Psychological Motivational Profile of a Serial Killer "Mercy-Hero" vs. Power/Control Type

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Abstract: On October 2010, the death of an elderly woman in a geriatric residence in the province of Girona (Catalonia), launched a police investigation, which ended up with the confession of eleven murders committed by one employee, Joan Vila Dilme (JVD). The killings were committed between August 2009 and October 2010; the eleven victims were elderly people between 80 and 96 years old, who lived in the residence. The employee administered to the victims a mixture of psychotropic drugs, insulin and caustic products. Different multidisciplinary teams evaluated, with forensic assessment proposed, the offender mental state and his biographic and personality background focused on a clinical-pathological vs. psychosocial-criminological perspective. Although he always claimed that his primary motive was to help those people he loved to stop suffering. On June 2013 he was condemned to one hundred and twenty-seven and a half years in prison, becoming 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 analyse in depth this particular case, which provoked a strong media effect, highlighting the psychological factors regarding the offender motivation, his psychobiography background and his mental state.

Keywords: Serial killer, mercy hero, personality, criminal motivation, elderly victims, forensic assessment.

1. INTRODUCTION

Serial killers have always fascinated and terrified society. Despite the increased media and movies attention to these cases, the scientific investigation is still scarce. The sensationalist and stereotyped perspective has built a serial killer profile based on the superficial analysis of some of the most socially relevant and shocking cases becoming the entertainment industry products. However, since the 1950s, the scientific literature has been studying the demographic, psychological and behavioural factors of the serial killers through the analysis of their background, motivations, and the nature of their crimes. The profile of the serial killer is frequently presented as a white male in his late 20s or 30s, who suffered abuse as a child, killing strangers, and characterized as a sexual sadist [1].

This article aims to analyse in depth the case of eleven killings committed by a person who does not fit the serial killer stereotype, both in psychological and biographical factors, illustrating the psychological assessment complexity in such cases and the need to take into account the interaction of individual, relational, social, cultural, and contextual factors.

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2. CASE HISTORY

The case presented took place in a geriatric residence in Olot, the province of Girona (Catalonia). Joan Vila Dilme murdered, between 29th of August 2009 and the 17th of October 2010, eleven elderly people between 80 and 96 years old, nine women and two men, all of them residents in the geriatric where he worked (Table **1**).

Table 1: Murders Committed by JVD Along 2009-2010 Period

Homicide date	Victim / age
29th August 2009	Woman. 87 years.
19th October 2009	Woman. 88 years.
14th February 2010	Woman. 89 years.
28th June 2010	Woman. 85 years.
18th August 2010	Woman. 80 years.
21st August 2010	Man. 84 years.
19th September 2010	Man. 94 years.
25th September 2010	Woman. 96 years.
12th October 2010	Woman. 87 years.
16th October 2010	Woman. 88 years.
17th October 2010	Woman. 85 years.

The trigger of these facts took place on October 17th 2010, after the death of an elderly resident woman, whose autopsy revealed she did not die by natural causes. She presented burns in the respiratory tract,

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oesophagus and mouth. 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 relative 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 deaths 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). 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.

The aggressor knew the eleven victims due to his work, explaining the emotional and expressive components in the crimes; and also, the lack of a rational or structured plan [2]. Although their advanced age, the great majority of victims weren't in terminal condition. The method of killing in the first eight murders was due to an insulin overdose and a mixture of psychotropic drugs, being the medication and doses used quite diverse and chaotic. The last three victims died by the ingestion of caustics, in a quite similar way but also more close in time.

