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Review Article

Perspectives on Indirect Matricide in Male Violent Offenders

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Abstract

The infant's earliest relationship with the mother is associated with comfort, feeding and love. In writing this paper, we consider the developmental failure in integrating such inner experiences in the violent offender's mental functioning and suggest an association with displaced matricidal urge - so-called indirect matricide. We believe this offers a more nuanced approach in the risk analysis of future violent offending. We review and consider literature on matricide in the context of male offenders who commit inexplicable violent acts. We argue that this compulsion to violence may be traced to early unprocessed anxieties manifest in a personality retreat that defends the self against psychotic breakdown. We advocate a consistent multi-disciplinary approach to contain the patient's paranoid anxiety, and gradual therapeutic exploration of multiple layers of traumata that allows the patient to view his violence with more realistic and depressive concern. We argue for the case of developing shared clinical and risk formulations that trace a patient's early anxieties with the development of personality defences that repeat cycles of traumata.

INTRODUCTION

In our work with personality disordered offenders, we come across a striking number of cases of serious violent crimes committed without any apparent rational motive. Expert forensic psychiatrists working with the Courts tend to compound the violent offence analysis by wiping out curiosity for a motive when seeking out manifest psychotic symptoms to explain the crime. Among this group of offenders, we come across a significant number of cases who are 'stuck' in prison pathways, commonly long after the tariff in their sentence has expired. These high-risk personality disordered offenders repeat a pattern of self-sabotage and systemic failures, which manifests in a cycle of repeated trauma in prison settings.

By pursuing a model of care and treatment that does not perpetuate a systemic and diagnostic split, the patients deemed suitable to be transferred to the Oswin Unit[1] are not restricted to the presence or otherwise of psychotic symptoms, or features of personality disorder because of the unhelpful parallel process in the patients' mind [1,2].

The cases we have in mind share in three particular features:

(1) The circumstances involved in the violent offence are disproportionate to the patient's explanation and is acted on by the victim through, what seems, an irresistible impulse, and the absence of a rational trigger.

(2) After the violent act is done, the patient vacillates between states of indifference or minimisation and apparent amnesia when describing the offence, in the absence of any organic explanation or identifiable feigning.

(3) During the course of step-wise therapeutic gains and the building of trusting relations, the patients reveal highly ambivalent and embedded maternal attachments: early traumatic loss and impingements, along with hidden doubts and fears about sexuality.

Here, the maternal attachment is considered in the context of Lindner's [3], concept of the matricidal equivalence. The patient's unconscious defense, namely displacement, shifts the aim of the violent act some distance from the primary source of care and nurturing. The subject of the violence represents the displaced primary maternal or a substitute maternal figure. Thus, we develop a formulation-based approach in diagnosis, treatment and offence analysis of the violent act as a function of an indirect matricidal urge.

Forensic clinicians are able to use this framework to trace

1 Oswin Unit is a National Health Service Medium Secure Personality Disorder Service, co-commissioned by NHS England and National Offender Management Service based in Newcastle upon Tyne, UK.

childhood anxieties and traumata that previously the patient remained shut off from. Failure to open up a shared narrative that attempts an understanding of the function and conflict between early loving feelings and early hatred repeats the patients' early experiences that conflict and persecutory anxieties are not processed (maternal containment).This is most evident in the repeated cycle of interpersonal violence and punitive reaction in prison systems that leave the patient 'stuck' within the Criminal Justice System. Here, risk analysis that relies on standardized tools of behavioral engagement / change, often does not reflect the patients' ability to tolerate depressive feelings without snapping with aggression. This form of inner change depends on slow, consistent, and psychologically-informed therapeutic work that remains relatively sparse in prison settings despite current ambitions [4]. Here, we propose a shared formulation framework that may be incorporated into traditional methods of risk analysis, and helps the patient make sense of apparently motiveless violence [5].

MATRICIDE AND MENTAL DISORDER

We undertook searches of PsycInfo, EMBASE and Medline and Google Scholar, using a mix of keywords and database subject headings, including: indirect matricide, matricide, violent offender, personality disorder, and male. No limits of publication date or language were applied to the search. The search resulted in zero articles that apparently fitted all the criteria. When we undertook a literature search and excluded indirect matricide there were many results. We have included them in this paper.

Matricide has remained a very rare crime [6]. In the United States, about two per cent of all homicides recorded between 1976 and 1998 were murderers of a parent. Adolescent sons who kill their mother are rarer still [7]. This is supported by the review of the literature conducted by D'Orban and O'Connor [8]. While female perpetrators are not unsubstantial [7], we focus our attention on male perpetrators.

