Matricide and schizophrenia in the 21st century: a review and illustrative cases

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Abstract
Studies have shown an association between homicidal behaviour and psychiatric disorders although it remains difficult to conclude that definite causal relationships exist between specific mental illnesses and particular forms of homicide. However, matricide has been linked to schizophrenia for several decades with an assortment of explanations to explain the connection. To review the psychosocial, contextual and clinical issues involved in the perpetration of matricide by patients with schizophrenia. Two detailed case reports are presented alongside review of relevant literature. There are complex psychodynamic, phenomenological and contextual factors in the act of matricide by persons with schizophrenia. The observation that ambivalent relationships exist between schizophrenics and their mothers (or other carers) probably suggests the need for adequate clinical intervention with families of affected patients in resolving psychological tension which might be the provoking stimulus to murder.

Keywords: Schizophrenia; Matricide; Ambivalence; Psychodynamic factors

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Introduction

Studies have shown an association between homicidal behaviour and psychiatric disorders.[1,2,3] Although definite causal relationships between specific mental illnesses and specific forms of homicide have been difficult to establish, Gillies (1965)[4] made the bold assertion that matricide is the ''schizophrenic crime''. Since his curious impression, several studies and case reports in the last century had attempted to substantiate or repudiate his claim.[5,6,7,8] Research evidence within the first decade of the 21st century also seems to suggest that matricide although rare, still occurs within the context of schizophrenia[9,10,11,12] and other psychotic disorders.[11,13] Here, we present two case reports which highlight the psychodynamic, phenomenological and contextual issues involved in the perpetration of matricide by schizophrenic patients.

Case 1

A 29 year old single, unemployed, male secondary school leaver was referred for psychiatric evaluation following an act of assault on his mother. About 3 weeks to presentation, he killed his mother by striking her repeatedly on the head with a pestle. He admitted to killing his mother, appeared unperturbed and offered no resistance during his arrest. According to him he felt he had to kill his mother, though could not explain why he felt that way. He was neither under the control of external agents nor acting on hallucinatory commands.

A few months prior to this incident, Mr. A had been withdrawn from others. He had been laughing and talking to self too. He heard hallucinatory voices commenting on his activities and giving commands. Although Mr. A also had a history of ongoing nicotine and cannabis abuse, he was neither smoking nor drinking when it occurred. The last time he smoked was about three (3) weeks before the act. About a year before the matricide, Mr. A had his first contact with a psychiatric facility on account of schizophrenia with cannabis abuse. Though he remitted fully on treatment with Tabs Haloperidol 15mg daily, there was medication non-adherence post-discharge.

Mr. A is the 3rd of 9 children in a polygamous family. He is the only son of his mother's three children. His parents separated in his fifth year of life and he lost his father when he was aged thirteen. He endorsed a long-standing feeling that his mother preferred his sisters to him and as such, he asserted that he was not ''close'' to her. He lived with his mother in their rented apartment and depended largely on her for his upkeep. As at the time he committed the act, he was unemployed and lacked the prerequisite qualifications to proceed with his studies. Mr. A had no prior contact with law enforcement agents.

A mental status examination showed Mr. A to have a euthymic mood but a blunted affect. He dispassionately gave a detailed account of how he killed his mother during the

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interview. He had auditory hallucinations with voices commenting on his activities.

On admission, his symptoms resolved with antipsychotic medication. He acquired vocational skills through occupational rehabilitation. His reintegration into his community was however hindered by the social distance and stigma arising from the matricide. On the whole, he was on admission for about one year and nine months largely on account of difficulty in getting his family to accept and rehabilitate him.

Case 2

A 24 year old, single, unemployed, female secondary school drop out who was first seen in our hospital two weeks after fatally wounding her mother. She had attacked her mother suddenly over a minor disagreement. She hit the mother on the head with a wooden pestle from which she suffered severe head injury which led to her demise. The patient stated that she could not explain why she attacked her mother violently. However, she was aware of her actions and she did not act in response to commanding auditory hallucinations. She endorsed beliefs that she was being persecuted by her siblings (not her mother) and she was noted to be unduly irritable and restless; there were episodes of undue elation interspersed with weepy spells. There were occasions on which she stripped herself but claimed that she did not know when she did so.

