DARK EMBRACE:
ORESTES COMPLEX, CATATHYMIC CRISIS AND METHOD OF MURDER.
A STUDY OF MATRICIDE IN A FORENSIC PSYCHIATRIC SAMPLE.

by

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Abstract

A study was conducted to investigate and identify differences inherent in two subtypes of psychosis driven or mentally disordered homicide: matricide versus any other biological intrafamilial homicide or attempted homicide. Matricide was further investigated through the exploration of offence specific details, as well as demographic and diagnostic characteristics of persons who had committed (or attempted) homicide against the mother and were subsequently found not criminally responsible and detained by the Ontario Review Board between 1992 and 2012. Matricidal accused were more often diagnosed with childhood disorders and paranoid schizophrenia. As adults, they failed to mature sexually and socially, and continued to live at home, dependent on the mothers that were the ultimate victims of their violence. Attachment theory is offered as a proposed explanation for the matricidal impulse.

Keywords

Matricide, Parricide, Intrafamilial Homicide, Forensic Mental Health, Ontario Review Board, Not Criminally Responsible, Attachment.

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Introduction

The purpose of this study is to investigate and identify differences inherent in two subtypes of psychosis driven or mentally disordered homicide: matricide versus any other biological intrafamilial homicide or attempted homicide. This study investigates the construct of matricide through the exploration of offence specific details, as well as demographic and diagnostic characteristics of persons who have committed (or attempted) familial homicide and were subsequently found not criminally responsible. Chapter 1 begins with a brief history of the forensic mental health system in Ontario in order to provide contextual information about the process through which accused persons go when their offences are deemed legally and clinically "mentally abnormal" (Simpson, A.; McKenna, B; Moskowitz, A; Skipworth, J.; Barry-Walsh, J.; 2006). Subsequently, a review of the literature describes the historical and cultural perspective of matricide, as well as research completed on psychosis driven intrafamilial homicide with a particular focus on parricide and matricide in particular.

A Brief Overview of the Forensic Mental Health System in Ontario

In 1992, in order to modernize the terminology of the old Bill and to limit the jurisdiction of the Lieutenant Governor, the Federal Government amended the Criminal Code of Canada with its introduction of Bill C-30. According to Section 16(1), "no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the

nature and quality of the act or omission or of knowing that it was wrong" (Criminal Code, 1985). The term "mental disorder" is defined in the Criminal Code as "disease of the mind" and the legal interpretation is any "illness, disorder or abnormal condition which impairs the human mind from its functioning, excluding self induced states caused by alcohol or drugs as well as transitory states such as hysteria and concussion" (in Raaflaub, 2005, p.4). To be able to appreciate, one must have the ability to forsee and measure consequences (rather than to simply know, in a cognitive sense), while nature and qualityrefers to the physical consequences of the act (Hucker, 2010). Additionally, the Code indicates that persons are presumed not to suffer from a mental disorder unless, on the balance of probabilities (the civil standard of proof), the opposite can be demonstrated. Furthermore, the burden of proof is on the party that raises the issue of criminal responsibility (Criminal Code, 1985). That is, the party that raises the issue of criminal responsibility in court bears the burden of providing evidence, by way of seeking an expert opinion, to support the position that the accused person is not criminally responsible.

Once the issue of criminal responsibility is raised, the presiding judge issues an order, a Form 48 (assessment of criminal responsibility) under the Mental Health Act and the accused is assessed for criminal responsibility via a " psychiatric assessment by a court expert" (Statistics Canada, 2009). The assessment may take place in the courthouse, with the accused held in custody at a detention centre, or as an inpatient in one of Ontario's forensic mental health centers. Assessment orders of this nature are typically 30-60 days in duration. During the assessment period, the accused is seen by psychiatry as well as social work, psychology, recreation therapy and/or nursing staff who provide

interdisciplinary information pertinent to the assessment. Once case specific information has been gathered, the forensic psychiatrist then offers an expert opinion on the accused's *mens rea*, his ability to appreciate the nature and quality of his actions at the time of the offence, and/or the accused's *actus reus*, his ability to know that the actions were wrong.

Prior to 1992, the supervision of the criminally insane fell under the jurisdiction of the Lieutenant Governor. Today, once a mentally disordered person is deemed not criminally responsible (NCR) for his actions, he falls under the jurisdiction of a provincial review board (the Ontario Review Board or ORB in Ontario). The ORB is then charged with the review of the status, conditions and the rehabilitation of the accused. Thus, each NCR accused is subject to an initial (and then subsequent annual) hearing in front of the panel of board members, which consists primarily of legal and psychiatric members. In preparation for ORB hearings, an opinion is generally provided by way of a hospital report to the board members to inform of the accused's current status, and whether or not he poses a significant threat to the safety of the public that would, in turn, justify an order for detention. The report may contain information about the accused's personal and developmental history (including childhood, family, alcohol and drug use, education, employment, and relationship history) as well as psychiatric history (including previous diagnoses, medical, and legal history) and the circumstances surrounding the predicate offence. If the accused is being held in a hospital at the time of the hearing, the document may also include details of his course in hospital, current mental status and an actuarial risk assessment. If the accused is not held in hospital, he may be ordered by the ORB to attend hospital for a Form 48.1 assessment in order to address the issue of significant threat. Once the issue of significant threat (and whether or not the test is met)

has been assessed, the evidence is presented to the Board at the hearing. The ORB then uses that testimony to determine one of three outcomes for the accused: detention, conditional discharge or absolute discharge.

Within two weeks of having reached a decision, the ORB issues the disposition order; the formal written decision concerning the accused's placement, required level of security, privileges and conditions for the upcoming year. Within two months of the issue of the disposition, the ORB issues a document known as the reasons for disposition, outlining select details of the case history and providing an explanation for the decision. Except in unusual circumstances, ORB hearings are open to the public and documents entered as evidence (including the annual report) become part of the public legal record, as do the disposition and reasons generated by the ORB.

Mentally Abnormal Homicide

Coid (1983) defines mentally abnormal homicide as including cases of accused persons who were examined shortly after their arrest and found to be mentally ill and those for whom the court returned a verdict of not guilty by reason of insanity or manslaughter due to diminished responsibility – or the legal equivalent "according to the country of origin" (p.855). It has been posited that because mentally abnormal homicide rates are directly influenced by prevalence of mental illness (rather than violence), they are relatively stable internationally (Large, Smith, Swinson, Shaw & Nielssen, 2008). Coid also suggested that mentally abnormal homicide rates are fixed at a rate of about 0.13 per 100 000 population per year (in Large et al., 2008, p.130). In their study of a New Zealand population, Simpson, McKenna, Moskowitz, Skipworth & Barry Walsh (2004) found that mentally abnormal homicides constituted 8.7% of the 1498 homicides

committed between 1970 and 2000 (p.394). Mental illness and homicide followed by suicide is even more rare, and complicated, but appears to be more prevalent in cases of intrafamilial homicide (Moskowitz, Simpson, McKenna, Skipworth & Barry-Walsh, 2006).

While rare, homicide by mentally ill offenders makes for sensational news that only serves to further stigmatization and promote fear of the mentally ill by the general public. A recent Ontario case that has highlighted public controversy around mentally abnormal homicide is the 2011 death of Sergeant Ryan Russell at the hands of Richard Kachkar. The victim and the accused were unknown to each other. In the weeks leading up to the offence, Kachkar was noted as having behaved erratically, was religiously preoccupied and repeatedly expressed fear for his safety. On the night of the offence, he commandeered an idling snowplow then struck and killed Russell, a Toronto police officer. He was arrested, assessed by three different forensic psychiatrists, declared NCR, and detained at Ontario Shores in a medium secure forensic psychiatric unit. Since the finding of NCR, the public has expressed increasing fear of violent offenders who are mentally ill and called for more restrictive and punitive treatment of the accused. And while cases like Kachkar's seem to have become the poster children for homicide by mentally ill offenders in Canada, they are not the norm. Contrary to media representation, more often than not the victims of violence by the severely mentally ill are not strangers at all – they are involved in a close relationship with the accused (Liettu, Saavala, Hakko, Raanen & Joukamaa, 2009).

Matricide

Keeping this close relationship in mind, it makes sense that family members, more often than anyone else, are the victims of violence committed by the mentally ill (Chan, 2008). According to Statistics Canada (2011), approximately one third of all homicides in Canada between 2001 and 2011 were committed by family members. Of those, a very small proportion would have been committed by mentally ill offenders. In 2004, police suspected a mental or developmental disorder in 14% of all accused persons, and those with a mental illness were noted as more likely to kill a family member if they were homicidal (Dauvergne, 2004). Parricide, or the killing of one's parents, is said to account for less than four percent of all homicides in Canada (Fedorowycz in Heide & Frei, 2010).

The link between parricide and madness has roots as far back as Greek mythology. In the Olympian creation myth, Cronus castrates his father Uranus. The furies are created from his blood and their function is to avenge crimes of parricide by causing insanity. Taken from the story of Orestes, matricidal themes abound in the subsequent plays of famous Greek and Roman playwrights: although each varies in the details, in its simplest form, Orestes' father Agamemnon is murdered by his mother Clytemnestra and her lover. Years later Orestes, in a state of mental distress, kills his mother and is said to have gone mad in the years that followed: "Orestes, then, had reasons for killing his mother. She betrayed and murdered his father, married his father's cousin, deprived him of his home and his inheritance" (Peck, 1995, p.3). After the murder, Athena judges that the life of a woman is less important than that of a man therefore Orestes was justified in the killing of his mother (Clark, 2009, p.242). Finagrette (1963) postulated that Orestes'

matricidal act was nothing more than liberation from “libidinal attachment to the mother and a childhood dependence” (in Rubenstein, 1969, p.100).

In Babylonian mythology the storm god Marduk slays and dismembers the body of his mother Tiamat (the chaos monster) after she wages war on her children, the first generation of deities. It is said that the universe – all of heaven and earth – was formed from the pieces. In Egyptian myth, Horus was born to his mother Isis after she retrieved the dismembered pieces of her husband, Osiris’s body in order to resurrect him and conceive a son. Horus was said to be a vulnerable boy, and Isis the ideal protective and devoted mother. A battle between Horus and his rival is the scene for his mother’s death: in an attempt to protect her son, she strikes him instead and he, in a fit of rage, beheads her. These and other stories of matricide have been identified as symbolizing the maturing son’s attempt to break free of the authority and dominance of the mother in his struggle for independence (Dalmu, 1967 in Green, 1981).

Historical tales of matricide also abound. Cleopatra III (Queen from 161 BC -101 BC), ruled Egypt jointly with her mother and son, Ptolemy, for six years but was murdered by him after his expulsion from Alexandria. Nero, Roman Emperor from 54 AD-68 AD, was perhaps the most notorious figure to have committed matricide. It is said that he ordered the execution of his mother either to increase the likelihood of marrying his lover (they were both married to others at the time) or to thwart his mother’s plans to place another on the throne. Interestingly, Nero’s mother is consistently noted as dominating and controlling – especially of her own son. Another notable figured to have committed matricide was the English writer Mary Lamb (1764-1847) who stabbed her mother to death during an argument that took place while cooking dinner: Mary is said to

have become angry with her young cooking partner and shoved her. Her mother, angered by her daughter's behaviour, yelled at Mary who picked up a kitchen knife and stabbed her mother in the chest, repeatedly, in front of her younger siblings. After the murder, she was admitted to a local mental facility and a verdict of lunacy was issued by the coroner.

It is said that the male youth of an East African tribe, the Akikuyu, feared that their first instance of sexual intercourse may be fatal so they found a substitutive mother, an old woman, and stoned her to death after raping her in an attempt to symbolically ward off incest (in McKnight, Mohr, Quinsey & Erochko, 1966, p.100). Anthropologically, in a number of primitive tribes, part of a boy's transition to manhood involved injury to his mother or substitutive matricide: in Fiji, sons beat their mothers while Iroquois and Apache sons wounded their mothers with arrows in a "ritual expression of manliness" (McKnight et al, 1966, p.100).

According to Luce Irigaray, western society is founded on matricide: "toute notre culture occidentale repose sur le meutre de la mere" (as cited in Smart, 2000, p.385). Through her study of Greek myth and myths of the social contract, she proposes that the culture in which we live, infused with the myths that we live by, is based on the death of the powerful link to the mother's body, and replaced with the bourgeois ideal of motherhood as love object, and provider of care and comfort. Building on Irigaray's work, Benjamin (1988) goes on to say that the mother has been profoundly desexualized, and "her power may include control over others, but not over her own destiny" (in Smart, 2000, p.386). Interestingly, Friedman and Gassell (1951) interpreted Clytemnestra's murder as a symbolic act of intercourse, and Bunker (1944) as a "regressive substitute for incest".

Today, of intrafamilial violence, parricide, or the killing of one's parent, accounts for approximately 2% of homicides in Western countries (Heide & Petee, 2007). Matricide, taken from the latin words *mater, matris* [mother] and *cadere* [kill] is defined as the murder of a mother by her son or daughter. While a very rare event, matricide is said to be the most common form of parricide in Canada (Bourget, B., Gagne, P., & Labelle, M., 2007).

Case studies are the most commonly published account of matricide, and add to our general understanding of its dynamics. In An Unusual Case of Matricide (1929), Jones presented a case in which a woman was found by police, lying nude on the kitchen floor in a pool of bloodied water, being embraced by her twenty-four year old son who was going through the motions of artificial respiration. He said that she had "died three times" during the night, but that he was able to revive her on each occasion and thought that, given the chance, he may be able to again (p.628). Injuries were noted as severe and included lacerations all over the body, the eyes had been gouged out, the cheeks lacerated with fingernails; there was hemorrhage to the brain, a large laceration to the perineum as well as a tear in the rectum -- both of "which would admit the whole arm into the abdominal cavity" (p.628). Pieces of the colon, stomach, and intestines had been removed and strewn about the room. Upon investigation, the mother was noted as having behaved peculiarly in the years leading up to her death, and it was suggested by relatives that she and her son may have been better off in an institution. The house was disordered and unkempt, again perhaps reflective of the "mental condition of both the mother and son" (p.628). He was noted as having had a good education, was said to have been athletic, although he was noted as having a misshaped head "and did not look well balanced in his

general appearance" (p.628). He had recently lost his job. His parents no longer lived together. In the months leading up to the offence, the son had been spending time with a young woman and the mother had "remonstrated: she did not want him to get married" (p.628). When he was later interviewed by police, he indicated that he wanted to "wash his mother's sins away" (but wasn't known to be particularly religious) and said to his mother "you love God?" before he repeatedly hit her (p.628). He was subsequently examined by three "alienists, found to be a case of dementia praecox" and hospitalized (p.628).

Dark Legend: A Study in Murder (1941) presented the first in depth case study of matricide: the story of a young Italian man who, at seventeen years old, stabbed his mother to death in order to avenge her promiscuous behaviour after the death of his father. Written by Frederick Wertham (1895-1981), a German born American psychiatrist who is said to have chosen his field after conversing with Freud, the publication was seen as a work that "would finally lead to a better understanding of psychological, psychiatric and sociological problems" by using a dialectic approach to understanding the accused's homicidal behaviour (Solby, 1941, p.423). In his book review, Solby noted Wertham's stance on the act: "Matricide is a disease of a patriarchal society […]. It involves the social forces that under-lie all human development" (p.423). Although Werthem acknowledged that murderous impulses toward the mother had been considered by others to be derivations of the Oedipal conflict, he proposed a new entity, the Orestes Complex, and said that it manifested through six characteristics: excessive attachment to the mother-image, hostility toward her, a general hatred of women, indications of homosexual tendencies, ideas of suicide, and an emotional disorder based on proud

feelings of guilt (Wertham, 1941, p.222). Further, he attempted to define the clinical entity known as the Catathymic Crisis – the progression of the subject through five distinct stages: an initial thinking disorder, crystallization of a plan, extreme tension culminating in the violent crisis, superficial normalcy, and insight and recovery – as it related to cases of matricide that he had been seen in his clinical practice (Wertham, 1937, 1978). As it was noted as the seminal work on Matricide, Wertham's concepts of the Orestes Complex and Catathymic Crisis would be recurrent themes throughout future articles and studies on the subject, and his ideas are central to the current study.