Compared to adolescent murderers, cases of adolescent matricide do not have a forensic history of previous violence [9]. The young male mother-murderers have histories that reveal trauma and abuse [10], their mothers tend to be dominating and intrusive, and their fathers are passive or absent [11]. Also, they have tried to run away from home before the killing, which suggests an adolescent attempt to shield the mother-figure from their violent impulse.

Attempts to understand the adult matricidal cases have implicated the presence of severe mental illness, such as schizophrenia [6,12,13]. In Green's [12], sample of cases, the dominant motive identified was persecutory paranoid anxieties manifest as delusional beliefs about the mother.

The failure among psychiatrists to be persuaded by Wertham's [14], analysis of the matricidal impulse as a form of hidden catathymic crisis has been compounded by terms such as "schizophrenic crime" [12], that has narrowed our understanding of the function of this violent act.

More recent reports are more circumspect about the causality between schizophrenia and matricidal violence [15,16]. Nearly a third of Green's cases (29 per cent), included individuals with personality disorder who made attempts to break away from domineering or enmeshed experiences. This is an underestimate when compared with the Hillbrand [17], sample, which has the total figure at 43 per cent when the scenarios of impulsivity, and escape from enmeshment are combined.

We believe the motivating features in this crime are partly described by the pathological mother-son relationship manifest in the son's desperate wish to rid himself of intolerable attachment to his mother [18]. Whilst in adults, more overt features of personality disorder act as a defence against psychotic breakdown. This developmental formulation of the motives is supported by an excessive pre-oedipal dependent attachment to the mother highlighted by Geha [19], that links the act of killing the mother to feelings of inadequacy [20].

Based on our brief review of the literature and using Wertham's [14], formulation of matricide; characterised as a sexually immature, homosexually-oriented son trapped in a dependent but hostile relationship with a possessive mother. The circumstances leading to the matricidal act involve the individual acquiring the idea that he must carry out the violent act as the only way to release overwhelming inner tension. The act of matricide is imbued with symbolic meaning and after the violent crisis is attempted or carried out, there is a gradual resumption of superficial normality and the development of awareness and inner equilibrium.

This symbolic aspect of matricide is described in the Greek myth of Orestes. Who appears as a frightened and persecuted figure, overwhelmed and confused by what he hates within himself, namely an inner passive (female) role. This feminine aspect is identified in the mother who, in turn, is believed to hate the subject's self. His hate-filled passivity is linked to the internal feminine, which he is driven to kill, thus exacting his unconscious suicide. Here, maternal love is misinterpreted as a threat to the self that must be killed off to survive, thereby a form of self-preservative aggression.

PRIMARY MATERNAL RELATIONS

In normal development, the infant's early emotional life is characterised by introjections of, and admiration for the mother's life-giving qualities, as well as envy for this capacity [21]. According to Klein's seminal research, *Psychoanalysis of Children* (1932) the normal developing infant has to deal with early anxieties fueled by an unconscious terror of being devoured and destroyed by the mother. This inner conflict, which the child experiences from birth, is dealt with by a degree of schizoid withdrawal and processes of splitting of the mother figure into the idealized mother and the terrifying figure. Persecutory anxiety that is part of the paranoid-schizoid position [22], is compounded by the infant's destructive impulses, which are mitigated, only up to a point, by projective relegation to deeper recesses of the mind.

For the infant to navigate the inevitable experiences of frustration along the way towards a more depressive position [22], involves the presence of a consistent, loving primary maternal, or maternal-substitute figure. One able to contain and process the infant's projections towards a more realistic and integrated mother-figure, and subsequent psychological maturity.

When we trace the developmental roots in the violent patients we have in mind, they gradually reveal (and in the transference) accounts of double trauma of loss and impingement. We begin to hear about and suspect maternal failings that reflect Winnicott's [23], account of a breakdown in the mother's capacity to firmly establish the 'conditions for loving', and a striking absence of the father.