3. PSYCHOLOGICAL FACTORS

3.1. Psychobiographic Development

Joan Vila Dilme (JVD) was born in 1965, in a small countryside village (pop. 1000), raised by a middle class family. He was an introverted child, with low self-esteem and few affective bonds both with his peers and his parents. His parents showed a high reticence and negativism to show any sign of affection, avoiding the emotional and interpersonal implication of a child-parent relationship. They tended to overprotect their son by keeping him at home and away from the other children. JVD developed a fearful attachment with a negative vision of himself and the referent figures, generating high levels of anxiety and social avoidance [3]. He spent most of his childhood in the house with his mother, with whom JVD felt more comfortable and understood despite the lack of affection and fondness manifestations. In his own words, JVD explains that the most disturbing factor and source of his discomfort, was his excessive feminine conduct [4], provoking a great isolation and social refusal from his equals [5]. However, the behavioural pattern of JVD followed the masculine role, discordant with his feminine feelings and identity. Besides, his parents did not want to realize about their son psychological worries and psychosexual dysfunctions, trying to maintain the social appearance of a standard family. 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.

During his early childhood, when JVD was 13 months, his younger sister died. Although this traumatic experience was not consciously processed due to his age, it marked his posterior psychosocial development [6]. His mother also experienced this death as a key factor in the family development, but never affronting it. Furthermore, the death of JVD aunt, almost the only source of emotional support, after a long and painful ill, provoked the beginning of his high fear / attraction feeling about death and suffering of his loved ones, which gradually increased throughout his life. He felt a compulsive need to take care of his old parents, as his sister would have done but never reaching her level due to his perception of strong limitations, sexual inadequacy and for not being a real woman.

The social rejection feelings and the progress of symbolic game maximized the development of a mighty compensatory fantasy [7] 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, reinforced in his childhood by games associated with femininity (dolls, cooking, mummy's roles), and in his adulthood by behaviours such as dressing like a woman and adopting the social feminine role in his interpersonal relationships. However, his acute feelings of insecurity, lack of emotional contact, and the absence of social support [8] remained constant, structuring the parental home as a shelter or safe place against social conflicts.

During his adolescence, the emotional, cognitive and behavioural impairments were magnified as a result of his inability to develop his feminine sexuality, and at the same time to deal with the social rejection that would imply. His copying strategies were structured thorough an affective blockage, diminishing his social skills [9], being influenced by the others opinions, deliberately ignoring and disparaging his own needs.

His first homosexual love affair was based on a mighty fantasy to get away from an undesired reality. However, this relationship based on superficial and sexual elements did not satisfy his emotional needs. Later on, JVD engaged in a few more relationships like his previous one, questioning himself about these kind of relationships and finally rejecting them because he did not understand a simple physical and sexual contact without an emotional and affective bond.

At the age of 24, after an unstable personal and professional period, 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.

When JVD was forty, he started working in a geriatric center, which increased his positive 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 reduce their pain, driving them to a death without suffering. He did his work fine, but he decided to go to another geriatric center, nearer his home. For the first time in his life he felt good. He carried out a job he liked, he felt valued, so his self- esteem improved and he created strong emotional bonds with the elderly victims he took care of.

However, due to changes in the organization and the staff of the geriatric center, there were two clearly differentiated periods in JVD career. For the first six months the center was run by a religious order, who according to JVD's perception, showed concern for their residents' physic and psychological welfare. Afterwards, it became a public center, so the number of patients increased and JVD noticed a change in elderly people's care. The work rhythm was faster, demanding and strict, lacking real interest by doctors and medical staff about the wellbeing of the elderly.

3.2. Mental State

3.2.1. Psychological and Psychiatric Background

JVD showed anxiety disorders from his childhood (enuresis, onycophagy) starting psychological and psychiatric treatment at the age of 23-24 for anxiety-depressive disorders with panic attacks and obsessive personality traits, in absence of aggressive behaviour. In all his therapeutic relations he hid the central core of his worries, his disturbances, his low self-esteem, his own perception of inferiority, and his inappropriateness with his sexual role and identity. Thus, JVD exhibited poor adherence in all his therapeutic relationships and low monitoring of the pharmacological treatment regarding the more serious social impairments, with constant and recurrent disturbances in the anxiety sphere: anxiety, loss of control, insomnia, difficulties with concentration, lack of vital energy, which he tried to mitigate through compulsive compensatory behaviours [10] such as, excessive consumption of energy drinks, caffeine, food and shopping. His psychopathologic diagnosis before the crimes showed a few variations. The consistent data were anxiety-depressive disorder with panic attacks, personality with obsessive features and poor assimilated homosexuality. The diagnosis of a psychotic disorder, as well as the delusional and bipolar diagnosis was discarded. Any personality disorder of psychopathic, antisocial or narcissistic type wasn't detected neither the presence of sadistic traces.

