging remained in high-secure facilities. This resulted in significant gender differences in terms of offending and clinical profiles of forensic patient populations in such secure forensic facilities (Bartlett, 1994; 2004; Coid et al., 2000a; 2000b; Hassell and Bartlett, 2001; Jamieson et al., 2000; Sarkar and Di Lustro, 2011; Warner and Ford, 1998). In summary, these studies demonstrated that men in high-secure facilities were more likely than women to have committed violent (especially homicidal) offences, and to have severe forms of mental disorder; whereas women were more likely to have a pre-offence psychiatric history, personality disorder, and to have committed non-violent index offences.

The number of women in forensic psychiatric care in the UK is declining, with disproportionately more women in private-sector than state-sector facilities (Bartlett, 2004). The distribution and vulnerability of women within various forensic mental health services in the UK has been explored by a number of studies. Bartlett and Hassell (2001) found approximately half of patients in low-secure units were female; in contrast, 10% of medium-secure and 24% of high-secure forensic patients are women; and 18% of patients in prison

hospital sections respectively (these figures reflect the relatively small number of women who commit serious or violent offences in the UK). Bartlett and Hassell also suggested that the situation for women in mixed medium-secure units is likely to be similar, or worse, than in special forensic hospitals, especially with respect to unwanted sexualised, social contact with male forensic patients who have backgrounds of gender-based violence, and harassment and/or assault by both male patients and staff. Similar concerns were raised by Warner and Ford (1998) who did an audit of 263 adult acute psychiatric wards and 33 adult psychiatric intensive care wards in the UK. The results showed that 94% of wards were mixed-gender; two-thirds of female patients had no access to female-only sleeping spaces, and one-third had no access to female-only bathroom facilities. Hassell and Bartlett (2001) similarly surveyed medium-secure forensic units in the UK, and identified a total of 1836 medium-secure beds, 342 of which were occupied by women, most of whom (94%) were in mixed-gender units. In addition, in single-gender forensic units, most beds in the state-sector were for men (56 beds), whereas the majority of private-sector beds were for women (79 beds).

The vulnerability and distress of many women, even within secure forensic hospitals, was further highlighted in a study of suicide in high secure forensic in-patients: in comparison to community samples, suicide rates were found to be 40 times higher among female forensic patients during their inpatient stay (compared with 7 times higher among men) (Jones et al., 2011). Post-discharge suicide rates were also remarkably high: 45 times higher for women and 23 times higher for men respectively. Gender differences in victimization were examined in 218 male and 218 female forensic patients in the Netherlands by Bohle & de Vogel (2017). Prevalence rates of victimization were higher among female patients than among male patients, both during childhood and adulthood. Childhood sexual abuse was reported to be more prevalent among women than men. Women with a history of early emotional and/or sexual

abuse were significantly more often diagnosed with borderline personality disorder than women without childhood victimization. In contrast, men with a history of physical abuse were significantly more often diagnosed antisocial personality disorder than men without childhood victimization.

There are a few studies that conclude that outcomes are generally better for women who are managed within secure forensic facilities. Jamieson and Taylor (2002), for example, have reported that women housed in high-secure facilities are more likely than men to return to community-based living at some point. In addition, after controlling for important confounders (e.g. mental disorder diagnosis; nature of offence; age, etc.), women were also three times less likely to re-offend than men. Gender differences in post-discharge re-offending risk of forensic patients were similarly investigated by Maden et al. (2006). Twelve percent of a sample of 959 patients were women, who had an unexpectedly higher reconviction rate within the two years following discharge in comparison to their male counterparts. Adjustments for histories of deliberate self-harm, substance misuse and previous offending however, reduced the re-offending risk in women to approximately half that in men, highlighting the importance of gender-related confounding variables.

Gender bias (by other patients, non-clinical staff and health professionals alike) may extend to how women are managed within forensic mental health facilities. In comparison to men, women, for example, are more likely to report psychological distress and have more psychotropic medications prescribed (Bartlett and Hassell, 2001). Whilst this may reflect that women are more likely to report internal, subjective distress, with men tending to display externalized, behavioural manifestations of distress; but Bartlett and Hassell also considered it evidence of possible bias in the forensic clinical approach to, and management of, men and

women respectively. In other words, there a tendency for antisocial or violent behaviour of female offenders to be medicalized (that in men would have been criminalized), and a potentially systemic gender bias may be present within forensic mental health systems (Bartlett and Hassel, 2001; Bland et al., 1999; Fryers et al., 1998). Interviews of 31 female in-patients (half of whom had a psychotic disorder) and 58 (male and female) staff members of single-gender forensic units were conducted by Mezey et al. (2005). Although none of the female patients reported being directly sexually assaulted, many reported being threatened, bullied, harassed, or verbally abused by others (especially women), and none indicated a preference for mixed gender wards. Among the staff interviewed, not all considered segregated wards to always be helpful, with a few observing that segregated wards are sometimes useful to protect male patients from sexually provocative, intrusive and/or violent women. Dell et al. (1993a; 1993b) conducted psychiatric surveys of female remand prisoners in Holloway Prison in the UK: of the 95 psychotic female prisoners identified, relatively few had committed serious or violent offences; of the 101 non-psychotic female prisoners, the majority had committed minor offences, with the most common diagnostic categories being “mental handicap” or personality disorder. Bartlett and Hassel (2001) similarly raised the issue that, in addition to the disproportionately large number of women unnecessarily detained in forensic facilities (especially high-secure ones), women were more likely than men to be admitted under the legal category of “psychopathic disorder” (in terms of the British mental health legislation), as opposed to men being more likely to be detained under the “mental illness” category. The authors concluded that it is increasingly recognized that mixed-gender forensic mental health units are not usually appropriate for women, and this had resulted in the state-sector having to rely increasingly on private-sector care provision for these women (possibly compromising effective continuity of forensic care).

Forensic Mental Health Profiles

Female offenders with mental illness are generally more likely to be detained under civil sections of mental health legislation (Bland et al., 1999). The few studies that have reported on the profiles of women offenders within forensic mental health services describe women who tend to be relatively young, socioeconomically deprived, without stable partners, with poor educational and occupational histories, and who have high rates of prior abuse, substance abuse and severe forms of mental disorder (Herjanic et al., 1977; Lamb and Grant, 1983; Maden et al., 1994a; 1994b; Nagdee et al., 2019; Putkonen and Taylor, 2014; Washington and Diamond, 1985). Furthermore, women admitted to forensic hospitals in the UK are more likely to display deliberate self-harm, to have active mental illness during their confinement, and to behave aggressively toward staff (Bartlett and Hassell, 2001). Heads et al. (1997) studied 102 forensic in-patients with schizophrenia and a history of violence, and found a higher incidence of abuse during childhood for women than men. They suggested that such experiences may have a significant influence on psychological and behavioural presentations (including offending), in later life. Furthermore, women within secure forensic facilities have particularly high rates of psychotic-spectrum disorders, affective disorders, and psychiatric comorbidity (Putkonen and Taylor, 2014). Bartlett and Hassell (2001) summarised the differential gender characteristics of patients within most forensic mental health systems, though these are not consistent across all studies (as shown in Table 7 below). In the first instance, female forensic patients are more likely than males to: be diagnosed with a personality disorder (especially of the borderline type) and/or depressive disorder; have fewer previous psychiatric admissions; have fire-setting index offences; to display self-harming or suicidal behaviour; and be at higher risk of damaging hospital property and/or aggression to hospital staff. Male forensic patients, in contrast, tend to be more likely than females to: be classified as having a severe mental disorder other than

personality disorder; have committed sexual assault or homicidal index offences; have prior criminal records; and be at higher risk of sexualized behaviour within institutional settings.

The majority of studies on women offenders within the forensic mental health systems have emanated from the developed, Western world (mostly from the UK and US), with only one large study from Africa or any other part of the developing world (Nagdee et al., 2019). In South Africa, most research on forensic psychiatric populations have been limited by relatively small samples, and an almost exclusive focus on men (Barrett, et al., 2007; Calitz et al., 2006; 2007; Du Plessis et al., 2017; Marais et al., 2011; Strydom et al., 2011). Offen (1986), however, examined residents of a forensic unit at Valkenberg forensic psychiatric hospital in Cape Town, and not only found the majority of women not to be severely mentally ill, raised concerns that gender and race may have played a role in the process of court referrals to forensic services, as well as the issue of the “medicalization of female deviance”. Overall, the findings of research on women within forensic mental health systems suggest a heterogeneous and complex profile, with a summary of key research outcomes from the more robust studies highlighted in Table 7.

Table 7
Profiles of Women Offenders in Forensic Mental Health Services

Continent*	Study*	Sample and setting	Key outcomes
Africa	Nagdee et al. (2019)	Women referred by courts for psychiatric assessment to six large forensic hospitals in South Africa (n = 573)	Mean age = 35 years; majority (56%) had no permanent partner (single, divorced, widowed or separated); over half (51%) failed to progress to secondary school; 78% unemployed at time of arrest; high rates of pre-offence abuse exposure (31%), mental illness (49%) and alcohol abuse (38%); majority (60%) had violent index offences (especially murder, attempted murder, and assault with

Continent*	Study*	Sample and setting	Key outcomes
			grievous bodily harm); property offences accounted for less than 18% of cases; over 70% had at least one psychiatric diagnosis, with most common diagnostic groupings being psychoses (22%); psychiatric comorbidity (12%) and bipolar disorders (10%)
Europe	Bartlett et al. (2007)	In-patients at medium- and low-secure forensic units in London, England (n = 706 males and 75 females)	One-third of women had committed violent offences (murder; attempted murder; assault with grievous bodily harm); majority (90%) had severe mental illness; women were more likely to have personality disorder than men
	Bland et al. (1999)	Female in-patients at high-secure forensic hospital, Broadmoor, England (n = 87)	Most frequent offences were assault (71%), arson (47%), theft (37%) and murder (21%); high rates of pre-offence abuse (68%), alcohol abuse (38%), illicit drug abuse (37%) and eating disorders (17%); acts of deliberate self-harm (in 94%) more problematic than aggression during confinement; majority (90% received psychotropic medication but minority (32%) had psychotherapy
	Coid et al. (2000a)	In-patients at medium-secure (n = 2209 males and 396 females) and high-secure (n = 1032 males and 194 females) forensic hospitals in England and Wales	Women had fewer prior convictions but higher rates of pre-offence psychiatric problems, fire-setting index offences and diagnoses of borderline personality disorder than men
	Coid et al. (2000b)	Female in-patients at Special Hospitals and medium-secure forensic units in England and Wales (n = 471)	Three main diagnostic groups were personality disorder, major mental illness and organic brain syndrome
	Kelly (2008a)	Female in-patients at a forensic hospital in Dublin, Ireland between 1868-1908 (n = 70)	Mean age = 32.8 years; over 50% had index offence of homicide, with majority of these victims (70%) being children; homicidal women were significantly younger than women convicted of other offences; infanticidal women were less likely to be married than those who killed

Continent*	Study*	Sample and setting	Key outcomes
			adults; 10% were “sane” on admission; “mania” and “melancholia” were most common diagnostic groupings
	Kelly (2008b)	Female in-patients at a forensic hospital in Dublin, Ireland between 1910-1944 (n = 42)	Mean age = 36.4 years; 75% had index offence of homicide, with majority of victims being children; most common diagnoses were “mania” or “delusional insanity” (38%) and “melancholia” (24%); 7% were “sane” on admission
	Long et al. (2010)	Female in-patients at a medium-secure forensic unit in Northampton, England (n = 65)	Mean age 31 years; majority (88%) had pre-offence substance abuse; majority (94%) had prior convictions; most (60%) had violent index offences and one-fifth (22%) committed arson; most common diagnostic groups were personality disorder (90%; primary or co-morbid); psychoses (28%); substance disorder (15%); PTSD (14%) and affective disorders (8%); deliberate self-harm in 94% and aggression in 95% at some point during confinement
	O’Connor and O’Neill (1991)	Female in-patients at a special forensic hospital in Dublin, Ireland between 1983-1988 (n = 99)	Mean age = 26.4 years; no cases of homicide; most common index offences were drug-related; primary diagnostic groups were personality disorder (36%), “depression and stress” (23%), “drug addiction” (16%), schizophrenia (11%), mania (7%), and “mental handicap” (2%)
	Sahota et al. (2010)	In-patients at medium-secure forensic units in Leicester, England (n = 502 males and 93 females)	Women had lower prior offending histories than men, but higher rates of fire-setting index offences; violent women less likely than men to be convicted and imprisoned, and more likely to be diverted to forensic mental health system; women had significantly higher mental health needs, morbidity and mortality rates, and poorer outcomes overall than men
	Thomson et al. (2001)	In-patients at a high-secure forensic hospital for Scotland and Northern Ireland (n = 213 males and 28 females)	Mean age = 31.5 years for women (35 years for men); women had significantly fewer prior offences and violent index offences than men, but significantly higher rates of prior deliberate self-harm and abuse;

Continent*	Study*	Sample and setting	Key outcomes
			schizophrenia was most common diagnosis for both men and women(70% of cases); psychiatric comorbidity was common; significantly more women diagnosed with antisocial personality disorder (14% of women; 4% of men) but high-level security was deemed unsuitable for 90% of women
North America	Stone, et al. (2005)	Infanticidal women with mental illness in a forensic hospital in Hudson, US (1978-2000) compared to infanticidal women with no mental illness	Infanticidal with mental illness were significantly older and killed older children than those without mental illness; but there were no other significant differences in sociodemographic profiles with poverty, low education and lack of a partner being common in both groups
	Strick (1989)	Female in-patients at a forensic hospital in Pennsylvania, US (n = 100)	Mean age = 35.8 years; majority (81%) had no permanent partner; 11% were living with their partners at arrest; 50% did not complete secondary school; majority were first-time offenders; violent crimes were most common index offences (56%); victims of violence were known to one-third of offenders, and were children in one-half; all women who were violent toward children were psychotic; most common Axis I diagnostic groupings overall were schizophrenia (40%), bipolar disorder (17%), other psychoses (14%), depressive disorders (8%); Axis II diagnoses (primary or co-morbid) in 70% of cases, most commonly personality disorder

Note. * Alphabetical order of reference per continent

Women who are diverted by courts from the criminal justice system into the forensic mental health system tend to be labelled as more “mad” and less “bad” i.e. as mentally ill as opposed to “simply” criminal (Bartlett, 1994; 2006; 2007; Bartlett and Hassell, 2001; Bland et al., 1999). Despite this, there are indications that, in comparison to men, disproportionately

more women are assigned personality disorder diagnoses (predominantly of the borderline type) in many secure forensic hospitals, and are more likely to be kept longer as in-patients (Bland et al., 1999; Coid et al., 2000a; 2000b; Milne et al., 1995; Portier, 1993; Smith et al., 1991; Tidmarsh, 1980). In their survey of female forensic admissions, Smith et al. (1991) concluded that women offenders with personality disorder may actually require longer periods of treatment than those with other types of mental health problems, and questioned whether their admission to medium-secure units represented efficient use of service resources. Milne et al. (1995) also questioned whether an effective service was being delivered to women in medium-secure forensic care, observing that proportionately more women than men were transferred to Special Hospitals. Dolan and Mitchell (1994) evaluated the prevalence and degree of personality disorder in female offenders referred to the hospital section of a British prison ($n = 50$), in comparison to those housed in a hospital specializing in the management of severe personality disorder ($n = 100$) respectively. The results revealed a high level of personality impairment in the imprisoned women, with 76% meeting formal diagnostic criteria. The incidence and diversity of personality disorder diagnoses in the hospital sample was significantly greater than amongst the prison sample, with borderline personality disorder being the most common in both groups. Similarly, a survey of ten “highly disturbed” women (using interviews and the Millon Clinical Multiaxial Inventory (MCMI-II) in the psychiatric wing of Holloway prison revealed high incidence of arson and self-harming behaviour, with over 90% of women having a primary personality disorder diagnosis, all of whom had background of childhood abuse (Gorsuch, 1999). The women in this study also displayed “extreme ambivalence” in interpersonal relationships, with Gorsuch arguing that “help” as opposed to “treatment” was a more meaningful for female offenders with personality disorder, and that “attachment (theory)-minded” services should be the focus.

Kelly (2008a; 2008b) contended that the outcomes in female forensic patients are usually heavily influenced by a complex combination of adverse social, economic, legal and clinical variables, emphasizing the importance of the broader context in the appraisal and management of mentally ill female offenders. Similarly, Thomson et al. (2001) concluded that female forensic patients generally require intensive, rather than high-secure, forensic psychiatric care. In addition, many researchers have highlighted the heterogeneity of needs within the female forensic population, requiring similarly diverse, and individualised, therapeutic approaches, levels of security, and risk management strategies (Bartlett and Hassell, 2001; Coid et al., 2000b; Long et al., 2008).

Gender-focused Forensic Mental Health Treatment

The UK Mental Health Act Commission (1999), as cited in Bartlett and Hassell (2001), identified four key areas of concern with respect to secure forensic mental health services for women: (a) inadequate privacy in wards; (b) wards being potentially dangerous environments for women; (c) regimes of care did not reflect modern social and gender values; and (d) services being expensive and their efficacy poorly researched. Bartlett (2004) reflected on two important subsequent changes in forensic mental health services for female offenders in the UK. Firstly, there has been increasing awareness that many women offenders have backgrounds of abusive relationships that influence their ways of relating to both themselves and others. These women tend to have poor self-esteem, lack in self-confidence, under-achieve in many spheres of their lives, and are at high risk of creating and pursuing self-destructive, abusive and damaging relationships themselves irrespective of whether they have mental illness or not (and if they do, this serves to exacerbate their difficulties). Secondly, has been the recognition that most women offenders within the forensic system are also vulnerable as a result of the added burden of severe mental disorder, and that this is exacerbated when they are required to share

institutional spaces with male forensic patients, many of whom have histories gender-based sexual, physical and emotional violence. The need to develop forensic mental health services for women that better emphasize gender-focused needs, policies, practices and outcomes is therefore also increasingly recognized in many countries (Bartlett and Hassell, 2001; Edwards et al., 2002; Long et al., 2008). There has been some debate with respect to the specific characteristics of gender-focused forensic therapeutic environments required for women, especially in terms of the physical environment, composition of both staff and patients (though most research remains based in non-forensic settings). A growing body of research suggests that a large proportion of women in forensic mental health units require less emphasis on physical security and more on relational security (Bartlett, 2004; Bartlett and Hassell, 2001; Kaye, 1998; Long et al., 2008; Sarkar and Di Lustro, 2011; Warner and Ford, 1998). This includes attention to the nature of the therapeutic relationships between clinical staff and patients, and to interpersonal variables such as empathy, supportive attitudes, and gender-sensitivity with respect to staffing, staff training and therapeutic interventions. Other key features of such services would include: women-only domestic spaces and activities; predominantly female staff (especially nursing and security personnel); reduced physical security infrastructure in favour of gender-sensitive relational security; and prioritized attention to mental health, social and maternal needs (Bartlett, 2004). Subsequently, a new tier of gender-specific forensic mental health service was introduced in England: Women's Enhanced Medium Secure Services (WEMSS), which have (in addition to the customary infrastructural and procedural security arrangements) enhanced relational security and a focus on gender-specific behavioural therapeutic techniques e.g. dialectical behaviour therapy for women who self-harm (Linehan et al., 2006; Putkonen and Taylor, 2014; Sarkar and Di Lustro, 2011). Similarly, innovative, flexible and gender-focused approaches to forensic mental health management of women have been described elsewhere including, for example, models

grounded in attachment theory for antisocial women, and trauma-focused models for women with personality disorder (Barber et al., 2006; Putkonen and Taylor, 2014).

There is little research on specific gender-focused mental health treatment needs of women offenders, even those within forensic services with severe mental disorders (de Vogel & Nicholls, 2016; Taylor and Bragado-Jimenez, 2009). Nonetheless, psychotropic medication is generally offered (for all offenders with severe mental disorders, irrespective of gender) as the mainstay of treatment for severe mental disorder, associated behavioural challenges, the reduction of violence, the prevention of re-offending, and so forth (Putkonen and Taylor, 2014; Swanson et al., 2000). In general, women tend to have higher serum levels of psychotropic medications than men, with a slightly different adverse effect risk profile (e.g. greater tendency to experience neuroendocrine effects such as hyperprolactinaemia from anti-psychotic medication) (Radler and Naber, 2007). A prospective cohort study in Finland of forensic patients with either schizophrenia or schizoaffective disorder (847 women and 1383 men, followed over 7 years after discharge from hospital), showed no significant gender differences in re-hospitalization rates, but outcomes regarding efficacy of treatment with anti-psychotic medication appeared less favourable for women (Tiihonen et al., 2006). Most research on psychotropic medication efficacy and effects, however, do not consider gender-specific issues at all (Putkonen and Taylor, 2014). The influence of female hormonal physiology on the presentation, course and prognosis of mental disorder (including the risk of associated offending) has also received little research attention. Some women, for example, are more vulnerable to precipitation, exacerbation or relapse of mental illness during the peri-partum and post-menopausal periods; and psychiatric symptoms are known to vary during the course of the menstrual cycle for others (Häfner et al., 1998; 2003; Hallonquist et al., 1993). Whilst a Cochrane review of four small randomised, controlled trials showed no specific evidence of

benefits to mental health of adjunctive oestrogen treatments (Chua et al., 2005), a trial by Kulkarni et al. (2008) of therapeutic hormonal modulation for women with severe mental disorder showed potential benefits, albeit of modest effect.

There have also been very few studies of gender-focused psychotherapeutic approaches for female forensic patients. Whilst cognitive-behavioural therapy is increasingly employed in the treatment of psychotic disorders such as schizophrenia (including during acute phases of the illness) in civil psychiatric settings, its ultimate efficacy and utility among women offenders with psychosis remains unclear. There is little convincing research evidence of specific gender differences in the overall response of people with schizophrenia (irrespective of offending history) to cognitive-behaviour therapy (Gould et al., 2001). Anger management using cognitive-behavioural techniques has been successfully employed in women offenders with mental disorder, with some evidence of amelioration of both delusional symptoms and violent behaviour (Haddock et al., 2009; Renwick et al., 1997). Psychotherapeutic interventions in offenders with borderline personality disorder (e.g. with dialectical behaviour therapy), by contrast, has been better evaluated in women than men (whether as a mainstay or adjunctive treatment), with mixed results regarding its long-term efficacy but generally favouring active treatment against placebo (Putkonen and Taylor, 2014).

Conclusion

In summary, it is clear that women who offend, especially those incarcerated in prison or interred in forensic psychiatric facilities, are a unique, marginalized, stigmatised and vulnerable group. Women offenders are significantly more likely than men to have experienced pre-offence violence and abuse themselves, as well severe mental health problems, including: psychotic-spectrum disorders (especially schizophrenia); mood disorders (especially

depressive syndromes); substance-related disorders (related to both alcohol and illicit substances); personality disorders (especially of the cluster B type); trauma-related disorders (especially posttraumatic stress disorder related to prior abuse); self-harming and suicidal behaviours; and psychiatric comorbidities (especially in the form of a primary mental disorder co-occurring with a substance disorder) respectively. Related to such mental ill-health, women offenders have particularly intense mental health care needs, which most prisons (especially in South Africa) fail to adequately meet. Whilst women offenders who are diverted to forensic mental health systems may have better access to therapeutic services, most of these remain similarly androcentric, inadequate, and often inappropriate to the needs of women. Despite this, there has been scant research, academic and socio-political attention paid to the forensic mental health issues of women, particularly in the developing world.

Chapter Four: Mental Health of Violent Women

Violent behaviour has been debated, conceptualized and researched from a variety of philosophical, sociological, criminological and clinical perspectives, with increasing recognition of its gendered patterning (Burman et al., 2001; de Vogel & de Spa, 2019; de Vogel et al., 2016). Sex and gender are some of the most consistent and robust demographic correlates of violent offending, with extreme forms of violence invariably masculine i.e. perpetrated by men in the vast majority of instances. This chapter will initially provide an overview of criminological, offence-related, psychosocial, contextual and developmental issues in respect of violent women offenders. This will lead to consideration of the complex, but poorly understood, associations between gender, mental health and violence. A detailed review of research evidence on violent women in forensic mental health systems will be followed by a focus on specific mental disorders associated with violent women (particularly psychotic, mood, substance-related and personality disorders). The chapter will conclude with a review of recidivism by violent women with mental disorder.

Criminological Profile

Women are significantly under-represented among criminal samples and populations in every category of crime, but especially violent crime, for all socio-demographic categorizations, at any time and in all societies worldwide: men significantly outnumber women in the commission of most crimes (and certainly for violent crimes in particular), as well as for prison or forensic mental health service occupancies (Eagly and Steffen, 1986; Janeksela, 1997; Steffensmeier and Haynie, 2000; Stueve and Link, 1998; Weizmann-Henelius et al., 2004a; 2004b). Women comprise 51% of the United States population, for example, but only 11% of those arrested for violent crimes are women (Robbins et al., 2003). Similarly, in

the United Kingdom women are estimated to comprise only 6% of the prison population and less than 12% of the hospitalized forensic psychiatric population (Taylor and Bragado-Jimenez, 2009). In Finland, between 1991 and 2010, women's contribution to crime rose from 13 to 19% of all convictions, with embezzlement/fraud and petty theft comprising almost one-third of all female crime (Putkonen and Taylor, 2014). The proportion of female-perpetrated violence displayed similar increases, from approximately 5% in 1980 to 17% in 2010. Although there are limitations to the reliability of self-reported data, it is estimated that less than 15% of violent offence perpetrators are reported by victims to be female (Steffensmeier and Allan, 1996; Greenfeld and Snell, 2000). Swanson et al. (1990) studied a wide range of self-reported violence, including assault of intimate partners or children, physical altercations with others, and the use of weapons. They found that 2% of participants reported at least one such violent event in the preceding year, with twice as many male as female perpetrators, but that this gender disparity was significantly reduced among people with major psychiatric disorders. A similar self-report study of over 8000 British households by Yang and Coid (2007) found men, however, to be thrice as likely to report violent behaviour as women. Greenfeld and Snell (2000) undertook a detailed survey of female involvement in violent crime across the United States during the 1990's, and summarised a number of key patterns and trends: (a) based on victim self-reports of violence, males displayed per capita rate violent offending rates six times that of females; (b) the majority of violent female offenders (75%) committed less serious "simple assault", as opposed to more violent "aggravated assault" committed by the majority of violent male offenders; (c) approximately one-quarter of violent female offenders were juveniles; (d) victims were of the same gender as perpetrators in the majority (70%) of cases; (e) almost two-thirds (62%) of violent female offenders were known to their victims as intimate partners, parents, relatives or acquaintances (by contrast, only just over one-third (36%) of violent male offenders were known to their victims); (f) approximately 4 in 10 violent women

offenders were reported by their victims to have been intoxicated at the time of the offence (a similar rate as male offenders); (g) nearly half of all violent female offenders committed their offences at or close to the victim's home or school (as opposed to less than one-third of male offenders); and (h) in cases of violent offences involving the use of weapons, the consequences were more serious for victims of male violence, with respect to frequency of weapon use, severity of injury caused, and financial losses incurred by the victim.

These statistics notwithstanding, the proportion of women engaging in violent offences appears to be increasing (Weizmann-Henelius, 2006). Female participation has grown especially for minor assaults, and there is also increasing evidence of an increase in rates of female-perpetrated domestic violence (Archer 2002; 2004; Bookwala, 2002). Women, however, still account for the vast minority of more serious violence (e.g. aggravated assault or homicide) (Janeksela, 1997; Kruttschnitt et al., 2002; Putkonen and Taylor, 2014). Studies of the offending careers of violent female offenders show that, in comparison to men: women participate in significantly less violence during their lifetimes; violent offending by women typically commences and peaks slightly earlier; and women are considerably less likely to be violent recidivists (Janeksela, 1997; Schwartz and Steffensmeier, 2007). Verona and Carbonell (2000) divided their sample of violent incarcerated female offenders according to history of prior violence: "non-violent", "once violent" and "repeatedly violent" groups. There were more homicidal offenders in the "once violent" group, but the "repeatedly violent" group had significantly more disciplinary reports for violence whilst in custody.

In line with the many previously reviewed theories of offending behaviour in women, a number of bio-psycho-social theories have been proposed to explain the significant gender gap in the propensity for violent behaviour. Psychoanalytic approaches, for example, focus on

differential defence mechanisms such as projective identification; feminist theories emphasize social conditions, gender inequality and female responses to misogynistic and oppressive social traditions; biological theories highlight the role of hormonal and neurochemical influences (especially catecholamines, cortisol and testosterone); whilst attachment theorists point to the influential and gendered role of childhood experiences, early family relationships, and parenting styles in motivating violent conduct (Eagly and Steffen, 1986; Elbogen et al., 2001; Putkonen, 2003; Putkonen and Taylor, 2014; Welldon, 1991). Eagly and Steffen (1986), however, in a meta-analytic review of gender differences in aggressive and violent behaviour (from 63 studies) cautioned that although men were more aggressive than women on the average, gender differences were both complex and inconsistent across studies. In comparison to women, men tended to engage more in aggressive acts that produced physical pain and injury in the victim, than for aggression that produced psychological or social harm without physical injury. In addition, gender differences in aggressive behaviour were larger to the extent that women tended to perceive, to a greater degree than men, that enacting violent behaviour would produce harm to the target, guilt and anxiety in oneself, as well as danger to oneself. Eagly and Steffen concluded that gender differences in aggression were primarily related to the perceived consequences of aggression, with these being learned as a function of gendered socio-cultural roles and norms.

Psychosocial and Situational Context

Irrespective of gender, violent crimes are often preceded by, or the result of, interpersonal conflict between perpetrator and victim, with many studies suggesting this to be a particularly common factor in violent (especially homicidal) offending women, most often in the context of prior abuse by victims who are intimate male partners or family members (Jurik and Winn, 1990; Maxfield and Widom, 1996; Weizmann-Henelius, 2006; Widom and White, 1997).

Violent women do tend to direct violence against people well known to them, as intimate partners, family members, children and/or acquaintances, with violent acts more often occurring in the home setting than is the case with men (Eckhart and Pridemore, 2009; Husain et al., 1983; Jurik and Winn, 1990; Maden, 1997; Monahan, 1992; Richardson and Hammock, 2007; Roe-Sepowitz, 2007; Rossegger et al., 2009; Weizmann-Henelius, 2006; Weizmann-Henelius, Sailas et al., 2003; Weizmann-Henelius, Viemero et al, 2003; Yourstone, Lindholm and Kristiansson, 2008). Women involved in violence also tend to be intimately related to their attackers when they are victims, and to their victims when they are perpetrators (Janeksela, 1997). Weizmann-Henelius, Viemerö et al. (2003) examined the relationship between violent women and their victims, with a focus on motives and psychological factors that influence the offences. They divided their sample of 61 women into 3 groups: those who victimized people closely related to them, acquaintances and strangers respectively. Overall, victims were closely related to perpetrators in 34%, acquaintances in 41% and strangers in 25% of cases. The victims in homicidal offences were more often closely related to the perpetrator (in almost half of call cases) than in non-homicidal assaultive offences (in less than one-fifth of cases). The majority of victims of violent attacks were men (less than one-fifth were women), with very few victims being children (less than 8% of cases); children, however, were more likely to be victims of lethal (4 cases) than non-lethal violence (2 cases). Interpersonal conflict and mental health problems were the most frequently occurring context in which violent offences were committed. Nonetheless, neither self-defence as a motive nor a history of abuse of the perpetrator were commonly reported (even by women who were violent toward intimate partners). The most frequently cited motives related to confrontations in which the perpetrator and/or victim were intoxicated with alcohol. Women who victimized acquaintances and strangers were more likely to have had prior criminal records, substance-related disorders and antisocial personality disorder, as compared to those who victimized those close to them. There

were no significant differences between women who had previously been abused themselves and those without such abuse experiences. The authors concluded that violent behaviour by women more often has a fatal outcome when the victim is closely related to the perpetrator and of the male gender. The researchers did not support the view that violent female offending (including homicidal violence) occurs primarily as a result of provocation or precipitation by the victim. Instead, alcohol-related conflict between perpetrator and victim was the most strongly associated contextual factor in most instances in this particular study.

Rossegger et al. (2009) found in Swiss study of over 200 violent offenders (187 men and 16 women) that women were significantly more likely than men to have experienced childhood adversity or abuse (in one-third of women), and to have significant mental health problems. The offences of women were also less diverse in range than those of men, with over 90% of female-perpetrated violence falling into just four crime categories: homicide, arson, robbery and assault respectively (with homicide and arson being the most common). In addition, a disproportionate number (almost half of the women) had a prior criminal history. The authors interpreted their results as supportive of the importance of gender-focused theories of female offending in trying to understand violence by women, especially those with mental health problems.

It is reported further that the profile of violent women, and the context in which the violence is committed, is likely to be changing in a number of ways: (a) violent female offending is increasingly occurring outside of private or domestic settings; (b) victims are more often strangers or acquaintances, as opposed to intimate partners or close family members; (c) the proportion of women engaging in instrumental violent criminality is increasing; and (d) the rate of alcohol-abusing women initiating violence is increasing significantly (Archer, 2000;

2002; 2004; Chase et al., 2003; Weizmann-Henelius, 2006). This changing profile in violent women offenders was considered by Weizmann-Henelius (2006) to be reflective of changing gender and social roles of women (and changing attitudes toward these), possible reductions in leniency for violent female offenders by judicial systems in some countries, and increased levels of alcohol consumption amongst women generally. Whilst women still commit serious violence relatively rarely, the evidence supports the view that violent female offending is growing increasingly similar with respect to patterns, trends and case profiles to that of men (Logan and Blackburn, 2009).

In addition, the issues of race or ethnicity are complex, and controversial, with respect to the risk of violent female offending. Sommers and Baskin (1992), for example, reported that black and Hispanic women in New York City were more likely to be arrested for violent crimes than white females, and further that the violent offending rates and patterns for black females tended to parallel those for white males. Women of colour living in other countries (whether with predominantly black or white populations), however, do not display such disproportionately high per capita rates of violent offending (Janeksela, 1997; Kruttschnitt, 1993; Wilson and Daly, 1992). There are, of course, numerous confounding variables that need to be accounted for in the interpretation of these outcomes (Putkonen and Taylor, 2014).

Developmental Pathways to Violence in Women

There has been relatively scant research examination of how violence may influence, or be influenced by, the early experiences of girls and young women, and how these may be mobilized into particular pathways of offending behaviour e.g. the manner in which they are violent, how they might use or manage violence, how they deal with violent encounters, or how they desist from being violent (de Vogel & Nicholls, 2016). The reasons for adolescents

resorting to violence are postulated to display gender differences. Violence by girls is more often ascribed to relational conflict, emerging as a reactive response to disappointment, threat, humiliation and/or abuse; boys more commonly use violence as a behavioural means aimed at an end beyond inflicting physical harm e.g. as an attempt to entrench dominance or establish status (Crick and Grotpeter, 1995). It has further been suggested that for girls, crossing the threshold of perpetrating physical violence has a potentially greater impact on mental health than is the case for boys, partly due to entrenched gender bias with respect to individual and societal expectations of how girls “should behave” (Berkout et al., 2011; Chesney-Lind, 1986; 1988; 1989; Loeber and Keenan, 1994; Odgers and Moretti, 2002; Rivera and Widom, 1990). Numerous specific risk factors for violence in adolescent girls have been identified including: childhood abuse experiences; disturbed family and social interactions; absent, aggressive, antisocial and/or criminal parents; and certain social cognitive characteristics (such as low frustration tolerance, misplaced perceptions of hostile intent by others, external loci of control and responsibility, and selective preference for aggression and confrontation as opposed to more pro-social choices) (Leschied et al., 2001; Loeber and Hay, 1997; Loucks and Zamble, 1999; McCorkle, 1995; Rossegger et al., 2009; Yourstone, Lindholm and Kristiansson, 2008). In a systematic review of 46 studies of aggression in adolescent girls, Leschied et al. (2001) reported that, in comparison to adolescent males, violent girls tend to be involved in lower-risk forms of aggression (such as verbal as opposed to physical aggression), and tend to direct aggression more often toward females and to those close to them (especially family members). Loeber and Hay (1997) also considered empathy deficits and sensitivity to rejection to be particularly important risk factors in the development of aggression in adolescent girls.

A number of studies have further emphasized that adolescent female offenders are more likely to have experienced prior abuse than their male counterparts. Early, repetitive childhood

trauma, especially sexual abuse, has been postulated to have many adverse longer-term consequences, with abused girls frequently becoming distressed, troubled, abusive and violent women themselves (Hiday et al., 2001; Siegel, 2000; Siegel and Williams, 2003). The associations between traumatic childhood experiences and later mental health and behavioural problems in women has been extensively documented (Kendler et al., 2000; Koivisto and Haapasalo, 1996; Putkonen and Taylor, 2014; Weizmann-Henelius, 2006). The conclusions of a large prospective study by Dodge et al. (1990) were that abused children and adolescents tend to develop aggressive and violent behaviour largely as a result of disturbances in the processing of interpersonal and social cues. Although gender-sensitive studies are uncommon and conclusions preliminary, the cycle of a subsequent tendency to violence may be stronger in women who were traumatized as children, as compared to men (Fagan, 2001). There are also indications that mental health problems are more frequent amongst violent adolescent girls than boys, and that self-harming and suicidal behaviour may correspond more closely with violence toward others than is the case in boys (Gammelgård et al., 2012). These authors studied gender differences in the risk of violence in 231 institutionalized adolescents and reported boys to have higher risk related to issues around conduct disturbances, problem-solving skills, attention deficits, and externalized antisocial behaviours; whereas girls had higher risk ratings on variables related self-destructive, internalized behavioural patterns, especially those related to past violent abuse and life stressors. Adolescent girls with childhood experiences of dysfunctional family relationships, early trauma and victimization (especially if the perpetrator was a parent or significant other) and poor social support also tended to engage more often in a violent manner than other girls. Violent girls who persist in delinquency, and particularly those who receive little or no psychosocial interventions to address their problems, also tend to display considerably more functional impairment, social marginalization, substance misuse, mental ill-health, poor occupational adjustment and engagement in abusive and chaotic

relationships as adults (Silverthorn and Frick, 1999). Smith and Thornberry (1995) similarly reported significant associations between early childhood abuse (especially before 11 years of age) and subsequent delinquency and mental health difficulties. Widom and White (1997) conducted a prospective cohort study of abused and neglected children and adolescents, and concluded that females, but not males, were at significantly higher risk of substance misuse and arrests for violent offending in adulthood than were controls. Jasper et al. (1998) conducted a retrospective review of the clinical records of 100 girls in an adolescent forensic mental health service. Whilst 68% of girls had assaulted at least one person in the past, 90% had broken the law in the six months prior to forensic assessment, and violent or aggressive behaviour was documented in 54% of the cases (with half of these also abusing substances) The majority (71%) had been abused in some way, and 76% had deliberately harmed themselves. Whilst relatively few (14%) of self-harming girls had a severe mental disorder (14%), half had abused substances, and the majority (54%) had been sexually abused.

Associations between Gender, Mental Health and Violence

There are likely to be significant differences in the nature of, and reasons for, violent behaviour by men and women with mental disorder, though female offenders have been relatively neglected in this area of research in comparison to men (de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Newhill et al., 1995). Women, in all settings and countries, are much more likely to be the victims of violence than perpetrators (Logan and Blackburn, 2009). Overtly violent behaviour perpetuated by women has traditionally been viewed as an exception or anomaly, and understood to be the collective result of numerous bio-psycho-social variables e.g. physiological factors; reactions to maltreatment, abuse, neglect or victimization; gendered patterns of socialization and expressions of psychological distress and/or mental ill-health, etc. (Chesney-Lind, 1986; 1989; Wood and Eagly, 2002). Whilst

variables such as experiences of violence in intimate relationships may be relevant risk factors for either gender, it is likely that they influence men and women in different ways. Similarly, whilst mental disorder (including personality disorder and substance-related conditions) is often considered a critical risk factor in studies of violence, its relative influence on the occurrence and expression of violence may well exhibit significant gender differences (Dean et al., 2007; Logan and Blackburn, 2009). Weizmann-Henelius (2006) postulated that the social taboo of female violence, and the denial thereof, as well as gender bias regarding traditional or “ideal” feminine and maternal roles, have reduced awareness of, and interest in, the phenomenon. Research has also tended to focus on homicidal female violence, to the relative exclusion of studying other forms of violence. This is despite the fact that violent women offenders are reported to commit a significantly greater number of non-homicidal acts of violence overall (Weizmann-Henelius, 2006). There is also considerable concern regarding the generalization of research findings from male samples to women, especially with respect to violence assessment, risk, management and the broader, gendered psychosocial context of violent behaviour (Logan and Blackburn, 2009).

Many studies have documented robust associations between more severe forms of mental disorder and violence in both men and women, and possibly more so in women (Putkonen and Taylor, 2014; Taylor and Bragado-Jimenez, 2009). Violent female offenders generally display higher rates of severe mental illness than both violent men and women who commit non-violent offences (Cloninger and Guze, 1970; Hollin and Palmer, 2006; Maden et al., 1990; 1994a; 1994b; Rossegger et al., 2009). Violent conduct in women has been empirically linked to more severe forms of mental disorder, especially psychotic spectrum disorders, dual diagnoses and other forms of psychiatric comorbidity (Boles and Miotto, 2003; Brennan et al., 2000; Eronen, 1995; Fazel and Grann, 2006; Fazel, Gulati et al. 2009; Fazel, Långström et al., 2009; Monahan,

1992; Nicholls and Petrila, 2005; Putkonen et al., 2003; Walsh et al., 2002). It is also generally accepted that, irrespective of gender, the acute phases of mental disorders (especially for schizophrenia and other psychotic-spectrum disorders) are associated with an increased risk of violent conduct (Mullen, 1997). Yet other studies emphasize that the extent to which mental disorder moderates the relationship between gender and violence may depend on many complex and interacting factors e.g. the type of violent behaviour, the specific psychosocial antecedents of the violence; and the diagnostic profile of the individual perpetrator, and its unique psychopathological and behavioural manifestations (Hodgins, 1992; Swanson et al., 2002; Wessely et al., 1994). In their sample of people with schizophrenia and other psychotic spectrum disorders who acted violently, Swanson et al. (2002) explored the psychosocial context of violence in patients with mental disorder attending community mental health services (280 women and 522 men; two-thirds of patients were diagnosed with schizophrenia or schizoaffective disorder, almost a third had bipolar disorder, and the remainder suffered from major depressive disorder or “other serious mental disorder”). They found that early abuse in both male and female patients was directly associated with the risk of subsequent violence. For women, however, additional factors in their mental state and environmental situation (e.g. prior abuse, social adversity and illness characteristics) mediated these associations to a greater degree than was the case for men. The authors identified a hierarchy of the relative impact of abusive experiences for people with mental disorder, in relation to the likelihood of subsequent violence. People with histories of abuse during childhood only were no more likely than those without such childhood traumatic exposure to act violently as adults; those who were abused as both children and adults were the most likely to exhibit subsequent violence. This association of prolonged victimization and abuse with later violence in people with mental illness attained statistical significance for both men and women, although the risk of violence was greater for men. Mediating factors for women included variables such as severity of mental disorder (e.g.

more severe symptoms and frequent hospitalizations) and recent homelessness. Substance-related and personality factors were not reported as independent influences in this particular study. Taylor and Bragado-Jimenez (2009) suggested such findings presented potentially more preventive approaches, intervention opportunities and therapeutic modalities with women, as current/dynamic factors (as opposed to static/historical ones) could be the target of attention.

Hence, whilst severe mental disorder, especially in combination with substance-related disorder, personality disorder and/or neuropsychiatric comorbidity (e.g. neurocognitive disorders or intellectual disability) is associated with an increased risk of violence, there is some debate about the exact role of gender in mediating this relationship. There is research evidence that gender differences in violence apparent in the general population (e.g. men being more frequently and severely violent than women) may not necessarily hold true for people with severe mental disorder (especially within in-patient settings). Whilst a few studies have found male psychiatric patients to be more frequently violent than their female counterparts (Depp, 1976; Pearson et al., 1986; Rossi et al., 1986), numerous other studies have refuted this. An attenuation of the gender gap in violent behaviour in people with severe mental disorder has been demonstrated in numerous studies of psychiatric populations within: (a) the community settings (Archer, 2002; 2004; Binder and Mc Neil, 1990; Bland and Orn, 1986; Brennan et al., 2000; Hiday et al., 1998; Hodgins, 1992; Hodgins et al., 1996; Lam et al., 2000; Lidz et al., 1993; McNeil et al., 1998; Newhill et al., 1995; Stueve and Link, 1998; Swanson, 1993; Swanson et al., 1990; 2002; Tam et al., 1996); (b) general (i.e. non-forensic) mental health services (Binder and McNeil, 1988; 1990; Flannery et al., 1999; Fottrell, 1980; Krakowski and Czobor, 2004; Lam et al., 2000; McNeil and Binder, 1994; Mulvey, 1994; Nicholls et al., 2004; 2009; Rabinowitz and Mark, 1999; Rappeport and Lassen, 1966; Skeem et al., 2005; Tam et al., 1996; Tardiff, 1984); and (c) forensic psychiatric services (Daffern et

al., 2003; 2005; Gammelgård et al., 2012; Nicholls et al., 2009; Putkonen, Weizmann-Henelius et al., 2011; Rasmussen and Levander, 1996) respectively.

The results of two large Scandinavian cohort studies provide significant support for the conventional interaction hypothesis (i.e. that severe mental disorder predisposes to violence more in women than in men). Firstly, Hodgins (1992) investigated the mental health and conviction records of a 1953 birth cohort in Sweden, and compared groups of patients who were hospitalized to psychiatric facilities and those with intellectual impairment, on the one hand, with control populations who were mentally and intellectually healthy. Although men were generally more likely than women to be convicted of violent offences irrespective of diagnostic status, the gender gap was significantly smaller among those diagnosed with more severe forms of mental disorder (e.g. schizophrenia, schizoaffective disorder, or bipolar disorders), in comparison to those with less severe forms of mental disorder or no mental health problems at all. Approximately 15% and 6% respectively of men and women diagnosed with a severe mental disorder were violent offenders (a less than 3-fold difference), compared with 6% and 1.5% respectively of men and women with less severe mental ill-health (a 4-fold difference), and 6% and 0.5% respectively of men and women with no mental health problems at all (a greater than 10-fold difference). Hodgins et al. (1996) reported similar results from a large Danish cohort: for the period 1959 – 1977, approximately 5% versus 0.5% respectively of men and women with severe mental disorder were convicted of a violent crime (a 9-fold difference), compared with 2% versus 0.1% respectively for men and women without mental disorder (a 20-fold difference). Similarly, for the period 1978 – 1990, 7% versus 1% respectively of men and women with severe mental disorder were convicted of violence (a 7-fold difference), compared with 1.5% versus 0.1% respectively of men and women without mental health disorder or intellectual disability (a 15-fold difference).

These research outcomes notwithstanding, the links between gender, severe mental disorder and violent behaviour are complex, and remain poorly understood. There is also much research that questions the conventional interaction hypothesis (i.e. that mental disorder predisposes to violence more in women than men). Some studies, for example, report similar associations between gender and violence irrespective of the presence of mental disorder (e.g. Link et al., 1992; Monahan, 1992), whilst others have highlighted the presence of numerous confounding variables in explaining these apparent associations e.g. socio-demographic factors (such as age, race, and marital, financial and occupational status), co-morbid substance abuse and/or personality disorder, and non-adherence to prescribed medication (Hodgins et al., 1986; Rice and Harris, 1995). In a large national Norwegian study of the prevalence and characteristics of dangerousness among female psychiatric patients, Linaker (2000) reported the overall prevalence of mentally ill patients considered to be dangerous by mental health clinicians was 9.9/100 000 adults, with the female prevalence being 3.1/100 000. In comparison to a matched sample of men, fewer women had prior offending histories resulting in incarceration. The study also found no gender differences with respect to frequencies of psychosis, intellectual disability, personality disorder or substance abuse. The female group, however, had higher rates of self-injurious or suicidal behaviours, and previous non-violent, property offences. Weizmann-Henelius, Sailas et al. (2003) explored the relationship between blame attribution, feelings of guilt, offence characteristics, social background and personality factors in 58 violent Finnish female offenders. A series of structured mental health rating scales revealed lower scores of guilt feelings in women than in comparator male samples. Whilst feelings of guilt were higher amongst homicidal compared to non-homicidal violent female offenders, these were lower in cases with prior histories of violent offending. No differences were found between offenders with psychiatric problems and mentally healthy prisoners. The

duration of hospitalization or incarceration did not result in any differences in levels of blame attribution or guilt, but when victims survived the violent attack, feelings of guilt increased with time. External blame attribution was related to motives of the criminal act, but past traumatic experiences did not have any significant impact upon degree of blame attribution. The degree of guilt experienced and the attribution of blame were both, however, significantly related to the personality profile of perpetrators (being expectedly lower in women with psychopathy). The authors suggested that, in general, it may be more difficult for women to cope with violent offending than previously appreciated, but that psychopathic traits impact on attenuating guilt feelings, and consequently on coping with the outcomes of violent behaviour. In Switzerland, the lifetime conviction records of people admitted to a Swiss psychiatric hospital were compared to demographically matched controls in a study by Modestin and Ammann (1995). The percentage of male and female controls convicted of violent crimes were 1% and 0% respectively; by contrast, the figures were 4% and 0% for men and women respectively diagnosed with psychotic disorders, 10% and 1% respectively for affective disorders, and 8% and 2% respectively for a combined group with other psychiatric disorders. These results hence suggested that the relationship between mental disorder and violence appeared to be more robust in men than women.

Another large epidemiological analysis by Swanson et al. (1990) examined self-reported violence in community residents with and without mental disorder. In their first report, gender differences in demographic and diagnostic profiles were not adjusted for, and results suggested that women with severe mental disorder were: firstly, as likely as men with similar disorders to report recent violence (10% versus 11% for women and men respectively); and secondly, significantly more likely to report violence than women with no mental disorder. In a subsequent analysis that controlled for gender differences in socio-demographic factors,

however, Swanson (1994) found no such significant interactions between gender, psychiatric diagnosis and violent behaviour i.e. the gender gap was roughly constant irrespective of mental health profile. Stueve and Link (1998), in another large epidemiological survey of self-report data of a psychiatric sample, investigated whether the associations between gender and violent conduct were moderated by three mental health variables: treatment status, psychiatric diagnosis and threat/control override symptoms of psychosis. The analysis revealed that treatment status and psychiatric diagnosis moderated the relationship between gender and violence, but that this was not necessarily true for threat/control override symptoms. In their study of violence both preceding and during psychiatric hospitalization, Binder and McNeil (1990) reported that prior to hospitalization, men engaged in significantly more physical attacks and fear-inducing behaviour than women. During short-term psychiatric hospitalization, however, women engaged in proportionately more physical attacks than men. In a study of outcomes in discharged English psychiatric patients, Steadman et al. (1993; 1998) found only slightly fewer women than men displayed pre-admission violent behaviour (35% of women versus 39% of men), but more women than men were violent in the community after being discharged (33% of women versus 22% of men). Newhill et al. (1995) similarly investigated violence towards others in the community by discharged psychiatric patients in an urban catchment area. Males and females exhibited more or less equivalent levels of community-based violence in the 6 months following their psychiatric admission, and gender was not considered a significant risk factor when other relevant variables were controlled for. Women, however, were significantly more likely to be violent at home toward a family member, whilst men were more likely to be violent in public toward strangers. A number of studies have, however, also reported that strangers do not appear to be at any more risk of falling victim to violence from psychotic patients, irrespective of gender (Angermeyer, 2000; Swinson et al., 2007).

In a study of 331 severely and persistently mentally ill inpatients, Hiday et al. (1998) found that gender influences on the prevalence of violence varied with the nature of violence. Whilst there were no specific gender differences in the incidence of “any physically assaultive behaviour”, this changed when different inclusion criteria were used for violent actions. Males were significantly more likely than females (29 % versus 13% respectively) to be considered violent when more restrictive definitions were applied e.g. physical fighting, threats involving weapons, actual physical injury to others, etc. This was not the case when broader, more inclusive measures of “physical violence’ were used e.g. verbal threats, and fights not involving weapons or actual injury to others (54% in men versus 47% in women). In addition, gender was predictive of violence more robustly in the presence of co-morbid substance-related problems. Lam et al. (2000) examined the relationship between gender and violence resulting in staff injuries in an in-patient psychiatric unit. The clinical records of 76 patients (34 women and 42 men) who had injured staff members were reviewed and compared with those of 314 non-violent patients admitted over the same period. Nearly half of all staff injuries were the result of female in-patient aggression. Multivariate logistic regression analysis, however, showed no associations between the gender of patients and staff injuries after confounding correlates of violence were controlled for (e.g. prior violence, violent thought content upon admission, and non-adherence to medication). The authors concluded that injuries to staff were as likely to be caused by male and female patient violence. Robbins et al. (2003) analysed data from the MacArthur Violence Risk Assessment study from a sample of patients in acute psychiatric wards (667 men and 469 women) who were followed up for a year after discharge. Whilst rates of violence committed immediately following discharge were higher for men, the prevalence of violent behaviour over the course of the year showed no gender differences. There were, however, substantial gender differences in the context of the violence committed:

men were more likely to have been intoxicated (with alcohol and/or other substances), and less likely to having been adherent to prescribed psychiatric medication at the times prior to being violent. Men were also more likely to have inflicted serious injury to victims, and to being arrested subsequently. Women were more likely to act violently in the domestic setting toward family members. Weizmann-Henelius (2006) examined the profiles of 61 violent female offenders in Finland, with a view to clarifying their relationship with victims, and identifying psychological risk factors for violent offending (in comparison to matched controls). Violent female offenders were typically assessed to have antisocial personality disorder with co-morbid substance-related disorders, as well as having poorer social and coping skills to deal with interpersonal conflict or psychosocial stressors. In addition, there were no specific associations between violent offending and prior abuse in this particular study.

A number of risk assessment studies have considered gender-based disparities in the accuracy with which mental health professionals assess and predict violent behaviour. Lidz et al. (1993), for example, found that whilst mental health professionals were generally able to predict violence by acutely ill male psychiatric patients fairly well (i.e. better than chance), this was not the case for violence predictions for female patients, in whom the process of violence risk assessment appeared less robust and outcomes less accurate. Similarly, Coontz et al. (1994) found in their examination of psychiatric emergency room clinical transcripts that male cases involved significantly greater clinical discussion and investigation into behavioural history than was the case with female patients. Further evidence for gender bias in risk assessment was provided by Elbogen et al. (2001), who investigated the relationship between gender and the judgement of dangerousness by 81 mental health professionals in civil psychiatric facilities. Whilst male patients were generally rated as displaying higher potential for dangerousness as compared to females, gender of clinicians also influenced perceptions and judgement of

dangerousness. Female clinicians perceived a greater gender gap in the risk of violence by patients, whilst male clinicians perceived little to no gender differences (i.e. perceived male and female patients to have similar violence potential).

Violent Women in the Forensic Mental Health System

An examination of the pertinent research evidence from studies of violent women within forensic mental health systems illustrates the unique diagnostic features and treatment needs of this subgroup of offenders (de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Nicholls et al., 2004; 2009; Skeem et al., 2005). Hodgins et al. (1986) examined 29 Canadian women offenders assessed to lack criminal capacity by virtue of mental illness, and concluded that whilst women constituted the small minority of the “criminally insane”, they were more likely to suffer from severe mental disorders (especially schizophrenia and mood disorders), and less likely to have antisocial personality disorder, in comparison to their male counterparts. In addition, whereas women offenders in general have lower rates of prior criminality and re-offending, those deemed “criminally insane” were more likely than men to face violent charges (especially attempted murder and murder). The overall profile of the female insanity defence acquittee in the Hodgins et al. sample was of women with violent index offences who were older than 30 years of age, with poor educational and occupational attainment, and who were also more likely to have attempted suicide following their index offences. A number of other studies on women in forensic services have documented similar profiles (Daffern et al., 2005; Rogers et al., 1983; Steadman, 1980). In another Canadian study, Nicholls et al. (2009) explored gender differences in the prevalence, severity and nature of violence by forensic psychiatric patients. Mentally ill women were involved in more incidents of in-patient aggression than men. Whilst substance-related disorders were the most common mental health problem in men (65% of men versus 48% of women), major depressive disorder

(especially when severe with psychotic features) was more common in women (8% of women versus 1% of men respectively). Significantly more males had antisocial personality disorder (40% of men versus 12% of women), whereas significantly more females had borderline personality disorder (23% of women versus 7% of men). Men were also significantly more likely than women to have had prior criminal convictions, especially of a violent nature (73% of men versus 49% of women). There were, however, no significant gender differences in the likelihood of committing violent index offences (70% in both men and women).

In the United Kingdom, Thomson et al. (2001) compared female (n = 28) and male (n = 213) inpatients of a high-security forensic psychiatric hospital. Over 70% of women had active delusions (compared to 44% of men), and over 50% had recently exhibited violent behaviour in the ward (compared to only 21% of men). The disproportionate representation of women in the commission of violence within forensic institutional settings was confirmed in a subsequent English study by Rutter et al. (2004), in a study of the 2180 violent incidents recorded in a medium-secure forensic unit between 1980 and 1996. Only 6% of patients (9 men and 8 women) accounted for 67% of these incidents, with the majority of these diagnosed with a psychotic disorder. In addition, patients who had committed 25 or more violent incidents were much more likely to be women (41% of the women versus 13% of the men). Another English study by Logan and Blackburn (2009) of 95 violent women offenders in forensic psychiatric care focused on risk assessment and management of violence. Over one-third of the women had an index offence involving “major violence”. There were disproportionately high levels of psychiatric morbidity and comorbidity present in the sample, with the most common individual diagnoses being cluster B personality disorders (82% of women), substance-related disorders (65%), mood disorders (63%), psychoses (40%) and PTSD (38%) respectively. Women who had committed “major violent” index offences were four times more likely to have a diagnosis

of borderline personality disorder than those with offences involving minor levels of violence. In a large study of the entire population of 2094 mentally ill offenders in Japan between 1980 and 1994 (over 87% of whom were male), Xie (2000) found schizophrenia and other psychotic-spectrum disorders to be the most common diagnoses, being more or less equally prevalent amongst both men and women (in 58% and 54% respectively). Whilst substance-related conditions were more common in males (20% of men versus 4% of women), depressive disorders were significantly more common in females (20% of women versus 5% of men). Women offenders were also significantly more likely than men to have committed with violent crimes against the person, especially homicide which was perpetrated by almost half (49%) the women sampled (versus only 14% of men). Almost half of the female offenders attacked family members (most commonly children), a rate much higher than men who tended to have attacked strangers. In contrast, whilst men were more commonly charged with non-violent offences (especially crimes against property), they had a greater number of prior convictions.

In a study of young violent forensic psychiatric outpatients in the Netherlands, Leenaars (2005) qualitatively examined the socio-demographic, behavioural and personality characteristics of participants in an “Emotion Control Therapy” programme. The most common diagnoses amongst the females were conduct disorder, oppositional defiant disorder, ADHD and Cluster B personality disorders. Over one-third of female patients had a prior history of sexual abuse, whilst almost half reported being victims of parental physical aggression and/or emotional violence. Violent female patients in particular tended to display more emotional lability, behavioural impulsivity, and lower levels of frustration tolerance, than both violent males and non-violent females. Violent women also more frequently reported generally higher levels of depression, anxiety and anger than comparator groups. No statistically significant gender differences were reported, however, between violent males and females in the

frequency of aggression nor other expressions of anger and hostility (whether verbal or physical).

A series of multi-centre comparison studies on gender differences in violent offending were conducted in four Dutch forensic psychiatric hospitals. De Vogel et al. (2016) examined the files of 275 female and 275 male forensic patients, and reported the majority of women to have severely traumatic backgrounds, complex psychopathology, multiple previous treatment failures and many adverse incidents during treatment. Female patients had more complex histories of victimization, were more often diagnosed with borderline personality disorder, were more likely to commit homicide and arson, less likely to commit sexual offences, and were more often involved in in-patient aggression, in comparison to their male counterparts. Similarly, an analysis of 218 female and 218 male forensic patients who were on mandatory treatment orders was conducted by de Vogel & de Spa (2019). Important gender differences in violent offending profiles were reported. Female violence was more often directed toward those close to them (e.g. children or close relatives) and driven primarily by relational frustration. In addition, female patients received lower criminal punishments compared to male patients, and were more often considered to have diminished criminal accountability for their offences due to mental illness.

Mental Disorder in Violent Women

The literature has focused particularly on psychotic, mood, substance-related and personality disorders in studies of mental disorder in violent women, with the pertinent research evidence for each of these diagnostic groups reviewed below.

Psychotic and Mood Disorders

The relevance, role and influence of psychosis on pathways to violence are complex issues. Much of the violent expression of psychosis is not random, but often motivated by, or causally related, to psychotic symptoms e.g. the content of hallucinatory or delusional symptoms directing a specific course of violent action. Junginger (1996) suggested that an analysis of the relationship between violence and specific psychotic content could potentially identify not only psychiatric patients at risk for committing violence, but also their intended targets. In general, the risk of violence among individuals with psychosis is known to be associated with the presence of active psychotic symptoms (especially auditory hallucinations, delusions of persecution and control, and threat/control-override symptoms), psychiatric comorbidity (especially with substance-related and/or personality disorders), and non-adherence to medication (Link et al., 1998; Moran et al., 2003; Swanson et al., 1990; Swartz et al., 1998). Unprovoked aggression is often cited as a common result of psychosis, especially if the patient feels threatened or believes s/he is in imminent danger (Humphreys et al., 1992). Taylor (1985) documented a strong association between active psychotic symptoms and recent violence in men, with 93% of the study sample having active psychosis at the time of the violent act, and almost 50% being “definitely” or “probably” motivated directly by their psychosis. The presence of persecutory delusions or command hallucinations per se may not necessarily escalate the risk of violence sufficiently in many patients, with the issue remaining under debate, especially in psychotic women (Appelbaum et al., 2000; Hellerstein et al., 1987; Putkonen, 2003; Taylor, 1998). Teasdale et al. (2006) analysed data from the MacArthur Risk Assessment study of discharges from general psychiatric hospitals in the US, with a focus on gender and “threat/control-override” symptoms in 902 patients. Whilst psychotic women were less likely than the men to act violently in response to threat delusions, there were no gender differences regarding violent behavioural responses to control-override delusions. Link and

Stueve (1994) had previously found that whilst psychotic men were generally more frequently violent than psychotic women, the gender gap in risk of violence was reduced when threat/control-override symptoms were included in the analysis.

Schizophrenia is the psychotic disorder most commonly linked to violent behaviour in general, though it is less clear whether, and to what extent, gender influences this association (Arseneault et al., 2000; Taylor and Bragado-Jimenez, 2009). Whilst it is also true that the community prevalence of schizophrenia in most countries is slightly lower for women than men (Aleman et al., 2003; McGrath et al., 2004), higher rates of schizophrenia and other psychotic disorders have been reported for violent women offenders in particular (in comparison to both other non-psychotic women offenders and non-offending women) by many studies (Brennan et al., 2000; Coid et al., 2006; Fazel, Gulati et al., 2009; Wallace et al., 2004). The meta-analysis by Fazel, Gulati et al. (2009) found that schizophrenia significantly increased the risk of violence in both sexes, but particularly for women, with the risk increased further by co-morbid substance abuse (the presence of substance-related comorbidity in schizophrenic patients in fact independently identified most individuals with schizophrenia who were at high risk of violence). The presence of psychiatric comorbidity in psychotic individuals (especially in the form of substance-related and/or personality disorder) has been proposed to significantly increase psychotic drive (i.e. psychotically-motivated behaviours), and in so doing, increasing the risk of violent outcomes (Taylor and Bragado-Jimenez, 2009; Taylor et al., 1998). Swanson et al. (2006), however, also reported that whilst violence risk was increased in patients with schizophrenia who abuse substances, serious violence was more strongly associated with active symptoms of psychosis and/or mood disturbances, especially when combined with the absence of negative symptoms. This suggests that more serious levels of violent behaviour would be expected at earlier stages of schizophrenic illness i.e. when

positive symptoms predominate over negative symptoms which develop later in the course of the illness.

Violent women with psychosis exhibit gender-specific patterns not only in the nature of their individual psychopathology, and its behavioural manifestations, but also with respect to the antecedents and broader context within which violent behaviour is expressed. Multiple psychiatric comorbidities (especially with substance-related disorders), and significant psychosocial stressors are common, though this is not unique to violent psychotic women (Taylor and Bragado-Jimenez, 2009). Taylor and Bragado-Jimenez concluded that not only are experiences of childhood adversity particularly important in the genesis of both subsequent psychosis and violence, but that gender is an intrinsically influential factor on such pathways. Swanson et al. (2008) examined criminogenic pathways to violence in two cohorts of schizophrenic patients: 488 patients with childhood conduct problems, and 956 patients without. Whilst the detailed gender breakdown of the study sample was not specified, they reported no specific gender disparities i.e. there was a similar gender distribution in each group. Similarly, Taylor et al. (1998) proposed that there appear to be two distinct groups of people with psychosis who are also violent: those with childhood-onset conduct problems, in whom psychosis plays a relatively minor role in motivating violence; and those with prior childhood conduct disorder, in whom psychotic symptoms exacerbate the risk of subsequent violence. Research on the antecedents to both psychosis and violent offending in women in particular is rare, but a few key studies are illustrative. Earthrowl and McCully (2002) screened 150 new inmates in a female prison, and found over 25% of these women to have a psychotic spectrum disorder, with the majority of these also having psychiatric comorbidity and complex pre-offence psychosocial problems. Spauwen et al. (2006) surveyed a sample of 2500 young German patients and reported that early traumatic experiences (especially if associated with

extreme fear and/or helplessness) predisposed to subsequent psychosis (though a minority (40%) of the participants who reported trauma were female). The relationship between early trauma and schizophrenia was similarly explored by Bebbington et al. (2004) in a survey of 8500 people in the UK (though the gender distribution of the sample was unspecified). Whilst early trauma of all types were associated with the development of psychotic disorders in adulthood, this was particularly so for early sexual abuse. In contrast, whilst a prospective Australian study found several mental disorders (including mood disorders) to be associated with early abusive experiences, this was not the case for schizophrenia (Spataro et al., 2004).

Studies on the relationship between psychosis and violence that do have a specific gender focus have been conducted across general psychiatric, community, prison and forensic psychiatric settings. In an examination of violent women within civil psychiatric service settings, Fazel and Grann (2006) examined the clinical records of patients discharged from Swedish psychiatric hospitals between 1988 and 2000, and linked these with criminological data of violent offence convictions. Of the 98 000 patients with “severe mental illness” (most of whom suffered from psychotic disorders), over half (56%) were women, who between them had committed in excess of 21 000 violent crimes (comprising approximately 5.2% of overall crime in the study period). Violent women offenders (irrespective of whether they were psychotic or not) were less likely than their male counterparts to have been convicted. Having a diagnosed psychotic disorder, however, disproportionately increased the risk of violent offending among women compared to men, especially in women aged 40 years and above (psychotic women committed 20% of violent crimes by women in this age group). Fottrell (1980) examined violent behaviour in a sample of psychiatric in-patients in the United Kingdom (most of whom were schizophrenic), and noted that female patients were more likely to be physically assaultive than males. Tardiff and Sweillam (1980) similarly reported that

whilst pre-admission violence amongst patients with schizophrenia was higher for men, this gender gap was reduced for rates of violent acts during differences in rates of violence during in-patient residential stay, a finding that was confirmed by a large prospective study of over 2000 acute psychiatric in-patients in Switzerland (Aberhalden et al., 2007). In addition, a Swedish study examined in-patients with psychosis and found further gender interactions in respect of violent behaviour: psychotic female patients were significantly more likely to direct violent behaviour toward female, rather than male, staff (Omérov et al., 2002). Krakowski and Czobor (2004) similarly looked at the relationship between violence, clinical symptoms and psychosocial factors in patients with psychotic disorders (schizophrenia and schizoaffective disorder) and bipolar disorder (1028 men and 459 women) at two American psychiatric hospitals. No gender differences were reported in the proportions of men and women who had acted violently (17% for each gender group). Nonetheless, violent psychotic women tended to be older, not of African-American racial background, and to have schizoaffective disorder or bipolar disorder, as opposed to schizophrenia and other psychoses, in comparison to their male counterparts. Violent female patients were also less likely to have a history of prior violence, but were significantly more aggressive within the first 10 days of hospitalization than men (though this gender disparity was not evident beyond 3-4 weeks into their admission). Whilst violence of psychotic women tended to be generally of a less serious nature in comparison to men, more severe psychopathology was associated with more severe violence for both sexes, but there were certain gender effects regarding these trends. Severe, persistent psychosis was associated with later onset, persistent violence with no specific gender differences; whereas earlier remission of psychotic symptoms (especially hallucinations) was associated with earlier onset but progressive reductions in violence with time, particularly in psychotic women.

In Denmark, Munkner et al. (2003) examined a cohort of schizophrenic patients managed within general psychiatric services (3121 men and 1498 women). Clinicians tended to show more reluctance in diagnosing schizophrenia in women during their first psychotic episode; whilst both violent offenders and non-offenders had similar ages of onset of schizophrenia, with no gender disparities. Also in Europe, the criminal records of schizophrenic patients discharged from a German psychiatric hospital (685 men and 977 women, between 1990-1995) were examined by Soyka et al. (2007). Only 5% of patients were convicted of a violent offence prior to admission; following discharge, however, almost one-quarter of women (23%) and three-quarters of men (77%) were convicted of a violent offence. Whilst no further gender-specific information was provided, patients with post-discharge violent convictions tended to have poorer insight and higher scores on rating of hostility, and were less likely to be depressed upon either admission or discharge. Furthermore, in one of the few studies on gendered risk of violence in patients with bipolar disorder in particular, Fazel et al. (2010) found bipolar female patients to have a two-fold higher risk of violent crime than men with bipolar illness; and as was the case with schizophrenic psychosis, these gender associations were strengthened by the co-occurrence of substance abuse.

There is a relative paucity of studies that have examined the relationship between gender and violence amongst psychotic patients in community and forensic settings. In the UK Wessely et al. (1994) compared people with schizophrenia living in the community (279 men and 259 women) with a control group of mental health service users without psychosis. Schizophrenic women were at increased risk for offending in general, but men with schizophrenia were at higher risk of violent crime. Onset of offending behaviour was also later for people with psychosis, irrespective of gender, but psychotic women tended to desist sooner. In a large prospective study, Dean et al. (2006) investigated a British sample of 304 women

with chronic psychosis living in the community, in order to identify predictors of violence. The 2-year prevalence of assaultive behaviour was reported to be 17%, with violence particularly associated with previous violence, non-violent prior convictions, prior abuse, African-Caribbean race, co-morbid personality disorders (especially Cluster B types), and high levels of psychosocial adversity and unmet needs. In one of the earlier forensic studies on female offenders, Herjanic et al. (1977) examined the records of offenders referred by courts to a forensic psychiatric service (127 women and 1068 men, over a 22-year-period). Women defendants were less likely than men to be referred for forensic assessment in the first place, and were more likely to be charged with murder, arson or fraud. Women were also more frequently diagnosed with mood or neurotic disorders, as opposed to psychotic (including schizophrenia) or personality disorders. Jones et al. (2010) studied schizophrenic patients in an English forensic hospital (190 women and 1404 men, between 1972-2000), and found that female patients were significantly more likely than the men (79% versus 42% respectively) to have commenced violent offending soon after their first psychiatric hospital admission (i.e. early in the course of schizophrenia). Heads et al. (1997) conducted a study of 33 women with schizophrenia in an English forensic hospital, in comparison to a randomly selected sample of 69 male patients. The prevalence of a background of “passive” childhood adversity and trauma (e.g. poverty; parental neglect, mental illness or criminality, etc.) showed no significant gender disparities. More severe, intrusive and traumatic adversities (such as early-onset sexual or physical abuse) were, however, significantly more common amongst the women. Female schizophrenic patients with violent backgrounds had also presented with an earlier onset of schizophrenic psychosis, and were more likely to have been aggressive children, in comparison to the male cohort. In the US, Abram et al. (2003) reported that under 10% of women prisoners had a “major mental illness”, and suggested that psychotic women are also likely to be over-represented in violent prisoner subgroups. This seemed to be confirmed among women

imprisoned for violent offences in England and Wales, in which approximately one-fifth were reported to have psychotic disorders (O'Brien et al., 2003). Nonetheless, in another British forensic study, far fewer women than men were reportedly psychotic (32% of women versus 46% of men respectively) (Coid et al., 2000a; 2000b). It has been argued by Taylor and Bragado-Jimenez (2009), however, that this does not necessarily imply that psychotic women are less likely to be violent than psychotic men; instead, these findings raise the possibility that forensic mental health services may be more tolerant of women with psychotic disorders.

Following their extensive review of the literature on the relationship between psychotic disorders and violence, Taylor and Bragado-Jimenez (2009) concluded that whilst there may not always be clear gender differentials present, there are a few clinically important differences of moderate magnitude between men and women if personal history, psychosocial context, and individual psychopathology (e.g. personal meaning and timing of symptoms) are taken into account. Taylor and Bragado-Jimenez drew four main conclusions in this respect: (a) whilst psychotic women in general tend to be older and relatively less functionally impaired than their male counterparts, these trends are not as clear for psychotic women who are violent; (b) psychotic women tend to commence violent offending behaviour later and desist sooner; (c) whilst rates of exposure to childhood trauma are similar for both men and women with psychosis who are violent, sexual abuse is disproportionately more common among women; and (d) there are no particular gender effects regarding the risk of re-offending, nor for overall mental health outcomes (Taylor and Bragado-Jimenez, 2009).

Substance-related Disorders

The presence of psychiatric comorbidity, and especially dual diagnoses in the form of a psychotic disorder co-occurring with a substance-related disorder, substantially escalates the

risk of violence, possibly more so in women (Bennett et al., 2012; Hiday et al., 1998; Nagdee et al., 2019; Soyka, 2000; Steadman et al., 1998; Wallace et al., 1998; Walsh et al., 2002). Brunette and Drake (1997) reported schizophrenic women to be at least as likely to abuse alcohol and/or other substances as men with schizophrenia, and that such comorbidity conferred a risk of aggression and violence that was at least equivalent to that of men (though women were less likely to be criminally convicted). In a community-based study of 119 people with chronic mental illness, most of whom suffered from a psychotic disorder, Fulwiler and Ruthazer (1999) found that whilst a co-morbid substance-related disorder was not necessarily causally related to violent outcomes, pre-morbid substance abuse was (and probably independently from conduct disorder). The comorbidity of alcohol dependence is especially high with both mental disorder and personality disorder, reaching above 70% in studies of hospitalized psychiatric patients (Driessen et al., 1998).