Abraham [24], showed that failure in each developmental phase leads to 'fixation-points' and increases inner susceptibility for adult mental illness. We have come to believe that a combination of early traumatic losses - failure of a maternal containing function for infantile projections and subsequent paternal absent identification - sets up the conditions for a broken psychic functioning and a deep sense of aloneness. The adult male patient learns to deal with this through the use of personality disordered defences against more manifest psychotic breakdown that include self-punitive and / or extra-punitive acts. This repeated cycle of self-sabotage in prison settings belie his core sense of aloneness. Repeated failings in the system of care reflect the patient's developmental experience of failed (maternal) processing of early anxieties. Here, Brenman [25], identifies withdrawal into a narcissistic personality structure that defends the self from overt psychotic processes through the use of an omnipotent alliance with, 'narrow loveless narcissistic gods'.

CASE ILLUSTRATIONS

Mr A

When the author (RL) first met Mr A in prison he was too frightened to leave the confines of his cell. After Mr A was admitted to hospital, it soon became apparent he was profoundly tortured by his internal agitation, depression and persecutory anxieties.

With slow therapeutic work, the very real nature of his terrible traumata emerged. This included his childhood and adult experiences of cruelty and loss, as well as the traumatic nature of the murder he committed on a female neighbour. His only other violent offence was committed weeks before the murder, involving an assault on his ex-wife's boyfriend, who mocked and humiliated him.

In the weeks leading up to the murder, Mr A drank heavily and was suicidal. Initially, his explanation for killing the female was that she had made empty threats to take an overdose, which he felt merited him impunity. Mr A's amnesia for the killing was an understandable defence against the trauma of recalling the violent frenzied attack.

Over the course of the following 18 months of therapy, which included the necessity to biologically treat Mr A's affective symptoms, he revealed his phallic (homosexual) conflict in the transference relationship with the author (RL). This involved passive idealisation of the author's interpretations, while at the same time experiencing these as abusive homosexual intrusions. This compounded his sense of confusion and intensified his withdrawal.

Bit by bit, through consistent psychosocial work with the multi-disciplinary team, Mr A was able to build trusting relationships and felt less alone. He began to find words for the overwhelming compulsion to kill the victim. This allowed him to begin experiencing real depressive concern for the female victim and link this to his frustration about his mother's depressed and suicidal state. He made contact with his estranged brother and his daughter, and her new family. He began to look forward to progressing through the prison system.

Mr L

Mr L spent each day in a high secure prison personality disorder service collecting fag ends and refusing to engage in prison activities or associations. He was over twenty years past his tariff and stuck.

Prior to the repeated offences of setting fires, Mr L lived a vagrant lifestyle. He occasionally did labouring work on farms but quickly fell out with the male farmers because he felt they threatened him. Mr L formed few relationships and was confused about his sexuality.

Days before the index fire setting offence, Mr L had been residing in a hostel. He believed the female occupant in the bedroom above was his girlfriend who had been unfaithful with a number of male partners. He knew he had to kill her. Mr L went to her room carrying a bag containing the tool to kill her and her male partner. As he stood outside her door, the zipper to his bag failed. This appears to be the trigger for Mr L turning away and not killing these people. What ensued was a series of apparently unprovoked fires to nearby farm buildings. Later, Mr L suggested this fire-setting was linked to an old grievance against the farmer who had employed him and then rejected him.

When I asked to see Mr L he refused to come to my prison clinic. When I went to his cell I was met by a frightened and agitated man. The prison system tried to progress him to open conditions, but days before the move Mr L sabotaged it by setting fire to his cell. Mr L had been involved in a brief homosexual encounter whilst in prison, which had caused him deep inner conflict.

Through slow treatment in hospital, Mr L began to reveal his experience of true cruelty at the hands of his mother, who mocked his vulnerability. At a crucial developmental stage in his life, she threw his favourite teddy in the fire along with his fossil collection. Being witness to his mother's many sexual partners exposed him to his father's phallic impotence. The connection here to Mr L's delusional belief about the female near-victim is not to be ignored.

Mr L's manifest schizophrenic symptoms required antipsychotic treatment. The positive response to this treatment allowed him to work therapeutically with the multi-disciplinary team. Mr L opened up and began to explore his early maternal relations. He took an active role in the ward as well as showing a remarkable artistic talent. We developed a shared formulation with Mr L about his need to protect himself in a narcissistic retreat as a child and as an adult. This defence against overt psychotic breakdown was missed in the prison setting and had confounded his progression. Mr L adopted a vagrant life-style in prison.

In predicting future risk, we argue that it would not be sufficient to note alienation. What is needed is a thorough

understanding of the trigger to his potential unzipping. This break with reality, in our view, is best understood as a shift into a psychotic state of mind, where the inner cruel and vengeful mother takes over the self.

