Forensic Psychiatry

Influences of Evil

EDITED BY

Tom Mason

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Preface

In the 1990s, while working in a high-security psychiatric hospital in the United Kingdom, two colleagues, Dave Mercer and Joel Richman, and I undertook a series of research projects relating to the care and management of mentally disordered offenders. These projects were approved by both an academic research committee and an ethics committee. During the course of one of the projects, the notion of "evil" emerged from the discourse of the subjects (hospital staff) as a corollary to our investigation. In no way were we attempting to evoke or elucidate this concept at the time. Simply stated, this was a research finding. The fact that the subjects were forensic psychiatric practitioners who claimed a high degree of professionalism is a point of academic interest. However, what intrigued us was the way in which their commentary on "evil" impacted their practice.

There are some who may claim that psychiatry is a science (and a few may even make the claim for forensic psychiatry) and as such is based on empirical knowledge obtained through the testing of hypotheses with conclusions drawn from *a priori* relationships. These relationships may be statistically expressed or otherwise represented but, nonetheless, the claim is for a science of psychiatry. In this perspective, it is usually argued that the notion of evil is at best a question for theologians or moral philosophers and at worst, a concept that is irrelevant to psychiatric practice. Certainly, some maintain that "evil" does not exist in any real physical sense, but it most assuredly does as a metaphysical reality within the spheres of human action and social consciousness. No judgments of right or wrong are offered here; merely an acceptance of and respect for another's belief. One aim of this book, therefore, is to challenge the notion that psychiatry as "science," and "evil" as either divine or secular, are mutually exclusive constructions.

Others claim that although psychiatry may not be a science in the true sense of the word, the concept of evil is not helpful to our understanding of the aberrations of human thinking and behavior. In this view, there is an implicit message that those mental health professionals who do not dismiss the idea of evil as irrelevant in psychiatric practice are somehow engaging in a lesser

degree of professionalism, are entertaining a negative judgmentalism, or are unable to "bracket out" personal feelings in their professional lives. Others may counterclaim this moral position by asserting it to be sophistry based on narrow-mindedness and a limitation in thinking capacity. Whatever the perspective, it may be useful to point out that to dismiss other social constructions, such as marriage, family relations, and religion, in the quest to understand the ravages of the human mind may be somewhat naïve. Therefore, another aim of this book is to offer a balance to those who have the ability to reflect on alternative thoughts and who are able to be responsive to the possibilities and potential in the points of view of others.

Thankfully, only a few see psychiatry in such narrow terms and for people who do, it is highly unlikely that any text in itself will produce any real change in their thinking. One purpose of this book, therefore, is to offer material for others to challenge those with such restricted views.

Fortunately, the majority of professionals working in the field of forensic psychiatry appreciate that their craft is inchoate and that they need to respond to the issues that are raised in a reflective manner. In *Forensic Psychiatry: Influences of Evil*, the relationship between forensic psychiatry and evil has been dealt with from various and diverse disciplinary perspectives. The rationale for this approach is that both forensic psychiatry and the notion of evil are part of our developing society, and we should not be afraid of embracing these divergent viewpoints in our quest for understanding. Thus, another aim of this book is to open up further the debate on forensic psychiatry and its incorporation of extremes of aberrant behavior in relation to its social function. Therefore, this book should not only be relevant for all those working in these varying disciplines, but also be pertinent for many others in society at large who may well have given some thought to the problems of evil and its medicalization.

Tom Mason

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Chapter 1

Introduction

Tom Mason

Introduction

Forensic Psychiatry: Influences of Evil is intended to highlight the complex relationship between psychiatry and the notion of evil. It is one in which forensic psychiatry confronts the concept of evil and at the same time is a part of the social processes that both constructs it and is a part of evil itself, at least from certain perspectives. This book is testimony to the one response to evil that forensic psychiatry is not permitted—ignoring it.

Forensic Psychiatry

Histories tend to be a matter of interpretation based on cultural values and societal influences, rather than an absolute truth extrapolated from supposed facts. One only needs to read interpretations of, say, world wars, from each country's perspective to see how their causes, progression, and outcomes vary according to each one's point of view. Similarly, the history of forensic psychiatry is very much dependent on the values and professional socialization of those undertaking the interpretation, and this, understandably, leads to differences in histories. For example, one major historical approach to the development of forensic psychiatry is to see it as the result of kind, benevolent, invariably male doctors, who have championed the cause of psychiatry through grounding it in scientific credence and claiming it to be a unique body of knowledge—in fact, the seat of all knowledge. However, it can easily be seen in political terms as the result of a series of events involving dignitaries,

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usually royalty or politicians, who have been murdered or attacked in some way. This results in changes in the law with psychiatrists responding accordingly with claims of developmental knowledge in specific types of offenders. The current dangerous severe personality disorder (DSPD) debate in the United Kingdom is testimony to this. Another historical theme is the development of forensic psychiatry in terms of sensational cases and the clamor of some psychiatric professionals to build a caseload of infamous offenders—a type of living "Madame Tussauds." Michel Foucault *(1)* outlined this by proclaiming forensic psychiatry to be, first and foremost, a pathology of the monstrous. Finally, another thematic history is the development of forensic psychiatry in terms of the expansion of professional power and the ever-expanding dominance of the medical gaze *(2)*. Once under the influence of medicine, it is increasingly difficult to gain any form of independence from it, or even to gain acceptance of an alternative—the midwives and the complimentary therapists will no doubt attest to this.

Whatever history suits your purpose, the kind march of men or the unkind encroachment of power, there are a number of factors that appear universal for the development of forensic psychiatry. First, there is a need for the profession to be able to establish difference, that is, the abnormal from the normal. Without this differentiation, it is baseless. Second, the profession must be able to provide, or attempt to provide, some element of etiology to the behavior or mental state under consideration. This then can be located into a nosological framework to form a "diagnosis." Third, a treatment program is necessary. Nowadays, this is predominantly pharmaceutically orientated but previously included the "talking" therapies and the notorious milieu therapy. Fourth, the prognosis is required. Prediction forms the major thrust in contemporary forensic psychiatry, both in terms of risk assessment and risk management and is the area most challenged, by politicians and the public when things go wrong. Finally, there is a need to deal with the relationship between a mental state and the offensive behavior. This is usually undertaken through various discourses, for example, the language of research, philosophical reflection, experiential anecdotes, by dismissing its relevance, and so on. Irrespective of this, the *a priori* relationship between a mental state and behavior has not been established and remains axiomatic only.

Irrespective of the historical framework, what we can say about the development of forensic psychiatry is that it is concerned with the application of psychiatric and psychological practices and principles on people with mental health problems, or who have personality disorders, who have interfaced with the law at one level or another. Forensic psychiatry has grown alongside the law, and in fact has both a symbiotic and parasitical relationship with it. The

legislation surrounding forensic psychiatry involves tensions between human rights and notions of compulsory detention and forced treatments. The law attempts at one level to circumscribe dangerousness by coercion into psychiatric institutions and at another level is deeply concerned about civil liberties. Forensic psychiatry, then, needs legislation to capture its clients but sits uneasily at its feet when challenged regarding therapeutic efficacy. From Foucault's pathology of the monstrous *(1)* to contemporary notions of evil, forensic psychiatry is at pains to grapple with, even in its denial of, this most difficult of concepts.

Evil Needs No Introduction

In writing this introductory chapter, it became apparent that evil needs no introduction. Whatever else it might be, and throughout this book we will see numerous interpretations, evil is a human thing. *Thing* is probably not the best word in this instance as a concrete thing it is not, but the word *human* certainly is. The word *evil* is rarely applied to the rest of the animal kingdom or even natural events, but when they sometimes are evil, as in earthquakes or severe floods, it is applied to give that animal or natural action the human quality ascribed to evil. Thus, evil is humanness and as such, needs no introduction. Of course, there is much to humanness that is not evil, but evil is at least one aspect of being human. Fortunately for the discerning reader, many of the chapters in this book deal with the complexities involved in the relationship between evil and humanness. Therefore, I need not dwell on this here. However, this leaves me with the problem of what to write in an introductory chapter when its central theme needs no introduction. An easy option would be to focus on forensic psychiatry, the main part of the title of this book. However, that would be evading the issue. Although forensic psychiatry in its broader sense of incorporating many professional disciplines within its boundaries may need a few words of introduction, it is the underpinning relationship with the concept of evil that is truly the essential theme. Therefore, I feel I need a different approach.

Many health care professionals working in the field of forensic psychiatry including psychiatrists, psychologists, psychoanalysts, nurses, and so on, refuse to deal with the issue of evil, with varying approaches including denying its existence, dismissing its relevance, assigning it to someone else's domain, or retreating from it into the safety of "science" (*see* the preface). However, there are many more professionals working in this field who are prepared to think about the concept of evil, some at a philosophical (moral or otherwise) level, some at a social constructionist level, and even some at a psychoanalytical level. For all those working in the field of forensic psychiatry, what no

one can deny is that many others in our society frequently employ the word evil to describe some of the patients. For example, police may use the term when investigating a particularly heinous crime, judges may use the term in their sentencing statements, claiming that the offender is the most evil person to come before them or that the person's crime is an evil act, and the media often uses the term in its reporting of certain cases. One reason why these groups use the word evil is that most people in society, at least at one level, know and understand what the term is referring to and these institutions—the police, the judiciary, the media—are representatives of the wider society. Furthermore, there is a relationship between these social institutions and the general public, and the employment of the word evil is meaningful to them all, despite the fact that it may well be analytically complex at other levels.

A starting point, then, in the relationship between forensic psychiatry and evil is the fact that some patients are referred to as evil whether or not some professionals are prepared to deal with the issue. Immediately, a number of questions regarding this relationship arise, at least for those who think beyond mere denial. These questions include how the label of evil is applied; what it means for those deemed to be so; its amenableness to psychiatric, psychological, or psychoanalytical interventions; how it is to be dealt with; and its prognosis. This book highlights many answers to these questions, but raises many more questions. These questions revolving around evil fall into two main areas, at least for the purposes of this introduction. First, is evil explainable and, second, is it understandable, and consequentially is there a difference between the two?

Does Evil Need to be Explained?

Or, more accurately, do we need, as human beings, to explain what evil is? Well, there are consequences if we do and consequences if we do not. Furthermore, we will need to discuss what we mean by explanation, in any event. In arriving at a scientific explanation of something in our world, we may see this in terms of deductive explanation or probabilistic explanation. Deductive explanation employs a universal generalization, that is, an examination under which the generalization holds true. It deals with the rules of cause and effect and attempts to explain an event within formal logic. The underlying feature of a universal law is that it encompasses all cases in the category to which it applies (e.g., all apples fall under gravity to the earth). Probabilistic explanation does not deal with universal laws but with arithmetical ratios between phenomena, events, or generalizations that are amenable to such arithmetical tendencies. Probabilistic, or inductive, explanation

can focus on individual cases, but its major drawback is that conclusions cannot be drawn from such particular events in relation to wider groups *(3)*. Whether evil will be viewed as a universal law is difficult to foresee, and whether we can draw conclusions from particular evil acts is equally fraught with difficulties. Yet, it may be that, for some, evil is explainable in terms of a grand narrative, e.g., psychiatric, psychological, psychoanalytical, religious, and so on.

Philosophically, explanation has been well covered from many, no lesser than Aristotle, Hume, Kant, and Mill, but in its heyday of prominence it is the covering-law model that reigned supreme. In this framework, it takes explanation to be a logical argumentation based on a law of nature playing an essential role in the interplay of premises. However, this is as close as science can get, for me, and really doesn't get close enough to the concept of evil. The covering-law model was challenged in the post-World War II era on four counts: (a) the problem with the relation between premises and the construction of idealized arguments, (b) the problem with attempting to explicate the characteristics of a law of nature, (c) the problem with the disparities between theories of explanation, and (d) the problems associated with statistical interpretation *(4)*. In the abandonment of the covering-law model, the main focus is now based on explanation as an appreciation of the causal factors. However, this too has philosophical difficulties, not to mention our particular problem, i.e., accounting for evil. Suddenly, or perhaps not so suddenly, the refuge of science does not seem so safe.

The difficulties encountered in explanation are augmented when we consider the two great traditions of explaining historical and social events. First, no matter the detail of facts available to us regarding, say, the outbreak of World War II, we are left with trying to construct an argument about its cause based on the individual actions of a large number of human beings. Even if we are able to do this, we have no way of guaranteeing that these individual actions actually caused World War II. Thus, World War II is not explained absolutely by our appreciation of the individuals' actions, nor by our construction of a logical argument. In any event, identifying any number of so-called causal factors does not explain the actual event. Second, in our attempt to explain something we may approach it by appreciating what its function is, say, a particular social structure (e.g., marriage) may be explained by its contribution to social stability. In short, explanation of an event is attempted through a comprehension of its effects. But this is just as problematic in the theory of explanation. It is just as unsatisfactory to attempt to explain what some event is by an examination of its causes or its effects *(5)*. However, having said that, this may be as close as we can get.