Whilst substance abuse and violence are often correlated phenomena, the use of substances also interacts with a range of mediating factors that result in violent outcomes, including (but not limited to) personality structure, contextual and situational factors, social norms, interpersonal dynamics and mental health (Zhang et al., 1997). Hodgins (1992), in a large birth-cohort study, found that violent offending rates were higher amongst women with substance-related disorders than amongst comparable male samples. Furthermore, women with substance abuse or dependence in this particular study were also over 50 times more likely to have a violent offence conviction than women with no substance-related disorders. Weizmann-Henelius et al. (2009) examined the relationship between substance intoxication and violent behaviour in a sample of Finnish female offenders, with a focus on personality profiles, psychosocial context and background characteristics of these offences. In their sample of 60 women, the vast majority (82%) had been intoxicated at the time of the offence. When the

cohort of women who were intoxicated was compared to those who were sober at the time of offence, the former group had significantly higher prevalence of substance-related disorders (73% versus 0%), personality disorder (90% versus 36%) (and especially antisocial personality disorder: 67% versus 0%), and a prior criminal background (69% versus 0%). There were, however, no significant differences between the two groups in terms of levels of exposure to prior abuse or other traumatic life events. The intoxicated group of women were also less likely to direct violence to intimate or “emotionally close” victims, as compared to the non-intoxicated group (24% versus 67% respectively).

Alcohol abuse is also one of the most robust risk factors for offending amongst women in particular, with the role of alcohol intoxication at the time of the commission of violent offences being especially well documented (though there is debate on the issue of direct causality) (Boles and Miotto, 2003; Hodgins, 1992; Johnson, 2006; Lipsey et al., 1997; Loucks and Zamble, 2000; Martin and Bryant, 2001; Philips et al., 2002; Weizmann-Henelius et al., 2009; Zhang et al., 1997). Martin and Bryant (2001), for example, reported alcohol intoxication to have a 3-fold higher level of predictive power in relation to violent offending, as compared to men. This study also reported alcohol intoxication to be significantly associated with violent crimes, whereas illicit substances (especially cocaine) were more likely to precede property-related offences for both men and women. Violence in the domestic setting has been linked to substance abuse in women as well as men (Stuart et al., 2003), but women who abuse alcohol have been reported to be at particularly high risk of acting violently toward intimate partners (Chermack et al., 2001). Furthermore, Roche and Deehan (2002) emphasized that the pattern of female drinking has changed over time which may account, in part at least, for victims of female violence to increasingly be intimate partners and strangers, as opposed to family members (i.e. more closely approximating the pattern seen in male-perpetrated violent

behaviour). In the UK, McMahon et al. (2003) studied trends in alcohol abuse by patients admitted to high-secure forensic hospitals over a 25-year period. Whilst men who abused alcohol far outnumbered women in the 1970's, by the turn of the century there had been a disproportionate increase of almost 25% in the proportion of women abusing alcohol (as opposed to 7% increase in the male rates during the same period), with women with co-morbid psychosis and/or personality disorder accounting for most of this increase.

Personality Disorders

A large survey of mentally ill offenders by Yourstone et al. (2009) reported a greater proportion of women to have been diagnosed with personality disorders, in comparison to non-offending women. Evidence of personality disorder (especially antisocial personality disorder and psychopathy) is an important factor to consider with respect to both the assessment and management of violent offending in particular (Maden, 2004). There is consistent research evidence that antisocial personality disorder and psychopathy have considerable predictive value and validity in studies on violent offending and recidivism in men (Hare; 2003; Hemphill et al., 1998; Walters, 2003), whilst for women offenders the evidence is far less robust. Correlations have been documented between antisocial (and to a lesser degree, borderline) personality disorder and violent conduct in women (Logan and Blackburn, 2009; Mauricio et al., 2007). In a large birth cohort study in Denmark, Hodgins et al. (1996) calculated that the risk of violent offending was significantly higher in people with antisocial personality disorder, especially in women for whom the odd's ratio was 12.2 (CI 8.8 – 16.9), as compared to men with an odd's ratio of 7.2 (CI 6.5 – 8.0). In addition, Mulder et al. (1994) found antisocial personality disorder in women to be more strongly associated with an increased risk of psychiatric hospitalization than was the case in men.

There has also been much research focus on the issue of psychopathy in women with the pertinent conclusions as follows: (a) there are far fewer women than men who are considered to have psychopathy, as revealed by numerous community and institutional studies on female offenders in different countries; (b) most women offenders, including those who are violent, do not demonstrate the characteristic symptoms, signs or behavioural patterns of psychopathy; and (c) the applicability, relevance and validity of standardized rating scales (e.g. Psychopathy Checklist-Revised (PCL-R) or the Historical, Clinical and Risk Management- 20 (HCR-20)) for women remain unclear (Cale and Lilienfeld, 2002; Grann, 2000; Hamburger et al., 1996; Hare, 2003; Jackson et al., 2002; Loucks and Zamble, 1999; Nicholls et al., 2005; Salekin et al., 1997; 1998; Vitale and Newman, 2001; Vitale et al., 2002; 2011; Warren and Burnette, 2012; Warren et al., 2002; 2003; 2005; Warren and South, 2009; Weizmann-Henelius et al., 2004a; 2004b). There is, nonetheless, some evidence of a weak but positive association between psychopathy and recidivism in some women, with some studies reporting the risks for violent recidivism in women with psychopathy being similar to those of men (Nicholls et al., 2004; Putkonen et al., 2003).

Recidivism of Violent Women with Mental Disorder

Bonta et al. (1998) conducted a meta-analysis by of criminal recidivism among mentally disordered offenders found the predictors of violent recidivism were similar for offenders with or without mental disorder, and did not identify gender to be a particularly influential factor on overall outcomes. There is, however, some evidence that women with psychosis who behave violently tend to desist from violence sooner than their psychotic male counterparts (Taylor and Bragado-Jimenez, 2009). Two large Swedish studies both reached similar conclusions of psychotic women tending to have shorter offending careers with different trajectories, in comparison to both non-psychotic women and psychotic men. Lindqvist and Allebeck (1990)

conducted a prospective follow-up of discharged schizophrenic patients in Stockholm (330 men and 314 women) and found that: (a) both women and men shared two age peaks for the onset of violent offending (21-29 and 50-59 years of age respectively); and (b) the violent offending careers of schizophrenic women were less sustained than those of men. Hodgins (1992) examined a Stockholm birth cohort of 15117 individuals followed up for 3 decades, and identified 79 women and 82 men to have been diagnosed with a severe mental disorder (psychotic or mood disorder). Whilst the proportion of women commencing their criminal careers was stable in each age category, re-offending rates in women increased significantly after the age of 21 years. To better understand the developmental patterns of female crime, Caufmann et al. (2015) studied the offending trajectories and criminogenic risk factors of 172 young (aged 14 – 25 years) violent offending females and a matched sample of 172 males in the U.S. There was great heterogeneity in criminal behaviour amongst the female offenders, with approximately 7% of female criminal careers persisting into adulthood. Notable gender differences in criminogenic risk factors were found. Females who persisted in their criminal careers tended to be exposed to more violence in their lives, had more mental health problems, and experienced more adversarial interpersonal relationships compared to those who desisted. Studies on violent male and female offenders with mental illness (especially those with severe forms of mental disorder, including psychiatric comorbidity) also have significantly higher mortality rates in comparison to the general population, particularly as a result of suicide (Pérez-Cárceles et al., 2001; Putkonen and Taylor, 2014; Robertson et al., 1987).

There is also evidence that violent offender-patients who have received specialized forensic rehabilitation and management have more favourable overall outcomes, and probably more so for women. Maden et al. (2006) conducted a national prospective cohort study of discharged forensic patients in the UK (116 women and 843 men). There were no significant

gender disparities in age profile, length of hospital stay, and likelihood of hospital readmission in the first-year post-discharge. Fewer women than men (11% versus 16%), however, were convicted of another offence within the two-year post-discharge period; but following adjustments for historical risk factors (e.g. substance abuse or prior criminal record), this gender difference became negligible. Similarly, Coid et al. (2007) studied patients discharged from seven forensic units in the UK (177 women and 1167 men). One in eight men were re-convicted within 6 years following discharge, as compared to only one in sixteen women (with arson being the only post-discharge re-offence which was more common amongst women than men). An extensive follow-up over two decades of 93 female and 502 male patients admitted to an English medium-secure forensic mental health facility was carried out by Davies et al. (2007). The only significant gender difference in re-offending trends was that more men than women had been convicted of “standard list” (less serious) offences within 5 years post-discharge. Over the entire study follow-up period of 20 years though, 11% of the women who were initially legally detained under the “mental illness” category of the English mental health legislation had committed violent offences, compared to 14% of their male counterparts i.e. there was no significant gender discrepancy in the violent re-offending rates for people with mental ill-health. Most patients, irrespective of gender, also had at least one hospital re-admission during the study period, and the minority were well enough to engage in some gainful employment. Jamieson and Taylor (2002; 2004) similarly followed a discharge cohort from an English high-security forensic hospital of patients (40 women and 183 men) over a period of 12 years. Of those women leaving for an alternative placement, the vast majority (97%) successfully achieved community-based rehabilitation (including desisting from re-offending). A similar proportion of women to men re-offended post-discharge but the re-offending rates were lower amongst women in this series. Two other British forensic outcome studies, however, found that gender was not a particularly strong predictive indicator of re-

offending risk (Buchanan, 1998; Steels et al., 1998). In Finland, Putkonen et al. (2003) studied the risk of repeat offending amongst a cohort of violent women diagnosed with psychotic and personality disorders respectively (between 1982-1992, with patients followed up for a minimum of 7 years): overall, a quarter of these women re-offended, but those with psychotic disorders fared better regarding recidivism, with only 10% re-offending.

Conclusion

It is apparent that gender exerts an influence on risk assessment and management, clinical decision-making, treatment interventions and policy direction in mental health settings. Women who commit violent offence have a distinct demographic, psychosocial, criminological, clinical and forensic profile. There is evidence of robust associations between female-perpetrated violence and severe forms of mental disorder (especially psychotic-spectrum disorders, either alone or in combination with other conditions e.g. substance-related, personality and/or neurocognitive comorbidity). There are, however, mixed results from studies in this regard: the balance of the evidence suggests that severe mental disorder modifies the relationship between gender and violent conduct, but exactly how, to what degree and in which clinical context it does so remains open to some debate.

Chapter Five: Mental Health of Homicidal Women

Lethal violence is a leading global public health concern, with the World Health Organization having reported that it claims the lives over half a million people annually (Krug et al., 2002). Homicide is predicted to increase significantly, together with its associated social and health burdens, over the next few decades and beyond (Murray and Lopez, 1997). Homicide as a criminal act, social construct or behavioural outcome is largely a masculine phenomenon, which many theorists propose has evolutionary roots related to male competition for resources, social status, and/or access to, and control of, sexual partners i.e. that it may be “instinctive” for many men (Polk, 1993). Such approaches have been criticized for drawing on stereotyped notions of gender, in assuming men to have a natural predisposition to lethal violence, whilst women are presumed to kill only as a last resort to protect themselves or their children, or when suffering from some “explanatory” mental ill-health (Kirkwood, 2003). According to Kirkwood, these simplistic perspectives serve to further marginalize, stereotype and/or pathologize women who commit homicide, further entrenching gender bias that equates masculinity with aggression and violence, and femininity with passivity and subservient victimhood. There is increasing research focus on homicidal women with mental health problems, with a growing number of studies examining female patients in forensic psychiatric facilities (de Vogel & Nicholls, 2016).

This chapter provides an overview of forensic mental health issues relating to homicidal women, with an initial examination of their offence profile, the psychosocial and situational context of their offending, and specific mental disorders associated with this particular group of offenders. The focus will then shift to a detailed review of mental health issues in women who murder adults and children respectively. In respect of the former, attention will be given

to mariticial, parricidal and femicidal offending by women. A review of the substantial research literature on mental health issues pertinent to women who murder children is then undertaken, in terms of: epidemiology; peri-partum mental health; contrasts between filicidal, infanticidal and neonaticidal offending; and an appraisal of the various typologies of child homicide, respectively. A summary of qualitative research evidence of mental health issues in homicidal women is then provided, prior to a consideration of recidivism by homicidal women with mental disorder.

Offence Profile

There are substantial differences in homicide rates between countries. For countries with relatively reliable criminological data, this varies from being highest in some South American and African countries (e.g. in excess of 25 homicides per 100 000 population in Brazil and South Africa, to over 50 per 100 000 in Venezuela), compared to the lowest rates in Nordic and European countries (0.5 – 4 homicides per annum per 100 000), with the US in between these ranges (approximately 6 per 100 000) (Cooper and Smith, 2011; Lehti, 2013). South African violence rates are amongst the highest in the world, with the homicide rate in 2012 estimated to have been in excess of 31 per 100 000, though this is a reduction from the estimated rate of 48.5 per 100 000 in 2000 (United Nations, 2013).

Criminological data supports the contention that homicide is largely a masculine phenomenon in terms of: (a) the majority of both offenders (85-90%) and victims (65 – 70%) being male; and (b) the prevailing psychosocial constructs regarding homicidal behaviour (Polk, 1993). Related to these observations, are a number of additional gender-based criminological considerations. Whilst perpetrators of non-lethal assault and robbery, irrespective of gender, tend to be relatively young (adolescence to early adulthood), female

homicidal offenders are more likely to be older, with arrests for murder peaking in the late twenties to late thirties, after which it drops off (Janeksela, 1997; Kruttschnitt et al., 2002). Women are also much more likely to be victims of homicide than perpetrators (Eckhardt and Pridemore, 2009). Most studies estimate that less than 10% of all homicides are committed by women (Coleman et al., 2007; Cooper and Smith, 2011; Goetting, 1988a; Häkkänen-Nyholm et al., 2009; Mouzos, 2000; Putkonen and Taylor, 2014; Smith et al., 2010; Swinson et al., 2007). Whilst the relatively low female contribution to the homicide rate has been stable in many countries, it has been demonstrated to be increasing in others. In Finland, for example, women committed 6% of murders in the 1970's and 1980's, rising to around 11% in the subsequent two decades, with this increase being ascribed largely to increased alcohol abuse in women offenders over this period (Putkonen et al., 2008; Putkonen, Weizmann-Henelius et al., 2011).

There have been many surveys and studies conducted in the US which have provided important perspectives on female-perpetrated homicide. In an early, large and seminal study of homicide offenders, Block (1985) compared male and female offenders (n = 12872) in Chicago between 1965 and 1981. Of the 2188 women studied, (constituting 17% of offenders in this sample, which is higher than the majority of subsequent study estimates) "assaultive homicide" was the most common category (as opposed to homicides committed in association with robbery, burglary and other crimes). The majority of victims of assaultive homicide were known to the offenders. In another large national study of homicide, Wilbanks (1983b) provided a similar picture of homicidal women i.e. they tended to act following an interpersonal altercation in the majority of cases, with spouses, other intimate partners and family members being the victims of the resultant violence. The majority (87%) of women also did not murder in the context of another crime, African-American women were responsible for a

disproportionately large proportion of homicides, and women were more likely to use weapons to kill (especially with firearms and knives), in comparison to men. Scott and Davies (2002) examined all 42 cases of female-perpetrated homicide in three rural Georgian counties between 1990 and 1994, and reported the typical offender to be a young African-American woman who was unemployed and of low socio-economic standing, and who used a weapon against a known victim (most often an intimate partner). The majority of victims (85%) in this study were adults, who were known to the offender in 93% of cases. Intimate partners were victims in 32% of cases, followed by neighbours (14%), children, (14%), acquaintances (11%), other women whom the offenders' partners were also intimate with (9%), and parents (7%), respectively. In a large national survey of women offenders in the US, Greenfeld and Snell (2000) described some important additional gender-focused trends regarding homicidal women: (a) homicide rates for both sexes declined between 1993 and 1998, with the per capita rate for women in 1998 (1.3 per 100 000) being the lowest since such data collection commenced in the mid-1970's; (b) whilst just over half of women (as opposed to two-thirds of men) used a firearm, women were substantially more likely than men to have used a sharp object or knife to commit the homicidal act (31% versus 18% respectively); (c) of the approximately 11000 children murdered by parents or step-parents between 1976 – 1997, mothers or step-mothers committed approximately half of these child murders; and (d) neonates and infants tended to be killed by biological mothers, whilst fathers were more likely to kill older children. In a subsequent US study on homicide trends between 1980 and 2008, however, Cooper and Smith (2011) reported that intimate partners were murdered by men in 70% of all cases, family members in 74%, infants in 63% and elderly victims in 85% of cases respectively. Women were more likely than men to be the victims of intimate partner homicide (64% of cases) and sex-related homicides (82%); homicide involving male victims were more likely to be associated with gang (95%) or drug-related (91%) offences. Women were hence far more likely to be the victims of homicide,

as opposed to perpetrators; and female victims were over 5 times more likely than male victims to have been killed by an intimate partner. Homicide using firearms and arson were also more likely the modus operandi of male perpetrators (92% and 79% of male-perpetrated cases respectively); a high proportion of women used poison to kill their victims (40% of female-perpetrated cases). For either gender though, it is well established that prior violence is one of the most robust predictors of future violence (Bonta et al., 1998; Eronen et al., 1996a; Monahan, 1988; Widom, 1989b; 1989c). In comparison to the general population, for example, homicide offenders in Finland had a 10-fold higher risk of committing another homicide if they had a history of having committed a prior homicide (with the second homicide most likely to occur soon after release from prison) (Eronen et al., 1996a).

The role of ethnicity and racial stereotyping of homicidal behaviour has also been repeatedly raised in the research literature. Mann (1988; 1990), for example, examined the records of women arrested for homicide in the US, and found a disproportionate number (75%) to be of African-American descent, as compared to those of white (13%) and Latina (9%) racial backgrounds respectively. This trend has been documented in many other studies of female homicide offenders, especially in association with spousal homicide (Block, 1985; Goetting, 1987; 1988a; 1988b; Rodriguez and Henderson, 1995; Scott and Davies, 2002; Wilbanks, 1983a; 1983b; Wilson and Daly, 1992). Whilst this differs from European data, in which the majority of female homicide offenders are white and more reflective of the demographics of the general population (Kirkwood, 2003), it is also the case that indigenous Aboriginal women remain disproportionately represented as perpetrators of homicide in Australia (Mouzos, 2000). Most researchers, however, emphasize the importance and complexity of the broader situational context in the interpretation of such criminological statistics: there are a myriad of important confounding variables that are linked to race, including socio-economic, socio-

cultural, political and individual factors (Janeksela, 1997; Sommers and Baskin 1992; 1993; Wilson and Daly, 1992).

Psychosocial and Situational Context

Empirical gender differences have been reported regarding the criminal background, location of offending, weapon usage, victim-offender relationships (especially abusive ones), and the motivational aspects of homicidal behaviour (Jurik and Winn, 1990; Kellermann and Mercy, 1992; Sanford et al., 2006). A summary of the research evidence on the psychosocial background and broader context of female-perpetrated homicide follows, though conclusive explanations for gender differences remain largely elusive (Flynn et al., 2011; Peterson, 1999; Putkonen and Taylor, 2014; Yourstone, Lindholm and Kristiansson, 2008).

The issue of prior abuse of women who subsequently commit murder has been the focus of a number of studies. Mužinić Masle et al. (2000), for example, studied the forensic clinical records of 140 Croatian offenders (70 men and 70 women) charged with murder and attempted murder between 1983 and 1997. Female homicide offenders were more frequently related to their victims, more frequently exposed to distressing psychosocial during their childhood, more often victimized themselves in the past, and less likely to have backgrounds of chronic alcohol abuse than male offender. Similarly, Yourstone, Lindholm and Kristiansson (2008) studied Swedish court documents and psychiatric reports of all women convicted of lethal violence between 1995 and 2001, in comparison to a randomly selected sample of convicted men (n= 43). Female offenders had, were significantly more frequently, and to a greater extent, threatened and/or abused by their victims prior to their homicidal acts. Whilst female offenders in the study had more often experienced seriously adverse traumatic childhood events, the women had themselves displayed aggression in childhood less frequently than the men. The

women also had lower rates of prior criminality, and more ordered and stable social situations at around the time of their offence. In addition, women tended to use non-criminal coping strategies prior to the homicide more often than seemed the case for men.

Women who commit murder tend to do so in ways that reflect gender role behaviour: lethal violence, for example, is more commonly directed at people with whom the woman has a close relationship (particularly close family members and intimate partners), especially in the context of intense interpersonal conflict, chronic domestic abuse and/or dysfunctional family relationships (d'Orban and Connor, 1989; Flynn et al., 2011; Goetting, 1987; 1988a; 1988b; Häkkänen-Nyholm et al., 2009; Husain et al., 1983; Jurik and Winn, 1990; Kellerman and Mercy, 1992; Kirkwood, 2003; Marleau et al., 2003; McKee, 2006; McKee et al., 2001; Mužinić Masle et al., 2000; Putkonen, Collander et al., 2001; Putkonen, Weizmann-Henelius et al., 2011; Rogde et al., 2000; Saunders, 1986; 2002; Sommers and Baskin, 1993). The victims of homicidal women are estimated to be close family members in over 80% of cases, as opposed to the majority of victims of male homicide offenders being strangers (Stone et al., 2000). Family members who are killed by women are most commonly adult males (especially intimate partners), followed by adult females, and least frequently, biological children (Weizmann-Henelius, Viemerö et al., 2003). In a Finnish pre-trial study, almost one third of homicidal women convicted had reportedly been chronically and violently abused by their victims (Putkonen, Collander et al., 2001). Another Finnish surveyed homicide offenders between 1995 and 2004, and found 16% of women to have reported self-defence or an accident to be the context of the murder (compared to 12% of men), whilst a quarrel or conflict involving jealousy motivated 37% of women (versus 22% of men) (Häkkänen-Nyholm et al., 2009). In many of cases of intimate partner homicide, women who are exposed to repeated violence by their victims are postulated to develop the so-called "battered woman syndrome", in which the

killing of the abusive partner is seen as a desperate attempt to escape the abusive relationship and situation they find themselves in (Yourstone, Lindholm and Kristiansson, 2008).

There are also suggestions that there are often gender differences in the degree to which aggression is expressed within close relationships, possibly because females may, to a greater extent than males, be socialized to value themselves in terms of their relationships to those close to them (Jung and Rawana, 1999; Yourstone, Lindholm and Kristiansson, 2008). Related to this is the notion that lethal violence by women toward intimate male partners more commonly takes place in a domestic setting in which the victim has played a role in setting the context of the violence that ultimately leads to his own demise (Goetting, 1987; 1988a; Rosenfeld, 1997). Prior to carrying out acts of lethal aggression, many women have experienced higher levels of abuse, provocation and distress as a result of exposure to severe psychosocial stressors (e.g. related to physical or sexual abuse), in comparison than men who murder those close to them (Ogle et al., 1995). It has been proposed that women are hence more likely than men to have, initially at least, non-criminal coping responses to severe distress and to experience mental health problems as a result (e.g. depressive and anxiety disorders, self-harming and suicidal behaviour, and alcohol abuse) (Yourstone, Lindholm and Kristiansson, 2008). These authors further speculated that women could be expected to turn for external help, including to mental health services, more often than men, prior to resorting to extreme behavioural measures as homicide in an effort to resolve the problems and distress they face. Putkonen, Weizmann-Henelius et al. (2011) drew similar conclusions in a register-based study of Finnish homicide offenders (91 men and 91 women) between 1995 and 2004. Whilst men and women had higher than expected adverse childhood experiences, more women had been exposed to family violence (as victims and/or witnesses). Although there were no significant gender differences in the relative frequencies of specific psychiatric diagnoses,

women were more likely than men to have had previous mental health problems requiring professional care (especially related to self-harming and/or suicidal behaviour). By contrast, post-trial interviews of 39 female homicide offenders in Finnish hospitals or prisons found only 4 of them reporting prior violence directed at them by their victims, or any significant interpersonal conflict between victim and perpetrator (Weizmann-Henelius, Viemerö et al., 2003).

Whilst much research on homicide and gender has focused on situational precursors of offending behaviour, victim-offender relationships and offender characteristics. Häkkänen-Nyholm et al. (2009) argued that this type of information does not necessarily add much to an understanding of the psychological processes underlying female homicidal behaviour. There have been some studies on links between offender characteristics and crime scene behaviour for specific categories of homicide e.g. murder of intimate partners, family members or strangers respectively (Belfrage and Rying, 2004; Häkkänen and Laajasalo, 2006; Wahlund and Kristiansson, 2006). A few studies have also attempted to cluster homicidal crime scene behaviours into “instrumental” (originating from a desire for status or objects; and presumably more common in men) versus “expressive types” (in response to personal or interpersonal variables e.g. anger, threats, insults, abuse or psychological factors; and presumably more common in women) (Bijleveld and Smit, 2006; Salfati, 2000). A number of methodological limitations of such studies were, however, highlighted by Häkkänen-Nyholm et al. (2009) e.g. the inclusion of only offender-single victim cases, or the arbitrary nature of homicidal behaviour being categorised as necessarily either instrumental or expressive in nature. Häkkänen-Nyholm and colleagues proposed that the identification of offence-specific factors, and their relationship to gender-related and psychosocial offender characteristics would be more useful for legal, forensic and clinical purposes. In their study of the offence characteristics

and crime scene behaviours in relation to the gender of 91 Finnish female homicidal offenders, Häkkänen-Nyholm et al. (2009) concluded that gender played an influential role in respect of both the nature of homicidal offending, and the profile of victims. Family members were the victims of female offenders more frequently than those of male offenders; and women more often committed homicidal acts in domestic as opposed to public spaces. Child victims were almost always killed by women, but no gender disparities emerged regarding the proportion of intimate partner murders by female perpetrators. Male offenders tended to cover the bodies of victims in an effort at concealment of the crime, whereas for women this behaviour seemed to be motivated by emotional detachment from the victim. For women, post-offence behaviours were more frequently related to seeking help or expressing remorse, than was the case for males. There were only marginal gender differences in the degree of lethal violence used by men and women respectively. It has been reported in other studies, however, that the overall intensity of aggression during the homicidal offence tends to be significantly higher in male perpetrators (Mužinić Masle et al., 2000).

In an attempt to integrate the numerous individual, situational and structural psychosocial variables at play (e.g. personality, situational stressors, coping mechanisms and response to distress and arousal), Ogle et al. (1995) generated an integrated theory of “homicidal behaviour among women (HBAW)”. According to this theory, there are a number of fundamental gender differences concerning differential sources of early life stressors, and differential responses to these. Firstly, women are postulated as tending to internalize negative affect and psychological distress (especially as guilt and emotional pain), as opposed to externalizing it as directed extreme anger, rage and aggression, in a pattern more commonly associated with homicidal men. The existence of gender differentials in the nature of expressions of psychological distress is also supported by studies of adolescent behaviour. The aggression of girls and young women

is often described as being indirect, and commonly associated with introverted problems manifesting as self-harming behaviours, eating and self-image disturbances, and substance abuse; whereas expressions of intense emotions in the form of rage and physical aggression are more common in boys and young men (Jung and Rawana, 1999; Yourstone, Lindholm and Kristiansson, 2008). Gendered social roles and emotional “norms” for women also more often described to entail so-called “powerless responses” to severe stressors, including social withdrawal, anxiety, depression, fear and insecurity (Fischer and Jansz, 1995). From this perspective, women who commit lethal acts of violence are seen to be violating social expectations to a greater degree than homicidal men. Yourstone, Lindholm and Kristiansson (2008) also suggested that if it is the case that aggressive adolescent girls display more introverted psychological and behavioural responses than boys, homicidal women would be expected to have been less overtly aggressive during childhood than is the case for homicidal men. It could also then be expected that it takes a greater degree of provocation, frustration and anger for women to resort to such extreme measures as lethal violence. Early psychosocial and environmental adversity (e.g. family conflict, chaotic households, parental criminality and abuse-victimization) would then be understood to play a substantial role in escalating the risk of subsequent violence by these women. Related considerations are the fact that violent parental behaviour predicts not only their own subsequent tendency to violence, but also the future violence of their children; and that the children of recidivistic homicide offenders have been reported to have a higher risk of violent offending themselves (Putkonen, 2003; Putkonen et al., 2002).

Mental Disorder in Homicidal Women

There has been increasing research interest in the relationship between mental disorder and homicidal violence (Angermeyer, 2000; Côté and Hodgins, 1992; Daniel and Holcomb,

1985; Erb et al., 2001; Eronen, 1995; Eronen et al., 1996; 1996a; 1996b; 1998; Gottlieb et al., 1987; Hodgins, 1992; 1998; Hodgins et al., 1996; Putkonen and Taylor, 2014; Schanda et al., 2004; Shaw, 1999; Shaw et al., 1999; Taylor, 1997a; 1997b; Taylor and Gunn, 1984a; 1984b; 1999; Tehrani et al., 1998; Wallace et al., 1998). Although risk ratios in many studies demonstrate moderate risk, the vast majority of people with mental disorder do not commit homicide: a range of other factors (e.g. male gender, youth, socio-economic deprivation, substance misuse, etc.) pose larger risks than mental ill-health per se (Monahan, 1992; Putkonen, 2003). There are complex interactions between female-perpetrated homicide and a number of broader contextual factors, including socio-economic adversity, interpersonal and family dynamics, psychosocial distress, mental ill-health, substance abuse, and numerous uniquely individual variables (such as coping, and social skills, temperament, personality structure, distress management, frustration tolerance, impulsivity, communication style, decision-making style, etc.) (Evans et al., 2013; Large et al., 2009; Silver, 2006). Nonetheless, it is estimated that up to one-third of homicidal offences are committed by people with documented mental disorder (Swinson et al., 2007; 2011; Swinson and Shaw, 2007).

The extensive National Confidential Inquiry into suicide and homicide in the UK led Swinson and colleagues to examine data on 743 homicide offenders who had pre-offence contact with mental health services. Almost 10% of the study sample were in recent contact with psychiatric services, 5% had a diagnosis of schizophrenia, and alcohol or other substance abuse substantially contributed to homicidal behaviour in approximately 61%. Furthermore, offenders with mental disorder were less likely to target strangers than those without. Most research has, however, focused on male homicide offenders in industrialized, Western countries, and their applicability and relevance to women offenders, especially in settings outside these, remains the subject of ongoing debate. This notwithstanding, the research

evidence suggests that women with a history of a severe mental disorder (especially schizophrenia) and psychiatric hospitalization commit lethal offences more frequently than women in the general population (Eronen, 1995; Hodgins, 1992; Putkonen, 2003; Wessely, 1998). Severe forms of mental illness also seems to have a more substantial impact on the risk of lethal violence in women than men, with up to two thirds of homicidal women estimated to have a severe mental disorder compared to around one-third of men (d'Orban, 1990; Gottlieb et al., 1987; Maden et al., 1994a; 1994b; Putkonen and Taylor, 2014; Silver et al., 2008; Yarvis, 1990).

In those who suffer from severe mental disorder, certain psychiatric diagnoses have been reported to be particularly important in contributing to the risk of homicide (Edwall et al., 1989; Weizmann-Henelius, Sailas et al., 2003; Yarvis, 1990). The study by Yarvis (1990), for example, examined a series of 100 male and female homicide offenders to discern overall patterns of psychopathology and mental disorder diagnoses. Substance-related and psychotic disorders accounted for almost two-thirds of Axis I diagnoses; and antisocial and borderline personality disorders accounted for over half of Axis II diagnoses respectively. The homicide offenders were reported to be a heterogeneous population, with a range of factors (including criminal history of assailants, gender, offence characteristics and relationships to victims) influencing diagnostic patterns. The Finnish study of Laajasalo and Häkkänen (2004) surveyed the psychiatric records of a sample of 183 homicidal offenders (10% of whom were women) and reported high rates of severe mental disorder and psychiatric comorbidity: almost 25% had a diagnosis of schizophrenia, with similar rates reported for personality and alcohol-related disorders respectively. Matejkowski et al. (2008) sampled 95 American patients (73 males and 22 females) with severe mental disorder who were convicted of murder. A history of pre-offence mental health problems was present in 65% of the sample, and women had particularly

high levels of substance-related disorders (in over 70% of cases) major depressive disorder (61%), psychotic disorders (43%) respectively. A pre-offence psychiatric history was present in two-thirds of all women offenders. Extreme rage as a result of interpersonal conflict with close relatives or intimate partners was the most commonly cited motive for murder. Evans et al. (2013) compared the socio-demographic, psychological and behavioural characteristics of 13 homicidal women with those of 13 non-homicidal women offenders under institutional forensic care in England. Whilst the two groups of women were similar in most respects, the non-homicidal group had “more troubled backgrounds”, especially relating to pre-offence psychosocial stressors and substance abuse. The two groups also responded similarly to forensic treatment programmes, although the homicidal group displayed significantly less aggression and challenging behaviour during the course of their in-patient stay. The authors concluded that whilst both homicidal and non-homicidal women had similar overall mental health care needs, substance-related interventions were particularly important for the non-homicidal group in this series.

In a critique of many other studies, Flynn et al. (2011) pointed out that methodological issues in some studies of female homicidal offenders with mental disorder (e.g. small sample sizes, study settings being limited to prison samples, retrospective and historical sampling, and case-inclusion bias) hindered the drawing of specific conclusions. Flynn and co-workers therefore conducted a large, population-based study of 4572 convicted homicide offenders (both men and women) in the UK between 1997 and 2004, using data from the National Confidential Inquiry into suicide and homicide by people with mental illness. The key conclusions drawn from this analysis were that, in comparison to men: (a) significantly more homicidal women had a lifetime of history of mental disorder; (b) women were more likely to have been experiencing active psychopathology at the time of their offence; (c) women

received non-custodial sentences more often, irrespective of whether they had mental illness or not; (d) in cases where victims were children or close family members sentencing by courts tended to be more lenient for women; and (e) gender and mental disorder both influenced the nature of homicidal offending, and potentially, the legal outcomes. The authors recommended that all homicide offenders should receive a gender-neutral, objective pre-trial psycho-legal evaluation. It has been contended that sociocultural prejudice about what is considered “normal” behaviour for women lead many, including those within the criminal justice system, to conclude that homicidal acts by women are in themselves evidence of psychopathology. Schanda et al. (2004), in an Austrian study of homicide and mental disorder spanning 25 years, concluded that there might exist in the criminal justice system a tendency toward disproportionately applying the “insanity defence” to cases of homicidal women, as opposed to homicidal men. This reflects the contention of a number of others of a bias within criminal justice and forensic mental health systems toward more readily psychopathologizing all violent women, and a tendency to define homicidal women in particular as invariably “mad” as opposed to “bad” (Flynn et al., 2011; Lamb and Grant, 1983; Putkonen and Taylor, 2014; Teplin, 1984; Wilczynski, 1997).

Due to the fact that Finland has one of the highest homicide rates in Europe, Finnish female-perpetrated homicide research, especially with respect to mental health issues, has been extensive and robust. A review of research evidence regarding the mental health of Finnish female homicide offenders is therefore pertinent. The overall per capita homicide rate in Finland has, for the past few decades, been approximately twice that of other European countries, and thrice the rate of other Nordic countries (Häkkinen-Nyholm et al., 2009). This has largely been attributed to an increase in of severe alcohol-related quarrels between unemployed, socio-economically deprived, middle-aged men. The percentage of convicted

female homicide offenders has also increased over the past few decades, from approximately 9% of homicide perpetrators being women in the 1980's to over 11% from the 1990's onward (Putkonen et al., 2008; Putkonen, Weizmann-Henelius et al., 2011). Eronen (1995) analysed the forensic psychiatric records of 127 Finnish female homicide offenders over a 13-year period, and found these women to have approximately 10-fold higher odds for having a psychotic or personality disorder than women in the general population. The diagnoses with the highest odds ratios were schizophrenia, antisocial personality disorder and alcohol abuse/dependence. Eronen concluded that mental disorder appears to have a statistically significant association with homicidal behaviour, particularly in countries with relatively low overall offending rates, and further that there may be subgroups of women with specific mental disorders in whom the commission of lethal violence is disproportionately high. The study of Putkonen et al. (1998) examined the records of all 132 women who underwent forensic psychiatric examination subsequent to committing homicide or attempted homicide in Finland during the decade spanning 1982 – 1992. The most frequent categories of victims of homicidal violence were intimate partners (in 54% of cases); friends and acquaintances (24%); and biological children (14%) of perpetrators respectively. Children in general were, however, victims of homicidal violence in 26% of cases (almost one-third of these were cases of neonaticide; and almost one-third of these involved more than one child victim). The most common homicidal methods were stabbing (65% of cases), followed by strangulation (12%) and assault with a blunt weapon (11%). Quarrels and conflict with victims were cited as the homicidal motive in the majority of cases (59%). A surprisingly low number of women (11 in total) reported self-defence as the motive, only one of whom was not intoxicated at the time of the offence. The majority of offenders had received pre-offence psychiatric care (61%). The most common individual psychiatric diagnoses were personality disorder (71% of cases), substance dependence (45%) and psychotic disorders (28%) respectively. Substance-related

and personality disorders were more common amongst younger women (under 33 years of age). All seven of the women who committed neonaticide had a diagnosed personality disorder, and three of these had a co-morbid psychotic spectrum disorder (though none had schizophrenia). None of these cases were deemed fully criminally responsible for their actions.

Psychotic and Mood Disorders

The research evidence regarding the association between psychotic and mood disorders, and female-perpetrated homicide, is not entirely conclusive. Estimates of the rates of psychotic illness amongst homicidal offenders in general vary from 7-9% in the UK and Australasia, and up to 30% in Scandinavian countries respectively (Eronen et al., 1996b; Fazel and Grann, 2004; Gottlieb et al., 1987; Putkonen et al., 1998; Shaw et al., 2006; Simpson et al., 2004; Wallace et al., 1998). Studies of male prisoners convicted of homicide reported particularly high rates of schizophrenia and major depressive disorders (Côté and Hodgins, 1992; Large et al., 2009; Taylor and Gunn, 1984a). In their meta-analysis of the relationship between schizophrenia and homicide, for example, Large et al. (2009) reported a robust correlation between homicide rates perpetrated by people with schizophrenia, on the one hand, and those in the general population on the other. The authors concluded that this may point to the presence of common aetiological factors (such as substance abuse and social adversity) that are possibly independent of mental disorder. Nonetheless, the acute phases of severe psychotic disorders are known to be associated with an increased risk of lethal violence (Mullen, 1997). There are correlations reported between active auditory hallucinations and persecutory delusions, in particular, as potential precipitating and/or perpetuating factors of homicidal violence (Junginger, 1996). Some studies have suggested that psychotically-driven homicides may occur more often during the first psychotic episode (Meehan et al., 2006; Nielssen et al., 2007), though others are equivocal on the issue (Fazel and Grann, 2006; Laajasalo and Häkkänen, 2006).

Research on the relationship between homicide and psychotic disorders has primarily focused on men, in part due to the relative infrequency of homicide by women (Bennett et al., 2012). There have been suggestions that men may be more likely to engage in homicidal behaviour in response to threat delusions (Teasdale et al., 2006), whilst for women, even in the context of psychosis, murder is often considered an act of self-preservation or self-defence (Goetting, 1998a; Jurik and Winn, 1990). It has further been proposed that where psychosis is an issue in the commission of homicidal acts, its individual characteristics may influence the nature of the associated violence (including the likely victim). It is, for example, unusual for women who have psychotic spectrum disorders to murder intimate partners, but it is more likely for women who kill children to have a psychotic disorder (Gottlieb et al., 1987; Putkonen, Collander et al., 2001). Schizophrenia, other psychotic-spectrum disorders and affective psychoses have all been postulated to place women at disproportionate risk of engaging in homicidal violence (Taylor and Bragado-Jimenez, 2009). In one of the early studies on the matter, Häfner and Böker (1973) conducted a decade-long retrospective study of mentally disordered violent offenders in Germany between 1955 and 1964. Men with schizophrenic psychosis outnumbered women (by a ratio of 3.8:1) in the commission of violent acts. For inpatients with affective psychosis however, this ratio was reversed. When the comparison was confined to completed homicide perpetrated by patients with affective psychosis, women outnumbered men by 6:1 (with the majority suffering from severe depressive disorders). Another German study by Erb et al. (2001) reported an odds ratio of 16.6 in homicidal offenders who had schizophrenia, though the analysis was an aggregate of men and women, and included both murder and attempted murder cases. A number of Scandinavian studies have reached similar conclusions. Eronen et al. (1996b), examined the records of almost 70% of all known Finnish homicide offenders over an eight-year period ($n = 693$). A diagnosis of schizophrenia

was associated with age-adjusted odds ratios for homicide in men of approximately 8 (95% CI 6.1 – 10.4), and for women of 6.5 (95% CI 2.6 – 16.0) respectively. The relative gender disparity for the commission of homicide by offenders with major depressive disorder was similar, with age-adjusted male: female odds ratios of 1.6:1.8. Other mental disorders (including other mood disorders, anxiety disorders, and intellectual disability) had no significant effect on elevation of the odds of committing homicide to any significant degree. This study further reported, however, that antisocial personality disorder increased the risk of committing homicide more than was the case for schizophrenia alone, and proportionately more in women than in men, although the absolute risk remained lower in women (the issue of psychiatric comorbidity in relation to homicidal risk is reviewed further below). Gottlieb et al. (1987) assessed the forensic psychiatric examinations of all homicide defendants in Denmark over a 25-year study period, and found 23% of homicidal women to be suffering from a psychotic disorder. In comparison to the general population, there were higher rates (and gender differences in association with these) of both schizophrenia (7% in men and 6% in women) and major depressive disorder (3% in men and 28% in women). The psychotic defendant's differed from those without psychosis by being older, less often substance abusing and by tending to murder close family members as opposed to strangers. Almost one-third of offenders were diverted by courts to psychiatric hospitals for treatment, rather than to prison. Another Danish study by Schanda et al. (2004) reported on associations between severe mental disorders and offending amongst 1087 homicidal offenders (also over a 25-year study period). Overall, severe mental disorders were associated with a significantly increased risk of homicidal behaviour, particularly in women, in whom there was a 6-fold increase (as compared to a 2-fold increase in men) in comparison to the general population, with these increases being almost exclusively due to schizophrenia (for which age-adjusted odd's ratios were 18.38 in women, and 5.85 in men, respectively). Co-morbid alcohol abuse / dependence increased the

odd's even further in patients with schizophrenia as well as in those with mood disorders (depressive and bipolar types). Large studies of homicide offenders in Iceland (Gudjonsson and Petursson, 1986) and Sweden (Lindqvist, 1986; Lindqvist and Allebeck, 1990) also found markedly increased rates of schizophrenia (10 – 15%) in these samples.

In Anglophone countries, a more mixed picture is reported in respect of both psychotic and mood disorders and their associations with homicidal behaviour. Of the 1594 homicide cases surveyed in England and Wales between 1996 and 2000 (1168 cases had psychiatric reports): for every one woman in the cohort without severe mental disorder, there were 10 men; and whilst having schizophrenia reduced the male:female ratio to 8:1, having a severe mood disorder reduced it to just 3:1 (Swinson et al., 2007; Swinson and Shaw, 2007). A smaller Scottish cohort study of 227 homicides (196 of these had psychiatric reports available) was more similar to the German study of Häfner and Böker (1973), in which the overall ratio of male to female perpetrators for homicidal acts by those without mental disorder was 10:1. The male:female ratio was, however, reversed (1:10) among homicide offenders with severe depressive disorders. Simpson et al. (2004) examined the national cohort of homicides in New Zealand between 1970 and 2000: almost 9% of the 1498 homicides during this period were deemed to have been committed by people with severe mental disorder. Women constituted 9% of the offenders in the “mentally normal” group, but a significantly higher 33% of the “mentally abnormal” group of offenders. Of the mentally ill offenders: 10% had been admitted to a psychiatric unit during the month prior to the homicide; 29% had no pre-offence psychiatric history; and victims were known to offenders in the vast majority of cases (74%). In an Australian study of convicted offenders, the presence of schizophrenia increased the likelihood of committing a homicidal act by approximately 10-fold in both men and women (Wallace et al., 1998). For affective psychoses, there was a distinct gender discrepancy, with the homicidal

risk increasing 5-fold in men and nearly 17-fold in women respectively. Nielssen et al. (2007) reported on an Australian series of 71 male and 19 female offenders who committed homicide during an active psychotic phase of illness over the decade from 1993 to 2002. High rates of co-morbid substance abuse (73%) were reported. Evolving auditory hallucinations and persecutory delusions were the psychotic symptoms most strongly associated with homicide. Like many other studies, victims were mostly family members or close associates (fewer than 10% were strangers). Most lethal assaults (69%) occurred during the first year of psychotic illness, and the first episode was found to carry the highest homicidal risk. Almost 50% of perpetrators had contact with psychiatric services in the fortnight prior to the offence. Similarly, Bennett et al. (2012) conducted a study of the forensic clinical records of all female homicidal offenders (n = 55) in Australia identified between 1997-2005, in comparison to a control group of 390 women drawn from the general population. Approximately 20% of the homicidal offenders were diagnosed with a psychotic-spectrum disorder (with the majority of these diagnosed prior to the homicidal act). The chance of any psychotic illness among the female homicide offender group was over 20 times higher than controls, and even higher for schizophrenia in particular, with the latter having an odds ratio of 43.17. The majority of offenders with mental disorder had a relatively long pre-offence psychiatric history requiring mental health care (69% of cases and less than 10% of controls respectively). The authors reported though that homicidal acts offences were not necessarily related to psychotic symptoms, and cautioned against drawing conclusions on direct causality between psychosis and homicide. The cumulative evidence suggests, however, that a higher proportion of homicidal behaviour among women may be attributed to psychotic disorders (especially schizophrenia) than is the case for men (Fazel and Grann, 2006; Putkonen and Taylor, 2014).

Substance-related Disorders

Studies that focus on substance-related issues in female homicide offenders are relatively scarce. Spunt et al. (1996) conducted semi-structured interviews with women imprisoned for homicidal offences (including murder and manslaughter), and reported alcohol, crack and cocaine to be the most commonly used substances at the time of offence commission. The majority of women interviewed characterized their homicidal actions as “drug-related” i.e. that substances had played a significant role in their homicidal violence. In the US, Kruttschnitt et al. (2008) found that female homicide offenders, like their male counterparts, had a significantly increased likelihood of having a diagnosed substance-related disorder. In their Australian study, Bennett et al. (2012) similarly reported that female homicide offenders were significantly more likely than controls from the general population to have a substance-related disorder (with an odds ratio of 67.91).

The homicidal act itself is frequently committed during substance intoxication among perpetrators of both sexes, with alcohol being disproportionately implicated in most of these cases (Jurik and Winn, 1990; Muscat and Huncharek, 1991; Putkonen, 2003; Spunt et al., 1996; 1998). A statistically significant correlation has been demonstrated between alcohol sales and homicide rates, and the increase in alcohol abuse has been implicated in contributing to the increase in rates of violence in general, and homicide in particular, across many countries (Rossow, 2001). The largest group of Finnish homicide offenders are reported to be marginalized, impulsive, antisocial and alcoholic men (Eronen et al., 1996a; 1996b). Drawing on data from the Finnish national homicide monitoring system, Kivivuori et al. (2007) similarly described the typical homicide case to involve a group quarrel following a weekend drinking binge, with the majority of male and nearly half of female offenders to have alcohol-related disorders. In addition, 66% of male and 49% of female offenders were unemployed, and 57%

of male and 28% of female offenders had prior criminal convictions respectively. Alcohol abuse was also responsible for a 49-fold increase homicide risk in Finnish female offenders in a study by Eronen (1995). Another Finnish study by Putkonen et al. (2008) compared data from a 1993-2005 female homicide offender cohort, on the one hand, to an earlier Finnish female homicide cohort from 1982-1992, on the other, to test the hypothesis that increases in alcohol consumption over time would be reflected in parallel increases in alcohol-related homicides. Whilst there were relatively small increases in the proportionate rates of female-perpetrated homicides, there was a significantly higher frequency of alcohol-related disorders in the later cohort (including a higher proportion of homicidal women being intoxicated with alcohol at the time of the offence itself). Fewer offenders were assessed to have a lack of (or diminished) criminal capacity in the later cohort. In addition, the victims of the earlier cohort tended to be emotionally and biologically closer to offenders. Putkonen and co-workers concluded that there are subgroups of homicidal women who are increasingly approximating the profile of homicidal men, especially regarding the increasingly influential role of alcohol in the perpetration of homicide. Alcohol-related homicide by women are also reported to more commonly involve non-domestic disputes, as opposed to domestic or intimate-partner disputes, in which alcohol is said to play a more prominent role in victims than offenders (Putkonen, 2003). Elsewhere, Shaw et al. (2006) demonstrated that the abuse of alcohol or other substances directly contributed to the commission of over 40% of homicides in England and Wales (90% of these offences were male-perpetrated). Furthermore, when alcohol was a contributory factor, offenders were less likely to have another co-morbid psychiatric disorder on Axis I and/or II, but when illicit substances were abused, the likelihood of having a personality disorder in particular was significantly increased. Eckhardt and Pridemore (2009), in contrast, found in their Russian study that homicidal women were less likely to be intoxicated at the time of the offence than homicidal men, and suggested a lesser role for alcohol in the commission of lethal

violence in women than for men. The data from this study, however, was drawn from police records and the reliability of certain information (e.g. laboratory levels of alcohol intoxication) has been questioned (Evans et al., 2013).

Personality Disorders

Personality disorders in general, but especially those in cluster B (antisocial personality disorder in particular) have been postulated to increase the risk of lethal violence in both men and women, though this association may well be mediated by other factors common to both personality disorders and homicidal behaviour in general e.g. impulsivity and/or substance misuse (Eronen et al., 1996b; Putkonen, 2003; Shaw et al., 1999). There have been very few studies examining the issue of personality disorder in female homicide offenders in particular, with Finnish research again being the most prominent. The national Finnish study of homicidal offenders by Putkonen, Weizmann-Henelius et al. (2011), for example, found that prevalence of antisocial personality disorder was not much lower amongst women (22%) than amongst men (31%). Eronen et al. (1996b) found people, of either gender, with any personality disorder to be at approximately 10-fold higher risk of committing homicide, with those with antisocial personality disorder in particular being at disproportionately high risk, especially in women: odds ratios for men were 15.8 (95% CI 12.9 – 19.4) and for women 75.7 (95% CI 40.1 – 142.7). Warren and South (2009), in a study of 261 women in a high-secure prison, did not find a diagnosis of antisocial personality disorder to be specifically associated with homicidal offences (though this study observed a consistent relationship between narcissistic personality traits and violent behaviour).

There has been some research on the issue of psychopathy in relation to female-perpetrated homicide. Edwall et al. (1989) found that women who fatally assaulted strangers

(as opposed to those who they had a close relationship with or emotional attachment to) tended to have an adolescent history and adult characteristics related to psychopathy. Kalichman (1988) specifically examined the personality profiles of offenders convicted of domestic homicide in comparison to those convicted of killing strangers. The women convicted of domestic homicide, whilst exhibiting some traits associated with “psychopathy and paranoia”, demonstrated a lower tendency toward psychopathy than men guilty of killing a stranger. Similarly, Weizmann-Henelius, Putkonen, et al. (2010) looked at psychopathy in women in a sample of 97 Finnish female homicidal offenders, and found the prevalence of psychopathy to be almost 10% with a cut-off Psychopathy Check List – Revised (PCL-R) score of 30 or more; and over 21% with a cut-off PCL-R score of 25 or more. This study emphasized the fact that psychopathy is a complex construct that includes diagnostic criteria of several personality disorders, and that much more research is required to draw conclusions on gender differences in its relationship to homicide.

Psychiatric Comorbidity

There are also complex interactions between personality disorder, substance abuse and homicidal behaviour. Both personality disorder (especially of the antisocial type) and substance abuse (especially of alcohol) have been reported to disproportionately increase the risk of homicide by women in particular (Eronen et al., 1996a; 1996b; Spunt et al., 1996; 1998). There have been numerous investigations which have confirmed disproportionately high rates of psychiatric comorbidity (dual diagnoses i.e. primary mental disorder co-morbid with substance-related disorders), in people of either gender who perpetrate lethal violence (Côté and Hodgins, 1992; Erb et al., 2001; Eronen, 1995; Eronen et al., 1996; 1996a; 1996b; Gottlieb et al., 1987; Putkonen et al., 2003; 2008; Schanda et al., 2004; Taylor and Gunn, 1999; Wallace et al., 1998; Weizmann-Henelius, Sailas et al., 2003). The role of co-morbid alcohol-related

disorders in this regard has been consistently demonstrated. Alcohol intoxication at the time of the homicidal offences have been shown to be more prevalent among women with personality disorder (Spunt et al., 1996). Alcohol dependence was also highly prevalent in personality-disordered homicidal offenders in Finland, which increases the risk of homicidal behaviour further (Tiihonen et al., 1993). The odd's ratios of risk for homicidal behaviour seem to increase significantly, in women in particular, when alcohol-related disorders co-occur with other mental disorders. For women with schizophrenia and co-morbid alcohol dependence, the odd's ratio in the study by Eronen (1995) was reported to be 77.0 (95% CI 24.4 – 242.6); and for personality disorder with co-morbid alcohol dependence it was 84.1 (95% CI 57.0 – 124.2). Eronen et al. (1996) analysed forensic psychiatric data in 93 homicide offenders with schizophrenia and found the homicide risk to be significantly higher (irrespective of gender) than was the case for people in the general population. Schizophrenia with no co-morbid alcohol abuse increased the odd's ratio more than 7 times, whilst schizophrenia with co-morbid alcohol abuse increased the odd's more than 17 times in males in particular. These odd's ratios are, however, also influenced by the fact that homicide by women are rare phenomena in the first instance (Putkonen, 2003). It has furthermore been shown that antisocial personality disorder with co-morbid substance abuse may be more prevalent in younger female homicide offenders, whereas primary mood disorders with co-morbid alcohol abuse may be more prevalent in older offenders (Husain et al., 1983; Robertson et al., 1987).

In Finland, Putkonen, Collander et al. (2001) reported that the diagnoses of personality disorders and psychoses formed distinct subgroup in female homicidal offenders. Homicidal women with personality disorder targeted adults (mostly in the context of interpersonal conflict) more frequently than those with psychotic disorders, who targeted children more often. In over two-thirds of cases in which children were killed (but excluding neonaticide),

the offender was diagnosed with a psychotic disorder. In addition, whilst over 71% of the women were intoxicated with alcohol at the time of their offence, personality disordered women were more likely to have been intoxicated with alcohol at the time of offence than women with psychosis. Putkonen and colleagues concluded from these studies that most of the homicidal women suffered from psychotic, personality and/or substance-related disorders, with high rates of co-occurrence of these. They tended to direct lethal attacks toward those close to them, and posed a longer-term risk both to themselves and others. Whilst homicidal women were noted to be broadly similar in profile to their male counterparts, more essential differences could potentially be found if study samples were grouped into those who killed as a result of psychotic versus non-psychotic factors. The authors emphasized, however, that the majority of people (of either gender) with mental health problems were not prone to severe and lethal forms of violence, and generalization in this respect is both inaccurate and stigmatizing.

Mental Health of Women who Murder Adults

The relatively small number of homicidal women overall has resulted in relatively few gender-focused studies of the mental health of women who commit different types of homicide (e.g. mariticide, extra-familial homicide, or adult versus child homicide). An analysis of the criminological data on 215 273 homicides in the US between 1976 and 1987 was undertaken by Kellermann and Mercy (1992). Women comprised over half the American population, but committed only 14.7% of the homicides during this period. Although the overall risk of being a victim of homicide was lower than that of men (77% of victims were male), the risk of women being killed by an intimate partner was significantly higher. In contrast to men who killed non-intimate adults or strangers in the majority (80%) of instances, women killed an intimate partner or close family member (including children) in over 60% of cases. A study by McKee and Shea (1998) went on to compare homicidal women who murdered their partners

(mariticide), children (filicide) and unrelated adult victims (non-familial homicide) respectively, and reported on a range of sociodemographic, forensic and clinical characteristics of these different cohorts of women. Compared to the other groups, women charged with filicide were more likely to have severe mental disorder, and less likely to have backgrounds of prior criminality or to have been intoxicated at the time of the offence. Filicidal women were also reported to generally lack the psycho-social resources required to cope with severe distress. The women charged with non-familial homicide tended to have prior criminal records, be facing other serious charges, be substance dependent, have co-defendants, and to have murdered in a non-residential setting. In other words, the homicidal crimes committed by the non-familial homicide group of women displayed profiles similar to those of homicidal men. The most distinguishing feature of the women charged with mariticide was that they were significantly more likely than the others to have been in an abusive relationship with their intimate partner and victim. There were no significant differences between the three groups in terms of age, race, intelligence, educational attainment or employment status. In a follow-up study McKee et al. (2001) compared Minnesota Multiphasic Personality Inventory-2 (MMPI-2) profiles of adult women defendants (n= 73) charged with filicide, mariticide and non-familial homicide respectively, and found no statistically significant differences between the groups on either the clinical or content scales. Closer inspection of the 53 valid MMPI profiles, however, revealed: (a) higher mean scores on scales associated with psychotic symptoms (e.g. hallucinations, delusions or disorganized thinking) in the filicidal group; (b) higher mean scores for affective symptom scales (especially depressed individuals in the context of poor interpersonal relationships) in the mariticial group; and (c) higher mean scores on scales associated with antisocial symptoms (e.g. history of criminal behaviour, substance abuse and marginal adjustment to societal norms) in the non-familial homicide group respectively.

Mariticide

Murders of intimate spouses, partners or acquaintances (mariticide) by women are commonly reported to occur in the context of years of physical, sexual and/or emotional abuse the offenders themselves had endured at the hands of their victims, with intense interpersonal conflict being a frequently cited precipitant of the homicidal act i.e. lethal violence is resorted to in self-defence, or as a direct result of threat or provocation by the victim (Goetting, 1987; Husain et al., 1983; Jurik and Winn, 1990; Kellerman and Mercy, 1992; Kirkwood, 2003; Mužinić Masle et al., 2000; Putkonen, 2003; Putkonen and Taylor, 2014; Rodriguez and Henderson, 1995; Stout, 1991; Swatt and He, 2006; Wilbanks, 1983a; 1983b; Wilson and Daly, 1992). Wilbanks (1983a), for example, studied a sample of 569 homicide offenders in the US, and found women to be more likely than men to be involved in homicides within a domestic setting, with victim-precipitated violence being a common antecedent. In an examination of case files of 56 North American women who murdered their husbands, Goetting (1987) reported the typical maritidal offender to be an African-American mother in her thirties, who was also under-educated, unemployed, a welfare recipient, and often with a prior arrest record. The homicidal act was most frequently a defensive gunshot, the culmination of an argument with her slightly older and chronically abusive husband. Goetting suggested that these women were often “victims themselves of a society stratified against them” (p. 340). In their examination of 2216 cases of homicidal Texan American women between 1980 and 1990, Rodriguez and Henderson (1995) similarly found these women to have most frequently killed intimate partners. They were typically young (under 35 years of age) and used firearms as weapons. African-American women were also over-represented in this study. Stout (1991) conducted a qualitative study by interviewing 18 women prisoners in the US state of Missouri, who were convicted of killing their intimate male partners. As in many other studies, lethal violence within the domestic setting was the most common scenario described. Almost 90% of

the women interviewed reported being physically, emotionally and/or sexually abused by their victims prior to the homicide (with 61% reporting that their children were also abused by their victim-partners). Most of the women used a firearm to kill their partners. Unlike other studies, however, most of the women in Stout's study were employed, well-educated and had no prior history of violent offending. In their investigation into the contextual factors of intimate partner homicides in Chicago, Swatt and He (2006) reported that women perpetrators more often experienced abuse (especially severe physical abuse) prior to the mariticide act; and were more likely than men to use a knife as a murder weapon, a finding the authors suggested as evidence of a self-defensive reaction to threats, provocation and/or abuse by victims.

Whilst the concept of the "battered woman syndrome" has been utilized both in the context of theorizing about female-perpetrated mariticide, and as a legal tool in murder defence cases, it has also been criticized for tending to pathologize or disempower all women in these situations, when this may not necessarily be appropriate or true (Sheehy et al., 1992; 2012). As with other forms of female homicide, there is evidence that women who kill their intimate partners are at higher risk of having mental ill-health prior to, during the commission of, and/or subsequent to the offence, but this not invariably always the case (Flynn et al., 2011). In support of this, a large Scandinavian study by Gottlieb et al. (1987), for example, reported that whilst filicidal women are a relatively heterogeneous group in respect of their mental health profile, women who kill intimate male partners are more likely than not to be mentally well and apsychotic at the time of the mariticide act.

Parricide and Femicide

The killing of a parent is a rare event, with daughters being responsible less often than sons, though an association with depressive disorders is described in many women who

perpetrate such offences (Bourget et al., 2007). In one of the very few studies that specifically examined parricide by women, d'Orban and Connor (1989) documented that the majority (over 80%) of these were matricidal offences (i.e. the killing of a mother), typically committed by middle-aged women with diagnosed mental disorder (especially psychotic, depressive, substance-related and/or personality disorders, and a high incidence of psychiatric comorbidity present). Matricidal women offenders also tended to have dependent but hostile relationships with their maternal victims, who were usually elderly and physically frail, with intensive, chronic care needs. Women who committed patricide (i.e. the killing of a father) were more likely to be younger and to have carried out lethal offences that were mostly retaliatory in nature against their chronically abusive fathers.

Whereas most studies note that homicidal women are most likely to kill across gender lines, there are very few studies that focus on the phenomenon of female-perpetrated femicide (i.e. the killing of another woman) (Putkonen and Taylor, 2014). Analysing data from the files of 15 cases of female-on-female homicide in the US, Goetting (1988b) reported that the profile of femicidal women was not very different from women who kill men. The typical offender in this series was a locally born, young (under thirty years of age), married, unemployed, poorly educated, African American mother living with her family, who had impulsively killed another female family member following a domestic altercation. This study reported further that many of the female victims were children. Mann (1993) (cited in Scott and Davies, 2002) similarly examined the homicide files of 57 North American women who killed other women between 1979 and 1983. Like Goetting's earlier findings, this study reported these women to be predominantly African American, with prior arrest records, poor educational backgrounds and poor occupational attainment, and whose lethal violence occurred within a family setting.

Mental Health of Women who Murder Children

Societal, criminological and clinical approaches to women who murder children have tended to be, historically at least, mostly reductionist in nature, seeing women as either “mad” (i.e. psychotic) or “bad” (i.e. antisocial), with relatively little consideration of the diverse perinatal, socio-demographic, cultural, contextual, structural and individual factors invariably associated with such events e.g. gender inequality, poverty, social isolation, domestic violence, abuse experiences, individual resilience, family support, mental ill-health, and so on (Ayres, 2007; Malmquist, 2013; Nau et al., 2012; Wilczynski, 1997). Oberman (1996; 2003) characterized three basic societal responses toward women who kill children as being “denial (the most common), punishment or prevention”. Whilst causal attribution is difficult to draw conclusions on, where mental health problems are implicated, psychotic and personality disorders have been highlighted as being particularly pertinent (d’Orban, 1979; Friedman, Horwitz et al., 2005; Putkonen et al., 1998). Many studies on the mental health of child homicide offenders have tended to restrict focus on the identification of psychiatric diagnoses and classification by motive (Dolan et al., 2003; Putkonen and Taylor, 2014; Stroud, 2008). In an extensive review of the four decades of research on child homicide, Porter and Gavin (2010) concluded that the majority of cases were not related to maternal mental illness, with the same conclusion reached by a number of other researchers (De Bortoli et al., 2013a; 2013b; Lambie, 2001; Marks, 1996; 2006; 2009). It has further been suggested that some of the high rates of mental disorder reported amongst mothers who kill their own children may be based, in part at least, on the tautology that mothers who kill biological offspring must necessarily be insane (Silverman and Kennedy, 1988; Stanton and Simpson, 2002; 2006; Stanton et al., 2000). The complexity of the matter is, however, increasingly appreciated as a result of growing evidence of distinctions between different types of child homicide, and the importance of the psycho-socio-cultural milieu in which such offences occur (Porter and Gavin, 2010). A significant

proportion of perpetrators (of either gender) have been shown to have multiple pre-offence psychosocial stressors and problems that contribute to mental ill-health and behaviour, though research focus on these broader, contextual issues has been less common (Stroud, 2008; Stroud and Pritchard, 2001). There remains a range of complicated, inter-related and inter-active, though poorly understood, factors associated with the phenomenon of child killing e.g. the role of gender, mental health, culpability, risk factors and how these cases are handled by the criminal justice and forensic mental health care systems respectively.

Epidemiology

Whilst a relatively rare crime overall, the killing of children is one of the more common types of murder, accounting for up to a quarter of all homicides, with rates reportedly increasing in many countries (Porter and Gavin, 2010). In the past few decades, whilst there have been global reductions in child mortality from infectious disease, accidents and congenital disorders, rates of child homicide (especially of younger children) has increased in many countries (Finkelhor and Ormrod, 2001). Child homicide incidence rates from studies conducted between 1994 and 2006 in industrialized, Westernized countries range from 2 to 8 cases per 100 000 (Pineiro, 2006; Porter and Gavin, 2010). The infanticide rate in the U.S, for example, is reportedly between 6 – 8 cases per 100 000, which is comparable to the adult homicide rate and twice the rate of road accident fatalities (Finkelhor and Ormrod, 2001; Malmquist, 2013). Many researchers consider these rates to be under-estimates, citing various reasons for the questionable reliability of the available data, including: classification and typological difficulties and differences across studies and countries; the socially stigmatized nature of the offence and the usually covert *modus operandi* as a result; difficulties in proving the cause of death beyond the required “beyond reasonable doubt” threshold; differences in the quality and extent of epidemiological data systems; methodological flaws and design variability across

studies; and inter-national and inter-cultural variations (Flynn et al., 2009; Putkonen and Taylor, 2014; Putkonen, Weizmann-Henelius et al., 2009). Nonetheless, child homicide remains a significant cause of childhood mortality in developed countries for which such reliable data is available (Marks and Kumar, 1993; 1996; Porter and Gavin, 2010; Somander and Rammer, 1991; Stanton et al., 2000). It is estimated that 20-25% of all homicide victims are children under 16 years of age, with most being killed by a biological parent (Jason et al., 1983; Porter and Gavin, 2010; Stone et al., 2000). Children are reported to be at greatest risk of being killed within the first 24 hours of birth, followed by their first year of life, following which there is a gradual reduction of risk into adolescence (Bourget and Labelle, 1992; Brookman and Nolan, 2006; Marks and Kumar, 1993; 1996; Putkonen, Amon et al., 2009; Putkonen, Weizmann-Henelius et al., 2009). In the study of Overpeck et al. (1988) half of child victims killed within the first year of life, were killed by their fourth month. A number of other studies have also found that infants under one-year age are at up to 4-fold greater risk of being killed than any other age group (Brookman and Nolan, 2006; Marks and Kumar, 1993; 1996).

The characteristics of child homicide offences, and its perpetrators, also demonstrate a number of gender-based distinctions (Scott and Davies, 2002). An estimated one-quarter of all female-perpetrated homicides involve child victims (Silverman and Kennedy, 1988); and over half of all child homicide victims are killed by women (d'Orban, 1979; Wilczynski, 1995; 1997). In addition, the younger the child victim, the higher is the likelihood that the mother is the perpetrator: up to 50% of children under one year of age are reportedly killed by their biological mothers (Bourget et al., 2007; Marks and Kumar, 1996; Porter and Gavin, 2010; Putkonen, Weizmann-Henelius et al., 2009; Vanamo et al., 2001). The study by Vanamo and co-workers of all 292 recorded child homicides in Finland between 1970 and 1994, for example, found that perpetrators were mothers in over 40% of cases, and fathers or stepfathers

in under 30% of cases, respectively. Approximately 60% of victims were less than 4 years old, and younger victims were disproportionately targeted by biological mothers. An analysis of trends in the US between in 1980 and 2008, demonstrated that the homicide of children under the age of 5 years was equally likely to be carried out by either parent: one-third of perpetrators were mothers, and one-third fathers, of victims (Cooper and Smith, 2011). In addition, in cases of children killed by a non-parental adult, perpetrators were male in the vast majority (80%) of cases, calling into question widely held assumptions that child homicide is primarily a female-perpetrated offence.

Peri-partum Mental Health

Whilst it is generally accepted that the mental health of some women during the peri-partum period (and especially the post-partum period) is one of increased vulnerability, regularly attributed to physiological distress and hormonal fluctuations (especially of progesterone, oestrogen and/or cortisol), there is much individual variability in the nature, extent, severity and pattern of peri-partum mental health syndromes described (De Bortoli et al., 2013b; Friedman and Resnick, 2009b; Porter and Gavin, 2010). Most research evidence, however, shows that such physiological and hormonal changes do not have a significant impact on the mental health of women in the majority of cases (Harris, 1994; Porter and Gavin, 2010; Wisner and Stowe, 1997). The lack of standardised terminology complicates the matter further: despite being distinct clinical entities, the terms “post-partum blues”, “post-partum (or puerperal) depression” and “post-partum (or puerperal) psychosis” are often used incorrectly, and at times even interchangeably. Up to 85% of women who give birth experience so-called “post-partum blues”, characterized by transient, mild and self-limiting depressive and/or anxiety symptoms (which may include irritability and agitation), which usually begin within a few days of childbirth and resolve within a week or two (Dobson and Sales, 2000). This is in

contrast to the more severe “post-partum depression”, which is more correctly conceptualised and described as a clinically significant mood episode (of the major depressive or bipolar type) with post-partum onset (within 1 month of delivery), and described as a discrete mental disorder within established classification system such as the DSM-5 (American Psychiatric Association, 2013) or ICD-10 (World Health Organization, 1992). These post-partum mood episodes affect up to 20% of women, have variable clinical presentations, and usually resolve within 6 months or so in the majority of cases (Campbell and Cohn, 1991; De Bortoli et al., 2013b; Friedman and Resnick, 2009b; Harris, 1994; Kauppi et al., 2008; Porter and Gavin, 2010; Wisner and Stowe, 1997). Despite the temporal association with childbirth, it has been demonstrated that depression during the post-partum period is not a type of mental disorder that is necessarily specific or unique to post-partum women (Cooper et al., 1988; Cox et al., 1993; Troutman and Cutrona, 1990). Rather than being the direct result of childbearing, post-partum depression may be a variant of a major depressive episode (albeit with post-partum onset) in women who are already predisposed to severe mood disorder (major depressive or bipolar disorder) independent of their puerperal status (Kumar and Robson, 1984; Porter and Gavin, 2010). There are likely to be a range of other contributory psychological variables (such as personality factors, a prior history of depression, ambivalence over parenthood, stress vulnerability, maternal neuroticism and introversion, interpersonal conflict, etc.) that are more relevant to symptom onset than simply the post-partum timing of the episode (Kumar and Robson, 1984; O’Hara et al., 1991; Porter and Gavin, 2010; Verkerk et al., 2005).

Whilst severe episodes of post-partum mood disorders may include psychotic symptoms, these are considered distinct from the syndrome of “post-partum psychosis”, which is a more severe form of post-partum mental disorder that usually necessitates urgent management in a specialist psychiatric in-patient setting. Post-partum psychosis is a relatively rare phenomenon,

presenting in only 1 to 3 per 1000 births, with symptoms usually emerging 2-8 weeks after delivery (Friedman et al., 2009; Porter and Gavin, 2010; Sit et al., 2006; Terp and Mortensen, 1998). Risk factors for post-partum psychosis are numerous, and include sleep deprivation, psychosocial stressors (e.g. interpersonal conflict, single parenthood, financial pressures, etc.), personality factors, a prior psychiatric history, psychiatric comorbidity and a variety of influential obstetric variables (e.g. perinatal hormonal shifts, primiparity, birth complications, etc.) (Friedman et al., 2009; Hay, 2009). Post-partum psychosis is also reported to be strongly related to an underlying genetic predisposition to mood disorders (especially of the bipolar type), with childbirth or its associated hormonal fluctuations considered precipitating, as opposed to causal, factors (Hay, 2009; Porter and Gavin, 2010; Sit et al., 2006; Tschinkel et al., 2007). As is the case with post-partum depression, longer term studies show that most women who experience a post-partum psychotic episode, will also experience subsequent mood and/or psychotic episodes irrespective of future childbearing (Lewis and Bunce, 2003; Robling et al., 2000; Valdimarsdóttir et al., 2009; Videbech and Gouliaev, 1995).

It also follows that child homicide attributed to be the direct result of post-partum mood or psychotic disorders are rare, as these post-partum syndromes are themselves relatively rare (Friedman, Horwitz et al., 2005). A direct implication of the introduction of early British legislation via the Infanticide Act of 1938 (which significantly influenced the drafting of similar legislation in many other countries) was that physiological changes accompanying birth or lactation were generally considered contributory to mental disorder, with the associated forensic implications in many cases of child homicide (e.g. prosecution against the lesser charge of infanticide rather than murder) (Malmquist, 2013). Infanticidal women were often portrayed as being incapable of acting otherwise i.e. lacking in criminal capacity for agency (a diminished responsibility defence was also available). Partly as a result of such statutes the

medico-legal precedent was created in which infanticide and neonaticide were distinguished from other forms of homicide in many parts of the world (Dobson and Sales, 2000). Whilst in the US all states handle infanticide in the same manner as other types of homicide (without any specific statutes for either infanticide or neonaticide), this is a model which is generally out of keeping with the many other countries in which such a distinction is still made (Malmquist, 2013). Most modern psycho-legal theorists, however, argue that women, like men, should be viewed as possessing agency in the first instance, rather than emphasizing limitations due to pregnancy or child-birth as being necessarily influential on homicidal behaviour and criminal capacity (Spinelli, 2004; 2005). Furthermore, the issue of malingering often arises in child homicide cases in which maternal mental health is in question, and especially those referred by courts for forensic evaluation. A review of neonaticide cases in Brazil (spanning almost a century of records), for example, found a clear increase in the number of women who claimed amnesia for the lethal act soon after the introduction of a 1940 infanticide statute that acknowledged the role of mental illness as a mitigating factor (Mendlowicz et al., 2002). The authors concluded that many of the women who claimed amnesia were malingering an essentially unverifiable symptom in an effort to escape criminal liability.