Mr C

Mr C was a prolific stimulant drug abuser. This made him feel he was "superhuman" when otherwise, he felt himself to be alone. He mistrusted his male and female friendships because he felt they took advantage of his generosity to buy drugs.

Mr C committed an unprovoked knife attack on a sleeping female. This was his only violent offence. Initially, when Mr C was admitted to hospital for an assessment of his mental state, prior to sentencing, he spoke of hearing a mumbled male voice telling him to attack the sleeping female, and described a dissociative figure doing the violent act. The hospital teams were not convinced by Mr C's account of psychotic symptoms. He received a very lengthy sentence.

Later, Mr C was transferred to the Oswin Unit. He initially maintained amnesia for the offence and struggled to offer an adequate explanation. Rather, he presented as emotionally disconnected, withdrawn, and lacking in motivation. He ascribed the attempted killing to an altered-state, and that the female victim, with another male had taken advantage of him and belittled him. Mr C expressed a similar pattern of passive attachment with a dominant male peer on the ward, with whom he placed himself in the subservient role, and then became watchful and guarded if away from his company or protection.

Gradually, the multi-disciplinary team began to formulate Mr C's defensive structure - passivity, withdrawal and dissociation – as apparently protecting him from a more overt psychotic breakdown. In group and individual therapy, Mr C displayed sudden bursts of irritability and aggression, if pressed or challenged, and spoke more generally about his reactive violence being in tune with his self-image.

After a careful and thorough review of Mr C's history, we decided to commence him on antipsychotic medication. Over the following fifteen months, Mr C showed a gradual reduction in his interpersonal sensitivity, the intensity of his dissociative and hallucinatory experiences, and he became more open to people's different viewpoints.

Mr C began to talk about his early exposure to sexualized trauma by his mother's domineering lesbian partner and his mother's failure to protect him. Mr C revealed his father's passivity when his mother mocked his disability. This constellation of confused identifications led to his firm belief that he had to protect his mother rather than her protecting him. We teased out an understanding with Mr C about his deeply hidden mixed emotions of hatred and need to protect his terrifying but dominated lesbian mother, which was manifest in his passive-aggression. This was a slow process and required much transference work, usually rejected by Mr C, who did not want to own his aggression.

Over the course of many months of treatment, which involved tolerating Mr C's withdrawn states, interspersed by his sudden snapping comments towards staff, he began to own his crime and express real concern for the female victim. This allowed Mr C to recognise the protective part of his personality that pushed the pram, in which lay the victim's sleeping child into an adjoining room before attacking the woman. Mr C's profound dysphoric mood and inner emptiness began to emerge, which coincided with intrusive violent thoughts towards the domineering male peer on the ward. Mr C withdrew himself and tried to avoid others. His somatic complaints increased in frequency and disturbance. We understood this passive-aggressive attack on his body as a parallel to the increased stimulant use prior to the index offence. On this occasion on the ward, in the absence of stimulant drugs, and with the care and space offered by the staff team, Mr C felt able to talk about his sense of self-criticism and harboured aggression.

Mr S

Unlike the other cases, Mr S had an entrenched criminal history of anti-social behaviour throughout his adolescence and adult life. At the time of the knife attack on an unsuspecting male, Mr S was living with his mother. He was dependent on her for money and berated her whenever she tried, in vain, to control his drug-taking. Mr S's father was absent in his life from his latency years.

On the day of the offence, Mr S had run out of drugs and was desperate for some money. His mother tried to distract him and eventually refused him any money. He became angry, approached his mother in an intimidating manner and kicked the television. Mr S left his home frustrated and furious. Within hours, Mr S had taken more drugs. He paced the streets of the city centre, becoming increasingly paranoid that others were mocking him. Mr S felt belittled by his mother and began ruminating about attacking someone. In the distance, he saw a stranger male walking. Mr S started to jog towards him and, without provocation, stabbed the male from behind with the knife.

When Mr S was admitted to the Oswin Unit for an assessment of his needs and a thorough risk analysis of his offence it became apparent that, somewhere in his mind he recognized he needed help, yet was far from allowing this. Just as his mother had tried to help him to stop using drugs (and because she was terrified by his flights to uncontrollable rage), so he refused help from the multi-disciplinary team. Rather, Mr S stalked the corridors in the ward and, armed with a pen, intimidated and threatened to attack fellow patients. He declined to be seen either, individually, or in a group, and demanded to be returned to prison. His explanation was, he felt calmer in prison because he knew who was a threat to him and how to protect himself, and he would have greater access to illicit drugs. We understood this as Mr S showing his true alliance with an inner cruel God [25], whom he felt he best knew, and with whom he could omnipotently manage his inner sense of terror and persecutory anxieties - projected into the claustrophobic ward situation.