In their article, A Case of Matricide (1943), Hill, Sargant and Heppenstall present the case of a twenty year old man who was accused of killing his mother in 1941 by stabbing her to death with a kitchen knife. In the days leading up to the offence they had been working on a project of the mother's, and on the night of the offence, entered into a heated argument over money. The case study noted that "from the history and examination we concluded that the accused had an abnormal personality, associated with which was a poor physique, severe inner-ear deafness, & a possible birth injury to the right hemisphere, and psychopathic inheritance" (p.527). Examination showed that the accused had low blood sugar at the time of the offence, which was reported to have caused abnormal functioning. It was decided that, while he knew what he was doing, and knew that it was wrong, his judgment was impaired to the point that he was "unable to appreciate fully the nature of the act" (p.527). The jury returned a verdict of guilty but insane.

Arnfred (1946) described the case of a grammar school boy who had killed his mother in what appeared to be a "single, abnormal reaction" (p.21). Through his

subsequent nine year hospitalization in a mental institution, the youth's psychosocial history was revealed. His mother had reported to a maternal aunt that she found her son to be difficult to educate. He was said to have walked and talked later than usual, was reserved and shy, lacked initiative, and was too slow and weak to play sports. A teacher reported that it was his mother who kept him from other children. In everyday life, she ruled: "he seemed to be under her command in everything he did […]. The mother in her turn took great care of her boy, and worried about his future [...] the boy was her great worry and joy" (p.25). Arnfred reported that girls did not interest the youth, but neither did he associate with his male peers. At the age of seventeen, he again had difficulty keeping up in grammar school and, despondent, eventually developed suicidal ideation. He concealed his difficulties from his mother, and shortly after one incident during which he went into a wooded area with a breadknife and an idea of suicide, he began to organize a plan to kill her. He said that the idea came to him while he sat staring at school lessons, unable to concentrate. On the day of the offence, he was (as he usually was) alone at home with his mother. That evening, while she was listening to music, he struck her in the head several times with an axe, and then cut her throat with a bread knife. It was reported that his "plans had been associated with vague thoughts of suicide which disappeared now, however, and on the beach he merely washed the blood off his hands" (p.27). In his first few months at hospital, he was noted as "calm and agreeable, though silent" (p.29). During the period of observation that followed, he was noted on several occasions to be "absent minded, restless, and still more reserved than usual, and which result in violent fits of rage with smashing of window panes" (p.30). Shortly after, he was found weeping and sobbing. Seven years after the murder of his mother, he was said to

have experienced a relapse that involved bizarre and suicidal behaviour. He was diagnosed with “insidiously developed schizophrenia” (p.35).

The story of Luke, a thirty three year old poet and actor who killed his mother in 1969, is presented in the article *Orestes in Southern California: a Forensic Case of Matricide* (Meloy, 1996). In the early hours on the morning of May 7, Luke’s mother awoke to her son attempting to smother her with a pillow. Despite this, she accompanied him downstairs to the living room to drink coffee. “Will you drink from my penis?” said the son to his mother, who was said to have recoiled from the thought. She indicated that she would have to go into the kitchen, and fled to her neighbor’s home. She told her neighbors what had happened, and then returned to her own home. Meanwhile, Luke was seen taking a bat and saber sword from the trunk of his car, then he re-entered the family home. He handed the bat to his mother and said “kill me”, then stabbed her in the abdomen repeatedly. The neighbors entered the home and attempted to pull Luke from his mother, but were unsuccessful. They fled to call police while Luke continued to “plunge the sword into his mother’s abdomen and chest, then turned her over and thrust the sword into her back” (p.78). When he was approached by police, Luke said “did I do the right thing? My mother suffered enough. Uh-oh, I’m in trouble now. A man’s got to do what a man’s got to do. The toys of your childhood, my mother was Satan you know” (p.79). The family history revealed that Luke’s mother had suffered an acute psychotic depression following the death of her husband when Luke was eighteen months old. He and his brother lived with their aunt during their mother’s one year hospitalization. His mother remarried and they had another son. Luke attended school and eventually went on to receive a bachelor’s degree in English. He characterized his twentieth year as the year

his “grand odyssey” began, however others described this as the “beginnings of his insidious decompensation into psychosis” which led to the matricide (p.84). At the age of twenty three he came to the attention of the police, and was eventually diagnosed with chronic paranoid schizophrenia. He was treated with medications, which were said to have had good effect, thus he returned to the theatre and was teaching as a graduate assistant before the homicide. He was rehearsing the trilogy *Orestia* and in the first play he was Agamemnon (Orestes’ father) while in the third play he played a fury who demanded revenge against Orestes for the murder of his mother. His behaviour was noted as having become increasingly peculiar in the weeks leading up to the offence. He spent a week in a psychiatric hospital, however upon his release he continued to behave erratically. The night prior to the homicide, he visited his girlfriend’s house and said that he wanted to kill his mother as she slept so that others would think she died in her sleep. He returned home, and couldn’t sleep so he went in to tell his mother: “she invited him into her bed with her, but this didn’t help. In fact, he became increasingly agitated” (p.91). When they went into the living room, Luke watched his mother smoke and thought about how powerful she was. He later stated that he knew he couldn’t have sexual intercourse with her because her vagina was sacred and belonged to his dead father. Likewise, he knew that anal sex was out of the question, thus he asked, “will you drink from my penis?”. Luke was found guilty of involuntary manslaughter and not guilty by reason of insanity (NGRI). He was given a diagnosis of schizoaffective disorder, spent seven years in a regional forensic hospital and was “restored to sanity” eleven years after the matricide (p.93).

Case accounts of matricide in which the accused is a young child are very rare. In Children Who Kill: A Case Study of Matricide (1986), Mouridsen and Tolstrup document the case of a nine year old boy who killed his mother by shooting her several times, from a hidden position, with a rifle. The boy' parents' marriage was said to be harmonious, and their son met developmental milestones appropriately. He was noted to have developed a pre-school aged interest in television programs with "themes of death and destruction". (p.512) Six months prior to the offence he made several taped recordings for relatives, who were living abroad, that contained themes of death. He became "absorbed" in drawing scenes in which people were killed or mistreated in "hateful ways" (p.512). He complained that he was being persecuted and bullied by his peers at school and in their neighborhood, but was described by teachers as a popular kid who did well socially. His close relatives described him as "unintegrated" (p.512). After the offence, he was sent for psychiatric examination. He did not express remorse for his actions. Superficially, he was said to be charming and spontaneous however upon closer examination, he was noted as unaffectionate, tense and guarded and the slightest of changes to routine were said to be problematic. Through play and drawings he evidenced fantasies of death and destruction, and he expressed (without affect) a desire to kill "all of mankind" (p.513). Eventually he disclosed what the assessors felt were hallucinations, both visual and auditory. The assessors could not determine when these symptoms first appeared, nor could they draw a connection between them and the offence. They eventually opined a diagnosis of schizophrenia and said "without a doubt he meant to kill his mother, but we could not at any time uncover a motive, so the killing can be seen as

an example of seemingly inexplicable outburst of affect sometimes found in schizophrenics" (p.514).

Slovenko (2003) presented a case in which a fifteen year old young man stabbed his mother to death in the court yard of a French Quarter hotel in New Orleans. The evening prior to the offence, he was said to have partied through the night, consuming alcohol and two hits of acid. He returned to the hotel mid-morning to be scolded by his mother who was drinking coffee by the hotel pool. She said "you're acting like that jackass friend of yours", which was said to have angered her son (p.252). He went up to the hotel room, retrieved the murder weapon (a knife that his mother had purchased for him, for protection) and stabbed his mother to death in the heart upon his return to the pool area. When he was approached in his hotel room by investigating officers, the accused asked if his mother was dead. When seen in the emergency department, he asked that his mother be notified of his presentation there. Five experts testified at his trial, one of whom had treated and admitted him to hospital at the age of eleven for bizarre behaviour, threatening violence, paranoia, flat affect and an inability to "separate fantasy from reality" (p.253). He was not diagnosed with schizophrenia at the time because "of the stigmatizing effect that label would have on a youngster" (p.253). After the offence, he was assessed and diagnosed with paranoid schizophrenia with polysubstance dependence. He was also noted as suicidal. The assessing psychiatrist said that "schizophrenics are at particular risk to become drug users, and family members, in particular mothers, are at risk of harm" (p.254). Although his parents had divorced when he was two years old, the accused's father testified that he had great difficulty ensuring that his son took medication, and allowed him to stop taking it before his trip to New

Orleans with his mother. The jury found the accused guilty of second degree murder; however the appellate court vacated the conviction and ruled that he was not guilty by reason of insanity.

Dogan, Demrici, Deniz & Erkol (2010) presented a brief case of matricide in which the corpse was decapitated and dismembered. The victim, a fifty-seven year old divorcee, lived with her thirty-three year old schizophrenic daughter. When questioned about her motive, the accused "confessed that she had killed her mother because her mother always criticized and humiliated her" (p.543). She had been receiving treatment for schizophrenia for fifteen years, had always lived at home and was not working. Her illness was noted as having been "in an active stage" during the offence (p.543).

As rare as case studies are, epidemiological studies on Matricide are even scarcer. Thus far, five cohort studies of adult male matricide offenders on forensic or hospitalized settings have been conducted, with sample sizes ranging from 13 to 58 (Campion, Cravens, Rotholc, Weinstein, Covan & Alpert, 1985; Green, 1981; O'Connell, 1963; Mcnight, Mohr, Quinsey, & Erochko, 1965 and Singhal& Dutta, 1992).

At a meeting held at Broadmoor Hospital, Scotland, Dr. B. O'Connell (1963) presented a paper on thirteen men who had murdered their mothers, "shed[ding] light upon the mother-child relationship" (p.1083). In his sample, all but one of the men were unmarried, and their ages ranged from 19-40 years. 11 of the 14 men had been diagnosed with schizophrenia, and all had a previous psychiatric history that ranged from 3 months to 25 years in length. A majority of the sample had given some warning prior to the offence, and only 3 cases were said to not have had a precipitating factor. Half of the cases were demonstrative of "gross and unnecessary violence", and "most" men

expressed relief rather than regret directly following their offences, although 11 of the 14 men eventually developed insight and expressed “regret and yearning” (p.1083). 9 of the 14 men came from homes with absent fathers, and “most lived with a possessive mother. None had mature sexual feelings, and only 3 had heterosexual feelings at all” (p. 1084). O’Connell concluded that the group was “passive, dependent, unambitious and hypochondriacal with strong feelings of social and sexual inferiority. Beneath superficial conformity, they were resentful and hostile” (p.1084).

In their paper entitled Matricide and Mental Illness (1966) McKnight et al. reviewed the cases of twelve men who had committed matricide in the province of Ontario and were admitted to the Ontario Hospital, Penetanguishene, between 1942 and 1964. The average age of the matricide group was 25 years old, and only one patient had been married (however this was noted as an usual marriage in that on their date of marriage, the accused was 16 years of age and his wife was a 34 year old widow. The marriage lasted only two years). None of the accused persons were married at the time of their offences. Of the total group, only three men lived alone with their mothers. With regard to birth order, the matricidal group tended to be “in the younger half” of the family sibline (p.104). None were noted as having had previous psychiatric admissions. In two cases the parents had intended to have the accused examined psychiatrically, and one was seen by a general practitioner the day before the offence, due to disturbed behaviour. Ten of the twelve of accused persons were diagnosed with either catatonic or paranoid schizophrenia. In only one of the twelve cases was there a documented history of prior assault with a knife on the mother, but 27% of the group had previous criminal convictions. In half of the cases, there was no noted “precipitating factor”: two men acted

on command auditory hallucinations, one had intended to rape his sister, and one had been under pressure to leave the family home. In two cases, arguments took place prior to the offence, one was over money and the other was over a handkerchief. In six of the twelve cases, the accused was home alone with his mother. In the remaining six cases, other family members were present, and one sister was murdered. Shooting was the most common method of murder, occurring in half of the cases. Three used blunt instruments, one mother was strangled with a towel and in the remaining cases a combination of knife and hammer or knife and axe was used. In eight of the twelve cases, extreme violence was noted. After their offences, two of the accused attempted to escape. Five reported the crimes immediately, two waited at home and one went to an uncle's house and tried to injure him. One patient was noted to have walked around in a "bewildered state" and one attempted suicide (p.105). The authors acknowledged that only the "bare outlines" of the data were presented, but suggested that a closer study of their cases suggested a connection to the central ideas of Wertham's Orestes Complex and Cathathymic Crisis, and noted a need for future research and exploration (p.105).

Using the same sample, Mohr and McKnight later went on to investigate Violence as a Function of Age and Relationship with Special Reference to Matricide (1971). They noted that matricide most often took place when the accused persons were in their late adolescence. They indicated that this could be viewed as a byproduct of "impulsivity and explosiveness" (p.31) but also described critical periods, a phenomenon known as "lockage", in which homicides tend to occur when a "relationship can no longer be sustained but also not given up" that result in either suicide or homicide as an escape from the intensity of the unsustainable relationship (p.31). They note that Russell (1966)

in his paper on juvenile murderers posited that adolescents, in a life and death struggle, unleash their aggressive and sexual impulses on their mothers in order to release from infantile dependence (p.30). Mohr and McKnight confirm the presence of “lockage”, but not of impulsive or explosive offences due to the accused’s young age. They indicate that in order to define causal relationships with regard to matricide, one must first have a clear view of the “structure of the various homicide phenomena” (p.31). In other words, they noted that – although matricide occurs in the context of problematic interpersonal relationships between mothers and sons – the phenomenon is complicated and cannot be easily studied, nor explained.

Green (1981) studied fifty-eight male offenders who had committed matricide and were subsequently admitted to Broadmoor, a high security psychiatric hospital in Scotland. In 74% of the cases, a diagnosis of schizophrenia was present (this included five cases of schizoaffective disorder) with a mean length of psychiatric history of six to eight years. (p.210). Forty-eight of the fifty-eight accused were not receiving medication for their illness at the time of the offence; however in some cases, medication had not yet been prescribed (i.e. it was the first admission). The study noted that “the great majority” of accused persons had lived with their mothers when they were not hospitalized or incarcerated. The deceased mothers were generally described in case histories, as “dominant, often possessive personalities” and their sons noted as “showing a high degree of dependency” (p.210). The sons’ attitudes toward their mothers was generally described as ranging from “subservient hostility to one of deep devotion” as noted in statements such as “she treated me like a little boy, she humiliated me” or “she was one of God’s treasures on earth” (p.210). In addition to poor employment records and

frequent psychiatric admissions, 41% of the sample had a criminal history with a prior history of physical violence: thirteen patients had reportedly attacked their mothers prior to the index offence. Psychosexual development was noted as "retarded in the group as a whole" with 57% of the sample having had no significant sexual experiences, and thirteen of the fifty-eight patients had "marked problems in sexual and emotional relationships with the opposite sex […] homosexual interest appeared common, […] and 85% of the patients had never married" (p.210). In almost half of the cases, the mothers were the only victims but in the remaining cases, fathers and other relatives were victims as well. All matricides were committed in or close to the maternal home, where 93% of the accused persons lived with their mothers. The age of the accused ranged from 18 to 51 years old, however the average age of those who had been diagnosed with schizophrenia was 30 years (significantly different from the mean age of 39 for the group who had diagnoses of depression). In nine cases, son-mother arguments were reported shortly before the offence, most commonly about food or money. Sharp instruments were noted as the most common murder weapon (knives and axes), followed by battering with blunt instruments or a combination of attack with blunt and sharp weapons, then shooting and asphyxiation (strangulation and/or gassing). Excessive violence was noted in twenty-five cases. Following their arrest and hospitalization, patients who had been diagnosed with schizophrenia rarely showed remorse (ten actually expressed relief), while those with affective disorders did demonstrate feelings of remorse. Twenty seven of the accused described persecutory delusions as the motive for their actions at the time of the offence, while in thirteen cases homicidal instructions from auditory hallucinations led to the matricidal behaviour. In eight cases, the accused's perception of the victim was

altered (e.g. she was seen as a devil or witch or someone other than who she was), and in seven cases, the accused feared that his mother was trying to harm him.