In summary, whilst many women experience relatively minor and transient emotional disruptions following childbirth, more severe forms of mental disorder, such as major depressive or psychotic episodes, that are directly related to the post-partum period itself are relatively rare. Most of the evidence suggests that such severe post-partum syndromes of mental disorder are not unique to the post-partum period in the majority of cases, but are rather manifestations of pre-existing mental disorder in genetically vulnerable women, with onset or occurrence that is triggered (for reasons that remain largely unknown) in the puerperal period.

The relationship between post-partum mental disorder and child homicide, however, remains complex and poorly understood.

Filicide

Whilst there is no absolute consensus on the matter, the following three broad categories and definitions are the most widely used in the child homicide literature: (a) “neonaticide” refers to the killing of a new-born child within 24 hours of their birth; (b) “infanticide” refers to the killing of a child up to one year of age, usually after his/her role in the family has been established; and (c) “filicide” refers to the killing of a child, irrespective of age, by a biological parent (Krischer et al., 2007; Porter and Gavin, 2010; Resnick, 1969; 1970). Since studies in this field have employed a range of definitions, study designs, sampling techniques, methodologies and theoretical approaches, comparisons between studies and drawing of clear conclusions are difficult. The violence of homicidal women is so frequently directed at their own children that many authorities consider filicide as a special category, with perpetrators usually viewed by lay people and professionals alike in stigmatized, prejudiced and pejorative ways (Oberman, 2003; Putkonen and Taylor, 2014). Whilst most research on the issue of child homicide has focused on filicide, neonaticide is also widely considered to be a distinct phenomenon and the latter will hence be considered separately from filicide in the literature review that follows (Malmquist, 2013; Porter and Gavin, 2010; Resnick, 1970).

Pre-offence Background. Filicide has been described as an offence that is substantially influenced by the psycho-social context in which it occurs, with variations in offender, victim and offence profiles being reflective of the broader context (Spinelli, 2004). The pre-offence background and characteristics of maternal filicide cases are varied and by no means uniform, being largely reflective of the many disparities in individual context, study design and setting,

sampling and definitions used. Many studies report the majority of filicidal perpetrators to be women i.e. mothers of victims (Goetting, 1988c; Putkonen, Amon et al., 2009; Putkonen, Weizmann-Henelius et al., 2009; Resnick, 1969). The assumption of maternal preponderance, however, is by no means certain, with some evidence that most filicidal offences are committed by fathers instead (Flynn et al., 2009; Liem and Koenraadt, 2008; Somander and Rammer, 1991). Data from the UK presented by Flynn et al. (2009), for example, reported the maternal:paternal filicide offender ratio to be as stark as 1:3, whilst others conclude approximate gender equivalence amongst perpetrators (Putkonen and Taylor, 2014; West et al., 2009). A number of features have been proposed to differentiate maternal from paternal filicide, include a range of victim and perpetrator profiles, method of killing, contextual factors and motives (Bourget and Gagné, 2002). Bourget et al., 2007). Whilst filicidal mothers are generally younger than filicidal fathers, they are similar in respect of the majority reporting troubled or abusive childhood's themselves (Friedman, Hrouda et al., 2005b; Putkonen et al., 2010; Putkonen, Amon et al., 2009; 2011; Putkonen, Weizmann-Henelius et al., 2009). Silverman and Kennedy (1988) focused on a comparison of women who killed their own children, as opposed to those who killed adults, and found that women who kill children in general are typically younger than those who kill adults. Nonetheless, there are divergent conclusions from different studies in this respect: filicidal women reportedly tend to be older (above 25 years of age) in a number of studies (Craig, 2004; Kauppi et al., 2008; Lewis and Bunce, 2003; Resnick, 1970), but relatively younger (with mean ages of under 20 years) in others (Overpeck et al., 1998). Rougé-Maillart et al. (2005) described two sub-groups of filicidal mothers: (a) relatively young, immature women in whom the abuse of their child victims had resulted in impulsive violence with a lethal outcome; as opposed to (b) older, married women, who are mostly gainfully employed and have good functionality, who kill their children in acts that tend to be pre-meditated and goal-directed. The profile of the former

group was generally similar to that of most neonaticidal mothers described by Friedman, Horwitz et al. (2005), who also tend to be single, of poor socioeconomic status, and who had sought or received minimal or no perinatal care.

Offence Profile. Most studies from Western countries have reported a slight male preponderance (55 – 60%) of filicide victims (Beyer et al., 2008; Brookman and Nolan, 2006; Crimmins et al., 1997; Oberman, 2003; Porter and Gavin, 2010; Vanamo et al., 2001). Victims of filicide in Asian countries such as China and India are more likely to be female (with a female:male ratio of up to 3:1 in India for example) (Oberman, 2003; Sahni et al., 2008). Whilst the possible underlying psychological motives for the killings may also differ between countries and cultures, together with socio-economic considerations, familial factors and socio-cultural attitudes to gender, the exact reasons for such inter-national discrepancies remain the subject of ongoing debate (Oberman, 2003; Porter and Gavin, 2010). Crimmins et al. (1997) conducted detailed interviews with 42 North American filicidal women, and found that almost half (47%) used physical force, without the use of weapons, to carry out the killing. Mothers are more likely to kill children by neglect, drowning or poisoning, whereas fathers tend to employ more overtly violent methods involving the use of weapons (e.g. shooting or stabbing) (Bourget et al., 2007). Furthermore, younger victims of filicidal women are more likely to succumb to smothering, strangling, suffocating and drowning, than by other means (e.g. starving, burning, poisoning, stabbing, cutting, shooting, gassing, exposure, blunt trauma or defenestration); whereas older children are most commonly battered to death (Brookman and Nolan, 2006; Herman-Giddens et al., 2003; Krischer et al., 2007; Mulryan et al., 2002; Porter and Gavin, 2010; Rougé-Maillart et al., 2005; Schmidt et al., 1996; Stanton and Simpson, 2002). There are also suggestions that offence motives may vary, in part at least, as a function of maternal age. The seminal study by d'Orban (1979) found that abuse-related child killings

(the majority of filicides in the study) were more frequently carried out by younger women, whereas “mercy killings”, killing related to spousal retaliation or psychotically motivated homicides were less common but more likely to involve older mothers (findings largely confirmed by Nielssen et al., 2009).

Forensic Mental Health Profile. Some have regarded the disintegration of the family unit as a particularly important risk factor for filicide (Mugavin, 2005; 2008). In line with this, there has been speculation that motivating influences for committing lethal violence tend to be more *intra*-personal for filicidal mothers, but more *inter*-personal for filicidal fathers (Putkonen, Amon et al., 2011; Putkonen and Taylor, 2014). Filicidal parents, and especially younger mothers, are widely reported to have relatively poor personal resources and resilience in coping with psychosocial stressors, exacerbated by a number of adverse contextual factors e.g. poor educational attainment; unemployment; socio-economic adversity; poor child rearing practices; impoverished primary support structures; interpersonal and family discord; domestic violence; substance misuse; and a history of being abused themselves (Bourget et al., 2007; De Bortoli et al., 2013b; Krischer et al., 2007; McKee and Shea, 1998; Overpeck et al., 1998; Putkonen et al., 2010; Putkonen, Amon et al., 2011; Stanton and Simpson, 2002; West et al., 2009). Wilczynski (1995; 1997) concluded that many women who killed their own their children did so due the child being unwanted or a hindrance in some way, when they are unable to cope with maternal care responsibilities, or as a direct result of severe psychopathology (especially psychosis); men are more likely to target non-biological children but when they do kill their own biological children, it is more often related to retaliatory and/or antisocial motives. Wilczynski argued that whilst filicidal women tend to offend as a result of bearing too much psychosocial responsibility for their victims, men tend to do so as a consequence of bearing too little.

The role of anger and coping skills, and how these are managed by infanticidal women, have been emphasized in a few studies. Crimmins et al. (1997) conducted life-history interviews with 42 convicted filicidal women, and found repeated physical and sexual victimization, self-harm, suicide attempts and substance abuse being commonly described experiences, especially amongst African-American women. They also reported these women to typically harbour a range of depressive emotions (e.g. feelings of worthlessness and low self-esteem), commonly display a reliance upon dysfunctional, and often abusive, intimate partners, and struggle to cope with maternal care responsibilities. Levitzky and Cooper (2000) found 70% of mothers caring for challenging infants with colic syndrome reported to having explicit fantasies and thoughts of aggression toward their children, whilst 26% harboured overtly filicidal thoughts. Similarly, Krischer et al. (2007), in a cluster analysis of 57 filicidal women, found a statistically significant association with poor anger management skills in the offenders.

There is some consensus that filicidal mothers are less likely than filicidal fathers to: (a) report rage, abuse, retaliation or angry impulsivity amongst their motives; (b) be intoxicated at the time of the filicidal act; (c) kill their intimate partners in addition to their child victims (Bourget and Bradford, 1990; Bourget et al., 2007; Marks and Kumar, 1993; 1996; Stanton and Simpson, 2002; Putkonen, Amon et al., 2011; Putkonen and Taylor, 2014). This notwithstanding, where severe mental disorder is present in filicidal offenders, the manner and extent to which this drives homicidal behaviour is not clearly established, and differs from individual to individual (Bourget et al., 2007; Friedman, Hrouda et al., 2005a; Porter and Gavin, 2010). Whilst there is evidence that many cases of filicide do not involve maternal mental disorder as a directly causal factor (De Bortoli et al., 2013b; Lambie, 2001; Marks,

1996; 2006; 2009; Porter and Gavin, 2010), and association between filicide and parental mental disorder (especially severe depression with psychotic features) has been documented by many studies (though prevalence rates vary significantly) (Bourget et al., 2007; Friedman and Friedman, 2010; Friedman and Resnick, 2007; 2011; Stanton and Simpson, 2002; 2006; Vanamo et al., 2001; Webb et al., 2007; West et al., 2009). A significant number of filicidal parents (up to 30% in the year prior to the offence) have sought professional mental health help prior to their offence, possibly more so with filicidal mothers (Bourget et al., 2007; Friedman, Horwitz et al., 2005; Putkonen et al., 2010), and some studies report up to 50% of women convicted of filicide are estimated to have a lifetime diagnosis of a severe mental disorder (Flynn et al. 2007; 2013).

With respect to the specific types of mental disorder associated with filicidal parents, Bourget et al. (2007) concluded from an extensive review of the research literature that up to 70% of filicidal mothers have depressive or psychotic disorders and are mentally ill at the time of their offences. This is in contrast to filicidal fathers, in whom rates of mental disorders were significantly lower (being approximately 20% for psychotic disorders, and 50% for depressive disorders respectively). Filicide is probably the offence most closely associated with severe forms of depression in women (Resnick, 1969; Putkonen and Taylor, 2014). In the British study of Flynn et al. (2007) rates of mental disorder were significantly higher amongst filicidal women than men, and the most common diagnostic category reported was depressive disorder and not psychosis. Similarly, in an investigation of depressive disorders in 45 filicidal mothers, Kim et al. (2008) reported the prevalence of bipolar depression in particular to be 73%, whilst severe depressive symptoms at the time of filicide were associated with post-partum onset, the presence of psychotic features, and a non-altruistic motivation for the offence. In addition, the majority of women had previously been sexually abused, very few had prior criminal records,

and none had violent offending histories. Over a third of women reported significant interpersonal conflict with the fathers of their victims, and most had multiple, severe psychological stressors preceding the filicidal act. Jennings et al. (1999) reported that over 40% of depressed filicidal mothers (compared to 7% of those without depression) in their study reported having regular pre-offence thoughts of harming their children or other violent cognitions, leading to fear in the women themselves of being alone with the infant or about their ability to care for them.

Filicide is also more closely linked to the subsequent suicide of the perpetrators than other types of homicidal offences, with up to half of filicidal women killing themselves soon after killing their child (or children) (Bourget et al., 2007; Adelson, 1991; Putkonen, Weizmann-Henelius et al., 2009; West et al., 2009). The strength of this association for men and women, however, varies between studies. Friedman, Horwitz et al. (2005), for example, reported that filicidal fathers had higher rates of suicide than filicidal mothers (40% versus 15% respectively). Similarly, Putkonen et al. (2010), in a study of Austrian and Finnish filicidal cohorts, showed that although a third of filicidal parents were significantly depressed (irrespective of gender) at the time of the offence, the suicide rates were in fact higher among filicidal fathers. Nonetheless, in murder-suicide cases that involve child victims, fathers also tend to more frequently kill both children and intimate partners (and mothers mostly only their children) prior to killing themselves (Byard et al., 1999; Lecomte and Fornes, 1998). Furthermore, Bourget et al. (2007) noted that suicide is significantly less common amongst women who kill infants, as opposed to those who target older children.

The role of psychosis (both primary psychotic disorders and in association with other mental disorders) in filicidal women in particular has also been the focus of some research

interest. A particularly high incidence of psychosis was reported by Friedman, Hrouda et al. (2005a) in their North American study of 39 filicidal women in forensic mental health care, and McKee and Shea (1998) found that whilst 80% of filicidal women had a confirmed psychiatric diagnosis, over half were suffering from a psychotic spectrum disorder. Similarly, Putkonen, Amon et al. (2011) found that whilst 80% of all filicidal offenders (regardless of gender) had at least one psychiatric diagnosis, psychotic disorders were significantly more common in women than men (35% versus 13% respectively), and women were also less likely to have non-psychotic depression than men (18% versus 30% respectively). This study also concluded that filicidal mothers were more likely than fathers to have co-morbid substance-related disorders, and to have lacked criminal capacity at the time of offending. Similarly, in a study of 55 filicidal women, Lewis and Bunce (2003) found the majority (53%) to be psychotic. Furthermore, it is reported that filicide by psychotic mothers more often than not involved children who were otherwise desired and well cared for; and that psychotic offenders also spontaneously (and often immediately) confessed to or disclosed their offence in most instances (as opposed to pre-meditated concealment of culpability). The study by Kauppi et al. (2008) of ten filicidal women with depressive disorders reported the majority (60%) to have had associated psychotic symptoms at the time of offending. Irritability, severely depressed mood, insomnia, fatigue, anxiety, suicidal ideation, and psychotic features were reported to be common elements in the clinical presentation. In addition, the filicidal event most commonly occurred when the maternal offender (often against her expressed wishes) was left alone with her child. Some studies of psychotic filicidal mothers also suggest that they may be more likely to use weapons, have better levels of education, and are less socially disadvantaged or socio-economically deprived than non-psychotic filicidal women (Lewis et al., 1998; Lewis and Bunce, 2003). Filicidal women with psychosis are also less likely to have prior criminal backgrounds than non-psychotic filicidal women (Porter and Gavin, 2010). Finally, whilst

alcohol abuse has been cited to be common amongst filicidal mothers, this is still to a lesser extent in comparison to filicidal fathers (Friedman, Hrouda et al., 2005a; Putkonen et al., 2010; Putkonen, Amon et al., 2011). Personality disorders, especially of the borderline type have also been associated with filicidal parents, and possibly more so in mothers (Bourget et al., 2007; Dolan et al., 2003; Putkonen, Weizmann-Henelius et al., 2009).

Despite the increased risk of mental disorder amongst filicidal women, this does not necessarily preclude the perpetrators from being criminally culpable. In d'Orban's (1979) study, for example, only one-quarter of the 89 filicidal cases involved mental disorder, with the majority of child killings reportedly motivated by other non-psychopathological factors (e.g. retaliatory acts against fathers of victims, or the removal of an unwanted child). Krischer et al. (2007), similarly report only one-quarter of their sample of 57 filicidal women to have been trial incompetent as a result of severe mental disorder. In South Africa, Khoele et al. (2016) conducted a review of the forensic clinical records of 32 women charged with the murder or attempted murder of their children. The mean age of the sample was 30 years, and over 40% had no mental illness. Psychotic and mood disorders comprised the majority of cases who were mentally ill (28% and 25% respectively); only 6% had a substance-related disorder; and none were reported to be personality disordered. The majority of women were found to be trial competent (70%), and criminally responsible (56%) for their offences.

Neonaticide

This was originally defined by Resnick (1969) as the killing of a child within the "first few hours of life", though it has become more widely accepted as killing within the first 24 hours of its life, a period during which children are at greatest risk of being killed (Porter and Gavin, 2010). Despite this, neonaticide is a crime of relatively low prevalence (Flynn et al.,

2007; Herman-Giddens et al., 2003; Marks and Kumar, 1993: 1996; Mendlowicz et al., 1998; Putkonen and Taylor, 2014). The large, population-based study by Herman-Giddens et al. (2003) in the US for the period 1985 – 2000, for example, reported a rate of 2.1 per 100 000 per year of newborn children were killed or deliberately left to die by a parent within a day of birth. Whilst mothers are most often implicated in the killing, neonaticide is not an offence that is exclusive to them (Flynn et al., 2009). Flynn et al. (2007) studied a series of 112 cases of infanticide in the UK between 1996 and 2001 (which constituted 4% of all homicides during this period), and found one-third of offenders to have been women. Whilst this demonstrated a significant shift in the usual overall ratio of female: male offenders from 1:9 to 1:2, women still remained in the minority in this sample. For cases in which children were killed within 24 hours of birth, however, only one of the 8 perpetrators was male. In addition, whilst 44% of children killed were under 3 months old, only 7% were under 24 hours old at the time of their demise.

Pre-offence Background. In general, the profile of the “typical” neonaticidal mother is described as a woman who is not mentally ill (or at least not severely so), who conceals an unwanted pregnancy, and kills the neonate whose presence is deemed unwanted; in addition neonaticidal women tend to be relatively young and immature single parents (often living with their own parents, and/or estranged from the victim’s biological father), socially isolated (during and after pregnancy), unemployed (or still attending school) and socio-economically impoverished (Beyer et al., 2008; Bonnet, 1993; Brookman and Nolan, 2006; Haapasalo and Petaja, 1999; Herman-Giddens et al., 2003; Mendlowicz et al., 1998; Oberman, 1996; 2003; Porter and Gavin, 2010; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007; Resnick, 1970; Sadoff, 1995; Silverman and Kennedy, 1988; Spinelli, 2001; Taguchi, 2006; Wilkey et al., 1982). Unlike women who commit neonaticide, women who kill older

infants tend to be older themselves (over 25 years of age), married, well educated, and whose homicidal acts are typically pre-meditated and goal directed (often as retaliation against another individual, usually, but not invariably, the biological father of the victim) (d'Orban, 1979; Kauppi et al., 2008; 2010; Krischer et al., 2007; Lewis and Bunce, 2003; Mulryan et al., 2002; Resnick, 1970). As for filicide, however, there have been a range of different, often opposing, conclusions on the socio-demographic profiles of neonaticidal women. Some studies, for example, have reported that most neonaticidal women are older, multiparous, married and relatively independent (Putkonen, Weizmann-Henelius et al., 2007), whereas others have concluded that neonaticidal women tend to be younger, single, primiparous and more dependent on parents or family (Beyer et al., 2008; Bonnet, 1993; Herman-Giddens et al., 2003; Kajese et al., 2011; Resnick, 1970; Tursz and Cook, 2011).

Offence Profile. The concealment or denial of the pregnancy and/or birth has been highlighted as a potentially important factor distinguishing neonaticidal from infanticidal cases (Porter and Gavin, 2010). In a study of all neonaticide cases in Finland between 1980 and 2000, Putkonen, Collander et al. (2007) found that two-thirds of the mothers had been pregnant previously, and almost one-third had previously concealed a pregnancy. Mothers who deny or conceal their pregnancies typically also make inadequate or no preparations for the labour, birth (which are often unattended) or post-natal care, further increasing the vulnerability of the neonate (Green and Manohar, 1990; Putkonen, Collander et al., 2007). Many studies identify a few common paediatric factors which are postulated to heighten the risk of both neonaticide and infanticide by making essential care-giving significantly more difficult, and triggering potentially violent responses by the mother e.g. prematurity, low birth weight, feeding and sleeping difficulties, persistent crying, failure to thrive, physical or intellectual disability, and so forth (Friedman, Horwitz et al., 2005; Kajese, et al., 2011; Overpeck et al., 1998; Wissow,

1998). Furthermore, most victims of infanticide are born in hospital, as opposed to neonaticidal victims who are born mostly outside hospital, often at or in close proximity to the maternal home (Overpeck et al., 1998). In a survey of neonaticide cases by Crittenden and Craig (1990), almost two-thirds of victims were discovered in domestic refuse bins or refuse sites close to the maternal home. None of these were matched to missing person reports, suggesting probable intentional concealment of the murder following birth. Many neonaticidal mothers in other studies similarly report being under the mistaken impression that the baby was stillborn (Friedman, Horwitz et al., 2005; Overpeck et al., 1998; Porter and Gavin, 2010; Putkonen, Weizmann-Henelius et al., 2007). In their survey of 40 neonaticidal mothers, Beyer et al., (2008), however, found that over half of the women had experienced previous pregnancies, precluding claims of being completely unaware of their pre-offence pregnancy or that the baby was born alive. In addition, the majority of the women progressed through labour and killed their neonates undetected (but often in close proximity to others), rarely called for help (also suggesting intentional secrecy and concealment), and did not suffer from mental disorder. Similarly, in a study of 81 women who had either concealed or denied their pregnancies, Friedman et al. (2007) documented none to have been psychotic, with a psychiatric assessment only request in under 5% of the women.

In terms of methodology, the majority of neonaticidal acts are committed without the use of weapons, and two broad types are generally cited: (a) the more common “active” neonaticide, characterized by a violent, specifically goal-directed lethal act e.g. suffocation, battery, strangulation, poisoning or drowning; and (b) “passive” neonaticide involving either gross neglect (e.g. food and/or water deprivation, or exposure) or deliberate withholding of essential medical care (Bonnet, 1993; Herman-Giddens et al., 2003; Marks and Kumar, 1993; Porter and Gavin, 2010; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et

al., 2007). Due to their small size and vulnerability, the murder of neonates also requires minimal physical strength or skill, partly explaining the fact that very few neonaticidal women use weapons to commit the murder (in contrast to women who kill older children and adults) (Porter and Gavin, 2010).

Forensic Mental Health. Though the crime is relatively poorly understood, the most commonly cited motive for neonaticidal violence appears to be the elimination of an unwanted child; and in the case of many older, married female perpetrators, in connection to extra-marital paternity (Bourget et al., 2007; Craig, 2004; Putkonen, Weizmann-Henelius et al., 2007; Resnick, 1970). Nonetheless, given the proximity to the birth, cases of neonaticide have often raised the question of physiological and neuro-hormonal factors associated with the perinatal period and delivery, and their impact on mental health and behaviour (Porter and Gavin, 2010). Neonaticidal mothers commonly report feelings helplessness and powerlessness, social and emotional isolation, perceptions of rejection and abandonment (often in the context of cultural and religious beliefs about termination of pregnancy), and fear of incurring the anger of parents, partners and/or significant others; and also described as having relatively poor resilience or coping skills in dealing with these psychosocial stressors (De Bortoli et al., 2013a; Porter and Gavin, 2010). Furthermore, irrespective of the uncertainty around specific aetiological pathways, there exists a distinct minority of cases in which women develop severe mental disorders (e.g. post-partum psychosis or post-partum mood disorders), or who suffer from pre-existing serious mental illness that impact on the offence or its aftermath (Dobson and Sales, 2000).

As for filicide in general, research conclusions on psychosocial risk factors and the mental health profiles of neonaticidal women have been diverse, influenced in part by

differences in study setting and design (Friedman and Resnick, 2007; 2009a; De Bortoli et al., 2013a; Porter and Gavin, 2010). Some studies describe the psychological profile of many neonaticidal mothers to display patterns of immature demeanour, denial, la belle indifference, timidity, and below average intelligence (De Bortoli et al., 2013a; Spinelli, 2001). Others yet find many neonaticidal women describe experiencing dissociative symptoms, amnesia, depersonalization or transient hallucinatory phenomena (though the possibility of malingering in the forensic context cannot always be excluded) (Beyer et al., 2008; Friedman, Horwitz et al., 2005; Porter and Gavin, 2010; Spinelli, 2001). Some evolutionary theorists have hypothesized that mentally ill mothers who commit neonaticide tend to display a less diverse range of psychopathology as compared to mothers who commit other types of filicidal acts, though reasons for this, if true, remain uncertain (Ciani and Fontanesi, 2012). The sub-sample of neonaticidal women who are truly mentally unwell as a result of severe forms of mental disorder (e.g. psychotic disorders) present a different profile to those who are mentally well, as the former tend to be older (above 25 years of age), married, have other children, are attentive to antenatal care, and neither conceal nor deny the pregnancy, nor the neonaticidal act for that matter (De Bortoli et al., 2013a). Neonaticidal women with mental disorder, however, are more likely to have had pre-offence psychiatric problems necessitating hospitalization (De Bortoli et al., 2013a; Friedman and Resnick, 2009a; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007). The Finnish study of Putkonen, Collander et al. (2007) of 14 neonaticidal women who underwent forensic psychiatric evaluation, found around 30% to have presented with psychotic symptoms. Similarly, Krischer et al. (2007) found psychotic disorders to be the diagnostic group of disorders most strongly associated with neonaticide in the US in their study of 15 Finnish neonaticidal mothers, Haapasalo and Petaja (1999) reported that these women to be significantly less likely to seek professional help for psychiatric or psychological problems prior to the offence, in comparison to mothers who had killed older children. The

authors concluded that mental disorder was not a particularly relevant variable in the majority of cases, although around 30% of women in their sample reported “psychological problems”. Whilst the majority of neonaticidal women do not have severe mental disorder, increased rates of personality disorder have been highlighted by a few studies (Pitt and Bale, 1995; Putkonen, Weizmann-Henelius et al., 2007; Resnick, 1970; Sadoff, 1995; Spinelli, 2001). The presence of a diagnosed mental disorder, however, does not necessarily render women trial incompetent nor absolve them from criminal responsibility. Beyer et al. (2008), for example, reported that all 40 female neonaticidal defendants in their study were found to be fully criminally responsible, with their actions judged to be motivated more by personal gain (e.g. not wishing to feel encumbered by the responsibilities of caring for an infant) as opposed to lethal violence related to mental illness per se.

In summary, the bulk of the evidence seems to suggest that: (a) neonaticidal women suffer less frequently from severe psychiatric disorders in comparison to other female homicidal offenders, and are not usually mentally unwell at the time of the offence; and (b) neonaticide is not commonly associated with severe forms of mental disorder, including post-partum psychosis, post-partum mood disorders or maternal suicidality (Beyer et al., 2008; De Bortoli et al., 2013a; 2013b; ; d’Orban, 1979; Haapasalo and Petaja, 1999; Friedman, Hrouda et al., 2005b; Oberman, 2003; Putkonen, Collander et al., 2007; Silverman and Kennedy, 1988; Spinelli, 2001; 2004; 2005).

Typologies of Child Homicide

Being such a complex, heterogeneous and multi-faceted phenomenon, child homicide has proved difficult to categorize, with numerous classifications, mostly arranged by motive, proposed over the years (Putkonen and Taylor, 2014; Silva and Leong, 2003). Child killings,

particularly filicide, have been attributed to having triggers or motives motivations rooted in a range of complex psychological (though not necessarily psychopathological) factors that occur in the context of, for example, perceived altruism, unwanted children, interpersonal conflict, retaliation or revenge, abusive, impulsive or accidental events, extended murder-suicide phenomena, and mental health problems (Bourget and Bradford, 1990; Bourget and Gagné, 2002; Bourget et al., 2007; Bourget and Labelle, 1992; d'Orban, 1979; Marzuk et al., 1992; McKee, 2006; Resnick, 1969; 1970; Rougé-Maillart et al., 2005; Scott, 1973; Somander and Rammer, 1991). Resnick (1969; 1970), Scott (1973) and d'Orban (1979) were the first researchers to propose structured typologies to describe, categorize and ultimately help understand filicidal events. From their initial proposals, numerous subsequent approaches of varying focus and clinical utility have been proposed, the most prominent of which are summarised in Table 8. Both Resnick's and d'Orban's classifications remain the most widely referenced and utilized, and are reviewed in further detail below.

Table 8

Typologies of Child Homicide by Women (in chronological order of publication)

Classification reference	Categories
Resnick (1969; 1970)	Altruistic killing Acute psychosis / delirium Unwanted infant Abusive / accidental Spousal revenge Neonaticide
Scott (1973)	Unwanted child Mercy killing Gross mental pathology Stimulus arising outside victim Stimulus arising from victim
D'Orban (1979)	Battering mothers Mentally ill mothers (neonaticide) Neonaticide Retaliating mothers Unwanted children
Bourget and Bradford (1990)	Mercy killing Pathological (altruistic or homicide-suicide)

Classification reference	Categories
Guileyardo et al. (1999)	Accidental (battered child or non-lethal intent)
	Retaliating
	Neonaticide
	Paternal
	Altruistic
	Euthanasia
	Acute psychosis
	Postpartum mental disorder
	Unwanted child
	Unwanted pregnancy (infanticide)
	Angry impulse
	Spousal revenge
	Sexual abuse
	Munchausen's syndrome by proxy
	Violent child
	Negligence / neglect
	Sadistic punishment
	Drug / alcohol abuse
	Seizure disorder
Bourget and Gagné (2002)	Innocent bystander
	Mentally ill
	Fatal abuse
	Retaliating
	Mercy killing
McKee (2006)	Other/unknown
	Detached mothers
	Abusive/neglectful mothers
	Psychotic/depressed mothers
	Retaliatory mothers
	Psychopathic mothers

Resnick's (1969) pivotal study on the psychiatric aspects of filicide categorized 88 cases on the basis of primary motive into: (a) "altruistic killing", where the mother kills her child as a means to relieve its perceived, or actual, suffering; (b) "acute psychosis / delirium", where a mother with severe mental disorder kills her child as a direct result of psychopathology (e.g. in response to auditory hallucinations or persecutory delusions); (c) "unwanted infant", where the child is killed as it is regarded as an intolerable hindrance in some way; (d) "abusive / accidental", where the child's death is a result of severe parental abuse and the violence is usually impulsive and enraged in nature; and (e) "spousal revenge", where the child is killed

in a pre-meditated fashion as a means of exacting harm, retaliation or revenge on the child's father. A sixth category of "neonaticide" was subsequently introduced by Resnick (1970). Friedman et al. (2009) examined the influence of mood and psychotic symptoms on Resnick's motive categories and concluded that: (a) child killings by acutely mentally ill mothers, or for altruistic reasons, are likely to be related to post-partum mental disorders (especially psychosis or depression); (b) infants who die as a result of severe parental neglect or fatal maltreatment are rarely related to maternal mental illness; and (c) unwanted children and those killed to exact spousal revenge are not likely to be related to maternal psychopathology either. Friedman et al. also emphasized that mental disorders are often diagnosed after the offence, and do not necessarily reflect the maternal mental state at the time of the offence. Furthermore, the extent to which Resnick's typology can be applied to the killing of infants under one year of age is unknown, though most evidence suggest most of these to be the result of parental abuse (De Bortoli et al., 2013b).

In another seminal longitudinal study of 89 mothers charged with the murder or attempted murder of their children by d'Orban (1979) also identified six groups: (a) "battering mothers" (36 cases) with impulsive and unstable backgrounds, who have been abused themselves, and present with a range of non-psychotic forms of mental ill-health (including personality disorders, depressive disorders, and intellectual disability); (b) "mentally ill mothers" (24 cases) who have severe psychotic disorders (with half of these having "puerperal psychosis"), mood disorders and/or personality disorders; (c) "neonaticides" (11 cases), in which the child was killed within 24 hours of birth, most commonly unwanted babies born to young, single mothers, who are first-time offenders; (d) "retaliating mothers" (9 cases), in which intense interpersonal conflict with partners results in the killing of children as a form of retaliation or revenge, with offenders mostly diagnosed with severe personality disorder; (e)

“women who kill unwanted children” (8 cases), in which the offences were either deliberate (albeit often impulsive) antisocial acts, or where children succumbed to severe neglect by passive and/or immature mothers; and (f) “mercy killing” (1 case) where children with medical illness, disability or deformity are killed as a perceived altruistic act to relieve suffering. Furthermore, 27% of infanticidal cases involved maternal mental disorder, but only for childhood victims under 2 years of age; the proportion of maternal mental disorder increased to 36% in cases of child victims above 5 years of age. In addition, approximately 70% of the infanticidal deaths were primarily due to maternal abuse (unrelated to maternal psychopathology), with a similarly high rate (61%) found by Overpeck et al. (1998). Other studies of child homicide have also found the high rates of prior abuse of the child victims (especially those younger than 2 years of age), with estimates ranging from 36% to 64% of cases (Nielssen et al., 2009; Kajese et al., 2011; Klevens and Leeb, 2010). Similarly, an Australian study by Nielssen et al. (2009) reviewed 165 cases of child homicide, and reported that the mean age of victims of abuse was significantly younger than those killed in the context of maternal psychosis (1.5 years versus 4.5 years respectively).

A number of subsequent researchers have placed greater emphasis on the psychological health of the women concerned, as opposed to specific psychiatric diagnoses, especially in relation to their individual personal, social and contextual circumstances (Friedman, Horwitz et al., 2005; McKee, 2006). In an analysis by McKee (2006) of the psychological evaluations of 32 adolescent girls and women who killed their biological children, for example, explanatory models with an emphasis on the psychological underpinnings of maternal filicide were generated. These emphasized the importance of understanding the role of individual psychological factors in driving these events e.g. lack of attachment to child victims; emotional distress as a result of daily life stressors; inadequate parenting systems; individual temperament

and personality profile; and the unique features of any maternal psychopathology. As a result, McKee introduced a classification system of child homicide that emphasized these broader elements of psychological health (Table 8).

Qualitative Studies of Homicidal Women

Research on women offenders with mental illness has been heavily biased toward quantitative studies that seek to categorize such women, as opposed to understanding them, or studies that focus on motives as opposed to recovery (Stanton and Simpson, 2002; 2006). Qualitative studies which explore the unique, individual perspectives and personal experiences of women offenders (especially those who commit homicide) with mental illness are even rarer, though there are a few illustrative and important research efforts that have been made in this regard. Chesney-Lind and Rodriguez (1983) conducted detailed interviews with incarcerated women in Hawaii (though not limited to those who committed homicide), and found the majority of their life histories to be characterized by high rates of prior victimization, which the authors concluded had resulted in a “process of criminalization unique to women”. Three central themes emerged from their thematic analysis: (a) histories of family violence, abuse, loss and/or neglect; (b) clustering of significant, “turning-point” events around early adolescence; and (c) events surrounding entry into criminal activity. It was proposed that such young girls and women turn to offending in their efforts to save themselves from cycles of further abuse. After fleeing their abusers, many are forced into offending by facing very limited choices to extricate themselves from vulnerability, related to a complex array of psychosocial factors: poor education; poor employment prospects; poverty; poor support systems; dependence on criminal and abusive men; substance dependence; limited resilience; and poor mental health. Chesney-Lind (1986; 1988; 1989) held further that the greater the severity of prior, especially childhood-onset, abuse of female offenders, the greater the level psychological

trauma and distress experienced by the survivors. The strong linkages between prior abuse, depression and substance abuse in female offending pathways were highlighted, and it was argued that women often employ a range of survival strategies (such as leaving the abusive domestic environment, prostitution, and involvement in complex interpersonal relationships), which may inadvertently serve to heighten the likelihood of violent offending. In other words, Chesney-Lind viewed the process by which women who are victims of violence come to be transformed from victims/survivors into offenders to be inextricably intertwined with the subordination of women in society. In other words, victimization by violence, coupled with economic marginality related to race, class and gender, then blurs the boundary between victim and offender.

Similarly, Gilfus (1992) conducted a qualitative study exploring the patterns by which women enter into criminal activities life history interviews with 20 women incarcerated in a North American prison for a range of offences. The interviews explored a range of potentially influential gendered factors e.g. socializing experiences, gender role interpretations, victimization histories, poverty and racism. A conceptual understanding of the longitudinal progression from victim to survivor to offender was constructed by thematic analysis. Like Chesney-Lind, Gilfus suggested that escape from male-perpetrated violence for many women took the form of “criminal survival strategies” such as fleeing their families or homes, substance abuse and immersion into street-crime. Their responses to abuse and violence, as well as their relational identities, were proposed to be factors which both motivated, but also potentially restrained, their subsequent criminality.

Martin and Hesselbrock (2001) focused on the complex emotional needs of female offenders by examining the interactions between women’s criminal histories, abuse-

victimization, personal relationships, individual strengths and vulnerabilities, and mental health, in a sample of convicted women prisoners in the US. Intensive interviews were conducted on 49 volunteers, and a cluster analysis yielded four categories of incarcerated women, that shaped recommendations for mental health assessment and treatment. Firstly, the “spirited” group, comprised women who committed substance-related offences, with relatively little childhood abuse histories and relatively good family support structures, but who also had relatively high rates of physical intimate partner abuse and mental disorder. Secondly, the “inured” group, comprised mainly of women who committed acquisitive offences, with average rates of childhood abuse and mental disorder, but high rates of sexual abuse. Thirdly, “the troubled” group of violent women offenders, with the highest rates of both traumatic childhood abuse experiences and mental disorder, especially PTSD, depressive disorders and antisocial personality disorder; and who also had poor social or family supports, but were the least likely to abuse substances extensively. Finally, “the volatile” group, being young women with a mixed offence profile (of property, public order and violent offences) from harmful and chaotic home circumstances, who also had relatively high rates of mental disorder (especially major depressive disorder, PTSD and alcohol dependence), high rates of sexual abuse, and the lowest levels of social and family support. This study reported particularly high lifetime prevalence’s of major depressive disorder (62%), PTSD (45%), substance dependence (above 40%; especially alcohol, opiates and cocaine), antisocial personality disorder (33%). Martin and Hesselbrock concluded that incarcerated women with the greatest vulnerability to mental health problems had experienced the greatest levels of abuse and violence as children, had the lowest levels of social and family supports, and exhibited a greater risk of subsequent violent offending themselves. Caution was, however, issued against generalization and simplification of the nature of these risks and vulnerabilities, as not all have mental disorder, substance abuse or abusive backgrounds which directly contribute to offending behaviour. Rather, Martin and

Hesselbrock emphasized the influence of set of complex inter-relationships between risk and vulnerability factors on the one hand, and resilience and protective factors on the other. Hence, healthy emotional bonds, and the moderating effect of parental, family and social support, may promote resilience and be protective against both mental ill-health and proclivity to violent behaviour.

In a large qualitative thematic-analytical study, Stroud (2008) focused on the pre-offence experiences of 68 British adults charged with child homicide or attempted homicide, 60% of whom were women. The majority of offenders (78%) were close relatives of child victims (as parents, parent substitutes or close family members), and a disproportionate number (one-third) were from minority groups. Most victims were young, with 70% being under five years of age when they were killed. Most offenders had experienced prior multiple, severe forms of childhood adversity, including parental separation, family discord, abuse and/or neglect, unstable homes and social instability. Stroud suggested that such experiences predisposed these individuals to psychological distress and mental illness: over half of the offenders (53%) had received pre-offence mental health care; 38% had attempted suicide; and 31% had received in-patient psychiatric treatment; and almost half were diagnosed with psychotic disorders, 20% with personality disorders and a further 20% with depressive disorders. Around one-third had experienced their first episode of mental disorder at around the time of the offence. Delusional beliefs were the most frequent form of psychopathology (documented in 44% of these cases), with psychotic individuals reported to have carried out the most severe violence (using knives in the majority of instances). Whilst most psychotic perpetrators were also parents or carers, 4 of the 6 stranger-perpetrated homicides occurred in this group. In perpetrators diagnosed with depressive disorders (the majority of whom were biological parents of victims), motives appeared to be related to perceptions of hopelessness and desperation, with the murder intended

to alleviate suffering (in both themselves and their children). In all cases, there was an apparently precipitating stressor just prior to the offence, especially one featuring a significant loss or threat. In 12% of cases, the murder reportedly resulted from parental loss of behavioural control, following frustration or anger at the behaviour of the child (all of whom were under 2 years of age); most of these offenders had a history of abusing their children in the past, denied the offence initially, and also had no diagnosed mental disorder. A further 12% of cases killed their children as “attention-seeking behaviour in order to meet their own psychological needs” in their intimate partner relationships. All but one of this group of perpetrators were young women (under 20 years of age) who had previously sought some mental health assistance. Another group of perpetrators (also around 12% of cases) described their predominant experience of being unable to cope with, or accept, their children, with the homicidal act intended to remove the perceived source of their difficulties. All of these were biological mothers of young victims (under 2 years old), with the perpetrators described as being “psychologically vulnerable” in the face of significant conflict with their families and/or intimate partners, but none of whom were diagnosed with a mental disorder. Almost two-thirds of individuals in Stroud’s sample also experienced long-standing relationship problems, especially with intimate partners and/or close family members. These relationships were characterised as being unsatisfactory for a variety of reasons, including: communication difficulties; feeling isolated or unsupported; abuse at the hands of those close to them (reported in 50% of cases); and a poor understanding of the mental health needs of offenders. Over half of perpetrators had previously committed or threatened violence toward others (including their children). The vast majority of perpetrators (90%) described having “very stressful lives” overall, though this was a heterogeneous and ill-defined category. Ultimately, three main, inter-related themes emerged from Stroud’s (2008) study: (a) the presence of pre-offence interpersonal conflict with significant others; (b) the heterogeneity of adverse, stressful life

circumstances (family, social, economic, occupational, etc.); and (c) the role of these first two variables in producing psychological distress and mental illness. It was proposed that possible attachment deficits between the child victim and offender in the context of significant daily psychosocial distress, compromises the offenders' ability to form healthy relationships with significant others (i.e. not just with their child victims), impairs her capacity to develop and sustain a sense of self-worth, and erodes her resilience to adversity and conflict. A cycle of ongoing interpersonal conflict, adversity and psychosocial distress, especially in settings without sufficient support available, ultimately contributes to the culmination of violent offending. Stroud held the view that conventional mainstream policies and practices that focus mainly on procedures and performance in the safeguarding of children, may not adequately address the complex intra- and inter-personal needs of the adults who pose a risk to these children. Early supportive and therapeutic mental health and social services to specifically engage with and address interpersonal conflicts were recommended.

In one of the very few qualitative studies focusing specifically on child homicide by women with mental disorder, Stanton et al. (2000) conducted interviews of six such women from New Zealand and thematically analysed the interview transcripts. The women were mostly white, and relatively young (in their twenties) at the time of the offence. All described intense investment in, and dedication to, the mothering of their children. No clear, consistent or extreme pre-offence external stressors were in evidence in any of the women, nor was prior abuse of the perpetrators themselves a prominent feature of their histories. Most women recalled little or no 'warning', nor planning of the filicidal offence, and none felt socially isolated nor particularly distressed just prior to the homicidal event. All women, however, had diagnosed severe mental disorder (a mood or psychotic disorder) requiring active and sustained treatment by a mental health service over a period of at least one year prior to the offence.

Suffering from severe mental illness was universally described as being particularly stressful, and mental disorder had negatively impacted on the mothering experience of all women interviewed (by its effects on relationships, sleep, motivation, daily functionality, meeting maternal responsibilities, etc.). Descriptions of their children were generally unremarkable (most were young, ranging from a few weeks to 7 years of age), but all women described a deep commitment to ensuring the welfare of their children prior to the offence. Most women were unable to provide well organized or detailed accounts of their offences, with recollections of the homicidal event being patchy but distressing, and which they tended to avoid thinking or talking about. Methods of killing included stabbing, fire-setting, drowning, suffocation and jumping off a building. Motives for this particular group of women were characterised as either: morbidly and mistakenly 'altruistic' in nature, especially regarding attempts at saving or protecting the child from a psychotically-based fear or threat, or as an extension of a suicide attempt, especially in the context of severe depression (as opposed to children dying due to maternal neglect or deliberate abuse). Intense self-judgement and self-loathing followed the homicide, with all the women bitterly regretting the killing, and deeply mourning their loss. Whilst all women knew they were mentally ill at the time of the homicidal act, all described nonetheless some intention to kill at the time, and were aware of their actions and its consequences. None of the women attempted to evade detection following the offence; on the contrary, most contacted family, friends, neighbours or the authorities to report the event immediately or soon after it had occurred. All women felt personally responsible for the demise of their children, though they were also all found to lack criminal capacity, and were declared by courts to be not guilty by reason of insanity. The women were particularly distressed about ongoing perceptions of others that they presented a persistent danger to other/all children, and many had been rejected by their families, partners, other children and home communities as a result. Managing their mental illness was not considered a major challenge; rather,

acknowledging the role of mental disorder in the commission of the offence was considered important to the recovery and rehabilitative process, and all the women valued ongoing relationships with surviving children and their families. Stanton et al. (2000) concluded that there are problems with conventional approaches to the identification of risk and prevention of filicide by mentally ill women. Precursors to the offences were complex, and the aftermath traumatic and devastating. The offenders were otherwise caring, nurturing and dedicated mothers, with little or no sense of filicidal urges, intent or violence preceding the event. Psychosocial stressors were more likely to precipitate mental illness, as opposed to the homicidal act itself, in the women interviewed. In summary, a combination of multiple contributory and contextual factors, more closely related to the unique features of individual maternal psychopathology than to clearly identifiable precipitating psychosocial stressors, converged and culminated in filicidal behaviour. Stanton et al. proposed the early identification and treatment of mental ill-health (especially in high-risk mothers) as the most important potentially preventive strategy in these situations.

In a follow-up qualitative study of the same women interviewed by Stanton et al. (2000), Stanton and Simpson (2006) focused on descriptions of their post-offence recovery experiences. A central focus of the thematic analysis was an exploration of how roles, responsibilities and agency, in the context of mental illness and filicidal offending, were addressed during the process of forensic mental health rehabilitation and recovery. A number of key themes were noted, including: difficulty managing the horror of memories of the homicidal event; the detached, third-person language often employed in describing the offence; the intense self-hatred and regret which posed the main obstacle to self-forgiveness; the importance of their roles as mothers, and their ambivalence about this identity following the offence; the unexpected and overwhelming support they received from their families and

mental health care workers in the aftermath; the unpleasant and distressing experiences of the criminal justice system and its agencies; how improving personal relationships with family and friends was considered crucial to recovery; and how mental illness was seen by most as a relief in respect of efforts to understand the filicidal event, and in accepting the need for forensic mental health care. A number of important therapeutic goals and recommendations were highlighted e.g. prioritizing and optimizing treatment of mental illness; rebuilding a sense of self-worth, especially as a good mother when not deflected by the reality distortions of severe mental illness; supporting women in acknowledging the role of mental disorder in the commission of the offence, and in so doing managing the guilt and self-hatred experienced; developing insight into mental illness in order to engage with treatment, promote recovery and facilitate regaining of the maternal; and maximizing contact with, and support from, close personal networks.

A more recent case series report from South Africa provided a qualitative summary of the profile of filicidal women with severe mental illness in a female forensic unit in Johannesburg (Edge et al., 2017). The majority of offenders were diagnosed with psychotic or mood disorders, and all had committed offences directly related to their psychopathology (e.g. as behavioural responses to command hallucinations or persecutory delusions). A disproportionate number of women had prior mental ill-health, suicide attempts, substance abuse or violent behaviour. In addition, pre-offence backgrounds reflected numerous early psychosocial sources of distress, including: lack of parental involvement; rejection from parental figures; early separation from primary caregivers; socioeconomic distress; poor social support systems; domestic violence and family conflict; marital discord; and prior abuse. The authors reflected on the mental health effects of such pervasive psychosocial stressors on the women concerned, the majority of whom displayed a range of psychological difficulties, such

as: poor coping skills; feelings of neglect, abandonment or ambivalence; fearfulness and generalized anxiety; hopelessness, pessimism, apathy and ruminative thoughts; impulsivity; emotional dysregulation; poor self-esteem; and poorly developed self-image. Following the offence, their distress of many women was compounded by the fact that they were alienated from the fathers of their victims, and often rejected by their families and surviving children. The authors recommended the need for further qualitative research on women offenders, especially in the context of impoverished, developing countries such as South Africa.

Recidivism by Homicidal Women with Mental Disorder

Associations between mental disorder and homicidal recidivism has been described in both men and women (Bonta et al., 1998; Eronen et al., 1996a; Monahan, 1988; Putkonen, 2003; Robertson et al., 1987; Tehrani et al., 1998; Tiihonen and Hakola, 1994; Widom, 1989b; 1989c). Violent recidivism has also been associated with severe personality disorder (especially psychopathy), though most studies are on male samples (DeJong et al., 1992; Harris et al., 1991). Studies specifically on any type of recidivism (especially homicidal recidivism) in women are rare and data is sparse. Nonetheless, a Canadian study of Robertson et al. (1987) found female offenders in general to be recidivist in almost three-quarter of cases, with a strong association with substance-related disorders. Psychopathy in female offenders is reportedly less severe in its behavioural manifestations, and less predictive of subsequent violent recidivism (Salekin et al., 1998).

Since female-perpetrated homicide is a relatively rare event, longer term outcome studies on these women are also rare, but the available evidence highlights the vulnerability of these women to poor outcomes in a number of respects. The most extensive studies of this nature were conducted in Finland. Putkonen, Komulainen et al. (2001) reported from a study of all

132 Finnish female homicide offenders between 1982 and 1992, that 22 (17%) had died within 7 years of their index offence (8 from medical causes, 6 suicides, 6 accidents, 1 homicide and 1 undetermined cause). The majority (almost 70%) were diagnosed with a personality disorder, followed by psychotic spectrum disorders in over one-fifth of cases. The results showed a 200-fold elevation in risk of unnatural death in comparison to women in the general population, rising to a 400-fold higher risk for suicide in young homicidal women in particular. Whilst no statistically significant associations among any background variables were apparent, there was a higher trend among homicide offenders toward disproportionately increased mortality rates. The risk of recidivism on the same sample of homicidal women from 1982-1992, followed up for up to 17 years, was analyzed by Putkonen et al. (2003). Fifty-six percent of all women had committed another offence (33% of these were violent in nature) prior to the homicidal one. Of these, the majority (78%) had a personality disorder, whilst 18% had a psychotic disorder. Following the homicide, nearly a quarter of subjects (23%) had re-offended within the study follow-up period. A subsequent violent offence was committed by 15% of the women, and 4 of them committed a second homicide (these rates were similar to reoffending rates of men in Finland). In comparison to the original sample, a greater majority of recidivist's were personality disordered (81%), fewer were psychotic (10%), and over 90% had a prior conviction (in addition to the index homicide offence). Re-offending frequently took place soon after the index homicide offence, with almost 50% re-offending within 2 years. Eleven of the re-offenders did so either before their conviction for the index homicidal offence or whilst institutionalized in a forensic psychiatric hospital. Eighty-percent of the others re-offended within two years of their discharge from the prison or forensic facility. The odds ratio for violent reoffending was not significantly increased in the homicidal women, in comparison to other violent female offenders. In the regression analysis, a prior offending history was a best single predictor of re-offending, with personality disorder increasing the risk, and psychotic

disorder reducing the risk, respectively. Factors cited to be significantly associated with recidivism in these women were young age, prior criminality, substance misuse and personality disorder, confirming similar to earlier findings reported by Eronen (1995).

Whilst there is very limited data on the topic of female homicidal recidivism, in one of the earlier Finnish studies, Tiihonen and Hakola (1994) found that Finnish homicidal recidivists of either gender almost always have a psychiatric diagnosis, with schizophrenia, severe alcohol dependence and paranoid personality disorder being the most prevalent. There is even less data on filicidal recidivism by women, though the high risk of future maladaptive behaviour, relapse of mental illness, and repeated violence (including of a potentially lethal nature) has been noted in filicidal women with severe mental disorder (Porter and Gavin, 2010). Whilst women extremely rarely become serial killers, when it does occur the motive is commonly cited to be material gain in personality disordered women who knew their victims well (e.g. in a carer relationship with the victim), which represents a significant difference from male serial killers who tend to murder strangers (Putkonen and Taylor, 2014). Methods of female homicidal recidivists are usually covert, with sadistic or sexual gratification hardly ever described, again in stark contrast to male homicidal recidivists (Frei et al., 2006; Harrison et al., 2015). In their extensive analysis of 64 North American female serial killers, Harrison et al. (2015) reported almost 40% to suffer from a diagnosed mental disorder (especially mood, psychotic and personality disorders). However, only 9 of these women had received treatment for mental illness, and only 6 received such treatment prior to the serial homicides they perpetrated. The women in the study were typically white, well educated, married, held care-giving roles (e.g. as mothers or health-care workers), and were closely related to their victims. Mass murders of strangers by women (e.g. at schools or in public spaces) are even more atypical, although

women do occasionally kill as part of extremist political or war-based actions e.g. female suicide bombers (Putkonen and Taylor, 2014).

Conclusion

Whilst homicide remains a largely masculine phenomenon, gender trends in this regard are changing, with an emergent group of female perpetrators increasingly resembling men regarding various sociodemographic, criminological, social and psycholegal parameters. The central role of the gendered and mental health context of homicidal women is increasingly recognized, though this field of enquiry remains relatively poorly researched and understood. Crucial issues such as socio-economic background, social organization of gender, interpersonal and family dynamics, abuse and trauma exposure, substance abuse, psychological distress, pre-offence psychiatric background, and active psychopathology are all known to influence associations between gender, mental health and homicidal behaviour. The exact operational mechanisms, and ultimately, “explanations” for these phenomena remain elusive in most instances. Nonetheless, the research evidence suggests that the associations and relationships between gender-related variables, mental disorder and behavioural outcomes may differ for different types of homicide (e.g. where victims are adults versus children; or in cases where victims are neonates, infants or older children, respectively). Furthermore, the value of qualitative data in homicidal women with mental health problems has been demonstrated. Finally, there is clearly a paucity of data in this field of forensic mental health research endeavour in non-urban settings and in developing, non-industrialized countries.

Chapter Six: Methodology

A comprehensive description of the study methodology is provided in this chapter, which commences with details of the aims of the study (arranged into descriptive, comparative and qualitative categories respectively). The sequential phases of the mixed methods study design (i.e. quantitative phases, followed and informed by, a qualitative phase) are then outlined in turn. The specific procedures and measures employed in conducting the study are elucidated thereafter: quantitative data extraction from forensic mental health records of the total study sample at Fort England Hospital (FEH); and qualitative data which emerged from the semi-structured interviews of a sub-sample of violent women with severe forms of mental disorder under forensic mental health care. A detailed description of the data analyses then follows: (a) quantitative analyses (using both descriptive and inferential statistical techniques); and (b) qualitative, thematic analysis respectively. An appraisal of pertinent ethical considerations and safeguards in the design and conduct of the study concludes the chapter.

Aims of Study

The primary, broad aim of the study was to systematically explore and document the forensic mental health profile of women offenders in the Eastern Cape of South Africa who were court-referred to FEH for forensic psychiatric evaluation. It was anticipated that elucidation of these issues in this group of women would contribute to expanding the body of knowledge in this field in a number of ways by: (a) providing a focus on the central importance of gender in respect of offending behaviour and mental health, and in moderating the relationship between these in South African women offenders with mental disorder; (b) improving the accuracy of gender-focused information on context, criminogenic needs, risk analyses and management, and the provision of mental health services (forensic and generic)

in South Africa; and (c) facilitating an appreciation of the complexity of forensic mental health issues in South African women offenders, with potentially important implications for improving the necessary gender-focus of criminological, mental health, criminal justice and political policies. It is also anticipated that studies of this nature will stimulate further interest in this historically neglected area of academic and research endeavour in developing countries such as South Africa, as well as of the region and continent. The specific aims of the study may be conveniently categorized into descriptive, comparative and qualitative components respectively.

Descriptive

This sought to provide a detailed description of the study sample of women offenders with respect to their socio-demographic, criminological, mental health and forensic profile, with a focus on the following specific variables of interest: (a) *socio-demographic profile*: age distribution; language; race; marital status; number of children; educational background; occupational/employment status; source of income; and living arrangements prior to the index offence; (b) *criminological profile*: index offence characteristics (with a particular focus on women who committed violent offences); prior offending background; victim profiles (especially in respect of adult versus child victims of violence); self-reported versions of the index offence; and primary motives for offending behaviour; (c) *clinical profile*: pre-offence mental health, medical health, and substance use background; pre-offence abuse / trauma experiences; prevailing mental state during period of forensic evaluation; psychological test outcomes; and detailed, multi-axial diagnostic profile; and (d) *forensic profile* (as reflected in final forensic psychiatric court reports): forensic psychiatric diagnoses; trial competence; criminal capacity; and recommendations made to courts following forensic evaluation, respectively.

Comparative

This component of the study sought to compare, via inferential statistical analyses, the characteristics and profiles of various sub-groups of women offenders categorized by: (a) typology of index offence (i.e. non-violent offenders; violent but non-homicidal offenders; and homicidal offenders); and (b) type of victim (i.e. child versus adult) respectively. The statistical comparisons of the numerous socio-demographic, offence, mental health and forensic variables, within these sub-groups of women offenders, sought to investigate whether there were any statistically significant associations between variables of interest, as well as whether any specific variables could reliably be utilized for risk prediction of violent offending in particular.

Qualitative

Finally, detailed individual interviews were conducted with a sub-sample of women offenders with severe mental disorder who had committed violent offences (both of a non-homicidal and homicidal nature, and against both child and adult victims, respectively), and who were therefore within the forensic mental health system. This component of the study sought to explore the subjective perceptions, experiences and opinions, via thematic analysis of semi-structured interviews, of women who had the lived experience of both severe mental illness and violent offending. This systematic exploration of their personal thoughts, feelings, attitudes and insights sought to provide a deeper understanding of the broader individual, psychological, social, cultural and contextual factors in which their experiences are embedded. The views of the interview participants were sought on a range of issues around gender, self-image and identity, mental health, offending behaviour, individual coping mechanisms in the aftermath of their offences, and perceptions of the future. Furthermore, the interviews sought

to investigate their personal experiences of the criminal justice system (following arrest for their index offence) and forensic mental health system (following their declaration as State Patients and diversion to forensic mental health services for care, treatment and rehabilitation) respectively.

Study Design

The study adopted a mixed methods design, in which both quantitative and qualitative research approaches, techniques and data were utilized and combined, as this has been demonstrated to facilitate the benefits of each approach whilst minimizing their respective shortcomings (Fiorini, Griffiths and Houdmont, 2016). Further details of the quantitative and qualitative phases of the study are provided below.

Phase One: Quantitative

The criminal, administrative and forensic mental health records of women offenders referred by Eastern Cape courts to FEH for forensic psychiatric assessment were systematically examined. The post-hoc nature of the records, and the fact that multiple sources of quantitative data were accessed, allowed a broad range of pre-offence, offence and post-offence variables of interest to be included in the quantitative survey. This retrospective, records-based component of the study had a number of advantages, including: ease of access to detailed data, the allowance of smaller sample sizes (as there are relatively few women offenders, as compared to men, referred by courts), and reduction in the time and resources required (for the collection, categorization and description of data, conducting statistical analyses, and drawing of conclusions). Such retrospective, descriptive research designs have also been successfully utilized in many other female offender studies (e.g. Kelly, 2008a; Maden et al., 1990; 1994a; 1994b; Rossegger et al., 2009; Yourstone, Lindholm and Kristiansson, 2008). Whilst the

difficulty with confounding variables and minimizing bias in such retrospective designs is acknowledged, logistic regression modelling makes allowance for some confounding factors to be controlled whilst measuring the relative effect of predictor variables on specific outcomes (described in further detail below).

The first phase of the study therefore entailed two sequential, independent but related components: firstly, the collection and systematic description of data drawn from documentary records; and secondly, inferential statistical analysis of this quantitative data to draw conclusions on associations between research variable of interest, and devising potential risk predictions based on the strengths of these associations. With respect to the former, the criminal, administrative and forensic mental health records of all Eastern Cape women court-referred to FEH for formal forensic evaluation under the CPA (1977) were examined, via a structured, standardized data-collection sheet specifically (Appendix 1). With respect to the latter, the study sample was categorized by: (a) typology of index offence i.e. non-violent offenders (including all property, financial, and drug-related offences); violent but non-homicidal offenders (including common assault, assault with intent to do grievous bodily harm, public violence or other forms of violence against bodily integrity but excluding crimes against life); and homicidal offenders (including murder, attempted murder and culpable homicide) respectively; and (b) victim profile i.e. women offenders who acted violently against child as opposed to adult victims respectively. The statistical comparison of the socio-demographic, criminological, clinical and forensic mental health profiles of the sub-groups of women offenders sought to investigate whether, in the first instance, there were any significant associations (via χ^2 analysis) between variables of interest in each of these groups of offenders; and secondly, whether there were any significant risk predictors of violent offending, as well

as the odd's ratios attached to such risk, after controlling for confounding variables (via logistic regression analysis), respectively.

Phase Two: Qualitative

The second, qualitative phase of the study entailed interviewing of a sub-sample of women within forensic mental health services in the Eastern Cape who had committed violent index offences in the context of severe mental disorder. These were all women in whom prior formal forensic evaluation had confirmed the diagnosis of a mental disorder severe enough to impair trial competence and/or criminal capacity, resulting in court diversion to a specialized forensic psychiatric hospital (i.e. FEH) as State patients for longer term clinical management and rehabilitation. A clinical assessment to confirm capacity to provide informed, written consent was carried out prior to conducting detailed semi-structured interviews in the first language of participants (Appendix 2). Interviews were designed to optimize the collection of in-depth, qualitative information on the personal biographies, perspectives, and experiences of these women, with a focus on issues pertinent to self-image, gender, violent offending behaviour and forensic mental health. A naturalistic paradigm was adopted which facilitated and encouraged the expression of the unique, individual, subjective descriptions of personal experiences by interview participants, as opposed to seeking "objective" explanations of events and issues of research interest (Morse, 1994). This approach has been shown to be particularly useful when sensitive, complex and inter-related topics (such as gender roles, mental health, and violent offending) are being explored (Braun and Clarke, 2006). The interview was designed to invite responses that were meaningful, culturally salient, and nuanced, and to accommodate those that were unanticipated by the interviewer. Qualitative research of this nature tends not to focus on validity and reliability but rather on trustworthiness, which is optimised by factors such as: credibility (i.e. interview questions and discussions being valid,

and congruent with the participant's reality); transferability (generalizability to other situations and context's); dependability (the replicability of the qualitative outcomes); and confirmability (the degree to which the findings represent the participants experiences, ideas and opinions, as opposed to those of the researchers) (Lincoln and Guba, 1985). Although this was not a phenomenological study overall, the qualitative information obtained via interview hence informed, complimented, and enriched the quantitative data drawn from the criminal and clinical records.

Procedures and Measures

Forensic Records

The criminal, administrative and forensic mental health records of all women offenders in the Eastern Cape of South who were referred by courts to FEH for formal forensic psychiatric evaluation was accessed via the documentary archive system at the Hospital. These records included: (a) criminal dockets, court transcripts, criminal evidence related to the index offence, investigating officer reports, prosecutors reports, probation officer reports, social work reports, warning and witness statements, District Surgeon reports, post-mortem reports, and all other background information supplied by courts upon formal referral; (b) administrative forensic records of FEH, containing the legislative details underpinning the forensic assessment and communication of the findings; (c) detailed forensic, multi-disciplinary clinical and mental health records (compiled by forensic and general psychiatrists, medical officers, clinical psychologists, occupational therapists, social workers and psychiatric nurses) documented during the period of forensic evaluation (including details of forensic consultations, mental state descriptions, investigations, nursing observations, treatment received, etc); and (d) forensic psychiatric reports formally submitted to court at the conclusion of the forensic evaluation, summarising the forensic conclusions (including details of investigations

conducted, clinical diagnoses made, conclusions on pertinent forensic parameters (especially trial competence and criminal responsibility), and recommendations submitted to courts on legal options following these forensic findings (e.g. that the law take its course, or recommendations for diversion to general or forensic mental health services instead of prison).

Quantitative data on numerous domains of interest was recorded on a standardized data collection sheet (Appendix 1). Specific variables for which data was collected included (as applicable to, and available for, each case): (a) *socio-demographic variables*: date of birth; year of forensic evaluation; age; first language; race; marital status; parity and number of children alive; highest level of education attained; primary source of income; occupation/employment status; and living arrangements prior to arrest; (b) *criminological variables*: index offence(s); documentation received upon court referral; past criminal convictions; reason(s) for court referral; details of adult victims of violent index offences (including relationship to defendant; criminal, mental health, substance use and behavioural history of victims, and likely motive(s) for index offence); details of child victims of violent index offences (including relationship between offender and victim; age and gender of child victim, and likely motive(s) for index offence); defendant's version(s) of the index offence (including brief narrative summary of facts of the case, as provided by court docket; and narrative self-reported versions of the offence by the defendant); (c) *clinical variables*: pre-offence mental health history, diagnoses and treatment; family mental health history; pre-offence medical history; pre-offence substance use history; pre-offence abuse experiences (of defendant as victim); details of pre-offence abuse (including nature / type of abuse; relationship between offender and victim); presence of psychopathology / psychiatric symptoms (including timing of these in relation to index offence); prevailing mental state at time of index offence and forensic evaluation respectively; clinical investigation results (including medical and psychological tests); forensic social

worker and occupation therapist reports; and (d) *forensic variables* (as reflected on formal forensic psychiatric reports submitted to courts at the conclusion of the evaluation; Appendix 9); diagnostic conclusions (mental health and medical) as expressed by the DSM multi-axial system; conclusion on trial competence (fitness to stand trial) and criminal responsibility/capacity; and recommendations made to court following the conclusion of the formal forensic evaluation.

Semi-structured Interviews

Women offenders with severe forms of mental disorder who had committed violent index offences, and who were subsequently diverted by courts to the specialized forensic mental health services for further management (as state patients under section 42 of the MHCA (2002), were the focus for the qualitative phase of the study, which entailed conducting interviews with selected participants. Conducting of the semi-structured interviews were guided by the principles of consensual qualitative research in which a series of open-ended questions were posed around themes of interest, allowing participants the freedom to express, in their own terms, their feelings, thoughts, opinions and perceptions of the themes in question (DiCicco-Bloom and Crabtree, 2006; Hill et al., 2005). Women were considered as potential participants for interview using the following pre-selected inclusion criteria (all of which had to be met for eligibility to be interviewed): (a) adult woman offender (over 18 years of age) from the Eastern Cape province of South Africa; (b) charged with violent index offence(s) and referred by courts for formal forensic psychiatric assessment to FEH under section 79 of the CPA (1977); (c) formally declared on a forensic psychiatric court report to have at least one severe mental disorder which rendered them either trial incompetent and/or lacking criminal capacity; (d) subsequently declared a state patient (under section 42 of the MHCA, 2002) and diverted by courts to an in-patient forensic mental health service for forensic mental health care, treatment

and rehabilitation; and (e) in sufficiently good mental health (i.e. no active severe psychopathology), in addition to being intellectually able, to providing written, informed consent at the time of interview.

All potential interviewees were initially assessed for capacity to consent by the primary researcher, together with a research assistant who was fluent in the first language of the participant (all participants spoke isi-Xhosa, English, or Afrikaans as a first language). Following confirmation of capacity to do so, fully informed, written consent was obtained and documented (Appendix 2). All interviews were then conducted in the first language of the interviewee by: (a) the primary researcher (a male, first-language English speaker and registered specialist forensic psychiatrist); or (b) a clinically-trained research assistant, who was either a senior clinical psychologist (a male, first-language isi-Xhosa speaker) or a senior specialist psychiatrist (a female, first-language Afrikaans speaker), as required. Interviews were semi-structured to optimize participant choice in guiding the themes under discussion, whilst allowing the interviewer to maintain the discussion within the broad parameters of research interest. Questions were asked in an open-ended manner to facilitate rapport, allow flexibility and encourage full coverage of themes via non-judgemental discussion in a safe, non-threatening and supportive space. Arrangements were made prior to each interview to make available any additional clinical assistance that may have emerged during, or as a result of, the interview process e.g. in the event of any psychological distress, relapse of psychiatric symptoms, or any other issue that requiring clinical attention of the responsible multi-disciplinary team.

Guided by the pertinent issues identified in the preceding literature review, the interview was arranged into five primary domains of interest, each of which were explored in turn by a

series of gender-focused questions around: (a) self-image; (b) mental health; (c) offence-related issues; (d) post-offence issues; and (e) the future and other issues (Table 9 and Appendix 3). In addition to specific open-ended questions, the interview schedule allowed the option of using further prompting questions should it have been required for further clarity or in order to elicit additional information or details regarding responses received. Prior to the close of the interview, participants were also encouraged to explore or express views or comments on any further issues of their choice (whether related to the themes of research interest or not).

Table 9

Domains of Interest in Interviews of Violent Women Offenders with Severe Mental Disorder

Domain	Question(s)
Self-image	<ul style="list-style-type: none"> - How would you describe yourself as a person? (Prompt e.g. what sort of person are you?) - How do you see yourself as a woman? - How do other people see you? (Prompt e.g. family members or friends?) - What do other people think about you being a woman in your situation?
Mental health	<ul style="list-style-type: none"> - Do you see yourself as mentally ill? (Prompt e.g. previously, sometimes, currently?) - Do others see you as mentally ill? (Prompt e.g. family members, friends, others?) - How do you feel about having being referred by the courts to FEH for mental health assessment / treatment? - Do you think there is any relationship between your gender as a woman and your mental health? - Do you have any specific mental health needs as a woman? - Have you changed in any way since being admitted to a psychiatric hospital / prison?
The offence	<ul style="list-style-type: none"> - Could you outline what led to you being arrested and charged with a violent offence? (Prompt e.g. please tell me about the events around the offence?) - Please tell me about the complainant / victim of the offence? (Prompt e.g. who were they? Were they male or female? Adult or child?) <p><i>If the victim was an adult or a child other than the participants own child:</i></p> <ul style="list-style-type: none"> - What was your relationship like with him/her? (Prompt e.g. how did you feel about him/her?) - What motivated your behaviour around the time of the offence? (Prompt e.g. if you did carry out the offence, why did you do it?)

Domain	Question(s)
	<p><i>If the victim was the participants own biological child:</i></p> <ul style="list-style-type: none"> - What was your experience of the pregnancy, birth and the post-natal period? - What was your relationship like with him/her? (Prompt e.g. How did you feel about him/her?) - What motivated your behaviour around the time of the offence? (Prompt e.g. if you did carry out the offence, why did you do it?) - Did the fact that you are a woman have any bearing on the offence?
Post-offence	<ul style="list-style-type: none"> - Have you changed in any way since being charged with violent offence? - As a woman, how do you cope or deal with your current situation? - How do you cope or deal with your mental health being questioned by the court following your charge? - How do you cope or deal with your detention (in Hospital or prison)? - How do you cope or deal with being accused of a violent offence?
The future and other issues	<ul style="list-style-type: none"> - How do you see the future? - Do you have any questions or is there anything else you wish to talk about?

Relatively small sample sizes are considered adequate for in-depth, qualitative interviews of this nature due to the principle of saturation: the sample needed to be large enough to ensure repetition of subject content expressed in the interviews (which usually occurs with samples of six to twelve participants) (Morse, 1994; Braun and Clarke, 2006). Sampling for interviews was hence non-random, homogeneous, and purposeful in nature, and no further interviews were conducted after the point of “theoretical saturation” was considered to be reached i.e. at which new interview data no longer brought additional insights or substantive information to the research questions.

Interview sessions were voice-recorded to aid detailed qualitative analysis of emergent themes. Full transcriptions of the interviews were made and independently checked for accuracy by two mental health professionals (the primary researcher and one research assistant) in each case. Pseudonyms were assigned to each interview participant in order to ascribe

interview quotes anonymously, but accurately and consistently, with respect to the source of the interview data. Data from the interviews were qualitatively analysed and interpreted using thematic analysis, as outlined in further detail below (Braun and Clarke, 2006).

Data Analysis

Quantitative

The quantitative analysis comprised of two components: descriptive and inferential statistical analyses respectively.

Descriptive Analysis. Detailed descriptive statistics were computed as means and frequencies (counts and percentages) for all quantitative variables measured, and the results organized within the four broad domains extracted from the forensic records i.e. socio-demographic, criminological, clinical and forensic domains respectively.

Inferential Analysis. The data was then further examined by comparing individual variables against two primary outcome categories: (a) index offence (non-violent offences; violent but non-homicidal offences; and homicidal offences respectively), and (b) victim of violent index offences (adult or child victims) respectively. Two sequential statistical techniques were utilized for this purpose: (a) χ^2 analysis, followed by (b) logistic regression modelling. Contingency tables and the χ^2 test were initially used to examine the actual and observed values for categorical variables under comparison, in order to establish whether variables were independent of one another, or whether one variable was contingent on the other. The null hypothesis for the χ^2 test was that there was no association between any two paired variables concerned i.e. that they are independent and unrelated. Observed and expected frequencies for each cell of the contingency tables were calculated for each of the outcome

categories against all other variables. The Pearson χ^2 value (which represents the discrepancy between observed and expected frequencies in each cell of the contingency table) and its corresponding p-value (asymptotic value of $p < 0.05$) were used as the threshold for statistical significance (i.e. if the Pearson's statistic is large and $p < 0.05$, it is unlikely that the null hypothesis is true). Furthermore, the Cramer's-V statistic (or the Phi statistic in the case of 2x2 contingency tables) was examined as a measure of the relative strength of association between variables compared in the χ^2 analysis. The effect sizes illustrated by the Cramer's-V or Phi statistics are an indication of any practical and/or clinical (as opposed to purely statistical) significance. These measures of association are hence useful in cases in which variables being compared may not have quite reached statistical significance, but where there was nevertheless a demonstrable association between variables which was of potentially important practical importance. Such effect sizes were also categorized as: small/weak (if the Cramer's V or Phi statistic was less than 0.2); medium/moderate (if the Cramer's V or Phi statistic was between 0.2 and 0.4); and large/strong (if the Cramer's V or Phi statistic was above 0.4) respectively, providing further information on the relative strength of such associations (Cohen, 1992).