In this instance, we shared with the probation service our formulation of Mr S's entrenched and ambivalent relationship with his mother. We recommended that, any risk analysis ought to consider the potential risks to his mother or an indirect (maternal) victim, arising out of his unresolved childhood experiences of anxiety and loss. In the event of Mr S not being

able to engage in the work to learn how to tolerate old paranoid anxieties, without resorting to manic defences, it is likely his risk of violence would remain unmitigated.

The Oswin multi-disciplinary team have since kept in contact with Mr S and offered their help to the prison personality disorder service in developing a shared formulation of his needs and risks.

DISCUSSION

Mr S's continued reliance on old personality defences suggests he still required his defensive psychic structure because in the absence of this he feared something far worse, namely manifest psychotic breakdown. In a similar way, Mr C's ego syntonic rationalization of violence suggests he harbors the need for such old defences, albeit he has allowed some inner change to begin. This process towards change in the risky forensic patients we meet, and who are in states of internal and external crisis, requires mental health services and prison services to work in coherent partnerships that mitigate the tendency for splits in care.

Tracing the roots of hatred and a destructive drive in violent offenders to the patient's early anxieties in the maternal relationship allows the clinician to make sense out of, what otherwise appears to be, senseless and wanton acts of aggression, and violence [26]. These patients tend not to follow a path of expected recovery; with their inner experiences of traumatic and/or failed early care being compounded and repeated in prison settings. Here, the patient's risk of future violence remains unabated in the absence of the patient developing an understanding of their early anxieties. This shift corresponds with a more realistic and shared understanding of their traumata, along with depressive concern for the violent offence and empathy for the victim (s).

In clinical practice, we tend to rely on traditional standardized risk assessment tools to predict future violence, notwithstanding Monahan's [27], helpful reminder that such tools should, at best, be used as an adjunct to good clinical practice. It is a characteristic feature of a substantial number of personality disordered offenders who present with latent psychotic symptoms that the manifestations of personality difficulties act as a defensive shield against exploration and the development of shared understanding of the function of the violent act.

This dichotomous diagnostic view tends to lead to exclusion of personality disordered offenders from accessing meaningful psychological care and treatment in prison or hospital settings, and often leads to lengthy incarceration and inherent escalation in risk-related behaviours [28-30].

We very much agree with the propositions argued for by Minne [2], and in particular share her view about the source and nature of the patients' traumata that includes the violent offence. Here, we add that, while the clinician's impulse may be to rescue personality disordered offenders from their cycle of trauma repeated within prison settings the hospital personality disorder services should find a way to effectively work with the prison system. Thus, we advocate a coherent and consistent multi-disciplinary model of care that works in partnership with the prison service, and helps patients to progress through their prison sentence. This is predicated on a pragmatic, and psychologically informed approach that focuses on repairing broken relationships to allow the patient to develop a more realistic view of self and others.

We have developed a forensic personality disorder service in which we advocate a broadened framework of diagnostic formulation and risk analysis. At the core of this multi-disciplinary framework of care, is the intent to find a way of helping 'stuck' offender-patients to recover hidden early anxieties and traumatic memories [5]. In recovering the concept of the indirect matricidal urge, we hope to foster a climate of curiosity in our patients and the wider multi-disciplinary team about the function of the violent offence. Here, the work centers on building a consistent therapeutic setting in which the patient can begin to think the unthinkable; who is the victim - indirect maternal or substitute maternal figure - in the patient's mind. This allows for the irresistible impulsive violent act to be understood in the context of failures in maternal attachment linked to old split-off painful memories of loss.

Of particular value in the process of understanding the meaning of the violent act for the offender and the inner symbolic relationship to the victim (s), are the interpersonal communications integral to the process of working with individual patients and the multi-disciplinary group supervision situations. This process is challenging, complicated and not uncommonly lengthy.

When planning treatment pathways, we advocate beginning this process of exploring the meaning of the offence after initial stabilization and the forming of a therapeutic alliance. However, in reality, this work will require a consistent approach that ought to be continued once the patient-offender progresses into the community. With the support of probation services offering to monitor, we encourage clinicians to sustain a coherent and exploratory model, alongside other dimensions used to formulate cases, and instruments to assess risk.

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