3.2.2. Forensic Psychological Assessment

Since the arrest of JVD different professionals tried to approach an explanation of his behaviour and mental state in the period of the events. To this end, psychologist and psychiatrist named by the accusation and the defense of JVD carried out assessments and psychological and psychiatric reports. After his detention, JVD was evaluated several times in the penitentiary psychiatric center where he was admitted provisionally awaiting trial, in a clinical-pathological perspective.

As with his previous therapists, JVD felt insecure, uncomfortable and socially judged. Later, with the expert psychologist named by the defense, with a different perspective based on the psychosocial and criminal process, JVD was more open and willing to cooperate, being able of verbalizing and expressing the different circumstances that have accompanied him in his vital development and at the moment of the violent acts. This attitude and disposition change of JVD influenced the diagnosis results of the forensic assessments, showing significant differences.

The first forensic assessment took place between December 2010 and January 2011, when JVD was hospitalized in the penitentiary psychiatric unit for autolytic risk. The methodology employed in the forensic assessment was the semi-structured interview for making DSM-IV Axis II diagnoses (SCID-II), the Millon Clinical Multiaxial Inventory (MCMI-II) in order to provide information on personality traits and

psychopathology, the revised NEO Personality Inventory (NEO PI-R) which evaluates adult personality using five dimensions (emotional, interpersonal, experiential, attitudinal, and motivational styles) and the Weschler Adult Intelligence Scale (WAIS III) designed to measure intelligence and cognitive ability in adults and older adolescents.

This psychological forensic report highlighted the existence of psychically critic or traumatic experiences in the development of JVD, adding that there is more risk of psychological impairment when these experiences occur during childhood or adolescence and that can contribute to the development of a mental disorder. Nevertheless, the impact of these experiences in the psychological functioning of JVD is not analysed, affirming that only the traumatic experience, with no mental disorder, does not explain the symptomatology and its influence in the individual's mental state at the moment of the crimes.

The functional level of JVD is within parameters of normality, despite the alcohol abuse behaviour with no dependence pattern. Referring to clinical psychopathology, the depressive and anxious symptomatology appeared at his 20s, in a low-moderate level. During the period previous to the killings, showed a diminished mood, sadness, disinterest and reduced ability of enjoyment in the absence of psychotic symptoms. The existence of a recurrent major depressive disorder was concluded, being the closest episode to the facts of moderate character, preserving his cognitive and volitional capacities. The psychological assessment report also states that, although JVD showed no diagnostic criteria for any personality disorder, he presented desadaptative obsessive and psychopathic traits. However, despite the psychic discomfort that could cause to him or to others, his ability to understand and manage their behaviour appropriately was not impaired.

The explanation of JVD about the crimes was based on the avoidance of the victim's suffering helping them to move to a better life. Although this justification was assessed in terms of an overvalued or delusional idea, this diagnosis was ruled out by the absence of additional symptoms. It was not taken into account the explanation of this reasoning as a result of psychosocial factors and the structure of his personality, apart from a supporting mental pathology. Consequently, JVD was fully aware that the methods used to "help to die" produced a slow, painful and agonizing death to the victims, even when his assistant clinical condition allowed access to non-invasive and painless methods. These circumstances were assessed as contradictory with the intention of helping victims to end their suffering or any kind of active euthanasia. Therefore they did not consider appropriate to apply the concept of "Angel of Death" at least in its entirety, claiming the existence of a desire of power, enjoyment with other people's suffering and sadistic components in their criminal behaviour.

