# RISK MANAGEMENT PROJECT/ TRAINING

**Vignette C**

**DOB**: 1961

**Assessment context**

May 15 1999, C was convicted for the murder of his son on February 2. The son was 3 years old. At Psychiatric evaluation he was found to suffer from “a severe psychological disorder” and was sent to secure forensic psychiatric care. This assessment aims at investigating risk factors and treatment needs. He has now spent more than two years in hospital and is applying for unsupervised leaves to visit his family.

**Materials and assessments**

1. Several interviews with the patient care-staff on the ward and the patient’s brothers and sisters.

2. Act material from the police-investigation, court proceedings and verdict, pre-trial assessments (psychiatric and social services), copies from the national police register (previous arrests and charges) and the national psychiatric care register (all admissions to psychiatric clinics and hospitals).

3. Files from health care and the Forensic Psychiatric Assessment (4 week standard assessment following verdict).

4. Psychological Assessments: Neuropsychological screening (WAIS-NI & WCST), Personality assessments (MMPI-2 & IPDE).

5. The Hare Psychopathy Checklist: Screening version.

**Index Crime**

At the weekend in the beginning of February 1999 C has the care of his son. They spend the weekend in his flat. For a long period he has had problems getting access to his son. At the time of separation from the boy’s mother in 1998, C was granted the right of caring for the boy every other weekend by a family court. The mother has, however, made obstacles to this and boy and father has not seen each other since before Christmas 1998.
C had just started on a training programme for nursing assistants, but was officially off sick, because of psychological problems. He was suffering from depression, he had trouble to get up in the morning and to get started with schoolwork. He also had problem to concentrate in school due to his depression.

On Friday afternoon he picks up the boy from nursery. They spend the night at C's flat and on the Saturday they visit C's sister, who have children of a similar age.
During the weekend C becomes increasingly upset and desperate, assuming that his ex-wife will not let him see the boy again for a long time.
The boy has got a cold and is tired and a bit difficult. They spend the Sunday in the flat, awaiting Monday morning when the boy is to be left at the nursery, to be picked up by his mother in the afternoon. This is the usual procedure since C has a visitation restraint and is not allowed to approach his ex-wife's house.
On Sunday night, the boy is upset and has problems falling asleep. He lies in C's bed. C has thoughts about suicide, but feels guilty about psychologically hurting the boy by committing suicide and thus loosing his father.
He lights candles and puts on soft mood music in the bedroom. About one a clock in the morning he kills the boy by putting his hand over his nose and mouth and choking him.
When the boy is still and motionless he fetches a mirror to check his breath. When satisfied that the boy is not breathing he gets a piece of rope and tries to strangle himself. He fails to do this and calls his sister on the telephone and informs her of what has happened.
While she drives to the flat C dresses and leaves the flat, still with the piece of rope in a noose round his neck. The police find him like this, later on Monday morning in a nearby park. He does not resist arrest. During questioning he states that his intent was to kill the boy to prevent further psychological distress. He also states that his intention was to kill himself after killing the boy, an extended suicide. However, he failed to take his own life.

## Previous Criminality

C has two notes of previous criminality. In 1989 he was given a suspended sentence for handling illegal substances (cannabis), and in 1998 he was fined for not following a restriction order, when approaching his ex-wives house.

## Medical History

C is the second child and he has 4 biological siblings. The father has a further 7 children with, in total, 5 further women. The pregnancy and birth were uncomplicated. His older sister describes him as an active and affectionate child. He broke an arm at 6 years old but was essentially healthy during childhood and adolescence.

## Personal History

C is the second child in a family of five children. He has a two-year older sister, two younger brothers and a younger sister. There are 7 half-siblings on the father's side (with 5 different mothers) but C has had very little contact with them. The brother, who is next to C in age was adopted away at three because of economical hardship for the family they felt that they couldn't afford to have him. He had no contact with the family during childhood. During the first five years of his life C lived in a medium size town with the family. His father supported the family by doing business in art and antiques. This business was clearly in the "shady sector" and the father has been described as a "con-man", selling "van Goughs" door to door. In connection with the birth of the youngest sister, the mother became psychotic after the delivery.
The children were taken into care and lived for 6 months with foster parents. After this they moved back home after the mother was discharged from psychiatric hospital. The father was "around" but did not assume any responsibility for the family. The following two years was

characterised by instability. The mother took ill and was hospitalised repeatedly. Eventually she received a diagnosis of Schizophrenia. The parents were formally married for another couple of years but the father spent very little time in the house. They were divorced in 1972. During periods of the mother spent in hospital, the 4 children went to live with emergency foster homes or with their maternal grandparents. The family moved a number of times, covering large distances in the country. From 1980 they settled in a "large" city. Due to these changes, C frequently changed caring adults, schools and environment. The 4 brothers and sisters were however kept together and developed strong psychological bonds between themselves. The two older took responsibility for the younger ones, in a way that resembled parental responsibilities and roles. He describes the periods that the mother was at home as happy but odd. She would have problems taking on parental responsibility and handed this over to C and his sister. The mother was never frightening or threatening but had periods of odd or even bizarre behaviour. Her activities often became impulsive and uncontrolled. She would cook for days and in such quantities that most of it would have to be thrown out. She would paint the walls in an artistic way and the walls would assume different colours and motifs. She sometimes went dancing and applied makeup very exaggerated and was sometimes tormented by paranoid ideas.

The father made vary sporadic visits to the family after 1972.