Her past psychiatric history revealed that she had made contact with different psychiatric facilities in the last 8 years before the current presentation and had been poorly compliant with medication resulting in frequent relapses of her illness. She is the last of 10 full siblings and she grew up being very close to her father. She suffered the first mental decompensation at age 12 when her father died. Though not close to her mother, she continued to live with her in the same house. There was a positive family history suggestive of schizophrenia in two elder siblings who had been largely left untreated. She dropped out of secondary school on account of recurrent relapses and could not learn a trade - probably on account of same.

The patient volunteered that she heard voices of unseen people discussing her and voices from parts of her body. Based on the history of stripping herself and being unaware of it, the possibility of a complex partial seizure was entertained and features on EEG were suggestive of complex partial seizure; the patient was managed as a case of paranoid schizophrenia with co-morbid complex-partial seizure disorder.

However, she did not make remarkable improvement on either typical or atypical neuroleptics (with a trial of risperidone, 6mg daily). She had to be switched over to clozapine. The patient improved significantly on moderate doses of clozapine but had to be taken off the medication when the family could no longer afford it. She then reverted to the use of conventional neuroleptics with concomitant reversal in her mental state.

She was discharged after one year and six months on admission, this long stay occasioned by irregular supply of funds for medication, poor social support required for pragmatic rehabilitation plans and the vacillating picture of her mental state which was a consequence of inability to afford effective medication.

Discussion

Matricide was first studied critically by Wertham who proposed the ''Orestes complex'' which refers to an ambivalent attachment to the mother that may be converted into matricidal rage in vulnerable men.[5] This was presented as an alternative to early psychoanalytic thinking that hatred of the mother was a derivative of the oedipal complex.5 Most of the available studies have examined schizophrenic sons who killed their mothers[6,7,8] with very few mentioning maternal homicide by daughters.[9,11] In this report, we have presented a schizophrenic son and daughter who killed their mothers. Both of them were not close to their mothers yet they lived with them and were dependent on them. While the Orestes complex would appear acceptable as an explanation for the matricidal act by the male patient, it might be possible to suggest an exaggeration of the ''electra complex'' as being the psychodynamic explanation of this female patient's homicidal behaviour. Nonetheless, the hypothesis of the ambivalent attachment on which the Orestes complex rests is quite useful in both cases. Some studies have shown an ambivalent relationship between schizophrenic sons and their mothers whom they had killed.[7,9,11] Singal & Dutta[7] indicate that there is intense, conflict-laden relationship between schizophrenic sons and their mothers. The majority of the patients that they studied described their mothers as being domineering and demanding on one hand but tolerant and affectionate on the other hand. Both patients presented in this report reflect this ambivalent relationship in that they lived with their mothers and largely depended on them for survival; yet they claimed that they were not close to these mothers. Campion et al[5] stated that the act of matricide by schizophrenic sons can be understood as a desperate, violent act of self-assertion to separate from their mothers. Intra-familial tension as a precipitant for matricide has been suggested by Wick et al.[10]

The psychosocial characteristics of the patients presented in this report appear to be in keeping with the observation of previous studies and case reports.[4,5,9,11] Both of them were young, unemployed, poorly educated, dependent on their mothers, the last children of their mothers and of low socio-economic status.