Later, in 2013 the psychologists' experts of the defense, with whom JVD showed more open and cooperative, evaluated him. Their assessment adopted a multifactorial approach in the explanation of the complexity of JVD criminal behaviour, beyond the possible supportive psychopathology. The methodology used was based on psychosocial and psychopathologic interviews (both with JVD and his parents), psychometric and projective tests, criminal profiling and documental analysis. The psychometric instruments used were the State-Trait Anxiety Inventory (STAI) to evaluate anxiety affect, the State-Trait Anger Expression Inventory (STAXI-II) in order to assess the intensity of anger as an emotional state and the disposition to experience angry feelings as a personality trait, and the Personality Assessment Inventory (PAI) which evaluates psychopathological syndromes and provides information for clinical diagnosis, treatment planning, and screening for psychopathology. The projective tests employed were the Thematic Apperception Test (TAT) to reveal the underlying motives, concerns, needs for achievement, power and intimacy and problem solving skills, and the House-Tree-Person test (HTP) designed to measure aspects of a person's personality. These psychological assessment tools were used as a support to psychologists' clinical judgement.

Therefore, beyond the clinical diagnostic criteria, it was contemplated the relevance of the interaction of personality traits, psychobiography, the vital development, his psychological resources to manage the diverse life experiences and socio-labour environment in development criminal action. The results showed a person with stable cognitive functions and middle intellectual level, reasoning and solving-problem capacity. Nevertheless, concerning to his personality he presented obsessive traits funnelled through compulsive behaviours (alcohol consumption, food, writings about schedules, work planning, etc.), recurrent and intense anxiety-depressive states, with a deep psychological insecurity and poor emotional stability. He had a pessimistic and defeatist point of

view about future, few personal interests. He preferred familiar stuff instead novelty.

Referring to clinical psychopathology, he suffered a disorder on sexual identity, hidden and repressed, which led him to a major chronic depression, being the most relevant symptoms a persistent and profound sadness with no apparent cause, feelings of apathy and aboulia, a lack of energy and chronic fatigue, the presence of thoughts about death, slowed thinking, speaking and body movements, in conjunction with anxiety, somatizations and obsessions related to excessive health concerns [11]. He exhibited a compulsive consumption of food, alcohol and drugs in a variable level depending on his emotional and social adjustment. He had a high vulnerability to his own and the others suffering. He did not present a sadistic profile.

In social relationships he felt deeply uncomfortable, denying his feelings and emotions, maintaining high interpersonal distance to protect himself psychologically. His fears, insecurities and feelings of uselessness made him unable to face assertively stressing and conflictive social and emotional circumstances. He experienced a high frustration with the search for intimate or social relations, strengthening their moral conception to follow the standard set by the others despite his accused feeling of suffering.

To summarize, the main difference between the psychological forensic assessments of the defense and the accusation stem from the initial assessment aim. On the one hand, the accusation report was based on analysing the existence of a psychopathological diagnosis which could explain JVD criminal behaviour, and on the other hand the defense report was based on the psychosocial and criminological aspects of JVD behaviour such as, his coping strategies of his fears and worries, his psychological needs and motivations and his ability to deal with the personal conflicts regarding his sexuality and his absence of significant affective bonds. The divergence in the psychological assessment aim leads to an absence of a comprehensive and longitudinal behavioural analysis by the accusation psychologists, becoming the key point in the subsequent JVD motivational profile analysis.

4. PSYCHOLOGICAL AND BEHAVIOURAL MOTIVATIONAL PROFILE ANALYSIS

The previous forensic assessments show that the isolated psychopathological analysis does not explain JVD behaviour, since the clinical diagnosis by itself is insufficient to explain his criminal pattern. However, bearing in mind the development factors, psychological functioning and behavioural manifestations that contribute to analyse the complexity of the JVD criminal conduct, it is possible to establish a comparison with the criminal motivational profiles of the scientific literature that may explain his behaviour.