In their 1985 American study, Campion, Cravens, Rotholc, Weinstein, Covan & Alpert found that of the fifteen matricidal men, the majority (a group of eight) emerged with similar psychodynamic and diagnostic characteristics. They had all been diagnosed with schizophrenia. Seven of the eight had well established psychiatric histories, and had previously assaulted their mothers. Four of the men had attempted suicide prior to their offences, three had never lived independent of their mothers, while two had lived independently but had returned to their mothers' houses. Two had been living with other family members at the time the matricide was committed. None were living independently at the time of the offence. In six of the cases, the mothers were home alone with the accused. In one case a father was also slain and in the other, the sister of the accused slept through the offence and escaped unscathed. All eight men were noted as having been psychotic for days to months leading up to the offence. Four of the men were said to have been hallucinating at the time, while three had experienced persecutory delusions. The murder weapon was most commonly a knife, followed by beating and strangling. In one case an axe was employed. Projective testing completed after the offence commonly revealed weak and inadequate self image, ambiguous sexual identity, dependant personality, and inability to accept a separate and mature male role model. Their views of women were as "big, provocative, powerful, rejecting, intrusive, and domineering […]. In effect, these men perceived themselves as hopelessly locked in dependent relationships with their mothers, whom they saw as powerful, hostile, and provocative. It's as if each perceived his mother as *schizophrenigenic*: hostile and

covertly rejecting of him, while maintaining him in a symbiotic relationship in support of her own personality needs" (p.314). The authors conclude that schizophrenic men at risk for committing matricide are chronically ill, live alone with their mothers, have histories of previous assault against the mother, and have previously considered or attempted suicide (p. 315).

Singhal and Dutta (1992) studied sixteen men who had committed matricide and were admitted to three psychiatric hospitals in England. Their ages ranged from 28-55 years. Fifteen of the men had never married and all were single and living with their mothers at the time of their offences (p.214). Thirteen patients noted their mothers as domineering and argumentative. Eight had lost their fathers through some form of separation, and thirteen men described their fathers as passive and uninvolved. All sixteen men were given diagnoses of schizophrenia, and had psychiatric histories that ranged in length from three-twenty-four years. Three men were responding to voices and had persecutory delusions at the time of the offence, while four men believed that the matricide was an act of mercy to relieve his mother's suffering. In five cases, a provocative argument over food or money was noted to have taken place prior to the incident. Six patients used a knife as their murder weapon, while nine used blunt instruments. One used a gun. In fourteen cases, mother was the only victim. In the remaining two cases, father was the second victim. In their discussion summary, the authors noted "this study does suggest that young single schizophrenics living with their mothers seem to be a vulnerable group" (p.216). They go on to say that other factors, such as social isolation and provocation are important, as is treatment and education for families.

Despite the research challenge that low matricide base rates present us with, a review of existing literature indicates that that matricide offence characteristics are relatively stable. There is a high rate of psychiatric morbidity amongst the accused (Chiswick, 1981), and the most common motive for matricide is mental disorder (Liettu, Saavala, Hakko, Rasanen & Joukamaa, 2008). Matricides typically occur in the maternal home (Campion et al., 1985; Chiswick, 1981; Green, 1981) where the majority of accused persons still reside (Clarke, 1993 in Bourget, Gagne & Labelle, 2007). The majority of mothers are white (Heide, 1993, p.534) while the perpetrators are most often male, close to but younger than the age of thirty, and unmarried (Heide, 1993; Bourget et al., 2007; McKnight et al., 1966). The accused most often have a diagnosis of schizophrenia and are actively psychotic at the time of the offence (Campion et al, 1992; Green, 1981; Singhal & Dutta, 1992). Excessive violence and painful methods of murder are also common (Green, 1981). Most, if not all, of the existing research describes an ambivalent relationship between mother and son that spanned and encompassed fear and hatred to loyalty and yearning (Sadoff, 1971; Wertham, 1941; Singhal & Dutta, 1990, 1992).

Despite the general consensus on offence variables, inherent in a critique of the literature are several themes. In her 1992 paper, Heide noted that the literature suffers from many methodological problems. Matricide and patricide cases are often combined, and overlook the differences (demographic, case variables, motivational and otherwise) that may be inherent in the killing of one's mother versus one's father. Some studies include cases in which there is more than one victim, and double parricide cases are often included in matricide studies. The author suggests that "the dynamics are quite likely

different" from single victim matricides through to multiple victim homicides (p.5). Due to limited availability of cases, some studies contain both female and male accused. Again, one might assume that the motivational factors driving the killing of one's mother by a son would be different than those of a daughter. Many studies include both juvenile and adult offenders despite some research demonstrating that age differences result in different offence variables and, perhaps more obviously, length of psychiatric history. Heide and Boots (2011) suggest that motive is also different for juvenile offenders than it is for adults (p.646). Marleau, Auclair and Millaud (2006) posit that adults tend to suffer from severe mental illness, have violent histories and are more likely to threaten their victims while adolescents are less predictable and are motivated by the desire to terminate repeated victimization (p.321). Another criticism is in the inclusion of attempted homicide cases, although there is a suggestion that the main difference between attempted and completed homicide may simply lie in a chance factor (such as marksmanship or physical strength) that makes the inclusion of these cases acceptable. Some studies include the killing of a mother figure (i.e. stepmother), an act which, by nature, would suggest different motivational dynamics than the killing of one's biological mother. It has also been suggested that "repetitive summations of past work with limited new inquiry" is also problematic and lends itself to further research (Walsh, Krienert & Crowder, 2010). Even still, perhaps the biggest criticism of matricide research is that the literature, for the most part, consists of anecdotal case reports and smaller cohort studies (Heide, 1992; Heide & Frei, 2010; Millaud, Auclair, & Meunier, 1996).

Current explanations of matricide are varied and range from psychodynamic (psychoanalytical), through psychiatric (cognitive behaviorism) to psychosocial

(pathways or family systems) in nature. Psychodynamic interpretations of matricide posit that the impulse to kill one's mother has oedipal origins and is a defence mechanism against maternal hostility, maltreatment, or incestuous desires of the child toward the mother (Campion et al, 1985; Sadoff, 1971; Singhal & Dutta, 1990). Through his work, Freud postulated that the son – in his desire to possess the mother – wishes to be rid of his father/rival, yet also fears the father and wishes to be like him. He then gives up on the wish to possess his mother, and this unconscious wish becomes the seed for guilt. These natural processes become pathological when a tendency toward homosexuality or bisexuality is present, and the son (loving the father) wishes to remove and replace the mother (in Holcomb, 2000, p.268). Freud (1928) argued that the desire to possess the mother is the driving force behind the matricide in the Oedipal story of Sophocles, and in Hamlet. Bunker (1944) argued that matricide is a substitute for sexual intercourse with the mother, while Skinner (1961) said that in order to resolve the Oedipus complex, there "must be a struggle with the mother" (in Holcomb, 2000, p.269). Lipson (1986) said that matricide is the result of the accused "perceiving his victim as the externalized frustrating mother of his infancy, as well as the incestuous object of his sadistic desires" (p.113). Another psychodynamic conceptualization of matricide emphasizes the excessive attachment between mother and child that normally takes place at an earlier point of development than that of the Oedipal conflict. This attachment continues on past its natural due date, to become the source of conflicted relations between mother and child. Jung (1915) said that maturing sons must "destroy a frightening symbolic female figure in order to achieve manhood, just as a son must overcome negative qualities of the mother before successfully going on to manhood and marriage" (in Holcomb, 2000,

p.270). In Geha's (1975) treatise on rescue murder, he posits that "the coming together of incestuous urges and extreme hostility mobilizes extreme guilt. Thus to protect against psychic annihilation of the self, as a result of overwhelming desired for the mother that can never be satisfied, the person responds with homicide. The ego must save itself, no matter how" (in Holcomb, 2000, p.271). While psychoanalytic theory provides many important concepts for consideration when attempting to understand the driving force(s) behind matricide, they do not provide an exhaustive explanation. For example, sexual conflict and a desire to possess the mother may be present; however it is not easily observed or measured and is only sometimes evidenced in the existing matricide literature. Pre-oedipal excessive attachment and dependency upon the mother may lead to emotional conflict between mother and son (perhaps magnified if there are homosexual tendencies), but again, can not account for the act of matricide in all cases.

Psychiatric explanations for matricide include high rates of mental illness (primarily psychotic disorders) and lack of appropriate treatment for the mentally ill (Bourget, Labelle, Gagne et al., 2004; Bourget & Whitehurst, 2004 in Bourget, B., Gagne, P., & Labelle, M., 2007; Millaud, Auclair & Meunier, 1996). Thus, it follows that the mentally ill offender's behavior may be driven or directly motivated by delusions or hallucinations (Taylor, 1985 in Laajasalo & Hakkanen, 2006). Excessive violence has been associated with intrafamilial homicide committed by the mentally ill (Green, 1981), and at least one study has shown that a secondary psychotic syndrome associated with a lesion in the front neural network was responsible for a matricide committed by a forty year old woman (Orellana, Alvarado, Munoz-Neira, Avila, Mendez & Slachevksy, 2013). Neurological impairment, involving executive dysfunction and memory dysfunction, are

also more prevalent in homicidal schizophrenic men (Hanlon, Coda, Cobia & Rubin, 2012). One of the first cognitive behavioural conceptualizations of matricide was put forth by Ellis and Gullo (1971). The authors argued that most often, the accused who kill have "pathological personalities and can be diagnosed as psychotic or near psychotic. Only a small portion is sane" (in Holcomb, 2000, p.273). In their view, matricide occurs because the accused is paranoid (and think that mother is plotting against him); the mother has been unjust; he might benefit financially from the mother's death; or he is sufficiently mentally disturbed that he "doesn't know what he is doing" (in Holcomb, 2000). That being said, a strict psychiatric or cognitive behavioural interpretation of matricide is insufficient to account for the plethora of other variables inherent in these cases.

Silberstein (1998) noted that "at the heart of all psychopathology lie failures in relationships with a significant one" (p.213). He goes on to explain that when a child does not bond with a parent, and a parental coalition is not formed, the value of both parents is diminished. "A mother, who cannot become a suitable model of a love object because she constantly assumes a castigating attitude toward the child, creates a pathological relationship between her and the child" (p.214). Chambers, Eccleston and Brown (2009) present possible psychosocial explanations of assault (and violent offences in general). Their pathways models include several variables that contribute to assaultive offending behaviour. First are developmental experiences and responses to those experiences. For offenders with unsafe childhood home and/or public environments, violent behaviour that had been witnessed was modeled, and they, in turn, became violent themselves (p. 1430). Another variable that the authors noted as predictive was attitude

and subsequent reaction to anger. Accused persons who believed that violence had no role in their lives had more often than not experienced safe environments growing up, while those who had described unsafe childhood environments more often rationalized the use of violence. Lifestyle preceeding the offence (unstable versus stable), and assault offence characteristics, particularly the precipitating event that resulted in a planned or reactionary violent act, were also noted as predictive of violence. Other psychosocial explanations of violence in the mentally ill include prior history of hospitalization, previous violence and/or arrests, and substance abuse (Arboleda-Florez, Holley and Crisanti, 1996 in Chan, 2008). Lack of social structure and support is also correlated with familial homicide (Diem & Pizarro, 2010). Family systems theory posits that it is the unbearably abusive and pathological family structure that sometimes leads to one parent (consciously or otherwise) using the accused as an instrument of spousal murder (Easson & Steinhilber, 1961; Sadoff, 1971; Sargent, 1962; Vaisanen & Vaisanen, 1983 in Holcomb, 2000). Post (1982) further argued that the murder of the mother would not have taken place unless the family had created a “tenable situation in which the murder is a reasonable conclusion” (in Holcomb, 2000). Again, in family systems theory, the concept of lockage appears: the son or daughter, having tried to escape the relationship with mother and failed, turns to homicide as the only way out, inciting reactive matricide. Palmero (2010) simply states that “the most common factor in these violent manifestations is destructive anger” (p.3). He goes on to say that “even though negative feelings are usually contained through repressive mechanisms or because of situational factors, at times they reemerge, with stronger intensity, under unusually stressful

conditions" such as disinhibition and mental illness, "schizophrenia and highly distorted thinking" (p.3).

While each of these theories, on their own, may account for facets of matricide, none explains the phenomenon as a whole. Take, for example, the psychodynamic interpretation of matricide as a defense mechanism against repressed psychosexual feelings toward one's mother. If this were the sole impetus for the matricidal impulse, the crime would be far more common than it is, as most (if not all, as Freud would argue) young men, at one time in their lives, experience the sexual desire of their mother yet not all kill their mothers in response to those repressed feelings. Similarly, if we are to look at psychiatric explanations of matricide, paranoid delusions or frank psychosis may be present in almost all cases, but only a very small percent of the mentally ill are violent, and even less are homicidal. Thus, the pieces fit together to form part of the puzzle, but something is, indeed, missing. Finally, if we examine psychosocial explanations of matricide, we are left with the same dilemma. Substance abuse, anger, prior hospitalization and violence may all be common amongst those who kill their mothers, but do not offer the full explanation. If psychosocial factors were the only ones at play, matricide would be less an anomaly than it is today. Unfortunately, Occam's razor is not easily applied to the concept of matricide, for to parsimoniously reject the more thorough explanation in favour of the hypothesis that makes the fewest assumptions simply does not account for the phenomenon in its entirety.

Chapter Summary

Matricide committed by mentally disordered accused persons accounts for the majority of psychosis driven homicides in Canada, yet there is a paucity of original

research on parricide in general, and even less available research on matricide in particular. Of the five known published matricide studies, two are Canadian: McKnight et al. presented a brief outline of twelve Ontario matricide cases in 1966, while Bourget, Gagne & Labelle described a Quebec sample of twenty seven matricides in 2007. The three remaining studies present cases in Scotland, the United States and England, with sample sizes ranging from fifteen to fifty-eight.

The existing matricide literature is primarily descriptive in nature, and does not attempt to infer the processes at play that drive an accused person to kill his or her mother. The lone American study, published in 1985 by Campion et al., described a subset of eight men with “common diagnoses, psychodynamics, and family factors”, having come closest to exploring and describing the development of the matricidal impulse, rather than simply describing the sample.

From the limited number of known published case and epidemiological studies, several authors have summarized the existing literature with an eye toward developing a better understanding the concept of matricide; offering the psychodynamic, psychiatric and psychosocial explanations. Perhaps the most comprehensive work on Matricide was also one of the first. Through his clinical observations in New York City, Wertham (1941) proposed the Orestes Complex, thus describing an ambivalent attachment relationship between mother and son that, given the right (or perhaps the tragically wrong) circumstances, would lead to matricide at the height of the Catathymic Crisis (in Ogunwale & Abayomi, 2012). Twenty four years later, McKnight et al. suggested that their Ontario sample demonstrated some of the characteristics inherent in Wertham’s. Several authors have since referenced the idea of an Orestes Complex and Catathymic

Crisis when studying and describing matricide, however none have systematically explored Wertham's ideas in a sample of matricidal accused persons.