Following the χ^2 analysis, logistic regression modelling for binary / dichotomous variables was used as the multivariate inferential analytic technique to measure more precisely the degree of association between variables. Stepwise logistic regression was used to develop the multivariate models by selecting those variables which the preceding χ^2 analysis demonstrated to have achieved both: (a) statistical significance (Pearson χ^2 value and $p < 0.05$) and/or clinical significance (moderate to large effect size of Phi / Cramer's V statistic) and (b) variables that also had sufficiently large sample sizes to ensure a valid and robust regression analysis model. In order to explore the strength of association between variables identified, the following three binary outcomes of interest were identified for logistic regression modelling:

(a) *violent versus non-violent index offence*; (b) *homicidal versus non-homicidal index offence*; and (3) *child versus adult victim of violent index offence*, respectively. The relationship between these outcome (dependent) variables and a number of predictor (independent) variables, was explored by, firstly, determining which predictor variables had an independent influence on the outcome in question, in the presence of all other variables; and secondly, quantitatively evaluating the increase or decrease in the probability of the specific outcome for each of the predictor variables in turn. Logistic regression analysis is therefore a flexible means of analysing the strength of associations between binary outcomes and multiple, potentially confounding variables that influence such outcomes (Katz, 2003; Petrie and Sabin, 2005). This technique allows a measure of the magnitude of the effect on the outcome of the various predictor variables on their own, whilst adjusting or controlling for the different confounders, and in so doing, reduces confounder bias in drawing conclusions (Katz, 2003; Ghaemi, 2009). Further details of these statistical techniques, as well as the underlying rationale for their selection and use in mental health research of this nature, have been extensively described in the statistical literature (Cohen, 1992; Ghaemi, 2009; Howell, 2012; Katz, 2003; Petrie and Sabin, 2013). All quantitative data analysis was done using Statistical Package for the Social Sciences (version 22.0.0.0).

Qualitative

A naturalistic paradigm was used for understanding, processing and analysing the qualitative component of the study, which emphasized description as the focus of the exercise, rather than “explanation” of the experiences and perspectives of the interview participants. This approach facilitates the emergence of concepts from the qualitative data, as opposed to their imposition from theory (Braun and Clarke, 2006).

Thematic Analysis. Information obtained via interview was examined by thematic analysis, which is an accessible, theoretically flexible yet methodologically sound, and widely used qualitative approach in mental health research (Braun and Clarke, 2006). Thematic analysis has been demonstrated to have a number of advantages in mental health research in particular, including: flexibility; relative ease of administration; accessibility of both methodology and results; utility within a participatory research design (i.e. involving interview participants as collaborators as opposed to subjects); ease of summarizing key features of the complex and extensive variables of research interest; offering a nuanced and detailed description of the data set; ability to highlight similarities and differences across the data set; generation of unanticipated insights; facilitation of psychosocial interpretations of interview data; and producing qualitative analyses suited to informing mental health policy development (Braun and Clarke, 2006). The purpose of the thematic analysis in the current study was therefore to seek a socio-culturally appropriate and gender-focused sensitive understanding of the research themes of interest in terms of the values, opinions, social context and interpersonal background of the women concerned. Such information was also thematically analysed in an attempt to understand the presence and influence of relatively inaccessible, sensitive, complex and abstract factors, such as self-evaluation; family, social and gender roles and relationships; race; stigma; motivations and coping mechanisms; and the uniquely individual experiences, opinions, perceptions and attitudes of individual women with the lived experience of both violent offending and mental disorder. The role of such pertinent but complex variables played in respect of the research issues at hand may not have otherwise been apparent by way of quantitative analysis alone, highlighting the worth of the mixed methods research design.

Although thematic analysis is recognized to be a recursive (as opposed to linear) process, a number of structured phases and steps were followed, guided by the principles provided by

Braun and Clarke (2006), to process the interview data: (a) familiarization with the interview data following transcription by active reading and re-reading of the transcripts; (b) collating, organizing, interpreting and reducing interview data extracts by the systematic generation of initial codes (on the basis of interesting, replicated, persistent and/or consistent features in the emergent data set); (c) searching for potential themes and sub-themes by collation and categorization of codes (in practice, this entailed each interview transcript being analysed in detail by deconstructing participants responses to interview questions, and predominant, repetitive, common, consistent and/or interesting patterns of meaningful answers being categorized into themes when the information became sufficiently saturated); (d) cross-analysis, reviewing and interpretation of themes and sub-themes (within both the coded extracts and the entire data set), and the generation of an initial thematic summary; (e) amalgamating and examining descriptions and interpretations with respect to each theme and sub-theme to ensure that the descriptions adequately and accurately reflected the utterances of interviewees; (f) defining, naming, reviewing, remodelling and refining the specifics of each theme and sub-theme, in order to optimize internal homogeneity (i.e. data within themes being meaningful and coherent) and external homogeneity (i.e. clear and identifiable distinctions between themes) respectively; (g) contradictory and/or alternative interpretations being searched for; and (h) the production of a final thematic summary and map generated by final analysis of the saturated data set. Confidentiality and anonymity were preserved throughout, and pseudonyms were assigned to each interview participant for the thematic analysis and reporting of results.

Ethical Considerations

The criminal, administrative and forensic records held at FEH contain individual case data for all woman offenders in the Eastern Cape referred by courts for formal forensic psychiatric assessment i.e. information contained in the case files is obtained, compiled and

collated as part of the routine forensic assessment and administrative process prescribed by the CPA (1977) and its amendments. Consent for disclosure of information in respect of, and by, criminal defendants is hence implicit in the official criminal justice process that governs these evaluations. Furthermore, written and informed consent is obtained as a routine from each defendant upon admission to FEH at the commencement of the official period of forensic evaluation (Appendix 4). The quantitative data obtained from the documentary records were recorded on a standardized, fully anonymised and confidential data collection sheet (Appendix 1). Each case was also assigned a unique Study Identification Number on the data collection sheet, and the identity of individual defendants (corresponding to their Study Identification Number) was stored separately on a confidential case identification form (Appendix 5). This information, together with completed data collection forms, interview transcriptions and all other data related to the study, was kept in a secure, lockable filing cabinet and password-protected computer in the office of the researcher, located in a secure building with biometric access control on the FEH premises (which is itself a high-secure forensic psychiatric institution with strictly controlled access).

In respect of the qualitative phase of the study, an information sheet introducing the study and providing all relevant details (including its purpose, procedures, potential risks and benefits, rights of participants, ethical approval details, and research contact information) was provided to all prospective interview participants (Appendix 2). Given the mental health background of all potential interviewees, capacity to provide consent was clinically confirmed in the first instance, prior to obtaining informed, written consent to participate. This ensured that interview each participant understood the meaning of her participation, and was able to decide to make her decision about participation in a conscious, deliberate and voluntary manner. All participants were also explicitly reminded of their right to withdraw consent,

without needing to provide any reasons and without fear of any consequences, at any point in the study (i.e. prior to, during and after the interview). All information about the study and the consent documents was communicated (both verbally and in writing) in the first-language of the individual participants. Semi-structured interviews were also conducted in the first language of the participant using the interview schedule as a guide (Appendix 3). Following confirmation of consent to participate, pre- and post-interview briefings were held with individual participants, during which the availability of additional mental health assistance or any other appropriate intervention (if requested or required), was again made explicit. Reassurance was provided to each individual interview participant that any additional assistance they requested or required would be communicated to the mental health team responsible for their care. Such remedial interventions for any distressed participants included a range of possible multi-disciplinary treatment options, as determined by individual need (e.g. psychotherapy, pharmacotherapy, social work assistance, occupational therapy, etc.).

In summary, as per the Belmont report, the core principles of research ethics were respected throughout the study and at all times (Kass, 2001). These included: (a) *respect for participants*: ensuring autonomy, protection from exploitation by recognition of their vulnerability as institutionalized women offenders with mental health problems, acknowledging the inevitable power dynamic and sensitively managing this, and respecting the dignity of participants; (b) *beneficence*: a commitment to minimizing any potential risks (including psychological, social or any other) as a result of the interview process, by offering appropriate remedial interventions for any distressed participants; (c) *justice and respect for the community*: recognition of and respect for the specific context of the participants, and their roles as members of institutional, family, social, cultural, gender, and other groupings or identities; and (d) *confidentiality*: the anonymity, confidentiality and security of all data

(quantitative and qualitative) was ensured at all times; the details of all personal documentary information and interview content (both recorded and transcribed) was not divulged to other participants nor any other persons except for the researcher and research assistant conducting individual interviews; full anonymity and confidentiality was also explicitly guaranteed for any subsequent reports, theses, presentations or publications that emanate from the study in the future.

Formal ethics clearance was initially obtained from the Rhodes University Ethical Standards Committee (Appendix 6). Written approval to commence the study at FEH was then formally obtained from the Eastern Cape Department of Health: Epidemiological Research and Surveillance Management Directorate (Appendix 7), and Hospital Manager / Academic and Research Committee of FEH (Appendix 8) respectively.

Conclusion

The mixed methods research approach entailed the integration of the sequential and complementary quantitative and qualitative components of the study. An extensive set of quantitative data was analysed by descriptive and inferential statistical means. Interpretations and understandings of these results were further contextualised and enriched by the interview narratives, experiences and opinions of individual women. Ethical considerations were paramount throughout, especially as related to the core principles of respect, beneficence, justice and confidentiality.

Chapter Seven: Results

The forensic mental health profile of all women in the Eastern Cape who were charged with an offence, and subsequently referred by courts to Fort England Hospital (FEH) for formal forensic psychiatric evaluation under the Criminal Procedure Act (CPA) (1977), and its amendments (CPAA, 2017), was systematically examined. A total of 173 such women underwent forensic evaluation at FEH between 1993 (the date from which archival records were available at FEH) and 2017 (the end of the study period).

The results are arranged in a structured, sequential manner: initial *descriptive* results are followed by the results of *inferential* and *qualitative* analyses respectively. In the first instance, descriptive results are provided with respect to the general socio-demographic, offence-related, clinical and forensic profile of the study sample as a whole. More focused descriptive results are then provided for sub-samples of: (a) violent women offenders in general; (b) women who have acted violently against adults versus children; and (c) homicidal women (including comparisons of the profiles of non-homicidal versus homicidal women; mariticial versus femicidal offenders; and female perpetrators of neonaticide, infanticide and the homicide of older children) respectively. Secondly, outcomes of the inferential statistical analyses are arranged by presenting results on the associations between variables of interest (via χ^2 analysis), followed by those regarding risk predictors of violence (via logistic regression analysis). For the former, associations between categorical variables of interest, and the relative strength of such associations, are presented by grouping results into two primary outcome categories: an index offence category (i.e. non-violent; violent but non-homicidal; and homicidal offences respectively); and victim of index offence category (i.e. adult and child victims) respectively. Results of the χ^2 analysis with respect to various socio-demographic,

offence-related, clinical and forensic groups of variables are presented for each primary outcome category in turn. The magnitude and nature of all statistically significant associations identified by the preceding χ^2 analysis were examined further by multivariate logistic regression modeling. Hence, the unique contributions of various predictor variables, after controlling for potential confounders, to three specific violent outcomes of interest (i.e. the commission of violent offences in general; homicidal offences; and violence toward children, respectively) are then described in further detail. Finally, qualitative results of interviews of violent women with severe mental disorder (via thematic analysis of interview transcripts) are described in terms of the key themes of interest i.e. related to self-image, mental health, the index offence itself, the aftermath of the offence, and the views of the future respectively.

Descriptive Outcomes

Results of the descriptive analysis have been grouped for presentation as follows: (a) *socio-demographic profile*; (b) *offence profile*; (c) *clinical profile*; and (d) *forensic profile* respectively. Whilst the total sample size comprised 173 women offenders and their associated records, sub-sample sizes used to calculate frequencies and further statistical analyses were based only on cases on which specific and explicit information on items or variables of interest was available. In addition, some offences involved more than one victim. Sub-sample sizes hence often varied accordingly, and are made explicit wherever necessary throughout the presentation of the study results that follows.

Socio-demographic Profile

The socio-demographic profile of the sample ($n = 173$) is summarised in Table 10. Ages of women within the sample ranged from 18 – 72 years (mean = 37.92; SD = 13.28). The most frequent age category (in 28%) was 31- 40 years of age. One-third of women were under 30

years of age, and almost two-thirds were under 40 years of age at the time of the forensic assessment. The majority of women (69%) evaluated spoke isi-Xhosa as their first language, followed by Afrikaans (in 22%), with these two languages together accounting for over 90% of the sample.

Table 10
Socio-demographic Profile (n = 173)

Variable	Category	Frequency (%)
Age	< 21	12 (6.9)
	21-30	46 (26.6)
	31-40	48 (27.7)
	41-50	37 (21.4)
	51-60	20 (11.6)
	>60	10 (5.8)
First language	isiXhosa	120 (69.4)
	Afrikaans	38 (22.0)
	English	13 (7.5)
	Sesotho	1 (0.6)
	Shona	1 (0.6)
Race	Black African	123 (71.1)
	Coloured	28 (16.2)
	White	22 (12.7)
Marital status	Single	114 (65.9)
	Married	29 (16.8)
	Widow	13 (7.5)
	Separated	10 (5.8)
	Divorced	6 (3.5)
	Common-law partner	1 (0.6)
Biological children	Nil	27 (15.6)
	1	47 (27.2)
	2	35 (20.2)
	3	28 (16.2)
	4	19 (11.0)
	>4	17 (9.8)
Highest level of education	No education	7 (4.0)
	Special needs education	3 (1.7)
	Grade 1 – 8	75 (43.4)
	Grade 8 – 12	82 (47.4)
	Tertiary	6 (3.5)
Employment / occupation (pre-arrest)	Unemployed	132 (76.3)
	Unskilled labourer	17 (9.8)
	Commerce	11 (6.4)

Variable	Category	Frequency (%)
	Professional	6 (3.5)
	Other	7 (4.0)
Primary source of income	Employment	28 (16.2)
	Social grant	66 (38.2)
	Family / intimate partner	79 (45.6)
Living arrangements (pre-arrest)	Extended family	50 (28.9)
	Immediate family	41 (23.7)
	Children only	26 (15.0)
	Intimate partner only	26 (15.0)
	Parents only	13 (7.5)
	Alone	12 (6.9)
	Other / non-family	5 (3.0)

The forensic records at FEH, as remains common practice in most state sector institutions in South Africa, contain references to the old “racial” classification devised by the apartheid government. The arbitrary, simplistic and outdated nature of such apartheid-era racial categorization notwithstanding, the majority of women offenders in the sample were indicated to be “Black African” (71%), with remainder comprising “Coloured” (16%) and “White” (13%) women respectively. Although there were no “Indian” women present in the study sample, women from previously disadvantaged racial groups therefore together comprised 87% of the sample (Table 10).

Almost two-thirds of women were single at the time of forensic assessment, with fewer than 20% of women being married or having a common-law partner (Table 10). Expressed differently, approximately 82% of the women had no stable or long-term intimate partner at the time of evaluation. The vast majority of women (84%) were mothers at the time of their arrest, with almost half of these women having 1-2 dependent children at the point of incarceration (more specific data on the ages of children of the women sampled was largely unavailable in the majority of records examined, except in cases in which biological children were the victims of index offences).

In terms of educational attainment, whilst the majority of women attended school, less than half (47%) progressed to high school, with only 4% of women having received a tertiary level education (post-school college or university) (Table 10). Most women (76%) were not gainfully employed on a full-time basis at the time of their arrest, with unskilled, poorly remunerated occupational roles comprising the largest single category (10%) of employment in the remainder. For unemployed women, the primary source of income was via family (including intimate partner) support (46%) and, to a slightly lesser extent, social grants (38%) respectively. In other words, the vast majority of women (84%) were financially dependent on others or the state at the time of incarceration. In line with this, most women (61%) indicated they were living with intimate partners or first-degree relatives (immediate family, children and/or parents) prior to their arrest. The most frequent living arrangement, however, was of those living in extended family settings (29%) (Table 10).

Offence Profile

Both prior and index offences were categorized by an adaptation of Snyman's (2014) classification, being the most widely used typology in South Africa (Table 1 and Appendix 1). An overview of reasons for referral to FEH for forensic evaluation, as provided by courts, will be presented prior to detailed results on the offence profile of women referred.

Reasons for Referral. The majority of women offenders (74%) had their multi-disciplinary forensic evaluation at FEH completed within the statutory 30 days (as per the CPA, 1977), with the remaining one-quarter of cases requiring a court-sanctioned extension beyond the customary 30-day period. In cases in which the reasons for referral for forensic evaluation was specified by referring courts in 171 cases. As shown in Table 11, clinically-based

motivations comprised almost two-thirds (63%) of all cases, and the remainder related to those in which criminological or court-related issues were the rationale for referral. A likely or confirmed pre-offence history of psychiatric problems and/or treatment comprised the basis of the majority of referrals (55%), followed by concerns regarding mental health as a result of unusual behaviour in court (16%), and legal counsel expressing difficulty in their consultations with the defendants (15%). In 11 cases (6.4%), courts considered the unusual or extraordinary circumstances of the offence itself as sufficient justification for referral, with the vast majority of these (8 cases) being those of violent offences against children (murder in 7 cases and attempted murder in 1 case respectively).

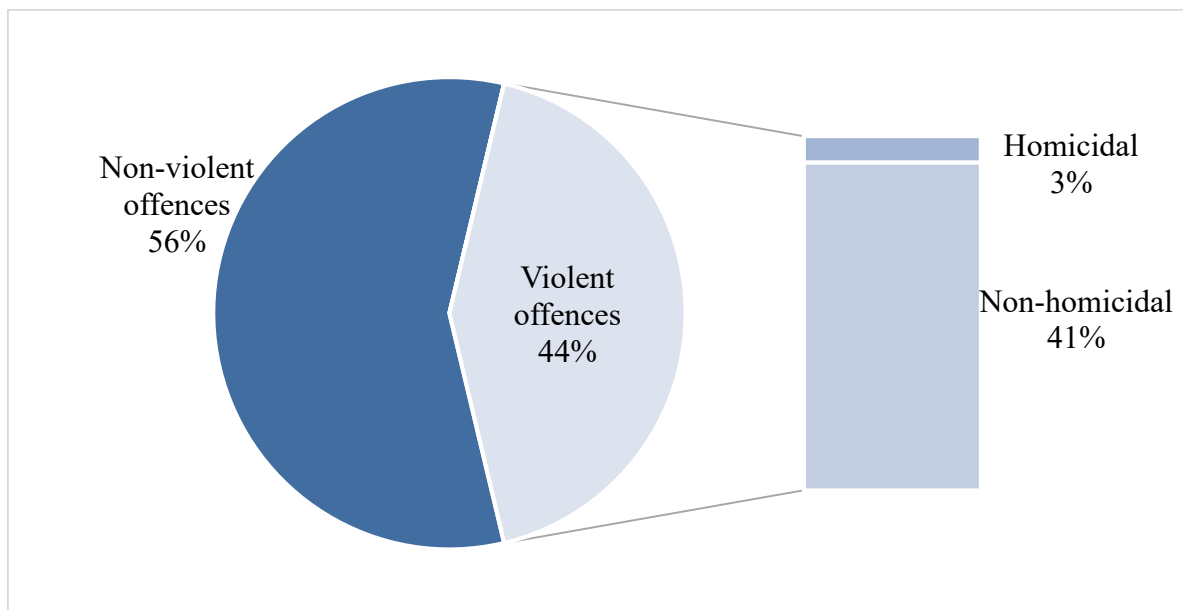
Table 11
Reasons Provided for Forensic Referral (n = 171)

	Specific reason provided upon referral	Frequency (%)
Clinical (n = 107)	Prior psychiatric history	94 (54.9)
	Intellectual disability	6 (3.5)
	Mental illness confirmed post-arrest	2 (1.2)
	Epilepsy	2 (1.2)
	Substance abuse	2 (1.2)
	Traumatic brain injury	1 (0.6)
Criminological (n = 64)	Behaviour in court	27 (15.8)
	Legal counsel unable to consult with defendant	26 (15.2)
	Unusual circumstances of offence	11 (6.4)

Prior Offences. Only approximately one-fifth of cases (n = 32) had a known history of prior offending i.e. the vast majority of women referred for forensic evaluation were first-time offenders. Of the women with prior offending histories, the majority (56%) were for non-violent offences, with most of these being property-related crimes e.g. criminal appropriation of property, malicious damage to property, financial offences, drug-related offences, etc. (Figure 3). The remainder of prior convictions were for violent offences directed against a

person: violent but non-homicidal offences against bodily integrity in 41% of cases (e.g. common assault, and assault with intent to do grievous bodily harm), and a very small proportion of cases (3%) having committed prior violent offences against life (e.g. attempted murder, murder and culpable homicide) respectively.

Figure 3
Prior Offence Convictions



Overview of Index Offences. A detailed breakdown of specific index offences (i.e. the primary offence which precipitated the referral for forensic evaluation is presented in Table 12. This demonstrates that: (a) violent crimes against the person comprised the majority of cases (58%), and included crimes against life (29.5%) and against bodily integrity (27.2%) respectively; and (b) crimes against property (36% of cases) and the community (6%) together comprised the minority of index offences. In addition, Table 12 also illustrates that the five most common individual index offences were (in order of decreasing frequency): (a) murder (26% of cases); (b) assault with intent to do grievous bodily harm (20.8%); (c) theft (13.3%); (d) malicious injury to property (12.7%), and (e) attempted murder / assault (3.5% each). In

other words, the three most violent crimes (assault with intent to do grievous bodily harm, attempted murder and murder) together accounted for over 50% of cases.

Table 12

Index Offence Profile (categories adapted from Snyman, 2014) (n = 173)

Offence category	Offence sub-category	Index offence	Frequency (%)	
Crimes against the community (n = 10)	Sexual crimes	Sexual assault	1 (0.6)	
	Crimes against the family	Contravention of Protection Order	4 (2.3)	
	Crimes against public welfare	Concealment of birth	1 (0.6)	
		Discharging a firearm	1 (0.6)	
		Drug offences	3 (1.7)	
Crimes against a person (n = 100)	Crimes against life	Attempted murder	6 (3.5)	
		Murder	45 (26.0)	
	Crimes against bodily integrity	Assault	6 (3.5)	
		Assault with intent to do grievous bodily harm	36 (20.8)	
		Domestic violence	4 (2.3)	
		Intimidation	1 (0.6)	
	Crimes against dignity and reputation	Criminal defamation	1 (0.6)	
	Crimes against freedom of movement	Kidnapping	1 (0.6)	
	Crimes against property (n = 63)	Crimes related to appropriation of property	Robbery	3 (1.7)
			Theft	23 (13.3)
Fraud and related crimes		Fraud	7 (4.0)	
Crimes related to damage to property		Arson	4 (2.3)	
		Housebreaking with intent and related crimes	4 (2.3)	
		Malicious injury to property	22 (12.7)	
		Total	173 (100)	

In almost 20% of cases (n = 34), defendants had additional charges lodged against them i.e. in addition to the index offence which was the focus of the forensic evaluation (Table 13). The majority of additional offences (65%) were property-related offences i.e. non-violent against the person. Almost one-quarter (24%) of additional offences were violent on nature

(with equal proportions for crimes against life and bodily integrity respectively). In summary, in cases where additional charges were laid, these were mostly of a less serious and non-violent nature.

Table 13

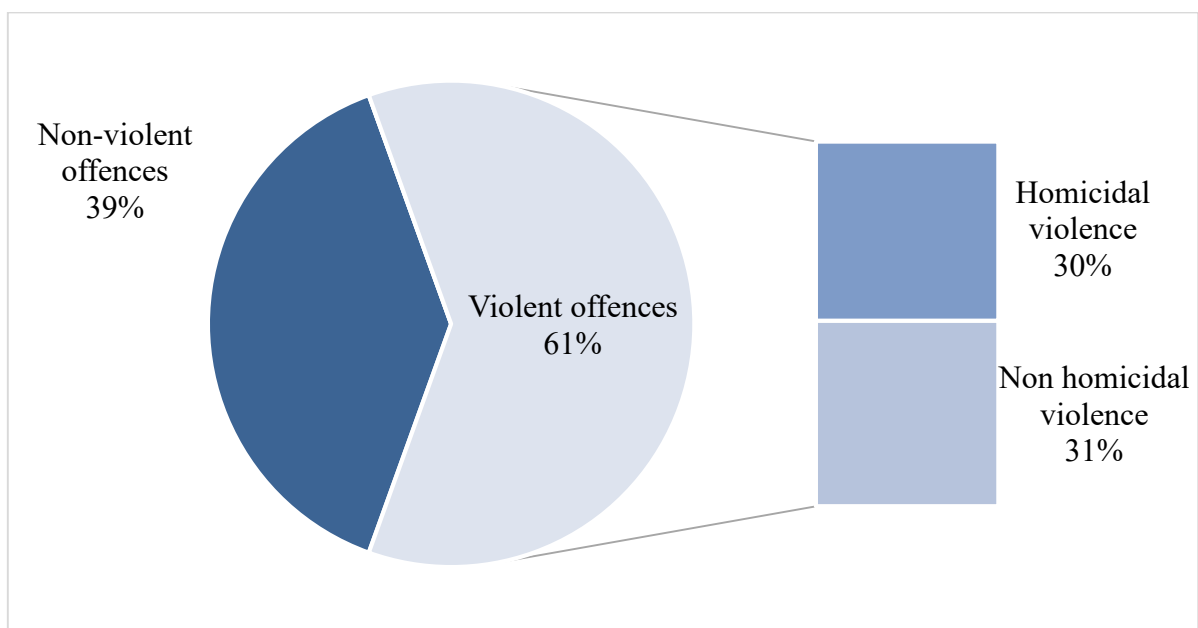
Offences in Addition to the Index Offence (n = 34)

Offence category	Offence sub-category	Frequency (%)
Crimes against the community (n = 4)	Crimes against the family	4 (11.8)
Crimes against a person (n = 8)	Crimes against life	4 (11.8)
	Crimes against bodily integrity	4 (11.8)
Crimes against property (n = 22)	Crimes related to appropriation of property	8 (23.6)
	Fraud and related crimes	4 (11.8)
	Crimes related to damage to property	10 (31.2)
Total		34 (100)

Violent Offences. To explore the offence profile of women offenders further, index offences were initially classified by a basic taxonomy of violence into non-violent and violent offence groups respectively: the former being cases in which no other person was placed at significant risk of harm or actually harmed; and the latter being cases in which a person (i.e. the victim of the violence) was placed at significant risk of injury or death, or actually physically harmed or killed as a direct result of the violent behaviour of the offender. Violent offences were then further classified into cases involving homicidal violence, and those which were violent but non-homicidal respectively. Hence, three discrete categories of index offences were established for further analysis, being those with: (a) homicidal index offences (n = 51), which included all crimes against life (murder and attempted murder); (b) violent but non-homicidal index offences (n = 54), which included all crimes against bodily integrity (assault, assault with intent to do grievous bodily harm, domestic violence and intimidation) and certain

crimes against the community (sexual assault, concealment of birth and discharging a firearm); and (c) non-violent index offences (n = 68), which included all other crimes. Figure 4 illustrates that violent offences in general accounted for 61% of all offences, with homicidal offences and violent but non-homicidal offences being responsible for approximately equal proportions of these.

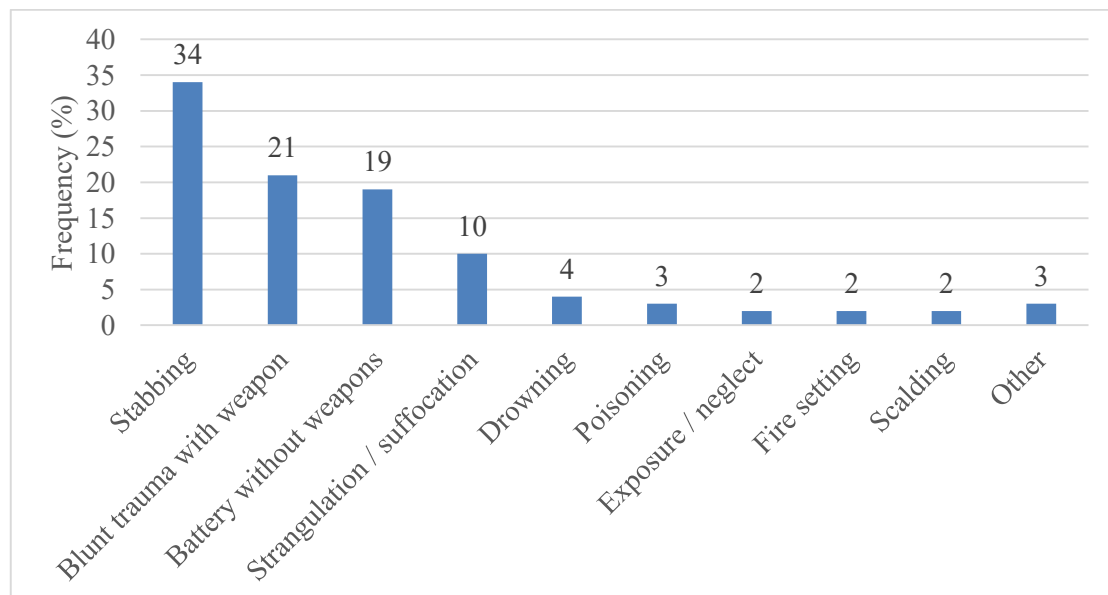
Figure 4
Index Offence by Taxonomy of Violence



In contrast to the prior offence conviction profile (Figure 3 above), the proportion of violent offences was higher for index offences (61% versus 44% respectively). This contrast was even more pronounced for homicidal violence, which accounted for 29.5% of index offences but only 3% of prior offences. Furthermore, in the sub-sample of women who committed violent index offences (n = 51): prior criminal convictions (i.e. for any offence) were present in 63% (n = 32), whilst prior convictions for violent offences in 28% (n = 14) of cases respectively.

Data on the specific methods of violence used in the perpetration of the index offence was known in 94 cases, which showed that a weapon was employed in the majority of these ($n = 52$; 55% of cases): penetrative injury inflicted by stabbing with a sharp object (e.g. knife, machete, spear, etc.) in 34% ($n = 32$), and trauma with a blunt object (e.g. hammer, brick, rock, etc.) directly inflicted upon victims in 21% ($n = 20$) of cases respectively. Battery without weapons (e.g. punching with fists, kicking, hurling against a hard surface or down stairs, etc.) (19%) and strangulation or suffocation (10%) were also relatively common methods of violent offending (Figure 5). These four categories (i.e. stabbing; blunt trauma with a weapon; battery without a weapon; and strangulation / suffocation) accounted for 84% of all violent methods employed. For homicidal offences ($n = 51$), whilst almost one-third of cases ($n = 16$; 31%) were killed by stabbing, there were no cases of firearm usage to lethal effect in any of the cases in the study sample.

Figure 5
Methods Used to Commit Violent Offences



Clinical Profile

Pre-offence Abuse. A documented history of pre-offence abuse of the offender herself was absent, unknown or unspecified in the majority of cases ($n = 129$; 74.6%). As shown in Table 14, in the women who reported prior abuse ($n = 44$), victimization occurred during their adulthood only in almost two-thirds (64%) of women; 27% reported being abused during childhood and/or adolescence only (i.e. before 18 years of age), and the remainder reported having experienced abuse to have persisted from childhood throughout their lives. The majority of abused women had suffered physical abuse (41%), followed by sexual abuse in a quarter of cases; the remaining third of cases reported being victims of multiple forms of abuse (e.g. neglect, physical, sexual or emotional abuse).

Table 14
Pre-offence Abuse of Offenders ($n = 44$)

Variable	Category	Frequency (%)
Timing of abuse	Adulthood only	28 (63.6)
	Childhood / adolescence only	12 (27.3)
	Childhood / adolescence and adulthood	4 (9.1)
Type of abuse	Physical	18 (40.9)
	Sexual	11 (25.0)
	Multiple	15 (34.1)
Abuse perpetrator	Intimate male partner	25 (56.8)
	Other relatives	8 (18.2)
	Parent	5 (11.4)
	Stranger	4 (9.1)
	Acquaintance	2 (4.5)

Abuse perpetrators were known to women in 91% of cases, with the vast majority of these occurring within the family context, especially by intimate male partners (57% of cases), other relatives (18%) and parents (11%) respectively (Table 14).

Pre-offence Mental and Medical Health. Information on pre-offence psychiatric history (or lack thereof) was available on 170 cases, as illustrated in Table 15. One-quarter of women (n= 44) had no pre-offence psychiatric history. A pre-offence diagnosis of schizophrenia or other psychotic-spectrum disorder was present in 29% of cases, followed by mood disorders, of the depressive type in 12% and bipolar type in 10% respectively. The majority (60%) of those with prior mental disorder received treatment from a mental health service or professional (psychiatrist and/or psychologist) in the past, with 12% receiving treatment from a general health service or professional (e.g. general practitioners) Treatment was sought solely via traditional healers in 5%, whilst 16% received no specific treatment at all, despite their mental health difficulties. Information on the psychiatric histories of close family members of defendants was unknown in a large proportion (60%) of cases. In the remainder of women in whom the family psychiatric history was known, the largest proportion (n = 31) were of mental illness in first-degree relatives i.e. parents, siblings and/or biological children.

Table 15
Pre-offence Mental Health and Medical History

Variable	Category	Frequency (%)
Pre-offence psychiatric history (n = 170)	Nil	44 (25.9)
	Psychotic disorders	50 (29.4)
	Depressive disorders	20 (11.8)
	Bipolar disorders	17 (10.0)
	Other mental disorders	18 (10.6)
	Unspecified	24 (12.3)
Pre-offence substance use (n = 172)	Nil	81 (47.1)
	Alcohol only	45 (26.2)
	Alcohol and cannabis only	27 (15.7)
	Alcohol and prescription medication only	3 (1.7)
	Alcohol, cannabis and other substances	8 (4.7)
	Cannabis only	6 (3.5)
	Prescription medication only	2 (1.1)
Pre-offence medical history	Nil	88 (50.9)

Variable	Category	Frequency (%)
(n = 173)	HIV infection	38 (22.0)
	Epilepsy	11 (6.4)
	Traumatic brain injury	6 (3.5)
	Other (including medical comorbidity)	30 (17.2)

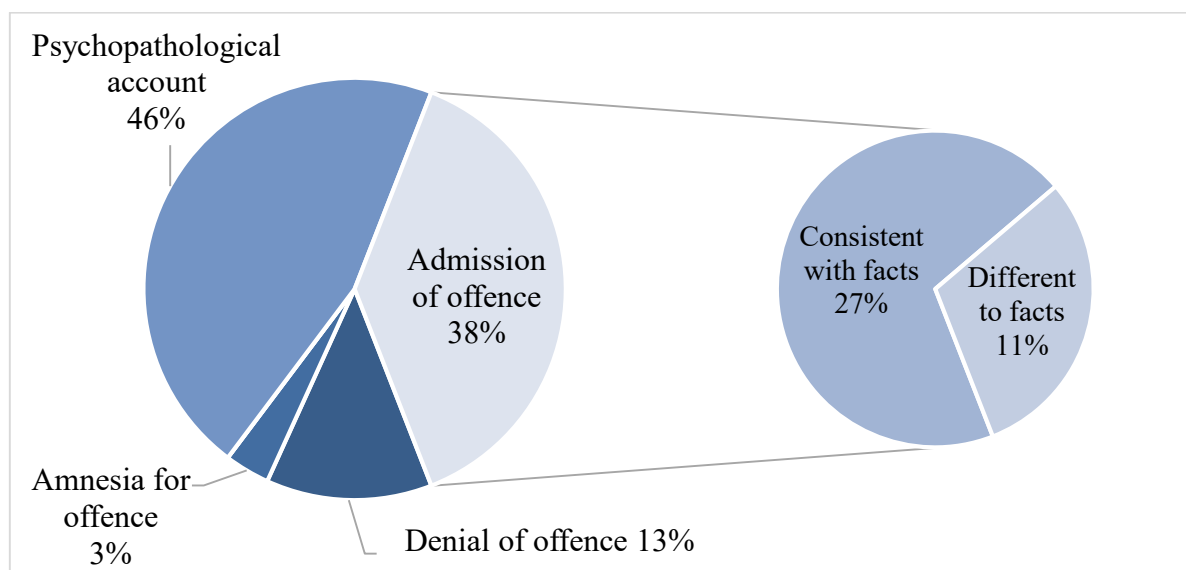
In respect of pre-offence substance use, almost half of women (47%) denied any substance use history at all. In the remainder, alcohol was by far the most commonly used substance prior to offending, used alone or in combination with other substances by 91% of all women who reported using substances (n = 83/91). Cannabis was the second most common substance of choice, reported (alone or in combination with other substances) by 45% (n = 41/91) of women who used substances (Table 15).

Approximately half the women referred for forensic assessment had no prior medical history (n = 88; 51%) (Table 15). Of the remainder, almost a quarter of women (22%) were HIV positive, being the most common medical condition present at the commencement of the forensic evaluation period. A history of epilepsy or traumatic brain injury was present in a small proportion of cases (10%), whilst almost one-fifth of women (17%) had other medical morbidities (including cases in which two or more medical conditions were present i.e. medical comorbidity).

Self-reported Versions of Index Offence. The content and reliability of self-reported accounts of the index offences provided by individual defendants during their forensic evaluation at FEH were dependant on numerous factors, including: the presence of active psychopathology; the forensic and criminal context of the assessment (e.g. possible secondary motives to evade conviction); nature and circumstances of the index offence in question; personal context and circumstances of the defendant; quality of referral information received

from the court upon referral; availability and reliability of collateral sources of information (e.g. family members or victims) and so forth. An attempt was made to categorize the various accounts of the offence provided by defendants into distinct themes (although it is acknowledged that such categorization is arbitrary in nature). Nonetheless, as shown in Figure 6, almost half ($n = 79/173$; 46%) of defendants had clinical evidence of active psychopathology that was severe enough to render the reliability of their respective accounts questionable e.g. defendants who were formally thought disordered (hence providing information on the offence that was disorganized, illogical or incoherent); delusional (hence distorting accurate, reality-based recollection of the offence, and/or their motivations for their actions at the time); or neurocognitively impaired / intellectually disabled (hence providing information which was impoverished or devoid of sufficient detail). A further proportion of defendants denied any involvement with the index offence (13%), or claimed complete amnesia for the alleged offence (3%), and therefore failed to provide any account of any offence at all. In the remainder (27% of defendants) admitted to committing the offence and provided versions thereof that were consistent with the “facts of the case” (i.e. the criminal evidence) contained in the various documents provided by courts upon referral for assessment. A further 11% of cases admitted to involvement in the offence in question, but provided versions thereof that were substantially different from the facts contained in the criminal docket.

Figure 6
Self-reported Versions of Index Offence



Mental Health Assessment. The prevailing mental state during the period of forensic assessment at FEH was normal (i.e. no evidence of active phase psychopathology) in 39% of cases (Table 16). Over a third of women (34%) were assessed to be psychotic at the time of evaluation, representing the most frequent clinical presentation of mental disorder documented. Clinically significant mood disturbances, i.e. major depressive, manic or mixed mood episodes (with or without psychosis), were noted in 12% of cases, whilst the remainder presented with neurocognitive disorders or intellectual disability (in approximately equal proportions).

Table 16
Prevailing Mental State and Psychological Testing Outcomes at Forensic Evaluation (n = 173)

Variable	Category	Frequency (%)
Prevailing mental state	Normal	67 (38.7)
	Psychosis	59 (34.1)
	Mood episode	21 (12.1)
	Neurocognitive impairment	14 (8.2)
	Intellectual impairment	12 (6.9)
Psychological testing outcomes	Normal / not tested	136 (78.6)
	Intellectual disability	15 (8.7)
	Neurocognitive disorder	13 (7.5)

Variable	Category	Frequency (%)
	Personality disorder	6 (3.5)
	Unknown / unspecified	3 (1.7)

A range of psychological tests, scales and instruments may be employed (as clinically appropriate) in the course of the forensic assessment process at FEH, ranging from “bedside” cognitive screening tools (e.g. Folstein’s Mini Mental State Examination, Montreal Cognitive Assessment) to more formal psychometric tests (e.g. Raven’s Progressive Matrices, Weschler Adult Intelligence Scale for intellectual assessment; Frontal Assessment Battery for executive and frontal lobe functioning; Minnesota Multiphasic Personality Inventory, Millon Clinical Multiaxial Inventory or the Psychopathy Checklist Revised for personality assessments, etc.). Psychological testing was either not clinically indicated or outcomes were within normal ranges in the majority of women (79%). Intellectual disability was confirmed in 9% of cases, neurocognitive disorder in 8%, and personality disorder in less than 4% of cases (Table 16).

Diagnostic Findings. Prior to the publication of the DSM-5 (American Psychiatric Association, 2013), the custom was to express the diagnostic and related clinical conclusions on the multi-axial system introduced by the DSM-III (American Psychiatric Association, 1980). The majority (n = 113; 65% of cases) of clinical records at FEH (i.e. all those prior to the publication of DSM-5) used the multi-axial system. For the purposes of consistency and simplicity, and in order to accommodate differences in terminology and categorization between the successive DSM versions in use over the study period (i.e. DSM III, DSM IV, DSM-IV-TR and DSM-5 respectively), all clinical diagnoses stated in case clinical records across the entire study period were listed on Axes, I, II and III respectively and grouped as indicated in Table 17. In addition, for purposes of further analysis (expanded on in the results sections that follow) the forensic clinical diagnoses listed in the final psychiatric court reports were

collapsed into simpler diagnostic categories e.g. all cases diagnosed with bipolar disorders and depressive disorders were combined into a single “mood disorders” category as indicated in Table 17.

Table 17

Multi-axial Diagnostic Categorization Used for Present Study (adapted from the DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013) respectively)

Axis	Specific diagnoses	Diagnostic category	
I	Axis I neurodevelopmental disorders (e.g. autism-spectrum disorders; attention deficit hyperactivity disorder (ADHD); specific learning disorders)	Neurodevelopmental disorders	
	All psychotic spectrum disorders i.e. schizophrenia; brief psychotic disorder; schizophreniform disorder; schizoaffective disorder psychotic disorder secondary to medical conditions or substances)	Psychotic disorders	
	All bipolar disorders All depressive disorders	Mood disorders	
	All anxiety, obsessive-compulsive and trauma/stressor-related disorders (including adjustment disorders)	Anxiety disorders	
	Alcohol-related disorders All other substance-related disorders	Substance disorders	
	All neurocognitive disorders i.e. delirium; dementia; neurocognitive disorders secondary to medical conditions or substances	Neurocognitive disorders	
	Malingering Borderline intellectual functioning All other V-codes	Other clinical conditions that may be focus of clinical attention (V-codes)	
	All other Axis I mental disorders	Other Axis I mental disorders	
	II	Mental retardation / intellectual disability	Neurodevelopmental disorders
	Cluster A personality disorders Cluster B personality disorders	Personality disorders	

Axis	Specific diagnoses	Diagnostic category
	Cluster C personality disorders	
III	Human Immunodeficiency Virus (HIV) infection	Medical disorders
	Neurological disorders (including epilepsy and traumatic brain injury)	
	All other medical conditions	
I, II and/or III	Any mental disorder (on Axis I or II) co-occurring with at least one other clinical diagnosis (on any Axis)	Psychiatric comorbidity

The key diagnostic outcomes, expressed separately for Axis I (mental disorders), Axis II (intellectual disability and personality disorders) and Axis III (medical disorders), are provided in Table 18. There was no diagnosis made on Axis I in 15% of cases ($n = 26$). Psychotic disorders comprised the most common diagnostic category, being present in almost one-third of all cases (32%), with schizophrenia being the single most common mental disorder diagnosed (in 18.5% of cases; $n = 32$). Cases in which substance-related disorders occurred as the only Axis I diagnosis comprised 16% of cases ($n = 27$), with alcohol being involved in more cases ($n = 16$) than all other substances combined. The category “Axis I comorbidity” incorporated women in whom more than one Axis I diagnosis was made (19% of cases; $n = 33$). Cases of so-called “dual diagnosis” (in whom a substance-related disorder was co-morbid with another mental disorder), was the most common type of Axis I comorbidity present ($n = 30/33$ cases), and over 90% of these dual diagnosis cases were alcohol-related. In other words, one-third of all women offenders (33%; $n = 57$) were diagnosed with a substance-related Axis I diagnoses, either independently ($n = 27$), or in combination with another mental disorder ($n = 30$), with alcohol being, by a significant margin, the most commonly implicated substance of misuse. Furthermore, a total of 23 women (13% of the sample) were intoxicated at the time of the offence, with over 95% of these women being intoxicated with alcohol in particular. Whilst

mood disorders comprised only around 12% of Axis I diagnoses, bipolar disorders were diagnosed more frequently than depressive disorders ($n = 14$ versus $n = 6$ respectively).

Table 18
Multi-axial Diagnoses (n = 173)

Axis	Category	Specific diagnoses	Diagnostic frequency	Category total (%)	
I (mental disorders)	No Axis I diagnosis			26 (15.0)	
	Psychotic disorders			55 (31.8)	
		Schizophrenia	32		
		All other psychotic disorders	23		
		Mood disorders			20 (11.6)
			Bipolar disorders	14	
			Depressive disorders	6	
		Substance disorders			27 (15.6)
			Alcohol-related disorders	16	
			All other substance-related disorders	11	
		Neurocognitive disorders			8 (4.6)
			Dementia / major neurocognitive disorders	5	
			Delirium	3	
		Axis I comorbidity			33 (19.0)
			Dual diagnosis	30	
			All other Axis I comorbidity	3	
	Other Axis I mental disorders			4 (2.4)	
		All other Axis I mental disorders	4		
			Total	173 (100)	
II (intellectual disability and personality disorders)	No Axis II diagnosis			142 (82.1)	
	Neurodevelopmental disorders			13 (7.5)	
		Mental retardation / intellectual disability	13		
		Personality disorders			18 (10.4)
			Cluster B personality disorders	15	
			Cluster C personality disorders	3	
			Total	173 (100)	

Axis	Category	Specific diagnoses	Diagnostic frequency	Category total (%)
III (medical disorders)	No Axis III diagnosis			88 (50.9)
	Medical disorders			51 (29.5)
		HIV infection	38	
		Neurological conditions	13	
	Axis III comorbidity			4 (2.3)
	All other Axis III medical disorders			30 (17.3)
			Total	173 (100)

Diagnostic findings for Axis II (personality and intellectual disorders) are also summarized in Table 18. The vast majority of cases ($n = 137$; 79%) had no Axis II diagnosis reflected in psychiatric court reports. Personality disorders were diagnosed in 10% of cases, with the vast majority of these (15/18) being of the Cluster B type. Intellectual disability (referred to as mental retardation prior to DSM-5) were diagnosed in a further 10% of cases.

Just over half of cases (51%) had no Axis III medical disorders stated on final psychiatric court reports (Table 18). The single most common medical diagnosis made was HIV infection, in over one-fifth of cases (22%). Neurological conditions (including epilepsy and traumatic brain injury) comprised less than 8% of cases. A heterogeneous group of other medical conditions (e.g. hypertension, diabetes mellitus, non-HIV infectious conditions, etc), and those with medical comorbidity on Axis III, comprised the remainder.

Forensic Profile

Following the completion of the forensic assessment at FEH, a summarized psychiatric court report is formally submitted to the referring court which addresses the specific legal brief outlined by the court upon referral, as per the CPA (1977) and its amendments. The key psycholegal items which the court report signatories submit a formal expert mental health

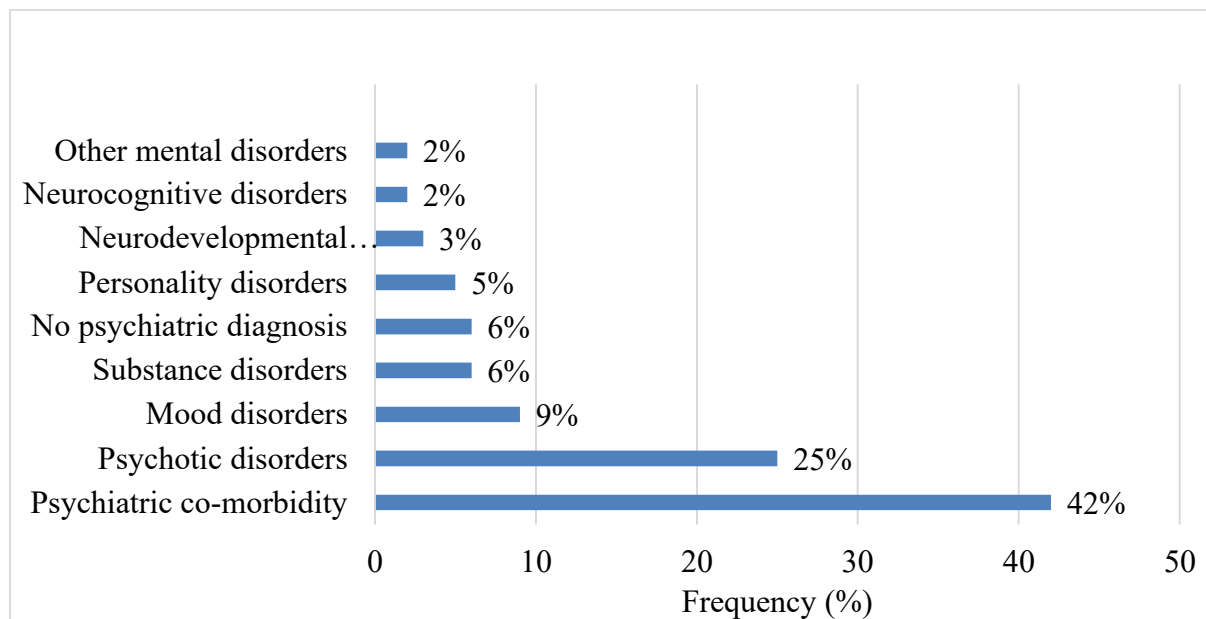
professional opinion on are: (a) the presence of any severe mental disorder pertinent to the criminal and forensic issues under consideration, and the details thereof; (b) trial competence i.e. the ability of the defendant to understand court proceedings; (c) criminal capacity i.e. the defendant's ability to appreciate the wrongfulness of the index offence (the cognitive component), and ability to act in accordance with such appreciation of wrongfulness (the volitional component); and (d) recommendations to the court on the further courses of action based on the forensic outcomes. Further details are provided in Appendix 10, which is the generic template of the psychiatric court report provided by the FEH forensic service to referring courts.

Forensic Diagnostic Outcomes. Combined, multi-axial forensic diagnostic outcomes, as stated in final psychiatric court reports (and categorized as outlined in Table 18 above), are illustrated in Figure 7. The category "psychiatric comorbidity" refers to the co-occurrence of: (a) any primary mental disorder (e.g. severe forms of mental illness, neurocognitive disorders and intellectual disability) *and* (b) at least one other Axis I, II and/or III disorder (including substance-related disorders, personality disorders and medical disorders with sufficiently significant mental health effects to have been included in the court psychiatric report e.g. HIV or neurological conditions). The psychiatric comorbidity forensic diagnostic group constituted the largest proportion overall ($n = 73$; 42% of total sample), with the majority of these cases involving dual diagnoses (i.e. cases with a substance-related disorder co-occurring with at least one other Axis I and/or II mental disorder), followed by women in whom a diagnosis of HIV infection co-occurred with an Axis I and/or II mental disorder. The second most frequent forensic diagnostic grouping was for the psychotic spectrum disorders (a quarter of all cases), the majority of which comprised cases of schizophrenia. Mood disorders comprised 9% of all cases. Substance-related and personality disorder groups

constituted between 5 – 6% each, and no mental disorder diagnosis was made in 6% of all cases. In summary, well over three-quarters of cases (83%) were diagnosed with a severe mental disorder (i.e. excluding women in whom no diagnosis was made, or those in which only substance-related disorders or personality disorders were diagnosed) (Figure 7).

Figure 7

Final Forensic Diagnostic Categories in Psychiatric Court Reports (n = 173)



Trial Competence and Criminal Capacity. Just over half (n = 90; 52% of cases) of women offenders were deemed to lack trial competence at the time of forensic evaluation at FEH (Table 19). These were women who were hence considered unable to adequately assist their legal counsel in the criminal proceedings against them by virtue of mental health problems (e.g. as a consequence of mental illness, neurocognitive impairment or intellectual disability). Similarly, the majority of women offenders (n = 96; 55.5% of cases) were evaluated to lack criminal capacity with respect to the commission of the index offences. These were women in whom a diagnosed mental disorder significantly impaired, at the time of the offence itself: (a) their cognitive capacity i.e. the ability to appreciate the wrongfulness

of the act in question; and/or (b) their volitional capacity i.e. the ability to act in accordance with such an appreciation of its wrongfulness. In other words, the lack of criminal capacity was evaluated to be due to a direct and demonstrable causal nexus between the unique features of the diagnosed mental disorder in the individual woman offender, on the one hand, and the unique circumstances and nature of the index offence which she committed, on the other. In those in whom criminal capacity was impaired (n = 96), approximately equivalent proportions of cases did not have the cognitive capacity to adequately appreciate wrongfulness of the offence (n = 47), as compared to those who had an appreciation of wrongfulness but lacked the volitional capacity to act in accordance (n = 49), respectively.

Table 19
Trial Competence and Criminal Capacity (n = 173)

Trial competence	Criminal capacity		Total (%)
	Yes (%)	No (%)	
Yes	70 (40.5)	13 (7.5)	83 (48.0)
No	7 (4.0)	83 (48.0)	90 (52.0)
Total (%)	77 (44.5)	96 (55.5)	173(100)

Of further note from Table 19 is the fact that 70 women (40.5%) referred by courts for forensic evaluation were deemed to have both trial competence and criminal capacity, despite any mental health issues that initiated the referral in the first place. Almost half of women (n = 83; 48%) were found to be *both* trial incompetent *and* not criminally responsible for their offences.

Recommendations to Courts. A summary of final court recommendations, as stated in psychiatric court reports (n = 171), is shown in Table 20. The forensic mental health professionals who conducted the forensic evaluation make such recommendations on the basis of the combination of forensic diagnostic outcomes with conclusions on trial

competence and criminal capacity (in accordance with the algorithm of forensic processes in South Africa outlined in in Figure 1). It was therefore recommended that the law take its course in the 69 individuals (40% of cases) who were deemed both trial competent *and* criminally responsible for offences committed. Diversion to mental health services for therapeutic care, treatment and/or rehabilitation (as opposed to punitive criminal conviction) was recommended in women offenders who were diagnosed with a severe mental disorder which impacted on the forensic parameters of trial competence and/or criminal capacity: (a) to general mental health services for women who committed non-violent offences (n = 41; 24%); or (b) to forensic mental health services for those who committed violent offences (n = 61; 36%) respectively.

Table 20

Recommendations to Courts (n= 171)

Recommendation	Frequency (%)
Law to take its course	69 (40.4%)
Referral to general mental health services as “involuntary” patients	41 (24.0%)
Referral to forensic mental health services as forensic “state patients”	61(35.6%)

Forensic Mental Health Profile of Violent Offenders

A more detailed description of the forensic mental health profile of violent women offenders and their offences is provided below, commencing with an overview of women who committed violent offences in general, followed by an examination of contrasts between perpetrator and victim profiles in cases of different types of violence i.e. non-lethal versus lethal violence; violence against adult versus child victims; and different types of homicidal violence (e.g. mariticial, femicidal, neonaticidal and infanticidal offences) respectively. Sub-sample sizes for all the frequency tables were based only cases in which specific, explicit information

was available for the variables of interest (hence sub-sample sizes may differ from variable to variable accordingly).

Overview of Violent Offenders. There was a total of 105 violent index offences, with the overall forensic mental health profile of the perpetrators being provided in Table 21 (whilst there were 105 violent index offences, sufficient information about victims was not available in the forensic records of all cases). The mean age of violent offenders was 37.8 years, with almost two-thirds being over the age of 30 years. As with the sample as a whole, the majority of violent offenders were single (70%), had dependent children (85%), had poor educational attainment (only 47% progressed beyond Grade 8 at school), and were unemployed at the time of their arrest (80%). Most women were first-time offenders, with only a small proportion (13%) having prior criminal histories. Half of the women used a weapon for the offence, mostly sharp weapons (especially knives) used to inflict penetrative injuries in over one-third of all violent offences. Victims of violence were adults in the majority of cases (68%) for which the information was available in the forensic records; similarly, there was also a preponderance of female victims (59% of cases in which this information was specified). Active psychopathology was responsible for the commission of violence in just over half (51%) of all cases. Motives related to interpersonal conflict accounted for a further one-third of cases. Almost one-third of violent offenders had a pre-offence history of being victims of abuse themselves. The majority also had pre-offence histories of psychiatric problems (68%) and substance misuse (52%). Over two-thirds (68%) of violent women were diagnosed with a severe mental disorder (i.e. any severe Axis I and/or II disorder, including intellectual disability but excluding solely occurring substance-related or personality disorders) following forensic evaluation: these were most commonly schizophrenia or other psychotic spectrum disorders (25% of cases) or women with complex forms of psychiatric comorbidity (24%) respectively.

Half of these women were nonetheless deemed trial competent, and slightly less than half (45%) were considered criminally responsible for their offences.

Table 21

Forensic Mental Health Profile of Violent Offenders (n = 105 unless otherwise stated)

Variable	Category	Frequency (%)
Sociodemographic profile	Age > 30 years	67 (63.8)
	Marital status: single	73 (69.5)
	Dependent children	89 (84.8)
	Highest level of education > Grade 8	56 (46.7)
	Unemployed at arrest	84 (80.0)
Offence profile	Prior criminal history	14 (13.3)
	Weapon use for offence	52 (49.5)
	<i>Victim profile:</i>	
	Adult	69/101 (68.3)
	Child	32/101 (31.7)
	Male	37/91 (40.6)
	Female	54/91 (59.4)
	<i>Primary motive for offence:</i>	
	Psychopathology	53 (50.5)
	Interpersonal conflict	34/101 (33.7)
Clinical profile	Prior abuse of offender	34 (32.4)
	Prior psychiatric history	67 (63.8)
	Prior substance misuse history	55 (52.4)
	Severe mental disorder (Axis I or II)	71 (67.6)
Forensic profile	Trial competence	52 (49.5)
	Criminal capacity	47 (44.8)

Violence Against Adults. There was a total of 101 victims of violent index offences about which sufficient data was available for further examination, with the majority of these (n = 69; 68%) being adults. Table 22 illustrates a number of key outcomes in respect of violent offences against adults in particular (sub-sample sizes reflect cases for which specific information on the respective variables was available in the forensic records). Adult females

were the targets of violent offences in almost two-thirds of cases (64%). The vast majority of adult victims ($n = 58/62$; 94%) were known to the offender: as intimate male partners (21%); family members (39%); or neighbours, friends or acquaintances (34%) respectively. Conclusions on the likely primary “motives” for violence were drawn from examination of multiple sources, including: criminal evidence provided by courts upon referral (including prosecutors reports detailing the “facts of the case”, official court evidence, witness statements, statements made by the accused upon arrest, etc.); the accounts of the defendants themselves during clinical interviews; assessment of their mental state at the time of the offence; and the psychiatric court reports submitted upon completion of the forensic assessment. Table 22 shows that active psychopathology motivated the behaviour of almost 60% of violent women offenders who targeted adult victims. In cases where mental disorder did not play a role in the commission of the offence, retaliatory or revengeful acts in the context of inter-personal conflict with the victim (i.e. volitional behaviour, which included acts of self-defence) accounted for the largest proportion of cases (33%). Substance-related factors (especially the disinhibiting effects of alcohol intoxication) at the time of offence was the reason for violent offending behaviour in the remainder.

Table 22
Violence Against Adults

Variable	Category	Frequency (%)
Gender of victim ($n = 66$)	Male	24 (36.4)
	Female	42 (63.6)
Relationship of victim to offender ($n = 62$)	Intimate male partner	13 (20.9)
	Parent	9 (14.5)
	Sibling	5 (8.1)
	Other relatives	10 (16.1)
	Neighbour / friend / acquaintance	21 (33.9)
	Stranger	4 (6.5)

Variable	Category	Frequency (%)
Primary "motive" for offence (n = 69)	Psychopathology	40 (58.0)
	Inter-personal conflict	23 (33.3)
	Substance-related	4 (5.8)
	Other	2 (2.9)

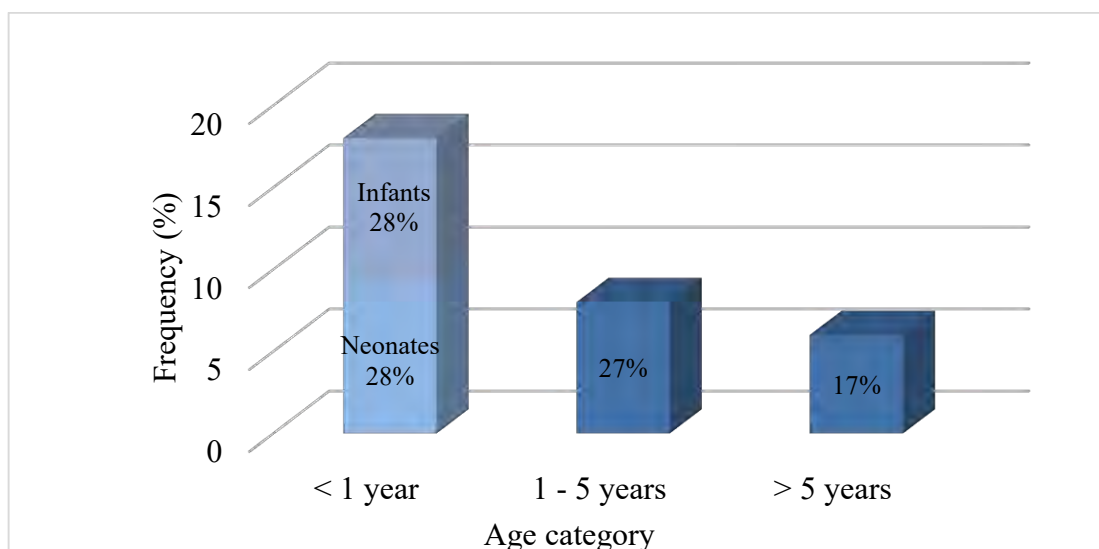
Violence Against Children. A total of 32 children were victims of violent index offences, comprising almost one-third of all victims of violence, with the vast majority of these children (n = 28; 88%) being victims of homicide. The gender, age, relationship to offender and primary "motives" for violent offending against children are shown in Table 23 (sub-sample sizes reflect cases for which specific information on the respective variables was available in the forensic records).

Table 23
Violence Against Children

Variable	Category	Frequency (%)
Age of victim (n = 32)	Neonate (< 1 month)	9 (28.1)
	Infant (1 month – 1 year)	9 (28.1)
	Older child (> 1 year)	14 (43.8)
Gender of victim (n = 27)	Male	14 (51.9)
	Female	13 (48.1)
Relationship to offender (n = 32)	Biological child	26 (81.3)
	Child of relative	3 (9.4)
	Child of friend / acquaintance	1 (3.1)
	Child of stranger	2 (6.2)
Primary "motive" for offence (n = 31)	Psychopathology	13 (41.9)
	Inter-personal conflict	6 (19.4)
	Unwanted child	5 (16.1)
	Impulsive	4 (12.9)
	Substance-related	2 (6.5)
	"Altruistic"	1 (3.2)

The mean age of child victims at the time of the offence was 30.3 months. Over 56% of child victims were under one-year of age (equally proportioned for neonates (less than one month old) and infants (one month to one year of age) respectively), with the remainder (44%) being older than one year of age at the time of the offence (Table 23). The skewed distribution of age of child victims of violence is more explicitly illustrated in Figure 8 below, in which it is apparent that the risk of children falling victim of violence was approximately inversely proportional to age i.e. the risk was highest for neonates and infants under a year old, and grew progressively less with increasing age beyond this. In cases in which gender of child victims was specified ($n = 27$), an approximate gender equivalence was evident for those targeted (Table 23). Furthermore, child victims were biological children of violent offenders in a significant majority ($n = 26$; 81%) of cases, and the child victim was known to the offender in 94% of cases.

Figure 8
Age Distribution of Child Victims of Violence ($n = 32$)



As previously reviewed in earlier chapters, there are many different approaches to classifying motives for violent offences against children (especially homicidal offending by

mothers against their biological offspring). As each of these typologies have different strengths, limitations and utility, for the purpose of the current analysis as many of the common features of the most prominent typologies were incorporated into a combined classification system. Primary motives for violent offences against children were hence categorized as those due to: (a) *psychopathology*: offences which were directly and demonstrably related to active psychopathology as a result of severe mental disorder (but excluding substance-related disorders and personality disorders) of the offender; (b) *inter-personal conflict*: retaliatory or revengeful offences motivated by interpersonal conflict (usually, but not exclusively, with the father of the child victim); (c) *unwanted child*: offences motivated by children that were perceived by offenders as unwanted or burdensome, leading to deliberate acts of violence, abuse and/or neglect (usually, but not exclusively, directed at neonates); (d) *impulsive*: offences motivated by perceived provocation by the child victim, leading to impulsive, enraged acts of violence by battery or other forms of physical abuse (usually, but not exclusively, with non-lethal intent); (e) *substance-related*: offences directly, demonstrably and primarily related to the effects of substances of abuse (usually, but not exclusively, during intoxication); and (f) *altruistic*: offences in which the primary motive was related to the perceived alleviation of suffering of the child victim (e.g. so-called “mercy killing”).

Table 23 demonstrates that active psychopathology at the time of offence directly accounted for only 13 cases (42%) of violence against children, with the majority of women offenders motivated by factors other than mental ill-health. This represents a reversal of the adult victim pattern (Table 22), in which motives related to psychopathology of perpetrators accounted for the majority of violent cases (58%), with the minority motivated by other, non-psychopathological variables. Violence related to retaliation or revenge secondary to interpersonal conflict with others (most commonly with the father of the victims) accounted

for the second largest category, comprising almost one-fifth of cases (19%). Children that were perceived by women offenders as unwanted or burdensome, and leading to deliberate acts of violence or neglect, accounted for 16% of cases. A similar proportion of cases (13%) were attributed to impulsive violence as a result of perceived provocation by the child victim. Violence directly attributed to the effects of substances, especially alcohol, (during either intoxication and/or withdrawal, but more commonly the former) accounted for 7% of cases, with “altruistic” violence accounting for the remainder (3%), in which the child was harmed in order to relieve suffering (most commonly related to hardship related to socio-economic distress).

Homicidal Offences. A total of 51 cases of homicide (including murder and attempted murder) were recorded, comprising 30% of index offences. Over two-thirds (68.6%) of homicidal offenders were diagnosed with an Axis I and/or II mental disorder, with psychiatric comorbidity comprised the largest group in these cases (28%), followed by psychotic disorders (22%), substance-related disorders (12%), mood disorders (10%) and personality disorders (6%) respectively. A comparison of offender and victim profiles in cases of violent but non-homicidal offences versus homicidal offences in general is undertaken below, followed by more detailed descriptions and comparisons of homicidal violence against adults and children respectively. As indicated before, sub-sample sizes for all the frequency tables that follow may differ according the availability of specific information in the forensic records for specific variables of interest.

Non-homicidal and Homicidal Violence. Table 24 highlights key aspects of offender and victim profiles in cases of violent but non-homicidal (n = 54) versus homicidal offences (n =

51) respectively. This will be followed by a detailed consideration of different types of homicidal offences and the perpetrators of these.

Table 24

Non-homicidal Violence (n = 54 unless otherwise stated) and Homicidal Violence (n = 51 unless otherwise stated)

Variable	Category	Violent non-homicidal offences	Homicidal offences	
		Frequency (%)	Frequency (%)	
Sociodemographic profile	Age > 30 years	34 (63.0)	33 (64.7)	
	Marital status: single	43 (79.6)	30 (58.8)	
	Dependent children	44 (81.5)	45 (88.2)	
	Education > Grade 8	29 (53.7)	20 (39.2)	
	Unemployed at arrest	46 (85.2)	38 (74.5)	
Offence profile	Prior criminal history	6/51 (11.8)	8/47 (17.0)	
	Weapon use	28/43 (65.1)	24 (47.1)	
	<i>Victim profile:</i>			
	Adult	46/50 (92.0)	23 (45.1)	
	Child	4/50 (8.0)	28 (54.9)	
	Male	13/46 (28.3)	24/35 (68.6)	
	Female	33/46 (71.7)	21/35 (60.0)	
	Intimate male partner	3/40 (7.5)	10/22 (45.5)	
	Biological child	3/5 (60.0)	23/27 (85.2)	
	<i>Primary motive for offence:</i>			
	Psychopathology	33/51 (64.7)	20/49 (40.8)	
	Interpersonal conflict	12/49 (24.5)	11/52 (21.2)	
	Clinical profile	Prior abuse of offender	11 (20.4)	23 (45.1)
Prior psychiatric history		44/53 (83.0)	27/49 (55.1)	
Prior substance misuse history		30 (55.6)	25/50 (50.0)	
Severe mental disorder (Axis I or II)		45 (83.3)	35 (68.6)	
Forensic profile	Trial competence	20 (37.0)	32 (62.7)	
	Criminal capacity	19 (35.2)	28/50 (56.0)	

The majority of violent offenders were, irrespective of the lethality of their offence, similar in overall socio-demographic profile to the rest of the sample: relatively old (above the age of 30 years), single with dependent children, with relatively poor educational attainment, and high rates of unemployment at the time of arrest. Nonetheless, women who committed non-homicidal violent offences tended to be slightly older (mean ages 39.4 years) than homicidal women (mean age 36.4 years) respectively. Table 24 shows that perpetrators of non-homicidal violence also tended to be more commonly single and unemployed at time of arrest, but with proportionately better educational attainment. Whilst homicidal women tended to have offended previously (though still in the minority of instances), they were also relatively less likely to have used weapons against their victims. The vast majority of victims of non-lethal violence were adults, whereas children were more commonly targeted in cases of homicide. In addition, males were more commonly the victims of homicide, with the opposite being the case for non-homicidal offences. Intimate male partners were disproportionately targeted in cases of adult homicide (in comparison to any other single category of adult victim), and biological children in child homicide cases respectively. There were relatively more violent but non-homicidal offences motivated by psychopathology than was the case for homicidal offences (65% versus 41% respectively), with interpersonal conflict being the second most commonly cited motive for both non-homicidal and homicidal violence (25% and 21% respectively). Whilst homicidal women were more frequently experienced prior abuse, women who committed violent but non-homicidal offence tended more often to have had prior mental health difficulties (i.e. higher proportion of the latter group had prior substance abuse and psychiatric histories) as well as higher rates of severe mental disorder diagnosed following forensic evaluation e.g. severe psychotic disorders, mood disorders, neurocognitive disorders or psychiatric comorbidity on Axis I, or intellectual disability on Axis II (i.e. excluding substance-related and/or personality disorders). Finally, the majority of homicidal women were assessed

as trial competent and/or criminally responsible for their actions, whereas this was the case in the minority who committed non-lethal acts of violence (Table 24).

Homicide of Adults and Children. A comparison of cases of homicide against adult (n = 23) and child victims (n = 28) respectively is provided in Table 25. Whilst the socio-demographic profile of both groups was generally in keeping with that of the total sample, these two samples demonstrated a few key differences. Women who murdered adults tended to be older (mean age 42.8) and less well educated (only 17% attaining higher than Grade 8 at school) than those who murdered children (mean age 30.9; 57% progressing beyond Grade 8). Women who killed adults, in comparison to those killed children, also more frequently had a prior criminal record (30% versus 12%), and used weapons in the commission of the offence (87% versus 14%). Stabbing with a sharp object was the most common single method used in the commission of homicidal acts against adults (54% of cases), whilst the most common methods used to kill children were by suffocation / strangulation (25%) and blunt trauma / battery (21%) respectively. There was a slight male preponderance of victims, irrespective of whether they were adults or children. In respect of relationship between homicide offenders and their victims: the vast majority of victims were known to the offenders in cases of homicide; intimate male partners were the most frequent category of adult victims (46%); and biological children were the most frequent category of child victims (86%) respectively.

As also shown in Table 25, active psychopathology at the time of offence appeared more common in women who killed adults than children (48% versus 32%). Besides psychopathology at the time of offence, other common motive categories in women who murdered adults were retaliation or revenge in the context of interpersonal conflict with the victim (48%), with intimate male partners being the most common group of victims in these

latter cases. Non-psychopathological motives for child homicide were more varied and included: interpersonal conflict (most often with the biological father of the victim) (21%); impulsive, enraged attacks on the child secondary to perceived problems related to the provision of maternal care (18%); and pre-conceived killings related to the removal of unwanted children (18%) respectively.

In respect of pre-offence mental health, women who killed adults were also much more commonly: the victims of pre-offence abuse themselves (57% versus 36%); had prior psychiatric histories (74% versus 39%); and had substance-related problems (70% versus 36%) respectively. Similarly, the minority of women who killed children had a severe mental disorder (43%), versus the majority of women who killed adults (70%). For mentally ill women who killed adults, psychiatric comorbidity was the most common single final forensic diagnostic grouping (44% of cases); as opposed to schizophrenia and other psychotic-spectrum disorders being most common in mentally ill women who killed children (29%). In comparison to women who killed adults, those who killed children were also more often trial competent (71% versus 57%) and criminally responsible (68% versus 48%) respectively (Table 25).

Table 25

Homicide of Adults (n = 23 unless otherwise stated) and Homicide of Children (n = 28 unless otherwise stated)

Variable	Category	Homicide of adults	Homicide of children
		Frequency (%)	Frequency (%)
Sociodemographic profile	Age > 30 years	18 (78.3)	15 (53.6)
	Marital status: single	13 (56.5)	18 (64.3)
	Dependent children	21 (91.3)	25 (89.3)
	Education > Grade 8	4 (17.4)	16 (57.1)
	Unemployed at arrest	19 (82.6)	20 (71.4)
Offence Profile	Prior criminal history	7 (30.4)	3/26 (11.5)
	Weapon use	20 (87.0)	4 (14.3)

Variable	Category	Homicide of adults	Homicide of children
		Frequency (%)	Frequency (%)
	<i>Victim profile:</i>	12 (52.2)	15 (53.6)
	Male	11 (47.8)	13 (46.4)
	Female		
	<i>Adult victims:</i>		
	Intimate male partner	10/22 (45.5)	-
	Other relatives	5/22 (22.7)	-
	Acquaintance / friend / stranger	7/22 (31.8)	-
	<i>Child victims:</i>		
	Biological child	-	24 (85.8)
	Child of relative	-	2 (7.1)
	Child of acquaintance / friend / stranger	-	2 (7.1)
	<i>Primary motive for offence:</i>		
	Psychopathology	11 (47.8)	9 (32.1)
	Interpersonal conflict	11 (47.8)	11 (21.4)
	Unwanted child	-	5 (17.9)
	Impulsive attacks	-	5 (17.9)
	Other	1 (4.4)	3 (10.7)
Clinical profile	Prior abuse of offender	13 (56.5)	10 (35.7)
	Prior psychiatric history	17 (73.9)	11 (39.3)
	Prior substance misuse history	16 (69.6)	10 (35.7)
	Severe mental disorder (Axis I or II)	16 (69.6)	12 (42.9)
Forensic profile	Trial competence	13 (56.5)	20 (71.4)
	Criminal capacity	11 (47.8)	19 (67.9)

Mariticide and Femicide. As demonstrated in Table 25, intimate partners were disproportionately targeted in cases of lethal violence against adults, and all cases of intimate partner homicide were male. Almost as many adult women were victims of homicide as men (48% of victims were women), and adult victims who were not intimate partners were also predominantly women (79%), with 90% of these female victims being known to the offender (as parents, siblings, other relatives, friends or acquaintances). Despite the relatively small

sub-sample sizes, a descriptive comparison regarding cases of murder of intimate male partners (mariticide; $n = 10$) and women (femicide; $n = 11$) respectively, the results of which are shown in Table 26. Whilst most women (60%) who killed their intimate male partners were above the age of 30 years (mean age of 39.2 years), a greater proportion of women who killed other women (90%) were older than 30 years (mean age 46.5 years). Relatively more femicidal than mariticial women were single (70% versus 46%), had dependent children (91% versus 80%) and were unemployed at the time of arrest (91% versus 80%).