Understanding Might be Enough

Although the meaning of understanding is not agreed on, I would like to distinguish this from explanation through two opposing views: understanding as prediction and understanding as empathy. Although I mentioned prediction previously, in terms of statistical relationships and cause and effect, it is beyond this that I wish to view prediction here. The logical empiricists will argue that we can attain objective knowledge of our world, both natural and social, through discovery and verification. In short, through the scientific method. But is this enough? The research method alone is yet another restriction, as Popper notes *(6)* "in my view the 'normal' scientist…is a person one ought to be sorry for…the 'normal' scientist…has been badly taught. He has been taught in a dogmatic spirit: he is a victim of indoctrination. He has learned a technique which can be applied without asking for the reason why. …" As some things fall outside of the paradigm of the scientific, others are limited by its scrutiny. Predictive understanding of meteorological events means more than we are burned by the heat, wet with the rain, and blown by the wind. It means that we are in touch with our feelings, thoughts, and experiences of our world. It also means that we are in touch with our lives, in terms of planning, navigating, and making our way through it. Predictive understanding might serve us well in terms of evil, certainly as a quest, possibly as an achievement, but unlikely as a solution.

On the other hand, there is understanding as empathy, loosely translated into the German as *verstehen*. According to the *verstehen* tradition, social scientists employ different methods from their natural science colleagues as they need to be cognizant of both the historical and subjective elements of human behavior. They accept that the social world is different from the natural world and therefore investigate each differently. They see the human being as operating within a web of relationships, in a complex structure of interrelationships, and employing communicative strategies to construct meaning. Human communicative action is diverse and employs language, symbols, and behavior at both individual and social levels. Semiotics and symbolic interactionism are but two developmental approaches that have emerged from the *verstehen* tradition. Herbert Blumer, a leading proponent of symbolic interactionsim, believed that the subjective element of human action was central to our understanding of human behavior and, furthermore, that the social act was in a constant state of becoming. Individuals, for Blumer, are constantly remaking their social order, which inevitably makes understanding a dynamic form of interpretation *(7)*.

So, it is within this foregoing framework that I can state my position. I do not take issue with the natural scientists, statisticians or otherwise, who

wish to interpret their *p* values in order to attain some level of understanding of evil. Nor do I take issue with the social scientists, symbolic interactionists or otherwise, who wish to interpret their narratives, signs, and symbols in order to attain another level of understanding of what evil means to us. I do not view one approach, view, or interpretation as being right or wrong, closer or further away, better or worse. I see them all as diamonds forming the kaleidoscopic pattern. There is not but one truth, only another shake of the kaleidoscope. In shaking this book, the individual authors are, of course, responsible for their own contribution but the overall pattern that they create is mine. Individually, all the chapters are diamond stories but taken together, pictured as a whole, the book is just another human endeavor, an effort of will, to provide a glimpse into the mirror of the human soul—just a glimpse.

Contents of This Book

In Chapter 2, Dave Holmes and Cary Federman discuss organizations as evil structures. They show how architectural settings serve to operate as sites of power, control, dominance, and punishment through techniques of surveillance and strategies of submission. They are not merely benign organizations fulfilling a social need, the authors argue, but are influential in adapting human behavior on many levels. Holmes and Federman outline the role of the forensic practitioner as one that is set in multifaceted administrative systems comprising of at least two (e.g., justice and health care), if not more, constructs. Forensic psychiatric settings, for these authors, operate as apparatuses of capture as do prisons, which gives them a duality of functional purposes that of the provision of health care and that of a disciplinary technology. The main strategy through which this is enacted is through the operationalization of power. This power is not only at play between patients and professionals, but also between the organization and its inmates (both staff and patients). Everyone becomes both the watchers and the watched.

In Chapter 3, Brian Kean takes on the pharmaceutical companies who clearly have a vested interest in the process of psychiatry. Drawing on the major authors who have spoken out against the ravages of drugs used in psychiatry, he sets out a stark picture concerning the murky relationship between prescribing psychiatrists and pharmaceutical companies. However, Kean goes further into this relationship than previously seen, drawing on the function of government agencies and research academics, some of who, he believes, are complicit in the scheme. Kean's analysis of the literature reveals how drug companies withhold or suppress negative data, how government agencies are slow to respond, and how academics publish ghost written articles that confound and confuse the real data. Public knowledge of medication, Kean argues,

is constructed and manipulated through this tripartite relationship among drug companies, government agencies, and academics. A dark conclusion is drawn in this revealing narrative.

In the majority of clinical research on the issues of madness and badness, it is generally concluded (albeit only temporarily) that insanity provides some degree of mitigation or defense against culpability, whereas badness (evil) carries a heavier degree of responsibility for their actions. In Chapter 4, Tamas Pataki unpacks the complex area of *actus reus* (voluntary) and *mens rea* (intention), drawing on historical precedents and contemporary philosophical thought. Although this author draws on the metaphysical characteristics involved in will and intention, he grounds them in a pragmatics of common sense. The issue of culpability lies at the heart of many defenses (and prosecutions) in criminal law and both lawyers and psychiatrists would benefit from reading this chapter. Pataki takes us on a labyrinthine journey through the notion of intention and with a breath of fresh air leads us out of, at least, one exit.

The argument put forward in Chapter 5 is that just as homicidal monomania was a fictitious condition that psychiatry accepted as genuine for approximately 100 years, psychopathy may well prove to be equally as fictitious. Not that the human actions associated with psychopathy do not occur, but that it is not a medical condition and should not fall under the rubric of psychiatry. This author puts forth the suggestion that through philosophical works and the development of psychiatric knowledge during the 19th century, psychopathic disorder emerged to replace the vacuum left by the notion of homicidal monomania. The close relationship among philosophy, psychiatry, and religious thinking of that time fused to locate good and evil, right and wrong, and morality and immorality into a supposed "clinical" condition based on the conduct of the individual. It is suggested that psychopathic disorder may eventually fall from the remit of psychiatry, perhaps into another domain, or it may just disappear as a historical curiosity, as did homicidal monomania.

Mick McKeown and Mark Stowell-Smith deal with the notion of evil through the lens of horror in Chapter 6. In doing so, they set out the relationship between society's revulsion of the evil act and its fascination by it. Although in reality secure hospitals may exist to circumscribe and confine such horror, in fantasy it is revealed and exposed through the film. McKeown and Stowell-Smith highlight how forensic professionals, as well as media pundits, operate in the hinterland between reality and fantasy, employing scientific diagnostic labels, as well as sensationalist headlines in order to dampen and simultaneously rouse societal anxieties. This chapter moves eloquently through a range of what we may call toggle concepts, ranging from legislative frameworks, juridical processes, and psychiatric nosology, revealing the sophistry

of such concepts as DSPD. These authors expose the false premise of psychiatric diagnostics enacted through nosological structuring. These toggle concepts, operating as they do in the middle ground between our revulsion of, and fascination with, horror and serve to placate our abjection. McKeown and Stowell-Smith put it this way, "people find that which is abject both revolting and fascinating, yet, nevertheless, are drawn to contemplate its existence." This suggests that even in its denial (evil, horror), it is given existence. What basis, then, for the denialists?

Evil is often viewed as lying along the continuum of good and bad, but its usual location is somehow positioned beyond the pole of bad, it is viewed as having crossed this threshold and therefore out of reach for many. In Chapter 7, Deidre Greig deals with the ever thorny relationship among madness, badness, and evil, and does this by revealing the tensions that abound amidst psychiatry and law. This is achieved through a revelatory case history of a severely disturbed person whose actions and threats were so severe that they lay beyond the scope of both the law and psychiatry. Operating in what became known as the domain of evil, the systems of law, psychiatry, prisons, and mental health facilities were left in disarray. Specialist "one-man" units were built and laws were changed as a direct result of this person's behavior—all to no avail. Greig lucidly exposes the difficulties that we all face when the mix of madness, badness, and evil join forces to challenge the foundational efficacy of both punishment and therapy. The manner in which this author weaves the tragedy of the human story, with the ideologies of law and psychiatry, revealing severe limitations for all concerned, is illuminating.

David Winter writes on destruction as a constructive choice in Chapter 8, employing Kelly's personal construct theory (PCT) in attempting to comprehend the incomprehensible. He analyzes violence and homicide through the PCT and shows how the "evil act" is revealed as a considered choice of action. That the evildoer sees the evil act in a positive manner does not come as a surprise but that their relationship with violence and homicide may twist, turn, and tumble in a kaleidoscope of constriction, shared construction, impulsivity, and choice is revelatory. This chapter unravels, at least in some part, the human condition as applied to violence and homicide. For Winter, evil appears to reside in the relationship that the person shares with his or her own freewill and the notion of choice of action. However, this author takes us further into the dark realm of evil by proposing a fulfillment of the will of the "other" as a pivot on which the evil act can be enacted. Winter illuminates the I–Thou relationships through a series of exploratory conceptual frameworks in which the perpetrator appears partly victimized and the victim has his or her part to play in the evil act.

Whatever the theoretical musings on evil might be, its one certain corollary, in its operational functioning, is that it means suffering for someone. This may be located directly in the victim of an evil act, felt as a result of witnessing it, experienced as a loved one of a victim, or borne as in the psychic pain of the perpetrator. However viewed, evil is "suffering itself." In Chapter 9, Stephen Diamond locates his lifelong work in the extremely difficult area of attempting to treat the suffering that such evil generates. He takes the face-to-face stance of treating violent offenders, whose acts are often termed as "evil," through a pragmatic, in-the-flesh evaluation conducted through the interview process. What makes this earthy approach so rich is that Diamond employs the theoretical frameworks of Jung, Freud, and May, among other psychoanalytical thinkers, to reveal a breathtaking analysis of the role and function of such evil human acts. His treatment focus of this very difficult group of offenders is from an existential depth psychology. Yet, in this chapter he seems to offer even more than this. From his own philosophical perspective, he appears to pull together the practical difficulties of evaluating and prognosticating on violence, with the realities of attempting to treat offenders, and then sets down his empathic core in relation to the thorny issues of punishment and penance (as a psychological sacrament). Diamond argues that the human race is being devoured by anger and rage and that we must move toward learning how to understand this, live with it, and address the problem. He warns us that we must not ignore it. This, then, according to Diamond is the question, and he ominously concludes "we will decide our own destiny. Let us choose wisely."

In Chapter 10, Dave Mercer and Joel Richman offer a deeply personal account of their lives, research, and experiences working in a high-security psychiatric hospital in the United Kingdom. Focusing on their work with sex offenders, they highlight a complex interplay of symbolic imagery, revealed through discourse frameworks from both public and professional arenas, and institutional limitations. Caught up in a web of maleficent intrigue, these authors show how forensic psychiatry can be seen as an impotent field in which its effects are but one element in the salving of the social conscience. The authors dismiss this salving as an impossible project. Furthermore, in an emotionally charged personal apologia, Mercer and Richman expunge their demonic evil in relation to their role in the system. These brave reflections, now cast in print, are what we have come to expect from these tried and tested learned men.

Employing an historical analytical perspective in Chapter 11, Victoria Van Slyke produces a series of cases who were admitted to the Boston Psychopathic Hospital in the early part of the last century. She explores docu-

mentary evidence from a number of sources to reveal how conceptions of evil were fused through discourse frameworks surrounding medical diagnostic constructions and apparently uncontrollable sexual behavior in young children. It becomes clear that medical discourse is a powerful tool, not only when it is applied to claim that a set of behaviors is a result of a psychiatric condition, but also when it can be equally claimed that the same set of behaviors are not owing to such a psychiatric condition. Slyke highlights this latter perspective when psychiatrists were able to purport that the sexual behavior of these children was not solely because of their mental state, which then left the diagnostic vacuum open to interpretations of sexual promiscuity, nymphomania, morally bad, and ultimately evil personality.

In Chapter 12, David Kinzie offers a wonderful insight into the thoughts on evil from a clinical perspective. Working with victims of terrible crimes and torture brings one into the close proximity of such terrible suffering and it is sometimes difficult to reach out and help the afflicted person struggling with the deep psychological trauma. Kinzie makes us pause and reflect on the evil actions of human beings inflicted on another and paints a thorny picture of how we can feel the evil through the pain of the victim. This author tells us that evil is a difficult concept to grasp and understand, but proclaiming that it should not happen to you, me, or anyone, and being there to help in any way possible is a starting point to counter the dispassionate evil action.