Purpose

The purpose of this research study is to investigate and identify differences inherent in two subtypes of psychosis driven or mentally disordered homicide: matricide versus any other biological intrafamilial homicide or attempted homicide. There is a specific focus on exploring and developing a further understanding of the characteristics of matricide specifically. While the characteristics inherent in the offences of matricide and intrafamilial homicide share many similarities, there are unique differences that have not fully been articulated in the literature. This research is valuable as it will contribute to the overall literature on mentally abnormal homicide with a focus on immediate family members, particularly mothers, who are most often the victims of violence committed by the mentally ill. This research may lead to a better understanding of the variables that lead to the matricidal impulse, and subsequently enable mental health professionals to better educate and guide the families of mentally disordered individuals in an effort to prevent intrafamilial violence, and particularly matricide, in the future.

Research Questions

1. What makes mentally abnormal matricide different from mentally abnormal intrafamilial homicide? Are the matricidal accused inherently different than other perpetrators of intrafamilial homicide? Are the offence characteristics different?
2. Is there, as Wertham suggested, characteristics consistent with an "Orestes Complex" inherent in matricide cases?

3. Are there characteristics of the Catathymic Crisis, as described by Wertham, inherent in the act of intrafamilial homicide?

In order to answer these three research questions, the remaining chapters of this study will review the research methods used, report results of data analysis, and discuss the results obtained. Chapter 2 focuses on the participants studied, the measures used, and the procedure used to collect data. Chapter 3 provides detailed results from the statistical analyses employed on the data. Finally, Chapter 4 provides a brief summary and possible explanation for the results obtained, as well as a discussion of limitations and future implications of the research.

Methods

This chapter gives an overview of the methodology used to complete the current study and begins by describing how the sample was selected for research. Next, procedures used to collect data are discussed. Finally, the statistical analyses are detailed.

Sample

The sample employed in the current study consisted of case histories of persons (referred to as the accused) found not criminally responsible on account of mental disorder or not guilty by reason of insanity for Attempt Murder, Murder 1, Murder 2, or Homicide of an immediate biological family member. Cases had been adjudicated by a trial judge, and the accused persons were detained under the jurisdiction of the Ontario Review Board between 1992 and 2012, with their clinical and forensic risk managed by one of eight forensic mental health centres in the province of Ontario. Information contained within documents generated for and by the ORB, namely hospital reports, dispositions and reasons for disposition, was coded for the purpose of answering pertinent research questions as outlined in Chapter 1. In total, there were eighty nine case reports identified that had clearly stated victim-accused relationships. Of these, forty two were matricides, and forty seven were non-mother immediate biological family member homicides. The accused persons were predominantly male, slightly older than thirty years of age. They had achieved at least some high school, and had limited (up to a year) employment history. The majority of case histories were taken from the Centre for Addiction and Mental Health hospital reports prepared for the Ontario Review Board (see Table 1).

Table 1
Overview of Sample

	Matricide	Intrafamilial
Homicide Type	n=42 (47%)	n=47 (53%)
Gender		
Male	n=38 (91%)	n= 41(87%)
Female	n=4 (10%)	n=6 (13%)
Age	M=31.07 SD(8.73)	M=32.53 SD(11.22)
Legal Finding		
NCR	n=33 (81%)	n=40 (85%)
NGRI	n=8 (20%)	n=7 (15%)
Education		
Some High School (1)	n=17 (59%)	n=12 (43%)
High School (2)	n=4 (14%)	n=4 (14%)
Some University (3)	n=2 (7%)	n=5 (18%)
University (4)	n=4 (14%)	n=1 (4%)
Some College (5)	n=0 (0%)	n=1 (4%)
College (6)	n=0 (0%)	n=2 (7%)
Graduate Studies (7)	n=0 (0%)	n=2 (7%)
Elementary School (8)	n=2 (7%)	n=0 (0%)
Primary School (9)	n=0 (0%)	n=1 (4%)
Length of Employment		
0-1 Years	n=4 (20%)	n=8 (36%)
1-2 years	n=3 (15%)	n=1 (5%)
2-3 Years	n=4 (20%)	n=4 (18%)
3-5 years	n=3 (15%)	n=2 (9%)
5-7 Years	n=2 (10%)	n=1 (5%)
7-10 Years	n=2 (10%)	n=3 (14%)
10+ Years	n=2 (10%)	n=3 (14%)
Forensic Hospital		
CAMH, Toronto	n=16 (38%)	n=13 (28%)
Waypoint, Penetanguishene	n=5 (12%)	n=3 (6%)
Ontario Shores, Whitby	n=7 (17%)	n=6 (13%)
North Bay Regional Health Care Group	n=3 (7%)	n=5 (11%)
Royal Ottawa Mental Health Centre	n=5 (12%)	n=11 (23%)
Thunder Bay Regional Health Sciences Centre	n=0 (0%)	n=1 (2%)
Providence Continuing Care Centre, Kingston	n=0 (0%)	n=3 (6%)
St. Joseph's Health Care Hamilton	n=6 (14%)	n=5 (11%)

Note: n = number of cases included in the condition. % = the proportion of the listed characteristic for cases by condition.

Measures

In order to assess the sample and answer the research questions, case histories were coded for demographic information as well as diagnostic and offence specific details (see Appendix A, p. 85 for coding sheet). A coding manual was developed specifically to guide coding of the eighty variables in the study (Appendix B, p. 90). Only cases for which there was a finding of not criminally responsible or not guilty by reason of insanity were coded for inclusion in the study.

Demographic, as well as personal and developmental history included several variables. Gender was coded as male or female. Date of birth was coded in years, while place of birth was coded as Canada, the Caribbean, Asia, Europe, South America, the Middle East, or Africa. Highest educational achievement was coded as having achieved some elementary school, completion of elementary school, some high school, completion of high school, some post secondary, completion of college or undergraduate degree, some graduate level education or completion of graduate level education. Length of employment history was coded as up to one year, one to two years, two to three years, three to five years, five to seven years, seven to ten years, or more than ten years. The accused's place of residence at the time of the index offence was coded as the maternal/victim's home, independent or other. It was also noted and coded whether the accused had ever been married, if he was still married at the time of the index offence, and whether or not he had ever had children.

Previous legal history was coded as not present, or present and subsequently categorized into one to three previous charges/convictions or more than three previous charges/convictions. Previous psychiatric history was coded as present or not, and

denoted by formal contacts with mental health professionals for assessment or treatment of psychiatric disorder. Age of onset of illness and age at first admission to hospital for treatment of psychiatric illness was also coded in years.

Diagnostic and Statistical Manual (DSM) psychiatric diagnoses were coded as those noted in the document(s) prepared for or by the Ontario Review Board (DSM versions were not noted in the materials provided, and are therefore, not noted in this paper). Diagnoses had been opined by the assessing psychiatrist at the time of the NCR assessment, or by the treating physician in the clinical period leading up to the ORB hearing. Psychiatric diagnoses were coded as schizophrenia, schizoaffective disorder, depression, anxiety disorder, delusional disorder, bipolar disorder, pervasive developmental disorder and/or psychosis NOS. If schizophrenia was noted as a diagnosis, it was further coded if the subtype was noted as paranoid schizophrenia. Active psychosis in the form of paranoid delusions or command hallucinations was coded if the accused was noted as actively psychotic in the period immediately preceding or at the material time, and that symptomatology was opined to be at least partially responsible for the criminal acts. Personality disturbance was coded as present if the accused person had formally been diagnosed with a personality disorder (including NOS) or if personality traits were noted diagnostically. Likewise, cognitive ability was coded as intellectual deficit (noted as present if the accused person had a diagnosis of mental retardation) or no intellectual deficit. Substance use disorder was coded as present if there was a formal diagnosis in the file information. Alcohol and drug history were coded as present if there was indication in the psychosocial history that substance use was significant enough to have had interfered with or impaired the accused’s life functioning. Childhood diagnoses

were coded as attention deficit hyperactivity disorder, conduct disorder or not present. Psychopathy Checklist Revised (PCL-R) scores were recorded, and ranged from one to twenty eight of a possible forty (Hare, 1991). Violence Risk Appraisal Guide (VRAG) bin scores were also recorded, and ranged from two to eight out of a possible range of one through nine (Harris, Rice & Quinsey, 1993).

Age at the time of the index offence was coded in years, as was the age at the time of adjudication of the index offence. The index offences were coded as follows: Murder 1, Murder 2, Manslaughter, Attempt Murder, Weapons Charges, Sexual Offences, Utter Threats, Assault, Criminal Harassment, Failure to Comply, Confinement/Abduction, Robbery, Arson, Break and Enter, and/or Miscellaneous (drug charges, driving related charges). The total number of offences was coded as the number of index offence convictions for which a finding of NCR or NGRI was issued. Victim was coded as mother, father, sister, brother, son or daughter, and were coded for victim one, victim two and victim three for those accused persons having had multiple victims. The method of murder was coded as either weapon, fire, choking, or other. Weapon was further specified as knife, gun, scissors, hammer, axe, screwdriver or other. Extreme violence was coded as present if police noted more than the amount of force needed to cause significant injury or death in their description of the offence (as noted in Mcknight et al., 1966). The location of the index offence was coded as having taken place at the victim's home or any location other than the victim's home.

The Orestes Complex characteristics as denoted by Wertham (1941) are as follows: excessive attachment to mother/victim; hostility against the mother/victim; a general hatred of women; indications of homosexual potentialiality; ideas of suicide; and

emotional disorder based on profound feelings of guilt. It should be stressed that the description and analyses of Orestes Complex variables was conducted in an effort to explore these ideas as set out by Wertham, rather than an attempt to prove or disprove his theory. They were operationally defined for this study through a review of the relevant literature, and/or the application of current forensic mental health risk assessment and management methodology. Excessive attachment to the mother/victim was coded as present if the accused – as an adult who would normally have achieved some level of independence – was noted at the time of the index offence as having been dependent on the mother/victim, primarily, for the necessities of life such as food, shelter, and/or completion of activities of daily living such as cooking, cleaning, self care and/or medication compliance. Hostility against the mother/victim was coded as present if there was documentation, including formal charges or convictions, for previous verbal or physical aggression with potential for physical or psychological harm. Aggression was defined as violence, as outlined in the Historical, Clinical Risk Management Scales (HCR-20) structured risk assessment scheme (Webster, Douglas, Eves &Hart, 1997). General hatred of women was coded as present if the accused, at any time throughout the psychosocial history or at the time of the offence, was noted as having made obvious misogynistic statements or expressed an aversion to women. Homosexual potentialities were coded as present if the psychosocial history was positive for a statement of homosexual preference, or for homosexual relationships. While not noted as a characteristic by Wertham, this variable was also considered in the context of an absence of intimate sexual encounters, as the matricide literature indicates that many men who commit this crime have retarded sexual development, with no significant sexual

experience (Chiswick, p.1279) or an absence of sexual interest in members of the opposite sex, and in some cases, sexual preoccupation with their mothers (McKnight et al., 1966). “Ideas of suicide” was coded as present if the accused’s history was positive for suicidal gestures, ideation or attempts, up to and including the material time. Emotional disorder based on profound feelings of guilt was coded as present if emotional tension around guilt, fear, or jealousy was inherent in the accused’s statements, behaviour or psychiatric symptoms (i.e. an expression of guilty though delusional content or hallucinations) leading up to the index offence.

The concept of catathymic behaviour was first described by Maier (1912), but was subsequently redefined by Wertham in 1937 for application in forensic psychiatry (1978, p.165). For the purposes of this study, the Cathathymic Crisis is the progression of the accused through five distinct stages as proposed by Wertham: “an initial thinking disorder, which follows a precipitating (or traumatic) circumstance; crystallization of a plan when the idea of a violent act emerges into consciousness. The violent act is seen as the only way out. Emotional tension becomes extreme, and thinking becomes more and more egocentric; extreme emotional tension culminating in the violent crisis in which a violent act against oneself or other is attempted or carried out; superficial normality, beginning with a period of lifting of tension and calmness immediately after the violent act. This period is of varying length, but usually several months; and insight and recovery, with the establishment of inner equilibrium” (1941; 1978). Again, it must be stressed that that the description and analyses of Catathymic Crisis variables was conducted in an effort to explore these ideas as set out by Wertham, rather than an attempt to prove or disprove his ideas as a theory. It should also be noted that the order in

which an accused person experienced these stages was not suggested (save for his notion that one would progress through them), nor was it recorded nor analyzed in this study.

The initial thinking disorder was coded as present if the accused had been diagnosed with a psychiatric disorder that had the capacity to interfere with his access to rational thought (i.e. any psychotic illness). Crystallization of a plan was coded as present if the accused, at any point, was noted to have verbalized the idea that he must carry out a violent act against the victim, and this subsequently materialized in a plan to do so (as confessed by the accused or was noted by police or clinicians in the file) that led to his actions at the time of the index offence. Extreme tension culminating in the violent act was coded as present if there was evidence of a prolonged conflicted relationship between the accused and the victim (resulting in a delay in carrying out the matricidal plan), or if there was a conflict in the days leading up to the index offence that directly contributed to the accused's actions at the material time (i.e. an argument over medication, money, etc.). Superficial normality was coded as present if, after the commission of the offence, the accused expressed a sense of relief, or was noted as behaving as if nothing had happened (i.e. carried on with activities of daily living, without a direct attempt to hide the index offence). Insight and recovery was coded as present if, in the years following the offence, the accused was noted as having gained insight into his actions at the material time, and experienced a remission of psychotic symptoms. Although one might assume that the accused person would progress through these stages in some chronological order, the order in which the accused experienced them was not specified by Wertham nor considered for the purpose of this study.

Procedure

Ethical approval for the current study was obtained from Laurentian University's Research Ethics Review Board (Appendix C, p. 94) , the Ontario Review Board (as part of a larger homicide study being completed at the Centre for Addiction and Mental Health, see Appendix D, p. 95), and the CAMH Ethics Review Board (Appendix E, p. 96). Using CAMH's University of Toronto research privileges, several searches of LexisNexis (an electronic database of public legal and journalistic documents) were executed throughout April and May 2012 to identify Ontario Review Board cases and resultant Dispositions or Reasons for Disposition using the search terms 'homicide', 'manslaughter' and 'murder' for the years 1992 through 2012 inclusive. These searches resulted in 2392 case files containing at least one of the key search terms, which were, in turn, reviewed for suitability for inclusion. The 426 resultantunique cases that met search criteria were then reviewed individually in order to identify immediate biological family victims (mother, father, sister, brother, son, daughter).

After appropriate Disposition or Reasons for Disposition were identified by offence and victim, the resultant 100 case files of immediate familial homicide (or attempted homicide) were electronically downloaded for data collection. Of those available, several documents were missing pertinent information, thus hospital reports prepared for the ORB were identified and accessed from the CAMH database where available. Additionally, 62 case reports were requested directly from the Ontario Review Board. Due in part to documentation difficulties (no formal electronic database of cases, and files only accessible in paper version, stored in boxes by year) and time restraints, access had not been provided to these files at the time of writing.

Once case files (Disposition, Reason for Disposition or ORB report) had been accessed and downloaded, they were coded for 80 variables. In terms of ethical considerations, no physiological, psychological, or social risks were anticipated since all data were retrieved using historical case files.