The scientific literature on serial killers has proposed different serial killers profiles according to the psychological characteristics of the individual and factors related to their criminal development activity. Some authors consider the sexual motivation as the primary in most serial killers. However, considering that such behaviour adopts many forms, both at a cognitive and behavioural level, the materialization of a sexual motivation in the criminal action will be greatly heterogeneous depending on the individual characteristics of each person.

The results of the two forensic assessments reflected mixed, and sometimes contradictory results. On the one hand, JVD presented a power-control motivation with sadistic traits, and on the other hand it was established a compassion for the victims as the motivational basis. These two approaches are part of two criminal motivational profiles of serial killers: power-control and mercy-hero ("angel of death").

4.1. Power-Control Profile

The serial killer profile motivated by the need for power and control is based on the offender search to subdue, dominate and humiliate victims, as well as the psychosexual pleasure provided by his capacity to decide about the life and death of the victims. Therefore it affects the different stages of the criminal act.

Usually, in the pre-criminal phase power-control serial killers present a highly organized and planned criminal structure through powerful fantasies in order to ensure in time their desire for power and control [12].

Behaviour during the criminal action is directed toward that sense of power. To fulfil their primary psychological need, the method of killing seeks physical contact (strangulation, stabbing), performing humiliating acts, sexual activity and aggressive and demeaning language, in order to turn the victim into an object. Post-criminal conducts may include staging, moving the body of the victim to a place, or in a certain position, which increase his humiliation, injury and post-mortem sexual behaviours are associated with the psychological need for power and control [13].

Generally, this motivational profile presents sadistic traits, since the decision to cause pain and suffering on the victim increases their sense of power and consequently, their satisfaction and gratification by observing their conduct and its effects. In consequence, these serial killers exhibit well-structured physical violence in their criminal behaviour, such as small lacerations, burns, violent sexual activity and use of various objects to cause them suffering, but always trying to lengthen in time this criminal process [14]. Additionally, power-control serial killers exhibit post-mortem behaviours such as evisceration, amputation and necrophiliac acts, but always more associated to extend their domain after the victim death than to the sadistic impulse since it is not possible to observe the pain and suffering inflicted when the victim is dead.

4.2. Mercy-Hero Profile

The “angel of death” or mercy-hero profile has been little discussed in the scientific literature, and sometimes has been classified into one of the pre-existing typologies. Generally, this serial killer profile has been related with clinical or healthcare environments where high responsibility doctors or hospital staff acted as if they were an omnipotent figure deciding on the life and death of their patients. However, this interpretation leads to a profile that would be more associated with individuals driven by a motivation of power and control than with feelings of compassion, linked with the profile presented here [15].

The mercy-hero profile is characterized by individuals with low self esteem, whose defense mechanisms are based on emotional apathy, social withdrawal, trying to distance themselves and not getting involved, alternating with periods of great physical and psychological agitation and emotional manifestation [16]. It is JVD own perception of the others suffering and pain (not the social one) that guides his criminal action, feeling the moral imperative to act accordingly. The method of killing is the administration of drugs that are being routinely used in hospitals, and without a special need of physical contact with the victim at that time. Commonly, after the administration of these substances there is no contemplation of victim physical death, thus leaving the crime scene once the aggression has been done. Post-mortem behaviours are distinguished by a high emotional level and a personification of the victim, occasionally staging the crime scene by placing the body in a more "comfortable" way and with the best possible appearance.

4.3. JVD Criminal-Motivational Profile

In order to establish the criminal motivational profile of JVD, it should be taken into account his psychobiographical development and the different criminal behaviours.

The eleven murders did not follow a pattern of organized and planned behaviours. The killings were developed from JVD self-perception of the environment and his personal consideration of the medical condition of the victims. So his actions were compulsive, there was no progression in the sophistication of the Modus Operandi used, and there was a persisting absence of physical contact in the method of killing. The presence of a high empathic expression and peri-mortem care is remarkably during all murders, establishing verbal contact with the victims, giving them pills carefully, keeping them warm and leaving them comfortably. Later on he leaves the crime scene and does not watch the physical death.