Psychiatry and psychology may not be able to tell us much about the nature of evil in relation to divine notions of godliness and a good human nature, according to Gwen Adshead in Chapter 13. However, she does believe that the mental health sciences should be in a position, or developmentally aiming to be, to inform us on the nature of extreme forms of human behavior. She argues that although certain behaviors are viewed as bad and undesirable, and possibly appropriately so, they should be taken out of the realms of moral judgments and placed in the domain of pathology (i.e., the mental health sciences). In an extremely interesting way, this author sees psychiatry and psychology as not only aiming to identify what illness and disease are, but also on a moral level, what they are not. Citing the case of homosexuality, Adshead believes that although there are claims for mental health sciences to be morally neutral endeavors, there must be some form of moral currency in terms of treatment and the promotion of social welfare. In her words, "psychiatric and psychological practice also acquires a positive moral valence by offering to remove harmful thoughts and behaviors with treatment; the traditionally beneficent identity of the healer. Small wonder then that no textbooks of psychiatry or psychology offer accounts of evil." For Adshead, evil is a failure of the moral identity that we aspire to and in this sense makes us

less than we are and what we can be. It is the quest of mental health sciences to stand against this.

Forgiveness is the focus of Chapter 14. Human nature being what it is offers us both the potential for forgiveness and also the capability of being unforgiving. Marguerite La Caze provides an illuminating analysis of this complex area, employing numerous philosophical works with an emphasis on Jacque Derrida. Again, La Caze delineates radical evil from "ordinary" evil and suggests that, for some, it is a question of forgiving the unforgivable. In this sense, perpetrators may not ask for forgiveness and therefore may not receive it. Furthermore, it is argued that it is the victim's gift of forgiveness and not the function of politicians or professionals, to forgive on behalf of others. La Caze suggests that although it is the perpetrator's responsibility, or not as the case may be, to work toward reconciliation, they cannot expect it as a right. This author goes beyond Derrida's view that we should be less forgiving of the unforgiving and that (almost) everything can be forgiven, and suggests that in terms of radical evil we need not necessarily take that leap. Moving into the realms of inhumanness La Caze sets out a cogent argument to break the philosophical difficulties of the inhuman act and the humanness of forgiveness. This chapter is a glowing testimony of the way in which lucid contemplation and sophisticated argumentation can clear so much of the muddy waters of practical application.

Michael Levine pulls no punches in Chapter 15. He begins by setting out his argument for three interrelated claims: (a) it is not possible to naturalize the term "evil," (b) the attempt to naturalize the term is undesirable, and (c) psychiatrists, psychoanalysts, lawyers, judges, and probably journalists should avoid using the term. Putting some hefty "meat" on the "bones" of these claims he argues that psychiatry is, and always has been, a discipline in crisis and that this crisis is based on the confusion regarding the nature of mental illness and what cause and effect are. The psychiatric focus on pharmacology (for some) is, according to Levine, a result of attempting to reduce all mental illness to an organic causation, and, in effect, this is grounded on the belief in scientificity. However, this is not the only tension this author reveals. He also highlights the strain between the use of the concept of evil from a secular point of view and its employment within religious (metaphysical) frameworks. On the one hand, if we view evil as belonging in the domain of God, and by default this is nonscientific, then the professions, it is argued, should not use the term. On the other hand, if evil is naturalized (secular sense) then it should be examinable by science. Clearly, this establishes yet another tension.

In Chapter 16, Fred Alford employs the theoretical framework of Thomas Ogden in order to analyze his own research data gathered from inmates and

free citizens on the issue of evil. Ogden's theoretical framework involves three positions of lived experience that stand in relationship to each other. He calls these positions autistic-contiguous, paranoid-schizoid, and depressive. Interestingly, Alford uses the term *dread* to connect evil with human experience and claims in his own research that although free citizens told rich and fanciful stories about evil, the inmates were much less imaginative. It is almost as if the evil act shares the same ground between symbolic and real, or sacred and secular. As Alford writes, "consider the possibility that an imagination for evil is the alternative for doing it." As in so many instances throughout this book it appears that evil shares some form of relationship possibly between good and bad, victim and perpetrator, even thought and action. Alford puts this even better, "for some inmates, I had the impression that doing evil was a way of bringing the idea to life." This truly frames evil as banality. In this chapter, Alford cogently argues the case for seeing evil as suffering, that is, dread of being human, not in terms of being cold, detached, and remorseless but bizarrely, crazily, and perversely being part of the human web.

It is not in doubt that forensic psychiatry first proclaimed itself "a pathology of the monstrous" *(1)*. However, it is now also about the mundane, and in its everyday practical application it professes to apply interventions, produce effective treatment regimes, and provide some element of prognosis in relation to its efficacy. In Chapter 17, Joel Richman, Dave Mercer, and I report on one element of our research in a high-security hospital in the United Kingdom. We undertook a series of semistructured interviews with nursing staff and also analyzed a number of the care plans that had been devised for some of the patients who may well have been labeled as evil. Although the nursing staff attempted to employ medical/nursing theorizing to analyze the patient's actions, when the notion of evil was raised, they abandoned such medical theorizing in favor of lay language of "badness," "beyond," "too far," and so on. We build a model of motivation in which a person's rationale for action is revealed, which in turn impacts how their care is constructed. If the patient is seen as evil, he or she is viewed as being "beyond help."

That we may despair in the face of evil is understandable. However, if we cannot overcome such despair then we will succumb to its force and the evolutionary process stumbles. Geri Miller and Ron Hood provide a basis of hope in the face of such terrible human action in Chapter 18. They argue that we experience evil within a human "box," which is in a dynamic state, but from which we cannot "explain" this phenomena. From this position, these authors highlight the relationship that we can adopt in order to foster and maintain hope. Through an understanding of our own vulnerabilities in the face of evil, and an awareness of countertransference issues we can adopt a

therapeutic alliance. In this, the authors argue, we can "feel" the suffering that evil causes in others and increase our sensitivity to it by focusing on hope as a collaborative effort between therapist and client. Miller and Hood are at pains to point out that evil can affect both the therapist and the therapeutic encounter and counselors should take care of themselves, in terms of their feelings, needs, and drives. It is by design that this lucid chapter is placed at the end of the book and these authors do, indeed, offer hope in the face of evil.

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Chapter 2

Organizations As Evil Structures

Dave Holmes and Cary Federman

Background

Nursing practice in forensic psychiatry opens new horizons in nursing. This complex, professional, nursing practice involves the coupling of two contradictory socioprofessional mandates: to punish and to provide care. The purpose of this chapter is to present nursing practice in a disciplinary setting as a problem of governance. A Foucauldian perspective allows us to understand the way forensic psychiatric nursing is involved in the governance of mentally ill criminals through a vast array of power techniques (sovereign, disciplinary, and pastoral), which posit nurses as "subjects of power." These nurses are also "objects of power" in that nursing practice is constrained by formal and informal regulations of the forensic psychiatry context. As an object of "governmental technologies," the nursing staff becomes the body onto which a process of conforming to the customs of the forensic psychiatric milieu is dictated and inscribed.

> *Estrangement is the core function of spatial separation. Estrangement reduces, thins down and compresses the view of the other: individual qualities and circumstances which tend to be vividly brought within sight thanks to the accumulated experience of daily intercourse seldom come into view when the intercourse is emaciated or prohibited altogether: typification takes then the place of personal familiarity, and legal categories meant to reduce the variance and to allow to disregard it render the uniqueness of persons and cases irrelevant.* (1)

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Introduction

In order for modern society to be a success, those who prey on others must be separated out. The early idea of modern incarceration was premised on the creation of a community of captives who willingly accepted their terms of confinement because society made it clear that certain types of persons needed to be excluded from the general population for security reasons. The founders of the carceral regime of prisons and hospitals were convinced that the "removal of deviants and dependents from the community was a prerequisite" of any moral civilization *(2)*. The Quakers thought the purpose of the prison was to foster each individual's "inner light," a substance that all persons carry within them. The prison, then, had at its origin a somewhat benign purpose, a desire to uplift those who have fallen away. True, the prison confined; but, among American republican theorists, it was also educational and restorative. Could the prison be one thing without being another? What kind of institutional setting was constructed?

Gilles Deleuze speaks of "centres of enclosure" *(3)* that mark the advent of modern society. The individual "moves from a closed circle to another. …It is a never ending beginning" *(3)*. The creation of the modern hospital and prison around the idea of a panopticon reinforces the idea of an institution of capture as circularity; and further marks these institutions as disciplinary, whether in a Quaker sense or not is irrelevant. The point is that incapacitation was the result of an individual failure that needed to be restored (or simply confined) for the purposes of the general good. The hospital and prison, then, are in constant dialogue between the agents of care and the imprisoned. These agents exist as a duality: they are in the prison but free from it. What role, then, does the setting play in the idea of confinement?

The panopticon is, of course, the modern-day sign not just of prison, but also of society itself. Surveillance is a product of modernity *(4)*. Deleuze, however, sees the panopticon as a failed myth *(5)*. The failure of the panopticon lies not just in an inability to achieve its original aims and the exploitation of uncertainty, but also in the visibility of power and the rationality of control. The panopticon belongs to the "social physics" of the Enlightenment philosophers *(6)*, an 18th-century understanding of power relations based on institutional balancing and social harmony. The panopticon allows for a stark duality that expresses a form of governance that we relate to: not only are the prisoners under constant surveillance, but so too are the guards. We are all prisoners; we are all being watched. The gaze is everywhere. But this begs the question, whose gaze? The panopticon image (as a 19th-century image) fails to note the creation of "zones of indistinction" *(7)*, the breaking down of walls and structures and the merging of concepts that previously existed as binary

structures. Zones of indistinction mean the creation of spatial ambiguities that allow for rethinking concepts and power relations, in which meaning can be found in between spaces, as in the modern creation of persons as both subjects and objects, or in the twofold meaning of "discipline" that refers both to an academic enterprise and a manner of control. The "dissolution of bounded social sites" that accompanies the presence of "zones of indistinction" experienced by late modernity doesn't exclude the reintroduction of new and different power relations. The overall tenor of such assessments, according to Yar *(8)*, "is that corrective panopticism was the correlate of a socio-historically specific regime of power (that of discipline), and that with its decline the normalizing panoptic principle is also passing into abeyance, replaced by mechanisms which correlate with the logic of power-as control."

What we would like to show in this chapter is that the idea of capture does not just have a passing resemblance to Jeremy Bentham's panopticon. Surveillance, control, and the need for disciplinary tactics are all part of the fabric of carceral institutions that have merged nicely with the idea of surveillance in postmodern society. Giddens *(4)*, for example, sees surveillance operating on two levels in modernity: the use of surveillance for "internal pacification" purposes, crucial for the inner workings of the nation-state, and the monitoring of the workplace *(4)*. In either case, the point to note here is that the setting of surveillance is an important factor in the control of captive populations housed in forensic psychiatric settings.

Architectural settings do more than structure organizations; they influence behavior at multiple levels within the organization *(9)*. Surveillance techniques operating in the workplace track and monitor behavior at every stage of production (as seen in chain stores throughout the United States and Canada), as well as in many aspects of our public lives, for example, as on the streets of London. As Gary Marx writes *(10)*, "New technologies for collecting personal information which transcend the physical, liberty enhancing limitations of the old means are constantly appearing." However, the control over captive populations within some forensic psychiatric settings still rely on old-fashioned techniques of control, the manipulation of caring professionals, the use of pacification techniques to obtain docility, and the outright use of power and fear to tame potentially recalcitrant populations. Pointing out some differences with the "new surveillance" in no way suggests that power is one directional. On the contrary, inquiry into the role of nurses reveals just how "capillary" power is. It comes from all sides of the prison hospital complex. It resides not in one institution or within one regulatory scheme, but attaches itself to bodies throughout the organization. Power infects everyone in forensic psychiatric settings.

Dispositifs, Capture, and Forensic Psychiatric Nursing

It is necessary to understand that so-called forensic psychiatric nurses evolve in a state "*dispositif*" (apparatus) that comprises two (if not more) multifaceted administrative systems (e.g., the justice system and the health care system), each of which conceive the security and health of a captive population as the official goal of their mandate *(11–13)*. An apparatus in this context should be understood as: "A thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions…the apparatus itself is the system of relations that can be established between these elements" *(14)*.