Statistical Analysis

Statistical analysis consisted of a series of descriptive analyses to determine the mean and standard deviations of the sample's demographic characteristics, where appropriate. Descriptive analyses were also employed to provide an overall description of the matricide group, for comparison with this population in previous studies. Comparisons were then made between the matricide and intrafamilial groups to see if there were significant group differences. Next, independent sample *t*-tests and non-parametric tests were performed to see if the matricide and intrafamilial groups differed on demographic, diagnostic and offence specific variables. Chapter 3 details the results of the statistical analyses used in order to address the research questions outlined at the end of Chapter 1.

Results

This chapter is organized to answer each of the research questions posed in the introduction, and present findings of data analysis for the current study. The primary purpose of the study was to explore differences inherent in two subtypes of psychosis driven or mentally disordered homicide: matricide versus any other biological intrafamilial homicide or attempted homicide. Two techniques were used to analyze the data. First, a descriptive analysis was used to describe the groups' demographic and offence specific characteristics. Second, where possible and appropriate, independent sample t-tests and chi-square tests were completed to analyze matricide and intrafamilial group differences. An alpha level of .05 was used for all statistical tests. Of the 100 cases identified for the specified time frame of the current study (1992-2012), only partial data was available for a portion of the cases (i.e. hospital reports were not made available or ORB documents were missing pertinent information). Therefore many analyses were performed with less than the total number of cases that were initially identified, and other variables were not coded due to lack of information.

Research Questions Restated

The first question was designed to explore inherent differences between mentally abnormal matricide and mentally abnormal intrafamilial homicide, through description and comparison of the groups' demographic, diagnostic and some offence specific details: *what makes matricide different from other non-mother intrafamilial homicides?* The second question was designed to explore the presence or absence of ideas inherent in the Orestes Complex, as defined by Wertham: *is there, as Wertham*

suggested,characteristics of the Orestes Complex that are present in matricide cases but not in non-mother intrafamilial homicide cases? The third and final question was designed to investigate the presence of ideas inherent in the Catathymic Crisis, again described by Wertham: *is there evidence for characteristics of the Catathymic Crisisin all intrafamilial homicides?*

Demographic characteristics

The matricide and intrafamilial groups were compared to investigate differences with respect to demographic characteristics. Group differences were noted for age at first psychiatric admission to hospital, likelihood of having lived independently as an adult, of having been married or in a domestic partnership (at the time of the offence or otherwise), and for having had children.

Of the cases where the victim's relationship to the accused was noted in the materials available, 47% were matricide, and 53% were non-mother intrafamilial cases. Males were overrepresented in the sample, comprising 89% of the total group. By homicide type there were no significant gender differences between groups. The matricide group was 90% male, while the intrafamilial non matricide group was 87% male. Again, there was no significant difference between groups with regard to age, which ranged from 17-62 years. The average age of the matricide perpetrator group was 31 years (SD = 8.73), while the intrafamilial group's average age was slightly higher, at 33 years (SD = 11.22). Of those cases noting country of origin, the sample was rather evenly split between those who were born in Canada (50%), and those who were born outside of Canada.

With regard to educational achievement there were no significant differences between groups. Overall, 52% of theaccused had achieved some high school, 12% had attended university, 9% had graduated from university and 3% went on to graduate studies. There was no significant difference between groups for employment history. 29% of the sample had worked for one year or less, 19% had worked for two to three years, while only 12% had worked for more than ten years. The Intrafamilial group was, however, more likely to have lived independently (i.e. not with parents and not with the victim) than the matricide group $X^2(2, N=86) = 10.89$, $p = .004$. The majority of accused persons lived with their victims at the time of the offence: 85% of matricide perpetrators lived with their mothers, while 73% of intrafamilial, non matricide perpetrators lived with their victims at the material time. The matricide group was less likely to have been married than the intrafamilial group $X^2(1, N=83) = 5.47$, $p = .019$. They were subsequently less likely to be in a marriage or domestic relationship at the time of the index offence than the intrafamilial group $X^2(1, N=84) = 8.55$, $p = .003$. With regard to children, 24% of the overall sample had not had children, while 95% of the matricide group was childless. This denoted a significant difference between groups: $X^2(1, N=84) = 13.16$, $p < .001$.

There was no significant difference between groups for previous legal history. 49% of the sample had no formal charges or convictions, while 26% had 1-3 previous charges and 25% had more than 3 charges. The majority of the sample did, however, have a well documented previous psychiatric history. The matricide accused experienced their first psychiatric admission at a younger age (M=21.76, SD=5.13) than the intrafamilial accused (M=27.17, SD=9.07). Because Levene's test indicated unequal variances ($F=4.92$, $p = 0.03$), the degrees of freedom were adjusted from 31 to 15. Thus,

this difference approached, but did not reach significance $t(15) = -1.898$, $p = 0.07$. It should be noted, however, that despite not having reached statistical significance, the group difference impresses as noteworthy, as will be discussed in chapter 4.

Table 2
Demographic Characteristics

	Matricide	Intrafamilial	Overall
Birthplace			
Canada	n=16, 64%	n=7, 35%	N=23, 51%
Carribean	n=2, 8%	n=1, 5%	N=3, 7%
Asia	n=2, 8%	n=5, 25%	N=7, 16%
Europe	n=3, 12%	n=3, 15%	N=6, 13%
South America	n=1, 4%	n=0, 0%	N=1, 2%
Middle East	n=1, 4%	n=0, 0%	N=1, 2%
Africa	n=0, 0%	n=4, 20%	N=4, 9%
Place of residence			
Victim's home	n=35, n=85%	n=33, 73%	N=68, 79%
Independent	n=1, 2%	n=11, 24%	N=12, 14%
Miscellaneous	n=5, 12%	n=1, 2%	N=6, 7%
Married	n=5, 13%	n=16, 36%	N=21, 25%
Married IO	n=2, 5%	n=14, 30%	N=16, 19%
Children	n=2, 5%	n=18, 39%	N=20, 24%
Legal History			
1-3 charges	n=9, 27%	n=9, 27%	N=18, 27%
3+ charges	n=7, 21%	n=9, 27%	N=16, 24%
Psychiatric History	n=28, 88%	n=29, 83%	N=57, 85%

Note: n = number of cases included in each group. N = total number of cases included in the sample. % = the proportion of the listed characteristic for cases by group and for the overall sample.

Diagnostic characteristics

The matricide and intrafamilial groups were compared to investigate differences with respect to diagnostic characteristics. Group differences were noted for paranoid schizophrenia, as well as childhood diagnoses of Attention Deficit Hyperactivity Disorder and Conduct Disorder.

Diagnostically, schizophrenia was the most prevalent psychiatric illness and 62.2 % of the sample had received this diagnosis. This was followed by schizoaffective disorder (10.1%), depression (7.9%), bipolar disorder (7.9%), psychosis NOS (6.7%), and delusional disorder (2.2%). Of those who had been diagnosed with schizophrenia, 35% of the sample overall were noted as having a paranoid subtype, however the matricide group was diagnosed with paranoid schizophrenia at a significantly higher rate than the intrafamilial group $X^2(1, N=89) = 5.73$, $p = .017$. There was no significant difference between groups for active psychosis at the time of the offence. The primary psychotic symptoms experienced by the accused persons were paranoid delusions (74.7%), followed by command hallucinations with paranoid delusions (20.3%), while only 5.1% of the sample reported command hallucinations alone. There were no significant group differences with regard to personality pathology and/or intellectual disability. Slightly less than a third of the population (27%) were noted as having some form of personality disturbance (traits or disorder), and only 4% were noted as having intellectual deficits that would qualify for a diagnosis of intellectual disability (then mental retardation).

Overall, 34% of the sample had been given a diagnosis of substance abuse disorder, however 59% were noted as having an alcohol abuse history and 50% were noted as having a drug abuse history. There were no significant group differences noted for prevalence of substance disorder or use. Childhood diagnoses of Attention Deficit Hyperactivity Disorder and Conduct Disorder were not commonly noted, however they were more predominant in the matricide group than in the intrafamilial non-matricide group $X^2(2, N=89) = 5.93$, $p = .05$. Although case reports that actually contained PCL-R and VRAG scores were very limited (n=26 and n=21 respectively), the PCL-R scores

ranged from 1 (very few psychopathic characteristics) to 28 (many psychopathic characteristics). Of those, half fell below a value of 10. The VRAG "bin" scores ranged from two (low risk of violent recidivism) to eight (high risk of recidivism) with a mode of 3 and a mean of 4.10.

Table 3
Diagnostic Characteristics

	Matricide	Intrafamilial	Overall
Diagnosis			
Schizophrenia	n=29, 69%	n=26, 55%	N=55, 62%
Paranoid Schizophrenia	n=20, 48%	n=11, 23%	N=31, 35%
Schizoaffective Disorder	n=5, 12%	n=4, 9%	N=9, 10%
Depression	n=1, 2%	n=6, 13%	N=7, 8%
Delusional Disorder	n=2, 5%	n=0, 0%	N=2, 2%
Bipolar Disorder	n=1, 2%	n=6, 13%	N=7, 8%
Psychosis NOS	n=2, 5%	n=4, 9%	N=6, 7%
Not Specified	n=2, 5%	n=1, 2%	N=3, 3%
Active Psychosis			
Paranoid Delusion	n=27, 75%	n=32, 74%	N=59, 75%
Command Hallucination	n=3, 8%	n=1, 2%	N=4, 5%
Both	n=6, 17%	n=10, 23%	N=16, 20%
Personality Disturbance	n=12, 29%	n=14, 30%	N=26, 29%
Cognitive Deficit	n=2, 5%	n=2, 4%	N=4, 5%
Substance Disorder	n=17, 41%	n=13, 28%	N=30, 34%
Substance Use History			
Alcohol	n=21, 68%	n=13, 48%	N=34, 59%
Drug	n=17, 55%	n=12, 44%	N=29, 50%
Childhood Diagnosis			
ADHD	n=2, 5%	n=0, 0%	N=2, 2%
Conduct Disorder	n=3, 7%	n=0, 0%	N=3, 3%

Note: n = number of cases included in each group. N = total number of cases included in the sample. % = the proportion of the listed characteristic for cases by group and for the overall sample.

Offence characteristics

The matricide and intrafamilial groups were compared to investigate differences with respect to offence characteristics; however no significant group differences were noted.

Just as there was no significant group difference for age at the time of the index offence, the accused's age at the time of NCR/NGRI finding also did not differ significantly. The mean age for the matricide group was 32 (S=9.3) and 33 (SD=11.1) for the intrafamilial group. The number of charges that resulted in convictions during the commission of the Index Offence varied from one to nine and ranged from Murder to Mischief. A majority (72%) of the sample committed only one offence, and 36% of those cases resulted in convictions for Attempted Murder, 30% were Murder 1, 30% were Murder 2 and 3% were Manslaughter. Only 17% of the sample committed two offences, and of those, 43% were Attempt Murder, 43% were Murder 1, and 14% were Murder 2. A mere 3% of the sample committed three or four offences, 1% committed five or six offences, while 2% of the sample committed nine offences. Of those who committed three offences, both were convicted of Murder 1. Of those who were convicted for more than three offences, the subsequent charges were for non homicide offences. There were no significant differences between groups for number of offences or offence type. After mothers (n=42, 47%), fathers were most often victims (n=22, 25%), followed by daughters (n=10, 11%), sons (n=5, 6%), sisters (n=5, 6%) and brothers (n=5, 6%).

87% of the victims were subject to attack with a weapon, which was predominantly a knife (60%), followed by gun (9%). Other weapons included scissors (1%), hammer (9%), axe (4%), and screwdriver (3%).

2% of the victims were subject to death by fire, while 5% were subject to choking. 69% of the total cases noted extreme violence at the time of the offence, which most often (91%) took place in the victim's home. Again, there were no significant group differences with regard to method of murder, weapons, notation of extreme violence or location of the offence.

Table 4
Offence Characteristics

	Matricide	Intrafamilial	Overall
Number of offences			
One	n=27, 64%	n=37, 79%	N=64, 72%
Two	n=10, 24%	n=5, 11%	N=15, 17%
Three	n=1, 2%	n=2, 4%	N=3, 3%
Four	n=2, 5%	n=1, 2%	N=3, 4%
Five	n=1, 2%	n=0, 0%	N=1, 1%
Six	n=0, 0%	n=1, 2%	N=1, 1%
Nine	n=1, 2%	n=1, 2%	N=2, 2%
Offence one			
Attempt	n=15, 36%	n=17, 36%	N=32, 36%
Murder 1	n=12, 29%	n=15, 32%	N=27, 30%
Murder 2	n=13, 31%	n=14, 30%	N=27, 30%
Manslaughter	n=2, 5%	n=1, 2%	N=3, 3%
Offence two			
Attempt	n=3, 30%	n=3, 75%	N=6, 43%
Murder 1	n=5, 50%	n=1, 25%	N=6, 43%
Murder 2	n=2, 20%	n=0, 0%	N=2, 14%
Offence three			
Murder 1	n=1, 100%	n=1, 100%	N=2, 100%
Victim 1			
Mother	n=42, 100%	n=0, 0%	N=42, 47%
Father	n=0, 0%	n=22, 47%	N=22, 25%
Daughter	n=0, 0%	n=10, 21%	N=10, 11%
Son	n=0, 0%	n=5, 11%	N=5, 6%
Sister	n=0, 0%	n=5, 11%	N=5, 6%
Brother	n=0, 0%	n=5, 11%	N=5, 6%
Victim 2			
Mother	n=0, 0%	n=2, 33%	N=2, 13%
Father	n=9, 90%	n=0, 0%	N=9, 56%
Daughter	n=0, 0%	n=1, 17%	N=1, 6%
Son	n=0, 0%	n=1, 17%	N=1, 6%

Sister	n=1, 10%	n=0, 0%	N=1, 6%
Spouse	n=0, 0%	n=2, 33%	N=2, 13%
Victim 3			
Sister	n=1, 100%	n=0, 0%	N=1, 50%
Spouse	n=0, 0%	n=1, 100%	N=1, 50%
Method			
Weapon	n=39, 93%	n=38, 81%	N=77, 87%
Knife	n=23, 59%	n=23, 61%	N=46, 60%
Gun	n=2, 5%	n=5, 13%	N=7, 9%
Scissors	n=1, 3%	n=0, 0%	N=1, 1%
Hammer	n=6, 15%	n=1, 3%	N=7, 9%
Axe	n=2, 5%	n=1, 3%	N=3, 4%
Screwdriver	n=0, 0%	n=2, 5%	N=2, 3%
Miscellaneous	n=5, 13%	n=6, 16%	N=11, 14%
Fire	n=1, 2%	n=1, 2%	N=2, 2%
Choking	n=2, 5%	n=2, 4%	N=4, 5%
Other	n=0, 0%	n=6, 13%	N=6, 7%
Extreme Violence	N=30, 77%	N=28, 62%	N=58, 69%
Location of Offence			
Victim's Home	n=39, 93%	n=42, 89%	N=81, 91%
Other	n=3, 7%	n=5, 11%	N=8, 9%

Note: n = number of cases included in each group. N = total number of cases included in the sample. % = the proportion of the listed characteristic for cases by group and for the overall sample.

Orestes Complex

Group comparisons were made to investigate ideas inherent in the Orestes Complex as described by Wertham (1941). It was hypothesized that the following six characteristics would be more prevalent in matricide than in other mentally abnormal homicides: excessive attachment to the mother; hostility against the mother image; general hatred of women; indications of homosexual potentialities; ideas of suicide; and emotional disorder based on profound feelings of guilt. Group differences were noted for excessive adult attachment to mother, previous violence against the victim, homosexual potentiality, and lack of a previous sexual partner.