Table 26

Mariticide (n = 10 unless otherwise stated) and Femicide (n = 11 unless otherwise stated)

Variable	Category	Mariticide	Femicide
		Frequency (%)	Frequency (%)
Sociodemographic profile	Age > 30 years	6 (60.0)	10 (90.9)
	Marital status: single	7 (70.0)	5 (45.5)
	Dependent children	8 (80.0)	10 (90.9)
	Education > Grade 8	1 (10.0)	2 (18.2)
	Unemployed at arrest	8 (80.0)	10 (90.9)
Offence profile	Prior criminal history	3 (30.0)	2 (18.2)
	Weapon use	9 (90.0)	9 (81.8)
	<i>Primary motive for offence:</i>		
	Psychopathology at time of offence	4 (40.0)	6 (54.5)
	Interpersonal conflict	6 (60.0)	4 (36.4)
	Other	-	1 (9.1)
Clinical profile	Prior abuse of offender	8 (80.0)	3 (27.3)
	Prior psychiatric history	6 (60.0)	9 (81.8)
	Prior substance misuse history	9 (90.0)	4 (36.4)
	Severe mental disorder (Axis I or II)	8 (80.0)	7 (63.6)
Forensic profile	Trial competence	4 (40.0)	8 (72.7)
	Criminal capacity	4 (40.0)	5 (45.5)

Table 26 also shows that more mariticial women, in comparison to their femicidal counterparts had pre-offence criminal convictions (30% versus 18%). The majority of both mariticial and femicidal women used weapons in the homicidal act (90% and 82% respectively), with stabbing the victim to death being the most common modus operandi for both mariticial (70% of cases) and femicidal offences (55%). Furthermore, fewer mariticial women experienced active psychopathological symptoms at the time of the offence (40% versus 55% respectively); in contrast, primary motives for mariticial offences were related to interpersonal conflict with intimate male partners in the majority (60%) of cases, as opposed to the minority (36%) in cases of femicide. In addition, mariticial women more commonly reported experiencing abuse themselves (80% versus 27%) and had substance abuse problems (90% versus 36%) prior to the index offence. In the case of mariticial women with prior abuse experiences, this was perpetrated by their intimate partner victims in 88% of instances. Fewer mariticial than femicidal women offenders, however, had pre-offence psychiatric histories (60% versus 82%). Nonetheless, following the offence and formal forensic evaluation, women who killed intimate male partners were diagnosed with severe mental disorder in 80% of cases (most commonly co-morbid psychiatric conditions and psychotic disorders), with the minority found to be trial competent (40%) or criminally responsible (40%). Femicidal women presented fewer cases of severe mental disorder (64%), with the majority being trial competent (73%) and almost half (46%) deemed criminally responsible for their actions (Table 26).

Neonaticide, Infanticide and Homicide of Older Children. A more detailed overview of offender and victim profiles in different types of child homicide is provided in Table 27, comparing cases of neonaticide (killing of children under 1 month of age; n = 8), infanticide (killing of children from 1 month to 1 year of age; n = 8) and homicide of older children (killing of children over 1 year old; n = 12) respectively. Whilst the sociodemographic profiles of

women who committed these different types of child homicide were broadly congruent with the overall sample, a few specific trends were apparent for these particular sub-samples of offenders: (a) mean age was lowest for infanticidal women (24.0 years) and highest for women who killed older children (36.8 years), with the mean age for neonaticidal women between these (28.8 years); (b) the minority of women who killed older children were single (33%), as opposed to the majority of other child homicidal offenders (88% in each category); (c) all women who killed older children had other dependent children, whilst the majority of women killing younger children had other children of their own (75% of neonaticidal women and 88% of infanticidal women respectively); (d) infanticidal women were relatively poorly educated (75% did not progress beyond Grade 8 at school, in comparison to the minority in the other groups); and (e) the majority of women who killed children were unemployed at the time of their arrest, irrespective of the age of child victims.

Irrespective of the type of child homicide, the small minority of women who killed children had prior criminal convictions, used weapons to carry out the homicidal act, or had evidence of active psychopathology at the time of the offence. Victim profiles for the different types of child homicide are also shown in Table 27, in which it is apparent that: (a) all neonaticidal victims were all the biological offspring of offenders; (b) the majority of victims of infanticide were also biological children of offenders (88%), with the remainder being the child of a relative (i.e. all child victims were well known to the offender); (c) whilst three-quarters of women who killed older children targeted their own biological children, the remainder of cases were spread across other categories of relationship to the offender; and (d) most neonaticidal victims were female (57%), whilst most other children killed were male (63% of infanticidal victims, and 53% of older victims respectively). Further examination of the different motives and methods used for each type of child homicide revealed that: (a)

women who killed neonates most commonly did so in order to remove unwanted children from their lives (50%), with psychopathology accounting for a further 38% of cases; (b) infanticidal women tended to act primarily in the context of interpersonal conflict (most often with biological fathers of their victims) in 38% of cases; or acted impulsively (mostly in response to perceived provocation by the victim, or distress about not coping with some aspect of maternal care) in a further 38% (with active psychopathology accounting for 25%); (c) a varied range of motives were cited for the killing of older children, but most commonly active psychopathology at the time of offence (in one-third of cases); (d) substance-related and “altruistic” motives did not play a part in any of the neonaticidal nor infanticidal offences in the sample; and (e) there was a heterogeneous variety of methods used for each type of child homicide, with no particular method being particularly prominent, except for a disproportionate number of infanticides being achieved through strangulation or suffocation (38% of cases).

Table 27

Neonaticide (n = 8 unless otherwise stated), Infanticide (n = 8 unless otherwise stated) and Homicide of Older Children (n = 12 unless otherwise stated)

Variable	Category	Neonaticide	Infanticide	Homicide of older children
		Frequency (%)	Frequency (%)	Frequency (%)
Sociodemographic profile	Age > 30 years	4 (50.0)	3 (37.5)	8 (66.7)
	Marital status: single	7 (87.5)	7 (87.5)	4 (33.3)
	Dependent children	6 (75.0)	7 (87.5)	12 (100.0)
	Education > Grade 8	5 (62.5)	2 (25.0)	9 (75.0)
Offence profile	Unemployed at arrest	5 (62.5)	6 (75.0)	9 (75.0)
	Weapon use	1 (12.5)	2 (25.0)	1 (8.3)
	<i>Victim profile:</i>			
	Male	3/7 (42.9)	5 (62.5)	8/15 (53.3)
	Female	4/7 (57.1)	3 (37.5)	7/15 (46.7)
	Biological child	8 (100.0)	7 (87.5)	9 (75.0)
	Child of relative	0 (0.0)	1 (12.5)	2 (8.3)
	Child of acquaintance / friend / stranger	0 (0.0)	0 (0.0)	1 (8.3)

Variable	Category	Neonaticide	Infanticide	Homicide of older children
		Frequency (%)	Frequency (%)	Frequency (%)
	<i>Primary motive for offence:</i>			
	Psychopathology	3 (37.5)	2 (25.0)	4 (33.3)
	Interpersonal conflict	1 (12.5)	3 (37.5)	2 (16.7)
	Unwanted child	4 (50.0)	-	1 (8.3)
	Impulsive attacks	-	3 (37.5)	2 (16.7)
	Other	-	-	3 (25.0)
Clinical profile	Prior abuse of offender	2 (25.0)	2 (25.0)	6 (50.0)
	Prior psychiatric history	2 (25.0)	2 (25.0)	7 (58.3)
	Prior substance misuse history	3 (37.5)	3 (37.5)	4 (33.3)
	Severe mental disorder (Axis I or II)	3 (37.5)	3 (37.5)	6 (50.0)
Forensic profile	Trial competence	6 (75.0)	6 (75.0)	8 (66.7)
	Criminal capacity	5 (62.5)	6 (75.0)	8 (66.7)

Trends with respect to pre-offence clinical backgrounds revealed that: (a) prior abuse was experienced by half of women who killed older children, and one-quarter of each of the other two groups; (b) the majority of women who killed older children (58%) had a prior psychiatric history, with the minority of the other two groups of offenders (25% in each); and (c) approximately a third of women who killed children had abused substance previously, irrespective of the age of child victims (Table 27). Finally, the key forensic outcomes following forensic evaluation in these three groups of women demonstrated that: (a) severe forms of mental disorder were diagnosed in over one-third of both neonaticidal and infanticidal women, but in half of the women who killed older children; (b) in women with mental illness who killed children, schizophrenia and other psychotic-spectrum disorders were the most common psychiatric diagnostic category irrespective of the age of the child victim; and (c) the majority of women who killed children were deemed trial competent and criminally responsible for the actions (Table 27).

Comparative Outcomes

The comparative component of the analysis entailed the sequential application of two inferential statistical procedures in order to systematically explore associations amongst variables of interest: (a) χ^2 analysis to identify significant associations between variables; followed by (b) logistic regression modelling to test the magnitude of such associations and functional relationships between specific variables. The χ^2 analysis examined relationships between categorical variables by assessing the associations between pairs of variables, and the relative strength of such associations. The data was grouped into two primary outcome categories (each of which were used to create contingency tables against all other variables): (a) *index offence* and (b) *victim of index offence* categories respectively, each of which are considered in turn below. The variations in sub-sample sizes used for the individual analytical procedures, and all the associated tables, reflect the fact that not all forensic and clinical case records were complete and information for some variables may not have been explicitly specified or known. In addition, some cases involved more than one offence and/or victim.

Index Offence Category

The index offence (the “outcome” variable) for each case was classified into a basic taxonomy of violence as follows (as previously described): (a) *non-violent offences*; (b) *violent but non-homicidal offences*; and (c) *homicidal offences* respectively. Each of these index offence categories were then compared, using contingency tables generated by the χ^2 analysis, to specific variables in turn, grouped in the same manner as for the descriptive results previously presented i.e. sociodemographic, criminological, clinical and forensic groups of variables respectively.

Socio-demographic Variables. As illustrated in Table 28, the χ^2 analysis of index offence category against various socio-demographic variables yielded two statistically significant associations. Firstly, women offenders who spoke isiXhosa as a first language were significantly more likely to commit violent index offences (both non-homicidal and homicidal), with this association having an effect size of medium strength (Pearson's $\chi^2 = 21.148$; $p < 0.001$; Cramer's $V = 0.350$). In addition, women whose race was recorded as black African were also significantly more likely to have committed violent offences, compared to women from other racial backgrounds, again with a medium strength of association (Pearson's $\chi^2 = 18.921$; $p < 0.001$; Cramer's $V = 0.331$). None of the other socio-demographic variables attained statistical significance in terms of their respective relationships with the index offence category.

Table 28
Index Offence Category and Socio-demographic Variables

Socio-demographic Variable*	Index offence category **			N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Non-violent	Violent: non-homicidal	Violent: homicidal				
Age					1.666	0.797	0.069
<30 years	20(23)	20(18)	18(17)	58			
31-50 years	34(33)	27(27)	24(25)	85			
>50 years	14(12)	7(9)	9(9)	30			
			Total	173			
First language					21.148	<0.001	0.350 (M)
isiXhosa	34(48)	47(37)	39(35)	120			
Other	34(20)	7(17)	12(16)	53			
			Total	173			

Socio-demographic Variable*	Index offence category **			N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Non-violent	Violent: non-homicidal	Violent: homicidal				
Race					18.921	<0.001	0.331(M)
Black African	36(49)	47(38)	40(36)	123			
Other	32(19)	7(16)	11(5)	50			
			Total	173			
Marital status					7.078	0.132	0.143
Single	41(44)	43(36)	30(34)	114			
Married	12(11)	6(9)	11(9)	29			
Other	15(12)	5(9)	10(9)	30			
			Total	173			
Children					1.711	0.789	0.007
Nil	11(11)	10(8)	6(8)	27			
1-2	34(32)	25(26)	23(24)	82			
>2	23(25)	19(20)	22(19)	64			
			Total	173			
Education					4.706	0.319	0.117
Nil / special needs	3(4)	4(3)	3(3)	10			
< Grade 8	26(30)	21(23)	28(22)	75			
> Grade 8	39(35)	29(27)	20(26)	88			
			Total	173			
Income					4.778	0.311	0.118
Employment	14(11)	5(9)	9(8)	28			
Social grant	23(26)	26(21)	17(19)	66			
Family	31(35)	23(21)	25(23)	79			
			Total	173			
Employment					3.675	0.159	0.146
Employed	20(16)	8(13)	13(12)	41			
Unemployed	48(52)	46(41)	38(39)	132			

Socio-demographic Variable*	Index offence category **			N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Non-violent	Violent: non-homicidal	Violent: homicidal				
			Total	173			
Living with:					3.720	0.445	0.104
First-degree relatives / intimate partners	43(42)	28(33)	35(31)	106			
Other family	18(19)	19(16)	13(15)	50			
Other	7(7)	7(5)	3(5)	17			
			Total	173			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type

** Each cell contains observed and expected frequencies respectively

*** Effect sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Offence Variables. Table 29 illustrates associations between index offence category and the various criminological variables. The presence of offences in addition to the index offence demonstrated a significant association with index offence category, with a large effect size strength of association (Pearson's $\chi^2 = 19.108$; $p < 0.001$; Cramer's V = 0.750): women who had non-violent index offences tended to have non-violent additional offences, and those with homicidal index offences tended to have disproportionately more additional offences of a violent nature. There was also a significant association between the reason's courts provided for referral for forensic assessment, and the nature of the index offence: women whose basis of referral for forensic evaluation was linked primarily to criminal justice or legal factors (as opposed to those referred mainly on the strength of clinically-related concerns), were significantly more likely to have committed homicidal index offences in particular (Pearson's $\chi^2 = 8.378$; $p = 0.015$; Cramer's V = 0.221). There was insufficient

evidence to reject the null hypothesis of no significant relationship between the presence or nature of past offences and index offence respectively.

Table 29*Index Offence Category and Offence Variables*

Offence variable*	Index offence category**			N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Non-violent	Violent: non-homicidal	Violent: homicidal				
Other offences (in addition to index offence)					19.108	<0.001	0.750 (L)
Violent	1(4)	1(2)	6(2)	8			
Non-violent	18(15)	7(6)	1(5)	26			
			Total	34			
Past offences					5.584	0.061	0.187
Yes	18(13)	6(10)	8(9)	32			
No	44(49)	45(41)	39(38)	128			
			Total	160			
Past offence category					8.081	0.089	0.340
Non-violent	13(11)	2(3)	3(5)	18			
Violent: non-homicidal	5(8)	3(3)	5(4)	13			
Homicidal	0(0)	0(0)	1(1)	1			
			Total	32			
Reason for referral					8.378	0.015	0.221 (M)
Clinical	48(43)	36(33)	23(31)	107			
Criminal justice	20(25)	17(20)	27(19)	64			
			Total	171			
Victim of violent index offences					21.200	<0.001	0.458 (L)
Adult	-	46(34)	23(35)	69			

Offence variable*	Index offence category**			N	Pearson χ^2	p- value	Phi / Cramer's V (Effect size)***
	Non- violent	Violent: non- homicidal	Violent: homicidal				
Child	-	4(16)	28(16)	32			
			Total	101			
Adult victim: relationship					16.625	0.011	0.350 (M)
Intimate male partner	-	3(8)	10(4)	13			
Parent	-	8(6)	1(4)	9			
Other relative	-	11(9)	4(5)	15			
Acquaintance / friend / stranger	-	18(16)	7(9)	25			
			Total	62			
Adult victim: gender					8.652	0.013	0.347 (M)
Male	-	11(14)	12(8)	23			
Female	-	30(28)	11(16)	41			
			Total	64			
Adult victim: offence motive					2.122	0.346	0.167
Psychopathology	-	29(27)	11(14)	40			
Other	-	17(19)	12(10)	29			
			Total	69			
Child victim: relationship					1.757	0.185	0.234
Biological child	-	3(4)	23(22)	26			
Other	-	2(1)	4(5)	6			
			Total	32			
Child victim: age					0.090	0.434	0.236
Neonate	-	1(1)	8(8)	9			
Infant	-	1(1)	8(8)	9			
Older child	-	2(2)	12(11)	14			

Offence variable*	Index offence category**			N	Pearson χ^2	p- value	Phi / Cramer's V (Effect size)***
	Non- violent	Violent: non- homicidal	Violent: homicidal				
			Total	32			
Child victim: gender					0.345	0.557	0.113
Male	-	2(3)	12(11)	14			
Female	-	3(2)	10(11)	13			
			Total	27			
Child victim: offence motive					3.547	0.060	0.338
Psychopathology	-	4(2)	9(11)	13			
Other	-	1(3)	17(15)	18			
			Total	31			
Version of offence category					3.799	0.434	0.105
Psychopathology	33(31)	28(25)	18(23)	79			
Admission to offence	23(6)	19(21)	24(19)	66			
Denial / amnesia	12(11)	7(9)	9(8)	28			
			Total	173			
Method of violence used					4.794	0.309	0.159
Stabbing with weapon	-	16(15)	16(17)	32			
Blunt trauma with weapon	-	12(9)	8(11)	20			
Other / no weapons	-	15(19)	27(23)	42			
			Total	94			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type

** Each cell contains observed and expected frequencies respectively

*** Effect sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Table 29 also demonstrates associations between victim-related variables and violent offences. There was a statistically significant relationship between age of the victim (i.e. adult or child) and the nature of the violence committed: women who carried out homicidal offences were significantly more likely to target children rather than adults; and those who acted violently but non-lethally were significantly more likely to have targeted adults, with a large effect size characterizing these associations (Pearson's $\chi^2 = 21.200$; $p < 0.001$; Cramer's $V = 0.458$). For adult victims, significant associations were evident between index offence category and the relationship between the offender and her victim: intimate partners of offenders (all of whom were male) tended to be victims of homicidal violence significantly more than expected by chance alone; and non-homicidal violence being directed more often toward parents, other family members, acquaintances and strangers instead (Pearson's $\chi^2 = 16.625$; $p < 0.011$; Cramer's $V = 0.350$). In line with this finding, adult homicidal victims were significantly more likely to be male, and adult victims of non-homicidal offending were significantly more likely to be female (Pearson's $\chi^2 = 8.652$; $p = 0.013$; Cramer's $V = 0.347$) respectively. There appeared to be no significant relationship between the type of index offence and psychopathological motives for offending in cases involving adult victims.

With respect to child victims of violent offences, there was no evidence of any statistically significant associations between the nature of the index offence and: offender-victim relationship, age or gender of victim, or the motive for offending. The remaining two offence-related variables (i.e. the defendant's version of offence, and the methods used in the commission of violent offences) similarly appeared to be independent of index offence category and no statistically significant associations were in evidence.

Clinical Variables. The associations between index offence category and the various clinical variables are illustrated in Table 30. There was a significant relationship between the pre-offence psychiatric history of the offender and the nature of the index offence: women with prior mental ill-health tended to commit either non-violent or violent but non-homicidal offences, whilst women with no such prior mental health problems tending to commit disproportionately more homicidal offences than expected by chance alone (Pearson's $\chi^2 = 16.328$; $p < 0.001$; Cramer's $V = 0.310$). This notwithstanding, neither a psychiatric history in the offender's family nor pre-offence substance use by the offender herself displayed an interdependent relationship with index offence category. A pre-offence history of abuse of the offender herself was statistically significantly associated with the type of index offence committed: women who reported prior abuse experiences appeared to be significantly more likely to commit homicidal offences than women without such prior abuse (Pearson's $\chi^2 = 15.255$; $p < 0.001$; Cramer's $V = 0.297$). Furthermore, the identity of the perpetrator of such abuse was also significantly associated with the nature of subsequent offending: homicidal women were more likely to have been previously abused by their intimate partners than by others (Pearson's $\chi^2 = 5.768$; $p = 0.050$; Cramer's $V = 0.362$). There was no evidence of any statistically significant associations between index offence category and any other clinical variables related to the forensic evaluation, including: mental state assessments (at time of offence and evaluation respectively); medical or psychological investigations; nor of any specific diagnostic categories (on Axes I, II and/or III respectively), as stated on final psychiatric court reports.

Table 30
Index Offence Category and Clinical Variables

Clinical variable*	Index offence category**			N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Non-violent	Violent: non-homicidal	Violent: homicidal				
Psychiatric history					16.328	<0.001	0.310 (M)
Yes	58(52)	44(40)	27(37)	129			
No	10(16)	9(13)	22(12)	41			
			Total	170			
Family psychiatric history					1.715	0.424	0.129
Yes	14(12)	12(11)	9(12)	35			
No	21(23)	21(22)	26(23)	68			
			Total	103			
Substance abuse history					0.322	0.851	0.043
Yes	36(26)	30(29)	25(26)	91			
No	32(32)	24(25)	25(24)	81			
			Total	172			
Prior abuse of offender					15.255	<0.001	0.297 (M)
Yes	10(17)	11(14)	23(13)	44			
No	58(51)	43(40)	28(28)	129			
			Total	173			
Prior abuse perpetrator					5.768	0.050	0.362 (M)
Intimate partner	4(6)	4(6)	17(13)	25			
Other	6(5)	7(5)	6(9)	19			
			Total	44			
Mental state at offence					8.699	0.191	0.159
Normal	19(22)	15(18)	23(17)	57			

Clinical variable*	Index offence category**			N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Non-violent	Violent: non-homicidal	Violent: homicidal				
Psychotic episode	27(26)	25(20)	13(19)	65			
Mood episode	10(8)	7(7)	4(6)	21			
Other	12(12)	7(9)	11(9)	30			
			Total	173			
Mental state at evaluation					8.281	0.218	0.155
Normal	24(26)	17(21)	26(20)	67			
Psychotic episode	25(24)	24(18)	10(17)	59			
Mood episode	8(8)	6(7)	7(6)	21			
Other	11(10)	7(8)	8(8)	26			
			Total	173			
Abnormal medical investigations					4.468	0.346	0.114
Nil	41(41)	34(32)	29(31)	104			
HIV	11(15)	14(12)	13(11)	38			
Other	16(12)	6(10)	9(9)	31			
			Total	173			
Abnormal psychological investigations					0.315	0.854	0.043
Yes	16(14)	11(12)	10(11)	37			
No	52(54)	43(42)	41(40)	136			
			Total	173			
Axis I diagnostic category					2.435	0.876	0.091
Psychotic disorder	22(23)	19(18)	14(14)	55			
Mood disorder	9(8)	5(7)	6(5)	20			
Substance disorder	9(11)	9(9)	9(7)	27			

Clinical variable*	Index offence category**			N	Pearson χ^2	p- value	Phi / Cramer's V (Effect size)***
	Non- violent	Violent: non- homicidal	Violent: homicidal				
Other (including comorbidity)	20(18)	16(15)	9(12)	45			
			Total	147			
Axis II diagnostic category					0.558	0.587	0.129
Intellectual disability	7(7)	5(6)	6(5)	18			
Personality disorder	8(7)	6(6)	4(5)	18			
			Total	36			
Axis III diagnostic category					2.830	0.587	0.129
Neurological	4(5)	5(4)	4(4)	13			
HIV infection	11(13)	14(13)	13(12)	38			
Other (including comorbidity)	16(13)	9(11)	9(10)	34			
			Total	85			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type

** Each cell contains observed frequencies, with expected frequencies in parentheses

*** Effect sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Forensic Variables. The relationships between index offence category and various forensic variables are shown in Table 31. A statistically significant association was apparent between index offence category and forensic psychiatric diagnostic group: women with psychiatric comorbidity (within Axis I and/or II or between Axis I and/or II) appeared to commit disproportionately fewer homicidal offences (as opposed to non-violent or non-lethal violent offences) than women with no such psychiatric comorbidity (Pearson's $\chi^2 = 12.802$; $p = 0.046$; Cramer's $V = 0.272$). In addition, women who were deemed to be trial competent

were significantly more likely to have committed homicidal offences than those found to be trial incompetent, who tended to commit non-violent or non-homicidal offences instead (Pearson's $\chi^2 = 7.116$; $p = 0.028$; Cramer's $V = 0.203$). The relationship between index offence category and criminal responsibility was marginally statistically non-significant, but with a tendency for women who committed homicidal offences to be more likely to have been criminally responsible, as compared to those who committed other types of offences (Pearson's $\chi^2 = 4.616$; $p = 0.099$; Cramer's $V = 0.164$). Finally, court recommendations were also significantly associated with index offence category, and with a large effect size in this regard (Pearson's $\chi^2 = 76.726$; $p < 0.001$; Cramer's $V = 0.474$). Following forensic evaluation, it was recommended to courts that the law take its course in disproportionately more homicidal women offenders than expected by chance alone. In addition (and as expected in the context of the South African legislative framework), mentally ill women who committed violent offences (whether of a homicidal nature or not) tended to be recommended for court-directed diversion to specialized forensic mental health services, as opposed to mentally ill women who committed non-violent offences for which diversion to general mental health services was more frequently recommended instead.

Table 31*Index Offence Category and Forensic Variables*

Forensic variable*	Index offence category**			N	Pearson χ^2	p- value	Phi / Cramer's V (Effect size)***
	Non- violent	Violent: non- homicidal	Violent: homicidal				
Forensic diagnostic group					12.802	0.046	0.272 (M)
Psychotic disorder	18(17)	14(13)	11(13)	43			
Mood disorder	6(6)	4(5)	5(4)	15			

Forensic variable*	Index offence category**			N	Pearson χ^2	p- value	Phi / Cramer's V (Effect size)***
	Non- violent	Violent: non- homicidal	Violent: homicidal				
Psychiatric comorbidity	32(28)	27(23)	14(22)	73			
Other	12(17)	9(13)	21(12)	42			
			Total	173			
Trial competence					7.116	0.028	0.203 (M)
Yes	31(32)	20(26)	32(25)	83			
No	37(35)	34(28)	19(26)	90			
			Total	173			
Criminal capacity					4.616	0.099	0.164
Yes	30(30)	19(24)	28(22)	77			
No	39(38)	35(30)	22(27)	96			
			Total	173			
Court recommendations					76.726	<0.001	0.474 (L)
Law to take course	26(27)	19(22)	26(20)	69			
General services	37(16)	4(13)	0(12)	41			
Forensic services	4(24)	33(19)	24(18)	61			
			Total	171			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type
 ** Each cell contains observed frequencies, with expected frequencies in parentheses
 *** Effect sizes of statistically significant associations: (S) = small; (M) = medium;
 (L) = large (Cohen, 1992)

Victim of Index Offence Category

The victims in violent index offence cases were categorized as either adult (18 years and older) or child (less than 18 years of age) victims (the “outcome” variable), which was then compared, using contingency tables generated by the χ^2 analysis, to all other variables (grouped as before into sociodemographic, criminological, clinical and forensic variables respectively).

Socio-demographic Variables. The χ^2 analysis of victim of index offence category against socio-demographic variables yielded two statistically significant associations (Table 32). Firstly, the age of offenders was shown to be significantly associated with the age of victims: younger women (under 30 years of age) were significantly more likely to target children in the commission of violent offences, as opposed to older women who tended to target adult victims (Pearson's $\chi^2 = 7.780$; $p = 0.020$; Cramer's $V = 0.278$). Secondly, whether an adult or child was the victim of violence was also associated with the primary source of income of the offender: women who acted violently toward adults were significantly more likely to be receiving state-sponsored social grants, than those who targeted children who tended to receive income from other sources (Pearson's $\chi^2 = 7.780$; $p = 0.020$; Cramer's $V = 0.278$). There was insufficient evidence to assert significance to associations between age of victims and other socio-demographic offender variables (including first language, race, marital status, number of children, educational attainment, employment status or the living arrangements of the offender prior to arrest).

Table 32*Victim of Index Offence Category and Socio-demographic Variables*

Socio-demographic Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Age				7.780	0.020	0.278 (M)
<30 years	18(23)	14(9)	32			
31-50 years	41(39)	13(15)	54			
>50 years	14(11)	1(4)	15			
		Total	101			
First language				0.179	0.672	0.042

Socio-demographic Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
isiXhosa	60(61)	24(23)	84			
Other	13(12)	4(5)	17			
		Total	101			
Race				0.070	0.791	0.026
Black African	61(61)	24(24)	85			
Other	12(12)	4(4)	16			
		Total	101			
Marital status				2.813	0.245	0.167
Single	51(52)	21(20)	72			
Married	11(12)	6(5)	17			
Other	11(9)	1(3)	12			
		Total	101			
Children				0.401	0.818	0.063
Nil	10(10)	4(4)	14			
1-2	32(33)	14(13)	46			
>2	31(30)	10(11)	41			
		Total	101			
Education				0.706	0.703	0.084
Nil	6(5)	1(2)	7			
< Grade 8	36(36)	14(14)	50			
> Grade 8	31(32)	13(12)	44			
		Total	101			
Income				7.780	0.020	0.278 (M)
Employment	8(9)	4(3)	12			
Social grant	36(30)	6(12)	42			
Other	9(34)	18(13)	47			
		Total	101			
Employment				0.659	0.417	0.081
Employed	13(14)	7(6)	20			

Socio-demographic Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Unemployed	60(59)	21(22)	81			
		Total	101			
Living with:				1.427	0.490	0.119
First-degree relatives	44(43)	16(17)	60			
Other family	19(21)	10(8)	29			
Other	10(9)	2(3)	12			
		Total	101			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type
 ** Each cell contains observed frequencies, with expected frequencies in parentheses
 *** Effect Sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Offence Variables. Table 33 illustrates associations between victim of index offence category and various criminological variables. The nature of the index offence was highly significantly associated, with a large effect size, with whether the victim was an adult or child (Pearson's $\chi^2 = 21.200$; $p < 0.001$; Cramer's V = 0.458): homicidal offences were disproportionately directed against children, as opposed to other offences (whether violent or not), which more often targeted adult victims. In addition, women who were charged with other violent offences, in addition to the index offence, also tended to target children to a significant degree (Pearson's $\chi^2 = 7.467$; $p = 0.006$; Cramer's V = 0.730), though this outcome was interpreted with caution in light of the small sub-sample sizes involved (with many cells in the contingency table having frequencies less than 5). No statistically significant relationships were evident between past offending and the victimization of adults versus children. Whilst the nature of past offending (i.e. non-violent; violent but non-homicidal or homicidal) was statistically significantly associated with the age of victims (Pearson's $\chi^2 = 9.360$; $p = 0.009$; Cramer's V = 0.721), this outcome was also interpreted with caution due to

the small sub-sample sizes involved. As for the previous χ^2 analysis using index offence as the outcome variable, the reason for court-directed referrals for forensic evaluation was significantly associated with whether victims tended to be adults or children (Pearson's $\chi^2 = 8.717$; $p = 0.003$; Cramer's $V = 0.295$): women whose referral was on the basis of non-clinical, criminal justice factors targeted children disproportionately more frequently than those in whom clinical referral motives were cited. The final criminological variable that demonstrated a statistically significant relationship (with a large effect size) with age of victims was in respect of the method of violence used in the commission of the offence (Pearson's $\chi^2 = 31.455$; $p < 0.001$; Cramer's $V = 0.594$): women who used weapons to inflict violence were significantly more likely to do so against adult victims (i.e. children tended to be subjected to violence that did not involve weapons per se e.g. strangulation, suffocation, poisoning, drowning, etc.). No significant contingent relationships were apparent between the offender's version of offence and the victimization of adults versus children respectively.

Table 33*Victim of Index Offence Category and Offence Variables*

Offence Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Index offence category				21.200	<0.001	0.458 (L)
Non-violent	6(4)	0(2)	6			
Violent: non-homicidal	44(35)	5(14)	49			
Violent: homicidal	23(33)	23(13)	46			
		Total	101			
Other offences (in addition to index)				7.467	0.006	0.730 (L)
Violent	2(4)	4(2)	6			
Non-violent	8(6)	0(2)	8			

Offence Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
		Total	14			
Past offences				0.931	0.334	0.099
Yes	14(12)	3(5)	17			
No	56(58)	23(21)	79			
		Total	96			
Past offence category				9.360	0.009	0.721 (L)
Non-violent	3(4)	2(1)	5			
Violent: non-homicidal	12(10)	0(2)	12			
Homicidal	0(1)	1(0)	1			
		Total	18			
Reason for referral				8.717	0.003	0.295 (M)
Clinical	49(42)	10(17)	59			
Criminal justice	23(30)	18(11)	41			
		Total	100			
Version of offence category				1.609	0.447	0.126
Psychopathology	38(35)	11(14)	49			
Admission of offence	27(28)	12(11)	39			
Denial / amnesia	8(9)	5(4)	13			
		Total	101			
Method of violence used				31.455	<0.001	0.594 (L)
Stabbing with weapon	29(22)	2(9)	31			
Blunt trauma with weapon	19(14)	1(6)	20			
Other	15(27)	23(11)	38			
		Total	89			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type
 * Each cell contains observed frequencies, with expected frequencies in parentheses
 ** Effect Sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Clinical Variables. The associations between victim age category and the various clinical variables are illustrated in Table 34. As for the previous χ^2 analysis for index offence category as the outcome variable, a pre-offence history of mental ill-health was significantly associated with whether the victim was an adult or child, with a large effect size characterizing this relationship (Pearson's $\chi^2 = 15.743$; $p < 0.001$; $\Phi = 0.401$): women who targeted children tended to have no prior psychiatric history, whereas those who targeted adults tended to have had prior psychiatric problems. None of the other clinical variables had any statistically significant association with victims being adults or children, whether historical pre-offence factors (i.e. family psychiatric history; substance abuse history; or prior abuse history) or clinical post-offence variables from the forensic evaluation (i.e. mental state assessments; investigation outcomes; or diagnostic conclusions) respectively.

Table 34*Victim of Index Offence Category and Clinical Variables*

Clinical Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Psychiatric history				15.743	<0.001	0.401 (L)
Yes	58(50)	11(19)	69			
No	13(21)	16(8)	29			
		Total	98			
Family psychiatric history				2.324	0.127	0.189
Yes	17(14)	3(6)	20			
No	30(33)	15(12)	45			
		Total	65			
Substance abuse history				1.437	0.231	0.119
Yes	41(38)	12(15)	53			
No	32(35)	16(13)	48			

Clinical Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
		Total	101			
Prior abuse of offender				0.110	0.740	0.033
Yes	21(22)	9(8)	30			
No	52(51)	19(20)	71			
		Total	101			
Prior abuse perpetrator				1.296	0.255	0.208
Intimate partner	14(13)	4(5)	18			
Other	7(8)	5(4)	12			
		Total	30			
Mental state at offence				6.093	0.107	0.246
Normal	19(24)	14(9)	33			
Psychotic episode	32(30)	9(11)	41			
Mood episode	8(8)	3(3)	11			
Other	14(12)	2(4)	16			
		Total	101			
Mental state at evaluation				7.417	0.060	0.271
Normal	25(27)	13(11)	38			
Psychotic episode	29(27)	8(10)	37			
Mood episode	6(9)	6(6)	12			
Other	13(10)	1(1)	14			
		Total	101			
Abnormal medical investigations				2.429	0.297	0.155
Nil	41(43)	18(16)	59			
HIV	21(18)	4(7)	25			
Other	11(12)	6(5)	17			
		Total	101			
Abnormal psychological investigations				2.389	0.122	0.154

Clinical Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Yes	18(15)	3(6)	21			
No	55(58)	25(22)	80			
		Total	101			
Axis I diagnostic category				2.760	0.430	0.179
Psychotic disorder	26(27)	9(8)	35			
Mood disorder	7(8)	4(3)	11			
Substance disorder	12(12)	4(4)	16			
Other (including comorbidity)	21(18)	3(6)	24			
		Total	86			
Axis II diagnostic category				0.055	0.814	0.055
Intellectual disability	7(7)	3(3)	10			
Personality disorder	6(6)	2(2)	8			
		Total	18			
Axis III diagnostic category				2.751	0.253	0.203
Neurological	8(6)	0(2)	8			
HIV infection	21(21)	5(5)	26			
Other (including comorbidity)	13(15)	5(3)	18			
		Total	52			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type
 ** Each cell contains observed frequencies, with expected frequencies in parentheses
 *** Effect Sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Forensic Variables. The relationships between victim of index offence category and various forensic variables are shown in Table 35. Whether an adult or child was the victim of violent offending depended in part on whether the woman offender was ultimately deemed to

be criminally responsible for her offending behaviour or not, with this association being statistically significant with a moderate strength effect size (Pearson's $\chi^2 = 10.030$; $p = 0.040$; Phi = 0.315). Whilst not attaining statistical significance at the 95% level, there was a suggestion of association between forensic psychiatric group and the victims age (Pearson's $\chi^2 = 6.635$; $p = 0.084$; Cramer's V = 0.256). There was insufficient evidence to reject the null hypotheses of no significant relationship between age of victim and either trial competence or final court recommendations following forensic evaluation.

Table 35*Victim of Index Offence Category and Forensic Variables*

Forensic Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Forensic diagnostic group				6.635	0.084	0.256
Psychotic disorder	17(18)	8(7)	25			
Mood disorder	6(7)	3(2)	9			
Psychiatric comorbidity	35(30)	6(11)	41			
Other	15(19)	11(7)	26			
		Total	101			
Trial competence				1.752	0.186	0.132
Yes	31(34)	16(13)	47			
No	42(39)	12(15)	54			
		Total	101			
Criminal capacity				10.030	0.040	0.315 (M)
Yes	26(30)	15(11)	41			
No	47(43)	12(16)	59			
		Total	100			
Court recommendations				3.075	0.215	0.175

Forensic Variable*	Victim of index offence**		N	Pearson χ^2	p-value	Phi / Cramer's V (Effect size)***
	Adult	Child				
Law to take course	24(28)	14(10)	38			
General services	5(4)	1(2)	6			
Forensic services	44(41)	12(15)	56			
		Total	100			

Note. * Variables that display statistically significant associations ($p < 0.05$) in bold type
 * Each cell contains observed frequencies, with expected frequencies in parentheses
 ** Effect Sizes of statistically significant associations: (S) = small; (M) = medium; (L) = large (Cohen, 1992)

Risk Predictors of Violent Offending

The magnitude of the statistically significant associations identified by the preceding χ^2 analysis, and the specific relationship between the selected variables, were examined further by multivariate logistic regression analysis, in order to determine the unique contributions of various predictor factors to specific outcomes of interest. Selection of variables for inclusion in the logistic regression analysis was based on the variable: (a) achieving statistical significance in association with the outcomes focused upon in the χ^2 analysis, *and* (b) sufficient sub-sample sizes for the variable concerned i.e. variables that failed to meet both these criteria were excluded from the logistic regression analysis. The logistic regression model hence attempted to identify (and quantify) potential risk factors (predictor variables) in relation to the occurrence of three specific outcomes (outcome variables): (a) commission of violent offences in general; (b) commission of homicide; and (c) violence directed against children, respectively, by the women offenders in the study sample. In this manner, the logistic regression models sought to identify specific predictors of these outcomes of violence after controlling for potential confounding variables.

All Types of Violence. The relationship between the commission of any violent offence (the primary outcome variable), including both non-lethal and lethal violence, and a number of predictor variables (selected on basis of their statistically significant associations with outcome measures in the preceding χ^2 analysis) was explored by their systematic entry into the multivariate logistic regression model. The predictor variables included were: (a) *criminological variables*: reason for court referral for forensic evaluation (i.e. clinical or criminological); (b) *clinical variables*: presence of a pre-offence psychiatric history; pre-offence abuse of the offender; and (c) *forensic variables*: presence of psychiatric comorbidity, and trial competence respectively. The two socio-demographic variables of first language and race, whilst identified as having statistically significant associations with index offence category in the preceding χ^2 analysis, did not have sufficiently unique contributions to this particular logistic regression model, and were hence excluded as potential predictor variables. The results of the logistic regression analysis are shown in Table 36. There was documented information on the predictor variables available in a total of 167 cases, which provided the sub-sample included in the logistic regression model.

Table 36
*Relationship Between Violent Offending and Predictor Variables**

Variable**	β	SE	Wald χ^2	p-value	OR	CI
Regression constant / intercept	1.186	0.455	6.788	0.009	3.275	-
Reason for court referral	-0.117	0.409	0.082	0.774	0.889	0.399 - 1.982
Psychiatric history	-0.834	0.496	2.829	0.093	0.434	0.164 - 1.148
Prior abuse of offender	1.122	0.435	6.660	0.010	3.071	1.310 - 7.201
Psychiatric comorbidity	-0.532	0.343	2.406	0.121	0.587	0.300 - 1.151
Trial competence	-0.166	0.349	0.226	0.635	0.847	0.427 - 1.680

Note. * Abbreviations: β = parameter estimate; SE = standard error; OR = estimated odds ratio; CI = lower to upper 95% confidence interval limits

** Variables that attain statistically significance ($p < 0.05$) in bold type

The overall adequacy of the logistic regression model was assessed in the first instance by the χ^2 for co-variables statistic (13.798; $p = 0.017$), which verified that at least one of the predictor variables was significantly associated with violent offending in the offenders sampled. Secondly, the percentage of individuals correctly predicted by the model to have committed a violent index offence (i.e. how well all the predictor variables together predicted a violent outcome) was 63.5%. A number of conclusions were drawn regarding specific predictor variables and their relationship to the risk of violent offending. Firstly, a history of prior abuse of the offender herself was significantly ($p = 0.010$) and independently associated with the commission of subsequent violent offences, after controlling for other confounders. Women who had a history of abuse themselves had greater than three times the odds (OR = 3.071; 95% CI 1.310 to 7.201) of violent offending, as compared with those who had no such

history of being abused. In other words, the odds of committing a violent offence in these women was increased, after adjusting for other confounding co-variables, by over 200%. Secondly, there was a tendency for a history of psychiatric illness to be independently associated with a lesser likelihood of future violent offending, though this relationship was, marginally, not statistically significant ($p = 0.093$; OR = 0.434; 95% CI 0.164 to 1.148). There was no indication of any significant relationship between the commission of violent offences and any of the other predictor variables (i.e. reason for court referral, presence of psychiatric comorbidity, and trial competence respectively). This was despite all these latter predictor variables having been, in the preceding χ^2 analysis, statistically significantly associated with the index offence category (i.e. whether non-violent, violent but non-homicidal or homicidal in nature).

Homicide. The relationship between the commission of a homicidal offence and the selected predictor variables (i.e. those with statistically significant associations identified by the preceding χ^2 analysis) was explored by entry into a multivariate logistic regression model. The predictor variables selected were (a) *criminological variables*: reason for court referral for forensic evaluation (clinical or criminological); (b) *clinical variables*: psychiatric history and prior abuse of the offender; and (c) *forensic variables*: presence of psychiatric comorbidity and trial competence respectively (Table 37). As was the case for the logistic regression model for violent offending in general, the socio-demographic variables of home language and race (despite having statistically significant associations with the index offence by the χ^2 analysis), did not have sufficiently unique contributions to this logistic regression model either, and were hence excluded as potential predictor variables. As before, the logistic regression model for homicidal offending was also based on the 167 cases in which information of predictor variables was available.

Table 37
*Relationship Between Homicidal Offending and Predictor Variables**

Variable**	β	SE	Wald χ^2	p-value	OR	CI
Regression constant / intercept	-0.065	0.446	0.021	0.884	0.937	-
Reason for referral	-0.560	0.477	1.381	0.240	0.571	0.224 – 1.454
Psychiatric history	-1.108	0.510	4.714	0.030	0.330	0.121 – 0.898
Prior abuse of offender	1.756	0.467	14.130	0.000	5.788	2.317 – 14.458
Psychiatric comorbidity	-1.278	0.449	8.101	0.004	0.279	0.116 – 0.672
Trial competence	0.454	0.409	1.233	0.267	1.575	0.706 – 3.509

Note. * Abbreviations: β = parameter estimate; SE = standard error; OR = estimated odds ratio; CI = lower to upper 95% confidence interval limits

** Variables that attain statistical significance ($p < 0.05$) in bold type

The overall adequacy of the logistic regression model was confirmed by the χ^2 for covariates statistic (38.785; $p < 0.001$), which verified that at least one of the predictor variables was significantly associated with homicidal offending in the women sampled. The percentage of individuals correctly predicted by the model to have committed a homicidal offence (i.e. how well all the predictor variables together predicted a homicidal outcome) was 77.2%. A history of prior abuse of the offender herself was highly significantly ($p < 0.001$) associated with the subsequent commission of homicidal offences, after controlling for confounders. Women who had a history of abuse themselves had almost six times the odds (OR = 5.788;

95% CI 2.317 to 14.458) of homicidal offending, as compared with those who had no such history of being abused. In other words, the odds of committing a homicide in these women was increased, after adjusting for other confounding co-variables, by almost 480%. In addition, a history of psychiatric illness was also significantly associated with homicidal violence: individuals with a prior psychiatric history were significantly less likely ($p = 0.030$; OR = 0.330; 95% CI 0.121 to 0.898) to commit homicidal violence, in comparison to those with no such history, after confounding variables were controlled for. Similarly, women with psychiatric comorbidity were also significantly less likely ($p = 0.004$; OR = 0.279; 95% CI 0.116 to 0.672) to have acted with lethal violence, as compared to those without psychiatric comorbidity. There was no indication of any significant relationship between the commission of homicidal offences and any of the other predictor variables (i.e. reason for court referral and trial competence respectively). This was despite these latter predictor variables being, by the preceding χ^2 analysis, significantly associated with index offence category (whether index offences were non-violent, violent but non-homicidal or homicidal respectively).

Child Victims. The final multivariate logistic regression model explored the relationship between the commission of a violent offence against a child victim and a selection of predictor variables (as before, the selection being based on statistically significant outcomes in the preceding χ^2 analysis). The predictor variables were: (a) *socio-demographic variables*: age (being older than 30 years of age or not) and primary source of income (receiving social grant or not); (b) *criminological variables*: reason for court referral for forensic evaluation (clinical or criminological) and whether the index offence was homicidal or not; (c) *clinical variables*: presence of a pre-offence psychiatric history; and (d) *forensic variables*: presence of psychiatric comorbidity and criminal capacity respectively. This logistic regression analysis included a sub-sample of 96 cases, the results of which are shown in Table 38.

Table 38
*Relationship Between Child Victims of Violence and Predictor Variables**

Variable**	β	SE	Wald χ^2	p-value	OR	CI
Regression constant / intercept	1.344	1.211	1.232	0.267	3.835	-
Age of offender	-1.242	0.608	4.170	0.041	0.289	0.088 – 0.951
Source of income	-0.829	0.784	1.118	0.290	0.437	0.094 – 2.029
Homicidal index offence	2.427	0.744	10.629	0.001	11.324	2.632 – 48.712
Reason for court referral	-1.388	0.812	2.924	0.087	0.250	0.051 – 1.225
Psychiatric history	-0.264	0.858	0.095	0.759	0.768	0.143 – 4.128
Psychiatric comorbidity	-1.654	0.723	5.228	0.022	0.191	0.046 – 0.790
Criminal capacity	0.283	0.711	0.159	0.690	1.327	0.329 – 5.347

Note. * Abbreviations: β = parameter estimate; SE = standard error; OR = estimated odds ratio; CI = lower to upper 95% confidence interval limits

** Variables that attain statistically significance ($p < 0.05$) in bold type

The overall adequacy of this logistic regression model was also confirmed by the chi-square for co-variables statistic (47.064; $p < 0.000$), which verified that at least one of the predictor variables was significantly associated with children being victims of violent offending by the women sampled. The percentage of individuals correctly predicted by the model to have committed a violent index offence against children (i.e. how well all the predictor variables together predicted a child rather than adult to be the victim of a violent

index offence) was 87.5%. After controlling for confounding variables, women who committed homicidal offences in particular had over eleven times ($p = 0.001$; OR 11.324; 95% CI 2.632 – 48.712) the odds of directing lethal violence toward child victims rather than adults, as opposed to women who committed non-homicidal offences. Individuals who were above the age of 30 years were significantly less likely ($p = 0.041$; OR = 0.289; 95% CI 0.088 – 0.951) to target children, as opposed to younger women offenders. In addition, women with psychiatric comorbidity were significantly less likely ($p = 0.022$; OR = 0.191; 95% CI 0.046 – 0.790) to have acted violently against child victims, as compared to those without psychiatric comorbidity. There was no indication of any statistically significant relationship between the commission of violent offences against children and any of the other predictor variables i.e. reason for court referral for forensic evaluation; primary income source; pre-offence psychiatric history; and whether criminal capacity was intact or not, respectively. This was despite all these latter predictor variables being significantly associated with the outcome variable of interest (i.e. child victim of violent offending) in the preceding χ^2 analysis.

Qualitative Outcomes

After confirming capacity to consent and obtaining informed, written consent, detailed individual interviews were conducted with eight female State Patients at Fort England Hospital. Each of the participants had the shared experience of: (a) having committed a violent offence; (b) being diagnosed with a severe mental disorder following formal forensic evaluation at the request of the courts; and (c) being formally declared State Patients and transferred to a specialised, secure forensic psychiatric facility (Fort England Hospital) for care, treatment and rehabilitation. Semi-structured interviews using open ended questions were conducted, focusing on five key domains of interest (Appendix 3), with respect to: (a) *self-image*; (b) *mental health*; (c) *the offence committed*; (d) *the aftermath of the offence*; and (e) *the future*

and other issues, respectively. The naturalistic conceptual framework of Braun & Clarke (2006) was employed in order to draw qualitative conclusions. Interview transcripts were thematically analysed for specific emergent themes (i.e. by systematic thematic analysis of replicated responses to the point of saturation), and thematic maps were generated to assist in understanding the qualitative information obtained. A summary of emergent interview responses for each domain of interest in turn is provided below, via a series of pertinent and illustrative quotes from individual participants (together with pseudonyms of participants and the respective question number, from Appendix 3, which elicited the response under consideration). This is followed by a summary of the key features of the thematic analysis, illustrated by via initial and final thematic maps respectively.

Self-image

The two main themes around the issue of how women perceived themselves concerned gender and social roles, on the one hand, and an evaluation of their personal attributes, on the other. In respect of the former, many women described shaping their sense of self primarily in relation to their responsibilities to, and relationships with, significant others (especially children, intimate partners and other family members). In respect of the latter, many other women drew contrasts between self-evaluation of their personal attributes during episodes of active mental illness, as opposed to times when they were mentally well.

Gender and Social Roles. The majority of women described themselves primarily in terms of their gendered roles in relation to caring for those close to them, especially as mothers nurturing and raising their children:

- “I would describe myself first as a mother. That’s how I am. To always be there for my children. They can come to me and discuss things, in good as well as bad times...I am just a mother in her home” (Destiny; Q1).
- “I like to do things for my children and other people. I cook for them. I make sure the children are clean and that they go to school. Also, when people do not have food or clothes...I like to help out...As someone that likes to do things for others...I took care of financial matters and the house and my children. They [others] see me as a good person” (Thobeka; Q1 and Q2).
- “I see myself as a woman who can resolve conflicts with the people [that] I have disagreements with” (Maria; Q2).
- “I see myself as a mother. I am a mother with a husband. I have family responsibilities that I have to take care of. To ensure that they [my family] are taken care of, they eat, they are clean...But others see me as a quiet person” (Thandeka; Q2).
- “I like to do female activities, like cooking and cleaning the house and looking after my children. I also like singing. I used to belong to a group of singers” (Noxolo; Q5).

A few participants were unsure, ambivalent or unable to articulate how they viewed themselves as women, or described this in gender-stereotyped ways:

- “No, I really don’t know” (Destiny; Q2).
- “As a woman, I am alright. Other people say I’m alright. I don’t do anything bad to anyone” (Busisiwe; Q2).
- “As a woman, I waste money. I like to spend. Other people see me as a woman who loves herself. At times they think I am aloof...they think I like being a bully. It’s not that I’m like that. I am just straight-forward” (Sindiswa; Q2).
- “Others also see me as a woman...as an okay person I guess” (Maria; Q3).

- “I’m not really sure...Perhaps they see me as a gentle person? I don’t know” (Noxolo; Q3 and Q4).

Personal Attributes. Most women described, and in many defined, themselves by emphasizing the virtuous attributes of their personality, but also by making direct reference to their mental health, and a sense of feeling different and stigmatized as a result of mental illness:

- “I’m a person who likes people. I am a kind person. I like my neighbours. I’m not a bad person” (Maria; Q1).
- “I don’t like wrong things. I see myself as a harmless person” (Noxolo; Q1).
- “I don’t like bad things...I’m alright ever since I’m at Fort England [hospital]” (Busisiwe; Q1).
- “I see myself as someone who is different from other people. I feel like I am not like others...since I’m [mentally] ill. I am not like others. Other times I feel alright. I feel like I might be someone who could have their own cars, have my own house...I can be someone or go to school...become a social worker...When I am ill, I would not feel like doing anything...I would be quite irritable and involved in fights” (Xoliswa; Q1 and Q2).
- “To put it simply, they think I am mad. I live in a small community, and they do not understand psychiatric problems. I also didn’t know about it before I came here [to Fort England hospital]” (Destiny; Q4).
- “They think I am mad since I’ve been admitted here [Fort England hospital]. They will think that I suffered a mental illness and that I’m sick” (Thandeka; Q4).
- “People are happy to see me now. They tell me I’ve changed from the person I used to be. They are amazed at my progress since taking treatment [for mental illness] and encourage me stay that way. Their feedback makes me happy” (Sindiswa; Q4).

A number of women responded to enquiries about self-image by emphasizing differences in how they viewed themselves, or how they felt they were perceived by others, during episodes of mental illness in comparison to periods of remission during which they are relatively free of symptoms (with some also expressing these issues in gendered terms):

- “I’m a kind person. I love people but...when I’m sick, I become angry quickly. When I’m sick, I become resentful...I get this intense hate” (Sindiswa; Q1).
- “I am a quiet person...but I have been unfortunate to find myself here [in a psychiatric hospital] after I assaulted someone. I stabbed him. I’m a quiet person who has been unfortunate” (Thandeka; Q1).
- “When men are angry, it easy to intervene between them...[but] women’s anger can be unstoppable...I saw it in myself when I was sick. My 18-year-old son often tells me he is scared of me. That’s my child. He says that at times I have a look...he then would ask if I would ever harm him. I would tell him that I would never do anything like that to him as I am not that [mentally] ill and I take my treatment. He is afraid because when I was once [mentally] ill, I assaulted my mother. But he always tells me he loves me because I am his mother and that I have raised him. I have greatly improved. Others remind me of how I was and things I used to do...I am now a calm person. I am no longer easily angered, even when provoked. I am calmer as a woman” (Xoliswa; Q2, Q3 and Q4).
- “They ignore things about me [because] they love me and see me as an okay person now that I am well” (Maria; Q4).
- “They [others] see me as someone who is mental, but I know that I am taking my treatment” (Thobeka; Q4).

Mental Health

A number of further issues were explored around mental health, distinct from those that arose in relation to descriptions and perceptions of self-identity. Three specific themes emerged in this respect: firstly, the importance of recovery from mental ill-health; secondly, the contrasting experiences of the criminal justice and forensic mental health systems respectively; and thirdly, expressions of a range of gendered health care needs.

Mental Health Recovery. All but one of the eight women interviewed emphasized the fact that they were mentally ill before (especially around the time of the offence) but have since recovered (or are on the path to recovery) as a result of the forensic mental health care received. A range of symptoms relating to the experience of mental illness were described, with some women making reference to culture-bound psychiatric syndromes as idioms of understanding, and expression, of their mental illness. Most women highlighted how recovery from mental ill-health had improved their lives, particularly in terms of the perceptions of others and in their relationships with people close to them. A few women highlighted the importance of mental health advocacy in promoting better understanding of mental illness in the community, and reducing stigma that persists in many communities:

- “I was mentally ill for years. I married young and I then got sick with these nerves. Even before [the offence]...I have always been on treatment. It [treatment] keeps me changed, even now. They [others] say I am mentally ill and when I’m ill they do not like that. Ordinarily I am not someone who swears at or assaults other people...these things happen when I am ill but the treatment has helped” (Maria; Q5).
- “Initially I had depression...and used pills that I am still using. I do have some disturbance. I am not really mentally ill but I do have some mental disturbance. I have been diagnosed with schizophrenia and I use medication. I had post-natal depression

in the beginning. Those things indicate that I do have some disturbance but not always. I'm not always disturbed as I take medication so I'm not severely or really mentally ill" (Thandeka; Q5).

- "I am not at all [mentally] sick at the moment. I was ill before receiving treatment. Everything is gone now...I don't hear any voices [of unseen people]. They [my family] now understand that I was ill before and they accept me for who I am" (Destiny; Q5 and Q6).
- "Sometimes I am [mentally] sick...at times it gets so bad that I do not want to do anything, not even take a bath...I would want to stay dirty...I would be irritable and become impossible. But on other days I would be fine...wake up early and clean the house. I am mentally ill but not that much now. Currently I feel much better and they [family and friends] now see me [as] much better. They complement me on the way I interact and commend me on my behaviour." (Xoliswa; Q5 and Q6).
- "I would say that I am mentally ill because I once had a motor vehicle accident and I woke up in hospital. I'm not sure how mentally disturbed I am because I do not do some of things I see being done by other patients here [at Fort England hospital]. I started being mentally ill after my husband began having an affair with an older woman who was planning on bewitching me with *amafufunyana* [a culture-bound psychiatric syndrome in South Africa related to belief in witchcraft and bewitchment]. I was taken to a traditional healer and then brought here until I was better. They say I that [when mentally ill] I would not want anything to do with my small child but I don't remember that. They say I wanted to injure my child. I only remember my child being taken away from me. I don't remember being mentally ill at the time. But I am here in a psychiatric hospital so I must be ill. So, yes they say I'm mad. Community

members say I'm mad because they were there when I was mentally ill and my family had to take me to [a psychiatric] hospital" (Busisiwe; Q5 and Q6).

- "Now I am mentally well...it's the treatment that is keeping me well...but if I stopped my treatment then I would be mentally ill again. Before, I used to be very ill. I would isolate myself and would not want to leave my house. I would sit in the dark and play music. I would sing at the top of my voice, design my own clothes and my clothes would draw attention in the streets. But not now...now people see me as being mentally well. Even at home they are amazed at the difference since [receiving] treatment. They even think that perhaps I am meant to be a traditional healer because of the change...I tell them it's not cultural...this is bipolar disorder and its treatable and I show them my medication. Because I do not believe in *ukutwasa* [a culture-bound psychiatric syndrome in South Africa related to belief in ancestral callings to become a traditional healer]...that's not my thing" (Sindiswa; Q5 and Q6).
- "Yes, I am mentally sick, but not at the moment. The medication has helped with my symptoms...Others see me as mentally ill because they know I receive medication from the clinic...but they don't judge me for it" (Thobeka; Q5 and Q6).
- "My father wanted to take me to a mental institution...a few years ago. They thought I was ill because I got angry quickly...and I was verbally aggressive. But its better now" (Noxolo; Q6).

Experiences within Criminal Justice and Forensic Mental Health Systems. All women interviewed, without exception expressed their post-arrest experiences within the criminal justice system (i.e. as defendants charged with violent offences, and as remand detainees) as being largely negative, perplexing, intimidating, depressing or distressing. All women contrasted this with their more positive and therapeutic experiences within the forensic

mental health system (i.e. as State Patients at Fort England Hospital). The majority of women also described how they had changed in significant ways during their stay in a forensic mental health facility, and felt more optimistic, reassured, supported and better understood since receiving mental health care:

- “They say that prison changed me. Prison was rough...the warder assaulted us...other prisoners assaulted us...its unlike here at the hospital where we are safe...I was not well at all when I arrived here [at Fort England Hospital] but over time I became better. The doctors here are very good. Had I remained [in prison] I’m sure I would be dead by now...prison was horrible...my fear was dying in prison” (Xoliswa; Q6, Q7 and Q16).
- “At the time of my first court appearance I wasn’t aware of my surroundings...I didn’t know when to talk and when to keep quiet. I think they saw I needed help and sent me here [to Fort England Hospital]. When I came here the second time [as a State Patient] I was better because I had received my medication. As I have a family history of mental illness, I thought it was my turn to be sick and I was very upset...But since I came here, I have become humble. I don’t take things for granted anymore. I didn’t understand myself when I was ill...because I changed so much since I got help...Prison was an experience that I do not want to go through ever again. I was involved in a fight and my glasses broke. I was kicked and assaulted by the other prisoners” (Destiny; Q7, Q10 and Q16).
- “I was very happy to be taken to [Fort England] Hospital...so that I can learn to relate better with people and for my mind to be alright...I was happy that I ended up being on the right treatment so that I can return to being the person, the [Maria] I was before” (Maria; Q7 and Q10).

- “I feel lucky because other people maybe do not get the opportunity to be diagnosed as mentally ill. Maybe they committed the crime and just continued with life. I received help and learned that I was ill when I did it [the offence]” (Thandeka; Q7).
- “They just told me that I would be sent here [to Fort England Hospital] for a month. I cried a lot since I wasn’t use to the situation and I was scared...and nervous... because I didn’t know why I was here. But the month [of the forensic assessment] went by very quickly. I’ve been readmitted to hospital since [as a State Patient] and I miss home but I’m getting help. I have become quieter and more introspective since...which is a good thing” (Noxolo; Q7 and Q10).
- “I remember crying at first as I was hearing voices of unseen people and I was afraid. I felt better when I was admitted to Fort England [Hospital], though I don’t remember too much of that time...but I am fine...I am better now” (Busisiwe; Q7 and Q10).
- “I was really angry at first when I was arrested and the court said I should come here...I didn’t see myself in a place like this [a psychiatric hospital]. I felt trapped and thought I was being removed from my home to be abandoned in some place like that...but I see that this place has been good...My behaviour has changed. In the past I used not to care about what I did...now I am more considerate in my actions...I am afraid of doing wrong things...even on the outside” (Sindiswa; Q7 and Q10).
- “I was very disappointed initially because no-one explained the reason for coming here [to Fort England Hospital] as a [State] patient. Afterwards, I understood it was necessary and I was glad. The hospital doctors helped me to understand my illness...what it means to have bipolar disorder. I also realize the importance of medication and went into a mental wellness programme for a month and it meant a lot to me” Thobeka; Q7 and Q10).

Gendered Needs. Most women interviewed felt that there were no clear links between their gender and mental health / ill-health, or were ambivalent on the matter.

- “My paternal uncle is mentally ill and I am the only female in my family [who is mentally ill]. This confuses me” (Destiny; Q8).
- “I have never thought about that [linking gender and mental health]. It’s just that at times I tend to think I’m different [from others], even my girl-friends” (Xoliswa; Q8)
- “I do not think my gender has any relationship with my mental illness, as I’ve been mentally ill for years” (Maria; Q8).
- “What do you mean? I don’t think there is any connection between my gender and mental problems” (Thandeka; Q8).
- “I just don’t know” (Noxolo; Q8).
- “I think my husband’s affair really affected me mentally...it damaged me” (Busisiwe; Q8).
- “Mental illness is mental illness...it doesn’t have anything to do with my gender” (Sindiswa; Q8).
- “No. I cannot see the link” (Thobeka; Q8).

Despite the majority of women considering there to be little or no connection between gender and mental health, most participants articulated a number of social, interpersonal and health (including mental health) needs, with these often expressed in gendered terms:

- “I need a lot of attention as a woman. And love. My children provide this...We regularly talk on the phone and have a good relationship. There is a very special bond between me and my daughter” (Destiny; Q9).

- “I enjoyed the things we did in female [groups in] occupational therapy...knitting, making pillows. I really enjoyed that, and I learnt also to do some of these things when I’m home on leave” (Xoliswa; Q9).
- “I need a lot of rest...and need to see my friends. This keeps me from fighting and I would also like to worry less as a mother about my children. I have spoken to them [my children] on the phone...they seem very supportive although my eldest daughter said this is my problem and I have to sort it out. My husband mentioned that the pills they give me here are making me [more] mad...but I really don’t know why he said this” (Noxolo; Q9).
- “Being female and mentally ill makes you very vulnerable...you can be raped and people can take advantage of you because you are ill. It is easy to be caught up when one is [mentally] ill because your mind thinks you are enjoying everything and doing everything right...men would use your state [of mind] and take advantage of that...so as soon as a woman is mentally ill they need to be taken to a place of safety like Fort England [hospital] and be given [mental health] treatment immediately” (Sindiswa; Q9).
- “Yes, I need to be supported as a woman and mother and wife...especially to see a psychologist” Thobeka; Q9).

The Offence

Two main themes emerged in relation to the offence: firstly, the contextual importance of both mental illness and interpersonal conflict in the commission of violent offences; and secondly, the heterogeneity of views on the extent to which gender-related issues may have contributed to violent behaviour at the time:

Context of the Offence. All women interviewed committed violent offences against people well known to them (as intimate male partners, children, other family members, neighbours, friends or other acquaintances), with the exception of a woman who murdered a stranger in an unprovoked attack related to severe psychosis at the time. There was a background of interpersonal conflict with adult victims of the offence itself (or with the fathers of child victims) in the majority of women interviewed. Some women made direct, causal connections between the commission of their violent offences and the psychiatric symptoms they experienced at the time (though most had only patchy recall of the details of the actual events). Some provided no clear account of their psychopathology at the time of offending, denied being mentally ill at the time, minimized their role in the offence, or were unable or unwilling to provide details. Many women, however, also seemed to accept a degree of personal responsibility for their actions, and its consequences, and feeling regretful and remorseful, despite also being aware that they were mentally unwell at the time:

- “She [my neighbour] had my bank cards and would not return them to me. She used to keep them when I was mentally ill, and returned them when I was okay. She would not give them [the bank cards] to me and insulted my brother and my son. That hurt me...I then woke up in hospital. I vaguely remember holding a knife and slightly stabbing her. I don't know where I got the knife from but I was protecting myself because I lived alone and kept it under the bed so that no-one can kill me. Even before the mistake [offence] that I have done, I was not well...I found myself here in hospital...I do not know how I got here. I thought I would be quickly treated but it turns out that I am going to be here for a long time...I was told never to use a weapon when I fight with someone...I must resolve things with people by talking to them or by walking away” (Maria; Q5, Q11 and Q12).

- “You know, when I look at my illness and symptoms before, I can see that at times the fault was mine [for committing the offence] and not someone else’s. I heard voices of people in the community, mostly of my neighbours...I would be in a room and I would hear one of them speaking, but when I looked, they were not there. The voices told me of the things my neighbours were doing to me, and most of the time they said bad things about my children. They wanted to hurt my children and this upset me. [On] the day the incident happened, I was at home. I heard the voices and they were saying they were planning to hurt my daughter. I got very angry, went outside and threw stones...My neighbour had a baby daughter inside the house at the time. I was relieved to hear that one of those stones did not hurt the baby” (Destiny; Q10, Q11 and Q12).
- “I had defaulted on my treatment...and then fell [mentally] ill. I was shouting at my mother...she later told me that I assaulted her on the head...apparently I was carrying a garden spade...I don’t know what else. It appears that in my confusion, I intended chopping my mother...I do not have a clear recollection but sometime after being in hospital I started recalling pieces of the events but not fully...We [my mother and I] had an amazing relationship and we got along well...we still do...but she brings back that incident and remind me how I assaulted her...to be honest she upsets me, but then I remind myself that she is elderly and that I was mentally ill and...tempted by the devil to commit the offence” (Xoliswa; Q11 and Q12).
- “I was entering my yard and this girl [who lives] next door...she threw a rock at me. As I approached her to confront her, she charged at me and we ended up fighting...I did not interact much with her but I had an argument with her boyfriend in the previous week...I told him to stop following the children everywhere...he must keep to his

yard and not my yard. He told me he would severely assault me” (Thandeka; Q11 and Q12).

- “I had a fight with my neighbour...it’s been going on for years...our relationship has been bad for a long time...and she has drawn up a document that states they do not want me in the area anymore. I find this hard as neighbours are supposed to support one another. She wants me to do everything she tells me to. On that day, she hit me and I tried to fight back...she wanted to take my property and wanted me to be her maid. I do not know what she has against me. She took secret videos of me when I got her angry” (Noxolo; Q11 and Q12).
- “They say that they found a dead body in my yard...I don’t remember how it got there but I had been locking myself into my house. I do not know the deceased person but they say it was a man. I don’t even know his name. They say I killed him but I do not know how. I don’t know if I did it or I did not do it...they never even showed me the body...then the police came” (Busisiswe; Q11 and Q12).
- “I had a fight with my boyfriend’s sister...we’ve long not gotten along, even as children, and we compete about everything...it’s quite petty really. Her boyfriend had promised to marry her but had broken her heart and I used every opportunity to remind her about it. I then broke the family’s gates. A protection order was taken out against me but I contravened it by going into that home....I told the police that I’m a psychiatric patient, and they then took me to Fort England [Hospital]” (Sindiswa; Q11 and Q12).
- “I cannot remember much...they said I left my newborn [baby] by the road. I never did realize I was pregnant. I’m not sure if I was mentally ill at the time but I now think I was. It must have been my illness but I can’t remember the events leading up to it.

No-one has told me what really happened and I feel really bad about it” (Thobeka; Q11 and Q12).

Gender Issues in Relation to the Offence. Approximately one-third of women interviewed felt that gender-related issues had some bearing on the offence; a further third felt that gender was not an important factor; and the remainder were ambivalent on the matter:

- “Yes, the fact that I am a woman and mother is important. It [the offence] was all about my love for my children. Everyone knows I will do everything and anything for my children” (Destiny; Q13).
- “I think I was not taking my treatment as well as not realizing that I was sick that made me commit my offence” (Xoliswa; Q13).
- “No, it [the offence] just happened” (Maria; Q13).
- “I don’t know why the girlfriend intervened in a matter between me and her boyfriend...I don’t think me being a woman had any bearing on the offence” (Thandeka; Q13).
- “Yes, I was a woman and this woman [the victim] was jealous of my property...she tried to control me just like she used to control her mother” (Noxolo; Q13).
- “Yes, as a woman, my behaviour at the time demeaned my status as a woman. A woman is not supposed to shout in the streets and act like that. A woman is not supposed to assault another woman...shouting...breaking things...if I was a man, I probably would have done worse damage though. However, women tend to be more instigators than men” (Sindiswa; Q13).
- “No, I don’t know” (Thobeka; Q13).

After the Offence

The two main themes that emerged in relation to the time following the offence were: firstly, improvement in mental health and behaviour since receiving forensic mental health care, and changes in self-image and self-esteem as a result; and secondly, acceptance of the situation and the importance of learning to cope with the aftermath of the offence:

Mental Health. All women interviewed, without exception, expressed that they had changed improved significantly since the onset of mental illness and the commission of the offence itself. As before, most women emphasized the contrasts between their self-image, temperament, attitudes and behaviour when they were actively mentally ill, as opposed to how they feel and what they are like since experiencing recovery as a result of treatment and support:

- “Oh yes, I have changed a lot. I am not like I was before. When I got sick, I turned into someone who I’m not usually. I was very aggressive when I was sick. I didn’t have patience with others...but now that I am healthy again, I have lots of patience and can handle many things” (Destiny; Q14).
- “I saw that my behaviour had to change. I could no longer swear at people or assault them. I must live peacefully with others. Even my [family] custodian reminds me that I am still a prisoner and I must behave well. I see that I am not the aggressive animal I used to be. I joined the church and choir now” (Xoliswa; Q14).
- “I was shocked and never thought I could commit such an offence. I would never do that now that I am well” (Maria; Q14).
- “I don’t do things that I used to do because I’m here. I have to sit and wait and be patient. I am no longer a mother. I no longer perform the duties of being a mother. It does not feel the [same] way it does when I was home” (Thandeka; Q14).

- “I am changed. I am a different type of person. I’ve tried to pull myself together. I am soft and gentle now, and don’t shout at people any more. I used to fight a lot but now I am quiet” (Noxolo; Q14).
- “Yes, I’ve changed. I’m needed at home now but I’m here and don’t know for how long. I’m no longer sick and I don’t hear voices any longer” (Busisiwe; Q14).
- Yes...I focus on taking my treatment well. After being charged, I was forced to deal with my illness. I got to know that the only help is for me to take my treatment or else it [my mental illness] will destroy me” (Sindiswa; Q14).
- “I have changed a lot. My mood is changed, and also my behaviour. I had bad mood swings and would sometimes isolate myself, but not now” (Thobeka; Q14).

Coping Since the Offence. Many women expressed acceptance of having committed a violent offence and their mental ill-health, as well as a degree of resignation to the situation they find themselves in as a result i.e. as a State Patient compelled by courts to receive treatment within the forensic mental health system until well enough for their mental health status and risk profile to support eventual discharge. A number of women drew attention to the importance of learning how to cope themselves, whilst also drawing on others for support in dealing with the personal, mental health, social and other ramifications of the offence and its aftermath. These were generally cited as important components of rehabilitation and recovery, with the process being an empowering experience for many. Few women, however, expressed an opinion that gender-related issues were important in the process of coping and recovery:

- “I’ve accepted that this is my situation, and I’m aware that this is not a common situation. I know I won’t go directly home from here...I will go on leave first and it will probably take a few years before I am discharged... No-one has told me up front that I am mad though and many times I wonder how I would feel if they told me this

to my face...I am okay here in hospital and ever since the voices are gone it is going really well with me” (Destiny; Q15, Q16 and Q17).