Some are "apparatuses of capture" (e.g., prisons, psychiatric institutions), whereas others seem to be neutral or benevolent in their objectives and practices. But all are carefully designed to achieve specific purposes and all of them are permeated by a vast array of power relations *(13,15–19)*. No doubt that forensic psychiatric units (and programs) whether in jails, hospitals, or community settings are apparatuses of capture. As Mason and Mercer *(13)* point out, despite their architectural features and designs, the true nature of these apparatuses are to be found at their micro-level. Following up on this assertion, we are interested in showing the importance that human agents have when deployed (as objects/subjects of power) within these apparatuses, because they constitute the agency that produces and reproduces the culture of such institutions. Such institutions are known to house the dangerous selves.

Mentally disordered offenders have often been portrayed (and continue to be seen) as monsters or maniacs. Monsters show themselves in many different and culturally specific forms *(20)*. However, their bodies no longer betray their danger; modern-day monsters do not appear in the guise of monsters *(21–23)*. They emerge as products of civil society, produced by institutions and subject to the mores of modernity. Seltzer *(24)*, for example, locates the rise of the serial killer (a modern-day monster) around 1900 along with the advent of the modern corporation and the rise of the United States as a military power. A modern monster is both a physical and a mental phenomena. The signs of the inner monster are buried within the respectable self *(25)*.

Foucault *(26)* points out that modern monstrosity really began with Louis XVI: "all human monsters are the descendants of Louis XVI," because the fight over deviance and liberty during the Revolution was a fight over the space to define those terms. Saint Just categorized Louis XVI an enemy of the social body, a producer of filth. But if Louis XVI was easily seen as a monster in revolutionary France, modern monstrosity takes on different characteristics. Modern monsters are much more dangerous than the monsters of the Renais-

sance, who looked dangerous because of physical deformities. It is now necessary to find the "key" that will enable the health care professional to "detect" the "disease" that lies buried deep within the subject's personality *(27)*. As Judith Halberstam *(28)* wrote: "Monstrosity no longer coagulates into a specific body, a single face, a unique feature, it is replaced with a banality that fractures resistance because the enemy becomes harder and harder to locate, and looks more and more like a hero."

In forensic settings, monstrosity takes on the multiple masks of murderer, rapist, thief, and so on. Modern monstrosity, however, implicates the role of institutions in the formation of monsters. Images of monstrosity permeate traditional understandings of institutions. Prisons, for example, are not only places of punishment (if they ever were), but also of physical and mental torture *(29)*. For the pupose of this chapter, however, we would like to partially distance ourselves from this perspective, and look at institutional monstrosity and explore how forensic psychiatric settings are evil structures permeated by power relations.

Power is most pervasive and visible in "total" institutions such as forensic psychiatric organizations, where groups of mentally disordered offenders eat, sleep, and interact. Nearly all elements of the captives are minutely regulated—practices must be tightly scheduled and regimented in time and space for the institution to function "efficiently" *(19)*. Such institutions are also characterized by barriers to social intercourse with the outside world *(17)*, in which the imperatives of therapeutic care and security collide. But in the creative tension between them, a subtle collusion emerges around the broader agenda of social control in which nurses are enjoined in the regulation of deviance, and the extension of surveillance (as a primary mechanism of control) into all spheres of inmates' activities *(30)*. The disciplinary technologies deployed in forensic psychiatric settings represent a continuation and intensification of what happens in "ordinary places," such as schools and homes *(19)*. The anatomopolitical (management of the body through disciplinary power) investment of everyday life is pervasive and rendered visible through the deployment of specific intervention tools, such as hierarchical observation, normalizing judgment, and finally, the examination. The corollary of the exam (client assessment of all forms) is the confession, which serves as a prerequisite to rehabilitation and normalization *(31)*. These microtechniques are common to all forensic psychiatric settings, fitting functionally within a larger system. Few health care settings escape the gaze (read tyranny) of the "expert" as an instrument of a normalizing power and arbiter of deviance. Renewed forms of governance replace forms of centralized, authoritarian state power, focusing on the cultivation of new subjectivities of personal empow-

erment and risk management *(32,33)*. In forensic settings, inmates and nurses are subjected to various forms of power (sovereign, disciplinary, and pastoral) *(12)*. Both are emotionally invested in acquiring and displaying social or professional competence in their understanding and uptake of institutional dominant discourses as fundamental to their own personal growth and identity, and in so doing both become bound to new "softer" (but no less strong) tentacles of power *(19)*.

Organizational Evil at Play

Prisons and hospitals are the signs of modernity. The old joke that when a sailor washed ashore on a deserted island and said, "Ah, civilization" at the sight of a guillotine, tells us more about modernity (and ourselves) than we acknowledge. The origin of modern, liberal government is inseparable from the problematic duality of the invention of the subject. Modern liberalism first introduced the idea of society as a near-impermeable space, virtually cut off from the state and its operations. The central image was of a blind market force operating alongside the sovereign individual. The production of this view of man, working with a minimal degree of friction within the open space of civil society, meant that the subject of society was both a free subject and subjected to society's limitations. This is not as paradoxical as it sounds. To act freely, "the subject must first be shaped, guided and moulded into one capable of responsibly exercising that freedom through systems of domination" *(34)*. The abstraction society, then, is not as beneficent as it first appeared. The individual can only operate within a structured space of a juridically created liberalism. Institutions become the only source through which individuals can mediate between state and society. Institutions perform a managerial technique, designed (in principle) for the benefit of those being managed. In this view, institutions can be perceived as liberating, in the sense that the agents who carry out the institutional schemes are doing so without bias.

Forensic psychiatric settings, of course, are not only institutions operating within society; they are perceived as caring institutions, where health care professionals are not agents of the state or of power, but of care. But the duality of subjectivity is not lost in a forensic psychiatric setting. Nurses as subjects of power constitute a cluster of state agents, who link the goals of forensic settings and programs to the very objects of these goals, i.e., mentally disordered offenders. As subjects of power, nursing personnel are vested with the mission of providing psychiatric nursing care that is coupled on a daily basis with the mission of discipline, which includes surveillance and punishments. These two missions merge toward the official goal: a so-called "successful social rehabilitation of mentally disordered offenders." Empiri-

cally speaking, such a duality—to care for and exert control over a population of psychiatric inmates—proves to be complex in the socioprofessional sphere. As pointed out by Burnard *(35)*, the forensic psychiatric role must take on various "opposing" functions and as such to "consider illness, crime, morality, treatment, containment and possibly punishment." Such affirmations are corroborated by several other authors in the field *(13,36–42)*.

Furthermore, in order to carry out this paradoxical task, institutional rules support that nurses must show initiative and authority *(12,18)*. Hence, it is not surprising to see nurses utilize various forms of power in order to care (and control) for inmates while ensuring safety and order. Thus, power exerted by nursing staff over a secluded population is continuous and takes on many faces: sometimes straightforward and visible, sometimes rather subtle and insidious. These forms of power, as they pertain to this peculiar nursing practice, take on various forms according to circumstances and desired results, such as coercion, discipline, and therapy, all of which are directly and respectively concerned with finalities, such as repression, transformation, and assistance.

In their daily practice, nurses fulfill functions related to control, discipline, and psychiatric care. Although hired as nurses, they also play an active role in the penal/psychiatric apparatus. Indeed, nurses are officially permitted in forensic psychiatric settings (e.g., the jail) to apply the necessary measures needed to ensure the respect of institutional regulations. According to Castel *(15)* and Goffman *(17)*, staff working in total institutions find themselves in the paradoxical pitfall of caring while enforcing strict regulations that threaten this very caring process. Forensic psychiatric nurses can thus deal directly with delinquents or indirectly by bringing the punishable incidents to the attention of another competent authority *(43)*.

While on duty the nurse carefully assesses this option and acts as a subject of power by making the strategic decision to call for the authority figure most likely to cause the patient's submission *(17)*. We can thus see how essential correctional guards are to the nursing practice in a forensic psychiatric setting. Its crude and even brutal manifestation characterizes this first form of power. Without physically restraining inmates, nurses use a coercive power, in which correctional guards are the executants in order to reach disciplinary or therapeutic goals.

Moreover, forensic nurses resort systematically to a disciplinary type of power in their daily practice with mentally disordered offenders. Nursing duties are not limited to the psychiatric treatment *per se*, but rather are assorted with additional tasks aimed at ensuring that penitentiary operations run smoothly and inmates are controlled. Indeed, nurses are directly involved in discipline in forensic psychiatric settings, to the extent that they undertake functions

related to surveillance and reprimand, control over activities, and punishment of deviant acts with regard to norms ruling the premises.

Discipline touches all aspects of the inmates' everyday life. It is understood that the nursing staff must reinforce conformity with regard to the distribution of inmates within the environment and as it pertains to exerting control over their activities or the sequencing of these activities. Conformity plays an active part in structuring inmates in space and time *(44)*. Each prisoner occupies his own space and shares common areas where he may socialize with peers. This regulation is enforced with regular rounds carried out by nurses and correctional agents alike *(43)*. The spatial distribution of inmates is thus enforced by internal regulations particularly for safety reasons. Such spatial ordering is reminiscent of Foucault's historical work on prisons as the paramount of all disciplinary spaces.

Despite the importance of the nurse–patient relationship, the discipline imposed on prisoners relies on continuous surveillance in addition to possible sanctions, in order to increase its efficiency. Nurses are commissioned to this task. During their daily rounds, nurses collect data of both a clinical and a correctional nature with regard to the prisoners they are in charge of. Moreover, these rounds serve the purpose of cell inspections, for hygiene purposes, or to identify signs of illegal activities, such as substance abuse or the manufacturing of contraband alcohol *(43,45)*. Rounds provide the perfect opportunity for nurses and correctional guards to search cells and personal effects. Suspicious objects that may serve as weapons, tools for drug use, or fruits to be used for brewing alcohol, and so on, may be confiscated by staff. However, because the use of coercion and discipline does not prove to be sufficient in reaching the very grain of mentally disordered offenders, forensic psychiatric settings reinforce these two forms of power exploited by nursing personnel by a third one: therapy.

Along with coercion and discipline, psychiatric nursing care provided to inmates constitutes an important dimension of nursing practice and power. Thus, investing time in observing the inmate is a key to the "therapeutic" process *(43)*. The delinquent must become accountable with regard to his mental condition, personality disorder, or any other "criminogenic factors," which could lead to a punishable offense.

From the moment that a prisoner is accountable for his mental health and the transformations needed for his behavioral re-education, he must devote himself to his treatment. He must feel the obligation to constantly behave responsibly and respect the penal apparatus *(43)*.

Treatment aims to eradicate criminal conduct, so that an individual no longer poses a threat to fellow citizens. In order to reach this goal, nurses are

directly involved in therapeutic actions that encourage global awareness with regard to one's difficulties. This awareness supposes a dialogue, which involves a "caring" power, traditionally associated with nursing practice in a psychiatric setting. Thus, nursing interventions aim to consolidate behavioral self-regulation by a prisoner who faces many challenges. In this respect, nurses convey the official discourse of the forensic psychiatric setting.

Indeed, nurses favor introspection and awareness by the prisoner in the face of his personal problems. Ultimately, resocialization of a prisoner rests on the acquisition of intellectual and emotional abilities, such as self-control, accountability for one's actions, and behavioral self-regulation. Clinton and Nelson *(46)* suggest that discipline and surveillance can also be achieved through noncoercive approaches. "For by engaging in self-care, people with a mental illness not only seek to recover themselves, but also to regulate themselves and their behaviors in more deeply penetrating ways than was possible when psychiatric practice was at its most coercive" *(46)*.

However, this "therapeutic" encounter is subdued by a strict code of conduct enforced by the institutional culture. The prisoner is invited to talk about his family or grief following the loss of a loved one. Nurses explained that their reaction to the suffering expressed by an inmate differed from their response to the expression of suffering by a patient in a civic hospital. An informant added that if an inmate cried, she would not touch him in an attempt to offer comfort as she would in a hospital setting *(12,45)*.

Within a forensic psychiatric setting, nurses use coercion, discipline, and therapy because of their hybrid socioprofessional status (care and custody) and the mandate with which they are vested. In a forensic psychiatric setting, surveillance, control, coercion, and discipline rely on nursing practice, which in turn relies on them, thus creating a paradox not devoid of socioprofessional friction for nurses. Such a "therapeutic process" through "pastoral" acts does not exclude concomitant use of coercion and discipline in order to govern mentally disordered offenders.