Analysis of the Orestes Complex variables indicated a significant group difference in attachment to the mother, $X^2(1, N=80) = 19.27$, $p < .001$. While only two of the matricide group (of an n=36) were not considered “excessively attached”, the intrafamilial group was more evenly divided in their attachment to either their mothers (22 of an n=43) or the victim (17 of an n=44). Hostility (coded as previous violence) against the mother was significantly more prevalent for the matricide group, than for the intrafamilial group$X^2(1, N=73) = 28.73$, $p < .001$. When hostility (previous violence) against the victim (mother or otherwise) was considered for both groups, again there was a significant difference with only 11 (of an n=39) having evidenced at least one aggressive incident against the non-maternal victim$X^2(1, N=73) = 26.59$, $p < .001$, compared to 30 (of an n of 40) having evidenced previous aggression against the mother.

The incidence of demonstrated or verbalized misogyny (hatred of women), was low overall (4.2%) and did not differ significantly between groups. Homosexual tendency or potentiality was more often noted for the matricide group than for the intrafamilial group$X^2(1, N=66) = 9.14$, $p = .003$. The matricide group was also more often noted as not having had previous intimate sexual partners than the intrafamilial group$X^2(1, N=60) = 14.82$, $p < .001$.

Approximately half of the sample had expressed suicidality (either previous attempts, or notation of suicidal ideation voiced at the material time) however this did not differ significantly between groups. The majority of the sample (n=45, 64%) did not evidence an expressionof guilt either in the accused’s symptomatology or in his behaviour or verbalizations leading up to the time of the index offence.

Table 5
Orestes Complex Characteristics

	Matricide	Intrafamilial	Overall
Excessive Attachment Mother	n=34, 94%	n=21, 49%	N=55, 70%
Excessive Attachment Victim	n=34, 94%	n=27, 61%	N=61, 76%
Hostility Mother	n=30, 88%	n=10, 26%	N=40, 55%
Hostility Victim	n=30, 88%	n=11, 28%	N=41, 56%
Hatred of Women	n=1, 3%	n=2, 5%	N=3, 4%
Homosexual Potentiality	n=9, 33%	n=2, 5%	N=11, 17%
Absence of Sexual Partners	n=19, 76%	n=9, 26%	N=28, 47%
Ideas of Suicide	n=16, 52%	n=19, 48%	N=35, 49%
Guilt	n=9, 43%	n=7, 29%	N=16, 36%

Note: n = number of cases included in each group. N = total number of cases included in the sample. % = the proportion of the listed characteristic for cases by group and for the overall sample.

Catathymic Crisis

Group comparisons were made to investigate the characteristics inherent in Catathymic Crisis (also described by Wertham in 1941). It was hypothesized that Catathymic Crisis, as denoted by the evolution of the accused through five distinct stages, initial thinking disorder; crystallization of a plan; extreme tension culminating in the violent crisis; superficial normality; insight and recovery, would be equally as prevalent in matricide cases as in other mentally abnormal homicides. As hypothesized, no significant group differences were noted.

The two groups did not differ significantly around diagnosis of thinking disorder or psychotic illness as a variable of the proposed Catathymic Crisis variables. That is, both groups were equally ill (only 1 matricide case of the overall sample n=87 had not been diagnosed with a psychotic disorder). There was also no significant difference between groups for planning the offence: 53% of the overall sample (n=73) had demonstrated planning leading up to the time of the offence. Again, there was no statistically significant difference between groups with regard to tension in the home or

between accused and victim leading up to the offence: 88% of the sample reported extreme tension that culminated in the violent act. There was also no significant difference in superficial normality after the commission of the offence(s): both groups' accused persons experienced a sense of relief, or carried on with activities of daily livingmore (at 62%) than not. Finally, insight and recovery was noted as having been achieved for the majority (59%) of the sample, with no significant difference between the matricide and intrafamilial homicide groups.

Table 6
Catathymic Crisis Characteristics

	Matricide	Intrafamilial	Overall
Thinking Disorder	n=39, 98%	n=47, 100%	N=86, 99%
Plan	n=20, 61%%	n=19, 48%	N=39, 53%
Extreme Tension	n=31, 91%	n=37, 86%	N=68, 88%
Superficial Normality	n=24, 67%	n=24, 59%	N=48, 62%
Insight and Recovery	n=25, 66%	n=23, 51%	N=48, 58%

Note: n = number of cases included in each group. N = total number of cases included in the sample. % = the proportion of the listed characteristic for cases by group and for the overall sample.

In sum, groups were compared for significant differences for demographic, diagnostic, offence, Orestes Complex and Catathymic Crisis characteristics. Significant group differences were found with respect to likelihood of the accused persons having lived independently as an adult, of having been married or in a domestic partnership (at the time of the offence or otherwise), and for having had children. Group differences were also noted for having received a diagnosis of paranoid schizophrenia, as well as the childhood diagnoses of Attention Deficit Hyperactivity Disorder and Conduct Disorder. Group differences for age at first psychiatric admission to hospital approached significance. Significant group differences were also noted for excessive adult attachment

to mother, previous violence against the victim, homosexual potentiality, and lack of a previous sexual partner. Chapter 4 will discuss the results presented in this chapter.

Discussion

This chapter discusses results obtained from the current study. A summary highlights the major findings from data analyses. Next, a more in-depth analysis of the findings of the study in relation to research questions using existing research is discussed. Chapter 4 ends with limitations of the study, implications for future research, and conclusions.

This research adds to the existing literature on mentally abnormal or psychosis driven parricide, with an emphasis on matricide. Research questions were addressed through the identification of group differences (matricide versus any other intrafamilial homicide or attempted homicide) for demographic, psychosocial, psycholegal, diagnostic and offence specific characteristics. The present study included all cases of mentally abnormal or psychosis driven attempted or completed homicide for which the accused person had been found not criminally responsible or not guilty by reason of insanity and was detained under the jurisdiction of the Ontario Review Board between 1992 and 2012. This sample, by nature, excluded cases of mentally abnormal intrafamilial homicide in which the accused person committed suicide after the index offence.

Consistent with MckNight et al. (1966), current results indicate that mothers are the most likely victims of mentally disordered intrafamilial homicide. In the present study, approximately half of the mentally abnormal, or psychosis driven intrafamilial homicides (or attempted homicides) committed and adjudicated to the Ontario Review Board between 1992 and 2012 were matricidal in nature. 47% of the victims were noted as mothers, while the remaining 53% of victims consisted of fathers, sons, daughters, sisters and brothers. These results, however, are in contrast with the results of others

whose samples include non-psychosis driven offences and non-mentally ill offenders. In these samples, patricide is more common than matricide (see Bourget et al., 2007; Heide, 1993; Walsh, Krienert & Crowder, 2010).

The accused persons in the current study were most often Canadian born males in their early thirties, who were unmarried and childless. This is, again, consistent with previous research describing the typical parricidal accused (Clark, 1993; Green, 1981; McKnight et al., 1966; O'Connell, 1963; Sadoff, 1971). In this sample, the majority of accused persons had attended but not completed high school and had limited (less than one year) employment experience, which is consistent with the "poor employment records" found by Green (1981). The matricide accused were significantly less likely than their intrafamilial non-matricide counterparts to ever have lived independently. They were also less likely to have been married or to have had children, and were less likely to be married or in a domestic relationship at the time of their offences. The majority of accused persons lived with their victims at the time of the offence, with no significant difference between the matricide and intrafamilial groups. This, too, is consistent with the literature, which suggests that matricidal perpetrators often reside with the victim (Bourget et al., 2007; Clark, 1993; Green, 1981, Campion et al., 1989).

Approximately half of the accused persons had a criminal history prior to the conviction for the index offence, a quarter of the sample had 1-3 previous charges or convictions, and a quarter had more than 3 charges or convictions. The majority (85%) of the accused persons had a well documented psychiatric history, with the matricide group requiring hospital admission for illness management at a younger age (22 years of age versus 27 years of age). Childhood diagnoses of conduct disorder and ADHD were rarely

noted, but were significantly more prevalent in the matricide group when they were included in the file information.

The results of this study reflect an overall schizophrenia diagnosis rate of 62%. It was, as in other studies, the most common diagnosis amongst the accused (Clark, 1993; Green, 1981, Campion et al., 1985). In descending prevalence order, Schizophrenia was followed by schizoaffective disorder, then bipolar disorder, psychosis NOS and finally delusional disorder. A little over a third of the sample had been diagnosed with a paranoid subtype of schizophrenia; however the matricide accused were diagnosed at a significantly higher rate than the intrafamilial accused (48% versus 23%). Again, consistent with the literature, the vast majority of the accused were actively psychotic at the time of the offence (Clark, 1993; Campion et al., 1985; Cravens et al., 1985), with a majority, 70%, of the accused having experienced paranoid delusions as a primary motivating symptom, similar to the results found by Green in 1981. Command hallucinations combined with paranoid delusions were motivating symptoms for 20% of the sample.

Approximately 30% of the overall sample was noted as having had characterological difficulties in the form of diagnosed or clinically significant personality pathology; higher than the rate of 10% found by Green in 1981. Only 5% of the sample was noted as cognitively impaired to the point that warranted a diagnosis of intellectual disability or mental retardation. Approximately one third of the sample had been formally diagnosed with a substance abuse disorder, however problematic substance use was far more prevalent: slightly more than half were noted as having had an alcohol abuse history and half had a drug abuse history. Again, these results are consistent with previous

investigations, as comorbid substance abuse is a common theme found in the literature (Green, 1981; Campion et al., 1985).

Overall, the accused as a group were not rated as psychopathic, nor did they fall into particularly high reoffence risk categories on the VRAG – the actuarial tool used to score their risk for violent recidivism. It must be noted, however, that the data were very limited for these two variables as the Dispositions and Reasons for Dispositions rarely reported such numbers, and the available hospital reports were inconsistent in their reporting of actuarial measures.

On average, it took approximately one year for the accused persons to be adjudicated from the courts to the Ontario Review Board, with no significant difference of processing time between groups. The majority (72%) of the sample committed only one offence for which a conviction was issued: of those, 36% were attempt murders, 30% were Murder 1, 30% were Murder 2 and 3% were manslaughter. 17% of the sample committed two offences: of those 43% were attempt murders, 43% were murder 1 and 14% were murder 2. Of those convicted of three offences, both accused persons were convicted of Murder 1. As matricide was the focus of the current study, all cases in which there was only one victim were mothers (n=42). In cases where there were two or more victims, the primary victim was recorded as the victim of the more serious offence (i.e. Murder 1 versus attempt murder). Therefore, the category of victim two included two victim mothers, nine fathers, one daughter, one son, one sister, and two spouses. The category of victim three included one sister and one spouse.

The most common method of murder was a weapon, and the most frequently used weapon was a knife. This is consistent with Green's 1981 study of the Broadmoor

population, but is inconsistent with the findings of McKnight et al. (1966). It is also inconsistent with Bourget et al., who found that blunt instruments were predominantly used in a non-psychiatric sample (2007). In the current study, after knives, guns were most often used to inflict violence, followed by hammers, axes, screwdrivers and scissors. The "other" category included a typewriter, a rock from a turtle terrarium and an electric guitar. After the use of a weapon, victims were most often subject to violence by fire, then choking. Also in keeping with the two thirds reported by Green in 1981, extreme violence was noted in the majority (70%) of cases in the current study, regardless of group. Likewise, regardless of group, the offences most often took place in the victims' homes which is in keeping with parricide literature in general (Bourget et al., 2007; Campion et al., 1985; Green, 1981; McKnight, 1966).

In an attempt to understand the motivation and psychological processes at play behind mentally abnormal, psychosis driven matricide, this study attempted to operationally define and investigate characteristics of the Orestes Complex and Catathymic Crisis as proposed by Wertham in 1941 (as suggested for future research by McKnight et al. in 1966).

Given the results, it can be said that there was evidence for some, but not all, characteristics of Wertham's Orestes Complex in the matricide group that were not as prevalent in the non-mother intrafamilial cases. The matricide accused were rated as excessively attached to the mother victim at significantly higher rates that their non-matricide intrafamilial accused counterparts. Hostility against the mother, in the form of previous violence against the mother/victim, was also more prevalent for the matricide accused than for the intrafamilial accused persons. Incidence of hatred of women was

rare and/or not overtly evident for either the matricide accused or the non-mother intrafamilial accused. Indication of homosexual potentiality was more prevalent in the matricide group than the non-mother intrafamilial group, as was a lack of previous sexual partners. Suicidality was present at about equal rates (almost 50%) for both groups. The majority of accused persons did not demonstrate a thinking disorder that was based on guilt (measured by observations of expression of guilt in the accused's symptomatology, behaviour or verbal expression).

As predicted, characteristics of the Catathymic Crisis, also proposed by Wertham as a process at play specifically in matricide cases, was equally as prevalent in both groups. Both the matricide and the non-mother intrafamilial accused persons were diagnosed with psychotic disorders that would have robbed them of the ability to appreciate the nature and quality of their actions, or of the ability to know that their actions were wrong at the time of their offences. A little more than half of the sample had executed some planning in preparation for their offence(s), and the majority (88%) of accused persons' situations were described as exhibiting extreme tension that culminated in the violent act. Superficial normality was measured equally in both groups, with approximately 62% of accused persons having experienced relief and carried on with activities of daily living after the commission of their offences. Sometimes it happened shortly after the offence, and sometimes it took years, however the majority of accused persons (59%) achieved insight into their actions at the material time, as well as a level of recovery within the forensic mental health system.

Consider, again, question one as outlined in chapter one: what makes mentally abnormal matricide different from mentally abnormal intrafamilial homicide? Are the

matricidal accused inherently different than other perpetrators of intrafamilial homicide? Are the offence characteristics different? Developmentally, matricidal accused are diagnosed with disorder more often in childhood, and seem to require hospitalization for major mental illness at a somewhat younger age. They experience a psychosocial decline, likely in the prodromal period in late adolescence, prior to the end of high school. As adults, they are more often diagnosed with a paranoid subtype of schizophrenia which, then, drives the matricidal offence. Illness prevents or limits their ability to work, prevents them from living independently, and from fully maturing, both socially and sexually. They most often live at home as adults, dependant on their mothers who, having assumed and maintained a caregiver role, are over-involved at best, and intrusive and overbearing at worst.

While previous explanations of matricide have included psychodynamic, psychiatric and psychosocial theories, they do not (nor could they be expected to) account for all of the intricacies inherent in mentally abnormal matricide. Using the results from the current study, attachment theory, specifically pathological attachment, is presented as a motivation for mentally abnormal matricide.

Born of Freud's theories on love, attachment theory as described by Bolby (1953) was appropriated and applied to the development of mother-child bonding. He had been supervised by Melanie Klein for a period of his training as a child psychiatrist, and "troubled by the dogmatism of psychoanalysis at the time, its extrapolations from the couch to the crib, and its dismissive attitude toward empirical investigation of normal development, Bowlby's long-standing interests in Darwinsim led him to the new science of ethology. This provided him with a truly scientific framework within which to

reformulate his psychoanalytic knowledge, and attachment theory began" (Holmes, 1995 in Meloy, 2002). While an in-depth review of the attachment literature is well beyond the scope of this paper, an overview of major relevant points of the theory would include the following: attachment behaviour is influenced by and causes changes in biological mechanisms, that is – it is hardwired as an adaptive biological strategy for the survival of the human species (Hofer, 1995 in Meloy, 2002). Emotion and cognitions are central to attachment (Bowlby, 1979 in Meloy, 2002) and our most intense emotions surface during the "formation, maintenance, disruptions and renewal of attached relationship" (Meloy, 2002, p. 511). Furthermore, representational models of the self and others are derived from our attachment interactions and they serve to motivate and regulate human behaviour (Bowlby, 1979 and Fonagy, 1999 in Meloy, 2002). For example, attachment has an effect on caregiving, in that when caregiving is activated by the parent, the child's attachment seeking is unnecessary, and subsequently deactivated.