- “I was glad the court found me to be mentally ill because it meant I was going to be out of prison...Here in hospital I see others are also mentally unwell, and many are more ill than me. People don’t assault each other and they care because they get treatment...I have accepted my situation and will await the decision of the doctors that manage my care. What is difficult is that even though I get LOA [leave of absence] I still have to return to hospital. It can be stressful because some patients who are really mentally ill say things that upset you but the [nursing] sisters would talk to me...reminding me that I am much better than that ill patient who was insulting me” (Xoliswa; Q15, Q16 and Q17).
- “I have joy within me and that helps me cope. My son told the court that I was admitted to a psychiatric hospital before and being sent here meant that I will receive the treatment I need to be better and live well with my family and others...I have accepted being in hospital. I’ve been here for three years and my son died whilst I was in [hospital]. That really troubled me...since it feels like no-one cares for me...no-one visits me...no-one brings me things like he used to. Family members don’t take my calls and I rely on the hospital and staff for everything now” (Maria; Q15, Q16 and Q17).
- “My husband calls me every day...I really look forward to these phone calls. He also comes to visit me...it eases that thing...the pain...that I am here and not at home with him...Even here, I will cope through my [religious] faith. Also, we are kept busy here in hospital...we wash dishes and make tea...at least being busy distracts the mind” (Thandeka; Q15, Q16 and Q17).

- “It is difficult to cope because I know I am not crazy. That woman [the victim of the offence] just said so because she wanted to control my life...Being in hospital isn't easy...I receive medication and that helps me to be calm, but it's the same for me as it would be for a male patient. That's all” (Noxolo; Q15, Q16 and Q17).
- “I do not know how to cope. I have troubled sleep...I'm just stuck here...how could I cope?” (Busisiwe; Q15).
- “The police officer who took me to Fort England [Hospital] told me that being sent here was the best thing for me and that one day I will realize that. I did not see then how that was possible, but when I look back now...that police officer was telling the truth...I've been sent on leave and will be [conditionally] discharged...now I can focus on life and my music...I have learnt a lot from being in hospital and now I can go on with my life...I am getting my life back....Seeing how well I have become with the treatment is coping enough, so much so that I am now even willing to help other people who are in the same position as I was in when I was sick. I don't walk past anyone who is mentally ill now...I help them find help” (Sindiswa; Q15, Q16 and Q17).
- “I was put into this situation and I had to accept it...I cope well now...being here has helped me a lot, especially with understanding my illness and treatment...I have realised that I have bipolar disorder. It is not always easy for men to understand and come to terms with these things in a woman. But I am a strong woman now and I have much hope” (Thobeka; Q15, Q16 and Q17).

As an extension to the exploration of how women coped with their offences and mental health issues, women were also asked about how they coped with committing a violent offence in particular. Whilst a few women showed good insight into their role in acting violently toward

others (especially those close to them), and how they have come to terms with this, others remained hesitant and ambivalent about this aspect of their lives:

- “This is something that I have not comes to terms with yet. It was the first time in my life I had done anything like this [the offence] and my first time in court. I’ve never had any problems with the police before...And I was already fifty [years old] when this happened” (Destiny; Q18).
- “I am remorseful of my actions. I even told the magistrate that I was not mentally well. My mother told me that laying charges against me was so that I could be admitted to a mental hospital and receive the help I needed” (Xoliswa; Q18).
- “It still troubles me but I am around people so I bear with it until I am allowed to return home...I live well with my neighbours and I will not do any shenanigans” (Maria; Q18).
- “Yoooooooo...I will go to church and ask forgiveness” (Thandeka; Q18)
- “I am looking forward to going home...my children will help me dealing with it [committing a violent offence]” (Noxolo; Q18).
- “I do not have peace because now I landed up here...I tell myself to be patient until I am released” (Busisiwe; Q18).
- “My wish is to apologise to her [the victim of my offence] and to find peace with each other, but she is surrounded by people who do not want me near her. There are people who are still igniting our tension. So, I’m giving her space and we will be alright” (Sindiswa; Q18).
- “I keep myself busy with caring for my other [surviving] children and doing my housework. I have three other children. I also have been in a relationship with the father [of my children] for twenty years and it is stable and he really helps me” (Thobeka; Q18).

The Future and Other Issues

The most common themes emerging from enquiries into views of the future was one of hope in the face of adversity, looking forward to being re-united with their children and families, and re-integrating into society as productive, healthy people again. Upon invitation to raise any further issues of their own choosing, most women were interested in when they would be eligible for leave of absence or discharge from hospital, in order to return home to their families:

- “I don’t own a house anymore and I am now dependent on my children...although I still feel very independent. I am looking forward to be a part of society again...I see it as a brand-new beginning...I want to spend time with my children and grandchildren” (Destiny; Q19 and Q20).
- “I would love to do arts and crafts because I am not well educated. I became ill in 1982 and I would like to work again...I’d like to know when I can go on leave again” (Xoliswa; Q19 and Q20).
- “If I take my medication, my future will be fine...I would like to go home to see my house and my sister’s children and my family” (Maria; Q19 and Q20).
- “I see my future as bright...I will go back to school and then proceed to a diploma in theology...I would like to know when I’ll be given leave so that I can start my life again” (Thandeka; Q19 and Q20).
- “I’m not too sure about the future...it can be good or bad...maybe I’ll have to stay longer [in hospital]...maybe they’ll let me go. I want to ask for a leave period...I’d like to extend my house and watch my children grow up...I just want to know how much longer I have to stay here” (Noxolo; Q19 and Q20).
- “I am behind in life because I am here...I think a lot about this but I have not come up with any solution[s]....Being here will make me end up being as confused as some

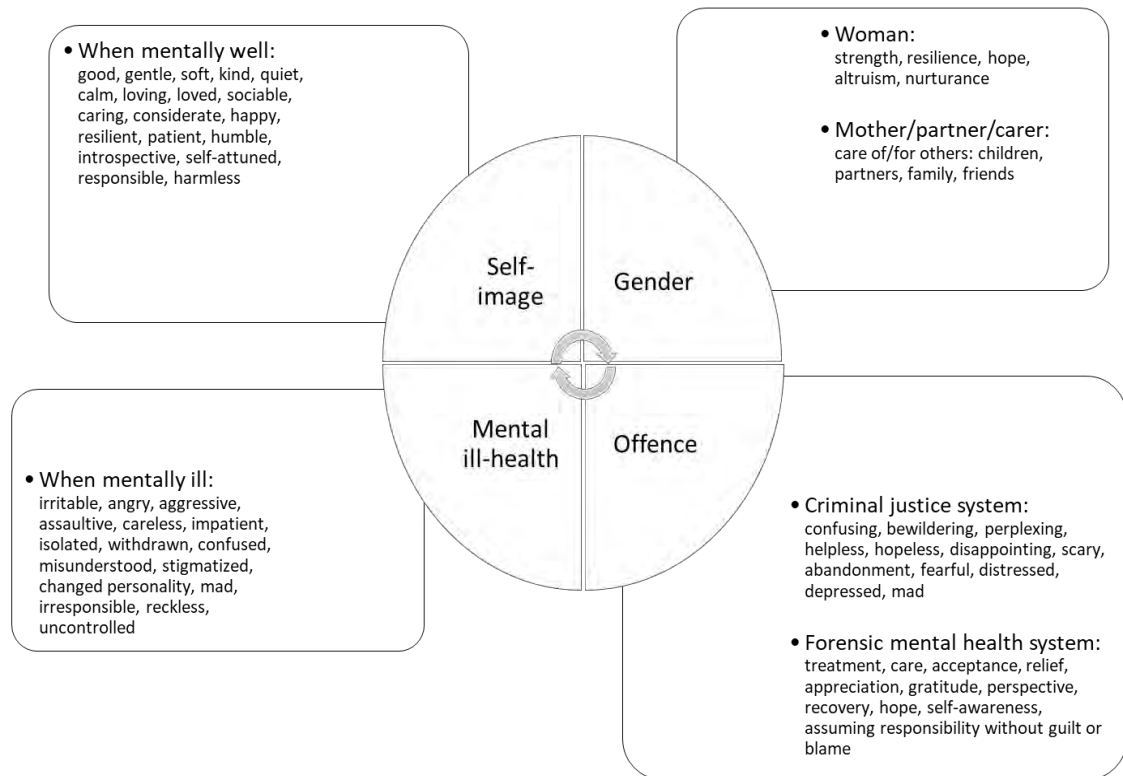
of the other patients here...but I think I'm doing okay...how do you think I'm doing?" (Busisiwe; Q19 and Q20).

- "I feel brand new...I feel like I'm a sweet sixteen...like I'm going to start afresh...I will be doing performances with my music band and we will keep active...Are there any opportunities for bands like mine in the department [of health]?" (Sindiswa; Q19 and Q20).
- "I would like to be home with my partner and children and also to work again...I used to be a waitress at a five-star guest house...when I became ill, the demands became too much...I'd like to see a psychologist and work in the future" (Thobeka; Q19 and Q20).

Thematic Analysis of Interviews

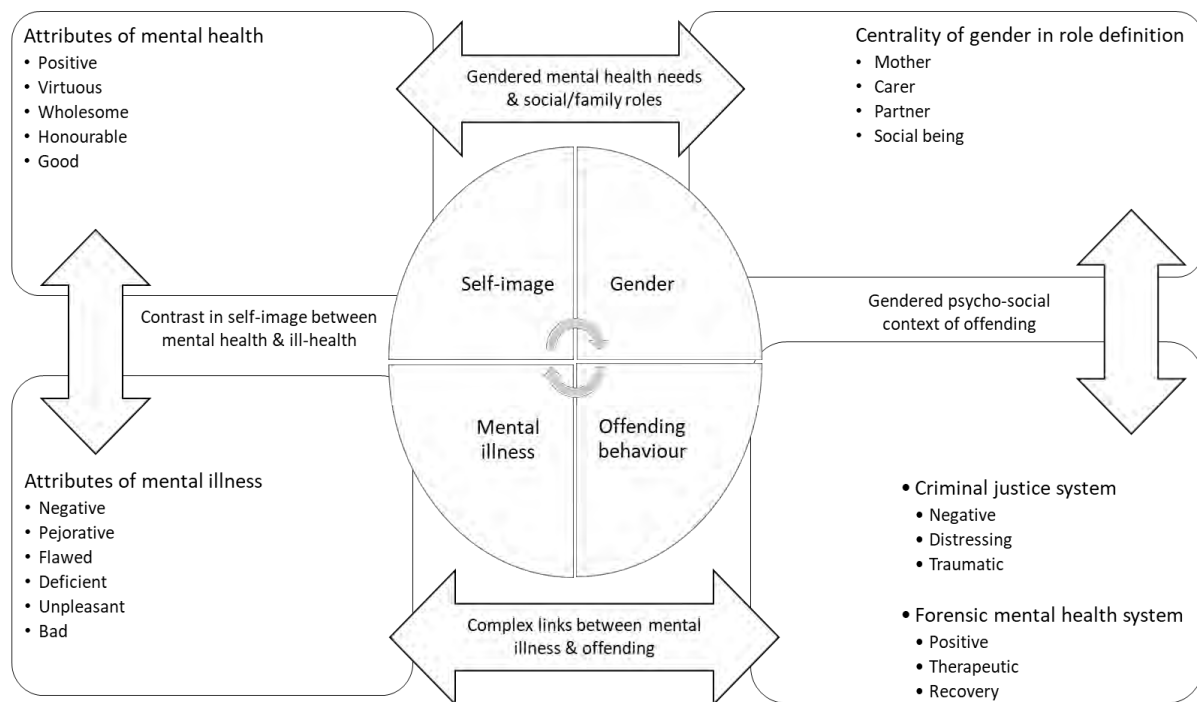
Interview narratives were systematically examined and thematically analysed, culminating in the generation of an initial thematic map (Figure 9). The primary domains of interest which semi-structured interviews explored with participants are indicated in the central circle i.e. issues around self-image, gender, mental health and offence-related issues respectively. Figure 9 further illustrates an expansion of the most prominent recurring themes in relation to each domain of interest, and how these might relate to each other, by the provision of illustrative examples of descriptive phrases expressed by participants in course of the interviews.

Figure 9
Initial Thematic Map



The systematic refining of the initial thematic map culminated in devising the final thematic map shown in Figure 10, which sought to summarise more succinctly the most important themes to emerge from the interview process, and to integrate these, via thematic analysis, into an understanding of how the complex variables at play around these themes may interact.

Figure 10
Final Thematic Map



A few women who were interviewed were uncertain or ambivalent about how they saw themselves and how they thought they were perceived by others. Nonetheless, as depicted in Figure 10, most women viewed their sense of self, personal attributes, mental state and behaviour when mentally well (i.e. before the onset, or during remission, of severe mental illness) to be in stark contrast to their self-image during episodes of mental ill-health. Most women were reassured, however, by their understanding that their mental state and behaviour at times of ill-health did not reflect or define who they truly believed themselves to be. In other words, most women had reasonably good insight into the fact that whilst episodes of mental illness may transiently change how they thought, acted, felt, communicated and/or behaved at the time, this was more a reflection of what they had (i.e. a specific mental disorder) than who they really were.

Most women interviewed emphasized how they valued their unique inter-personal, family and social roles, and how gender was an important defining feature of these. Figure 10 also depicts their descriptions of the centrality of their roles as mothers of surviving children, carers of family members, intimate partners and social beings within their respective homes and communities. In addition, all women described how these roles were (to varying degrees and in different ways) interrupted, disrupted or discontinued as a result of both mental illness and their violent offending. All women expressed their desire and/or need to resume these roles as soon as was feasible and as they progressed in their individual journeys of rehabilitation and recovery. In relation to this, a number of gendered mental health needs were also described, including the need for sensitivity, understanding, empathy, positive regard, support, care, protection and treatment, as women offenders with mental health problems and the broader context they were embedded within. These needs were sought not only from the forensic mental health professionals responsible for their clinical care, but equally importantly, also from their children, partners, families, friends and the broader community to which they felt they still identified with and belonged to. Most women valued the mental health care, multi-disciplinary treatment and rehabilitation they received following their offence and subsequent admission as State Patients to a forensic mental health facility. Much value was particularly placed particularly on their ongoing recovery, and the persistent hope and expectation of an eventual return to their pre-offence lives, especially as women who were carers for significant others within their homes and productive members of society.

Closely related to these gendered roles were issues related to the broader psychosocial context of their prior offending. A complex array of important criminogenic and contextual factors regarding offending behaviour were referred to during the course of interviews, including issues around: socio-economic adversity; financial dependence on others; limited

educational and occupational opportunities; disruptions in family life; traumatic abuse experiences; patriarchal family and social norms; being single mothers; substance misuse; persistent and daily psychosocial stressors; the psychopathology, behavioural disturbances and stigma associated with severe mental disorder; the psychosocial aftermath of violent offending; and being referred to a forensic psychiatric institution for treatment. All women described life histories characterised by significant disadvantage, distress, victimization and/or adversity. Most women also described a longitudinal progression from their pre-offence situation, to the onset and experience of mental illness, subsequent violent offending, and ultimately to their recovery and rehabilitation i.e. the progression from victim to offender to survivor. Whilst not all women made links between gender and mental illness, or even between gender and violent behaviour in general, all women appreciated the connections between their own mental illness and violent offending i.e. they generally displayed a good understanding of the causal nexus between psychopathology and violent outcomes. Most women expressed relief at their diversion into the forensic mental health system as patients, as opposed to their incarceration in correctional centres as prisoners. Most women drew sharp contrast between the distress, trauma and punitive nature of the criminal justice and corrective systems, on the one hand, and the more supportive, therapeutic focus of the forensic mental health system, on the other (Figure 10). In addition to the amelioration of psychopathological symptoms related to their respective diagnoses, the clinical interventions provided by the specialised, multi-disciplinary forensic mental health team were considered essential to improvements in self-esteem and confidence, and in helping reduce and reverse the inevitable shame, stigma, self-reproach and guilt many experienced as a result of the nature of their mental illness and their violent behaviour. In other words, amelioration of psychiatric symptoms by psychotropic medication was considered as important as facilitating improvements in self-image, personal growth, rehabilitation. In so doing, women felt empowered to assume ownership of their situations,

foster agency in their lives, work toward sustaining recovery, and ultimately, making reintegration into their families and society a realistic and attainable goal.

Conclusion

The quantitative results described in this chapter represent the most detailed description and analysis to date of the socio-demographic, criminological, clinical and forensic mental health profile of women offenders in the Eastern Cape of South Africa. Together with the qualitative results, the outcomes also provide the most comprehensive mixed methods study in this field of forensic mental health research of women to date nationally and continentally. The extent and diversity of the variables of research interest reflect not only the multiplicity of interacting criminogenic needs of women offenders who have mental health problems, but also the importance of the broader context in which such offending occurs. This, in turn, highlights the complexity of the relationships between gender, mental health and offending behaviour, as well as the need for a more nuanced and gender-focused understanding of these phenomena than has been the case thus far. These issues will be systematically appraised and critically discussed in the final chapter of the thesis that follows.

Chapter Eight: Discussion

A total of 173 women were referred by Eastern Cape courts to Fort England Hospital (FEH) for forensic psychiatric evaluation between 1993 and 2017, with the current study undertaking a detailed forensic mental health investigation of all these women. A mixed-methods research strategy was adopted, and data was obtained by, firstly, quantitative examination of the administrative, clinical and forensic records held at Fort England Hospital; and secondly, qualitative examination of the semi-structured interviews of a sub-sample of 12 violent women offenders with mental illness (all being State Patients within a specialised forensic mental health facility). This chapter will present a focused discussion and critical appraisal of the study outcomes, how they compare to the research literature, and the key implications of the study findings. The chapter is arranged into three sections. Firstly, a discussion of the overall socio-demographic, offence-related, clinical and forensic mental health profile of the total sample women offenders under study is provided. Secondly, an appraisal of the profiles of women who committed violent offences, and homicidal offences, respectively is undertaken. With respect to the former, issues around violent women who target adults versus those who target children are considered in further detail. With respect to the latter, women who murdered adults are considered initially, followed by a discussion of child homicide (with specific focus on neonaticide, infanticide, killing of older children and a proposal for a combined, integrated typology of female-perpetrated child homicide, respectively). Finally, the findings of the qualitative thematic analysis are brought under discussion, providing further appreciation of the broader, gendered context, and enrichment to understanding of the findings.

Overview

A discussion of the general forensic mental health profile of the study sample as a whole, structured to be congruent with the various components of the descriptive results (i.e. socio-demographic, offence-related, clinical and forensic aspects) is undertaken, prior to the more detailed consideration of violent offending in general, and homicidal offending in particular.

Socio-demographic and Offence Profile

The socio-demographic data shows that if we were to characterize the “typical” woman offender referred by Eastern Cape courts for forensic evaluation, she would be a black African, isi-Xhosa-speaking, single mother, between 30 – 40 years of age, and with one or more dependent children at the time of arrest. She would have not progressed beyond a Grade 8 – 12 school education, would be unemployed and living in difficult socio-economic circumstances with her family. She would be reliant on family members and/or state-sponsored social grants for financial support, both for herself and her children. She would have a disproportionately high risk of having been the victim of prior abuse at the hands of someone close to her (especially an intimate male partner). She would also be at increased pre-offence risk of abusing substances (especially alcohol), experiencing significant psychosocial distress, and having prior mental health problems. This overall profile is consistent with that of female pre-trial defendants, offenders, prisoners and forensic psychiatric patients described in the majority of published studies abroad (Bohle & de Vogel, 2017; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Bartlett, 2007; Binswanger et al., 2010; Bland et al., 1999; Bloom and Covington, 2008; Caufmann et al., 2015; Derkzen et al., 2013; Greenfeld and Snell, 2000; Herjanic et al., 1977; James and Glaze, 2006; Kelly, 2008a; 2008b; Lamb and Grant, 1983; Martin and Hesselbrock, 2001; Singer et al., 1995; Strick, 1989; Veysey, 1998; Washington and Diamond, 1985).

It is noteworthy that the vast majority of women offenders have dependent children at the time of arrest: up to 75% in the literature (e.g. Greenfeld and Snell, 2000; Martin and Hesselbrock, 2001), and a higher proportion (84%) in the present study. This is compounded by the fact that many of these mothers are single-parent carers (two-thirds of women in the study sample were single). The extent and intensity of such maternal responsibilities, especially in impoverished settings such as the Eastern Cape with its associated difficulties, is likely to be a source of significant distress for many single mothers, and have been proposed to be precipitating, aggravating and/or perpetuating factors with respect to mental health problems (de Vogel & Nicholls, 2016; Hurley and Dunne, 1991; Putkonen and Taylor, 2014). The vulnerability to psychological distress is compounded by the arrest and incarceration of single mothers, and their separation, often for extended periods, from children who are directly dependent on them. There are numerous consequences of extended maternal incarceration, including: children potentially being left in the care of often dysfunctional and/or abusive families (especially where mother-child units are not widely available in prison systems, as is the case in South Africa); disruption in mother-child attachment, and the deleterious effects on both; and a range of negative sequelae throughout personal, familial and social systems which are invariably associated with mental health problems as a result (DeHart et al., 2014; Hollin and Palmer, 2006; Karatzias et al., 2018; Sorbello et al., 2002).

The role of race and ethnic or cultural background in offending pathways has received some attention in the literature (though there is a dearth of information and ongoing uncertainty on its significance), with black, immigrant and other racial minority women being generally over-represented both in prison surveys and studies of women offenders in other settings (Derkzen et al., 2013; Wang & Stamatel, 2019). In the present study, a somewhat complex

picture emerged in this respect. Black African women were under-represented in comparison to both the provincial and national population averages (using census data from Lehohla (2014) for comparative purposes): 71% versus 86% (provincial) and 79% (national) respectively; whilst coloured (mixed race) women were over-represented: 16% versus 8.3% (provincial) and 8.9% (national) respectively; women of Asian / Indian descent were also significantly under-represented in the current sample in comparison to the provincial and national averages (0% versus 0.4% (provincial) and 2.5% (national) respectively). The reasons for, and significance of, these discrepancies are unclear.

Whilst some aspects of the offence-related profile of the study sample were similar to those of studies elsewhere, South African women offenders also differed in a number of important ways, especially in respect of violent offending and its broader psychosocial context. Most of the women sampled (80%) were first-time offenders with no prior criminal background, a rate which is consistent with the majority of similar studies on women offenders conducted elsewhere, both in South Africa and abroad (Artz et al., 2012; Cloninger and Guze, 1970; Maden et al., 1990; 1994a; 1994b; Singleton and Meltzer, 2002; Strick, 1989). As for most of these other studies, in women offenders with prior convictions in the present study, the majority of these (56%) were for relatively minor, non-violent, property-related offences (e.g. relating to the appropriation of, or malicious damage to, property, or financial offences); the remainder had histories of prior violent offending against the person (41% had committed prior violent, but non-lethal, assaults against bodily integrity, and 3% had previously committed homicide, respectively). The research literature cites a number of specific offence categories which are reportedly disproportionately committed by women offenders with mental health problems, including: prostitution, child abduction and fire-setting, with the latter constituting, for example, the most common single offence category in women within most forensic mental

health services (Taylor and Bragado-Jimenez, 2009). The offence profile in the present South African sample, of women offenders referred for forensic evaluation, was in stark contrast to this: there were no cases of prostitution; less than 1% of cases were of child abduction; and less than 3% were for fire-setting offences. The frequency of fire-setting and acquisitive offences was hence substantially lower in the study sample in comparison to data from female forensic populations abroad e.g. arson only comprised 2.5% of cases in the study sample, as compared to rates of 20 – 50% abroad; and theft was the index offence in only 13% of cases in the study sample, as compared to rates of 30 – 40% abroad (Bartlett et al., 2007; Coid et al., 2000a; 2000b; Long et al., 2010; Sahota et al., 2010).

In contrast to the vast majority of equivalent studies elsewhere, most index offences in the South African sample were of violent offences against the person and life (in over 60% of cases), with the minority having been arrested for non-violent, mostly property-related, offences. Offences against life (attempted murder and murder) in particular comprised almost one-third of all cases, a ten-fold increase in comparison to the prior offence profile (in which only 3% had previous convictions for homicidal offences); and murder was the single most common index offence (26% of all cases). In fact, the three most violent offences (assault with intent to do grievous bodily harm, attempted murder and murder) together accounted for over half of all cases in the South African sample of women referred by Eastern Cape courts for forensic evaluation. This rate of serious violence by women offender samples compares to the highest rates of up to 60% reported in the research literature (Kelly, 2008a; 2008b; Long et al., 2010; Strick, 1989). Furthermore, violence by the vast majority of South African women offenders (in over 90% of cases) was directed toward victims well known to them: in the case of adult victims of violence, disproportionately toward family members (38% of cases), neighbours/friends/acquaintances (34%) and intimate male partners (21%); and in cases of

child victims, toward biological children (81% of cases) respectively. Whilst this victim profile may be similar to patterns described for violent female offending described in the published literature, the relative frequency of violent offences in the South African setting stands in stark contrast to the results of published studies elsewhere (Hollin and Palmer, 2006; Kelly, 2008a; 2008b; Moffit et al., 2001; Putkonen and Taylor, 2014; Schwartz and Steffensmeier, 2007; Steffensmeier and Allan, 1996; Strick, 1989).

Crucial to understanding of these especially violent offending patterns amongst women offenders in the Eastern Cape of South Africa, is an appreciation of the complexity of contributory criminogenic risk factors, all of which are embedded in the unique, gendered psycho-socio-environmental milieu from which these women emanate. In the first instance, the organization of gender in the largely patriarchal society of rural South Africa influences all areas of social life. Important interacting factors in this respect include the potentially criminogenic influence of gender norms, roles, stereotypes, identity, sexuality, controls, and stigma, as well as coping mechanisms employed in response to these (Andrews and Bonta, 2010; Blanchette, 2002; Byrne and Howells, 2002; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Caufmann et al., 2015; Hollin and Palmer, 2006; Palmer et al., 2010; Phillips and Harm, 1998; Schwartz and Steffensmeier, 2007; Steffensmeier and Allan, 1996; Steffensmeier and Haynie, 2000; Van Voorhis et al., 2010). Family disruption, gender-based abuse, structural oppression, discriminatory cultural values and traditions, social upheaval and socio-economic vulnerability contribute to marginalization of women and an increased risk of offending (Belknap and Holsinger, 2006; Chesney-Lind, 1989; Daly and Chesney-Lind, 1988; Holsinger, 2000; Schwartz and Steffensmeier, 2007). Female identity in traditionally patriarchal settings is also derived, in part at least, from significant others i.e. in relation to women's roles as mother, carer and/or intimate partner. This derivative identity has

been postulated to potentially draw some women into criminal behaviour e.g. in an effort to provide for others in impoverished settings, or to protect themselves or others from abusive partners or family members (de Vogel & Nicholls, 2016; Steffensmeier and Allan, 1996). It is unsurprising then that in the current study, as with many others in the research literature, a significant number of violent offences occurred in the context of relational conflict with people close to them (in over one-third of cases). In the majority of cases, these took the form of violent retaliatory or self-defensive offences as a result of interpersonal strife with abusive intimate male partners, close family members, or with other women (mostly regarding disputes over intimate partners).

The differential association theory of offending (Sutherland et al., 1992) would hold that criminal attitudes and values in these women offenders are learned, in part at least, through differential exposure to pro-social versus pro-criminal associates respectively. The behaviour of the personal associates of these women, especially intimate partners and close family members on whom they are financially dependent, wield significant influence on the nature of their interpersonal relationships and associated behavioural patterns. In situations dominated by patriarchal power hierarchies and chauvinistic disrespect in male-female relationships, women may have a differential tendency to aggression and offending behaviour when under duress and faced with limited options or supportive resources. Social cognition and personality theories of offending (Andrews and Bonta, 2010; Bandura, 2001; Digman, 1990; Mischel, 2004; Taylor et al., 2013; van Langen et al., 2014) would add that the relative density of “rewards” associated with offending behaviour is also largely influenced by primarily psychosocial variables of the individual offender, including: personal attitudes and temperament; behavioural disposition; social cognitive and motivational attributes; and personality structure. These factors, in turn, are moderated by the individual’s domains of

personal interaction (e.g. with partners and family members), as well as those within social or occupational domains.

The life-course perspective of criminogenesis in women would, in addition to the gendered organization of families and societies, emphasize the importance of gender-based developmental stages in influencing future offending behaviour (de Vogel & Nicholls, 2016; Gilfus, 1992; Johnson et al., 1995; Kjelsberg and Friestad, 2009; Miller et al., 2010). Many adolescent girls and women experience a longitudinal progression in their life histories from victims (e.g. of domestic abuse, poor parental and social support, socio-economic adversity and/or substance abuse) to survivors (e.g. of their abuse experiences, environmental stressors and/or emergent mental health problems) to offenders (e.g. following interpersonal conflict with abusive intimate male partners, being overwhelmed by extreme maternal stressors and/or due to the active psychopathology of mental disorder) (Gilfus, 1992; van Langen et al., 2014). A similar conceptual framework, and an appreciation of the complex array of contextual factors, emerged from the thematic analysis of the interviews conducted with the sub-sample of violent women offenders in the current study. The narratives of many of these women reflected their framing of their violence as a result of their own mental anguish or as “survival strategies”, albeit criminal ones, perpetrated by women who viewed themselves as active survivors (e.g. of prior abuse, psychosocial adversity and/or mental illness) as opposed to passive victims (e.g. of their situations and mental disorder). Their responses to pre-offence adversity, distress and abuse experiences, and the influences of these gendered variables on self-image and mental health in particular, should be viewed as important contextual factors linked to the propensity to subsequent violence. In addition, many theorists would argue that many women offenders tend to take criminal risks for more altruistic ends than may be the case for men e.g. in an effort to protect or provide for children and loved ones, sustain family

relationships, or to extricate themselves from overwhelming, abusive or distressing personal situations (Schwartz and Steffensmeier, 2007; Steffensmeier, 1980; Steffensmeier and Allan, 1996). These concepts are also found to be inter-related in complex ways when considering the unique life histories and trajectories of individual women offenders. Early abuse experiences may initially be framed around issues of victimhood, but subsequent survival may increase vulnerability to offending behaviour, especially in the context of ongoing adversity, interpersonal difficulties and the associated distress of their daily lives. Following the criminal event, women are required to once again survive the post-offending ordeal of an adversarial criminal justice system, incarceration in prison, stigma, detachment from families and children, and the many mental health problems that are commonly encountered. When mental health problems are more severe and their offences of a violent nature, women may have to also cope with a new set of stressors e.g. related to the mental disorder itself, further stigma and alienation, long term institutionalization in forensic hospitals, learning of the role of mental disorder in the commission of often extreme forms of violence, etc. The cumulative effects of these interacting factors also form significant obstacles to their individual roads to rehabilitation and recovery.

As was the case for the study sample, there is robust evidence in the literature of poor educational and occupational attainment in women offenders, who also therefore tend to live in settings of social and housing insecurity (Blanchette, 2002; de Vogel & Nicholls, 2016; Hollin and Palmer, 2006; Home Office, 2007; 2012; Sorbello et al., 2002). Related to this are the roles of social discrimination, poverty, unemployment and socio-economic adversity in criminogenesis (Chesney-Lind, 1986; 1988; Daly, 1989; Schwartz and Steffensmeier, 2007; Steffensmeier, 1980). The influence of patriarchal power relations is postulated to entrench these influences on female offending through the systemic entrapment, victimization, and

marginalization of these women. Women who experience chronic intra- and inter-personal distress within such socially structured inequality are more prone to offending behaviour, though many confounding variables mitigate against direct causal associations. Application of the general strain theory of criminality (Agnew, 1992; Agnew et al., 2002) to offending by women in impoverished settings as the Eastern Cape emphasizes the importance of personal and psychological factors beyond economic strain, such as negative or unstable affect (e.g. frustration, irritability, anger); and the unique personality structure of individual women offenders (e.g. risk-seeking temperament; impulsivity; poor self-esteem; erratic social judgement). Such individual factors would modulate responses to the distress presented by the social milieu of patriarchy, poverty and inequality. Violent offending in particular is proposed to be, in part at least, mediated via frustration-anger-aggression pathways that women experience as a consequence of their disadvantaged personal and social context.

Furthermore, the crucial role of family and interpersonal dynamics as independent criminogenic risk factors should not be under-estimated (Bloom and Covington, 2008; de Vogel & Nicholls, 2016; Farrington and Painter, 2004; Hollin and Palmer, 2006; Kemppainen et al., 2002; Putkonen and Taylor, 2014). Numerous variables have been proposed to mediate or exacerbate the risk of offending in this respect. These include socio-economic adversity (which also makes it difficult for many women to leave violent, abusive home settings), high expressed-emotion families, and intense child-rearing / family caring responsibilities. The associated interpersonal conflict, emotional deprivation and psychological distress are postulated to lead to mental ill-health in some women, and the increased risk of behavioural outcomes such as violence (de Vogel & de Spa, 2019; de Vogel et al., 2016; Caufmann, et al., 2015). Psychodynamic interpretations would also emphasize the key links between the frustrations generated by such psychosocial disruption to value-linked behaviours, with

offending and violence viewed as potential coping strategies in response to such frustrations (Andrews and Bonta, 2010). The final pathways to offending should hence be understood as the culmination of a complex interplay of numerous dynamic variables, embedded within a gendered psycho-socio-cultural milieu.

Clinical Profile

Pre-offence Abuse. Over one quarter of women offenders in the study disclosed a pre-offence history of having experienced abuse themselves during childhood and/or adulthood. In the remainder of women, this was either not disclosed, denied, unknown or unspecified in the clinical records. The prior abuse reported by 25% of women in the current study sample is postulated to probably be an under-estimate of the true situation, with women likely to have under-reported this for many possible reasons in the setting of a forensic assessment. These include, for example, the lack of a fiduciary relationship in the context of a court-ordered forensic evaluation; potential power and gender dynamics between the assessing clinicians and the criminal defendant; the forensic evaluation itself producing anxiety or distress, and reluctance to disclose sensitive information which is distressing in itself; inadequate clinical history-taking and failure to explore pertinent issues by clinical assessors; active psychopathology obstructing access to such historical information; etc. Nonetheless, a rate of even one-quarter of all women offenders assessed would confirm the disproportionately high rates of prior abuse (of between 20 - 75%) amongst women offenders that have been extensively documented in the literature (Acoca and Dedel, 1998; Belknap and Holsinger, 2006; Bland et al., 1999; Bloom and Covington, 2008; Blount et al., 1994; Bohle & de Vogel, 2017; Browne and Finkelhor, 1986; Browne et al., 1999; Chesney-Lind, 1986; 1988; 1989; Chesney-Lind and Rodriguez, 1983; DeHart et al., 2014; de Vogel & Nicholls, 2016; Gaarder and Belknap, 2002; Gilfus, 1992; Greenfeld and Snell, 2000; Holsinger, 2000; Janeksela, 1997;

Jordan et al., 1996; Karatzias et al., 2018; Lowenkamp et al., 2001; McClellan et al., 1997; McKeown, 2010; Messina et al., 2006; Rodríguez et al., 2006; Roe-Sepowitz, 2009; Rossegger, et al., 2009; Schwartz and Steffensmeier, 2007; Singer et al., 1995; Snell and Morton, 1994; Sung et al., 2010; Yourstone, Lindholm and Kristiansson, 2008).

Among the women who reported prior abuse in the present study, over 70% also had prior mental health problems (and over 80% were formally diagnosed with at least one severe mental disorder following the forensic evaluation). These outcomes confirmed well established evidence that a prior history of abuse experiences (especially sexual) in women is independently associated with a range of psychological problems and mental illness (Bohle & de Vogel, 2017; Bryer et al., 1987; DeHart et al., 2014; Jordan et al., 1996; Karatzias et al., 2018; Martin and Hesselbrock, 2001; Messina and Grella, 2006; Saunders et al., 1992; Surrey et al., 1990). Abused women are reported by these studies to be especially prone to developing severe mood disorders (particularly depressive disorders), psychotic disorders, substance-related disorders, PTSD and personality disorders (particularly of the borderline type). Furthermore, women offenders with a history of abuse and mental ill-health are unlikely to realize goals of social, personal and economic independence, and remain vulnerable to perpetrating offending behaviour, unless their unique social and mental health needs are adequately addressed (Bloom and Covington, 2008). This includes bio-psychosocial interventions to address issues such as the trauma of prior abuse, persistent symptoms of mental illness, co-morbid substance misuse, and associated functional impairments that are invariably present.

Amongst women who reported prior abuse ($n = 44$), victimization occurred during their adulthood in the majority (64%), with childhood/adolescent abuse in a smaller proportion

(27%), and the remainder experiencing abuse throughout their lives. Whilst much of the literature focuses on childhood or adolescent abuse, the continuation of abuse into adulthood has been linked to a substantial further increase in the risk of offending behaviour, especially of a violent nature (Hollin and Palmer, 2006; Palmer et al., 2010). Many studies have also emphasized particularly close associations between prior sexual abuse and subsequent criminal pathways (Belknap and Holsinger, 2006; Browne et al., 1999; Siegel and Williams, 2003). The most common single type of abuse reported by women in the current study was physical abuse (in 41% of cases), followed by sexual abuse in 25%. Over one third (34%) of abused women reported experiencing multiple types of abuse (i.e. combinations of physical, sexual, and/or other types of abuse).

In those women who reported prior abuse ($n = 44$), perpetrators were known to the women in over 90% of cases. Of particular significance, is that prior abuse was most commonly perpetrated by intimate male partners (57% of cases), followed by abuse by other close family members (30%) respectively. The disproportionately high rate of prior abuse of South African women offenders by intimate male partners is approximately double the rates of around 30% reported by most other studies abroad (Greenfeld and Snell, 2000). Intimate male partners were also disproportionately targeted in the commission of violent offending (both lethal and non-lethal violence) in particular by women offenders included in the current study (intimate male partners comprised over one-fifth of all adult victims of violence). South African women offenders who had a history of prior abuse were in fact significantly ($p < 0.05$) more likely to subsequently commit violent (3-fold higher risk), and especially homicidal index offences (5-fold higher risk), respectively, in comparison to women who did not report such prior abuse. This issue is explored in further detail in the discussion on violent and homicidal offending below.

Pre-offence Mental Health. In view of the fact that the women offenders sampled were all referred by courts for forensic evaluation on the basis of suspected or documented mental health problems, it is not surprising that almost three-quarters of women had a prior psychiatric history i.e. were previously diagnosed with, or treated for, a mental disorder. The most common prior psychiatric diagnostic categories were psychotic (29%) and mood disorders (22%) respectively. There is compelling evidence in the research literature that women offenders are, irrespective of a history of prior abuse, at increased risk of severe mental health problems, both pre- and post-offence (Blanchette, 2002; Brinded et al., 2001; Daniel et al., 1988; de Vogel & Nicholls, 2016; DeHart et al., 2014; Hodgins and Côté, 1990; Hollin and Palmer, 2006; Palmer and Hollin, 2007; Palmer et al., 2010; Putkonen and Taylor, 2014). Considering the context of prior abuse experiences in many women described above, Comack and Brickey (2007) correctly suggested that the traditional patriarchal and binary conceptualization of women offenders as simply either “mad” or “bad” is complicated by the presence of at least a third dimension: The “victim”, which encompasses prior abuse experiences, situational adversity, and mental health problems (including substance misuse) in particular. These three dimensions are not mutually exclusive and they have strong inter-connectedness. This notwithstanding, the link between prior severe mental disorder and criminal offending is a complex one and remains poorly understood. The large systematic review by Fazel and Danesh (2002) of almost 23000 prisoners, for example, found only relatively weak evidence to support the contention that severe mental disorder is significantly more prevalent in women offenders.

The abuse of substances is widely accepted as a significant criminogenic risk factor in women (Bartlett, 2006; Blanchette, 2002; Byrne and Howells, 2002; DeHart et al., 2014; Hollin and Palmer, 2006; Mullings et al., 2002; Peugh and Belenko, 1999; Staton-Tindall et al., 2007).

Over half of women offender (53%) in the present study sample reported a history of pre-offence substance-related problems, which is less than rates reported from most studies abroad of up to 70% (Butler, et al 2003; McClellan et al., 1997). Gender differences in the criminogenic potential of substances, reveal that women offenders who misuse substances, in comparison to their male counterparts, display more severe patterns of substance abuse, tend to have a history of childhood abuse experiences themselves, and have higher rates of comorbid mental health problems in addition to those related to substances (Langan and Pelissier, 2001). In respect of specific substances of preference, alcohol was by far the most commonly abused substance in the South African sample, being used in 91% of cases who reported substance abuse (either alone or in combination with other substances); and cannabis was the most commonly abused illicit substance (in 45% of cases of substance-misusing women). This is different to most studies from abroad, in which women offenders are reported to preferentially use illicit substances over alcohol, with such illicit substance use significantly predicting future offending when other confounders are controlled for (Butler et al., 2003; McClellan et al., 1997). This notwithstanding, neither a history of substance abuse nor a confirmed substance disorder diagnosis were found to be statistically significantly associated with, or predictive of, offending behaviour in the current analysis.

Mental Health at Time of Offence. The conclusion of a direct causal nexus between mental disorder (either due to the active psychopathology of severe mental disorder or the result of intellectual disability) and a lack of criminal capacity, was reached in just under half of all women in the study sample. At the time of forensic assessment, active and persistent psychopathology (e.g. due to psychosis, and associated formal thought disorder and/or delusional belief systems; or due to intellectual disability) produced illogical, disorganized, impoverished or otherwise unreliable self-reported accounts of mental state and behaviour at

the material time of the index offence, in approximately 46% of cases. In the remainder of cases, less than 40% of women provided clear and reliable admissions to commission of the offence which were consistent with the criminal evidence before the court. Approximately 40% of women in whom a substance-related disorder was diagnosed at forensic evaluation were known to be intoxicated at the time of the offence (with over 95% of these women having been intoxicated with alcohol, either alone or in combination with other substances). This high rate of intoxication at the time of female offending was consistent with rates of 30 - 45% reported in the research literature (Fazel et al., 2006; Greenfeld and Snell, 2000). The issue of substance-related disorders is discussed in further detail below.

Post-offence Mental Health. Disproportionately high rates of mental ill-health (whether in comparison to rates in the community, non-offending women or men) amongst women offenders in general are extensively reported in the literature, with estimates of up to 60% (approximately double the rate of male offenders) diagnosed with a severe mental disorder requiring psychiatric treatment (e.g. Bohle & de Vogel, 2017; Derkzen et al., 2013; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Caufmann et al., 2015; DeHart et al., 2014; Diamond et al., 2001; Drapalski et al., 2009; Fazel and Danesh, 2002; Hollin and Palmer, 2006; James and Glaze, 2006; Jordan et al., 2002; Karatzias et al., 2018; Lord, 2008; Martin and Hesselbrock, 2001; Sacks, 2004; Singleton and Meltzer, 2002; Staton-Tindall et al., 2007; Schwartz and Steffensmeier, 2007). The current study of South African women offenders confirmed their vulnerability to mental ill-health: Three-quarters of women had a prior psychiatric history and 85% had at least one severe mental disorder diagnosed on Axis I on final psychiatric court reports. A number of factors may underlie these findings of disproportionately high rates of mental illness in the present study, foremost amongst which is sample bias: The study sample is drawn from those women offenders who were deemed by

courts to necessitate formal forensic evaluation i.e. there were questions regarding their mental health that prompted referral to FEH in the first place. This notwithstanding, there are a number of other variables that are likely to have contributed to psychological distress and the development of mental illness prior to, during or soon after the offence (in addition to those women who had an inherent vulnerability to mental illness independent of their offending behaviour or its consequences). These include the trauma of being arrested and separated from their dependent children and families, often for extended period of time; facing an adversarial, overburdened and inefficient South African criminal justice system and, in most women who were first-time offenders, one whose bureaucracy and processes are unfamiliar and frightening to them; the situational stressors of a patriarchal (and often misogynistic and abusive) prison system that is also not particularly attuned to gender needs; being incarcerated for extended period of time within prisons which have poorly resourced health services, and the grossly inadequate or non-existent mental health services. South African women who are arrested are hence unlikely to receive adequate, appropriate, or in many cases any, professional mental health care to meet existing or emergent mental health needs whilst incarcerated in prison facilities (as awaiting-trial remand detainees or convicted prisoners).

The extensive, global systematic review of 62 surveys, incorporating almost 23 000 offenders, of severe mental disorder in offending populations by Fazel and Danesh (2002) revealed particularly high rates of mood, psychotic, and personality disorders respectively. Whilst substantially high rates of severe mental disorder were confirmed in the South African study sample, the distribution of specific disorders was different to the Fazel and Danesh survey in a few respects: (a) much higher rates of schizophrenia and other psychotic-spectrum disorders were present in the study sample (32% of cases versus 4% reported by Fazel and Danesh); (b) much lower rates of personality disorders (9% versus 42%); and (c) approximately

equivalent rates of mood disorders (9% versus 12%) respectively. High rates of substance-related disorders (16%) and co-morbid Axis I mental disorders (19%) were also diagnosed in the South African women (unfortunately substance-related disorders were excluded and rates of mental disorder comorbidity were not reported upon in the Fazel and Danesh survey). A more detailed discussion of specific Axis I diagnostic groups in the study sample is provided below, followed by a consideration of pertinent findings on Axes II and II respectively.

Axis I. There was no mental disorder diagnosed on Axis I in the final psychiatric court report in only 15% of cases, and in the remaining 85% of women ($n = 147$), the most commonly occurring Axis I diagnostic groups (in order of decreasing frequency) were schizophrenia and other psychotic-spectrum disorders (32%); co-morbid Axis I mental disorders (19%); independently occurring substance-related disorders (16%); and mood disorders (12%), respectively. Whilst schizophrenia and other psychotic-spectrum disorders comprised the single most common diagnostic group, in almost one-third of all cases, schizophrenia itself was the most common single mental disorder diagnosed (in 32 cases). This appears to be at variance from suggestions that the later onset of schizophrenia in most women may confer some protection from some of the significant social consequences of the illness, including offending vulnerability (Häfner et al., 1998; 2003). The current study confirmed a number of other associations described in the literature in women offenders with psychotic-spectrum disorders, including the higher than expected rates of childhood abuse (Heds et al., 1997) and co-morbid substance misuse (McMahon et al., 2003) respectively. Furthermore, when all cases in whom a psychotic disorder was diagnosed (whether as an independent psychotic-spectrum disorder or co-occurring with another mental disorder) were examined further, it was apparent that the majority of psychotic South African women committed violent offences: (a) violent but non-homicidal offences in 24 cases; and (b) homicidal offences in 15 cases respectively (with the

remaining 28 cases charged with non-violent offences). A more detailed appraisal of the mental health profile of violent and homicidal offenders is undertaken in subsequent discussion below.

The second most common Axis I diagnostic group was of Axis I comorbidity (in 19% of cases) i.e. two or more co-occurring psychiatric diagnoses in one individual. The vast majority of these cases were related to “dual diagnoses” of a substance-related disorder in particular being co-morbid with another Axis I disorder (in 30/33 cases of comorbidity), with the vast majority of these (91%) involving alcohol. These findings are in keeping with those of many other studies regarding the particularly high occurrence of dual diagnoses in women offenders (Abram et al., 2003; Anderson et al., 2002; de Vogel & Nicholls, 2016; James and Glaze, 2006; Mumola, 1999; Veysey, 1998). In addition, the third most common Axis I diagnostic group was the substance-related disorders (i.e. independently occurring substance-related disorders without co-occurrence of another mental disorder on Axis I), in 16% of cases. The present study therefore confirmed the crucial role played by substance misuse (whether as independently occurring disorders or co-occurring with other mental disorders) in female offending pathways, and more especially alcohol-related disorders (e.g. Bohle & de Vogel, 2017; Byrne and Howells, 2000; DeHart et al., 2014; Fazel et al., 2006; Hollin and Palmer, 2006; Home Office, 2012; Johnson, 2006; Lanz et al., 2008; Lopes and Mello, 2010; Martin and Hesselbrock, 2001; Sorbello et al., 2002; Staton-Tindall et al., 2007). Fazel et al. (2006) in their systematic review of the prevalence of substance abuse amongst prisoners (across 13 studies, and a combined sample of 3270 women) documented that up to 50% of women offenders reported pre-offence substance misuse; whilst 10 – 24% of women offenders surveyed had a confirmed diagnosis of an alcohol-related disorder, this was less common than those with disorders related to illicit substances (in 30-60% of cases). In comparison, a reversal of this pattern was evident in the South African study sample in which alcohol was far more

commonly used than illicit substances: 59% of all independently occurring substance-related disorders were alcohol related (higher than all other substances combined), and over 90% of all cases of dual diagnosis involved alcohol. The dominance of alcohol as the preferred substance of abuse amongst women offenders in the Eastern Cape may be in large part be due to the fact that it is relatively affordable and universally available.

Substance misuse is also known to be more prominent in women offenders who are relatively young, financially dependent on others, unemployed and socially marginalized (de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014), being features common to many women included in the study sample. There is also good evidence of associations between substance misuse (especially of alcohol) and women offenders who have experienced prior abuse, with substance reportedly being used to help alleviate the distress of traumatic experiences in many of these women (Bartlett, 2007; Browne et al., 1999; DeHart et al., 2014; Harlow, 1999; Langan and Pelissier, 2001; Marcus-Mendoza et al., 1994). These trends were also apparent in the current study, in which women offenders who had backgrounds of prior abuse abusing substances more often than those without such past abuse (with the differences being particularly stark in respect of alcohol) e.g. 60% of abused women misused alcohol, compared with only 44% of women with no history of past abuse themselves. Despite this, there were no statistically significant associations found between substance abuse and index offences (neither with respect to the nature of the index offence nor victim-related factors respectively). Finally, mood disorders were diagnosed in 12% of cases ($n = 20$; bipolar disorders in 14 and depressive disorders in 6 women respectively), similar to the conclusions of other studies that bipolar disorders (especially episodes of psychotic mania) are disproportionately represented in samples of women offenders (Loucks and Zamble, 1999; 2000).

Whilst post-traumatic stress disorder (PTSD) is cited in many studies to be particularly prevalent amongst incarcerated women offenders (Henderson et al., 1998; Karatzias et al., 2018; McClelland et al., 1997; Singleton and Meltzer, 2002; Teplin et al., 1996; Tye and Mullin, 2006; Zlotnick, 1997), none of the women in the present study sample had documented histories of diagnosed trauma or stressor-related disorders (including acute stress disorder nor PTSD), nor were these diagnoses confirmed at forensic evaluation. Similarly, whilst women offenders are known to be at increased risk of self-harming and suicidal behaviour during periods of incarceration (Bartlett, 2007; Baxter, 1996; Baxter and Appleby, 1999; Corston and Britain, 2007; DeHart et al., 2014; Home Office, 2012; Karatzias et al., 2018; Liebling, 1994; Martin et al., 1985), no women within the study sample had any such behaviour documented in their records, neither during their prison stay prior to admission, nor during the period of their evaluation at FEH. Whilst the reasons for these discrepancies are not entirely clear, a number of issues may have been influential, including under-diagnosis and/or poor clinical documentation in the resource-deficient South African prisons; true differences in prevalence rates between the study sample and those reported in the literature; the fact that women offenders were admitted for forensic evaluation for a relatively short period of time (less than 4 weeks in the majority); trauma or stressor-related disorders may not have been adequately screened for during their time at FEH; and/or the possibility that the therapeutic setting and care available at a mental health facility may have contributed to a attenuation of active acute stress disorder or PTSD symptoms during the course of the forensic evaluation.

In summary, the Axis I diagnostic findings of this study suggest that the most commonly encountered mental disorders in women offenders in the Eastern Cape of South Africa are psychotic disorders, dual diagnoses, substance-related disorders and mood disorders, respectively (with particularly high rates of dual diagnoses), being consistent with the

conclusions of most other research evidence elsewhere (de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014).

Axes II and III. Whilst the vast majority of women (82% of cases) had no Axis II (personality disorder and/or intellectual disability) diagnoses made, personality disorders (most of which were of the cluster B type i.e. borderline, antisocial, narcissistic or histrionic) were diagnosed in around 10% of women, and intellectual disability was diagnosed in around 8% of cases respectively. Although a number of published studies report associations between cluster B personality disorders and female offending, the issues remains relatively poorly researched (de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014). There is, however, evidence of associations between severe personality disorder (especially of the borderline type), prior abuse, and high levels of psychological distress in female offending samples (Bohle & de Vogel, 2017; Rutherford and Taylor, 2004; Verona et al., 2005; Warren and Burnette, 2012; Warren and South, 2009; Warren et al, 2002; 2003; 2005). A variety of temperamental and contextual factors purportedly mediate these associations (e.g. interpersonal conflict within tumultuous relationships with significant others; impulsivity; substance misuse; suspicious attitudes; affective instability; financial and emotional dependence; single parenthood and so forth), but these are complex issues that remain poorly understood. Although antisocial personality disorder and psychopathy are well-described offending risk factors in general, these associations are better researched and more robustly demonstrated in male offender samples. Only one psychiatric court report in the current sample stated the defendant to have “antisocial personality traits”, and no cases of antisocial personality disorder or psychopathy were explicitly diagnosed. The literature estimates of the prevalence of antisocial personality disorder or psychopathy amongst women offenders is reported to be between 9 - 31% (Maden

et al., 1994b; Salekin et al., 1997; Vitale et al, 2002; Warren et al, 2003; Weizmann-Henelius et al., 2004b).

A number of factors are likely to have contributed to the negligible rates of personality disorder (including antisocial personality disorder and psychopathy) in the present study sample. Firstly, and most importantly, only mental disorder diagnoses that are pertinent to the forensic evaluation in relation to the specific offence under consideration are included on the psychiatric report submitted to court i.e. only those mental health factors (e.g. active psychopathology, neurocognitive impairment or intellectual disability) that are sufficiently severe to have direct and demonstrable bearing on trial competence and/or criminal capacity. In the absence of other co-occurring psychiatric conditions, personality disorders are hence not considered by South African legislation and the criminal justice system as mental disorders with sufficient forensic significance as to be routinely included in court psychiatric reports. Secondly, the reduced rate of personality diagnoses may also be related to sample bias and/or under-diagnosis by mental health professionals conducting forensic evaluations (or their reluctance to diagnose personality disorders on cross-sectional assessment). Thirdly, it is possible that the more overt symptoms of severe psychiatric syndromes, such as psychotic disorders, are more readily detected than personality disorders in the South African criminal justice system, with its relatively high caseload burden and poor professional resource availability. Finally, the low personality disorder rates may possibly reflect a true difference in prevalence rates between the South African study sample and those from studies abroad. Future research on South African women offenders may clarify these matters further (Nagdee, et al., 2019).

Whilst over half of the women assessed had no known prior medical history, approximately 50% of cases had a medical condition diagnosed on Axis III following the completion of their forensic evaluation listed. A disproportionate number of women (22% of all cases; 38/55 of cases with medical diagnoses on Axis III) were confirmed to have or diagnosed with HIV-infection. This HIV-infection rate is at least four to five times higher than rates of 3 – 4% quoted in the literature for women offenders abroad (Franklin et al., 2005; Greenfeld and Snell, 2000; Martin and Hesselbrock, 2001; Maruschak, 2004; Waring and Smith, 1991). The HIV-infection rate of 22% in the study sample was also substantially higher than estimates for South African women in the general of around 14% (and 10% in males); it was also higher than estimates of the overall provincial prevalence HIV-positivity rate of approximately 12% for the Eastern Cape (Shisana et al., 2014). The HIV-infection rate in the study sample, however, was approximately equivalent to the national average of 20% of women of reproductive age (15 – 49 years) (Statistics SA, 2018). It is also noteworthy that there is increasing evidence of the relatively high prevalence of mental disorder in people living with HIV/AIDS in South African samples. Olley et al. (2006), for example, reported that the overall prevalence of psychiatric disorders in HIV-positive patients attending a hospital-based HIV clinic was high, being around 56% at baseline and 48% at 6-month follow-up (with depression and PTSD being the most prevalent disorders at both baseline and follow-up) respectively.

Forensic Mental Health Profile

For the purpose of forensic evaluations in criminal cases, forensic mental health professionals in South Africa are guided by the Criminal Procedure Act (CPA) (1977) and subsequent amendments such as the Criminal Procedure Amendment Act (CPAA) (2017), and the Mental Health Care Act (MHCA) (2002). Clinical diagnoses of mental disorder

(incorporating both mental illness and intellectual disability) are only included in the final psychiatric court report if they have a direct and demonstrable bearing on the legal brief i.e. the impact of such diagnoses on (a) the ability of the defendant to assist in their own legal defence (“fitness” or competence to stand trial), pertaining to the mental state of the defendant at the time of forensic evaluation and trial; and/or (b) their criminal responsibility / capacity (i.e. appreciation of wrongfulness and ability to act in accordance with such appreciation of wrongfulness), pertaining to the defendants mental state at the time of offence respectively. The forensic court report also includes a recommendation to the court on the most appropriate course of action in light of the outcomes of the evaluation: (a) for the law to take its course in cases where there was no diagnosed mental disorder (or none of forensic significance); (b) referral to a general mental health services for treatment as an “involuntary” patient, in defendants with mental disorder but who have committed non-violent offences; or (c) declaration as state patients and referral to specialized forensic mental health services, in defendants with mental disorder who have committed violent offences, respectively.

Final Forensic Diagnostic Outcomes. Whilst over 94% of all women who underwent forensic evaluation at Fort England Hospital over the study period had at least one Axis I, II and/or III diagnosis made, a diagnosis of a severe mental disorder (whether mental illness or intellectual disability) of a nature and/or severity to have forensic relevance (hence inclusion in the final psychiatric court report) was present in 83% of cases. These included women with psychotic disorders, mood disorders, neurocognitive disorders, and intellectual disability, but excluded women with no diagnosis, or those with only independently occurring substance-related or personality disorders. The most frequently occurring forensic diagnostic category (i.e. combining all three axes and included on the psychiatric court report) was that of psychiatric comorbidity (defined in the present study as cases in whom at least one mental

disorder co-occurred with at least one other Axis I, II and/or III disorder), being present in 73 cases (42% of the study sample). The majority of women within the co-morbid diagnostic group (50/73), in fact, had dual diagnoses (i.e. a mental disorder co-occurring with a substance-related disorder); followed by women in whom a mental disorder was co-morbid with HIV infection in particular. Schizophrenia and other psychotic-spectrum disorders were diagnosed in a further 25% of cases, mood disorders (especially of the bipolar type) in 9%, and other diagnostic groups comprised between 2 – 6% each. Whilst many published studies of female forensic patient's report particularly high rates of personality disorders (of up to 85%) (Bartlett, 2007; Bland et al., 1999; Bohle & de Vogel, 2017; de Vogel et al., 2016; Dolan and Mitchell, 1994; Long et al, 2010; Smith et al., 1991; Tidmarsh, 1980), this was not found in the South African sample under study in which only 5% were diagnosed with personality disorder.

The forensic diagnostic outcomes of the present study confirm research evidence of disproportionately high rates of psychiatric comorbidity (especially of dual diagnoses) and psychotic disorders amongst incarcerated women offenders in numerous other settings (e.g. Abram et al., 2003; Bartlett and Hassell, 2001; Coid, et al., 2000a; 2000b; Derkzen et al., 2013; de Vogel & de Spa, 2019; de Vogel et al., 2016; Caufmann et al., 2015; Long et al., 2010; Marquart et al., 2001; Maruschak, 2004; 2006; Messina et al., 2004; Sahota, et al., 2010; Singleton and Meltzer, 2002; Thomson et al., 2001). The reasons for such high rates of co-occurring severe mental disorder, substance misuse and/or medical conditions (especially HIV infection) in women offenders in South Africa are complex and poorly researched, but are likely to include many influential contextual factors, such as socio-economic deprivation; availability and accessibility to appropriate health (especially mental health) services; poor nutrition; housing and occupational insecurity; poor levels of education; dysfunctional families; social instability; gender-based violence; stigma (especially in relation to mental

disorder and HIV); adherence to medication; culturally-based interpretations and explanatory models of illness and treatment; etc. The finding that women offenders under study are particularly vulnerable to complex psychiatric comorbidity presents significant challenges with respect to the provision of appropriate and adequate multi-disciplinary health care (psychological, social, psychiatric, medical, forensic, etc.). This is especially problematic in the context of a resource-scarce country as South Africa, since such diagnostic heterogeneity and complexity in women offenders are known to require costly clinical approaches, therapeutic regimes and risk management strategies to optimize chances of successful and sustainable outcomes (Bartlett and Hassell, 2001; de Vogel & Nicholls, 2016; Coid et al., 2000b; Long et al., 2008). A forensic mental health service for these women will need to include, for example, intensive, specialized and pro-active mental health care management (e.g. substance-rehabilitation; individual therapy to address prior abuse where required); mother and child care interventions; and attention to broader social (e.g. securing of social grants; assistance with occupational functionality; measures to address stigma) and family issues (e.g. interventions focused on family and intimate partner violence) that many of these women face. Whilst women offenders with mental ill-health are a particularly vulnerable and disadvantaged group and, they also generally have better prognoses than their male counterparts (especially in the light of their more favourable risk profile, and lower propensity to recidivism), and a few studies have questioned the wisdom of their continued management in high security forensic institutions (O'Connor and O'Neill, 1991; Putkonen and Taylor, 2014; Thomson et al., 2001). The socio-demographic, clinical and forensic mental health profile of most women in the South African study sample similarly supports consideration of their preferential management, as far as is appropriate and feasible, either within generic mental health services or within less restrictive environments than is currently the case within South African forensic psychiatric hospitals. The latter may include the establishment of community-based low- or medium-

secure units for these women, with mother-and-child care facilities, specialized forensic multi-disciplinary teams, and integrated social and family support services; and gender-focused, community-based forensic mental health services that prioritize the unique needs of women offenders with mental disorder.

Trial Competence and Criminal Capacity. Despite the presence of an Axis and/or Axis II diagnosis in over 90% of cases, and the presence of a diagnosed severe mental disorder in over 80%, almost approximately half of all cases (48%) were deemed to be trial competent (i.e. “fit” to stand trial), 45% were considered to have criminal capacity, and 41% were both trial competent and criminally responsible for their offences. In respect of trial competence, these are offenders who were assessed as being mentally stable and free of active psychopathology, at the time of the forensic evaluation, so as to be able to understand court proceedings and to assist their legal counsel in their own defence in court. In women who were deemed to be criminally responsible for their actions at the time of the offence, there was no significant impairment in cognition (regarding appreciation of wrongfulness) nor in the consequent volition (to act in accordance with such appreciation of wrongfulness) at the time of the offence respectively. A small proportion of defendants were considered to have mental health issues that diminished their criminal responsibility at the time of offending, but which were not of a nature nor severity that was considered sufficient to absolve them of criminal liability. Courts may take such findings into account in mitigation of sentence i.e. should the defendant have been found guilty and convicted for the offences at hand.

The relatively high rates of trial competence and intact criminal capacity, despite the relatively high prevalence of mental disorder diagnoses in the study sample is related to the fact that many psychiatric diagnoses (e.g. substance-related disorders, personality disorders,

borderline intellectual functioning, adjustment disorders with depressed mood, etc.) do not have any impact on the two key forensic parameters under consideration i.e. trial competence and criminal capacity respectively. In addition, many forms of severe mental disorder are episodic in nature, and severity of active symptoms wax and wane over time. There may have been no impairment on these forensic parameters if the mental disorder was assessed to have been in partial or full remission at the time of offence (in relation to criminal capacity), or at the time of forensic psychiatric evaluation itself (in relation to trial competence). In some cases, it is also possible that despite harbouring active psychiatric symptoms at the time of the offence, there was no demonstrable causal nexus linking the defendant's specific symptoms to the specific offence at the specific time of its commission. In other words, the mere presence of a severe mental disorder, does not automatically impair trial competence or criminal capacity, and each case is unique and individually appraised by the evaluating forensic team. If there is no specific clinical evidence of impairment of trial competence or criminal capacity, on the balance of probabilities, as a direct result of the unique psychopathology experienced by the individual defendant and only in relation to the specific offence in question, then courts would reject the so-called insanity defence, and the law would take its course in the usual manner.

Court Recommendations. The final recommendations made to the courts following the forensic evaluation are determined by the nature and circumstances of the offence, as well as the forensic conclusions reached in respect of clinical diagnosis, trial competence and criminal responsibility respectively. It was recommended that the law take its course in 40% of cases in which defendants were found to be both trial competent and criminally responsible for their actions. The majority of defendants were, however, either trial incompetent (52%) *or* lacked criminal responsibility (56%); and almost half (48%) were *both* trial incompetent and not criminally responsible, by virtue of severe mental disorder. In these women, the

psychopathology was considered to be of a nature and/or severity as to sufficiently impair (a) their ability to assist in the defence against criminal charges (trial competence); and/or (b) their appreciation of wrongfulness and/or their ability to act in accordance with such appreciation of wrongfulness (criminal capacity). Consequently, referral to mental health services (as opposed to correctional services) for care, treatment and/or rehabilitation was recommended, and included options of diversion to (a) general mental health services for women who committed non-violent index offences (24% of cases); or (b) forensic mental health services for women who committed violent index offences (36% of cases), respectively. Should the court accept the conclusions and recommendations contained in the psychiatric court report, and after establishing that the defendant did in fact commit the offence in question, the court would issue a ruling which effectively acquits the defendant and finds her not guilty by reason of mental disorder (constituting a successful “insanity defence”). She would then be transferred, on the authority of a court order, to the recommended mental health services for care, treatment and/or rehabilitation.

Women with mental disorder who have committed non-violent offences, are referred to general mental health services, under Chapter V of the MHCA (2002) for clinical management as considered appropriate and necessary by the treating mental health team. The treating psychiatrist clinicians would have the authority, without any further court involvement, to decide on what form such treatment would take (e.g. medication, psychotherapy, substance rehabilitation, occupational therapy, etc.), granting of leave of absence to her home and community, and ultimately to make decisions regarding discharge and clinical follow-up arrangements. Women with mental disorder who committed violent index offences would be declared by courts as forensic “State Patients”, and diverted to the specialized forensic mental health services under Chapter VII of the MHCA (2002) for longer term care, treatment and

rehabilitation (usually within a designated forensic psychiatric hospital). For these women, the treating psychiatrist would have the authority to administer clinical management as deemed necessary and appropriate, (including granting of community-based leave of absence), but would not have ultimate authority regarding decisions to discharge the patient from the care and supervision of forensic mental health services. After receiving the necessary forensic treatment and rehabilitation (the duration of which depends on each individual patient, but may last many years), the supervising psychiatrist has the option of applying to courts for the conditional discharge (and eventually unconditional discharge) of female State Patients who respond well to multi-disciplinary clinical management i.e. women who are mentally and behaviourally stable, of relatively low risk of re-offending, and in whom prospects for sustained and successful community based rehabilitation are demonstrably favourable. These would be women in whom there was evidence of, for example, good family and social support systems; good therapeutic response to mental health treatment received; good adherence to prescribed medication; sequential and sustained periods of leave of absence to their homes and communities which have been demonstrably successful; lack of co-morbid substance misuse; relatively good level of functioning; good insight of the patient into their own mental health issues; good social judgement; and good overall clinical and behavioural prognosis.

Violent Offending

For purposes of further analysis, index offences were classified into a basic taxonomy of violence as either non-violent index offences (in which no other person was placed at any significant risk of, or victim of actual, violence); and violent index offences (in which at least one other person was placed at significant risk of injury or death, or actual physically harmed or killed, as a result of the violent behaviour of the offender). The latter category was further sub-classified into cases of homicidal offences (murder and attempted murder) and violent but

non-homicidal offences (all other forms of violence e.g. assault; assault with intent to do grievous bodily harm; domestic violence; concealment of birth; sexual assault; discharge of a firearm, etc) respectively. Almost one-third of violent women in the study sample had pre-offence backgrounds of being abused themselves; over half had pre-offence substance abuse problems (most frequently alcohol-related); almost two-thirds had pre-offence psychiatric histories; and over two-thirds were diagnosed with a severe mental disorder after their offences (mostly psychotic or mood disorders). A more detailed appraisal of this context in respect of violent offences by female offenders in general is undertaken below, followed by a discussion of homicidal offences in particular.

Sociodemographic and Offence Profile

Violent offences in general comprised the majority of cases (almost 60%), with approximately equivalent frequencies of cases of homicidal versus non-homicidal violence (30% and 27% respectively). This disproportionately high rate of violent offending in South African women offenders in the forensic context confirms the conclusions of a number of other studies abroad (de Vogel & de Spa, 2019; de Vogel et al., 2016; Hollin and Palmer, 2006; Maden et al., 1990; 1994a; 1994b; Nicholls et al., 2009; Rossegger et al., 2009). Whilst female participation in the commission of assaultive offences in general has grown, it remains beyond dispute that the vast majority of violent offending is still committed by men (de Vogel & de Spa, 2019; de Vogel et al., 2016; Janeksela, 1997; Kruttschnitt et al., 2002; 2008). This gender difference, however, may be less stark amongst samples of people with severe mental illness (especially during acute phases of psychosis) (de Vogel & Nicholls, 2016; Mullen, 1997; Swanson et al., 1990; Yang and Coid, 2007).

Violent female offenders, in comparison to both male offenders and non-violent female offenders, are more likely to be older (above 30 years), married with dependent children and poorly educated (de Vogel & Nicholls, 2016; Hodgins et al., 1986; Hollin and Palmer, 2006; Putkonen and Taylor, 2014; Putkonen et al., 2008; Rossegger et al., 2009; Weizmann-Henelius, Viemerö et al., 2003). The overall profile of the South African sample of violent offenders was similar, with women tending to be older, and from backgrounds socio-economic adversity, poor educational attainment and high levels of unemployment (though most women in the study sample were single). With the exception of language group and race, none of the other socio-demographic variables (i.e. age, marital status, having dependent children, educational attainment, source of income, employment status and living arrangements at time of arrest) were, however, found to be significantly associated with violent offending in the present study. Whilst no statistically significant relationship was found between age of offenders and the overall index offence category (i.e. non-violent versus violent offences respectively), women older than 30 years of age (almost two-thirds of all cases) were found to be significantly less likely to target children during acts of violence i.e. they tended to direct violent attacks toward adults victims instead.

In respect of racial background, African-American and Hispanic women reportedly tend to have higher rates of violent offending than white women in North American studies, but this is not necessarily the case for women offenders in other study settings (Janeksela, 1997; Kruttschnitt, 1993; Sommers and Baskin, 1992; Wilson and Daly, 1992). In the South African context, black African and isi-Xhosa-speaking women demonstrated significantly higher rates of violent offences than other racial groups, as documented by the results of the χ^2 analysis. This notwithstanding, neither race nor first-language co-variables made any significant, independent or unique contribution to the logistic regression models for violent offending

(whether of a homicidal nature or not). These factors were hence excluded as potential predictor variables for the logistic regression analyses for both violent offences outcomes in general, as well for homicidal offence outcomes in particular.

As compared to men, women are heavily under-represented in the commission of all types of violent offences against the person (e.g. assault, assault with intent to grievous bodily harm, sexual assault, attempted murder, murder, etc.). Whilst women offender surveys demonstrate that the majority commit non-violent offences (e.g. property, acquisitive, economic, sex-industry, substance-related offences, etc.) the number of violent offences perpetrated by women is increasing, especially amongst those with mental health problems (e.g. de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Greenfeld and Snell, 2000; Home Office, 2012; McKeown, 2010; Putkonen and Taylor, 2014; Schwartz and Steffensmeier, 2007; Staton-Tindall et al., 2007; Taylor and Bragado-Jimenez, 2009; Yourstone et al., 2009; Yourstone, Lindholm, Grann et al., 2008). Overall, most large surveys have concluded that less than 5% of violent offenders were women in the 1980's, as compared to between 15 – 20% by 2010 (Putkonen and Taylor, 2014). The commission of violent offences were disproportionately common amongst the South African study sample: Almost 60% of women were charged with violent offences against the person, including crimes against life in 30% and against bodily integrity in 27% of cases respectively. Murder was in fact the most common single offence (26% of all cases), followed by assault with intent to do grievous bodily harm (21%) i.e. these two particularly violent offences alone accounted for almost half of all cases. The minority of offences (36%) were of a non-violent nature. Whilst the specific reasons for this offence profile are unclear, it is likely to be related to the complex and multi-factorial aetiology of violence in South African society in general. Contributory factors in this regard include, but are not limited to, the social consequences of the apartheid system;

persistent socio-economic adversity and inequality; political flux and uncertainty; poor political leadership; social instability related to lack of social, economic and occupational opportunity; high rates of illiteracy and unemployment; poor social and family cohesion; a proliferation of weapons; high levels of substance abuse; a growing population of marginalized, urbanized, unemployed and impoverished youth; under-resourced and poorly performing law enforcement, criminal justice, social developmental and health systems, etc. (Berg and Schärf, 2004; Schönreich and Louw, 2001). These issues, however, cannot be understood in isolation from the gendered nature of South African society, with its background of persistent female social and economic marginalization, occupational discrimination, and entrenched patriarchy. The profile of the women offenders in the current study can be viewed as a product of this psychosocial and economic vulnerability, being largely comprised of relatively young, poorly educated, unemployed black African women, who are also single mothers who are dependent on others, and many of whom have backgrounds of being abused, misuse of substances and mental ill-health.

Whilst violent offenders tend to have higher rates of prior convictions than non-violent offenders, violent women offenders are considerably less likely to repeat violent offences than their male counterparts (Caufmann et al., 2015; Hollin and Palmer, 2006; Janeksela, 1997; Rossegger et al., 2009; Schwartz and Steffensmeier, 2007). In addition, violent women offenders in forensic mental health surveys tend to have higher than expected prior convictions (in up to half of cases), but with the minority of these being for prior violent offences (in up to one-third) (de Vogel & de Spa, 2019; de Vogel et al., 2016; Nicholls et al., 2009). In contrast, whilst women in the current study had substantially fewer prior convictions overall (only one-fifth of cases had a previous criminal record, with the majority of these for non-violent, property offences), over half (58%) were referred by courts for forensic evaluation in relation

to violent index offences. In addition, the South African women who were first time offenders were more likely to have committed non-violent index offences, whereas those with a prior criminal background (of any kind) were more likely to have committed violent index offences.