However, a deeper look at the functioning of forensic psychiatric settings suggests that the nursing staff, like the group of inmates, is a target of a phenomenon that aims at objectifying them, thus forcing them to conform to the forensic psychiatric setting's norms. The results corroborate the panopticon metaphor used by Foucault *(44)* in his book *Discipline and Punish* to describe the "carceral" environment. Foucault states that although prisoners are under continuous surveillance, the same applies to the staff in corrections. The director of the institution may spy on his employees: nurses, doctors, foremen, educators, and guards; he will be able to judge them continuously, modify their behaviors and force his own ways on them as he sees fit *(44)*. In fact, every time there are numerous individuals to enforce a task or a behavior, the

panopticon pattern may be reproduced *(47)*. Although subject to change, it may be used in every institution in which a number of people must be kept under surveillance in a restricted space. This surveillance applies to inmates and nurses alike, because both are trapped in this "infernal machine," those who watch over are watched over in turn. Surveillance leaves nothing to chance and spares none. Thus, visibility is a trap. Whoever is watched, whether they are inmates or nurses, are inexorably exposed to the judgment of others *(45)*.

In light of previous research results *(45)*, we can establish parallels between inmates' living conditions and nurses' working conditions. The point here is to derive an overall picture of the institution in order to express a judgment about how all actors on the prison scene are subjects, whether they be inmates or nurses to various technologies of power. In an ethnographic study concerning the insane individual's social condition in psychiatric environments, Goffman *(17)* briefly discussed the working conditions of personnel in total institutions, placing the latter in opposition with the patients they look after. However, our data suggests that some of the inmates' existential aspects can also be found in the nursing staff. Indeed, a "conformation process to prison norms" that tries to force onto nurses a new nature and behavior adapted to a jail setting, was clearly identified throughout this research. Bodies of nurses are sites of inscription that are distributed in an "apparatus of capture."

According to Goffman *(17)*, the newly arrived individual enters a total institution with a representation of himself, which is the product of permanent dispositions from his domestic environment. However, as soon as he is admitted, the mental patient or the inmate sees himself stripped of this representation as the result of stages leading to a new identity. For Goffman *(17)*, isolation from the outside world accelerates this hazing process of identity "deconstruction" and "reconstruction." Safety devices and isolation consolidate, in a symbolic and practical manner, the barrier between the total institution and the outside world. Inmates are exposed to the institutional "objectification" described by Goffman *(17)* as a "civil death." Indeed, a range of psychiatric or forensic techniques is used on the mentally ill or on inmates to accomplish exclusion from society. However, the first step (exclusion) of the "mortification process" *(17)* is akin to the feeling of marginalization expressed by nurses who work in forensic psychiatric settings *(12,45)*. Hence, just as Goffman's inmate *(45)* witnesses the remodeling of his identity, nurses working in a forensic psychiatric jail setting come to realize that the prison regime modifies the roles, attributes, and representations of the person they care for and, as a result, forces them to adapt to the forensic psychiatric milieu by distancing themselves from their previous roles. This distance is necessary in order to force the staff to reproduce the organizational (penal) order.

For inmates, this distance between their "roles" also passes through a series of phases, in which his original personality is "mortified," even "violated" *(17,48)*. The processes used to mortify a personality are similar in every total institution *(17)*, whether they are prisons, asylums, or hospitals. Self-image degradation and moral contamination are two "personality mortification techniques" (as stated by Goffman) that are rather enlightening in light of this research. Inmates who live in a total institution lose those attributes that normally distinguish them from others in society. The inmates' self-representation is altered. Goffman made this observation, but it also applies to nurses. The "masculinization" of care and behaviors typically linked to feminine attributes, in order to follow the penitentiary order, is comparable to and well integrated in what Goffman calls "self-image degradation" *(17)*. Bourdieu *(49)* insists on the fact that institutional "rituals" render the domination of one group over another official. Institutional rituals refer to all activities taking place in an institution, which ensue from its particular "culture" *(17)*. Bourdieu *(49)* underlines the fact that institutional rituals confirm one group's hegemony (namely masculinity) because just as it dictates the order of things, the masculine order also dictates bodies through tacit injunctions, which are involved in work or a division of labor. It is through the training of these bodies that the most fundamental dispositions of virilization and defeminization will take place *(49)*. Indeed, some social milieus promote virilization and defeminization more strongly, meaning that such rituals facilitate the rupture with the "maternal" and "feminine" world. The virilization and defeminization processes occur on admission in a man's world *(49)*.

Empathy and attentiveness toward inmates are perceived as feminine characteristics that are strictly forbidden, leading to the need to suppress them, for instance, through scoffing in a typically machismo and chauvinistic manner by correctional guards (and some nurses as well). Regardless of whether male or female nurses express these caring attitudes, they are openly proscribed in the strict penitentiary order. This "adapted form" of caring is thus a constraint, which weighs heavily on nursing staff in general and female nurses in particular.

Moreover, nurses have to show continuous deference to correctional guards in order to obtain their collaboration when dispensing routine psychiatric nursing care. The moral constraint caused by this deference is a contributing factor to self-image degradation discussed previously by Goffman *(17)*, in his work on psychiatric patients' social conditions. Any contact with a prisoner must occur in the presence of a correctional guard for obvious safety reasons. However, the research data *(45)* also suggest that nursing staff must constantly "nurture" the relationship with correctional officers in order to

avoid possible personal or ideological conflicts that may interfere with their professional practice in a forensic psychiatric setting. Delays and excuses are frequent, and a correctional guard's refusal to do a "round" with one particular female nurse or male nurse (much rarer) will serve as a potent negative reinforcement on the nursing team as a whole.

Goffman *(17)* observed the deference expressed by inmates in a total institution and linked this behavior to the deprivation of their identity described earlier. Having to ask for permission to carry out an action that normally does not require another individual's consent emphasizes self-image degradation. Holmes *(45)* was able to witness interactions of the same nature among nurses (in Canadian forensic psychiatric settings), whose "reconstructed" identities bear striking resemblances to Goffman's description of the mortification phenomenon that shapes the inmate's personality. Goffman's conclusions describing the relationship between mentally ill patients and staff also illustrates the relationship between nurses and correctional guards in which words exchanged between inmates and staff members must often be accompanied with verbal manifestations of deference, feeling the need to implore, begging insistently or humbly for services *(17)*.

Conclusion

We are forced to acknowledge that nurses, as objects of power, share with inmates the sphere of the "governed." Nursing staff are also an object of governmental technologies. The parallel between the inmate's mortification process and the nurse's conformation process shows once again the complexity of social and professional relationships in a forensic psychiatric setting. Nurses, as agents of governmentality, practice at the core of the forensic psychiatry apparatus, at the crossroads of psychiatric and penal apparatuses, where they exert three types of power over inmates: sovereign (coercion), disciplinary (discipline), and pastoral (care). However, in such a perverse setting, nurses bear similarities with inmates, because they are both objects and subjects of technologies of "government," which attempts to mold their behaviors. Nurses and inmates are caught in a powerful web of power relations. They are both subjugated to the vicious effects of forensic settings.

We believe that forensic settings constitute an unrestrained variable of nursing practice. These settings deeply affect the quality of nursing care and make possible three forms of nursing care that can be expressed in the language of *governmentality*. These three capacities sometimes take brutal forms, sometimes subtle; they are sovereign, disciplinary, and pastoral. These forms of power constitute powerful instruments to control the conducts of a doubly stigmatized population. This double stigmatization of being both a prisoner

and mentally ill corresponds to the hybrid institutional medium of the forensic settings in which care takes place. The assumption of responsibility of a deviant and at risk population, by a group of experts, is registered in the heart of governmentality, in which the nurse acts like an agent of transformation, standardization, and conformation. Additionally, the representation that is made of the nurse and of the clientele he or she looks after results from the combination of many social variables (preconceived ideas, stereotypes, judgments, official institutional speeches, socialization with the tested personnel, offenses of the mentally disordered offenders, and so on). The summation of these variables leads to the construction of a symbolic identity system that exacerbates the negative characteristics of these delinquent patients described as dangerous, manipulative, and violent, constituting an important risk for the entire nursing staff. This representation of the patient as essentially at risk justifies that one remains wary of them, which burdens the bonds of confidence and makes the therapeutic intervention of the nurse more difficult.

It is now well established that forensic psychiatric settings do not constitute a neutral institutional setting in which care takes place free from the larger influences that operate within society. Forensic psychiatric settings are not caring institutions that have unfortunately evolved into carceral centers. Rather, they are part of the matrix of disciplinary institutions within civil society. They occupy an important space that is constantly expanding, ever-molding bodies to conform to ideas and practices that are found within the spaces occupied by the bourgeoisie. The forensic psychiatric unit is both an architectural and a disciplinary space. But it is also an exclusive space, "used to prolong and perpetuate that mutual estrangement between the governed and the governors" *(1)*. It more than just creates the image of care, it establishes the means by which care constructs its identity. Because of the spatial elements of forensic psychiatric settings, there is a carpentry to the institution of care that creates bodies and boundaries, and nurses and patients, that shapes the meaning of care in disciplinary directions. Monsters can only be created out of disciplinary institutions. If we only understand monstrosity as an individual phenomenon, and not as caught up with the matrices of institutional settings, then we will fail to grasp the importance of the workings of power in forensic psychiatric settings.

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Chapter 3

The Psychopharmaceutical Complex

Brian Kean

Background

This chapter presents sociological critiques of biopsychiatry, including Beck's critique in *Risk Society*. Interactions between drug companies, researchers, government agencies, and medical organizations are framed within Breggin's construct of the *psychopharmaceutical complex*. The construction of knowledge formed by the processes of the psychopharmaceutical complex implicates pharmaceutical companies in the systematic promotion of drugs for a burgeoning number of psychiatric disorders, ultimately leading to the mass medication of citizens in the last half of the 20th century, particularly in the United States. A review of the literature raises serious questions regarding whether the reliance on psychotropic drugs is leading to cures for psychiatry diseases, or is in fact manufacturing the opposite. The literature indicates a significant risk that treatments are potentially brain-disabling and create long-term disability. Claims and counterclaims in relation to scientific fact are reviewed with a specific focus on the use of selective serotonin reuptake inhibitor (SSRI) drugs with children and adolescents. The role of pharmaceutical companies in the control of academia, the construction of knowledge, and the manipulation of governments to increase sales of their drugs is documented. Ultimately, these processes create images of a "risk society" in which human rights disappear into the vacuum of individual immorality and corporate greed—the essence of modern evil.

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Introduction

Understanding the context of the hegemonic medical model of psychiatry is critical given the rapid increases in the number of individuals diagnosed with psychiatric disorders. The approach of defining behavior as abnormal and classifying individuals as deviant needs close scrutiny. What is considered normal in a society varies over time and the definition of deviance can and does change in accordance with the values of a society *(1)*. The significantly increased use of psychiatric diagnoses over the past 20 years raises questions concerning the forces in society that have led to the acceptance of, and increasing promotion of, drug treatments for an ever-increasing number of psychiatric disorders, evident in each new edition of the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) *(2)*.

Individual and community expectations of psychiatric medical intervention are that treatment will produce positive outcomes and improvements in functioning. However, negative consequences from pharmaceutical and biopsychiatric treatments are not new or uncommon phenomena. Iatrogenic outcomes owing to adverse drug reactions (ADRs) have been well documented in medicine (illustrated by the devastating consequences of thalidomide) and biopsychiatry (illustrated by the development of tardive dyskinesia in a significant percentage of patients as a result of long-term treatment with neuroleptic drugs) *(3)*.

Sociological Criticisms of Biopsychiatry

Prediction of scientific advance into the realm of biological social control was reflected in the following statement by Compton in 1942 *(4)*:

> *Biology is in a stage of transition from the phase of extensive observation and classification of form and function to the use of physical and chemical techniques for penetrating into the inner workings of biological processes. This relatively new approach to biology, and especially to physiology, opens up methods for investigating and control of the complicated factors involved. Among the many products of this approach are new clues to the understanding of the facts of genetics and the development of experimental techniques for accelerating or modifying natural trends. Because of this situation there is good reason to believe that biology is now entering an era of accelerating development analogous to that into which physics passed with the discovery of the electron and radioactivity. Biophysics and biochemistry are coming to the fore and are in turn leading the way to a field which we may call biological engineering.*

The trend predicted by Compton in 1942 of application of scientific method to attempt to biologically control perceived deviant, antisocial, or unacceptable human behavior has been reflected in the rise in the use of biopsychiatry in the second half of the 20th century.