The six criteria for attachment as described by Ainsworth (1989) are as follows: it is persistent; it involves a specific person; it is emotionally significant; proximity with the person is wished for and sought; distress is felt when there is involuntary separation; and the relationship brings security and comfort (in Meloy 2002). Meloy goes on to say that secure attachment, then, "exists over time and can be inferred, but not observed" (p.513). That is, when an attachment is healthy, the resultant behaviour is not remarkable, however when the attachment is pathological "the attachment behavioural system is activated in unusual, strange, and sometimes dangerous ways" (Meloy, 2002, p. 513).

Three types of attachment – avoidant, secure, and ambivalent/resistant – were discovered and described by Ainsworth in the Strange Situation experiment (1969), and

were further developed by Main and Solomon (1986, 1990) to include a fourth type: the disorganized/disoriented attachment (in Meloy, 2002). Basically, faced with the Strange Situation, avoidant infants explored without paying attention to their mothers, displayed minimal distress when they were separated, and ignored them upon their return. Secure infants expressed needs as they arose, and accepted maternal care. Ambivalent/resistant infants displayed separation anxiety even when their mothers were close, displayed distress when they left, and could not settle when they returned. Disorganized/disoriented infants were apprehensive in their attachment approach to their mothers when looking to have their needs met at any time.

This disorganized attachment style is said to become evident by the age of six in controlling behaviour of the child toward the mother: “it is often accompanied by childhood aggression […] and appears strongly related to diagnoses of oppositional defiance disorder, conduct disorder, and other externalizing problems in childhood” (Lyons-Ruth, 1996 in Meloy, 2002, p.513). Fonargy (1999) and colleagues have offered a psychoanalytical approach to attachment theory in their exploration of the “mentalizing and reflective self”. In short, they posit that “children find themselves in the mind of their caretaker, and the psychobiological vehicle for this discovery is a loving and secure attachment” (in Meloy, 2002, p. 518). Thus, if this positive reflection of self is not available – if the mother is troubled, is constantly anxious, angry or depressed – the child’s sense of the mother’s feelings toward them is not tolerable, and they internalize the “persecutory mental representations of the parent, which become a source of emotional volatility and turmoil”, thus, they continually project these representations onto those close to them as a “means of evacuating and controlling them” (in Meloy, 2002,

p.518). In other words, the negative feelings of the mother are taken on by the child as a pathological model of himself, and are projected back onto those closest to them throughout the lifespan in an attempt to gain control over and expel this negativity. In childhood, the target of this projection is typically the primary attachment figure – the mother – and in adulthood it would typically be an intimate partner.

In an effort to explore pathological attachment as a risk factor for violence and criminality, Levinson & Fonagy (1997) compared attachment styles of prison inmates, psychiatric patients and controls. Results indicated that "82% of the psychiatric patients and 36% of the prisoners were disorganized" (in Meloy, 2002, p.519). Fonargy went on to describe pathological attachment as a predictor for violence: it "is embodied as an act of overwhelming rage. Violent acts are only possible when a decoupling occurs between the representations of subjective states of the self and actions. Violence is a gesture of hope, a wish for a new beginning, even if in reality it is usually just a tragic end" (in Pfafflinc&Adshead, 2004, p.8).

If we are to look at mentally abnormal matricide through the lens of pathological attachment, we have, perhaps, uncovered some evidence through the results of the current study without having set out to do so. Although formal attachment measures could not be administered (data were collected from case histories), results were somewhat consistent with Fonargy's findings when he compared prisoners, psychiatric patients and controls. Those accused in the current study's matricidal group were more often diagnosed with childhood disorders, signaling potential and likelihood of attachment disruption at an early age. They were subsequently hospitalized at a younger age, and were diagnosed with major mental illness at a relatively young age. They developed co-morbid substance

use disorders and/or problems. They were not as sexually mature, and more often expressed homosexual tendencies (but had few, if any, sexual partners).

Perhaps because they were ill, they were less educated and unable to support themselves, married less often, procreated less often and lived at home with their mothers long past an age that would be considered developmentally appropriate. Notably, the matricidal group remained excessively attached to their mothers as adults. They depended on their mothers for food, shelter, clothing, medication administration and the most basic activities of daily living. This is, of course, in direct contrast with a healthy and "unremarkable" attachment style as described in the literature. Current results suggest that men who kill their mothers do not hate women in general, but they do have a history of hostility and previous violence against their mothers (significantly more than those who have non-mother intrafamilial victims). It may be possible, then, that in the throes of paranoid psychosis with building tension and conflict between the mother and her son, the matricidal accused kills his mother not in an oedipal attempt to possess her, but in a self serving act of psychotic rage. The act of matricide is self serving, then, in the sense that the pathologically attached son, in an effort to break free both of her projections and of his pathological model of self, commits the ultimate act of violence and kills her. Like other theories before it, disrupted attachment as explanation for matricide may explain at least part of the motivational dynamics for the matricidal impulse in a psychiatric population, and should be examined further in future research.

Limitations of the Current Study

This thesis was an exploratory study involving a highly specialized population, the mentally abnormal, psychosis driven matricidal and non-mother intrafamilial

homicide accused, and their offence characteristics. The study was conducted using pre-existing case history reports that had been generated by the Ontario Review Board or one of several forensic psychiatric facilities in the province of Ontario. This, in itself, presented some significant limitations which suggest that conclusions drawn from the data should be done so with caution.

A major limitation of this study was in the subjectivity inherent in the operational definition of the Orestes Complex and Catathymic Crisis variables. Because Wertham gives an outline of the constructs, and never fully describes the methodology he used to propose them, the current study used characteristics proposed in existing research to construct and operationally define the variables. Further, because of limited resources, inter-rater reliability measures were not conducted.

Another major limitation of this study was the limited data used for analysis. The type of data collected was restricted to the availability of both the reports to or from the ORB and the information contained within them. Despite having received ethical approval for the study, the availability of ORB materials was limited by the organization's inability to locate and/or access files efficiently. Even when reports were easily identified through LexisNexis, and located either in the Centre for Addiction and Mental Health's databases or in the ORB's files, the information provided within them was inconsistent. For example, if the index offence was committed when the accused was a young offender, often there was no identifying data for the accused except first and last initial, making even a simple variable like gender difficult to code. Richer psychosocial information, such as socioeconomic status or education level of the accused's parents, was most often available in the reports prepared by the hospital, but not in the documents

generated by the ORB. Unfortunately, the reports prepared by the hospital were not as readily available as were the ORB generated documents.

The initial intention of this study was to code reports for variables that may be relevant to matricide, and then perform a factor analyses to investigate which were predictive of the offence. Because the data that was retrieved from the case reports was predominantly nominal, group comparisons by way of chi square analyses were completed instead. Where possible, t-tests were employed to compare group means for ordinal data. In the end, the data simply did not allow for regression, or predictive, analyses. Noteworthy limitations of the analyses performed are the limitations of the chi-square analysis itself: limited information about the strength of relationship or its significance in the population; sensitivity to sample size regardless of relationship; and sensitivity of small expected frequencies in one or more cells of the frequency table. Several of the comparisons were done with small expected frequencies, thus even significant group differences should be considered and interpreted cautiously.

Noted as a limitation by several researchers, the current study included cases of matricide committed by males and females, thus introducing the possibility for different motivational dynamics between genders. Likewise, this study did not control for age. It has been suggested that weapons used in the commission of the offence may differ by age group, as may provocation to offend (Heide, 1993; Heide & Petee, 2003, 2007). The inclusion of single and double parricide cases also heightened the possibility of different motivational factors. The current study included attempted homicide in order to increase the sample size, and while it has been suggested that it is defensible to do so, “caution is advised as comparative analyses of parricide and attempted cases have found some

differences" (Marleau et al., 2003; Weisman & Sharma, 1997, in Heide & Frei, 2010, p.5). Overall, the selection criteria of cases for inclusion were set in order to increase the overall sample size, however this resulted in a sample that was not pure. Ideally, adult men who were found NCR for the homicide of their mothers would have been the only cases included.

The purpose of this section is to highlight limitations; however its strengths should also be noted. The matricide sample was larger than most, and was relatively representative of the population as described in the literature. However limited the information available and the subsequent analyses, the data did allow for exploration of the offence of matricide, those who commit it, and potential motivations behind the matricidal impulse. The results of the current study have added to the current literature on intrafamilial violence, and matricide in particular.

Implications

This section discusses implications of the information collected in the current study, and is divided into two areas. First, indications for future research are discussed to promote the use of practices that were useful in the present study, and to suggest areas in which further exploration may take place. Second, implications for practice are provided to suggest changes that might be made within the forensic mental health system in order to make mental health professionals aware of risk factors for matricide and intrafamilial homicide, and to promote awareness and provide support for family members living with dependants diagnosed with a major mental illness.

Implications for future research

From the current results, several suggestions can be made for future research. First and foremost, fatal violence committed against immediate family members by the mentally ill is a very rare phenomenon however, when it is carried out successfully, the price paid – a human life – is high. Any understanding of motivating dynamics could lead to a reduction in risk factors, potentially saving lives while simultaneously saving the forensic mental health system the years of highly specialized care that an accused person requires while under the jurisdiction of the Ontario Review Board.

This study explored diagnostic, psychosocial and offence specific characteristics of the accused persons, and found that matricidal and intrafamilial accused differed significantly in prevalence of child diagnoses, and approached significance for age at first admission due to major mental illness. Further exploration using the same methodology should gather inter-rater reliability measures for the variables that were coded. Future research might also employ a longitudinal study that follows children from initial diagnosis into adulthood, using measures of attachment as used by Levinson & Fonagy in 1997. The benefits of such a study would be widespread; the richness of information about the intersection of attachment, illness and the criminal justice system may lead to a better understanding of those who go on to commit violence against family members.

Current results also indicated that mothers and their sons exist in an abnormal and excessively attached relationship, which may contribute to the matricidal impulse. Future research might focus on the roles that mothers and immediate family members play in the lives of their adult children with mental illness, to identify specific variables that can be further isolated and explored for their predictive power in matricidal cases. Future

research might also isolate and explore differences inherent in cases for which the end result was attempted homicide instead of a successful homicide, in order to isolate potential protective factors.

Implications for practice

A limitation noted in the previous section was limited availability of information on the accused persons. This would suggest that a more thorough system for cataloging, recording and storing case reports might be implemented province wide in order that research might be carried out more easily. Additionally, a standardized report format, including consistent reporting of case history, offence variables and actuarial assessments, might be considered by the ORB and by the major provincial forensic hospitals, so that researchers might have increased access to relevant information, and investigate risk factors in order to inform public policy.

Results of the current study indicate that childhood diagnoses occur more often in those who commit matricide as adults. Conclusions of this study would suggest the need for more resources that are directed toward intensive behavioural interventions for these children and their families before they end up in the criminal justice system as youth or adults.

As adults, the matricidal group was more often diagnosed with a paranoid subtype of schizophrenia, and their paranoid delusions drove the behaviours at the time of the index offence(s). They were also violent more often, in the past, with their mothers. This would suggest that mothers (and other immediate family members) are particularly at risk if their adult children experience an episode of psychosis and experience paranoid delusions. They are especially at risk if those factors are present and the mother has been

subject to violence at the hand of her child (adult or otherwise) in the past. An awareness of these risk factors may promote families' and mental health professionals' vigilance in the care and monitoring of symptoms and behaviours of those in their charge.

Finally, the matricide group did not marry, live independently nor have children as often as the intrafamilial group did. They did not experience normal sexual development, in that their sexual relationships were quite limited. They demonstrated homosexual tendencies more often than the intrafamilial homicide group. Perhaps most importantly, they were excessively attached to their mothers. These results suggest that a portion of the resources allotted to the forensic system in Ontario might be better diverted to preventative care through the provision of independent or assisted living for adults living with mental illness, in order to foster a well developed sense of self and community, separate from the family of origin. If, indeed, the matricidal impulse stems at least in part from pathological attachment, it is an addressable phenomenon. Resources might also be directed toward the provision of intensive therapy that might address the maladaptive attachment of mother and child.

Conclusions

Overall, the current sample of accused persons who had committed mentally abnormal or psychosis driven homicide (or attempt homicide) of an immediate biological family member was reflective of the population as described in the literature. They were males in their early thirties, who – having no criminal history – murdered or attempted to murder their mothers in the maternal home, where they still resided, while labouring under the effects of paranoid delusions. There was notable conflict or tension leading up to the offence, which was planned – to some degree – in about half of the cases. The

accused had typically been diagnosed with schizophrenia, had not finished high school and had very limited work experience. About half had been diagnosed or struggled significantly with substance abuse. By the time their cases had been adjudicated by a trial judge, they had been found not criminally responsible for one offence, that most likely having been attempt murder first, and then murder 1 or murder 2. There was typically only one victim who had been subject to attack by knife. Extreme violence, or more force than was necessary, was noted as having been used in the commission of the offence.

The matricide group differed from the intrafamilial homicide group in the following ways: they were diagnosed with ADHD and conduct disorder as children more often, and were hospitalized for psychiatric illness at a younger age. As adults, they were more often diagnosed with a paranoid subtype of schizophrenia than their intrafamilial homicide counterparts (who were diagnosed with affective disorders at a higher rate). They married less often, lived independently less often, and had children less often than their intrafamilial homicide counterparts. They were more often sexually inexperienced, and demonstrated or verbalized homosexual tendencies more than the members of the intrafamilial group. Perhaps most notably, the members of the matricide group were excessively attached to their mothers as adults whereas only half of the intrafamilial group was considered excessively attached to their victims (fifteen of which were offspring of the accused). Despite the excessive attachment, hostility against the mother was more evident than hostility against the non-mother victim.

What makes matricide different from other non-mother intrafamilial homicides? Current results indicate that, while there are many similarities, the psycho-

neurobiological development of the accused and the resultant motivation for matricide may be what makes it inherently different from other non-mother intrafamilial homicides.

Are there, as Wertham suggested, characteristics consistent with the "Orestes Complex" inherent in matricide cases? There was evidence for some characteristics of Wertham's Orestes Complex, although not for the construct as a whole. Reframed as a pathological attachment complex, Wertham's ideas of excessive attachment and hostility against the mother resulting in matricide may hold more weight and meaning for a better understanding of the matricidal impulse in mentally disordered offenders in the future.

Are there characteristics of the Catathymic Crisis, as described by Wertham, inherent in the act of intrafamilial homicide? There was evidence for characteristics of the Catathymic Crisis – in short, "an act of extreme violence without apparent motivation" in both the matricidal and intrafamilial groups (Schlesinger, 1996). Most notably, all but one of the accused persons in the current study had been diagnosed with a major mental illness that had robbed them of the ability to know what they were doing at the time of their offence(s) and/or to know that their actions were wrong, and the majority of offences took place after a period of extreme tension that had developed between the accused and the victim.

Suggestions for future research include conducting longitudinal studies, following children from initial diagnosis into adulthood; the use of attachment measures in parricide research in general and matricide research in particular, with a potential for isolation and identification of protective factors for victims. Policy change that impacts allocation of funding for interventions for these families may help prevent future cases of matricide and other intrafamilial homicide. Contrary to the dark embrace of the matricidal accused,

illumination in the form of knowledge about the multifaceted subject of matricide, and its causes, may help to prevent future cases.