Examination of the sub-sample of violent women offenders in particular revealed prior convictions in one-third of cases, and violent prior convictions in 15% respectively. In contrast to violent men, the majority of violent women offenders (in up to 75% of cases) have been shown to commit less serious “simple assault” (referred to as “common assault” in South Africa), as opposed to more serious “aggravated assault” (assault with intent to do grievous bodily harm in South Africa) (de Vogel & Nicholls, 2016; Greenfeld and Snell, 2000; Putkonen and Taylor, 2014). In a stark reversal of this pattern, of the 47 South African cases of women in this study charged with violent offences against bodily integrity, only 6 were cases of common assault, with 36 being more severe cases of assault with intent to do grievous bodily harm respectively (the remaining 5 cases were of domestic violence and intimidation). Furthermore, the minority of violent women offenders (under 20%) are reported by surveys abroad to have used weapons in the commission of their offences (Greenfeld and Snell, 2000). In contrast to this, the majority (55%) of the South African women sampled used weapons. Stabbing and penetrative injuries caused by sharp objects were most frequent method of violence used (34% of violent offences), followed by blunt trauma with a weapon (21%). Not a single case of firearm usage was documented in the commission of any of the index offences by the women offenders in the study sample, though the reasons for this are not entirely clear, especially in the South African context where gun violence is a particularly common phenomenon.

The present study has confirmed the established pattern that the victims of violence by women offenders are usually well known to them (in up to 75% of cases), especially as intimate partners, biological children, close family members and acquaintances (e.g. de Vogel & de Spa, 2019; de Vogel et al., 2016; Vogel & Nicholls, 2016; Eckhardt and Pridemore, 2009; Richardson and Hammock, 2007; Roe-Sepowitz, 2007; Rossegger et al., 2009; Weizmann-Henelius, 2006; Weizmann-Henelius, Viemerö et al., 2003; Yourstone, Lindholm and Kristiansson, 2008). Amongst the South African women offender sample, over 90% of victims of violent offending were situated within the women's immediate family and/or direct inner social circle. Women who commit acts of violence are also more likely to be closely (and especially intimately) related to their attackers when they are victims, and to their victims when they are perpetrators of violence (Janeksela, 1997; Putkonen and Taylor, 2014). Female motives for violent behaviour are hence postulated (in the absence of psychopathology at least) to typically be driven by relational concerns in the context of intense interpersonal conflict with people close to them e.g. self-defence under threat; defence of sexual or moral virtue; or impulsive responses to the provocation, abuse or violence of others (de Vogel & de Spa, 2019; de Vogel et al., 2016; Dobash and Dobash, 1984; Dobash et al., 1992; Schwartz and Steffensmeier, 2007). In the presence of severe mental disorder, however, violent motives may also (in addition to responses to interpersonal conflict) be influenced by the unique features of the individual offender's psychopathology at the time of the offence e.g. psychotically driven violence in response to command hallucinations, persecutory delusions, misidentifications or misinterpretations of social cues; the agitation of substance intoxication or withdrawal; the poor frustration tolerance or impulsivity of intellectual disability; or as a result of the dysphoria of mania, etc. Despite relatively high rates of prior abuse of women who commit acts of violence, self-defence is not commonly cited by women as a direct motive (Weizmann-Henelius, Viemerö et al., 2003). In keeping with these trends, there were also a heterogeneous range of

motives for violent offences reported by the South African women, related to psychopathology (51% of cases); retaliation, revenge or impulsive violence secondary to interpersonal conflict (33% of adult victim of cases; 19% of child victim cases 29%); substance intoxication (6%) and a range of other motives in the remainder. Violent offenders (of either gender) also tend to victimize persons of the same gender as themselves (in up to 70% of cases) (Greenfeld and Snell, 2000). Whilst this was true for the majority of adult victims of the South African sample (64% of adult victims were female), it was not the case for child victims (for which there was approximately equivalent gender distribution. As there are substantial differences in the nature and context of violence committed by women offenders against adults versus child victims respectively, these will be discussed separately in further detail below.

Forensic Mental Health Profile

Whilst gender is undoubtedly a crucial factor in considering violence by people living with mental illness, women have traditionally been neglected in research in this area, and there are very few studies on the antecedents to mental illness *and* violent offending in women (de Vogel & Nicholls, 2016). This may be partly due to the social taboo of female aggression (and its denial) in many settings, in addition to the persistence of stereotyped gender roles in most societies. Although violent women with mental ill-health reportedly more commonly perpetrate non-lethal acts of violence, research on the theme has tended to focus on lethal female violence (Weizmann-Henelius, 2006). In the current study, cases of non-homicidal violence, as opposed to homicidal violence, occurred in approximately equal proportions of 31% versus 30% respectively. Severe mental disorder (especially schizophrenia and other psychotic-spectrum disorders, mood disorders, and psychiatric comorbidity) has been associated with violence and criminal behaviour in both men and women, but possibly more so in women (e.g. Boles and Miotto, 2003; de Vogel & de Spa, 2019; de Vogel et al., 2016;

DeHart et al., 2014; Fazel, Gulati, et al., 2009; Fazel, Långström, et al., 2009; Fazel et al., 2010; Hiday et al., 2001; Logan and Blackburn, 2009; Nicholls et al., 2009; Putkonen et al., 2003; Rutter et al., 2004; Thomson et al., 2001; Walsh et al., 2002). Studies on the mental health profile of violent women in forensic settings in particular are diverse in their findings. The large Canadian sample of Nicholls et al. (2009), for example, described particularly high rates of substance-related disorders, cluster B personality disorders and major depressive disorders. This contrasts with many American studies which report higher rates of schizophrenia and other psychoses, and relatively low rates of substance-related or personality disorders (e.g. Hodgins et al., 1986; Rogers et al., 1983; Steadman, 1980). Many European studies report particularly high rates of psychiatric comorbidity (especially between psychotic and substance-related or personality disorders) (e.g. de Vogel & Nicholls, 2016; de Vogel et al., 2016; Logan and Blackburn, 2009; Rutter et al., 2004; Thomson et al., 2001). A similarly mixed clinical picture emerged in respect of violent women offenders in the current South African sample, in whom psychotic spectrum disorders (especially schizophrenia) and psychiatric comorbidity (especially dual diagnoses) were both particularly common (reflected in 25% and 42% of psychiatric court reports respectively), followed by mood (especially bipolar disorders), and much fewer women being diagnosed with substance-related or personality disorders alone. Nonetheless, no statistically significant associations were apparent between violent index offences and the presence of any particular psychiatric disorder (including schizophrenia and other psychotic-spectrum disorders, mood disorders, substance-related disorders, or personality disorders). This was true irrespective of whether the psychiatric diagnosis was made pre- or post-offence.

Ultimately, some form of impaired reality testing, as a result of severe and active psychopathology (e.g. in the context of psychotic disorders, neurocognitive disorders,

intellectual disability, etc.) is likely to be an important mediating factor in the behavioural sequence leading to violent behaviour. In other words, in many women with severe mental disorder, impairment in reality testing is probably a vital, though not necessarily a sufficient, condition leading to violence. Many other features of mental illness, however, are likely to also contribute e.g. reduced impulse control, emotional dysregulation, poor cognitive flexibility, imbalanced social judgement, poor insight, attribution of aberrant salience, threat-control override, disorganized thinking, poor self-monitoring, and so forth. This supports the proposal of Stanton et al. (2000) that women with mental illness who commit violent offences are often better understood in terms of the unique psychopathological features in each individual, as opposed to simply focusing on environmental precipitants or underlying psychodynamics. The bulk of the research evidence suggests furthermore that the well-established gender differential in the commission of violence in general (i.e. of men being much more prone to acting violently than women) may not necessarily apply to people with more severe forms of mental disorder. This may, in part at least, help contextualise the finding that women in the study sample, who had high rates of severe mental disorder (in over 80% of cases), also had high rates of violent index offences (in over 60% of cases). Subsequent inferential analyses provided further insight into these associations, with statistically significant relationships, of moderate effect size, being especially evident between violent, non-homicidal index offences and both: (a) pre-offence psychiatric history, and (b) the presence of post-offence severe mental disorder (especially in the form of psychiatric comorbidity). No other mental health indicators or specific diagnoses (including substance-related or personality disorders) displayed any statistically significant associations with violent offending in the initial χ^2 analysis. Logistic regression modelling also failed to confirm either pre-offence psychiatric history or post-offence psychiatric comorbidity as significant predictor variables after controlling for confounders. These outcomes are reflective of the complexity in the relationships between violence and mental disorder in

women offenders. Whilst a growing body of research evidence suggests that mental illness is likely to modify the effect of gender on violence threshold, uncertainty remains regarding why and how this may occur, and to what extent this is generalizable to other samples and settings. Stueve and Link (1998) posed the following questions in this regard: (a) whether the subjective experience of serious mental illness (e.g. psychosis) alters perception, cognition and self-control to such an extent that gender-related mechanisms that normally deter female-perpetrated violence are either less effective or no longer operative; (b) whether other people in the social environment may respond more slowly or less effectively to defuse provocative, threatening or violence-inducing situations when they involve women with mental illness rather than men; and (c) whether women with mental illness may feel more threatened by, or less prepared to manage, distressing psychosocial situations they may encounter as a result of mental ill-health. In addition, a number of broader contextual actors have been shown to be influential, with many that are particularly important in the South African setting e.g. high levels of interpersonal conflict (especially with intimate male partners and close family members); domestic dysfunctionality and distress; social discord and marginalization; poor social and personal supports; gender roles within patriarchal societies; and early abuse experiences in childhood and adolescence (e.g. Bohle & de Vogel, 2017; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; DeHart et al., 2014; Gammelgård et al., 2012; Karatzias et al., 2018).

There is also extensive research evidence that violent women offenders are more likely than both violent men and non-violent women offenders to have backgrounds of early exposure to intrusive and traumatic adversity, and as a consequence to being vulnerable to substance abuse and mental ill-health as a result (e.g. Bohle & de Vogel, 2017; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; DeHart et al., 2014; Karatzias et al., 2018;

Loucks and Zamble; 2000; Rossegger et al., 2009; Swanson et al., 2002; Weizmann-Henelius, Sailas et al., 2003; Yourstone, Lindholm and Kristiansson, 2008). Victims of early abuse (especially sexual abuse in childhood) are known to be at significantly higher risk of adolescent delinquency and subsequent violence as adults (Caufmann et al., 2015; López and Emler, 2011; Rivera and Widom, 1990; Siegel and Williams, 2003; Widom, 1989a; 1989b; 1989c; Widom and White, 1997). The risk of subsequent violence by abuse victims therefore cannot be understood outside the gendered context of family, relational and social conflict, and the associated distress, disappointment, frustration, threats, humiliation, stigmatization and repression that abused girls and women experience in their daily lives (Berkout et al., 2011; Bohle & de Vogel, 2017; Chesney-Lind, 1986; 1988; 1989; de Vogel & Nicholls, 2016; Loeber and Hay, 1997; Loeber and Keenan, 1994; Odgers and Moretti, 2002; Rivera and Widom, 1990). It has further been postulated that early abuse experiences tend to foster maladaptive or deviant patterns of processing of social information, and this is likely to be an additional factor mediating the development of future aggression and violence (Dodge et al., 1990; Fagan, 2001; Siegel, 2000; Siegel and Williams, 2003). The associations between prior abuse and violent offending were robustly confirmed in the South African study sample, in whom: (a) 15% of women charged with non-violent offences reported a history of prior abuse, as compared to over 30% of those who acted violently; (b) prior abuse experiences were statistically significantly associated with violent offending in the χ^2 analysis; and (c) logistic regression modelling demonstrated that women offenders with a history of being abused themselves had over three times the odds of committing subsequent violent offences, in comparison to women with no such abuse exposure. In other words, the odds of committing a violent index offence in the South African sample was increased, after adjusting for confounding variables, by over 200%. As further confirmed by the thematic analysis of the present study (discussed below), qualitative studies of violent women (especially those who have been abused previously)

suggest that the risk of violent behaviour is a result of a complex interplay of contextual variables, many of which are related to the adversity and distress they encounter in their daily lives. Related to this are experiences of an array of “negative” emotional and behavioural responses e.g. anxiety, depression, anger, frustration, distress, impulsivity, desperation, emotional instability, irritability, aggression and so forth. Early life trauma is not only associated with a risk of the abused child victims becoming abusive and violent women themselves, but also to the development of persistent psychological distress that later manifests as mental illness (especially in the form of psychotic, depressive, anxiety, trauma-related, substance-related and personality disorders) (Bohle & de Vogel, 2017; de Vogel & Nicholls, 2016; DeHart et al., 2014; Karatzias et al., 2018; Kendler et al., 2000; Martin and Hesselbrock, 2001; Siegel and Williams, 2003; Weizmann-Henelius, 2006).

In respect of specific types of mental disorder in women and their relationship to violent behaviour, psychotic disorders (schizophrenia in particular) are reported to increase the risk of violence (de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014; Taylor and Bragado-Jimenez, 2009). Whilst no statistically significant associations were evident between violence and psychotic disorders in the current sample, the psychotic disorders (with schizophrenia comprising the majority of these) were the single most frequent Axis I diagnostic category, comprising almost one-third of Axis I diagnoses. The risk of violence by psychotic individuals is increased in the presence of acute, active psychotic symptoms (especially persecutory delusions and command hallucinations), the threat-control override phenomenon, psychiatric comorbidity (especially with substance and personality disorders), and non-adherence to psychotropic medication (Appelbaum et al., 2000; Junginger, 1996; Link et al., 1998; Moran et al., 2003; Swanson et al., 1990; 2002; 2006; 2008; Swartz et al., 1998; Taylor, 1998; Teasdale et al., 2006). Whilst women are generally less likely than men to be violent, the

presence of a psychotic illness may confer a disproportionate risk of violence on women, with the risk tending to be under-estimated by mental health professionals (Aberhalden et al, 2007; Arseneault et al., 2000; Dean et al., 2006; Fazel and Grann, 2006; Fottrell, 1980; Hiday et al., 1998; Hodgins et al., 1996; Jones et al., 2010; Lidz et al., 1993; Tardiff, 1984; Taylor, 1997b; 1998; Taylor and Bragado-Jimenez, 2009). In addition, Fazel and Grann (2006) conducted a study of the population impact of severe mental disorder on violent crime, and calculated the proportion of community violence attributable to psychotic disorders to have been almost equivalent for younger women and men (aged 15 to 25 years), but significantly higher for older women in comparison to older men respectively. Nonetheless, violent women offenders with psychotic disorders also tend to have shorter offending careers, desist from further violence sooner, and often have a better prognosis in respect of future violence than either violent psychotic men or violent non-psychotic women (Hodgins, 1992; Lindqvist and Allebeck, 1990; Taylor and Bragado-Jimenez, 2009). This lends support to the idea that many women offenders with psychotic disorders, including those who may have acted violently in the past, require holistic, individualised, gender-focused support, care and treatment within the forensic mental health system, but not necessarily at the same levels of high-security as violent, psychotic men.

Women who abuse substances (especially alcohol) are reported to be at significantly increased risk of committing violent offences, though there is debate on the extent of this association, and on the matter of direct causality (e.g. de Vogel & Nicholls, 2016; DeHart et al., 2014; Greenfeld and Snell, 2000; McMahon et al., 2003; Schwartz and Steffensmeier, 2007). A further consideration is that substance abuse by violent psychotic women is thought to increase the likelihood of delusional or psychotic drive in the commission of violent acts (Taylor and Bragado-Jimenez, 2009; Taylor et al, 1998). With regard to alcohol-related disorders in particular, the correlations with violence in women are thought to be mediated by

a range of inter-related factors, including personality structure, situational context, social and gender norms, interpersonal dynamics, individual responses to alcohol intoxication or withdrawal and psychiatric comorbidity (Boles and Miotto, 2003; Hodgins, 1992; Johnson, 2006; Martin and Bryant, 2001; Weizmann-Henelius et al., 2009; Zhang et al., 1997). There were relatively high rates of pre-offence substance abuse, in over half of all cases in the study sample; and relatively high rates of substance-related disorders (approximately 16% of Axis I diagnoses were for substance-related disorders alone, and a further 20% as part of psychiatric comorbidity), with alcohol being by far the single most commonly abused substance. Women who abuse alcohol are also known to be more likely to commit acts of violence against intimate partners in particular (Chermack et al., 2001; Stuart et al., 2003). In keeping with this, women in the present study who acted violently toward intimate male partners had a disproportionately high rate of prior alcohol abuse (in 85% of cases), as compared with less than half the cases in the total sample. No statistically significant associations were, however, in evidence between substance abuse and the nature of the index offence, nor with the targeting of adult versus child victims respectively.

There is also much research evidence of associations between violence and personality disorder (especially of the antisocial type), and especially when the personality disorder occurs concurrently with another mental disorder (e.g. de Vogel & de Spa, 2019; de Vogel et al., 2016; Logan and Blackburn, 2009; Mauricio et al., 2007; Nicholls et al., 2004; Putkonen et al., 2003; Yourstone et al., 2009). In the South African sample, however, low rates of personality disorders were diagnosed at the conclusion of the forensic assessment process, with only around 10% of women were diagnosed with personality disorder (in only 5% of cases was a personality disorder considered sufficiently pertinent from a forensic point of view to justify inclusion in the final psychiatric court report). There was also no evidence from the χ^2 analysis

of any significant associations between personality disorder and violent offending in the South African sample.

The relationship between violence and severe mental illness is also likely to be mediated in many female offenders by the presence of more complex combinations of mental disorder i.e. psychiatric comorbidity (especially dual diagnoses i.e. co-occurrence of mental disorder with substance abuse) (de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; DeHart et al., 2014; Fazel, Gulati, et al., 2009; Fazel, Långström, et al., 2009). Rates of psychiatric comorbidity (especially in the form of dual diagnoses of severe mental disorder and alcohol abuse), was indeed disproportionately high amongst women offenders in the present study: Almost one-fifth of women had Axis I comorbidity, with the majority of these ($n = 30/33$) being dual diagnoses around 90% of dual diagnoses were related to alcohol; and some form of psychiatric comorbidity (i.e. across diagnostic axes) was reflected in over 40% of psychiatric court reports, making this the most common single forensic diagnostic category. The χ^2 analysis revealed significant associations between psychiatric comorbidity and the nature of violence committed, with these women being significantly more likely to commit non-lethal offences (or non-violent offences for that matter) and less likely to commit homicidal ones. There was, however, no indication of any significant relationship reported by the logistic regression analysis between the commission of violent offences overall and psychiatric comorbidity as an independent predictor of such violence. Logistic regression analysis did demonstrate that individuals with psychiatric comorbidity were in fact significantly less likely to have acted violently toward children, as compared to women without such psychiatric comorbidity. This challenges commonly held societal, systemic and clinical assumptions that women with complex psychiatric problems necessarily pose inherent dangers to the children they come into contact with (whether their own children, those of relatives or

strangers to them). These outcomes also highlight the importance of dispelling misconceptions, prejudices and stigma regarding the relationship between mental disorder, gender and violence, especially in respect of women who suffer from severe mental disorder who are more likely to be victims than perpetrators of violence (de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014).

Violence Against Adults and Children

Almost 70% of all victims of violence in the study sample were adults, with the majority of these being women; in addition, over 90% of adult victims were well known to the offenders as intimate male partners (21% of cases); parents (15%); siblings (8%); other family member's (16%); and neighbours/friends/acquaintances (34%) respectively. Furthermore, there was a statistically significant association, of moderate effect between the offender-victim relationship for adult (but not child) victims of violence and the index offence category (i.e. whether non-violent, violent but non-homicidal or homicidal offence respectively). Significantly more intimate male partners were targets of homicidal violence in particular (considered in further detail in a separate discussion on homicidal violence below), whilst other categories of victims were significantly more likely to be victims of non-lethal attacks. The nature of the relationship between violent offenders and their adult victims was not, however, included as an independent predictor variable in the subsequent logistic regression analysis due to insufficient sub-sample sizes for such analysis. These patterns are, nonetheless, congruent with the research evidence of associations between the commission of interpersonal violence by women offenders with mental health problems, and especially violence directed at intimate male partners and close family members in the context of their own prior abuse by their victims (Bohle & de Vogel, 2017; de Vogel & de Spa, 2019; Jurik and Winn, 1990; Maxfield and Widom, 1996;

Weizmann-Henelius, 2006; Widom and White, 1997). Rivera and Widom (1990) showed that not only does childhood abuse serve as an independent predictor for later violent offending, but that the predictive element of early trauma is also linked to the subsequent development of mental health problems (including substance-related disorders). There is also evidence that women are more likely than male offenders to report extensive histories of physical, sexual and emotional abuse (Bohle & de Vogel, 2017; Bloom and Covington, 2008; DeHart et al., 2014; Karatzias et al., 2018). Female-perpetrated intimate partner violence has been particularly linked to psychological distress and defensive reactions resulting from prior chronic abuse by intimate male partners who are subsequently turned upon in retaliation (Weizmann-Henelius et al, 2012). South African women, like women elsewhere, are significantly more likely to be victims than perpetrators of intimate partner violence, with 30 - 55% of all women in South Africa estimated to have been victims (Gass et al., 2010). Breet et al. (2016) demonstrated that mental ill-health is an independent risk factor for the perpetration of intimate partner violence in South Africa, and concluded that the phenomenon can only be meaningfully addressed if gender-focused intervention strategies focus on alleviating the associated burden of mental illness, especially depressive and anxiety disorders. In other words, violent offending by South African women cannot be understood without an appreciation of its broader context, especially in respect of prior abuse experiences, alcohol misuse and mental ill-health, and prioritization of these areas for therapeutic attention.

In cases of violent offending against children in particular (n = 32, comprising almost one-third of all victims of violence), as opposed to those in which adults were victims, a somewhat different profile was apparent. There was approximate gender equivalence of child victims, and the mean age of child victims was 30.3 months. However, the age distribution was skewed, with a disproportionate number (almost 60% of cases) being less than one year of age,

with half of these being less than one-month old at the time of the offence. In other words, the risk of children being victims of violence was inversely proportional to their age, with the risk highest in neonates followed by infants less than a year old, and falling with increasing age thereafter. This confirmed the patterns described by studies elsewhere (Putkonen and Taylor, 2014). Child victims were also well known to the perpetrators in the vast majority of cases, with most in fact being the biological children of the offenders (in over 80% of cases). In addition, over one-third of these violent offences against children entailed serious violence against life (including murder, attempted murder, administering a noxious substance, and exposure of an infant). As with similar studies elsewhere, motives for violence directed toward children were relatively more diverse than violence towards adults, and included psychopathology (42%); retaliation / revenge secondary to interpersonal conflict with the father of the victim (19%); violence toward unwanted children (16%); impulsive, enraged attacks secondary to perceived “provocation” or “demands” related to maternal care-giving (13%); violence related to substance intoxication (6%); and “altruistic” acts related to perceived relief of suffering (3%).

These outcomes broadly confirm the results described by most other studies that biological children in their first year of life are a particularly vulnerable group of child victims, especially in cases where maternal offenders are likely to be suffering from mental ill-health (Bourget et al., 2007; Porter and Gavin, 2010; Putkonen and Taylor, 2014). There is also evidence that suggests that violence directed toward biological children is probably more often perpetrated by mothers than fathers (Ellonen et al., 2013; Putkonen and Taylor, 2014). Numerous factors put mothers at higher risk of acting violently toward their own children, including a history of being abused herself; young age; single motherhood; inadequate family support; impoverished living circumstances; poor education; multiparity; poor coping skills;

mental ill-health (especially depression and/or substance abuse); and developmental or behavioural problems in the child victim (Berlin et al., 2011; Hien et al., 2010; Locke and Newcombe, 2004; Sagami Rougé-Maillart, 2004; Windham et al., 2004; Wu et al., 2004). In the current South African sample, a mixed picture emerged with respect to these associations. No statistically significant associations were found between most quantitatively measured variables and violence against children, whether socio-demographic (e.g. language, race, marital status, number of children, educational level, employment status or living arrangements), criminological (e.g. history of prior offending), clinical (e.g. family psychiatric history, substance abuse history, prior abuse of the offender; mental state at time of offence; or multi-axial diagnostic outcomes) or forensic variables (e.g. forensic diagnostic group; or trial competence) respectively. Whilst women who targeted adults with violence were significantly more likely to be receiving state-sponsored social grants than women who targeted children (who tended to receive their income from other sources e.g. employment, partners or family members), source of income was not found to be a significant predictor variable in logistic regression modelling. The age of the offender was, however, shown to be significantly associated with violence against children: Younger women (under 30 years of age) who committed violent index offences were significantly more likely to target children than older women. Age was also a statistically significant predictor variable in the logistic regression model: Women who were older than 30 years were significantly less likely than younger women, after controlling for confounders, to target children with violence.

Findings with respect to maternal mental illness and its relationship to child violence were, in a few respects, divergent from many other studies. Women who acted violently against children, as opposed to adults, were significantly more likely, and with a large effect size, to have had *no* pre-offence psychiatric history. A prior psychiatric history, was not, however,

identified by subsequent logistic regression analysis as an independent predictor variable in the commission of violence against children. In addition, whether an adult or a child was the victim of violence also depended, to a statistically significant extent), on whether the woman offender in question was deemed to have criminal capacity with respect to her behaviour at the time of the violent act. Women who acted violently toward children, as opposed to adults, tended to be mentally well at the time of offence i.e. with no cognitive nor volitional impairments that impacted on criminal capacity. Further evidence for this pattern in the South African sample was provided by the fact that psychiatric comorbidity (within or between Axis I and/or II, as reflected on the final psychiatric report submitted to court) was identified as a statistically significant and independent predictor variable in the logistic regression model. Women offenders with psychiatric comorbidity were, after controlling for confounders, significantly *less likely* to have acted violently toward children as compared to women without psychiatric comorbidity.

In summary, the present study found that South African women offenders with longer standing and/or more complex forms of mental disorder (e.g. those with pre-offence onset of mental illness and/or with significant psychiatric comorbidity confirmed post-offence) tended to pose a *significantly lower risk* of acting violently toward children than women who had no prior mental health problems and/or those not burdened by psychiatric comorbidity.

Homicidal Offending

Homicide is largely a masculine phenomenon, with greater than 85-90% of offenders and 65-70% of victims, in most settings, surveys and countries being male, with women much more likely to be victims than perpetrators of lethal offences (Polk, 1993). When women do kill (especially those who kill their own children, do not fit the stereotypical image of the “battered

woman syndrome”, or who are considered simply “mad”), they are often viewed as “doubly deviant and doubly damned” and somehow “worse” than homicidal men (Comack and Brickey, 2007; Flynn et al., 2011; Oberman, 1996; 2003). In an effort to challenge such gender stereotypes, there have been increasing calls for the need to examine female homicidal violence in the broader gendered context of psychosocial and power dynamics (Kirkwood, 2003). Contrary to the common perception of homicidal women as being necessarily “mad”, “bad” or in some way abnormal or exceptional, the majority of homicidal women are “ordinary” in most senses, except for the homicidal acts which they have committed (Mann, 1988; 1990; Schanda et al., 2004; Wilczynski, 1997). Over the past few decades the features of female-perpetrated murders have increasingly resembled their male counterparts in many respects. These include an absolute rise in frequency of homicides committed; victims being increasingly less well known to them; and a significant increase in substance misuse, with alcohol abuse cited as probably the most important single factor driving many of these changes (de Vogel & Nicholls, 2016; Putkonen and Taylor, 2014; Weizmann-Henelius et al., 2009; 2012).

Socio-demographic and Offence Profile

A number of sociodemographic factors are known to be associated with homicide by women (including those with mental ill-health), particularly in relation to age, race and socio-economic status (Monahan, 1992; Putkonen, 2003). Male and female homicidal offenders display a similar age distribution, with a peak in late adolescence to early adulthood, following which it drops off significantly (Janeksela, 1997; Kruttschnitt et al., 2002; Putkonen, Weizmann- Henelius et al., 2011). In the South African study sample, the majority of homicidal offenders (65%) were, in fact, well over 30 years of age, with a mean age of 36.4 years (women who committed violent but non-homicidal offences had a mean age of 39.4 years in comparison). The χ^2 analysis, however, displayed no statistically significant relationship

between the age of offenders and the commission of any particular category of offence (i.e. non-violent versus violent but non-homicidal versus homicidal offences respectively).

In terms of racial background, African-American women in the US are reported to more frequently commit acts of lethal violence than both white and Latina women, especially against their intimate partners (Goetting, 1987; 1988a; Mann, 1988; 1990; Rodriguez and Henderson, 1995; Scott and Davies, 2002; Wilbanks, 1983b). This apparent association between female-perpetrated homicide and race is, however, related to a range of individual, social and systemic factors, as opposed to simply being a function of race itself (Janeksela, 1997; Sommer and Baskin, 1992; 1993; Wilson and Daly, 1992). Such broader contextual factors are particularly important in a country such as South Africa in which the extensive, socially destructive consequences of apartheid remain in evidence, even a quarter of a century later. In the South African study sample, both black racial background and the speaking of isi-Xhosa as a first language were both variables with apparently significant associations with the commission of violent index offences (whether homicidal or not). Neither race nor first language spoken, however, were factors that contributed sufficiently unique contributions to the logistic regression model for homicidal offending, and they were hence excluded as potential predictor variables. In addition, it should be emphasized that the vast majority of homicidal women were also drawn from backgrounds of socio-economic adversity, historical and/or present disadvantage, poor educational attainment and with significantly restricted occupational opportunity. These inter-related socio-demographic factors were likely to have confounded the apparent association between race and homicidal offending in the study sample. A related issue is the fact that female homicide offenders are more likely to come from backgrounds of poor occupational and educational attainment, in comparison to both men and non-homicidal women offenders (Mužinić Masle et al., 2000; Yourstone, Lindholm and Kristiansson, 2008).

Whilst over 60% of homicidal women offenders in the present study failed to progress beyond Grade 8 at school (as compared to around 45% of non-homicidal women), there was no evidence of any statistically significant associations between level of education and the type of index offence committed, including homicide. There were also no significant associations found between any specific index offence category, including homicide, and any of the other pre-offence socio-demographic variables under focus i.e. marital status, number of children, income, employment status or living arrangements, respectively. The relative influence of various sociodemographic variables was, however, different for cases of adult versus child homicide respectively (discussed in further detail below).

Homicidal women tend to be first-time offenders, with lower rates of prior criminality in comparison to both other female offenders and homicidal men (Mužinić Masle et al., 2000; Yourstone, Lindholm and Kristiansson, 2008). Approximately one-fifth of women (18%) in the total study sample had a history of prior offending, a similar rate to women who committed homicidal offences in particular (17%) and slightly higher than those who violent but non-homicidal offences (12%) respectively. No statistically significant associations were, however, evident between prior criminal history and the commission of any specific category of index offence (including homicide) offences in the subsequent χ^2 analysis.

Women who commit murder are reported by most studies to be more likely than other female offenders to have used a weapon for the lethal act (Scott and Davies, 2002; Wilbanks, 1983b). In large surveys abroad, however, fewer homicidal women than men (approximately half of women offenders versus two-thirds of men respectively) used firearms to perpetrate the lethal act, whilst women were more likely than men to use a knife (or some other sharp object) to stab the victim to death (30 - 65% of female homicide cases, as compared to 18 - 25% of

male homicide cases respectively) (Greenfeld and Snell, 2000; Putkonen et al., 1998; Swatt and He, 2006). In the South African sample by comparison: (a) weapons were used more often to perpetrate non-lethal violence (65% of cases) as opposed to lethal offences (47% of cases); and (b) a knife (or another sharp object) was the lethal weapon of choice in 16 of 51 cases of homicide (31%), followed by trauma inflicted with a blunt weapon (26%), strangulation or suffocation (18%) and a variety of other methods in the remaining cases. There were no cases in which a firearm was used to commit homicide, which was surprising given the disproportionately high levels of gun violence in South Africa in general. The reasons for this finding are unclear, but may be related to limited female access to firearms in the Eastern Cape and/or a result of sample bias. There were no statistically significant associations apparent between weapon usage per se and the commission of homicidal offences.

Whilst there is a trend toward strangers being increasingly targeted by homicidal women in some settings, the vast majority of victims of lethal violence by women in most studies remain those well known to them, especially as intimate partners and close family members (e.g. de Vogel & Nicholls, 2016; Mužinić Masle et al., 2000; Rogde et al., 2000; Scott and Davies, 2002; Weizmann-Henelius, Viemerö et al., 2003; Yourstone, Lindholm and Kristiansson, 2008). This was also true for the South African study sample, in which over 90% of homicidal victims were well known to the perpetrators, as intimate male partners, biological children, other close family members, neighbours, friends or acquaintances. In most studies, the victims of homicidal women, irrespective of the mental health status of perpetrators, also tend to be (in order of decreasing frequency) adult males (especially intimate partners), adult females (especially family members or acquaintances), and then children (especially biological children), respectively (Putkonen, 2003; Putkonen et al., 1998, Putkonen, Collander et al., 2001; Weizmann-Henelius, Viemerö et al., 2003). The present study sample presented a mixed

picture in respect of the profile of homicide victims: Children comprised the majority of cases of homicide (55%) and over 85% of child victims were the killed by their biological mothers; approximately equal numbers of adult victims were male and female respectively (52% vs 48% respectively); and almost half (46%) of all cases of adult homicide were intimate male partners. There were, in fact, a number of statistically significant associations apparent between certain victim characteristics and the type of index offence committed: (a) non-homicidal violence was significantly more likely to have been targeted toward adults, whereas homicidal offences were significantly more likely to be directed toward children as opposed to adults; (b) and adult victims of homicidal violence were significantly more likely to be male than female; and (c) adult homicide victims were also significantly more likely to have been intimate male partners respectively.

There are surprisingly few studies that focus on mental health issues of women who commit different types of adult homicide (e.g. parricide, femicide, etc.), in contrast to women who commit child homicide (e.g. neonaticide, infanticide, etc). McKee and Shea (1998) explored mental health issues of women who murdered biological children (filicide) as opposed to the murder of intimate partners (mariticide) and non-familial adult victims respectively. Filicidal women were more likely to display poor coping skills, have significant mental health problems and to have been intoxicated at the time of the offence. Mariticial women and those who murdered non-familial adults had a greater likelihood of prior criminality and substance-related problems. Most socio-demographic variables (including age, race, educational level and occupational status of women offenders) were similar across the different groups. In contrast to the McKee and Shea study, homicidal cases from the present study sample presented a few distinct differences: (a) women who committed homicide were significantly more likely to be mentally well (hence criminally responsible), at the time of the offence; (b) children were

significantly more likely to be murdered by younger women (under 30 years of age); and (c) the age of homicidal perpetrators was identified as a significant and independent predictor variable of child homicide (after controlling for confounders) by logistic regression modelling i.e. women over 30 years of age were significantly less likely to murder children, as compared to younger women . As there were many important differences in the profiles of women who committed homicidal offences against adults and children respectively, a more detailed discussion of each of these groups follows below.

Forensic Mental Health Profile

Research on the relationship between mental illness and homicidal offending is largely based on studies that focus on male offenders in urban centres of industrialized, Western countries, limiting the generalizability of findings to women offenders, especially those from developing countries and/or non-urban settings such as the Eastern Cape of South Africa. This notwithstanding, the relative contribution of mental illness to homicidal offending, for both men and women, seems to become more prominent as the severity of mental disorder increases, especially in respect of comorbidity between severe mental disorder and substance-related and/or personality disorders (e.g. de Vogel & Nicholls, 2016; Erb et al., 2001; Schanda et al., 2004; Taylor and Gunn, 1999; Tehrani et al., 1998; Wallace et al., 1998). Furthermore, mental illness may have a greater impact on homicidal risk in women than in men, and female homicide offenders have significantly greater rates of severe mental disorder than expected, with up to two-thirds of homicidal women estimated to have a psychiatric diagnosis as compared to around one-third of men (e.g. d'Orban, 1990; Eronen, 1995; Gottlieb et al., 1987; Maden et al., 1994a; 1994b; Putkonen and Taylor, 2014; Spunt et al., 1996; 1998; Yarvis, 1990). There is also substantial evidence that the population attributable risk of homicide by women is moderately elevated specifically in relation to psychotic-spectrum disorders

(especially schizophrenia), mood disorders, substance-related disorders (especially alcohol abuse), personality disorders (especially of the cluster B sub-type), and in those with co-occurrence of these psychiatric disorders respectively (e.g. Fazel and Grann, 2004; 2006; Flynn et al., 2011; Laajasalo and Häkkänen, 2004; 2006; Large et al., 2009; Matejkowski et al., 2008; Putkonen, 2003; Putkonen et al., 1998; Putkonen, Collander et al., 2001; Schanda et al., 2004; Shaw et al., 2006; Swinson et al., 2007; 2011; Swinson and Shaw, 2007; Taylor and Bragado-Jimenez, 2009). In comparison to these outcomes, a more mixed picture emerged at the conclusion of the forensic evaluations of the South African study sample. Over two-thirds of homicidal women in the study sample (69%) were diagnosed with a severe Axis I and/or II mental disorder, as opposed to over 80% of women who committed violent but non-homicidal offences. The most common diagnostic categories in homicidal offenders were women with psychiatric comorbidity (28%) and psychotic disorders (22%) respectively, which together accounted for half of all cases. Relatively low rates of mood disorders (10%) and personality disorders (6%) were also found amongst homicidal women. There were, furthermore, no statistically significant associations (in both the chi-squared and logistic regression analyses) between any specific psychiatric disorders and homicidal offences in particular. Positive correlations between homicidal behaviour in women and specific mental disorders, or even mental illness in general, hence cannot be considered to be universal, as confirmed by both this study and others (Mann, 1988; 1990; Putkonen, Weizmann-Henelius et al., 2011).

The relationship between homicide and mental illness in women is further complicated by the low base-rate of female-perpetrated homicide in the first place. This means that studies with large sample sizes and robust analyses are also less common, and risk ratios generated as a result may appear potentially exaggerated. Homicidal women offenders with mental ill-health are a heterogeneous sub-population, with a complex range of individualized variables that may

contribute to ultimate risk. The presence of mental disorder did not significantly raise the risk of homicidal violence in the present study; on the contrary, women with mental disorder were in fact less likely to commit homicidal offences than those without. Women with *no* prior psychiatric history committed significantly more homicidal offences than expected by chance alone. There were also no statistically significant associations between homicidal offences in particular and any other indicators of mental ill-health at the time of offence, nor on any markers of psychopathology at the time of the forensic evaluation (including abnormal mental state at time of offence or evaluation, psychometric investigation outcomes, or any specific Axis I or Axis II mental diagnoses in final psychiatric court reports). These associations were confirmed by the subsequent logistic regression modelling, in which women offenders with a prior psychiatric history were, after controlling for confounders, significantly *less likely* to commit homicide, in comparison to women with prior psychiatric problems. In addition, women with psychiatric comorbidity were also significantly *less likely* to carry out acts of lethal violence, as opposed to women without such comorbidity.

The fact that homicidal women in the study sample were more likely to be mentally well than ill, and further that severe forms of mental disorder were significantly associated with a reduced risk of homicidal violence, were also reflected in the forensic findings on the psychiatric court reports. Women who were declared to be trial competent following conclusion of the forensic evaluation (i.e. those with no evidence of any severe mental disorder at the time of the post-offence assessment) were statistically significantly more likely to have committed homicidal index offences, than those who were deemed trial incompetent. There was also a tendency, though not to a statistically significant extent, for women who committed homicidal index offences to be more likely to have been criminally responsible, as compared to those committing other types of non-lethal offences. Similarly, recommendations to the

court that the law take its course (i.e. for the trial to proceed in the usual fashion due to the lack of any forensic mental health issues pertinent to trial competence and/or criminal capacity) were made in a significantly greater proportion of homicidal than non-homicidal offenders respectively, with this association displaying a large effect size. These findings are in contrast to those of many other studies of similar homicidal female offender samples in the urban settings of developed countries, and again raises questions regarding the generalizability of findings from studies abroad to the situation in largely rural, less developed countries such as of South Africa. Further forensic mental health research in this field will assist in clarifying these issues.

Women who act violently in general are significantly more likely to have been victims of prior abuse themselves, with these associations also holding true for homicidal women offenders in particular (with up to one-third having experienced prior abuse) (e.g. de Vogel & Nicholls, 2016; de Vogel et al., 2016; Häkkänen-Nyholm et al., 2009; Mužinić Masle et al., 2000; Putkonen, Collander et al., 2001; Yourstone, Lindholm and Kristiansson, 2008). The association between prior abuse and subsequent violent offending was confirmed in the present analysis: Over 30% of all violent offenders had a history of prior abuse, compared to 15% of women accused of non-violent offences. Furthermore, women who had a history of prior abuse had in excess of three times the odds of subsequently committing a violent index offence. These associations were, however, especially robust for homicidal offending in particular: A prior history of abuse of the woman offender was highly significantly associated with the subsequent commission of homicide. Furthermore, the logistic regression analysis confirmed the predictive value of such prior abuse experiences, as these were highly significantly associated with the commission of subsequent homicide. After controlling for confounders, women who were abused themselves had almost six times the odds of subsequent homicidal violence, as

compared to women without prior abuse. Expressed differently, the odds of committing a lethal offence was increased, after adjusting for confounding co-variables, by over 480% in women who were previously abused, as compared to women who did not report prior abuse. Related to this, it is also prudent to emphasize that whilst a disproportionate number (over 20%) of all adult victims of violence were intimate partners, over twice this proportion (over 45%) of adult victims of homicide were intimate partners (with all of the latter being male). In other words, intimate male partners in particular were at much higher risk of being killed than any other category of adult victim (e.g. other family members, neighbours, friends, strangers, etc.). Women who killed adults were in fact statistically significantly more likely, with a moderate effect size, to target intimate male partners in particular. This relationship between victim and perpetrator was, however, not found to have sufficient independent predictive value after controlling for confounders in subsequent logistic regression analyses. The corollary to this was that women with prior abuse experiences at the hands of intimate male partners in particular were also significantly more likely to commit homicide than those without such prior abuse. As postulated by similar findings elsewhere, many of these women turn to intimate partner homicide, often in the context of years of abuse by their victims, when they feel seriously threatened or endangered, and when other less extreme alternatives are perceived to have been exhausted (Dobash and Dobash, 1984; Dobash et al., 1992; Schwartz and Steffensmeier, 2007).

The findings of this study also challenge many commonly held perceptions that homicidal women are more likely than not to be “mad” or “abnormal” in some way. It is likely that chauvinistic socio-cultural and systemic attitudes, and what is considered “normal” behaviour in women, may lead to assumptions that homicidal acts by women are in themselves evidence of psychopathology, especially if lethal violence is directed toward biological

children. Such prejudice may extend to policing, criminal justice, correctional service and health care systems, leading to potential bias in the appraisal of these cases and their subsequent handling, as has been asserted in other settings (Yourstone, Lindholm, Grann, et al., 2008). This may result in potentially lower thresholds by court officials in initiating forensic referrals for homicidal women in the first instance (although whether this is really the case, and to what extent, is speculative at this stage). Whilst there are very few studies examining longer term outcomes in homicidal women offenders with mental illness, indications are also that these women have poor prognoses in a number of respects. These include factors such as increased risk of chronic deterioration in mental health indicators (especially in cases with psychiatric comorbidity); violent, including homicidal, recidivism (especially in women who are young, with prior criminality, and who have substance abuse histories and/or are personality disordered); and mortality from unnatural death (especially by suicide) (Bonta et al., 1998; Kaufmann et al., 2015; Eronen et al., 1996a; Putkonen, 2003; Putkonen, Komulainen et al., 2001; Tiihonen and Hakola, 1994). The generally poor outlook for this group of vulnerable women illustrates the importance of prioritizing supportive, rehabilitative and therapeutic approaches to their management, as opposed to applying traditionally retributive models of criminal justice and/or restrictive models of institutionalized forensic rehabilitation. A paradigm shift in both the understanding and handling of homicidal women offenders is required, especially within law enforcement, criminal justice, correctional and forensic mental health systems. Some of the key recommendations required for such progressive change are highlighted below.

Adult Homicide

In comparison to male perpetrators, it is well established that risk of a lethal outcome in cases of violence by women is associated with, firstly, adult victims being of the male gender

(especially intimate partners) within the immediate family or social circle of to the perpetrator; and secondly, with a background of interpersonal conflict with, or abuse by, the homicidal victim (Goetting, 1987; Husain et al., 1983; Jurik and Winn, 1990; Kellermann and Mercy, 1992; Kirkwood, 2003; Moen et al., 2016; Mužinić Masle et al., 2000; Putkonen, 2003; Rodriguez and Henderson, 1995; Stout, 1991; Swatt and He, 2006; Weizmann-Henelius, Viemerö et al., 2003; Wilbanks, 1983a; 1983b; Wilson and Daly, 1992). These trends were confirmed in the present South African study setting with respect to adult victims of homicide: Over half of adult homicide victims were men; almost 90% of victims were known to the perpetrator; intimate male partners constituted the largest single category of victims (in 46% of cases), and were in fact at significantly higher risk of homicide rather than any other type of violence. Furthermore, whilst almost half (45%) of homicidal women, and the majority (57%) of women who killed adults, also had a history of prior abuse exposure themselves, disproportionately many (80%) who murdered intimate male partners in particular were previously abused themselves. The inferential analyses confirmed these trends in a number of important respects: (a) women who reported prior abuse experiences were found to be significantly more likely to have committed homicidal offences, in comparison to women who did not report such prior abuse; (b) women who reported abuse by intimate male partners in particular were significantly more likely to have committed homicidal index offences; (c) unlike the case with child victims of homicide, who were equally likely to be of either gender, adult homicide victims were significantly more likely to be male than; and (d) intimate male partners were significantly more frequently victims of homicidal violence in particular, as opposed to being victims of non-lethal violence. Ultimately, logistic regression modelling, which controlled for potential confounders, demonstrated that women with a history of prior abuse had over three times the odds of violent offending in general, and almost six times the

odds of homicidal offending in particular, as compared to women without such prior abuse experiences.

Women who murder intimate partners (as is the case with other victims well known to them) most commonly do so in the context of preceding interpersonal conflict with their victims and/or abuse at the hands of their victims (in up to around 60% of cases), with the final lethal act more often than not precipitated by such conflict and/or abuse (Moen et al., 2016; Putkonen, 2003; Putkonen et al., 1998; 2003; Putkonen and Taylor, 2014; Weizmann-Henelius, Viemerö et al., 2003). Self-reported citations of self-defence as the specific motive for lethal violence by women, however is generally surprisingly low, being reported as less than 10% by most studies (the comparative figure from present study sample was 6%) (Putkonen et al., 1998; Putkonen, Collander et al., 2001). Nonetheless, many homicidal women cited interpersonal conflict with their adult victims as the primary motive for their lethal violence. It was the motive in one-fifth of cases for homicidal offending in general (being second to psychopathological motives in 41%); the proportion of homicidal acts against adults in particular due to interpersonal conflict rose to 48%; but was the single most commonly cited motive (60%) by women killed intimate male partners respectively (there were however, no statistically significant associations apparent between interpersonal conflict and the commission of homicide in particular). Given this context, there have been suggestions that the expression of extreme anger, aggression and violence by many of these women is linked to prevailing gender roles which socialize women to value and define themselves in terms of their relationships to others (Jung and Rawana, 1999; Jurik and Winn, 1990; Yourstone, Lindholm and Kristiansson, 2008).

There is similarly much research evidence to conclude that lethal aggression by women against intimate partners (especially women who have been abused and who suffer from mental ill-health) is often precipitated by interpersonal conflict with the victim; and furthermore that such conflict, and the gender dynamics it is embedded in, are central to initiating the violent events that follow (e.g. de Vogel & Nicholls, 2016; Flynn et al., 2011; Häkkänen-Nyholm et al., 2009; Kirkwood, 2003; Mužinić Masle et al., 2000; Nagdee et al., 2019; Putkonen, Collander et al., 2001; Putkonen, Weizmann-Henelius et al., 2011; Weizmann-Henelius et al., 2012; Weizmann-Henelius, Viemerö et al., 2003; Yourstone, Lindholm and Kristiansson, 2008). In cases of prior abuse of the offender, lethal violence may then be considered in many as a response to the victimization or violence at the hands of her victim, and primarily motivated by distress, self-preservation, extreme provocation, fear, desperation and/or impulsive rage (as opposed to well-planned, calmly executed psychopathic homicide for secondary gain, or the relatively disorganized or deluded homicide of psychosis, for example). Goetting (1987) referred to these women offenders as “victims of a society stratified against them” i.e. in addition to being victims of abuse themselves by those purportedly closest to them, they tend to have multiple levels of disadvantage, in addition to their gender, which contribute to their vulnerability to both mental ill-health and violent offending. In this light, many factors in the South African study sample may have contributed to the risk of offending, including being female and black African (hence historically disadvantaged and vulnerable in numerous respects), socioeconomically impoverished, under-educated, unemployed, single mothers within patriarchal and poorly supportive domestic and family systems, in addition to having substance abuse, mental health and/or medical problems for which appropriate health care may not necessarily be available. As a result of such extreme pre-offence bio-psychosocial stressors, many women who ultimately commit intimate partner homicide initially may develop non-criminal coping strategies which take the form of severe psychological distress and mental

disorder. Many large studies have confirmed that women who kill intimate partners are particularly prone to having pre-offence psychiatric problems, and severe mental ill-health at the time of the offence or soon thereafter (especially severe psychotic, mood and substance-related disorders), though these associations are by no means certain nor universal (de Vogel & Nicholls, 2016; Flynn et al., 2011; Gottlieb et al., 1987; Putkonen and Taylor, 2014). In support of these patterns, the majority of South African women in the study who killed intimate male partners had a positive psychiatric history (60% of cases) and/or a confirmed severe mental disorder (80% of cases). Caution needs to be exercised in drawing direct conclusions, however, as closer examination of two further outcomes (with respect to pre-offence psychiatric history and the presence of post-offence psychiatric comorbidity) illustrate. Firstly, whilst there was a significant relationship between pre-offence psychiatric history and the commission of both non-violent and violent but non-homicidal offences, women with no such psychiatric history committed disproportionately *more* homicidal offences than expected by chance alone. Logistic regression modelling further demonstrated that women with prior psychiatric backgrounds were actually significantly *less* likely to commit homicidal offences, as opposed to other types of offences. Secondly, women whose post-offence forensic assessment confirmed the presence of more complex types of mental disorder in the form of psychiatric comorbidity were similarly significantly *less* likely to commit homicide than women with no such clinical comorbidity. Controlling for confounding variables by logistic regression modelling also confirmed psychiatric comorbidity to be a significant and independent predictor of *reduced risk* of homicidal offending. Whilst these were statistically robust outcomes, it is still not entirely certain whether these findings are a product of sample bias or reflective of the true situation; further South African research may shed further light on this important issue.

In addition to intimate male partners, almost as many adult victims of homicide in the study were other women (48% of cases), with 90% of these femicidal victims being well known to the offenders. Whilst there are very few published studies on female-perpetrated intrasexual homicide, typical offender profiles are of relatively young (under 30 years of age), married (but often separated), poorly educated, unemployed black mothers of dependent children, who are living with their families and tend to have criminal histories, and who are most commonly convicted of the impulsive killing of an adult female family member, following a domestic quarrel in the context of alcohol intoxication of offender and/or victim (Goetting, 1988a; 1988b; Mann, 1993; Scott and Davies, 2002). This is very similar to the profile of the ten femicidal women included in the present study, except in three respects: (a) the majority of the South African women were older (only 9% were under the age of 30 years, with a mean age of 46.5 years); (b) unmarried (almost half were single, and only a third were married at time of offence); and (c) had no prior criminal history (over 80% were first offenders) respectively. Again, further research is required to confirm these outcomes in developing countries such as South Africa.

Homicidal women, and especially those with backgrounds of prior abuse, mental ill-health and/or significant interpersonal conflict with intimate male partners, would also be expected to turn to mental health services for help in addressing their psychological distress and psychiatric symptoms, prior to resorting to extreme behavioural responses as lethal violence (Ogle et al., 1995; Yourstone, Lindholm and Kristiansson, 2008). Theoretically at least, such pre-offence contact with mental health services may be an opportunity for preventive intervention, risk management and clinical assistance to the distressed woman and offender-to-be. It is postulated that acknowledgement of the broader socio-demographic, psychological and clinical context of women at risk of extreme violence, whilst not justifying

the ultimately tragic events and outcomes, enhances a deeper understanding of these phenomena, and in so doing, provides potential opportunity for more focused amelioration and intervention. There is good reason to approach and manage women at risk of homicidal violence within the context of gendered power dynamics, and to appreciate the crucial role of healthy inter-personal relationships in this regard. This will not only improve better understanding of these phenomena, but also challenge traditionally gender-biased, stigmatised and stereotyped “explanations” thereof, as well as sensitising mental health professionals to potentially preventive opportunities in high-risk individuals that may present themselves before lethal violence actually occurs.

Child Homicide

Whilst children are less frequently than adults the victims of violent offending by women (an estimated one-quarter of female-perpetrated violence is against children), those children who are targets of violence are more likely to be victims of homicidal than non-homicidal violence (Weizmann-Henelius, Viemerö et al., 2003). Similar findings were apparent in the current study: Whilst adults comprised 70% of all victims of violent offending, a disproportionately high number of homicide cases involved child victims (28 of 51 cases); and the vast majority (almost 90%) of child victims of violence were murdered, as opposed to being assaulted with non-lethal levels of force. Homicidal offences were highly significantly associated with the targeting of child victims, with a large effect size characterizing this association. South African women who committed homicide in fact were found to have over eleven times the odds of targeting children rather than adults, as compared to women who committed violent but non-homicidal offences. It is important to emphasize, however, that child homicide overall is not primarily a female-perpetrated or maternal offence (Silverman and Kennedy, 1988). A number of studies report approximate gender equivalence of offenders

who kill young children (approximately one-third of cases being murdered by mothers and fathers respectively); and cases in which children are killed by a person other than a parent, the large majority (around 80%) of perpetrators are men (Cooper and Smith, 2011). Nonetheless, a substantial proportion of child homicide is carried out by parents of victims, especially by mothers who murder children in their infancy; for example, approximately 11 000 children were murdered by parents or step-parents between 1976 and 1997 in the US, with mothers or step-mothers responsible for approximately half of these offences (Greenfeld and Snell, 2000).

Children are also at greatest risk of being killed on their first day of life, followed by those in their first year of life, after which the risk decreases steadily with the age of the child (Bourget and Labelle, 1992; Brookman and Nolan, 2006; Flynn et al., 2007; Marks and Kumar, 1993; 1996; Overpeck et al., 1988; Putkonen, Amon et al., 2009; Putkonen, Weizmann-Henelius et al., 2009). This trend was confirmed in the present South African sample, in which the majority of child victims of homicide were under one year of age (in 16 of 28 cases), with half of these killed within their first month of life, and the remainder within their first year of life respectively. Furthermore, it has been found by numerous studies that child homicide tends to be a predominantly intra-familial phenomenon, and that the younger the child victim, the more likely it is that the biological mother is the perpetrator (up to 50% of child victims in their first year of life are reported to be murdered by their mothers) (Bourget et al., 2007; Marks and Kumar, 1996; Porter and Gavin, 2010; Putkonen, Amon et al., 2009; Putkonen, Weizmann-Henelius et al., 2009; Stroud, 2008; Stroud and Pritchard, 2001). This pattern was confirmed in the present study, in which over 85% of all child murders were committed by biological mothers; in addition, all cases of neonaticide, and 88% of infanticides, were perpetrated by biological mothers.

Women with severe mental disorders (especially psychotic disorders) who carry out lethal acts of violence are reported to disproportionately target children as opposed to, for example, intimate partners or adult family members (Gottlieb et al., 1987; Putkonen, Collander et al., 2001). Societal, criminological and even clinical approaches to women who kill children have, however, tended to be reductionist in nature, seeing such women as necessarily either “mad” (i.e. psychotic) or “bad” (i.e. antisocial) (Porter and Gavin, 2010). There has generally been insufficient consideration given to the complex nature of such phenomena and the important socio-cultural, psychological, structural and contextual factors associated with such events, especially in relation to gender inequality, poverty, social and occupational disadvantage, domestic violence, substance misuse, interpersonal and family dynamics, prior abuse of perpetrators, psychological distress, stressors related to child care, and poor social support networks (Ayres, 2007; Malmquist, 2013; Nau et al., 2012; Oberman; 1996; 2003; Wilczynski, 1995; 1997). Where maternal mental illness is implicated, psychotic and personality disorders are reportedly the most common diagnoses present (d’Orban, 1979; Friedman, Horwitz et al., 2005; Putkonen et al., 1998; Putkonen, Collander et al., 2001). There is also, however, a substantial body of evidence that the majority of child homicide cases, despite widely held perceptions to the contrary, are in fact not related to severe mental disorder of the women who perpetrate them (De Bortoli et al., 2013a; 2013b; Porter and Gavin, 2010). In the South African sub-sample of women who killed children, a few key features require highlighting: (a) whilst a disproportionate number (29%) were diagnosed with schizophrenia or other psychotic-spectrum disorders, the majority of women (57%) had no diagnosed severe mental disorder following comprehensive forensic evaluation (in contrast to women who killed adults, in whom 70% were diagnosed with a severe mental disorder); and (b) whilst almost 80% had at least one Axis I and/or II diagnosis, this included diagnoses that were not severe enough to have forensic relevance in relation to trial competence or criminal capacity (e.g.

substance related disorders; personality disorders; borderline intellectual functioning; post-offence adjustment disorders, etc.). The exact manner in which severe mental disorder is related to the homicide of children is also not certain, and attribution of direct causality is not easily established in most instances (Friedmann et al., 2005a).

The related issue of peri-partum (and especially post-partum) mental illness, and its relationship to child homicide, has received surprisingly little research attention, and there is little by way of good evidence establishing direct causal links (Friedmann, Horwitz et al., 2005). In the current South African series, there were 9 child homicide cases (32% of all cases) in which severe peri-partum psychopathology affected criminal capacity. Seven of these women were diagnosed with a psychotic disorder; and one each with delirium and an acute bipolar episode at the time of the offence respectively. In respect of the victims in these cases, three of these children were neonates, two were infants and the remainder were older than one year of age. Much of the published literature suggests that, in the majority of such cases, the psychopathology and associated behavioural disturbances are manifestations of a *pre-existing* (i.e. pre-offence) mental disorder in genetically vulnerable women, with onset or relapse that happens to be triggered, for poorly understood reasons, within the puerperal period (Friedman, Horwitz et al., 2005; Friedman et al. 2009; Porter and Gavin, 2010). Despite these reported associations between mental illness and child homicide, there were no significant associations between child homicide and the diagnosis of any particular mental disorder(s) in the perpetrators in the current South African study. On the contrary, women with complex psychiatric comorbidity were significantly *less likely* to murder children in comparison to women with no such comorbidity.

Much of the research literature has emphasized that different types of child homicide (e.g. neonaticide or infanticide) may exhibit important differences. In their review of over four decades of research, Porter and Gavin (2010) summarized some of the key issues in this respect: (a) neonaticide tends to be generally, but not invariably, committed by women who do not harbour severe mental disorder; who conceal their pregnancy and give birth away from hospital; and who murder unwanted newborn babies without weapon usage, prior to secretly disposing of the corpse; whereas (b) infanticides are generally committed by more mature women who use a variety of lethal methods and often premeditate the offence; and who engage in infanticidal behaviour for a wide variety of reasons (ranging from retaliatory acts, to child abuse or neglect, and mental ill-health). In addition, a subset of infanticides are committed by women with severe mental disorder (with most of these suffering from psychoses), but whose symptoms are mostly unrelated to hormonal fluctuations during the puerperium. The different types of child homicide will hence be considered in turn in the ensuing discussion in respect of the key conclusions of the current study.

Neonaticide. Whilst a child's greatest risk of being killed by its mother is within the first twenty-four hours of life, neonaticide is of course not exclusively perpetrated by mothers or women (Porter and Gavin, 2010). Neonaticide is best considered to be a distinct phenomenon embedded within the broader offending context and psychosocial health of perpetrators, with a background of maternal neglect (whether intentional or not), denial of pregnancy and/or concealment of birth reported to be hallmarks (Beyer et al., 2008; Bonnet, 1993; Dobson and Sales, 2000; Green and Manohar, 1990; Malmquist, 2013; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007; Porter and Gavin, 2010). In general, neonaticidal women from studies conducted abroad mostly describe older women who are not likely to be dependent on parents or other family members, and who tend to be timid, passive, immature,

emotionally labile, have cluster B personality traits and/or of below average intelligence, but who are not typically suffering from severe mental health problems (Beyer et al., 2008; De Bortoli et al., 2013a; d'Orban, 1979; Haapasalo and Petaja, 1999; Friedman, Hrouda et al., 2005b; Mendlowicz et al., 1998; Oberman, 2003; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007; Resnick, 1970; Sadoff, 1995; Silverman and Kennedy, 1988; Spinelli, 2001). The eight South African neonaticidal women included in the present study presented a somewhat mixed profile in comparison: they tended to be relatively young (mean age = 28.8 years), single parents who were estranged from the fathers of their neonaticidal victims; the majority also had poor educational attainment, were unemployed and living with extended family members, upon whom they were dependent for financial support. Only three women had concealed their pregnancies and severe maternal neglect was apparent in only two cases; one woman was recorded to have a cluster B personality disorder and one had borderline intellectual functioning; six women had no pre-offence psychiatric history; and the majority (five of eight) had no severe mental disorder that somehow "explained" the neonaticidal phenomenon (and all of these were declared both trial competent and criminally responsible for their actions). Research on neonaticidal women with severe mental disorder has reported a slightly different profile, as they tend to be older (above 30 years) and married; they rarely deny or conceal their pregnancies; and their pre-offence psychiatric problems mostly entail psychotic or mood-spectrum disorders (De Bortoli et al., 2013a; Flynn et al., 2007; Friedman and Resnick, 2009a; Krischer et al., 2007; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007). The current study sample only comprised three neonaticidal women (of 8 cases) who were diagnosed with a severe mental disorder: Their mean age was 30.6 years; only one woman was married; only one had a pre-offence psychiatric history; only one denied her pregnancy and concealed the birth; and two women were diagnosed with a psychotic disorder, whilst one woman had bipolar disorder.

An important similarity between other studies abroad and present study was, however, the fact that the most common primary motive for the neonaticidal act was the elimination of an unwanted child (as a maladaptive problem-solving strategy), in the context of relatively poor resilience or coping skills in the face of the demands of motherhood and poor partner, family and/or social supports (Bourget et al., 2007; Craig, 2004; De Bortoli et al., 2013a; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007; Porter and Gavin, 2010). Many mothers in such situations are expectedly overwhelmed, distressed and socially and/or emotionally isolated; this was reflected in the course of the semi-structured interviews and their subsequent qualitative analysis (discussed below). Whilst such maternal distress does not justify neonaticidal behaviour, it provides an important psychosocial context within which it commonly occurs. Also consistent with the findings of many other studies abroad, the majority of South African neonaticidal offences (seven of eight cases) were committed without weapons of any kind, with the hands of the mother being the primary instrument of the homicidal act itself (Bonnet, 1993; Herman-Giddens et al., 2003; Putkonen, Collander et al., 2007; Putkonen, Weizmann-Henelius et al., 2007; Porter and Gavin, 2010). Categorization of neonaticidal methodology has been suggested as either: (a) “active” neonaticide which entails goal-directed lethal violence such as suffocation, battery, strangulation, poisoning, drowning, stabbing, and so forth (which constituted 75% of cases in the current sample); or (b) more “passive” forms of neonaticide, in which maternal neglect and/or negligence is the primary modus operandi e.g. food and/or water deprivation, deliberate exposure; and withdrawal or refusal of requisite medical care (Porter and Gavin, 2010). The validity and utility of this approach, however, is uncertain.

Infanticide and Killing of Older Children. Unlike neonaticide which is more commonly perpetrated by women (and specifically mothers), the killing of infants and older children tends to be carried out by men and women in approximately equal frequencies (Porter and Gavin, 2010; Putkonen and Taylor, 2014; West et al., 2009). Victims are more likely to be male in industrialized, Western countries, as opposed to being mostly female in Asian countries such as India and China (Brookman and Nolan, 2006; Crimmins et al., 1997; Oberman, 2003; Porter and Gavin, 2010; Sahni et al., 2008; Vanamo et al., 2001). Infant and older child homicide victims in the present study showed a modest male preponderance, whereas slightly more female neonates were killed. The exact reasons behind gender differentials of child homicide victims remain unclear, though a potentially influential role has been postulated for gendered cultural practices (e.g. the perceived “desirability” of male instead of female children in many cultures), as well as political policies with gendered implications (e.g. the so-called one-child policy in China). As with neonaticidal acts, the research literature also reports that the minority of cases of infanticide involve the use of weapons (Brookman and Nolan, 2006;; Crimmins et al., 1997; Herman-Giddens et al., 2003; Krischer et al., 2007; Mulryan et al., 2002; Porter and Gavin, 2010; Rougé-Maillart et al., 2005; Stanton and Simpson, 2002). This trend was also confirmed in the current sample, in which the vast majority of infanticidal and filicidal cases did not involve the use of weapons; most women selected instead to severely neglect, suffocate, physically assault with hands, poison or drown their victims.

Overall, motives of the typical infanticidal (and filicidal) woman offender fall into one of three broad categories: (a) impulsive, enraged, abuse-related killings usually associated with single, younger, immature, unemployed and financially impoverished mothers of children who often have feeding difficulties, persistent crying, failure to thrive, medical illnesses, intellectual disability and/or behavioural problems (with these challenges postulated to make care-giving

significantly more difficult and potentially overwhelming); (b) pre-meditated murders related to acts of spousal retaliation on the background of significant interpersonal conflict, “altruistic/mercy killings, respectively (which tend to involve older, married, employed and socio-economically more stable mothers); and (c) infanticidal behaviour directly related to severe psychopathology suffered by the perpetrator at the material time (De Bortoli et al., 2013b; d’Orban, 1979; Kauppi et al., 2008; 2010; Krischer et al., 2007; Lewis and Bunce, 2003; Mulryan et al., 2002; Nielssen et al., 2009; Resnick, 1970; Rougé-Maillart et al., 2005). The cases in the current study again presented a somewhat mixed profile in comparison, with some key differences in cases of killing of older children beyond the neonatal period. In the infanticidal group (n = 8 cases), women tended to be younger (mean age = 24 years), single (7 cases), and relatively poorly educated (only 2 cases progressed beyond Grade 8 at school). In comparison, women who murdered older children (n = 12 cases) were older themselves (mean age = 36.8 years), married or separated (7 cases), and better educated (only 3 cases failed to progress beyond Grade 8) respectively. There were a mixture of motives apparent in each category. In the infanticidal sub-group, there were 3 cases of pre-meditated retaliation / revenge related to interpersonal conflict with a partner, 3 cases of impulsive, enraged abuse-related violence, and 2 women who acted under the direct influence of severe psychopathology at the time of offending. In cases in which older children were killed, there were 2 cases of retaliation / revenge due to interpersonal conflict with the fathers of the victims, 2 cases of impulsive, abuse-related violence, 4 cases of psychopathologically-driven violence, and the remaining 4 cases were motivated by a mixture of other factors e.g. effects of substance intoxication, altruistic acts, etc. In cases of impulsive, abuse-related violence at least, it is probable that these relatively young mothers have a number of risk factors that render them vulnerable to committing acts of lethal violence. These potentially include inadequate resilience in the face of enduring, multiple psychosocial stressors associated with issues such as single motherhood,

poor personal resources or coping skills, mother-child attachment problems, and/or pre-offence mental health problems. These difficulties are exacerbated in the broader context of poor support systems, within households in which socio-economic adversity, unemployment, domestic strife, substance abuse, violence, and poor access to services (e.g. social, health, welfare, housing and employment services), which are prominent features of daily life for most in the Eastern Cape of South Africa.

Unsurprisingly, many infanticidal and filicidal women with mental ill-health have troubled, distressed pre-offence backgrounds in which they were often subject to violence and abuse themselves, most commonly at the hands of those closest to them, especially intimate male partners or co-habiting family members (Friedman, Horwitz et al., 2005; Friedman, Hrouda et al., 2005a; Kim et al., 2008; Putkonen et al., 2010; Putkonen, Amon et al., 2009; 2011; Putkonen, Weizmann-Henelius et al., 2009). Consistent with this, a disproportionately high number of mothers who killed infants (one-quarter of cases) and older children (half of cases) reported a history of being abused themselves. A number of studies have also drawn particular attention to the potential role of affective, psychotic substance-related and personality disorders in filicidal events (Bourget et al., 2007; De Bortoli et al., 2013b; Dolan et al., 2003; Flynn et al., 2007; 2013; Friedman and Friedman, 2010; Friedman et al., 2009; Friedman, Horwitz et al., 2005; Friedman, Hrouda et al., 2005a; Friedman and Resnick, 2009b; 2011; Kauppi et al., 2008; Lewis and Bunce, 2003; McKee and Shea, 1998; Porter and Gavin, 2010; Putkonen et al., 2010; Putkonen, Amon et al., 2009; 2011; Putkonen, Weizmann-Henelius et al., 2009; Wilczynski, 1995; 1997). A complex diagnostic picture emerged from the study sample, in which psychotic disorders were present in one-quarter of infanticidal women and one-third of women who killed older children; and whilst a quarter of women who killed neonates and infants had prior psychiatric problems, a disproportionate majority (58%)

of women who killed older children had a prior psychiatric history. In contrast to findings from studies elsewhere, relatively small proportions of South African women who killed children were diagnosed with substance-related disorders (7%) or personality disorders (11%) respectively.

Severe maternal depressive syndromes in particular have been postulated to be especially influential in cases of infanticide and filicide, via their role in attachment difficulties, poor parental coping skills and inadequate or negligent caring patterns (Bourget et al., 2007; Porter and Gavin, 2010). The development of subsequent physical, emotional and/or behavioural problems in children may then act as additional triggers for abusive or violent maternal behaviour. Furthermore, exacerbating psychosocial stressors commonly associated with severe maternal depression (e.g. absentee fathers, domestic violence, poverty, unemployment, financial difficulties, family conflict or dysfunction, poor social supports, substance misuse, etc.) may contribute to lowering of the threshold for lethal violence by mothers toward their children, again highlighting the importance of contextual psychosocial variables in explanatory models of these phenomena (De Bortoli et al., 2013b; Lawrence, 2004). With respect to psychotic spectrum disorders (especially those as severe as schizophrenia), the specific characteristics of disorganized thinking and behaviour, delusions and hallucinatory phenomena are similarly all potentially contributory factors leading to lethal violence toward children (Bourget et al., 2007; De Bortoli et al., 2013b; Friedman, Horwitz et al., 2005; Friedman, Hrouda et al., 2005a; Lewis and Bunce, 2003; Porter and Gavin, 2010; Taylor and Bragado-Jimenez, 2009). The cumulative influence of adverse mental health variables is postulated to render these women more vulnerable to feeling overwhelmed at times of personal difficulty and/or crisis (perceived or actual) e.g. in the setting of children with intense, persistent and challenging care needs. This in turn exacerbates the risk of violence, in theory at least, though

it is not prudent to draw direct causal associations in the face of many interacting, dynamic and complex variables and confounders. In summary, the broader psych-social context and individual personal attributes (e.g. temperament, resilience, mental health status etc.) of the mother within that context, are all proposed to contribute to the threshold for extreme or lethal violence in otherwise nurturing and non-offending women. It is equally important to emphasize, however, that despite many women reporting experiences of passivity, helplessness, powerlessness or other forms of psychological distress (pre- and/or post-offence), most infanticidal women do not suffer from severe forms of mental disorder (Crimmins et al., 1997; d'Orban, 1979; Krischer et al., 2007; Porter and Gavin, 2010). The outcomes of the present study supported this trend, in which the majority of women who killed infants or older children had no severe mental disorder diagnosed upon formal forensic evaluation i.e. they had either had no mental disorder diagnosis at all, or were diagnosed with less severe forms of mental ill-health (e.g. substance-related disorder or personality disorder alone), which had no impact on either trial competence or criminal responsibility. This is a significant finding considering that the study sample was drawn from women offenders who were selectively referred for forensic psychiatric evaluation by courts as a result of concerns regarding their mental health in the first place. Even in those women who were diagnosed with more severe or complex forms of mental disorder, attributions of causality linking their specific psychopathology to the homicidal act itself are to be cautiously approached. Cases need to be individually, systematically and comprehensively appraised by a multi-disciplinary forensic mental health professional team before conclusions can be drawn. In this regard, and in line with studies elsewhere (Krischer et al., 2007; Porter and Gavin, 2010), the majority of the infanticidal/filicidal women in the present sample were declared trial competent (hence mentally well and stable at the time of the post-offence evaluation) and criminally responsible (hence mentally well and stable at the time of the offence) respectively. In these cases, the

women were considered to have acted in a goal-directed, though not necessarily pre-meditated, manner in order to serve some personal interest e.g. the infant being perceived as a hindrance, or threat to their lifestyle or relationships; or the lethal violence being in fact a proxy act as a form of revenge or retaliation directed toward a partner, etc.

A Combined Typology of Child Homicide. Numerous typologies of child homicide by women have been proposed and utilized over the years in order to categorize and understand these phenomena (d'Orban, 1979; Bourget and Bradford, 1990; Bourget and Gagne, 2002; Guileyardo et al., 1999; McKee, 2006; Resnick, 1969; 1970; Scott, 1973). A number of criticisms of these classifications have been raised, especially in relation to their accuracy, validity and clinical utility (Porter and Gavin, 2010). There have been concerns regarding potentially misleading or pejorative terminology e.g. "altruistic" as a descriptor of infanticidal motive, or child killing following a "stimulus arising from (the) victim". The typologies have also been criticized for being too reductionist and simplistic, for ignoring the multi-dimensional complexity of such events, in light of the fact that many cases are not easily placed into single, mutually exclusive categories (Porter and Gavin, 2010). Stanton and Simpson (2002) similarly cautioned that distinct separations between deliberate, fatal child abuse and homicide related to mental illness is not always possible. In addition, whilst many women who murder children often act alone, there are some whose behaviour in conjunction with intimate male partners (who in many instances tend to be violently abusive themselves), leads to a fatal outcome for the child (Putkonen and Taylor, 2014). Although Resnick's and d'Orban's typologies were innovative at the time, some modern researchers in the field consider the categories insufficient in themselves to be a useful classification, and suggest that they do not necessarily facilitate an adequate or accurate understanding of the complex phenomenon of child homicide (De Bortoli et al., 2013b). Overlapping causes and contextual variables may mean, for example, that mental

disorder may be an important and influential contextual factor, even when the primary motive may not be directly related to specific psychopathological symptoms. The composite nature of such motive-based categorization may therefore be misleading. Nonetheless, whilst there is no single, universally agreed classification of child homicide, there is at least a degree of convergence of themes across the various classifications (Putkonen and Taylor, 2014).