Szasz was one of the first significant critics of biopsychiatry. Szasz's initial text *The Myth of Mental Illness*, published in 1961, critiqued the biopsychiatric construct of mental illness and, along with other social critics including Laing and Foucault, highlighted the potentially flawed constructs of biopsychiatry *(5)*. Szasz's critical commentary is underpinned by libertarian views. He is damning of the role of psychiatry because of its coercive nature, reflected by involuntary treatment programs. Szasz's analysis goes beyond the problems of coercion associated with psychiatric intervention, and attacks the very construct of mental illness and associated treatments *(5)*.

More recently, in *Pharmacracy*, published in 2001, Szasz refined his analysis, defining "pharmacracy" as a totalitarian regime of social control that uses drug therapy being the main regulating mechanism *(6)*. The agents of the regime are the health care professionals, principally psychiatrists, whose certifying role classifies, what Szasz perceives as, socially undesirable, unacceptable, or criminal behavior as diseases and results in the use of psychotropic drugs and other biopsychiatric interventions for treatment and solution. Szasz viewed the transformation of human vices, wickedness, and social problems into a socially constructed framework of biopsychiatric disorders as replacing legislative control of human behavior with a form of social control he defined as pharmacracy *(6)*.

Throughout his work, Szasz dismissed biopsychiatric claims of a neurological basis for psychiatric diagnoses and suggested that if there were a neurological basis for such disorders then the domain of treatment would lie in the field of neurology and not in psychiatry *(6)*. Szasz illustrated his tenet using epilepsy as an example of a previously considered psychiatric disorder that was later discovered to be, as Szasz described, a true "brain disease" that can be diagnosed objectively *(6)*. By contrast, Szasz suggests that the vague, subjectively diagnosed "mental illnesses" are fraught with value-laden judgements combined with invalid or meaningless diagnostic procedures that allow human behaviors, including criminal actions, to be incorrectly claimed the result of a real biologically based/neurological disorder *(6)*.

Szasz draws on a historical perspective to defend his analysis. Behaviors previously deemed deviant by psychiatry include homosexuality and masturbation. Szasz noted that in the past homosexuals were incarcerated in psychiatric institutions and children were treated as deviant for exhibiting normal sexual behavior and subjected to antimasturbation treatments *(6)*. Szasz

also claimed that the labeling of children as having attention deficit hyperactivity disorder (ADHD) is congruent with past forms of social control. He noted that under the guise of psychiatry children are labeled hyperactive, generally for problems related to their schooling, and prescribed the illegal street drug called "speed," which, when named Ritalin®, is perceived as a cure for all their problems *(6)*.

Central to Szasz's analysis is his fundamental belief in libertarianism *(6)*. Szasz's viewpoint on psychiatry and psychotropic drugs centers on a belief in free choice. For Szasz, the right to use drugs, whether they are legal or illegal, prescribed or nonprescribed, is a fundamental human right. Szasz reported that 100 years ago citizens could freely purchase opium and heroin from the local drug store. What has changed, according to Szasz, is governmental control through the psychiatric profession, restricting many popular drugs so that the biopsychiatric model becomes the major distributor of mood-altering drugs in society *(6)*. Consequently, biopsychiatry can be viewed as a social control mechanism that has broadly increased its markets and vastly increased the profits of pharmaceutical companies. However, the new market is not only in the regulation of perceived deviants or dysfunctional citizens, but also in the provision of mood-altering drugs that alter levels of consciousness to the satisfaction of the consumer.

Szasz believes that all drug laws should be repealed and that it is a fundamental right of the individual to decide if and why they want to use a drug *(6)*. Szasz claimed that a paradox exists between those incarcerated for drug trafficking or substance abuse (predominantly from minority groups) and those who are licensed to supply often the same or similar substances (among the most highly paid and esteemed members of the community, psychiatrists) *(6)*.

In a similar vein to Szasz, other social critics have attacked the expansion of biopsychiatry and its socially constructed definitions of deviance. The work of Foucault on the influence of the hegemonic medical discourse as the tool to perpetuate power structures also constructed biopsychiatry as a social control mechanism defined by experts whose discourse structures the beliefs and social agency of others *(7,8)*. Constructs of deviancy driven by a biopsychiatric model creates a discourse that conceptualizes what is "normal" to define groups of individuals as "abnormal" in the DSM, and in need of being controlled in society using biopsychiatric intervention, including the use of psychotropic drugs, electroconvulsive therapy, and at the extreme end, lobotomy *(2)*.

Foucault perceived that psychiatry constructs negative stereotypical images of individuals who have a diverse variety of deviations from the defined norm *(7)*. This process perpetuates prejudice toward individuals and groups

that are by nature different from the normal majority. This difference from normality, in the case of children, can include challenging teacher or parent authority or performing below their expectations in areas ranging from educational performance to teachers' or parents' beliefs and perceptions concerning their behavior.

Foucault's analysis suggested that the power of the biopsychiatric discourse is subtle, insidious, and inescapable *(8)*, creating the truths and beliefs of psychiatrists, other health workers, politicians, and society. Foucault's thesis indicated that it is only through critical analysis and deconstruction of functions of power and knowledge that the hegemonic control can be reconstructed to overcome the disempowerment. The ascription of deviance to an individual or group becomes part of a stereotypical psychiatric construct through inclusion under a mental health disorder label that functions to de-individualize, disempower, and control.

In *Madness and Civilisation*, Foucault explored the convoluted concepts of madness, unreason, passion, and delirium in modern society and the impact of these representations on the individual *(9)*. Originally written as Foucault's doctoral thesis, *Madness and Civilisation* explored the idea that madness is not a natural unchanging state, but rather is contextual to the society and constructed belief systems *(9)*. Foucault argued that cultural, intellectual, and economic structures determine the definition of madness and how madness is perceived in society *(9)*. Ultimately, Foucault observed that madness is positioned in a particular cultural space within society and that the shape of this space and its impact on the individuals and their treatments are dependent on the construct of the biopsychiatric discourse itself *(9)*.

In this model, individuals are analyzed by socially constructed groupings, defined in the DSM, that provide a linguistic label that has an associated biological treatment for correction of deviancy. This has also been expanded to a broader market of reducing symptoms or satisfying individual need, generally concerning feelings about themselves, their social interactions, dealing with loss or grief, and perceptions concerning performance in schools or the workplace. Foucault's analysis suggested that the discourse of power at an individual level involves perception of behaviors that are defined by the psychiatrist as symptoms that classify the individual as having a disease and in need of treatment. On a broader level, madness is measured in society against a moral scale defined by psychiatrists and psychologists acting within a constructed discourse determined by biopsychiatric experts. Positivistic science is used to dismiss critics and the patient with claims about the infallibility of scientific method. This is established through randomized control studies, peer-reviewed journals, and the spectrum of research activity selectively transmit-

ted by biopsychiatric experts to psychiatrists, medical practitioners, other health workers, political systems, school systems, teachers, parents, and society.

In a similar critical critique to Foucault, Habermas concluded that the essence of science and technology has structured distorted communication in society *(10,11)* leading societies into a belief that science and technology are the only solution for the ills of the modern *(12)*. In this circumstance, science and technology work for their own purpose, removed from the reality of everyday lives, and ultimately leading to dehumanization and devaluation for all *(12)*.

Distorted communication occurs because of the god-like status of science and technology, including psychiatry. This distorted communication is combined with the inability of the political and social processes to effectively challenge the direction laid by experts, bureaucrats, and technocrats who use the scientific and technological discourse for disempowerment of critics and to affect social control *(10–12)*. The powerful economic forces driving biopsychiatry manipulates the experts, bureaucrats, and technocrats in the mental health industry. Consequently, the biopsychiatric discourse, with its purposive rational thought, becomes a social control mechanism that also works for the economic interests of pharmaceutical companies through expansion of markets and maximization of profits.

Foucault's tenet concerning governmentality, paralleling Szasz's pharmacracy, provides a generalized model to understanding the relationships between the individual, social culture, and the biopsychiatric discourse *(7)*. Governmentality is based on an analysis of the use of subjective power and knowledge of experts to maintain control through the governance of discourse *(13)*, in congruence with Habermas's thesis that distorted communication by experts defines the roles of agents, including government and bureaucratic organizations, to implement discipline over the body or subjects, whether individual or broader social groups. This process ensures that the hegemonic group maintains control and ensures that the social order is structured to meet the hegemonic ends *(13)*.

Foucault indicated that biopsychiatric dominance is maintained by knowledge and truth claims of medical experts *(7)*. The biopsychiatric view is grounded in beliefs concerning the absoluteness and infallibility of scientific method. However, the scientific method, when applied to studies of human behavior, particularly in the area of mental health, cannot be value-free or objective in the way it is constructed in the traditional areas of science, such as physics or even other medical specialties *(13)*.

Beliefs concerning what is abnormal, aberrant, deviant, or dysfunctional are relative to the social context held by those who define normality *(14)*. For

example, the inclusion of homosexuality in the early editions of the DSM is one example in which supposedly objective science was based on value-laden judgements *(15)*. In this case, changing societal norms and values have required redefinition of what is considered normal or abnormal. However, as Greig noted, even after the elimination of homosexuality as a psychiatric disorder in 1973, after a series of challenges by gay lobby groups, the classification reappears in a later version of the DSM in a different form *(16)*: "ego-dystonic homosexuality."

However, exposure of hegemonic medical discourse does not necessarily provide groups or individuals within society with a means of assessing risks and potential threats resulting from acceptance of a psychiatric diagnosis. The postmodern or poststructural form of analysis, although potentially useful as a method of social analysis to expose the political context and critique of positivism of the biopsychiatric discourse, will not necessarily delineate the potential risks that may become threats for the individual and for society.

Along with Habermas, Ulrich Beck comes from a tradition of critical theory that underpins the analysis in this chapter *(17,18)*. Beck's periodization of Western societies at the beginning of the 21st century as the risk society, provides a framework for understanding the biopsychiatric phenomenon in a broad sociological context with a specific emphasis on delineation of risks and potential threats *(17,18)*. This sociological interpretation informs an understanding of the implications of the widespread adoption of the increasing psychiatric diagnoses of citizens in Western societies. The claim and counterclaims made about various psychiatric conditions, the role of experts, and the dimensions of unawareness created by their consensus forms a perspective that provides a basis for understanding and interpreting the significant increases in the use of psychiatric diagnoses and the implications of this change for individuals and society.

Beck's theoretical perspective indicated that in moving towards the second modernity, democratization of the family and recognition of the rights of the child are central to protection of social structure *(17,18)*. Beck noted that the risk society is characterized by the process of individualization because of the effects of the modern on traditional family and social structures *(17)*. Beck placed emphasis on the need for individuals and communities to understand what he defines as *reflexive modernity (17,18),* interpreted as a need for individuals and communities to understand the complexity of social changes occurring because of the modernity reshaping everyday lives. Knowledge and awareness of the implications of radical social restructuring as a consequence of the first modernity forms a background for interpretation of the increases

in the use and acceptance of psychiatric diagnoses and associated drugs and other interventions aimed at reducing risk through the control of individuals, while at the same time increasing hidden risks. Development of awareness of risks and threats in the understanding of biopsychiatric phenomenon may allow individuals, making a decision on behalf of themselves or another, the child or adolescent, to make more informed choices.

In Beck's periodization of society, two key characteristics of the risk rociety are increasing globalization and individualization (*17,18*). Evidence of globalization is apparent in media, technology, and the spread of economic rationalistic approaches throughout all countries. This process is driven by multinational companies, dominated by the techno/scientific complex that becomes pervasive, and beyond the control of traditional political structures, nations, states, local communities, and individuals *(17,18)*.

Beck viewed the modern as a combination of industrialism and capitalism supporting an ever-increasing belief in, and dependence on, science and technology to maintain the modern and to solve the problems it generates. Beck's tenet concerning the second modernity indicated that it is a consequence of the modern. The institutional and national structures that supported and framed the first modernity are being restructured as societies move towards the second modernity as an uncontrollable by-product of the first modernity *(17,18)*. As Beck stated, "the second modernity, on the other hand, is characterized by ecological crisis, the decline of paid employment, individualization, globalization and gender revolution" *(19)*.

Beck's risk society theory is based on the assumption that the industrial capitalist society manufactures and generates its opposite *(17,18)*. The basis of modernity, Beck suggested, has changed and is mirrored by a growing inability to control consequences. At the same time, the risk society is characterized by assertive claims that science and the modern society have the ability and resources to maintain control based on rational and scientifically proven courses of action *(17–19)*.

Beck believed that in the process of transition between the first and second modernity, in order to survive, humanity must practice reflexive modernity. Unless this occurs, Beck indicated that the second modernity would be characterized by societies that are dehumanized with an absence of the recognition of individual human rights and values. The functionality of this process in the transition into the second modernity is not controlled and fragments the institutional, national, and social structures that created and supported modernity *(17–19)*.

