

The treatment of this slightly mysterious condition is also not wholly agreed. In a major reference work<sup>5</sup> on one page it is said to respond to injections of corticosteroids, while on another injections are described as painful and difficult. Some recommend phenylbutazone or other anti-inflammatory drugs; some heel pads or heel cups; some surgery, either by division of part of the plantar fascia or by removal of the medial tubercle of the calcaneum. An exotic if somewhat bizarre approach from Egypt<sup>6</sup> and later China<sup>7</sup> is to drill holes in the calcaneum to relieve pressure; this work has not been confirmed or refuted. The principal impression from experience and published reports is that most patients get better with rest and protection from direct pressure on the affected heel. Only in resistant cases should any other approaches be considered—and reconsidered.

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## Matricide

Murder within the family accounts for almost half of all homicides in Britain. Mental abnormality is more likely in those who murder a member of their family than in those who murder a stranger.<sup>1,2</sup> Matricide, the killing of a mother by her child, is one of the rarest forms of family murder<sup>3</sup> and is almost exclusively a crime of sons.

The matricidal theme has its roots in Greek mythology and is charged with high emotion. Psychoanalysts<sup>4-6</sup> have always been receptive to the matricidal fantasies of their patients and have theorised at length on the mental mechanisms behind such thoughts. Forty years ago Wertham,<sup>7</sup> drawing analogies between his patients and the matricidal figure of Greek mythology, coined the expression "Orestes complex." This term described a sexually immature but homosexually orientated son, trapped in a dependent but hostile relationship with a possessive mother. Escalating tension in such vulnerable sons could erupt in the commission of a murderous act, which Wertham called a catathymic crisis.<sup>8</sup>

Two small studies of matricide in Canada<sup>9</sup> and England<sup>10</sup> both found a substantial association with schizophrenia, and a Scottish study<sup>11</sup> of homicide, which included just four matricides, concluded that "matricide is the schizophrenic crime." Murderers with electroencephalographic abnormalities of doubtful significance<sup>12,13</sup> and with hypoglycaemia<sup>14</sup> have also been reported.

The problem of collecting a sufficient number of cases is formidable, and a recent report by Green<sup>15</sup> on 58 inmates of Broadmoor Hospital who had committed matricide is by far the largest study so far. Its findings require cautious interpretation, since the cohort is drawn from a population that has been subjected to the complex selection process leading to admission

to Broadmoor. By definition all Broadmoor patients have a mental disorder, but Green considers the Broadmoor matricidal patients to be representative of matricides in general. He may be right, but only a comprehensive and nationally conducted study would satisfy this crucial problem of sampling. Furthermore, the impact of the diagnostic findings of schizophrenia (74%), depressive illnesses (16%), and personality disorder (10%) is diminished by the lack of any comparison with a control group of other Broadmoor murderers. Such a comparison would have regularised the vagaries of diagnosis sometimes found in forensic psychiatry.

Not surprisingly, nearly all the sons were living at home with their mothers, and the bedroom or kitchen was the usual locus for the murderous attack. The mean ages of the victims and their assailants were 63 and 31 years respectively. Most of the women died of stabbings and batterings, with over two-thirds showing extreme degrees of violence. Some of the findings are a vindication for psychodynamic theory. About three-quarters of the households had an absent father figure and over half the offenders had had no significant sexual experience. In all but one case there was no attempt made to conceal the crime or escape detection, and a sexual element was identified in over a third of matricides. In two-thirds of the cases motivation centred on paranoid or altruistic ideation, but 11 cases could be explained by nothing other than sudden rage.

The apparent high level of psychiatric morbidity, particularly of schizophrenia, in matricidal killers cannot be ignored but must be put in context. Firstly, even if all matricides in England were committed by schizophrenics there would be only a dozen or so such cases each year. Moreover, thousands of schizophrenic sons live in peace with their mothers, neither assaulting nor killing them; and the contribution made by schizophrenics to the homicide rate in general is insignificant.<sup>16,17</sup> Secondly, family murder does not occur in a vacuum. It is a complex interaction of individual characteristics, precipitation by the victim, and environmental chance.<sup>18</sup> Victims do not give interviews, and the inevitable medicolegal preoccupation with the psychopathology of the offender has hampered psychiatric knowledge of these often strange crimes.

An association does appear to exist between matricide and schizophrenia, but how far the relation is causative remains unknown; simply allocating the diagnosis of schizophrenia to an individual is an incomplete and unsatisfactory explanation for his crime. The relation of schizophrenia to matricide, as distinct from other forms of family murder, might owe more to opportunity than psychodynamics. The socially disabling effects of the disease reduce the likelihood of marriage and prolong dependency on parents.