After the victims’ death, JVD showed an affective continuity with them and a personification of the victims, arranging them, cleaning them, and changing their clothes. JVD took leave of them with a huge personal agony by not being able to see them again, and with great physical contact, in the absence of aggressive or violent behaviours and without feelings of guilt afterwards (Table **2**).

Table 2: Comparison between Psychological Motivational Profiles and JVD Behaviour

JVD behaviours	Power-Control	Mercy-Hero
Peri-criminal		
No death observation		X
No physical contact in method of killing		X
Empathic expression		X
Peri-mortem cares		X
Sexualized Contact	X	X
Post-criminal		
Affective continuity		X
Victim personification		X
Post-mortem cares		X
Physical contact	X	X
Absence of paraphilia		X
Absence of guilt / remorse	X	X

This behavioural pattern does not show components of sadism: lack of need to observe the suffering and physical death, absence of paraphilia, absence of psychopathy and narcissism, and no feelings associated with social omnipotence.

CONCLUSIONS

Historically, some violent offenders have experienced dysfunctional and/or abusive childhoods, with poor relations and emotional bonds, social isolation and depressive symptoms [17]. Although we cannot say whether these ones or others are the specific reasons for JVD's criminal behaviour, they influenced on the imperfect matching of his personality, with continued frustrations, social rejections, and emotional isolation as well.

It stands as a prominent factor his inability to establish and maintain satisfactory affective bonds and a deficit management once established. His dysfunctional psychosexual development associated with his failure on sexual identity, influenced significantly his social life and psychological adjustment. He felt confused, disoriented and misunderstood, conforming a personality structure with large deficits in social competence because of his childish and immature vision of interpersonal relationships, absence of satisfactory intimate partners, construction of compensatory fantasies and inability to face suffering and social conflict.

His arrival at the geriatric center in Olot was a turning point, which provoked a change in its internal psychological state. He developed a more feminized role, taking care of elderly people and procuring their wellbeing. He began to feel loved and valued by a working environment that became a social one. He perceived himself as useful and necessary, not felling judged, and he began to feel better about himself. The elderly people he took care of, and the geriatric center became the fundamental and unique axis of his life.

At that time it was generated a compensatory relationship of his emotional deprivation, fading fears, worries and inner suffering. These parameters conceived as primary in an intimacy relationship were transferred to the working environment: need for physical contact, a sense of positive external assessment as a human being, a high perception of internal ability to give and receive affection. He saw reflected in the elderly victims his own pain and suffering, feeling the imperative need to avoid that pain and progressing mentally from the need to shorten it up to the urgent and peremptorily induction of death.

After analysing JVD criminal behaviour and its progression, we noticed that his psychological motivational profile does not correspond with those of serial killers based on power and control to satisfy their internal psychological needs. JVD would approach much more to a mercy-hero profile because of his compassion feelings for the victims, derived from his psychological vulnerability, consequence of a poor psychobiographical development.

While the absence of feelings of guilt and / or repentance could be considered indicative of a sadistic profile, these JVD's feelings are derived from a distortion in his moral values. Consequently, although JVD can objectively distinguish between good and bad, there was no attribution or consistent relationship between these values and the criminal actions developed.

Regarding the different forensic assessment approaches we conclude that the psychological forensic assessment proposed by the accusation, based exclusively on a clinical-pathological assessment does not explain or justify the JVD criminal behaviour, proposing a power/control criminal motivation inferred solely from a psychopathological diagnosis. Conversely, the psychological forensic assessment presented by the defense based on a multifactorial assessment, provides a deeper analysis of JVD development, behaviour and personality, which led to a scientific understanding of JVD criminal motivation matching with a mercy-hero psychological motivational profile.

JVD is currently serving his sentence and under therapeutic treatment.

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