A number of phenomenological risk factors have been proposed for violence in schizophrenia[4,14] and these include: fear and loss of self-control associated with non-systematized delusions, systematized paranoid delusions including the conviction that enemies must be defended against, irresistible urges, command auditory hallucinations, and strong negative affect in the form of depression, anger or agitation. In the case of Mr. A, he killed his mother and stated that he did not know why he did so; at other times during his admission, he claimed that he felt he was ''controlled''. He however admitted to relationship difficulties between himself and his mother. On one hand, she was ''nice'' but on the other hand, she deprived him of certain basic needs. Thus, it is likely that both irresistible impulse and a strong negative affect contributed to the killing. Reflecting on the female, she killed the mother in the context of a disagreement. Obviously, this probably represents the setting of anger. But more importantly, loss of self-control and impaired judgment must have played a major role. During the course of this patient's grief work, she believed that she put her mother out of her misery.

The method of achieving the matricidal acts under study is also worthy of mention. Gillies[4] identified five different methods used by the assailants in his study viz: sharp instrument, blunt instrument, strangulation/asphyxiation, shooting, and barbiturate

poisoning; sharp instruments were the most common followed by blunt instruments. A recent review[10] indicates a similar pattern of methods used in the act of maternal homicide but adds that a combination of methods may be visited on some victims. Bourget et al[9] in their own study found that blunt instruments were most commonly used followed by sharp ones and firearms. In the patients presented, both of them killed their mothers with pestles (a blunt instrument). It would appear that regardless of the kind of instrument, the essence is that the schizophrenic murderer looks for the closest available tool with which he/she must urgently achieve the task of murder. Apart from the instruments used, the degree of associated violence has also been reported in literature.[5,10] Dogan et al[12] recently reported a case of matricide involving decapitation and dismemberment of the victim by a daughter suffering from schizophrenia. In both cases illustrated in this report, the patients pummeled their mothers on the head with a pestle. Hitting these elderly women on the head with heavy pestles represents gross and excessive violence and is in keeping with the description provided by earlier workers on matricidal acts.

The presence of psychotic symptoms in the period (days to months) before the occurrence of violent acts has been observed by several studies.[6,14] Both of these patients had long-standing history of schizophrenia but they were poorly compliant with medications and it is not unlikely that in the months preceding their fatal attacks on their mothers, they had been hibernating a simmering psychosis which would boil over in the perpetration of matricide.

We are not unaware of the fact that these two patients have significant co-morbidities which must be highlighted. In the case of Mr. A, he had a second diagnosis of cannabis abuse. Studies have shown that cannabis use is associated with the risk of developing schizophrenia.[15] In addition, the observation that the use of cannabis may be associated with violence[16] and homicidal conduct[17] has been made. However, the clinical picture of the patient tends to suggest that the act was in the context of a schizophrenic relapse. With regard to the female patient, her clinical course reveals that in addition to a diagnosis of schizophrenia, she was also diagnosed with complex partial seizure disorder. Violent acts occurring in association with EEG abnormalities have been noted in literature[14] and violent acts occurring in the setting of epileptic automatisms are known in law.[18] Abiodun[19] noted in an old prison study that 54.5% of the patients with epilepsy had committed murder. It is more likely however, that she committed the act as a result of schizophrenic illness since the patient was aware of her actions and the likely outcome.

A major consequence of matricide as noted from our reported cases is rejection by the members of the perpetrator's family with attendant break down of the patients' social support. In both cases, the patients spent considerable amount of time on admission because their siblings could not comfortably re-integrate them into their previous social millieu.

Conclusion

Matricide tends to occur in the context of schizophrenia but our report would obviously be unable to validate it as the 'schizophrenic crime''. The complex psychodynamic, phenomenological and contextual issues involved in the act of matricide make it unpredictable and difficult to explain in each particular case. The finding of a female committing matricide in this report deviates markedly from earlier constructs projecting matricide as an essentially male crime. The observation that ambivalent and conflict-laden relationships exist between schizophrenics and their mothers (and indeed other carers) suggests the need for interventions at the family level in resolving the understandable occurrence of emotional conflicts as these may serve as the provoking stimuli to murder. Finally, the role of respite admissions and government's intervention in providing half-way homes for gradual re-integration of the patient with schizophrenia who has committed matricide cannot be overemphasized.

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