Risk society theory points to the power behind the changes, indicating that capital has become a global force that moves rapidly and restructures

economies without any possibility of international, national, or community control. The control of capital in the second modernity is not held within national boundaries, but is globalized and exploited by multinational capitalist forces working for their own benefit (power and profit) unchecked by any form of comprehensive systematic international, national, or local regulation *(20,21)*.

Risk society emphasizes the unanticipated, and sometimes disastrous, consequence of knowledge provides an opportunity for increased awareness of the need for the assessment of risks. This practice is central to both Beck's and Giddens' formulation of reflexive modernity. Beck and Giddens consistently illustrate their theories through the use of examples related to environmental crises (e.g., Chernobyl, global warming, mad cow disease), and the claims and counterclaims surrounding each crisis *(17–21)*. Society, in Beck's and Giddens' periodization, becomes preoccupied with avoidance and denial and is further fragmented into a social struggle of dealing with risks. In the risk society, the techno/scientific complex creates as many uncertainties as it solves, with solutions potentially creating further risk that cannot be resolved simply by further scientific advance.

Beck noted that a process characteristic of the risk society is the repression and denial of risks and threats. This process, Beck suggests, becomes a key focus in social and political management of information in the risk society. Giddens and Pierson formulated the process as one of claim and counterclaim played out in the public arena, without any credible arena for resolution, leaving individuals without any valid method to resolve truth claims and hence adequately assess risks and threats *(20)*.

The claims and counterclaims played out in local, national, and globalized media create the impression within society that contentious issues are being adequately and effectively analyzed and dealt with *(17–20)*. Governmental and scientific inquiries into matters of crisis or concerns may act to alleviate concerns of citizens by appearing to investigate the issues adequately. However, the inquiries may only be a means of reinstatement of the status quo as the discourse is still generally controlled by the consensus of biopsychiatric experts. In this circumstance, what occurs is a downplaying of risks that does not result in a realistic assessment beyond the limitations of biopsychiatric views.

In a situation of contradictory information, as is the case with the biopsychiatric phenomenon, decisions need to be made by individuals in society who are forced into risk situations in which regulatory controls have not been clearly defined, and assessment of the nature of risk is controlled by transmission of knowledge from a hegemonic biopsychiatric consensus of experts.

As a result, individualization occurs and citizens are forced to make their own assessments. The individual is then faced with dealing with the now contradictory state of scientific knowledge, linked with media debates associated with the controversy over the use of psychotropic drugs, particularly on children and adolescents that ultimately leaves the assessment of risks up to individual judgment as a result of contradictory claims by experts, counterexperts, and survivors of biopsychiatry. In many circumstances, however, individual judgment of risk and threat is not permitted as a result of mandatory treatment orders.

Beck viewed the assessment of aspects of unawareness as crucial to being reflexive. Beck stated that the following dimensions of unawareness should be considered in any analysis of risk and threat in society *(21)*:

1. Selective reception and transmission of the knowledge risk—"falsification" in Wildavsky's sense (on all sides in public, of course, among social movements, but also among the various experts and organizations).
2. Uncertainty of knowledge (in a concrete and theoretical sense).
3. Mistakes and errors.
4. Inability to know (which may in turn be known or repressed).
5. Unwillingness to know.

The Psychopharmaceutical Complex

Breggin defined the conglomerate effect of the interaction between drug companies, researchers, government agencies, and medical organizations as the *psychopharmaceutical complex (22)*. In this context, pharmaceutical company funding has organized a partnership with organized psychiatry in which "truth is the loser, along with the public and patients" *(22)*. According to Breggin, the six main elements of the psychopharmaceutical complex in the United States are *(22)*:

1. The pharmaceutical companies.
2. The APA and associated professional bodies.
3. The Food and Drug Administration (FDA).
4. The National Institute of Mental Health (NIMH).
5. Other government departments, particularly the Departments of Health, Welfare, and Education.
6. Community-based lobby groups given financial assistance from pharmaceutical grants for educational programs concerning particular mental health disorders in the community.

Breggin has documented the role of community-based lobby groups and their links with links with pharmaceutical companies in various texts *(22–25)*. In the United States, Breggin notes that parental and community lobby

groups have various forms of financial links with pharmaceutical companies. Examples include organizations such as Children and Adults with ADHD (CHADD) and the National Alliance for the Mentally Ill *(22–25)*. Breggin also detailed the relationship between the US Department of Education and CHADD that was used to distribute promotional material to schools, teachers, and the community promoting a biopsychiatric view of child behavior using the label ADHD *(22)*.

In the United States, the NIMH has been responsible for the overseeing and funding of extensive research conducted by experts in the area of biopsychiatry since the 1960s. Over the past 30 years, the APA has expanded the criteria of classification of mental disorders in the various versions of the DSM and with each revision significantly increased the percentage of the population who could be classified as having a psychiatric disorder, and as a result increasing the sales of drugs for pharmaceutical companies. Breggin's analysis adds support to Szasz's construct of pharmacracy. A government-sponsored and pharmaceutical company regime of biopsychiatric social control defining abnormality, promoting a constructed view of differing, abnormal, and criminal behavior as a result of a neurological disorder or biochemical imbalance. In addition, broadening the categories in the DSM has resulted in an explosion of use of psychotropic drugs in society that has become recently moved toward a globalized phenomenon.

Breggin's analysis of the psychopharmaceutical complex is construed as a conspiracy theory by critics *(26)*. Breggin intimated that in relation to ADHD there is a form of conspiracy and collusion between the drug companies, the FDA, Department of Education, NIMH, CHADD, and the APA that has vastly increased pharmaceutical company profits *(27)*. Behind Breggin's construct of the psychopharmaceutical complex is the power and money of the drug companies driving their own agenda—increasing demand and market share. Through funding research, promoting ADHD parental lobby organizations, and using their influence to create markets through the education system, the pharmaceutical companies have increased drug sales. Breggin's analysis in various texts details the complexity of similar patterns of interactions between the FDA, NIMH, psychiatric experts, and pharmaceutical companies in relation to a broad range of psychiatric drugs *(22–27)*.

Barkley, in a review entitled *ADHD, Ritalin, And Conspiracies: Talking Back To Peter Breggin*, refuted Breggin's construct:

> *Breggin claims that all are conspiring to "drug" America's school children for the management of their ADHD, among other behavior problems. Left unaddressed by the author is precisely how such a complex conspiracy could ever be organized and kept secret, if it actually existed. No persua-*

sive evidence of such a conspiracy is ever provided in the book, just the repeated assertion that an ADHD/Ritalin conspiracy exists. (26)

It is evident, however, that there has been widespread promotion of the notion of a biological basis for ADHD and also direct promotion by medical experts in media, texts, and public meetings that has resulted in very significant increases in the use of the ADHD diagnosis and movement towards globalized use of the diagnosis that was primarily only used in the United States before 1990. The interlinks between medical experts and parental lobby organizations whose promotional materials are claimed by Breggin as misleading raises questions about scientific integrity and the role of the FDA, NIMH, pharmaceutical companies, and researchers generally holding eminent positions in US universities. The financial gains involved as a result of dramatic increases in treatment for ADHD also result in financial benefits to medical experts. This aspect raises questions concerning the construction of knowledge, particularly in light of the claims promoting a proven biological/neurological basis for the disorder that has not been clearly established in research at this point in time *(22,28–30)*.

Central to the protection of human rights is the role that the FDA plays in approval and regulation of psychotropic drugs. The FDA process bases its analysis on randomized clinical control trials (CCTs) presented by the pharmaceutical companies for drugs they wish to market. Any drug with effectiveness marginally better than placebo is generally approved *(31)*. Analysis of the problems with the FDA's process, particularly in relation to the SSRI drugs detailed later in this chapter, highlights the complexity of interactions in the psychopharmaceutical complex that support the concerns raised by Breggin throughout the 1990s.

Breggin, as part of the analysis of the psychopharmaceutical complex, highlighted the financial links between drug companies and biopsychiatric experts and particularly the APA. The financial relationship between the APA and pharmaceutical companies became more closely linked in the 1980s through to the present day *(23,25)*. The drug companies' financial involvement with the APA is claimed by critics of biopsychiatry as the one of the driving forces fueling the promotion of psychoactive drugs as solutions to perceived psychiatric disorders *(23,25)*. Breggin claimed that there is an intimate link between the profit-driven ideology of drug companies and the profession of psychiatry. He reported that the financial support extends from the significant income derived by the APA from drug company advertisements in psychiatric newspapers and journals, drug company sponsorship of the APA's conferences, and direct donations of funds. Breggin also reported that in 1992 Upjohn Cooperation made one donation of $1 million to the APA. The medi-

cal director of the APA responded to his criticism, noting that they had a "partnership" with the drug companies to aid the understanding of psychiatric disorders *(22)*.

Big Pharma and the Mass Drugging of Society

There appears to be a heightening wave of promotion and use of biopsychiatric intervention into Western societies with the United States as the epicenter. Vera Sharav, the director of the Alliance for Human Research Protection, claimed that there also appears to be walls of secrecy behind biomedical research *(31)*. She suggested that there are significant conflicts of interest between expansion of government-recommended models for treatment and pharmaceutical company interests for profit generation.

To illustrate, Sharav reported that in relation to the Texas Medication Algorithm Program (TMAP) drug company investment to the state brought significant financial returns to the drug companies *(31)*. Sharav reported that Pfizer contributed $232,000, Janssen, $224,000, and Eli Lily, $109,000 to the state for the development of TMAP *(31)*. The return to the pharmaceutical company in terms of their investment resulted in Texas Medicaid spending *(31)*:

- $233 million for TMAP-recommended Pfizer drugs, particularly Zoloft®
- $272 million for Janssen's Risperdal®
- $328 million for Eli Lily's Zyprexa®

In combination with the advent of the use of TMAP, which attempts to direct mental health professionals into a systematic algorithm for treatment and drug choice, is a national movement in the United States toward the screening of all children and other selected target groups for mental disorders *(31)*. The US President's New Freedom Commission on Mental Health has also noted the usefulness of TMAP as a guideline for intervention on mental disorders. The recommendation for mass screening and potential algorithmic-mandated treatment reflects more of a totalitarian stance by the United States than the model of democracy it continually claims is necessary for the rest of the world to duplicate *(31)*.

Although not mandated at this stage, the New Freedom Commission on Mental Health makes clear recommendations for systematic screen in schools and as part of routine physical examinations *(32)*:

> *Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health problems, such as criminal justice, juvenile justice, and child welfare systems.*

Both children and adults will be screened for mental illnesses during their routine physical exams.

The report estimated that 5 to 7% of adults and 5 to 9% of children have a serious mental illness *(32)*. The report also claimed that *(32)*:

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening. Service providers across settings will also routinely screen for co-occurring mental illnesses and substance use disorders. Early intervention and appropriate treatment will also improve outcomes and reduce pain and suffering for children and adults who have or who are at risk for cooccurring mental and addictive disorders. Early detection of mental disorders will result in substantially shorter and less disabling courses of impairment.

Sharav reflected that there is a parallel between the new social order of state-sponsored movements toward mandated treatment and the eugenics movement of the early part of last century *(31)*. That is, the US society is moving toward the eugenics movement that promoted sterilization and better breeding to produce a better society. Based on elitist thought that parallels with the racist eugenics movement, the new algorithmic approach, in which treatments can also be imposed against the will of the person or even the parents of children classified with a biopsychiatric label, is based in a belief in the infallibility of the science, human judgment, and the absolute benefits of drugs to "help" those defined by others to be in need of treatment *(31)*.

As with eugenics, the biopsychiatric movement is embraced by medicine, academia, and corporate America *(31)*. Sharav claimed that biopsychiatry has the mantel of science without the substance of science. Benefits are not clearly defined; long-term outcomes are unknown and there is potential for causing a drug-induced social disaster on a scale that has not been adequately assessed in terms of the risks. The developments are congruent with Szasz's construct of pharmacracy, which Szasz viewed as the most significant threat to the liberty and rights of citizens. Spread beyond the context of the United States, globalized pharmaceutical company operations under the paradigm developing in the United States presents an even more significant threat, especially when the concept is applied to totalitarian states. Orwellian images and fictional predictions of Huxley's *Brave New World* appear to becoming a reality in the globalized Risk Society.