Prospective anticipation is a giant step from retrospective description, but how might doctors reasonably be expected to recognise potential danger? Many cases of matricide are neither predictable nor preventable, but the possibility should be borne in mind in treating schizophrenic sons who lead a socially isolated existence with their mothers and have little other family support. Sudden changes in mental state, delusional ideas concerning the mother, and threatened or actual violence call for swift intervention. Mothers who admit to being frightened of their sons should not be ignored.

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## Time for a change of MIND?

The National Association for Mental Health was formed in 1946 by the amalgamation of the Central Association for Mental Welfare, the Child Guidance Council, and the National Council for Mental Hygiene. In 1970 the association was renamed "MIND"—a change of title that seemed to follow a gradual shift in the political attitudes of the National Association for Mental Health to a more active stance over the previous 10 years, during which many proper criticisms of the mental health services had become sharp, confident, and, most important, public.

Now MIND is the leading mental health organisation in England and Wales; it offers a comprehensive range of information, educational, and therapeutic services and campaigning activities to the mentally disabled and to their relatives and professional helpers. The national operations are co-ordinated from a prestigious London head office and five regional resource centres. Much good mental health work is done by the voluntary members of the 160 affiliated local MIND associations.

Yet, while few would deny MIND's impressive successes as a pressure group in the general interest of psychiatric patients, many do regret that its continued, often inappropriate use of aggressive, confrontational, and uncompromising civil libertarian tactics has progressively lost the organisation medical sympathy. Nevertheless, some signs have recently emerged<sup>1</sup> of a change for the better in the role of MIND in relation to psychiatry; not the least among them is a belated recognition that MIND cannot function to best effect without active co-operation from the medical profession.

Further indications of such improvements came during the 1981 MIND annual conference "Psychiatric Treatment—Art or Science?," held in London last month. That a rapprochement is overdue may be judged from the fact that of the 600 delegates to the conference only a dozen were psychiatrists.

In contrast, and significantly, psychiatric academics predominated among the speakers at the plenary sessions. Indeed, the proceedings were influenced by two interdependent issues of special interest to doctors: the nature and efficacy of psychiatric treatments, and the prospects for the delivery of comprehensive mental health care in an economic season characterised by a drought of financial resources and a deluge of need. The consensus was that psychiatric treatment comprises a variety of physical, psychological, and social measures and that each prescription is guided partly by intuition and partly by reference to a body of systematic knowledge such as psychopharmacology. Many non-medical participants still seemed to place naive faith in the effectiveness of some treatments, especially "dynamic" psychotherapy, in the management of chronic psychiatric conditions and even in the prevention of mental disorders. A more realistic view prevailed among the majority, but clearly all mental health professionals need to develop more informed and critical attitudes about their treatment interventions.

The conference was also concerned with other, more mundane problems. Even now certain psychiatric patient groups (the elderly, the chronically mentally ill, and patients in special hospitals) tend to receive poor care, and their future expectations are little better. The prospects are equally bleak for the greater number of patients with minor psychiatric ailments who are treated in general practice. Meanwhile, just 4% of British medical graduates enter psychiatry, and half of all psychiatric trainees come from overseas. Where will the solutions come from to these problems? Perhaps NHS psychiatrists—who should give a lead—and their professional colleagues might do better in attracting skill and funds for psychiatric services and research if they began to organise their efforts in a way which might convince sceptical onlookers that psychiatry can be efficient; that current treatments are of general application and benefit to the bulk of the population (rather than to an elite section); and that their hard work can lead to achievements comparable with those in the other medical specialities.

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## Paediatricians and the law

Paediatricians—and indeed all doctors—will have been relieved that Dr Leonard Arthur was acquitted of the criminal charges made against him after the death of a baby with Down's syndrome (p 1340). In particular, the profession will be grateful to the President of the Royal College of Physicians, Sir Douglas Black, for the clear and forthright way in which he gave his evidence. Nevertheless, relief will be tempered with anxiety: will more similar charges be brought? The LIFE campaigners have lost this round in their attack on selective treatment for handicapped neonates; but their criticisms will not have been halted.

Doctors who believe that their management of newborn babies with severe handicaps was right in the past should not be deflected by Dr Arthur's experiences. In such cases the guiding principles must continue to be the welfare of the baby in the light of the parents' decisions. The first step should,