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Appendix A

Dark Embrace: Matricide *Coding Form*
Coder: Coding date:

☐ Reasons for disposition
☐ ORB report

1. Patient Name: _____
2. Gender: ☐Male ☐Female
3. Date of Birth (dd/mm/yyyy):_____
4. Place of Birth (country only): _____
5. Year came to Canada: _____
6. Place of residence at material time:☐Indepentent ☐Maternal Home ☐Other (specify)

7.Index Offence(s)(check all that apply):
☐Murder 1 ☐ Sexual specified: ☐Murder
☐Murder 2 ☐ Uttering threats ☐ Confinement/abduction
☐Manslaughter ☐ Assault specified: ☐ Robbery
☐Attempt Murder ☐ Criminal harassment ☐Arson
☐Weapons charges ☐Failure to comply ☐Break and Enter
☐ Rest category [drug charges (e.g., possession, trafficking), non-violent driving related charges]:

8. Date of Index Offence(s)(dd/mm/yyyy):_____
9. Total number of index offenses: _____
10. Age at index:_____
11. Finding: ☐ NCR ☐ Unfit
12. Date of Original Finding (dd/mm/yyyy):_____

13. Current Diagnoses (check all that apply):
☐ Schizophrenia ☐ Delusional disorder ☐ Pervasive developmental disorder
☐ Schizoaffective disorder ☐ Bipolar disorder ☐ Other psychotic disorder spec:
☐Depression ☐ Intellectual disability ☐ Personality disorder specified:
☐Anxiety disorder ☐ Cognitive deficits ☐ Substance use disorder spec:
☐ Personality traits ☐Paraphilia spec: ☐Query specified:
☐ Conduct disorder ☐ Other specified: ☐ Unknown

14. Active psychosis at the time of the index offence:
☐Paranoid delusions ☐Capgrass Syndrome ☐Command hallucinations
☐Other (specify)

15. Method of murder:
☐Weapon (specify) ☐Fire ☐Choking ☐Other (specify)

(Specify if extreme violence was noted): ☐Yes ☐No

16. Location of Index Offence:
☐Maternal Home ☐Room in maternal home (specify):
☐Other (specify)

17. Employed Within 1 Year Prior to Report: ☐Yes ☐No ☐Unknown
18. If employed within 1 year of report, how many months: ☐< 3 months ☐3-6 months ☐6-12months
19. If employed within 1 year of report, how frequent: ☐Full-time ☐Part-time ☐Unknown

Personal and Developmental History

20. Highest Educational Attainment:
☐Some elementary school (e.g. less than Grade 8) ☐Completed elementary school (up to Grade 8)
☐Some high school (e.g. less than Grade 12) ☐Completed high school (up to Grade 12)
☐Some post secondary education (college or university)☐Completed college diploma or undergraduate degree
☐Some graduate level education ☐Completed graduate level education
☐Unknown
21. Employed at time of index offence(s): ☐Yes ☐No ☐Unknown
22. Consistent employment for 1 year period just prior to index offence: ☐Yes ☐No ☐Unknown
23. Estimated total years of employment _____ years (if known) OR:
☐0-1 years ☐1-2 years☐2-3 years ☐3-5 years☐5-7 years ☐7-10 years ☐10+ years☐Unknown
24. Ever married or lived common law (> 6 months): ☐Yes ☐No ☐Unknown
25. Married/common law at time of index offence: ☐Yes ☐No ☐Unknown
26. Children: ☐Yes ☐No ☐Unknown
27. First language: ☐Unknown
28. Source Personal and Developmental History: ☐Self-report ☐Collateral ☐Both ☐Unknown

Alcohol & Drug History
29. History of alcohol abuse/dependence below age of 18: ☐Yes ☐No ☐Unknown
30. Other substance abuse/dependence below age of 18: ☐Yes ☐No ☐Unknown
31. History of alcohol abuse/dependence as adult (18+): ☐Yes ☐No ☐Unknown
32. Other substance abuse/dependence as adult (18+): ☐Yes ☐No ☐Unknown
33. Use of substances involved in index offence(s): ☐Yes ☐No ☐Unknown
34. Source Alcohol & Drug History: ☐Self-report ☐Collateral ☐Both ☐Unknown

Legal History/History of Community Supervision
35. Age at first arrest or charge: _____ ☐Unknown
36. Number of previous charges: _____ ☐Unknown
37. Number of previous convictions: _____ ☐Unknown
38. Previous NCR finding: ☐Yes ☐No
39. Charge/convictions-violent offences (past only, if applicable):
☐Yes ☐No ☐Unknown
40. Charge/convictions-sexual offences (past only, if applicable):
☐Yes ☐No ☐Unknown
41. Index offences were (check all that apply):
☐Non-violent ☐Violent ☐Sexual
42. Phallometric testing received, if index included sexual offense:
☐Yes (CAMH) ☐Yes (other institution) ☐No ☐Unknown
43. Total number of victims in index offense(s):_____
44. Index offence victim1 gender: ☐Male ☐Female ☐Unknown
45. Index offence victim1 age: ☐< 13 ☐13 - 17 ☐> 18 ☐Unknown
46. Index offence victim2 gender: ☐Male ☐Female ☐Unknown
47. Index offence victim2 age: ☐< 13 ☐13 - 17 ☐> 18 ☐Unknown
48. Index offence victim3 gender: ☐Male ☐Female ☐Unknown
49. Index offence victim3 age: ☐< 13 ☐13 - 17 ☐> 18 ☐Unknown

50. Relationship of victim(s) (check all that apply):
☐Mother ☐Spouse ☐ Child ☐ Sibling ☐Stranger
☐Father ☐ Professional ☐ Roommate ☐Friend ☐Officer
☐ Co-patient/co-tenant ☐ Colleague ☐ Neighbour ☐Extended Family
☐Other spec:

Past Psychiatric History
51. Age of first known psychiatric symptoms: _____ ☐Unknown
52. Age at first hospital admission for psychiatric problems: _____ ☐Unknown
53. Source past Psychiatric History: ☐Self-report ☐Collateral ☐Both ☐Unknown

Risk Assessment
54. VRAG date: _____ ☐ None available
55. VRAG score: _____ ☐ None available
56. VRAG bin: _____ ☐ None available
57. VRAG percentile: _____ ☐ None available
58. PCL date: _____ ☐ None available
59. PCL-R score: _____ ☐ None available
60. PCL-SV score: _____ ☐ None available
61. PCL Factor 1 score: _____ ☐ None available
62. PCL Factor 2 score: _____ ☐ None available
63. PCL percentile: _____ ☐None available

64. HCR-20 Administered: ☐Not administered ☐Yes; score-total: ___; H: ___; C: ___; R: ___; Date: _____

655. HCR-20 Summary risk score: ☐Low ☐Moderate ☐High ☐Unknown

Orestes Complex Variables
66. Excessive Attachment to the mother: ☐y ☐N ☐Omit/DK
67.Hostility against the mother image ☐y ☐N ☐Omit/DK
68.General hatred of women ☐y ☐N ☐Omit/DK
69.Indications of homosexual potentialities ☐y ☐N ☐Omit/DK
70. Ideas of suicide ☐y ☐N ☐Omit/DK
71.Emotional disorder based on profound feelings of guilt ☐y ☐ N ☐ Omit/DK

Catathymic Crisis Variables
72. Initial thinking disorder ☐y ☐N ☐Omit/DK
73 Crystallization of a plan ☐y ☐N ☐Omit/DK
74. Extreme tension culminating in the violent crisis ☐y ☐ N ☐ Omit/DK
75. Superficial normality ☐y ☐ N ☐ Omit/DK
76. Insight and recovery ☐y ☐N ☐Omit/DK

77. Current Disposition:
☐ No Disposition ☐DO without Community Living ☐DO with Community Living ☐ Conditional Discharge ☐Unknown

78. Hospital Recommends:
☐ No Disposition☐DO without Community Living☐DO with Community Living☐ Conditional Discharge ☐ Absolute Discharge ☐Unknown

79. ORB decision
☐DO without Community Living☐ DO with Community Living☐Conditional Discharge☐ Absolute Discharge ☐Unknown

80. Location at the time of hearing
☐Mental Health Centre Penetanguishene/Waypoint ☐Centre for Addiction and Mental Health ☐Ontario Shores Centre for Mental Health Sciences (Whitby) ☐Thunder Bay Regional Mental Health Services ☐North Bay Psychiatric Hospital ☐Providence Continuing Care Group ☐Royal Ottawa Health Care Group ☐St. Joeseph's Health Care System ☐Providence Continuing Care Group

Appendix B

Dark Embrace: Matricide Research *Coding Manual*

General note.
Check the document that is coded, either the ORB report or the reasons for disposition report.

3. Date of Birth (and dates in general)

All dates, including date of birth, are recorded in the format dd/mm/yyyy. If the date format in the report is unclear, it is assumed to be formatted as dd/mm/yyyy.

7.Index Offence(s)

Includes the offense(s) for which there is an NCR or unfit finding. Charges for which the individual was found criminally responsible (CR) are not included here.

8. Date of Index Offence(s):

If one index offense takes place over a range of time (eg., from March 2 – mar 14, such as in a criminal harassment charge), code the earliest date in this range. If there are discrete multiple dates, code all dates, starting with the earliest.

13. Current Diagnoses (check all that apply):

Current diagnosis made by attending clinician(s) and noted in the document.

A diagnosis of personality disorder qualifies even if NOS. Personality disordered traits or features do not qualify as a disorder, but should be captured as “personality traits”.

Include “in remission” diagnoses. Rule/out and differential diagnoses are considered query diagnoses.

14. Active psychosisat the time of index offence:

Note whether or not the accused was actively psychotic at the time of the offence, and if so, specify which was primarily responsible for the offence (paranoid delusions, command hallucinations, capgrass syndrome)

22. Consistent employment for 1 year period just prior to index offence

23. Estimated total years of employment

Approximate to the best of your ability, as this section is not always clear on the number of years employed.

27. First language:

Do not assume that the first language is equal to the native tongue of country of birth.

If they cannot communicate in English (e.g., they need an interpreter), and a main language is indicated, assume that this is their first language.Specify “non-English” if it is reported that English was not the first language and there is no indication of what the first language is.

Alcohol & Drug History

To qualify as dependence or abuse, there must be some indication that the use has impaired the person's life functioning – work, social, daily, etc. For example, being in treatment for substance problems qualifies as indication that drug or alcohol use has caused impairment.

Dependence or abuse is also coded as present when there is or was a diagnosis of alcohol or substance disorder (e.g., disorders in remission).

Legal History/History of Community Supervision

If there is no mention of first arrest or previous convictions, assume index offence is first offence.

Total number of previous convictions must include each count convicted on, e.g., convicted on 5 X assault = 5 convictions. Previous refers to before the index offense.

'Arrest': detained or restrained by police.

'Violence' (courtesy of HCR-20 manual): "…actual, attempted or threatened harm to a person or persons. Threats of harm must be clear and unambiguous (e.g., "I am going to kill you!"), rather than vague statements of hostility. Violence…is likely to cause harm to another person or persons. Behaviour which would be fear-inducing to the average person may be counted as violence (e.g., stalking)."

Offenses categorized as violent include any assault, sexual assault, murder, kidnapping, reckless driving, threatening, robbery and criminal harassment. Arson is non-violent unless otherwise specified (e.g., arson endangering life). Most sexual offenses will be considered violent as per the definition of sexual violence in the SVR-20: "…sexual violence is defined as actual, attempted, or threatened sexual contact with a person who is nonconsenting or unable to give consent. Sexual contact includes acts such as sexual battery (e.g., rape, sexual touching), communications of a sexual nature (e.g., exhibitionism, obscene letters or phone calls, distribution of pornography) and violating property rights for sexual purposes (e.g., voyeurism, theft of fetish objects)."

38. Previous NCR finding:

Code whether client has been previously found NCR, was absolutely discharged and is now back under the jurisdiction of the ORB for an unfit/NCR finding for new offense(s). This does not include whether they were previously assessed for NCR or fitness.

43. Total number of victims in index offense(s):

A victim is anyone who was impacted (physically, psychologically) by the crime.

Past Psychiatric History

Approximate the age at which client or other source(s) endorsed psychological symptoms.

Admission includes both emergency admission and hospitalization.

Source Personal & Developmental History, Alcohol & Drug History and Past Psychiatric History:

Source is specific to the items on the coding form and not the general section in the report.

'Collateral' refers to any external sources (outside of the client's self-report), such as family members, friends, police, etc. Institutional records (e.g., nursing, clinician notes) suffice as collateral when it is clear that the information was not derived from the client's self-report and thus is truly external. Note that records such as hospital notes will often suffice as collateral sources for Psychiatric History because the sheer documentation of admissions events is all you need to code this section. However, these records may

not always be sufficient as collateral sources for sections such as Personal and Developmental and Alcohol and Drug History.

Risk Assessment:

This information will usually be found in the ORB report however it may be contained in the Reasons for Disposition.

Orestes Complex Variables:

66. Excessive attachment to the mother is coded as present if the accused is noted as having been dependent on the mother, primarily, for the necessities of life (food, shelter) and/or completion of activities of daily living (cooking, cleaning, medication compliance).

67. Hostility against the mother is coded as present if there is documentation of previous verbal or physical aggression (with potential for physical or psychological harm) or violence (as defined in the HCR-20 manual) toward the mother.

68. General hatred of women is coded as present if the accused, at any time, is noted as having made obvious misogynistic statements (at least once) or verbally expressed an aversion to women (at least once).

69. Homosexual potentialities are coded as present if the psychosocial history is positive for a statement of homosexual preference or past/present homosexual relationships. Also considered in the context of an absence of mature sexual encounters/relationships.

70. Code if accused's history is positive for suicidal gestures, ideation or attempts, including those made at the material time.

71. Coded as present if emotional tension around guilt, fear or jealousy is inherent in the psychiatric symptoms (ie. in delusional content or hallucinations).

Catathymic Thinking Variables:

72. Presence of psychiatric disorder that interferes with rational thinking as noted by physician who assessed criminal responsibility.

73. The accused, at some point, is noted as having verbalized the idea that he must carry out a violent act against the victim, and this materialized in a plan to do so (as confessed by the accused or noted in the report).

74. Extreme tension is coded as present if there is notation of a presence of a conflicted relationship or confrontation in the days leading up to the offence, with resistance that results in hesitance or delay in the carrying out of the plan.

75. After the commission of the offence, the accused expresses the experience of a sense of relief and calm that things were ok, or the accused was noted as behaving as if nothing had happened (i.e. carried on with activities of daily living, without a direct attempt to hide the index offence).

76. Insight and recovery is coded as present if, in the years following the offence, the accused is noted as having gained insight (a common psychiatric term) into his actions and experienced a remission of psychotic symptoms.

79. ORB decision

Specifically found in the reasons for disposition report.

80. Location at the time of hearing

Noted in BOTH the ORB report and the reasons document. The location at the time of the hearing will also provide information as to where the ORB report was written.

Appendix C

Research Ethics Board
Office of the Vice-President - Research
(705) 675-1151, ext 2436
(705) 671-3850
ethics@laurentian.ca

This is to certify that theproposal entitled*Dark embrace:Orestes complex, catathymic crisis and method of murder. A study of matricide in a forensic psychiatric sample***File #2012-05-14has been submitted to the Laurentian University Research Ethics Board byColleen O'Brien with Paul Valliant, Michael Persinger and Cynthia Whissell, supervisors on June 1, 2012.**

Considering

- **The files are publicly accessible and there is no reasonable expectation of privacy**

the project has been declared by the Laurentian University Research Ethics Board tonot be subject to ethics review at this time.

Any modification of the purpose of the project will immediately require a new REBapplication.

Chair, Research Ethics Board

Date: June 6, 2012

Appendix D

CAMH 171-2012_O'BRIEN_expedited approval_Dec_5_12.pdf

Appendix E

115-2012_Simpson_S_Expedited approval_June 6 12.pdf

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