For the purpose of the present study, the common components of the most widely used and referenced classification systems were hence adapted in an effort to incorporate the most important elements of these typologies; these were then combined into a single, pragmatic classification system for the collection of data and its analysis. Women who killed children were categorized into cases in which the violence was primarily driven by, or occurred in the context of, one of six groups: (a) *psychopathology* (offences secondary to severe psychopathological symptoms, most often of a psychotic nature); (b) *retaliation / revenge* (offences in the context of severe interpersonal conflict, most often with the father of the child victim); (c) *unwanted children* (pre-meditated violence against children who were perceived to be a problem, obstacle or threat to the offender in some way); (d) *impulsive violence* (due to perceived “provocation” by the child victim of the offender, who were mostly immature mothers with a history of poor coping skills); (e) *substance-related* (behaviour directly due to the effects of substance intoxication or withdrawal syndromes, most often related to alcohol); and (f) “*altruistic*” offences (killing in an attempt to relieve actual or perceived suffering of the child e.g. due to intractable poverty, medical illness or physical/intellectual disability) respectively. The most common single behavioural driver and context for lethal violence against children by South African women in this study was psychopathology, in almost one-third of cases. This was not unexpected as the women included in the sample were referred by courts, following their arrest, for psychiatric evaluation on the basis of mental health questions

in the first instance. What was perhaps more surprising was the fact that psychopathology accounted for a relatively greater proportion of cases of lethal violence against adults (in 48% of cases) as opposed to children i.e. women offenders with severe mental disorder were more likely to kill adults than children. This appears to challenge commonly held misperceptions within both public and professional domains that women who kill children (especially their biological offspring) must invariably be “mad” or mentally unwell, as conclusions to the contrary are somehow considered less explicable. Furthermore, a diverse range of child homicidal categories accounted for the remaining cases, especially lethal violence due to interpersonal conflict (21%), unwanted children (18%) and impulsive violence due to perceived provocation (18%) respectively, with a small related to substances or perceived altruism. This is in contrast to adult homicide, in which almost 96% of cases were accounted for by only two categories i.e. offending due to psychopathology or interpersonal conflict (especially with intimate male partners) respectively. In other words, it is important to recognize the relatively greater diversity and complexity in cases of women with mental health problems who kill children, as opposed to those who kill adults. The combined typology of child homicide devised for the present study is proposed to have clinical utility, as it is sufficiently inclusive, comprehensive and pragmatic. If it is validated in future research endeavours, it could be considered for wider use in South African forensic mental health settings.

Thematic Analysis of Interviews

Qualitative research and thematic analysis of interviews are particularly valuable strategies when considering potentially sensitive topics such as personal identity, gender roles, violent behaviour and mental illness. For violent women offenders with severe mental disorders, these techniques allow participants to reflect upon their unique experiences,

emotions and opinions, and encourages the telling of their stories, in a safe, non-judgemental space. As emphasized by Murray (2003), for many interview participants the process can translate into a sense of validation, empowerment and normalization of their otherwise difficult, and often harrowing, experiences. In so doing, these discussions also hold potentially significant therapeutic value in themselves. Mixed methods research allows conventional quantitative data to be enriched with individualised qualitative data, and provides an opportunity to improve understanding, not only of the role of mental illness in violent female offending, but also the broader psychosocial context in which these phenomena occur. Such insights are helpful for the rehabilitative and recovery process for these women, but also have important implications for attempts to reduce violent behaviour from recurring. Whilst generalization of the findings of the thematic analysis (in the statistical sense) is not necessarily possible with this type of qualitative methodology, the identification of key themes helps forensic mental health professionals understand the common perceptions, experiences and problems faced by patients under their care. The information obtained may be useful to clinicians in many ways e.g. in managing the treatment, recovery and rehabilitative process; facilitating empathy in health professionals; assisting with the establishment of rapport and building of trust between patients and clinicians; aiding in the identification and understanding of symptoms of distress and mental illness; setting of realistic treatment goals and the selection of appropriate therapeutic strategies to achieve these; supporting and empowering the women, as well as their significant others, in self-monitoring and managing of risk; and, ultimately, achieving sustained recovery by returning to their families and communities.

A discussion of the key thematic analysis outcomes following interviews of the sub-sample of violent women offenders with severe mental illness, housed as forensic in-patients

at Fort England Hospital, is undertaken below, with respect to issues related to the pre-offence background, context and consequences of the offence, and post-offence recovery process, respectively.

Before and During the Offence

All women expressed a strong investment in their pre-offence gender roles as caring and dedicated mothers, partners, family members and social beings, and contrasted with changes following the onset of severe mental ill-health, as well as the commission of violent offences associated with this. They expressed particular dismay in how they saw themselves when mentally ill, and in the negative perceptions of others in the aftermath of their offences. These themes are similar to those described by a number of other qualitative studies on mentally ill violent women offenders (McGrath, 1992; Resnick, 1969; Stanton and Simpson, 2006; Stanton et al., 2000; Stroud, 2008). It was, however, difficult to identify any specific, recurring pre-offence stressors or risk factors in the narratives of the women interviewed. Most women were seemingly committed care-givers, with little or no prior “warning” of any violent urges. Detailed recall of the violent event was incomplete in most instances, as was detailed expression of their inner experiences, feelings, and perceptions at the time. This may have been the result of the active psychopathology they experienced at the time, suppression of distressing memories, or volitional preference to avoid disclosing these personal details during the interviews. Nonetheless, most women were able to remember certain aspects of the day’s events and could describe their psychiatric symptoms, the context and circumstances which led to the offence, and their behaviour at the time in question. The language used by some interview participants, however, appeared to deflect agency by, for example, repeatedly referring to the commission of the offence in the third person. It was also the case, though, that most women acknowledged some degree of personal responsibility for their violent conduct, whilst at the

same time recognizing the role of mental illness in influencing their behaviour. This mixed attribution of responsibility seemed to facilitate not only acknowledgement of the primary role played by their mental ill-health illness in the commission of violent acts, but also their acceptance of the need to forgive themselves for their conduct and its tragic consequences. In so doing, women allowed themselves to more meaningfully and fully engage with forensic mental health care professionals and services in order to forge a path to recovery.

After the Offence

Despite the fact that most women displayed a degree of avoidance of thoughts or reminders of their prior violence, and that disclosure of details of subjective mental state and behaviour at the time of actual offence was generally patchy, most women were also remarkably self-critical, reflective and remorseful. Feelings of loneliness, isolation, anxiety, distress and depression were commonly reported immediately following the offence. Even once the symptoms of their mental illness had subsided, and despite the resilience displayed by many in the aftermath of the offence, their recollections of the offence remained persistently ego-dystonic and distressing. The majority of women interviewed expressed profound regret and guilt for the harm and distress their behaviour had caused, especially for the victims, partners and family members. These post-offence emotional responses are potentially important targets of psycho-therapeutic intervention during the forensic rehabilitation and recovery process. In cases in which close family members were the victims of their violence, women were particularly concerned about the safety of their surviving children, partners and extended family. Most expressed intense frustration and dismay at their inability to directly care for their children, partners and families as a result of their prolonged in-patient admission as State Patients to a secure forensic institution. This is consistent with the reports of a number of other researchers that many women who commit violent offences whilst mentally ill

continue to place, following the offence, much importance on their perceived gender roles, especially as mothers or partners responsible for the care of their loved ones, despite their own predicament and inability to fulfil these roles whilst interned in forensic institutions (Bartlett, 1994; 2007; Bartlett and Hassell, 2001; de Vogel & de Spa, 2019; de Vogel & Nicholls, 2016; de Vogel et al., 2016; Martin and Hesselbrock, 2001; Stanton and Sampson, 2002; Stanton et al., 2000; Stroud, 2008).

The psychopathology associated with severe mental disorders in violent female offenders is itself often associated with significant interruptions or distortions in self-identity, perception of others, interpretation of environmental cues, and in the capacity to fulfil important interpersonal, social, familial, and occupational roles. These themes were reflected, albeit to varying degrees, in the narratives of all the women interviewed, who also expressed the importance of renewal in their sense self as healthy and healed women, partners, mothers and family members. In so doing, they understood the importance of recovery from mental illness, and re-establishing both purpose and meaning for themselves and their significant others in the aftermath of their offences. Related to this, all women expressed relief and gratitude at receiving individualized forensic mental health care, albeit as involuntary State Patients within a secure forensic psychiatric institution. The predominant theme in this respect was the value placed on receiving mental health support, care and treatment in a therapeutic setting that was not perceived to be punitive, adversarial or judgemental, whilst also being safe and secure. This supports the findings of Shepherd et al. (2016) who emphasized that appropriate boundaries, safety and security within a forensic hospital environment were as necessary elements in the recovery process, as were empathic and supportive care and treatment. Most women welcomed the multi-disciplinary forensic mental health treatment programmes provided at Fort England Hospital as essential elements to their healing. A particularly important aspect of recovery was

their emphasis on re-establishing good relationships with those close to them, especially surviving children, partners and family members. The women attached much value to rebuilding personal and social support networks beyond the hospital environment, as well as adherence to mental health treatment programmes, prescribed medication and forensic legislative requirements. The support received in the immediate aftermath of the offence and subsequently (which came as a surprise and relief to many), from family members, the community and mental health care professionals alike, was also valued and appreciated. Most women also felt reassured and empowered by the clinical progress they had made since receiving forensic mental health care, and had some measure of insight into their diagnosed mental conditions. Most were also generally optimistic about the future and their respective roads to recovery, and their ultimate discharge from the institutional forensic mental health system in order to be reintegrated with their families and communities.

Whilst the South African women interviewed conveyed their experiences as State Patients within the forensic mental health system to be largely positive, this contrasts with the findings of Shepard et al. (2016), who conducted a systematic review of qualitative studies of personal recovery experiences within other forensic systems. These authors reported the majority of forensic patients (male and female) to have been frustrated and commonly devoid of hope, largely due to a lack of clarity about the length of their in-patient hospitalization and pathways out of institutional care. The experiences of women within the therapeutic framework of the forensic hospital is also in contrast to the experiences of these women in correctional centres prior to their admission to Fort England Hospital as State Patients. Their experiences of the prison system were universally reported to be distressing and intimidating, in which they felt particularly vulnerable and without access to the support and mental health care they required. The profound deficiencies in mental health service provision within the

South African prison system, despite the disproportionately high levels of mental illness within incarcerated populations, is widely documented (Artz et al., 2012; Haffejee et al., 2005; Luyt and Du Preez, 2010; Nagdee et al., 2018; 2019; Sukeri et al., 2016). As highlighted by Skeem et al. (2011), the provision of adequate and appropriate mental health services to offenders with mental disorders, and more pro-active advocacy in this regard, are crucial if reductions in female offending behaviour, recidivism and stigma are considered sufficiently important priorities by policy makers. Directly addressing the psychological distress experienced by these women, including psychotherapeutic attention to its antecedents (especially prior abuse experiences) and pro-active treatment of psychiatric symptoms, are crucial to improving offence-related issues such as insight, reality testing, cognitive processing, and impulse control. This focus on mental health in turn facilitates self-forgiveness, improves self-esteem, aids in recovery and rehabilitation, and ultimately mitigates re-offending risk. There is, in fact, very limited research on the issue of recidivism in violent female offenders with mental disorder. In one of the few studies on the issue, Stanton et al. (2000) emphasized that all participants interviewed in their study of filicidal women found the violence to be profoundly ego-dystonic once the acute symptoms of mental disorder had resolved. In other words, prior to the offence, most women have relatively little insight into their mental ill-health, nor of the potential risks conferred. Following the offence, the provision of empathic support, effective treatment and bolstering of supportive networks are particularly important to relieving symptoms, reducing distress, improving insight, optimising recovery and reducing risk.

Summary of Qualitative Outcomes

The narratives of the South African interview participants confirmed the importance of a set of complex, heterogeneous and interlinking personal, gender and mental health variables and how these contribute to offending pathways, with similar themes emerging from a

qualitative studies of violent women offenders with mental disorder conducted abroad (de Vogel & Nicholls, 2016; de Vogel et al., 2016; Karatzias et al., 2018; Martin and Hesselbrock, 2001; Stanton and Simpson, 2006; Stanton et al., 2000; Stroud, 2008; Stroud and Pritchard, 2001). The outcomes of the present thematic analysis also highlighted the importance of enhancing mental health recovery through specialised, focused and multi-faceted forensic health management. This approach includes the identification and management of important antecedents of violent offending, especially prior abuse experiences and substance misuse; re-establishing links with the personal support networks of these women; rebuilding a sense of self as a good mother, partner, family member and social being when not deflected by the symptoms and reality distortions of severe mental illness; acknowledging the role of mental disorder in violent behaviour in individual cases, and in so doing, off-setting the associated guilt and self-loathing in the aftermath of offences; and providing a safe, secure, supportive, empathic, multi-modal therapeutic environment to facilitate recovery; and prioritising the goal of ultimately reuniting these women with their dependent children, and reintegrating them into their families and communities.

Conclusion

The key conclusions of the present thesis are similar to those articulated by Hollin and Palmer (2006) in respect of this complex array of gendered criminogenic needs and risks. Firstly, there is some overlap in the profile of male and female offenders, especially for background, pre-offence factors such as socio-economic status, education, employment, housing situation and substance abuse. What is uncertain is whether these variables have the same aetiology and level of importance for men and women offenders respectively. Secondly, the assessment of these criminogenic needs, especially those related to linking mental health and offending behaviour, is important not only because it guides risk management, but also

facilitates the implementation of appropriate and adequate forensic mental health services to address those needs. Thirdly, the gendered context of many criminogenic needs cannot be ignored e.g. the fact that certain adverse life events, such as pre-offence abuse by intimate male partners, confers a disproportionate risk of violent offending these women. A lack of specific focus on gender issues, leads to incomplete understanding, inaccurate assessment and inappropriate management of women offenders, especially those living with mental illness. It is likely that historical adversity (static factors) have psychosocial sequelae that, in turn, influence subsequent mental health, behavioural and functional outcomes (dynamic factors). Hence, whilst issues such as gender, prior abuse and mental health problems of offenders may not necessarily be criminogenic in themselves, for many women they are serve as cumulative needs and risks that alter the threshold for offending, and their responses to its consequences.

Chapter Nine: Conclusions and Recommendations

This chapter provides an integrated synthesis of the key study outcomes, summary of conclusions and the final set of recommendations to have emerged from this thesis.

Conclusions

Most women offenders came from a background of socio-demographic adversity, and were typically relatively young (almost two-thirds were under 40 years of age), single, black South African mothers of dependent children, with poor educational and occupational attainment, unemployed at the time of arrest, and financially dependent on the state and/or on the extended family members with whom they resided prior to arrest. Whilst the vast majority of women (80%) were first-time offenders (with the few with prior convictions being mostly in relation to minor property-related crimes), the majority of index offences leading to court-ordered forensic evaluation were for violent offences against the person (61%), comprising non-homicidal violence in 31% and homicidal violence in 30% of cases respectively. Weapons were used to commit violent offences in the majority of cases, especially by inflicting serious penetrative injury with the use of a sharp object (not a single case of firearm violence was reported). Murder was the single most common index offence (26% of all cases), followed by assault with intent to do grievous bodily harm (21%) i.e. these two categories alone accounted for almost half of all offences. Violence against adults accounted for over two-thirds of all violent offences, with the vast majority of adult victims known to perpetrators (94%) particularly as intimate male partners, close family members and acquaintances/friends. Over half of all child victims of violence were less than one-year old when victimised (with half of these being less than one month old at the time) i.e. the risk of children falling victim to violence by women sampled was inversely proportional to the age of child victims. The majority of child

victims (88%), in fact, succumbed to lethal violence. The vast majority (94%) of child victims of violence were well known to the perpetrator (as was the case with adult victims), with most of these (81%) being the biological child/ren of the offenders. In addition, whilst a notable proportion (42%) of violence against children was attributable to severe psychopathology of perpetrators at the time of offence, this was less frequent than was the case in violent offences against adults (60%).

There were high pre-offence rates of mental illness (in three-quarters of all cases, with psychotic-spectrum disorders being the most common diagnostic category), substance abuse (with alcohol being the substance of choice in over 90% of women who reported substance abuse) and HIV-positivity (in almost one-quarter of cases) respectively. Disproportionately high numbers of women (one-quarter of cases) reported being victims of abuse themselves prior to arrest, with the perpetrators of abuse being known to the women in over 90% of cases, especially at the hands of intimate male partners (in almost 60% of cases of prior abuse). Whilst the prevailing mental state during the period of forensic evaluation was normal in a large proportion of women (39%), almost as many women (34%) were found to be actively psychotic during this time. There were high rates of severe mental disorder documented in psychiatric court reports at the conclusion of forensic evaluation: Over 90% of women were diagnosed with an Axis I and/or II disorder (whilst only 6% of reports reflected no clinical diagnosis at all); 42% had significant psychiatric comorbidity (i.e. a primary severe mental disorder co-occurring with at least one other Axis I, II and/or III disorder); psychotic disorders were diagnosed in one-quarter of cases (with the majority of these being schizophrenic), whilst mood disorders (depressive or bipolar) were diagnosed in less than 10% of women; and relatively low rates of substance-related disorders alone (6%) and personality disorders alone (5%) were present. There were also relatively high rates of Axis III medical conditions diagnosed (in

almost half of cases), with HIV infection being the single most common medical diagnosis (in over one-fifth of all women). Almost half of the women (48%) were deemed to be trial competent at the time of forensic evaluation, and 45% were declared to be criminally responsible for their offences. In respect of combining these forensic parameters, around 41% of women were reported to be both trial competent and criminally responsible, whilst almost half (48%) were found both trial incompetent and lacking criminal capacity. In line with these forensic outcomes, recommendations made to courts were for the law to take its course in over 40% of cases, and for diversion to mental health services for care, treatment and rehabilitation in the remainder. The latter included diversion to general mental health services in 24% of cases with non-violent index offences; and to specialized forensic mental health services in 36% of cases involving violent index offences, respectively.

A series of inferential statistical analyses were employed to systematically explore the functional relationships between numerous variables of research interest. Chi-squared analyses identified significant and specific associations between variables; and multivariate logistic regression modelling controlled for potential confounders, in order to determine the unique contributions of different predictor variables to specific outcomes, and to test the magnitude of these contributions, respectively. Four primary outcomes in respect of the socio-demographic, offence-related, clinical and forensic parameters were identified, which illuminated a number of potential links between mental disorder and offending behaviour in the women in the study. Firstly, women offenders with prior abuse experiences had significantly higher risk of committing subsequent violence themselves: They had greater than three times the odds of violent offending in general, and almost six times the odds of homicidal offending in particular, compared to women with no prior abuse. Secondly, homicidal offences were significantly more likely to have been perpetrated by women with no prior psychiatric history and no psychiatric

comorbidity. Thirdly, women who committed homicide had over eleven times the odds of targeting children as opposed to adults. Finally, children were significantly less likely to be the victims of violence by women above the age of 30 years and without psychiatric comorbidity respectively.

The qualitative thematic analysis of interviews similarly highlighted the complexity and heterogeneity of influential variables in the sub-sample of violent women with severe mental disorder, and the broader context within which their offending pathways were embedded. These include multiple, interacting criminogenic risks and needs relating, but not limited, to factors such as adverse life circumstances (especially pre-offence abuse experiences); interpersonal conflict, social and family dysfunction; socio-economic impoverishment; unemployment; single parenthood; substance misuse; and persistent psychological distress and mental ill-health. Whilst none of these background factors were considered, in themselves, as necessarily sufficient nor causal for future violent offending, they are postulated to interact with other criminogenic risks in the profiles of the individuals concerned. The exact pathways linking the progression from social adversity, prior abuse, psychological distress or mental illness to offending behaviour, however, remain uncertain. Nonetheless, a number of important recurring issues emerged from the thematic analysis in this regard, including: (a) the centrality of gendered social and family roles; (b) the importance women attached to their personal roles as mother, partner and carer of those close to them in forging self-identity; (c) the complex relationship between self-image and behaviour on the one hand, and mental ill-health on the other; (d) variation in perceptions regarding the connections between gender, mental illness and offending behaviour; (e) the broader, gendered psychosocial context of violent offending; and (f) the stark contrast in their experiences and perceptions of a relatively adversarial and

punitive criminal justice and correctional services system on the one hand, and a more empathic, supportive and therapeutic forensic mental health system on the other respectively.

Recommendations

This study has highlighted the complexity of the relationship between a trio of key factors which impact on forensic mental health in women offenders in the Eastern Cape: (a) offending behaviour, influenced by variables such as socio-economic adversity, low educational attainment, unemployment, prior abuse experiences, interpersonal conflict, home circumstances, etc.; (b) mental health problems, increased by backgrounds of prior abuse, poor social and family support systems, pre-offence psychological distress, being a single mother of dependent children, alcohol abuse, etc.); and (c) individual and contextual factors, such as resilience, personality structure, attitudes, motivation, social judgement, relationship with significant others, adherence to treatment programmes, etc.. All these are embedded within a gendered context, and individual factors potentially exacerbate, mitigate or otherwise moderate both the associated risk and nature of the first two factors. In other words, the uniquely personal traits of individual women, as well as their gendered psychosocial and environmental context, are inextricably related to their vulnerability to psychological distress and mental ill-health, as well as their risk of engaging in offending behaviour. All these areas need to be proactively engaged by criminal justice, mental health, social and family systems for progress to be made in assisting women offenders with mental illness in achieving, and sustaining, recovery. The broad goals of forensic mental health management of these women, especially those with severe mental disorder and violent backgrounds, would hence include but not be limited to: (a) active and focused risk management, especially in regards to prevention of further offending (especially toward young children, partners and close family members); (b) identification and management of individual criminogenic factors and needs; (c) comprehensive screening for

mental health problems and disorder when women enter the criminal justice system in the first instance; (d) provision of gender-focused, appropriate and adequate biopsychosocial support and intervention for vulnerable, distressed and/or mentally ill women at every stage; (e) optimizing early engagement with forensic mental health care systems in order to optimize recovery and prognosis; and (f) developing and implementing suitable gender-focused policies in managing women offenders within the various systems they come into contact with following the offence. Specific recommendations that emerge from the findings of the present study will initially be considered in terms of the priorities related to social and family support (including mother/child care) and forensic mental health respectively. This will be followed by recommendations regarding violent women offenders in particular, prior to suggestions on future research directions in this field. In making these recommendations, it is acknowledged that resource-constraints, skills deficits and poor leadership (governmental or otherwise) will restrict the realization of many of these recommendations. Nonetheless, the recommendations outlined could serve as useful references in the identification of priorities, development of policies and implementation of strategic plans to meet the needs of women offenders with mental health problems.

Family, Social and Community Support

Many women offenders in the Eastern Cape and South Africa come from backgrounds characterized by a mixture of inherent, interacting and contextual criminogenic factors e.g. extreme socio-economic distress; poor educational attainment and occupational opportunities; dysfunctional family, social and community systems in which domestic violence, substance abuse and violent crime are rife; and poorly resourced, disadvantaged and under-developed areas. Combined with being entrenched within a largely conservative and patriarchal socio-cultural milieu, their daily life experiences render many women vulnerable to both mental

health problems and engaging in offending behaviour. Most women offenders also have dependent children at the time of their arrest (84% of women in the study sample); this exacerbates the impact of their incarceration in respect of the difficulty, or in most cases, the impossibility, of adequately meeting the associated child and maternal care needs (especially for those who are pregnant, breastfeeding or have very young dependent children at the time of arrest). This is particularly pertinent in resource-poor settings such as South Africa in which alternative carers are often unavailable or unaffordable, or in which the domestic situation may not be conducive to the safety and care of vulnerable children left behind following the arrest of their mothers. In many countries abroad, there have been attempts at meeting some of these complex mother-child care needs via the establishment of mother-baby units (MBU's) in prison and forensic mental health facilities (Aynsley-Green, 2008; Caddle and Eaton, 1997; Corston and Britain, 2007). The South African prison system is grossly under-resourced in this respect: There are only 22 prisons in the country that cater for mothers with children under 2 years of age, and none that cater for mothers with older children (Judicial Inspectorate for Correctional Services, 2008-2016). Furthermore, no specific provision is currently made to cater for maternal and child care needs within any of the forensic psychiatric hospitals in the country, despite the admission of ever-increasing numbers of female forensic patients who are also mothers of dependent children (Nagdee et al., 2019). A few priority recommendations therefore emerge in respect of strengthening of social and family support systems, including mother and child care, for South African women offenders, especially those with mental health problems:

- (a) An effective, coordinated, comprehensive and sustained drive is required to address the pervasive gender-based discrimination and violence toward women and children in South Africa. Preventative risk management and intervention systems are urgently required, and addressing domestic abuse and violence should be a national priority.

- (b) Development of adequate, appropriate and progressive family, social and mental health support services are required for women offenders (or ex-offenders) who are not incarcerated or institutionalized, especially those from abusive backgrounds living in impoverished provinces such as the Eastern Cape. Examples of these include dedicated community-based education and support groups; substance-abuse services; gender-sensitive trauma support services; housing support and safe-homes for abused women and children; employment and vocational workshops and services; improvements in social care grants; etc. Such community-based support systems are particularly important in mitigating against the extreme psychosocial distress invariably experienced by vulnerable women and their families.
- (c) Expansion of Mother and Baby Units (MBU's) within South African correctional facilities is required, both in terms of numbers of operational units and extending the age of children who can be accommodated within these. In addition, the establishment of MBU's within forensic mental health institutions for female patients who are pregnant, breastfeeding and/or who have dependent children of any age is also required. The mental health morbidity of both mothers and their children in these settings is known to be complex and disproportionately high, especially with respect to trauma and stressor-related, substance-related and depressive disorders in mothers; and psychological and neurodevelopmental problems in children, respectively. This emphasizes the need for these MBU's to be managed by specialized teams of mental health professionals as far as is feasible.

Gender-focused Mental Health Care

Whilst the majority of people, of either gender, with mental illness are not prone to violence, and the minority of violent offences are causally related to psychopathology, mental health issues may render some women more vulnerable to engaging in offending behaviour.

Mental health also plays an important role in how women cope following the commission of offences, and their subsequent arrest and incarceration, as well as how women are managed by the criminal justice and correctional systems respectively. Women offenders commonly experience high levels of distress in the ensuing post-offence process, including upon arrest, especially mothers who are separated from their dependent children; upon entry into poorly resourced, over-crowded, male-dominated police holding cells or prisons; during their often lengthy incarceration as remand detainees; through the course of the trial, during the period of forensic evaluation in forensic psychiatric hospitals; and following the conclusion of the criminal justice process (whether acquitted, convicted or referred to forensic mental health services). Many women experience significant mental health problems during these times, either for the first time or as exacerbations of pre-offence psychological or psychiatric problems (de Vogel & Nicholls, 2016; Henderson et al., 1998; Heney and Kristiansen, 1998; Hurley and Dunne, 1991). Historically, even in developed and well-resourced countries, prison mental health services for women have been inadequate and/or inappropriate (de Vogel & Nicholls, 2016; DeHart et al., 2014; Karatzias et al., 2018; Maden et al., 1994a; 1994b; Martin and Hesselbrock, 2001; Teplin et al., 1997). This is a particular problem in South Africa, where sufficiently gender-focused mental health services in both prisons and the health sector are rudimentary, and in many settings virtually non-existent (Artz et al., 2012; Haffejee et al., 2005; Luyt and du Preez, 2010; Nagdee et al., 2019; Sukeri et al., 2016). A number of areas therefore require urgent attention with respect to improving gender-focused mental health care in South Africa:

- (a) Raising awareness and improving insight of health professionals (including those working in mental health services), patients and their carers around issues of gender-focused mental health are required. Educational drives should be extended to the public, court and prison personnel, police, politicians and policy-makers. Public-education

campaigns in this regard should be coordinated and jointly driven by mental health clinicians, psychiatric institutions, state-sector governmental departments, professional bodies, and community-based non-governmental organizations alike. Mental health professionals in particular have a responsibility in taking a more active role in counteracting stigma related to mental illness in women, and its relationship to offending behaviour.

- (b) Accessible, affordable, integrated and gender-focused community-based mental health services are necessary for women in the general population, women released from prison, and female psychiatric patients who are engaged with mental health services (both generic and forensic). Improvements in community-based forensic mental health services, monitoring and support are needed for female forensic patients with severe mental disorders who are granted extended leave of absence or who have been conditionally discharged to the community (especially in light of the fact that re-offending, morbidity and mortality rates are known to be disproportionately high in these populations). This is particularly important in historically disadvantaged, impoverished, and rural areas (i.e. most of the Eastern Cape) where the risks and needs are greatest. Ongoing skills training of community-based health personnel (especially clinic nursing staff) in the early detection of psychological distress, and signs of early relapse of pre-existing mental disorders in women, needs to be bolstered. Related to this is the importance of facilitating family and social support for women with mental illness, and for its maintenance throughout the recovery period. Ultimately, unconditional discharge from forensic institutional care and a return to homes and communities should be the goal for all forensic patients (contingent upon clinical context, individual circumstances and appropriate risk assessment), but this is a particularly priority for those women with young, dependent children i.e. the majority of female forensic patients.

- (c) More gender-appropriate in-patient mental health care services for women (both generic and forensic) should be established or expanded upon. These should focus on the specific mental health care needs of women, in which their backgrounds and life experiences, as women, informs both the design and delivery of services, as opposed to the universal application of traditional systems of care designed by and for men. This would include applying improved gender focus on areas such as ensuring ease of service access, accurate early detection and intervention systems, assertive outreach programmes, and enlightened mental health treatment programmes for all girls (adolescent and younger) and adult women who need them, but especially those with backgrounds of family dysfunction, domestic violence and substance-related problems. In the South African context, there should be particular clinical focus on addressing associated issues such as abuse and gender-based violence (especially at the hands of intimate male partners and close family members); HIV-infection; alcohol abuse; building healthy inter-personal and family relationships; financial and occupational empowerment; and enhancing the coping skills, resilience and self-reliance of women offenders. Mental health services would hence need to improve collaboration with other state and private-sector agencies in order to address the gender-specific structural, social, educational, and occupational disadvantages girls and women with mental ill-health face in South African society. In this regard, Partridge (2004) emphasized developing innovative, multimodal, multidisciplinary, holistic, integrated and longitudinal models of care for women that focus on skills and capability enhancement, as opposed to the traditional focus on problem reduction and harm avoidance.
- (d) Prison mental health services in general, but for women offenders in particular, should be established in the many prisons where they do not yet exist, including throughout the Eastern Cape, or prioritised where they are deficient (Sukeri et al., 2016). Richie et al.

(2001) suggested a four-point strategy for a women-specific mental health prison treatment programme: (a) comprehensive programmes to meet the multiple needs of women offenders in an integrated manner; (b) community development, linkages and social change strategies to incorporate and implement relevant policies; (c) empowerment and awareness-raising efforts amongst women offenders to develop a sense of hope, a future-looking orientation, and help with taking responsibility for their lives; and (d) community-based mentoring and care to help women offenders to sustain their own recovery. This, again, entails a shift away from the traditional focus on risk and crisis management, often based on rigid, punitive programmes developed for men, toward more gender-appropriate mental health care, support and rehabilitation for incarcerated women.

- (e) Gender-appropriate psychotherapeutic support that prioritise issues pertinent to women offenders are equally essential. In the South African context, these would entail mental health professionals turning specific therapeutic focus onto issues such as: (a) dealing with the distress of prior abuse, trauma and violence; (b) remediation of the long-term psychological effects of incarceration; (c) identification and meeting maternal and child care needs; addressing substance misuse problems (especially the harmful personal, family and social effects of alcohol); (d) building healthy interpersonal relationships with significant others (especially children, intimate partners and close family members); (e) processing commonly experienced feelings such as guilt, poor self-esteem, self-loathing, hopelessness, worthlessness, anxiety and depression; (f) managing deliberate self-harm, and suicidal ideation, intent or behaviour; (g) support in acknowledging the role of mental disorder in offending behaviour; (h) improving insight into individual psychiatric diagnoses in order to engage with the requisite treatment; (i) addressing HIV and related psychosocial issues; (j) facilitating family and social acceptance and integration; (k)

identifying and confronting stigma; (l) actively promoting recovery and regaining of active maternal, familial and social roles; (m) facilitating and maximizing support from community support networks, and so forth. Progress will naturally depend on improving the availability of adequately trained, suitably skilled, empathic and gender-aware mental health professionals, especially counselling and clinical psychologists.

- (f) Sensitivity to gender issues should also be emphasized in the provision of other modalities of therapeutic intervention, including the prescription of psychotropic and other medications (e.g. anti-retroviral medication and contraception), occupational therapy, psychiatric nursing care, and social work interventions. A gender-focused, multimodal and multidisciplinary forensic mental health care approach would improve pathways to sustained recovery, especially if the goals are community-based rehabilitation, and ultimately, full and sustained reintegration into domestic, family and social life.
- (g) Better linkages and collaboration between criminal justice, correctional, mental health, policing and social services are required. This includes improvements in integration of information, monitoring and treatment systems within and across these platforms. In addition, systematic and co-ordinated multi-agency review of criminal justice, health and social policies is necessary, with a view to improving the gender-focus of policies related to mental illness and substance abuse amongst female offenders. Alternatives to the long-term incarceration of mentally ill women offenders in locked and closed forensic units, away from their dependent children and families, should be sought. This is especially important for the majority of women offenders who are at low risk of repeat offending, but at high risk of persistent psychological distress, mental disorder and/or substance abuse as a result of prolonged removal from their primary support systems.

- (h) It is equally important to hold the South African government, as well as all relevant state-sector agencies and departments, accountable to fulfilling obligations regarding the provision of adequate, appropriate and gender-focused mental health services for women, irrespective of their offending backgrounds, as specified in the Constitution of the Republic of South Africa (1996), the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) (United Nations, 2010), and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) (United Nations, 2015) respectively.

Violent Women Offenders

Drawing on both the research evidence from studies abroad and the present South African study, a number of further strategies require consideration with respect to violent women offenders, especially those with severe mental disorder. These include:

- (a) Educational campaigns are required to guide parents, especially first-time and single mothers, on preparing for the significant psychosocial stressors of child care. Parental skills coaching programmes should be widely available, accessible and affordable to all young mothers, especially those with the added burden of mental ill-health. There should be a specific emphasis on maternal mental health, and the harmful effects of mental ill-health on neonates and infants, who may be especially vulnerable to associated maternal neglect, abuse or violence (albeit this applying to the minority of cases). Investment in widespread public education, social activism and state-driven programmes are required to promote a socio-cultural climate which nurtures girls and women, and which strives to reduce stigma, patriarchy, chauvinism, misogyny and gender-based violence in South African society.

- (b) Assertive outreach and home visit programmes should be introduced for women identified by health or social welfare workers as being vulnerable to being abused (especially by intimate male partners and close family members), those at risk of severe substance abuse or severe mental disorder, as well those with a history of violent conduct. Individuals and families identified as suffering from undue psychological distress as a result of these factors require more intensive mental health, social and respite services. Once high-risk women and families are identified, multi-disciplinary cooperation and collaborative interventions are essential, with an aim to holistically manage immediate risks (e.g. via rapid response social care, mental health and police services), prevent further escalation of identified risks, and to offer priority, crisis-orientated mental health, social and other support as required.
- (c) The expansion of forensic mental health services for violent women with severe mental disorders (especially psychotic, mood, substance-related, peri-partum and HIV-related mental disorders) is required. Such forensic services should also, however, strive to develop and implement recovery-based models of care, as opposed to conventional paternalistic approaches which are primarily risk-driven. This requires forensic facility infrastructure being improved in the first instance, but with increasing emphasis on improved relational support by way of human resource investment, as opposed to the current focus on physical security, which is based on models of care for male forensic populations. Risk management systems hence need to be modified to be more appropriate and sensitive to women's mental health needs, with integration of services to meet these needs. Units for female forensic patients should also focus on improvements to the privacy and safety of women e.g. by minimizing intra-institutional exposure of vulnerable women to male forensic patients (many of whom have violent histories, including sexual offending) and male staff (especially non-clinical staff such as security

personnel). This is necessary to minimize gender-based bullying, harassment, intimidation, abuse and assault, and which is particularly damaging to the many forensic women who have experienced prior trauma, and those whose severe mental ill-health heightens their vulnerability. There is a credible argument to be made for the establishment of women-only wards in forensic mental health facilities, with female patients and female staff within institutional spaces that have reduced physical security infrastructure in favour of more gender-sensitive, nurturing, supportive, child- and family-friendly approaches to care. This would be another significant departure from the current male-dominated and male-focused models of care, and will require more permissive, innovative, flexible, creative and progressive paradigms, policies and practices than those currently in place.

- (d) Psychotherapeutic interventions should be offered within forensic mental health services that facilitate and support to women in understanding and processing the role played by mental ill-health in their violent conduct. In cases of severe violence (especially aggravated assault, attempted murder or murder), a crucial focus of therapeutic attention would be rebuilding these women's sense of self-worth, especially as mothers and carers, when not deflected by the distress, disturbance and reality distortions of severe mental illness. Developing insight into the relationship between psychopathology and violent conduct is an important part of the rehabilitative and recovery process. In addition, proactive management of psychological issues around guilt, self-hatred, depression and suicidality that many violent women offenders experience is necessary, in order to help patients more fully engage with treatment programmes. Similarly, assistance should be offered in regaining of healthy gender roles that individual women may identify as being particularly important to their recovery. Related to this is facilitation of support from personal networks, and the promotion of empathy, forgiveness, reconciliation,

acceptance and re-integration of the woman offender, wherever appropriate and possible, into the family, community and society to which she belongs.

Future Research

Whilst there has been growing interest in forensic mental health research in South African women offenders, there are a number of areas which invite further study in this field:

- (a) Further research on the mental health issues of women offenders in other provinces of South Africa, other African countries, and other developing countries, respectively is required, especially in order to compare these outcomes to those of the current study. More detailed understandings of the psychosocial context of female offending, and clarification of the specific role of prior abuse exposure, substance abuse and mental ill-health in offending pathways in these under-developed and impoverished settings are needed. Such an expanded research endeavour is underway in South Africa via an ongoing collaborative, multi-site, national forensic mental health research project on women offenders, the initial findings of which were recently published (Nagdee et al., 2019). This project also aims to explore more fully the forensic mental health profile of male offenders in South African forensic facilities, in order to provide more meaningful and robust gender-based comparisons.
- (b) The specific antecedents to female offending in developing countries, and the broader psychosocial criminogenic needs associated with these, should be another focus of future research. This would contribute to more refined understandings of, for example, criminogenic factors and needs in young girls, female adolescents and young adult women that may be amenable to early, preventive interventions in order to minimize the risk of offending later in life.

- (c) More extensive and comprehensive qualitative research on women offenders, especially women with mental illness, will expand appreciation of their uniquely personal attitudes, opinions, feelings, motivations, and lived experiences. In so doing, a more holistic understanding of these women will be gained, potentially offering further insights into preventive strategies regarding violent female offending in particular. In turn, more effective, gender-focused therapeutic and rehabilitative approaches for these women may be planned and implemented in due course.
- (d) Further exploration of the pathways of entry, thoroughfare and exit of women offenders through the criminal justice and forensic mental health systems, and policies guiding the management of women within these systems are required. There is, for example, insufficient evidence favouring the efficacy of any particular forensic mental health service framework or treatment model for women in particular. Further research is required to develop validated risk and needs assessment protocols and policies for female offenders, especially violent women with mental health problems, in order to construct more effective models of forensic care. Clarification of these pathways would assist in understanding the critical interactions between early adversity, psychological stressors, mental illness and subsequent violence. Whilst dedicated, specialised, evidence-based, gender-focused forensic mental health services for women offenders have emerged in a few developed, Western countries, such services are still not available for the majority of women across the world, including South Africa. Further research evidence on the forensic mental health of women offenders from developing countries would support and promote the importance of establishing such services.

In conclusion, whilst women remain a small minority of defendants presenting to the criminal justice system, there have been fluctuations and an increase in their offending and

conviction rates in recent decades. It has been argued that the nature and context of mental health problems faced by women offenders in particular present a higher order of complexity and interventional challenge, in comparison to men. This is partly, but no less significantly, related to the numerous gender issues faced by many women offenders, with many of these exacerbated in developing, resource-poor settings such as South Africa. Potentially important gender-related issues for women offenders with mental ill-health include physiological factors (e.g. the influence of hormonal cycles and fluctuations during peri-partum and post-menopausal periods); social and family factors (e.g. having dependent children, abusive partners, adverse family relationships and dynamics, financial distress, occupational adversity, cultural influences, etc.); psychological factors (e.g. related to traumatic abuse experiences, gendered power dynamics, socio-economic marginalization, individual personality structure, etc.); psychiatric factors (e.g. disproportionate vulnerability to substance abuse and severe forms of mental disorder); and broader systemic issues (e.g. widespread and persistent patriarchal attitudes and chauvinistic practices entrenched in most systems and societies) respectively. Ultimately, a full understanding of the specific role and impact of such multiple, complex and inter-related variables on individual women, their vulnerability to mental ill-health, and on their offending pathways, remains elusive. Nonetheless, these factors (whether independently, in combination, or cumulatively) render many women more vulnerable to both mental ill-health and engaging in offending behaviour (especially of a violent nature), though this thesis has demonstrated that the relationship between these outcomes is anything but simple. Much remains unknown about the offending pathways of women with the lived experience of mental illness, especially in developing countries such as South Africa. Nonetheless, there is sufficient information, including the contributions and recommendations of this thesis, to guide significant improvements to the detection, management and care of such women who find themselves in the criminal justice and forensic mental health systems.

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Appendices

Appendix 1: Data collection sheet

Socio-demographic data

1. Study ID number																		
2. DOB (if available)																		
3. Year of evaluation																		
4. Duration of evaluation	1			2			3			4								
	< 15 days			15-30 days			30-60 days			> 60 days								
5. Age (at time of evaluation) years	0		1		2		3		4		5		6					
	Unknown		< 20 years		20-30		30-40		40-50		50-60		>60					
6. Home language	1	2		3	4	5	6		7	8	9	10	11	12				
	Afrikaans	English		IsiNdebele	IsiXhosa	IsiZulu	SePedi		SeSotho	SeTswana	SiSwati	TshiVenda	XiTsonga	Other:				
7. Race	0			1			2			3			4			5		
	Unknown			Black African			White			Coloured			Indian			Other:		
8. Referral province	1	2		3		4		5		6		7		8		9		
	EC	Free State		Gauteng		KZN		Limpopo		Mpumalanga		NW		NC		WC		
9. Marital status	0	1		2		3			3		4			5				
	Unknown	Single		Married		Common-law partner			Divorced		Separated			Widow				
10. Para	0			1		2		3		4			>4					
11. No. of children alive (if applicable)	0			1			2			3			>3					
12. Highest level of education	0		1		2			3		4		5		6				
	Unknown		No formal education		Special education			< Grade 8		Grade 8 – 12		Diploma		Degree				
13. Primary source of income (prior to arrest; can be > 1)	0			1			2			3			4					
	Unknown			Employment			Social grant			Family			Other (specify)					
14. Occupation	0	1	2		3		4		5		6		7		8			

(prior to arrest; can be > 1)	Unknown	Unemployed	Scholar /student	Housewife	Administrative	Artisan	Unskilled	Professional	Other:
15. Living arrangements (prior to arrest; can be > 1)	0	1	2	3	4	5	6	7	
	Unknown	Parents	Husband / life-partner	Children	Other family members	Alone	Non-family	Other:	

Offence-related data

16. Index offence(s) Modified Snyman's Classification of crimes against: <ul style="list-style-type: none"> * The State and Justice (1-10) * The Community <ul style="list-style-type: none"> - Sexual crimes (11-23) - Family (24-25) - Public welfare (26 – 33) * A Person <ul style="list-style-type: none"> - Life (34-37) - Bodily integrity (38-41) - Dignity and reputation (42) - Freedom of movement (43) * Property <ul style="list-style-type: none"> - Appropriation (44-47) - Fraud etc (48-50) - Damage to property (51-54) 	1. High treason	6. Perjury and related crimes	12. Compelled rape	17. Displaying child pornography	22. Sexual offences against children	27. Extortion	32. Public indecency	37. Exposing an infant	42. <i>Crimen iniuria</i> / criminal defamation	47. Receiving or possession of stolen property	52. Arson
	2. Sedition	8. Conflicting statements under oath / false affidavit	13. Sexual assault	18. Engaging sexual services for reward	23. Sexual offences against mentally disabled	28. Drug offences	33. Violating a grave or corpse	38. Assault	43. Kidnapping	48. Fraud	53. Housebreaking with intent and related crimes
	3. Public violence	9. Escape from custody	14. Compelled sexual assault / self-sexual assault	19. Incest	24. Bigamy	29. Unlawful possession of firearm	34. Murder	39. Assault with intent to do GBH	44. Theft	49. Forgery and uttering	54. Trespass
	4. Contempt of court	10. Obstructing police	15. Compelling another to watch sexual acts	20. Bestiality	25. Common-law abduction	30. Concealment of birth	35. Culpable homicide	40. Intimidation	45. Removal of property for use	50. Theft by false pretences	55. Other (specify):

	5. Defeating/ obstructing justice	11. Rape	16. Exposing genitalia, anus or breasts	21. Sexual act with a corpse	26. Corruption	31. Participating in criminal gang activities	36. Administering poison / noxious substance	41. Pointing a firearm	46. Robbery	51. Malicious injury to property	
17. Court referral documentation	1 Prosecutors report		2 Charge sheet (J15)		3 Criminal record (SAP69)		4 Witness/warning statement(s)		5 Social report		6 Clinical report (s)
	18. Past criminal convictions (if yes, specify)					1 Yes:			2 No		
19. Reason(s) for referral	1 Epilepsy	2 Head Injury	3 Mental Retardation	4 Substance- related	5 Other psychiatric history		6 Behaviour in court	7 Unable to consult	8 Circumstances of offence	9 Unspecified	10 Other:
	20 – 26: violent offenders: adult victim(s) (as applicable)										
20. Relationship to victim	0 Unknown		1 Partner		2 Parent		3 Other relative		4 Acquaintance/friend		5 Stranger
	21. Criminal record of victim				0 Unknown			1 Yes (specify):		2 No	
22. Psychiatric history of victim	0 Unknown				1 Yes (specify):			2 No			
	23. Substance-use history of victim				0 Unknown			1 Yes (specify):		2 No	
24. History of victim threatening accused	0 Unknown				1 Yes (specify):			2 No			
	25. Presence of Protection Order				0			1		2	

(by accused against victim)	Unknown		Yes (specify):			No	
26. Likely motive(s) for offence (comment further if necessary)	0	1	2	3	4		
	Unknown	Retaliation/revenge	Self-defence	Psychopathology of accused (e.g. delusions)		Other (specify):	
27 – 29: violent offenders: child victim(s) (as applicable):							
27. Relationship to victim	0	1	2	3	4	5	
	Unknown	Own child	Step-child	Child of relative	Child of acquaintance/friend	Stranger	
28. Age and gender of child (if known)	Age:			Gender:			
29. Likely motive(s) for offence (from d'Orban (1979); comment further if necessary)	0	1	2	3	4	5	6
	Unknown	Impulsive (response to 'provocation' by child)	Retaliation/revenge (secondary to interpersonal conflict with partner)	Unwanted child (deliberate acts or neglect)	Psychopathology of accused (e.g. delusions)	Mercy killing	Other (specify):
30. Narrative summary of facts of case (as per police docket / court report; attach charge-sheet (J15))							
31. Narrative summary of version of offence (as per defendant)							

32. Defendant's version of offence (category)	1	2	3	4	5
	Denial	Admits to offence and consistent with docket version	Admits to offence but different to docket version	Amnesia	Other:

Clinical data

33. Prior mental health history (if yes, specify)	0		1			2			
	Unknown		Yes:			No			
34. Prior MH treatment (if applicable)	0	1	2			3	4		
	Unknown	Untreated	Mental health professional			Traditional healer		Other:	
35. Prior MH diagnosis/es (if applicable/available)									
36. Family MH history (if yes, specify)	0		1			2			
	Unknown		Yes:			No			
37. Medical history (if yes, specify)	0		1			2			
	Unknown		Yes:			No			
38. Substances use history 39. (can be >1)	0	1	2	3	4	5	6	7	8
	Unknown	None	Alcohol	Dagga	Mandrax	Tik	Over-the-counter:	Prescription:	Other:
40. History of previous abuse (of defendant)	0		1					2	
	Unknown		During childhood (< 18 years of age)					During adulthood (>18 years of age)	

41. Perpetrator of previous abuse	0	1	2	3	4	5	6	7	8	9	
	Unknown	Father	Mother	Husband/Life partner	Boyfriend	Friend	Other family member	Family friend	Stranger	Other:	
42. (of defendant as victim)											
43. Type of previous abuse (of defendant as victim)	0	1	2	3	4						
	Unknown	Physical	Emotional	Sexual	Other:						
44. Significant psychopathology / symptoms (can be >1)	0			1		2		3			
	None			At time of offence		On admission		During observation period			
45. Prevailing mental state at time of offence (can be >1)	1	2	3	4	5	6	7	8	9		
	Normal	Psychosis	Mania	Depression	Delirium	Dementia	MR / ID	Substance intoxication	Other (specify):		
46. Prevailing mental state at time of observation (can be >1)	1	2	3	4	5	6	7	8	9		
	Normal	Psychosis	Mania	Depression	Delirium	Dementia	MR / ID	Malingering	Other (specify):		
47. Abnormal medical investigations (if applicable)	0	1	2	3	4	5	6	7	8	9	10
	None	FBC	UandE	SYPHILIS	LFT	ESR	HIV	URINE THC	EEG	RADIOLOGY	OTHER:
48. Abnormal psychological investigations (if applicable)	0		1		2		3		4		5
	None		Intelligence:		Personality:		Neuropsychological:		Projective:		Other:

49. Forensic social worker report (if available; pertinent findings)	
50. Forensic OT report (if available; pertinent findings)	

Forensic data

51. Clinical diagnosis/es (as reflected on final court report)	Axis I		Axis II		Axis III		
52. Trial competence / fitness	1		2		3		
	Fit		Not fit		Fit with assistance (specify):		
53. Criminal capacity	1	2	3	4	5	6	
	Full capacity	Diminished (able to appreciate wrongfulness but ability to act in accordance diminished)	Unable to appreciate wrongfulness	Able to appreciate wrongfulness, but unable to act in accordance	Other 'non-pathological' factors present (specify):	Insufficient information to comment	
54. Recommendations	1.		2.		3.		4.
	Law to take course		'Chapter V' of MHCA		State Patient		Insufficient information to comment
55. Any other comments							

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Appendix 2: Interview participant information leaflet, capacity to consent and informed consent form

STUDY TITLE: The forensic mental health profile of female offenders in the Eastern Cape, South Africa

PHD INVESTIGATOR: Dr. M. Nagdee

SUPERVISOR: Prof. C. Young

INSTITUTION: Rhodes University and Fort England Hospital, Grahamstown, Eastern Cape

Introduction

Hello, I am a Forensic Psychiatrist and Clinical Head at Fort England Hospital, and a PhD candidate in the Department of Psychology at Rhodes University, Makhanda (Grahamstown). I am doing a research study and would like to invite you to participate in it. Before consenting to take part, please read this leaflet carefully which explains: what the study is about; why it is being done; the procedures that are being used; the benefits and potential risks; as well as your rights as a study participant, including your right to withdraw from the study at any time. You should fully understand what participation in the study involves before agreeing to participate.

Purpose of the study

You have been accused of committing a violent offence, and have previously been referred by the court to Fort England Hospital for a forensic evaluation of your mental health. The court

agreed with the conclusions of that evaluation which concluded that, due to your mental health problems, you should be referred to forensic mental health services for care and treatment. The aim of this study is to learn more about women in your situation. I wish to explore, together with you, your personal, social, cultural and mental health background, and your views and experiences associated with the offence(s) which you are accused of having committed, and the changes in your life this has brought about. This will give me a better understanding of you as an individual, your particular circumstances and context, your unique emotional and psychological experiences of these issues, and your opinion on these and related issues.

Procedures

If you do wish to participate, then the next steps will be as follows: (a) I will first confirm that you are able to consent to participation in this study; if so, (b) I will then ask you to grant informed, written consent to participate; and (c) I will arrange at least one personal interview with you (or more if needs be) to talk about the issues outlined in the section above (the purpose of the study). The interview will be conducted in the language of your choice, with the assistance of a translator if needs be. The interview will not last longer than 90 minutes, with a break every 30 minutes (or more often if you would prefer). In order for me to be able to listen to you attentively, without being distracted by having to write things down, and to be as accurate as possible in my assessment, I will also ask for your consent to allow me to voice-record the interview(s), and for transcriptions of the interviews to be made to assist me in my study. I will guarantee your full anonymity and confidentiality at all times, both during and after the study. If a translator is required, s/he will also be a qualified mental health professional, and will have signed an oath of confidentiality. Voice recordings and transcriptions will be kept strictly confidential and secure at all times, both during and after the study.

Potential risks and benefits

I fully appreciate the sensitivity of the issues under consideration. I wish to reassure you that there are no significant foreseeable risks attached to this study. Should you feel distressed or overwhelmed about your participation at any point prior to, during or after the interview, I will, with your permission, communicate with your clinical team to arrange any counselling, psycho-therapeutic support, medication or any other intervention that may be necessary. Your participation will provide you with the opportunity to reflect on your individual background, context, and subjective experiences in a safe, supportive and empathic space. Your feelings and opinions will be respectfully considered and explored. The interview may also identify previously unrecognized care needs or issues that may be a useful focus of attention for the clinical team caring for you. Your participation would help us to develop a better understanding of the psychosocial background, specific context, possible motives and emotional experiences of women who are accused of violent offences, especially in South Africa. This may assist in developing program's for helping women offenders with mental health problems to cope with the emotional consequences of their offences, or to develop appropriate and effective models of their care, treatment and/or rehabilitation. It may also help in designing strategies for reducing or preventing such offences in the future.

Rights as a participant in the study:

Your participation is entirely voluntary. If you decide to take part, you are still free to change your mind and withdraw your consent and participation in the study at any time, without needing to give a reason. This will not affect the type or standard of health care that you receive at Fort England Hospital or any other health service, nor will it affect the terms and duration of your care, treatment or rehabilitation as a forensic patient. The results of this study will be

made available should you so wish (we will need a written request from you for this). All information and results will be strictly anonymous and confidential at all times, and if any data is published your name will not be used, nor will any individual personal information be divulged. There will be no costs to you from the study, except for your time.

Ethical approval

This study has been approved by the Ethical Standards Committee of Rhodes University (Number PSY2013/28) and has further been formally approved by the Eastern Cape Department of Health (Epidemiological Research and Surveillance Management Directorate).

Sources of additional information and contact details

If have any questions at any time relating to this study, or any associated concerns, please do not hesitate to contact me as follows:

- **Postal address:** c/o Dr. M. Nagdee, Fort England Hospital, Private Bag X1002, Grahamstown, 6140
- **Telephone:** 046 602 2452
- **Fax:** 046 602 7114
- **Email:** drmonagdee@gmail.com

You are also welcome to contact my study supervisor, Prof. C. Young, at any time if you wish:

- **Postal address:** c/o Prof. C. Young, Dept. Of Psychology, Rhodes University, PO Box 94, Grahamstown, 6140

- **Telephone:** 046 603 8500
- **Email:** c.young@ru.ac.za

If you wish to participate in this study and your capacity to consent has been confirmed, then you will be required to please sign the consent form below.

Thank you.

Yours sincerely,



Dr. M. Nagdee

CAPACITY TO CONSENT

I, M. Nagdee, confirm that I am a specialist forensic psychiatrist registered with the Health Professions Council of South Africa and a PhD candidate in the Department of Psychology at Rhodes University. I further confirm that the under-signed participant is not under my direct clinical or therapeutic care. I have assessed the undersigned Participant on(date), in relation to her capacity to consent to participating in the study entitled “The forensic mental health profile of women offenders in the Eastern Cape, South Africa”. In particular, I confirm that the participant has the capacity to:

	Yes	No
(a) understand the relevant information		
(b) retain that information		
(c) use the information as part decision-making <i>and</i>		
(c) communicate her decision.		

Therefore, she has the capacity to provide informed consent to her participation in this study		
--	--	--

INFORMED CONSENT

I hereby confirm that the nature, purpose, procedures, benefits and potential risks of the study “The forensic mental health profile of women offenders in the Eastern Cape, South Africa” have all been explained to me. I have received, read and understood the necessary information regarding this study. I am aware that the results of the study will be anonymously analysed and placed into a study report. I may at any stage, without prejudice or fear, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and, of my own free will, declare in full agreement to participate in this study.

Study participant:

Name

Signature

Date:

Person administering the consent process:

I, M. Nagdee, confirm that the above-mentioned participant has been fully informed about the nature, purpose, conduct, benefits and potential and risks of the study, and has provided her written informed consent.

Signature

Date

Witness:

Name and signature

Date

Running head: FORENSIC MENTAL HEALTH PROFILE OF WOMEN OFFENDERS


Appendix 3: Interview schedule and guide in English, isi-Xhosa and Afrikaans

Question	English	Isi-Xhosa	Afrikaans
Self-image			
1.	How would you describe yourself as a person? (Prompt e.g. What sort of person are you?)	Xa unokuzichaza, ungumntu onjani? (Isigxininiso: Ungumntu onjani?)	Hoe sal jy jousef as 'n persoon beskryf? (Watse tiepe mens is jy?)
2.	How do you see yourself as a woman?	Xa uzijongile, ungumfazi onjani?	Hoe sien jy jousef as 'n vrou?
3.	How do other people see you? (Prompt e.g. family members or friends?)	Abanye abantu bakubona ungumntu onjani? (Isigxininisi: umzekelo, abantu ozalana nabo okanye izihlobo)	Hoe sien ander mense jou? (b.v. familie en vriende?)
4.	What do other people think about you being a woman in your situation?	Abantu bacinga njani ngokuba wena ungumfazi ozifumene ekwesisimo akuso?	Wat dink ander mense van jou, as 'n vrou, in jou situasie?
Mental health			
5.	Do you see yourself as mentally ill? (Prompt e.g. previously, sometimes, currently?)	Xa uzijongile, ungumntu ophazamisekileyo engqondweni? (Isigxininisi: ?ngaphambili, ngamanye amaxesha, ngoku)	Sien jy jousef as geestesongesteld? (Voorheen; soms; huidig?)
6.	Do others see you as mentally ill? (Prompt e.g. family members, friends, others?)	Ingaba abanye abantu bakubona uphazamisekile ngokwasengqondweni? (Isigxininisi: izizalwane, izihlobo, abanye abantu?)	Dink ander mense jy is geestesongesteld? (b.v. familie; vriende; ander?)
7.	How do you feel about having being referred by the court to Fort England Hospital for mental health assessment / treatment?	Uziva njani ngokuthunyelwa ziinkundla zomthetho esibedlele se Fort England ukuzovavanywa/ukuzonyangwa ngokwasengqondweni?	Hoe voel jy daaroor dat die hof jou na Fort England Hospitaal gestuur het vir psigiatryse evaluasie / behandeling?
8.	Do you think there is any relationship between your gender as a woman and your mental health?	Ucinga ukuba ikhona into edibanisa isini sakho nokusebenza kwengqondo yakho nje ngomntu obhinqileyo?	Dink jy daar is 'n verwantskap tussen jou geslaag, as 'n vrou, en jou geestesgesondheid?
9.	Do you have any specific mental health needs as a woman?	Zikhona izidingo ezikhoyo zempilo ngqondo ezifanele wena njengomntu obhinqileyo?	Het jy, as 'n vrou, enige spesifieke geestesgesondheid behoeftes?

10.	Have you changed in any way since being admitted to a psychiatric hospital / prison?	Emva kokulaliswa kwisibhedlele sabantu abagula ngengqondo / etrongweni, ukhona umehluko owenzekileyo kuwe?	Het jy op enige manier verander sedert jy in 'n psychiatriese hospital / tronk aangehou word?
The offence			
11.	Could you outline what led to you being arrested and charged with a violent offence? (Prompt e.g. Please tell me about the events around the offence?)	Ungachaza ukuba yintoni na eyenze ukuba ubanjwe ugqibe utyholwe ngokwenza isenzo esonzakalisayo? (Isigxininisi: Ndicela undixelele ukuba kwenzeka ntoni na?)	Kan jy beskryf wat daartot gelei het dat jy gearresteer en aangekla was van 'n krimineele oortreding? (Vertel my asseblief van die omstandighede wat tot die oortreding gelei het?)
12.	Please tell me about the complainant / victim of the offence? (Prompt e.g. who were they? Male/female? Adult/child?)	Ndicela undixelele ngomoniwa/ixhoba lesenzo? (Isigxininisi: ngubani, isini sakhe; ngumntu omdala/ngumntana?)	Vertel my asseblief meer van die slagoffer van die oortreding? (Wie was hulle? Manlike/vroulik? Volwasse/kind?)
12.1	<i>If the victim was an adult or a child other than the participants own child:</i> - What was your relationship like with him/her? (Prompt e.g. How did you feel about him/her?) - What motivated your behaviour around the time of the offence? (Prompt e.g. If you did carry out the offence, why did you do it?)	<i>Ukuba ixhoba lingumntu omdala okanye ngumntwana ongengoka mpenduli:</i> - Beunjani ubudlelwane benu? (Isigxininisi: Ubuziva njani ngaye?) - Yintoni eyenze ukuba wenze esisenzo usenzileyo? (Isigxininisi: Ukuba isenzo senziwe nguwe, usenzeleni?)	<i>As die slagoffer enige iemand anders as die deelnemer se eie kind was:</i> - Wat was jou verhouding met hom/haar? (Hoe voel jy oor hom/haar?) - Wat het jou gedrag gemotiveer ten tye van die oortreding? (As jy die oortreding gepleeg het, hoekom het jy dit gedoen?)
12.2.	<i>If the victim was the participants own biological child:</i> - What was your experience of the pregnancy, birth and the post-natal period? - What was your relationship like with him/her? (Prompt e.g. How did you feel about him/her?)	<i>Ukuba ixhoba ibingumntwana wompenduli:</i> - Uzive njani ngelaxesha ubukhulelwe, ukuzala nangelaxesha ubusowubelekile? - Beunjani ubudlelwane benu? (Isigxininisi: Ubuziva njani ngaye?)	<i>As die slagoffer die deelnemer se eie biologiese kind was:</i> - Wat was jou ervaring van die swangerskap, geboorte en post-natale periode? - Wat was jou verhouding met hom/haar? (Hoe voel jy oor hom/haar?)

	- What motivated your behaviour around the time of the offence? (Prompt e.g. If you did carry out the offence, why did you do it?)	- Yintoni eyenze ukuba wenze esisenzo usenzileyo? (Isigxininisi: Ukuba usenzile isityholo, usenzele ntoni?)	- Wat het jou gedrag gemotiveer ten tye van die oortreding? (As jy die oortreding gepleeg het, hoekom het jy dit gedoen?)
13.	Did the fact that you are a woman have any bearing on the offence?	Ingaba into yokuba ngumntu obhinqileyo inayo na indima eyidlalileyo ekwenzekeni kwesisehlo?	Het die feit dat jy 'n vrou is enige impak op die oortreding gehad?
Post-offence			
14.	Have you changed in any way since being charged with violent offence?	Emva kokutyholwa ngesenzo esonzakalisayo, ukhona umehluko owenzekileyo kuwe?	Het jy op enige manier verander sedert jy van 'n kriminele oortreding aangekla is?
15.	As a woman, how do you cope or deal with your current situation?	Uzixolisa njani na nje ngomfazi okulemeko okuyo?	Hoe hanteer jy / ervaar jy jou situasie as 'n vrou?
16.	How do you cope or deal with your mental health being questioned by the court following your charge?	Uzixolisa njani na emva kokuba iinkundla zomthetho zibe nemibuzo ngesimo sengqondo yakho emva kokubekwa isityholo kwakho?	Hoe hanteer jy / ervaar jy die feit dat jou geestesgesondheid na die oortreding deur die hof bevraag was?
17.	How do you cope or deal with your detention (in Hospital or prison)?	Uzixolisa njani na ngokubanjwa kwakho (esibhedlele okanye etrongweni)?	Hoe hanteer jy / ervaar jy jou opname in die hospital / tronk?
18.	How do you cope or deal with being accused of a violent offence?	Uzixolisa njani na emva kokuba utyholwe ngokwenza into enobungozi?	Hoe hanteer jy die feit dat jy van 'n kriminele oortreding aangekla is?
The future and other issues			
19.	How do you see the future?	Ikamva lakho ulibona linjani?	Hoe sien jy die toekoms?
20.	Do you have any questions or is there anything else you wish to talk about?	Unayona na wena imibuzo? Ingaba ikhona enye into ofuna uthetha ngayo?	Het jy enige vrae, en is daar enigiets anders waaroor jy wil gesels?

Appendix 4: Fort England Hospital Forensic Service consent form

 FORT ENGLAND HOSPITAL FORENSIC SERVICE ISAZISO KUMTYHOLWA	Name _____ Number _____ PLACE STICKER HERE
<p>Ullalitse kwiForensic Service, yesibhedlela sase Fort England, ngokwe candelo 79(2) ye "Criminal Procedure Act, Act 51/77, as amended" intsuku ezingamashumu amathathu (30).</p> <p>Injongo yokulaliswa apha kufuneka ingqwalasela kwimo yengqondo yakho ngoku nangexesha obubekwa ngalo isityholo. Ukuphela kwelixesha siza kuqulunqa ingxelo eza kunikezelwa kwinkundla zomthetho.</p> <p>Nayiphina inkcukacha onokusinika yona iya kuba yinxalenye yengxelo enokusetyenziswa kwiinkundla zomthetho.</p> <p>Nangona siya kuvuya xa usebenzisane kakuhle nathi awunyanzelekanga ukusinika nayiphina inkcukacha.</p> <p>Qaphela ukuba ulapha ukuza kuhlolwa imeko yengqondo kuphela hayi ukufumana unyango.</p>	
<p>Mna, _____, diyaqinisekisa ukuba ndiyifundile/ndicaciselwe ngokuchazwe ngentla.</p> <p>Imini yotyikityo _____ inyanga _____ 20 ____ e Rhini.</p>	
_____ Umtyikoityo kamtyholwa	_____ Umtyikityo ngqina
<p><small>Note: English on reverse. If the accused cannot understand Xhosa, Afrikaans or English, the contents of the Information Sheet should be competently translated. In such cases, all assessments should be performed using competent translation. Let wel: Afrikaans op keersy. Indien die beskuldigde nie Xhosa, Afrikaans of Engels magtig is nie, moet die Inligtings blad akkuraat vertaal word. In sulke gevalle moet alle ondersoek geskied me die hulp van bevoegde vertaling.</small></p>	



**FORT ENGLAND HOSPITAL
FORENSIC SERVICE**

INFORMATION FOR ACCUSED • INLIGTING VIR BESKULDIGDES

You have been committed to the Forensic Service, Fort England Hospital, for a period not exceeding thirty (30) days at a time in accordance with the provisions of Section 79(2) of the Criminal Procedure Act, Act 51/77.

The purpose of your committal is to assess your current mental condition and, or your mental condition at the time of the alleged offence, or offences. The assessment process is often referred to as "observation".

At the conclusion of the assessment, a report will be compiled and submitted to the referring court. The findings contained in the report may be submitted as evidence by the court and may be used against you. Any relevant information you may provide during the observation may be included in the report and may, therefore, be available to court.

While your cooperation with the assessment process is appreciated, you are under no obligation to divulge any information.

Please take note that you have been committed for the purposes of assessment, not treatment.

U is verwys na die Forensiese Diens, Fort England Hospitaal vir tydperke, wat nie dertig (30) dae op 'n keer te bowe gaan nie, ingevolge die bepalings van Artikel 79(2) van die Strafproses Wet, Wet 51/77.

U verwysing volg op 'n lasgewing om ondersoek in te stel na u huidige geestestoestand, sowel as u geestestoestand ten tyde van die beweerde misdryf, of misdrewe. So 'n ondersoek staan algemeen bekend as "observasie".

By afhandeling van die ondersoek sal 'n verslag oor u geestestoestand opgetrek word en by die hof ingedien word. Die bevindinge opgeneem in die verslag mag toegelaat word as getuienis in die hof en teen u gebruik word. Enige tersaaklike inligting wat u mag noem kan in die verslag opgeneem word, en dus ook bekend word aan die hof.

U samewerking word hoog op prys gestel. Des nie teen staande, verkeer u onder geen verpligting om inligting te verstrek nie.

Let wel, die doel van u opname is 'n ondersoek na u geestestoestand, nie behandeling nie.

I, _____ (full names and surname of accused), hereby confirm that I understand the above, having read the contents, or having had the contents read and explained to me.

Signed on this _____ day of _____ 20____ at Grahamstown.

Ek, _____ (volle name en van van beskuldigde), verklaar hiermee dat ek vertrouwd is met bogenoemde nadat ek dit gelees het, of die inhoud aan my gelees en verduidelik is.

Geteken op hede _____ dag van _____ 20____ te Grahamstad.

Accused/Beskuldigde

Witness/Getuie

Appendix 6: Rhodes University ethical clearance



RHODES UNIVERSITY
Guidelines • eintsa South Africa

DEPARTMENT OF PSYCHOLOGY

Tel: +27 (0)46 603 8300 • Fax: +27 (0)46 622 4032 • Website: <http://www.rhodes.ac.za/academic/departments/psychology>

RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

28 August 2013

Mohammed Nagdee
 Department of Psychology
 RHODES UNIVERSITY
 6140


Dear Mohammed

ETHICAL CLEARANCE OF PROJECT PSY2013/28

This letter confirms your research proposal with tracking number PSY2013/28 and title, 'The forensic mental health profile of homicidal female offenders in a South African context', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 27 August 2013. The project has been given ethics clearance.

Please ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely


 CHAIRPERSON OF THE RPERC

Appendix 7: Eastern Cape Department of Health research approval



Eastern Cape Department of Health

Enquiries: Zonwabile Marika

Tel No: 040 606 0350

Date: 13th August 2014

Fax No: 043 642 1409

e-mail address: zonwabile.marika@mpilo.ecdot.gov.za

Dear Dr M. Nagdee

Re: The forensic mental health profile of homicidal female offenders in a South African context

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT



Appendix 8: Fort England Hospital research approval



FORT ENGLAND HOSPITAL

Private Bag X1002, Grahamstown, 6140. Tel: +27 (0)46 622 7003. Fax: +27 (0)46 622 7630.

RESEARCH PROPOSAL APPROVAL

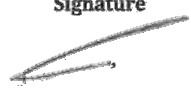

Date: 21 August 2014

Dear Dr. Nagdee,

Thank you for your application to conduct research at Fort England Hospital. We are pleased to inform you that your research proposal has been approved by the Academic and Research Committee at Fort England Hospital (as indicated below). A copy of our Research Policy is included herewith, for your information. Please do not hesitate to contact me should you require any further information or assistance.

Yours sincerely,


I Reid
Acting Chair: Academic and Research Committee

Primary Investigator	Name	Mohammed Nagdee		
	Position	Principal Specialist		
	Student or staff number	16270347		
	Address	Fort England Hospital, P/Bag X1002, Grahamstown, 6140		
	Telephone	046 602 2452		
	Email	drmona@dee@gmail.com		
Research project	Title	The forensic mental health profile of women offenders in the Eastern Cape, South Africa		
	Supervising University / Institution	Rhodes University		
	Supervisor	N/A		
	Ethics Approval from Supervising University / Institution	No	Yes (insert date) 28 August 2013	
Fort England Hospital Approval	Academic and Research Committee Chair (Mr Reid)	No	Yes (insert date) 21 August 2014	Signature 
	Acting Hospital Manager (Mrs Holder)	No	Yes (insert date) 21 August 2014	Signature 

Appendix 9: Fort England Hospital psychiatric court report template



PSYCHIATRIC COURT REPORT

The purpose of the enquiry was a psychiatric evaluation, in accordance with the provisions of Section 79 of the Criminal Procedure Act 51 of 1977, as amended (Criminal Procedure Amendment Act 4 of 2017):

SURNAME:
FIRST NAME(S):
AGE:
CHARGE(S):
CASE NUMBER:
HOSPITAL NUMBER:

SECTION 79(1): PANEL FOR THE PURPOSE OF ENQUIRY AND REPORT

[Name of psychiatrist 1] [Head of Health Establishment, or delegated psychiatrist; S 79(1)(a) or (b)(i)]
[Name of psychiatrist 2] [Psychiatrist appointed by court; S 79(1)(b)(ii)]
[Name of psychologist, if applicable] [Clinical psychologist appointed by court; S 79(1)(b)(iv)]

We, the panel members, hereby declare that we are duly registered with the Health Professions Council of South Africa and that we examined the accused at Fort England Hospital during the periodto We held discussions and report as follows:

SECTION 79(4): NATURE OF ENQUIRY

The accused was admitted to Fort England Hospital on, following an order made by the Magistrate of in accordance with the provisions of Section 79(2), dated During the period of observation at Fort England Hospital, the accused had numerous clinical interviews and assessments (including psychological testing where indicated); physical and neurological examinations; medical investigations (including blood tests), and was kept under constant observation by the psychiatric nursing staff. Reference was made to the prosecutor's report. Collateral information was obtained from the family of the accused / other health professionals with whom the accused had prior contact.

SECTION 79(4)(b) : DIAGNOSIS OF MENTAL CONDITION

•
•
•

SECTION 79(4)(c): CAPACITY TO UNDERSTAND COURT PROCEEDINGS

The accused is un/able to follow court proceedings so as to make a proper defence.

SECTION 79(4)(d) : CAPACITY TO APPRECIATE WRONGFULNESS & ACT IN ACCORDANCE

At the time of the alleged offence, the accused was un/able to appreciate the wrongfulness of the act in question, and un/able to act in accordance with such appreciation of wrongfulness.

RECOMMENDATION

It is respectfully recommended that the law take its course / accused be admitted to **Hospital as an involuntary patient** in terms of Chapter V of the Mental Health Care Act / that the accused be admitted to **Hospital as a State Patient** in terms of Chapter VI of the Mental Health Care Act, for the purposes of Sections 77(6)(a)(i)(bb) and/or 78(6)(b)(i)(bb) respectively, the accused is considered a significant risk to himself/herself and others due to the nature and severity of his/her mental illness/intellectual disability.

[Name of psychiatrist 1]
 Head of Health Establishment or delegated psychiatrist
 S 79(1)(a) or (b)(i)

[Name of psychiatrist 2]
 Psychiatrist appointed by court
 S 79(1)(b)(ii)

[Name of psychologist, if applicable]
 Clinical psychologist appointed by court
 S 79(1)(b)(iv)

DATE: