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Psychosocial Development on the Genesis of a Serial Killer "Mercy-Hero" Type

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Research Article

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ABSTRACT

On June 2013, Joan Vilà Dilmé was condemned to one hundred and twenty-seven and a half years by the murder of eleven old people at a geriatric residence. His case provoked a strong media effect and he became the most prolific serial killer in Spain on the current century, and the fourth for sixty years before. The goal of this article is to analyze in depth the living process as an important factor in the genesis of these criminal acts. To do so, we study the mental processes associated with motivations, feelings and fantasies. The methodology used is based on the analysis of the forensic reports made by psychological experts and psychiatrists, forensic interviews in prison and the documentary material taken from the crime scene. The results show the presence of disorders in the individual's psychosexual development, like identification with female role and a personality structure marked by his handicap to create stable and secure emotional bonds from his childhood. Both factors affect the individual's emotional development throughout his life, promoting the appearance of anxiety/depression symptoms, frustrations and insecurities. The conclusions show a serial killer, mercy-hero type, whose main motive is determined by the moral need to finish their victims' agony, in order to reduce his own suffering. That's why the lack of sadistic components. The psychosexual disorders, the absence of emotional bonds and the shortage of a stable and autonomous psychological structure, are compensated after beginning his professional activity at the geriatric. His first significant and firm emotional bond in his life appeared then, even though it involved a change in his morality. The analysis of his lifelong process reflects inconsistency and personal ambivalence in his criminal behavior, and allows understanding why the victims were the most important persons in his emotional life.

PSYCHOBIOGRAPHICAL BACKGROUND

Childhood

Joan Vilà Dilmé (JVD) was born in 1965, in a small countryside village (pop. 1000). He was raised by a middle class family, had a conventional relationship with his parents but poor affective contact. Besides, they both didn't know about their son's psychological worries and psychosexual dysfunctions either. It meant the development of a fearful attachment based on anxiety and social avoidance, with a negative vision of himself and his patterns [1]. Contrary to his parent's statements, JVD's childhood was marked by a great isolation and social refusal from his equals [2] due to a behavior too related with feminine vocabulary and gesticulation [3]. This psychosexual ambivalence led him to a traumatic development of self-identity and he even felt, from his early

childhood, like being a woman caught inside a man's body. He developed a strong trend to play games associated with femininity (dolls, cooking, mummy's roles, etc.). The progressive development of that symbolic game and the need of social acceptance improve the increase of a mighty compensatory fantasy [4] where he could be like a woman, with her own family and able to play the social role that he wanted. He progressively adopted in his mind a second life pattern, hidden from the other people, where all works perfect. However, his acute feelings of insecurity, lack of emotional contact and the absence of social support [5] made him to structure the parental home as a shelter or safe place against social conflicts from the outside and the psychosexual inadequacy that he was living. In order to get more psychological fitness, he developed an obsessive concern about his parent's physical well-being, transforming his personal suffering into a social behavior of assistance and sacrifice, surrendering his own well-being to other people's one and blocking the evolution of a stable psychological structure. He felt integrated as he ignored his own motivations and satisfied alien ones. During his early childhood, it's significant the death of a younger sister, when JVD was 13 months. Although at that moment he wasn't totally conscious due to his age, it became a traumatic experience throughout his life and very important in his psychosocial development [6] because it strengthened his will for taking care of his parents, as his sister would have done but never reaching her level due to sexual inadequacy as he wasn't a real woman. Furthermore, this somehow considered loss provoked the beginning of his high fear/attraction feeling about death and suffering which gradually increased throughout his life.

Adolescence – aduithood

JVD's adolescence was marked by the reinforcement of the mismatches already lived throughout his childhood. His fantasies are structured with high pain when he's 12–13, due to his incapacity to develop his sexual feminity according to his mind, unable to face the social rejection involved, as well [7]. His feelings of rejection and poor acceptance from his equals produce a deficit in strategies and interpersonal skills [8] and promote affective blocking. Constants insults and contempt to him increase his feelings of sadness and loneliness, but they're hidden behind a mask. Thus, in presence of his group of friends, he pretended or hid his experiences, and in family life he adopted the role of caretaker. In this context of instability and uncertainty there's one episode, which touched him deeply: the death of an aunt after a long and painful illness, experienced by him with big concern. This mutual relationship was the best, and only, emotional bond in his life because it offered affinity, understanding and a feeling of psychological security. An experience like that was relieved when he joined the geriatric residence as a caretaker, but then considered necessary. At 15 he began to study, without many hopes, hairdressing. In this period he constantly looked for social approval avoiding to face threatening or potentially painful situations [9]. He was easily influenced and totally led by other people's opinions ignoring his own ones. When he was 18-19, his first homosexual love affair took place. This one was based on a mighty fantasy to get away from an undesired reality. But at the same time, as in his further relationships, he also felt delocalized and misunderstood, because he didn't understand them without emotional or physical contact either fondness. Thus, he developed a big personal and professional instability, with a wide sort of jobs along a short period of time (hairdresser, plastic company employee, working for clothing industry, hostelry), until he was hired by the geriatric residence. As he was at the military service in Madrid, he didn't feel outcast either rejected. There weren't important problems and he spent that year quite unnoticed, At 21, he decided to leave his birthplace and went to the capital city for working and living there. At first, he felt more relaxed and free but he couldn't keep any stable relationship and in the mid-term his emotional isolation increased. When he was 24, he moved to Barcelona where he began to live his sexuality in an open and active way. He even felt somehow used and humiliated. Every sentimental failure meant personal disappointment. The search for a deep relation, based on love for couple, with fantasies and idealized from a feminine perspective, became some occasional episodes of sexual contact. Hence, he had to create new fantasies in order to compensate his frustration, insecurity and loneliness [10]. After his working, personal and sentimental failures in Barcelona, he decides to run his own business: a hairdressing salon. However, his efforts to get a change, to be a more independent self-made man didn't success, due to economic problems with his partner. In that period JVD became very unstable, changing jobs and his residence quite a lot until he returned to his parent's home. He looked for professional aid. At 24 he suffered from a panic attack and it was the beginning of a long pharmacological and psychological treatment. It lasted for more than twenty years, until his detention for criminal conduct. This situation, issued by disorientation, depression and unrest, made him compulsive. So, he enrolled in an ample sort of courses: quiromassage, cooking, couturier, foot reflexology, etc. At the same time he had his first contact with medicine environment attending clinical assistant classes. Nevertheless, he enrolled at the catering school and he worked for some restaurants and hotels in the province. During this period he kept on visiting the psychiatrist and the psychologist, not quite monitored by the patient though. He had symptoms such as anxiety, loss of control, insomnia, difficulties with concentration, lack of vital energy, which he tried to mitigate through compulsive behaviors [11], like: excessive consumption of energy drinks, caffeine, food, and shopping. Thus, according to his therapists, he showed very worried about a hand tremor that he thought was due to his innumerable dismissals. When JVD was forty, he made contact with old people for the first time. He was hired by a geriatric center, 30 km. from his village. That made increase his good feelings because he always liked being with old people. He considered them able to give him affection and respect, by contrast with children and adults. He worked there for five months and could see the first cases of natural death in his life. They weren't unpleasant for him, because he thought that medication helped terminally ill patients to die without suffering. He did his work fine, but decided to go to another center, nearer his home. At last he felt fine and valued in a job he liked, so his self- esteem improved and he created emotional bonds with older residents. However, there were changes in the organization and the staff of the geriatric center. Hence, we can

see two periods. For the first five months the center was run by nuns, who, according to JVD's perception, showed concern for their residents' physic and psychological welfare. Afterwards, it became a public center; the number of patients increased and JVD noticed a change in old people's care. The work rhythm was faster, demanding and strict; doctors and medical staff seldom looked interested in their duty.

Criminal actions

JVD was convicted and sentenced to 127 years and a half prison year (STS 651/2014 October 7th) by the murder of eleven persons at the geriatric where he had been working. The trigger of these facts took place on October 17 2010, after the death of an elderly resident woman. She presented burns in the respiratory tract, esophagus and mouth. Doctors concluded that it hadn't been a natural death. At this moment the police investigation started. After some interrogations of the geriatric staff, JVD confessed that he had forced the old woman to ingest a cleanser through a syringe. When this crime was revealed another patient's relative called the police to know the actual causes of her death, five days before. Being asked by the police, JVD confessed that he was the author of this death. Some hours later, in front of the trial judge, he admitted to be guilty of another old woman's death. As a result of the above, the Court of Instruction ordered to check all the passing's that happened at the geriatric since December 2005, when JVD began to work there. From the 59 deaths in that period, almost a half, 27, passed away at JVD's shifts (week- ends and feast days). On 2010, twelve deaths from fifteen occurred while Mr. Vilà was working; and on 2009, five from twelve cases during his watches. Forensic findings revealed intentional death in eight corpses. After their exhumation, on November 30 JVD confessed the murder of six from eight old people and, spontaneously, of two women in their eighties in 2009.

Victims

On balance, JVD killed, since August 29 2009 to October 17 2010, eleven elderly people, between 80 and 96 years old, nine women and two men, all residents at the geriatric center. All the victims were known by the aggressor due to his work. Besides, one of them was already known by him as a neighbor from his childhood days. The presence of a previous relationship between the aggressor and his victims explains the emotional and expressive components in the crimes; and also, the lack of a rational or structured plan [12]. The great majority of victims, although their age, weren't in terminal condition. Therefore, his selection method of the victims didn't come from an organized conduct, but from his perception of their suffering. He followed some criteria based on cognitive and emotional inner processes, connected to his relation with the victims [13]. His decision drew on self-perception of suffering and pain in the victims, which influenced on the genesis of the crime, the selection of them, their availability and accessibility. This self-perception also worked for prospects and wishes of victims' relatives. In a period of one year and two months the murders took place. The last three ones were committed with a temporal distance of few days. We can observe that on the remaining nine the "inter-criminals" lapse was decreasing.

Modus operandi

JVD had a stable, consistent Modus Operandi (MO), based on an opportunistic method, especially with respect to the contextual situation [13]. In such a way, the planning of the criminal act didn`t come from an organized behavior pattern. Nevertheless, the facts were developed through JVD's self-perception of the environment. Hence the compulsivity in his actions and the lack of progressive sophistication in the MO, as well. The self-perception of other persons' suffering resulted from the contact with them and also from the talk with their relatives. According to that suffering he chose the victim in order to prevent her /him from that pain without considering elder one's real will. The way to select the mechanisms to precipitate death didn't come from medical knowledge, either from a previous analysis of the effects to achieve. It was a vicar or social learning [14] that is to say based on the observation of the pharmacological treatment patients received in similar situations and how it was applied at the first residence where he worked. Medication and doses used weren't the same in all cases. The most common: insulin overdose and a mixture of psychotropic drugs. The last three victims died by the ingestion of caustics. It wasn't a change in his MO, but due to a pronounced compulsivity and chaotic development from the first death. He wanted to avoid suffering and had the self-imposed obligation to make it shorter. Finally, he provoked their death not thinking about the immediate pain caused by the chemical product. The approaching method is based on a trust relationship between victim and aggressor. JVD used deceit and manipulation, not deliberately yet, to reach his goal [4]. The emotional relation between victim and aggressor is structured from a difference in status. JVD is in a position of superiority, through the link patient– career. As a result, victim trusts JVD's conducts which are related with her care. Besides, it's the point of the accessibility to the victims through his professional activity. The attack method starts from his perception of victim's suffering. JVD doesn't use physic or verbal force; no signs of violence are reported. Probably, the language employed was affective and friendly, in conjunction with strategies and manipulative skills to reinforce the established confidence [13].

Criminal motivation

What made JVD commit these acts? Was he a sadistic and calculating individual, or was his compassion for suffering on others true? The analysis of JVD's psychosocial development shows the existence of a bunch of situations that were experienced traumatically. These ones interacted with a less integrated personality, which didn't allow him to build skills and strategies for facing stressful events. Thus, we observe that after a childhood and adolescence characterized by frustration, refusal and lack of emotional bonds, his adulthood is structured on a high instability in the set of psychological areas (work, sentimental partner),

compulsions grow and social isolation is exacerbated. In 2006, when he began to work in geriatrics, the bad feelings vanished. His world radically changed, and also did his social behavior. Being with old people, vulnerable and physically needy, improved his self-esteem. He felt socially valued, with mutual affection and respect. Therefore, he considered his relations with the residents as his only emotional bond, which compensated his emotional deficiencies and relational problems. For the first time in his life, he felt loved and fulfilled. His work wasn't a mere job and became the basic axis for his world. When he saw the suffering of the residents, he developed anxious behaviors, which resulted in compulsive actions: buying books compulsively, storage of objects, excessive food intake, consumption of energizers, etc. That's why he transferred his own suffering to his patients', being unable to distinguish between his own perceptions, feelings, moods and the residents' ones [15]. Apparently, JVD's main motive was to finish the agony and suffering of elderly people. Their lack of autonomy, physical integrity and welfare made him morally stressed. His personal agony was reflected in the social one, perceived through feelings of unnecessary suffering in the residents throughout their stay and "close" death. Thereupon, an extremely powerful vicious circle between social and personal agony emerged. When the repeated complaints to his superiors were fruitless, there was a change in attributions: he felt responsible for old people's agony and so he developed a personal moral duty to act. More than a gesture of compassion, it was a release of his own suffering, transferring the personal misery and apathy to elderly people. So, when he relieved their suffer-death he got a relief for himself. But secondly, when we read his documents, written then, we can observe how his bond with old people changed him. Instead of feeling submissive and complacent, became strong, useful, necessary and able to satisfy his motivation for power. Consequently, criminal compulsivity increased or he reduced the time gap between victims, due to a fall of the inhibiting threshold after his first crime. The absence of sadism and paraphilia's in his criminal behavior, the lack of psychopathic or narcissistic features, of power and social omnipotence as well [16] reinforce the argument of finishing agony as the main purpose.

MENTAL STATE AND FORENSIC PSYCHOLOGICAL EVALUATION

Psychological and psychiatric background

JVD showed anxiety disorders from his childhood (enuresis, onycophagy, psychotropic drugs consumption). When he was 23-24 received psychological treatment for anxiety-depressive disorders and obsessive personality. In all his therapeutic relations he exhibited poor adherence and low monitoring of the pharmacological treatment. JVD attended these treatments hiding important information about his unfitted self-assessment. His psychopathologic diagnosis before the crimes showed little changes. The consistent data were anxiety-depressive disorder, personality with obsessive features and poor assimilated homosexuality. Any personality disorder of psychopathic, antisocial or narcissistic type wasn't detected, either the presence of sadistic traces.

Period of the events

During his stay at the geriatric center, his perception of others' suffering and his own one became the heart of his personal and professional life. His anxious-obsessive behavior extended to the rest period. In the absence of the residents he constantly thought about them, in a compulsive way. Even during his holidays he visited the residents and brought gifts for them. Some days before first victim's death, JVD was with an emotional overload, due to stress feelings of impotence when he noticed doctors' indifference to that woman's pain. It provoked an anger sensation. He declared his complaints to his superiors but they avoided the questions. Thus, he developed thoughts related to self-attribution of responsibility and the consequent need for action. After his first victim, the inhibiting threshold lowered. He adopted a compulsive behavior [15], which grew for the days of the last three victims. Then we notice a loss of self-control in his behavior, increase in his impulsivity, a strong feeling of euphoria, a raise in compulsive consumption of alcohol, stimulant drinks and self- medication. His obsession for work was progressive, he compulsively wrote about schedules, activities to be performed, planning of the dining-room, old people care etc., with a ritualistic structure. Consequently, in his weekly behavior pattern, along the three last deaths, constant exhaustion and apathy were combined. In his free days he Stressed his euphoria and vital activity, helped by alcohol and stimulant drinks. He acted the same way specially moments before and after the deaths. Concerning his mental state after victims' death, there was a deep feeling of tranquility. He considered his acts as morally correct, although they weren't according to social establishment. It was rationalized through self-help readings where he found rational justification for his criminal acts. In order to fell himself psychologically fine, he did his will apart from others' opinion. He had been doing just the opposite until then and never reached happiness.

Psychological forensic evaluation

Since his arrest and for consecutive years, JVD submitted psychological testing and many interviews with mental health professionals. But, as with his former professionals, he felt uncomfortable, misunderstood and socially judged. Only with the psychological expert named by the defense he was open and co-operative. During the tests, JVD looks collaborative and predisposed to their achievement. However, he showed a high self- critical attitude and strangeness in relation to the motivation of his criminal acts. The results show a person with stable cognitive functions and middle intellectual level, reasoning and solving-problem capacity. Nevertheless, concerning to his personality, there were some aspects that interfere with his psychological function, such as depressive and anxious disorder with deep uncertainties and low emotional stability. He had a pessimistic and defeatist point of view about future, few personal interests. He preferred familiar stuff instead novelty. He constantly looked for a quiet way of life close to his parents; he saw them as a guarantee of his psychological and emotional safety. His poor self-esteem provoked a lack of self-reliance, resorting to fantasy to detach from surrounding reality. It implied an increasing loss of self-control.

In social relations he feels uncomfortable, denies his own feelings and emotions and keeps the interpersonal distance to protect himself, somehow a changing mask [17]. His fears, insecurities and feelings of uselessness made him unable to face stressing and conflictive circumstances. The frustration after his search of a sexual partner based on a more feminized role through affective physic contact is balanced by his relation with the residents of the geriatric. Referring to clinical psychopathology, he suffered a disorder on sexual identity, hidden and repressed, which led him to a major chronic depression in conjunction with anxiety, somatizations and obsessions related to excessive heath concerns [18]. He showed a compulsive consumption of food, alcohol and medication. He had a great vulnerability to the suffering of others and to his own one, specific of people diagnosed as major depressed. However, he didn't have a sadistic profile. Finally, his lack of self-reliance, difficulties with concentration and attention, problems with decision-making, negatively interfered with his social and working functions and spread throughout most domains of his life.

CONCLUSIONS

At first sight, a large part of serial killers are psychopaths and/or sexual sadists, or have an antisocial personality disorder. According to the circumstances of homicides and the state of victims, the diagnostic may change [19]. However, most of the forensic experts state that they are seldom individuals with psychotic disorders [20]. In JVD's case there is an interaction of personality features, psychobiography, vital development, psychological resources to manage his experiences, social and work environment. All these elements influenced dramatically on the development of a criminal act as a dysfunctional escape mechanism. From JVD's confession and data obtained along the police investigation, we know that the murders are numerous and frequent with lack of material benefits. His behavior pattern was relatively simple: he chose the victim by his individual perception of suffering. Then, he tried to make it shorter, as soon as possible. JVD identified elderly people's agony with his own one, and considered the geriatric as a home to protect and take care of. However, organizational changes in the center made him to perceive an unnecessary pain in the residents. His feelings of impotence and personal agony grew and he looked for compensatory mechanisms because his opinions weren't valued. Overall, JVD experienced, before the criminal acts, a failure of conventional morality, followed until then. He replaced the "social good" by a "personal good" and changed his personal suffering into a psychological well-being. "When other people will stop suffering, I will". Historically, some violent offenders have experienced dysfunctional and/or abusive childhoods, with poor relations and emotional bonds, social isolation and depressive symptoms [21]. We can't say whether these ones or others are the specific reasons for JVD's criminal behavior. But they influence on the imperfect matching of his personality, with continued frustrations, social rejections, and emotional isolation as well. Previous clinical assessments show that the most significant JVD's disorders referred to his psychological functioning and clinical symptoms in absence of severe psychological disorders. They are: obsessive concern about his physical well-being, social behavior poorly adjusted, emotional overload and compulsive consumption of alcohol and drugs. However, along the psychological forensic evaluation, some pathology was diagnosed in JVD, like sexual identity disorder, major depression and risk of suicidal behavior. Regarding to the conscience in his acts and his level of responsibility, there wasn't any perception of "helping to die" like something evil or incorrect. JVD knew the morals effects ok killing, discerned between good and evil, but his moral values were perverted. An attribution or consistent relation between these values and the developed criminal act didn't exist. Hence, he didn't exhibit senses of guilt or regret for precipitating the death of the victims, although he regretted to cause unnecessary suffering to the three last victims about their way of dying. At the present time JVD is serving the sentence and he follows psychiatric treatment.

REFERENCES

1. Bartholomew K and Horowitz LM, Attachment styles among young adults: A test of a four- category model. Journal of Personality and Social Psychology, vol-61, pp-226-244.1991.
2. Parker JG and Asher SR, Peer relations and later personal adjustment: Are low-accepted children at risk? Psychological Bulletin, vol-102, pp-357-389 , 1987.
3. Nancy H et al. Is gender identity disorder in children a mental disorder? Sex Roles, vol-43, pp-753-785. 2000.
4. Hazelwood RR, Analyzing the rape and profiling the offender. Practical aspects of rape investigation: A multidisciplinary approach. CRC Press Boca Raton Finland, 2008.
5. Kitamura T et al. Precedents of perceived social support: Personality and early life experiences. Psychiatry and Clinical Neurosciences, vol-53, pp-649-654. 1999.
6. Compas BE, Stress and life events during childhood and adolescence. Clinical Psychology, vol-7, pp-5-302. 1987.
7. Orejarena SJ et al. Trastorno de identidad sexual. MedUNAB, vol -7, pp-29-34.2004.
8. Dunstan LV and Nieuwoudt The relationship between indexes of childhood friendship and biographical, personality, and behavioral variables. The Journal of Genetic Psychology, vol-155, pp-303-312. 1994.
9. Ashley A and Holtgraves T, Repressors and memory: Effects of self-deception, impression management and mood. Journal of Research in Personality, vol-37, pp-284-296. 2003.

10. Busch F N, Anger and depression. Advances in Psychiatric Treatment, vol-15, pp-271-278. 2009.

11. Weinstein A et al. A study investigating the association between compulsive buying with measures of anxiety and obsessive-compulsive behavior among internet shoppers. Comprehensive Psychiatry vol-57, pp-46-50. 2015.

12. Cao L et al. Correlates of the victim-offender. International Journal of Offender Therapy and Comparative Criminology, vol-52, pp-1-15. 2007.

13. Turvey BE, Crime scene analysis. En Criminal Profiling: An Introduction to Behavioral Evidence Analysis CA: Academic Press San Diego, 2008.

14. Bandura A, Social learning theory. New York NY: General Learning Press, 1977.

15. Beine KH, Homicides of patients in hospitals and nursing homes: A comparative analysis of case series. International Journal of Law and Psychiatry, vol-26, pp-373-86. 2003.

16. Yorker BC et al. Serial murder by healthcare professionals. Journal of forensic sciences, vol-51, pp-1362-1371. 2006.

17. Eng W et al. Attachment in individuals with social anxiety disorder: the relationship among adult attachment styles, social anxiety, and depression, Emotion, vol-1, pp-365-380.2001.

18. Hollander E et al. Subtypes and spectrum issues. Obsessive compulsive disorder: Current Science and Clinical Practice West Sussex United Kingdom. 2012.

19. Geberth VJ and Turco RN, Antisocial personality disorder, sexual sadism, malignant narcissism and serial murder. Journal of Forensic Sciences, vol-42, pp-49-60. 1997.

20. Campobasso CP et al. A serial killer of elderly women: Analysis of a multi-victim homicide investigation. Forensic Science International, vol-185: pp-7-11. 2009.

21. Declercq F and Audenaert K , A case of mass murder: Personality disorder, psychopathology and violence mode. Aggression and Violent Behavior, vol-16, pp-135-143. 2011.