C adapted well in school, despite the frequent changes during the first seven years. He finished school with average grades. He then studied a further 2 years on vocational training for nursery school assistant. In connection with this at age 16 he and the older sister moved to different flats and lived independently. The housing and finances were supplied by social services. The younger siblings were taken into care permanently and were placed in a foster-home.

His mother committed suicide in 2001.

C was exempted from national military service because of a ”nervous disposition”.

During the1980's he worked in temporary positions at day-care facilities and nurseries for children. Meanwhile he also painted pictures and was involved in occult movements. He was part of a group of friends who were of a ”new-age” inclination. He smoked cannabis regularly and was involved in commercial aspects of this. He travelled on markets and fairs, where he sold paintings, crystals and other "new-age" paraphernalia.
He also developed an interest for physical therapies, massage and healing. He also converted to Hinduism. He trained as a masseur in the 1990's and supported himself as a masseur, with a steady list of clients, practicing in workplaces and in clients' homes. For additional income he gave evening classes in painting and had temporary jobs in children's nurseries.
In 1998 he starts training for nursing assistant in healthcare, but this is interrupted by the crime and subsequent sentence.
He has always had satisfactory housing and economical independence.
He married in 1990. Before this he describes a "religious celibacy". The marriage lasts for 5 years and is childless. The marriage ends in a triangle drama. C denies any jealousy or animosity, simply that his wife fell in love with another man. He still remains friends with the first ex-wife.
After the separation a single mother courts him with 3 children. He moves in with her in 1995, after she has become pregnant. He is very happy at the prospect of fatherhood. He adapts well into the new family and feels that the woman and her 3 children need him. He says that the

family had chaotic circumstances before he moved in, he thrived on being needed and sorting out problems for the children.
In 1996 the son is born and C and the mother decide to marry. He describes the following two years as happy. In the end of 1997 the relationship starts to deteriorate. In the summer of 1998 the couple separates, and C moves to a flat on his own, yet again. He wants to spend time and care for all 4 children but his wife objects to this. The matter goes to court and they are awarded joint custody of the youngest son. The wife feels threatened by C and gets a restriction order approved by the court at the end of the summer. He had threatened to kill her if she tried to take his child away from him.
The order is breached by his visits and telephone calls and he is taken to court and convicted for the breach (fined) in October 1998. He takes this badly and feels that he is being treated unfairly. At the end of the year he is often hindered from seeing his son and to be with him fortnightly weekends as previously arranged by the family court. He is becoming increasingly depressed and is unable to follow the training course that he started in September. The difficulties continue and culminate with the crime in February 1999.

## Forensic Psychiatric Assessment

In the mandatory assessment the investigating team states that the crime was committed under the influence of a "severe mental disorder". They also recommend that he receive psychiatric care rather than prison. Diagnostically he is considered suffering from atypical depression and schizotypal personality disorder.

## Behaviour in the Hospital

During the first weeks he keeps a low profile. He takes up painting in the workshop and has a considerable production of pictures. He paints pictures of his son in idealised ways. He constructs an altar-like devise with flowers, pictures of his dead son and other objects in his room. After a few months he has filled his room with paintings, pictures, plastic flowers etc. He also becomes very active in occupational therapy and physical training. He places an obituary with a poem, he has written, about his son in the local paper on the one-year day of his death. People around him find this offensive, something he finds hard to understand. There are a lot of emotions about C expressed by staff and fellow patients. Partly this is understood as reactions to his crime, but he's also perceived as a grandiose and a "busybody". He tries to help patients and staff without being asked. He is described as easily offended. After a further few months he is repeatedly positive on cannabis on routine checks. He denies any use of drugs. He perceives a general search of patient's rooms as offensive and complains to the proper tribunal regarding misuse of power and collective punishments. The tribunal dismisses the complaint.

## Interviews and Observations

C gives a good formal contact. He seems somewhat speeded and superficial and the impression is not in accordance with the feelings of depression and guilt that he verbally reports.
He says he has a need to be understood and to work psychologically with the crime and the circumstances leading up to it. He sees himself as an altogether good person and the terrible crime is incomprehensible to him.

He says that his looking for psychological depth in the contacts he has and he considers himself a good listener and good at solving problems for others. He states that he has always been a counsellor and amateur therapist for his friends.

On the personality assessments MMPI-2 and IPDE he replies in a valid way. The profile shows that he denies human weakness and has apprehensions about being appraised and criticised. He comes across as psychologically naïve and with inflexible values that are categorical and without nuances. There is a tendency to overact emotionally under stress. The assessment points to basic paranoid ideas and thoughts and to repression as a first line psychological coping. Persons wit this type of profile are usually extremely sensitive to anything that can be construed as criticism and are very self-conscious about their social role. They seek approval, and usually their polished and controlled demeanour and presentation reflects this. Underneath this veneer of correctness is a person who is distrustful, tense and even suspicious. Their feelings, however, tend to be ego-syntonic and denied.
Underneath a surface of cooperation and conformity individuals may harbour long-standing feelings of anger and resentment towards their immediate family. The anger tends to be rationalised and justified as self-protection.
Anxiety is often brief and situational and the client often projects and blames others for the emotional upsets. These individuals have very high expectations of themselves and for others around them. Many are described as difficult to get along with because of their self-focus and guarded posture.

The assessment for Psychopathy shows: PCL-R 24 points; PCL: SV 15 points, Factor 1 (lack of empathy grandiosity and shallow affect) is much higher than factor 2 (impulsivity, poor behavioural control). The level of Psychopathy is under the cut-off for a diagnosis.

The mental abilities are average and there are no indications of neuropsychological deficits.