In the United States, the first attempts at mass screening of children for mental health disorders, including the loosely defined psychiatric label hyperkinesis, occurred in the late 1960s when suggestions were made that every 6- and 11-year-old child should be screened for mental disorders to prevent

the development of social malignant personality disorder in adulthood *(33)*. Although the concept of mass screening as a process was defeated at the time, the use of amphetamines for behavioral modification of children developed in the period and has grown to be a massive industry surrounding the medicating of children with a range of drugs, including amphetamines, for the treatment of the disorder biopsychiatry now calls ADHD.

Concerns, including those about short-term risks such as ADRs, misdiagnosis, and discrimination against minorities and those living in poverty, are ignored in the biopsychiatric discourse that dismisses social contexts and views behaviors and differences as only having a neurological or biological basis. Although called for in 1970 *(33)*, adequate long-term research concerning the use of amphetamines for the treatment of ADHD and significant risks as a result of treatment, such as predisposition to the use of cocaine and other stimulant drugs in adolescence and adulthood, is absent even today.

Drugs are approved by the FDA sometimes with only data from 4-week-long CCTs *(23)*. Realistic assessment of issues as well as unforeseen and unpredictable risks are swept away through emotional claims related to helping those who are mentally ill, likely to commit suicide, and in need of relief from the symptoms of depression, biopolar mood swings, and an ever-increasing number of labels defined in each new version of the DSM. In the last 15 years of the 20th century, the most dramatic increase in usage of psychiatric drugs has been to treat mild, moderate, and severe depression. Are the interventions improving the situation or are there significant risks? Can the absolute faith in the biopsychiatry industry, clearly endorsed by the New Freedom Commission on Mental Health, be justified?

Adequate risk analysis is absent from the biopsychiatric discourse that appears to be creating a new social order. As Sharav highlighted, behind the scenes of the claims of the great social benefits from the biopsychiatric community are significant hidden conflicts of interests with big pharma money ultimately driving the agenda for their profits *(31)*.

Curing a Disease of Creating Long-Term Disability

The risk that increased use of biopsychiatry is worsening chronic long-term outcomes, serious long-term health risks, and increasing dysfunctionality in patients that results in increased need for social security support for mental health disability support, unpredictable social change, and financial costs to society is reflected by the analysis of Robert Whitaker, author of *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill (34)*. Whitaker provided an in-depth review on the United States' increasing use of psychotropic medications for the treatment of mental disor-

ders. One of Whitaker's key points is that the reliance on psychotropic drugs as a first-line intervention for mental health disorders may in fact be significantly increasing the risk of disabling the patient even further. In congruence with Breggin's theories delineated in *Brain Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Role of the FDA (25)*, Whitaker suggested that the reliance on psychotropic drugs as the first-line avenue of treatment for psychosis and depression, although initially suppressing the psychotic state in the short term or improving the initial symptoms of depression, may lead to increased and more frequent episodes of psychosis, worsening depressive states, increased readmissions to hospital, and disablement of the individual in the long term *(34)*.

Whitaker noted that since the introduction of the first SSRI drug for treatment of depression the number of US citizens on social security payments for disability as a result of mental health disorders has increased dramatically *(34)*. He pointed to social statistics, such as overall social security payments related to mental health disorder in which the number of recipients has increased from 3.5 million in 1987 when the first SSRI was introduced to 6 million in 2004 *(34)*. Instead of decreasing the number of citizens receiving this type of welfare payment, the number has doubled in the last 15 years increasing at a rate of approximately 145,000 per year *(34)*.

The SSRI drugs were heralded as a major medical breakthrough that would allow individuals with depression to participate more fully in society, that is, they were promoting drugs that assisted with maintaining employment and improving social functioning. Whitaker noted that statistical data in the United States does not seem to support the utility of the drugs in reducing the number of persons receiving social security for mental health disorders. In the period of rapid increase in the use of SSRI drugs there appears to be a correlation in the increase in the number of persons receiving social support as a result of a mental health problems. In addition, the increased costs in disability payments have also been coupled with a dramatic increase in spending on psychotropic drugs. Spending in 1987 totaling approximately $800 million skyrocketed to $25 billion in 2003 *(34)*.

Whitaker's analysis, in relation to SSRI drugs, is paralleled by his comprehensive review of refereed publications relating to the effectiveness of neuroleptic drugs *(34)*. Furthermore, his analysis of the scientific literature relates to the use of the antipsychotic drugs over a 50-year time span. Whitaker questioned the overall, broadly held biopsychiatric opinion that the treatment may in fact significantly worsen long-term outcomes. He claimed that almost 40% of patients would do better without any neuroleptic use *(34)*. In short, Whitaker claimed that neuroleptic drugs in treatment of psychosis may be

doing more harm than good *(34)*. Although initially effective in reducing psychotic symptoms, his review of the scientific literature led him to the conclusion that the use of a neuroleptic is more likely to cause the patient to be predisposed to further and ongoing psychotic episodes and hospital readmissions, and that patients not exposed had higher rates of remission of symptoms and less readmission to hospitals for treatment *(34,35)*.

Whitaker's review does not raise issues that have not previously entered the public domain. However, it reinforces the concerns raised by social critics detailed at the beginning of the chapter. The analysis also has congruence with Breggin's theories in the text *Brain-Disabling Treatments in Psychiatry (25)*. Breggin's critique of biopsychiatry detailed 11 key issues related to what he described as brain-disabling treatments that cause further damage beyond the symptoms of the initial diagnosis. This may lead to a significant number of patients entering into an ongoing spiral of psychotropic drug use, repeated electroconvulsive therapy treatment, and a lifetime of biopsychiatric intervention.

Breggin defined the principles of brain-disabling treatments in psychiatry as *(25)*:

1. All biopyschiatric treatments share a common mode of action—the disruption of normal brain functioning.
2. All biopsychiatric interventions cause generalized brain dysfunction.
3. Biopsychiatric treatments have their "therapeutic" effect by impairing higher human functions, including emotional responsiveness, social sensitivity, self-awareness or self-insight, autonomy, and self-determination. More drastic effects include apathy, euphoria, and lobotomy-like indifference.
4. Each biopsychiatric treatment produces its essential or primary brain-disabling effect on all people, including normal volunteers and patients with varied psychiatric diagnoses.
5. Patients respond to brain-disabling treatments with their own psychological reactions, such as apathy, euphoria, compliance, or resentment.
6. The mental and emotional suffering routinely treated with biopsychiatric interventions has no known genetic and biological cause.
7. To the extent that a disorder of the brain or mind already afflicts the individual, currently available biopsychiatric interventions will worsen or add to the disorder.
8. Individual biopsychiatric treatments are not specific for particular mental disorders.
9. The brain attempts to compensate physically for the disabling effects of biopsychiatric interventions, frequently causing additional adverse reactions and withdrawal problems.
10. Patients subject to biopsychiatric interventions often display poor judgment about the positive and negative effects of the treatment on their functioning.

11. Physicians who prescribe biopsychiatric interventions often have an unrealistic appraisal of their risks and benefits.

Breggin comprehensively detailed the ADRs and debilitating effects that can occur from the long-term use of psychotropic drugs *(25)*. It is beyond the scope of this chapter to provide a detailed review of ADRs and iatrogenic effects of psychotropic drugs. However, a brief review of akathisia, dysphoria, and a few of the long-term detrimental effects of use of neuroleptics as reported by Breggin illustrates aspects of the brain-disabling theory *(25)*.

One of the risks associated with biopyschiatric treatments is the development of akathisia. Akathisia is a drug-induced state of mental agitation that produces autonomic states of restlessness, agitation, tension, or anxiety that are generally associated with a total inability to relax. In this drug-induced state the individual may pace, move continually, and have extreme difficulty sleeping *(25)*. The degree can range from major to minor repetitive movements. However, cases have also been noted in which the associated movement is not a characteristic but reflected by a sense of inner torture characterized by anxiety, hostility, aggression, terror, or panic *(25)*. The symptoms, particularly related to the use of neuroleptic drugs to treat psychosis, can be misinterpreted as ongoing psychotic manifestation, leading to further increases in dosage to suppress the iatrogenic state *(3)*.

Akathisia can induce psychosis, aggression and violence potentially leading in extreme cases to homicide, suicide, attempted suicide, self-mutilation, or lesser degrees of abusive or self-abusive behaviors *(25)*. The behaviors can be mistaken as a result of the individual's mental disorder leading to increased dosage of the neuroleptic drug or polypharmacy that may cause further problems associated with the drug-induced condition *(25)*. In the extreme, drug-induced akathisia could also be mistaken as the failure of the drug to treat the condition leading to further increases in dose or use of other biopsychiatric interventions.

Another risk is the development of dysphoria, which can also be induced through the use of psychotropic drugs *(25)*. Dysphoria is associated with loss of motivation and will and physical lethargy. The physical movements may be dramatically slowed, characterized by slow shuffling or rigidity. Emotional bluntness, unresponsiveness, lack of engagement, drowsiness, and an inability to concentrate are all symptoms of neuroleptic dysphoria *(36)*. Mild to severe depression can be an ADR associated with long-acting intramuscular neuroleptic use and also can occur during oral treatment with the neuroleptic class of drugs *(37)*.

Tardive dyskinesia, tardive dystonia, and tardive akathisia are generally permanent disabling conditions associated with long-term neuroleptic drug

use, however, the conditions have also been noted in some cases, albeit rarely, even with brief treatment employing neuroleptic drugs *(25)*. The risk of developing these permanently disabling conditions increases over time *(25)*.

There is also a risk of death occurring through treatment with neuroleptic drugs as a result of the development of neuroleptic malignant syndrome. Symptoms of neuroleptic malignant syndrome include, but are not limited to, dyskinesia, akinesia, tachycardia, fluctuations in blood pressure, urinary incontinence, and temperature elevation *(25)*.

Claim vs Counterclaim

Analyses such as Breggin's or Whitaker's have been sidelined in the hegemonic biopsychiatric discourse. The overall stance taken in biopsychiatry is that the conditions being treated are biological or neurological in nature often as a result of dysfunction in chemical activity in the brain. With depression, particular emphasis is placed on serotonin and dopamine in relation to psychosis.

The claims made in the biopsychiatic discourse are supported through reference to experts' opinions, scientific research studies, and reports in refereed journals. Linked to the research studies and journal articles are medical scientific experts, many in esteemed positions in universities, whose power over the discourse is impenetrable even to practicing physicians, let alone nurses, other health workers, education systems, teachers, parents, and the individual diagnosed with the disorder.

Characteristic of the late part of the 20th century has also been the promotion of biopsychiatric disorders through media and promotional lobby groups such as CHADD and the National Allianace of the Mentally Ill. Counterclaims or expressions of concern about potentially brain-disabling treatments are dismissed or downplayed with emotional or humanitarian claims of the need to provide modern, biological, scientifically proven treatments that are necessary and essential for the improved functioning and relief of suffering in individuals or groups labeled with a particular disorder.

Linked with the claimed infallibility of science are the emotional and humanistic views that involve issues of having a mental health disease. Whitaker's analysis, related to the United States, highlighted social changes resulting in increased social security payments and disability claims that have a financial benefit to the recipient. In addition, mental health disorder is increasingly used as a defense for criminal activity, disability in the workplace, and a reason for dysfunction in everyday life. Social, family, and environmental factors are negated in the biopsychiatric discourse with any disabling mental

condition being linked with positivistic claims of proven genetic flaws and biochemical imbalances.

The Case of the SSRI Drugs

Behind the explosion in the use of psychotropic drugs, particularly in the United States, which is rapidly becoming a global concern, is a boom in profits to the pharmaceutical companies whose drugs are the key interventions promoted for these disorders. In a relatively short period, from 1987 to present, the SSRI drug sales have risen to what appears to be at an almost incomprehensible level within the United States, which reflects the success, in terms of sales, of the interventions for depression and other disorders using the newer antidepressant drugs.

In 2003, the five antidepressant topping wholesale returns to drug companies were Zoloft, Effexor®, Wellbutrin®, Paxil®, and Celexa™ with total sales of approximately $9 billion *(38)*. Sales of the new antidepressant and the resulting returns to pharmaceutical companies profits and their shareholders must be well above what could have been expected when the first SSRI, Prozac®, was marketed.

The first SSRI, fluoxetine hydrochloride (Prozac) was approved for use in the United States by the FDA on December 29, 1987. The entry of the drug to the marketplace was accompanied by extensive media coverage. By 1989, fluoxetine had gained rapid market acceptance with over 650,000 prescriptions per month. In subsequent years, demand for the drug significantly increased and by 1997 fluoxetine was the fifth most prescribed drug in the United States *(38)*. Following the market success of fluoxetine, the SSRI drug list rapidly expanded to include sertraline (Zoloft), fluvoxamine (Luvox®), citalopram (Celexa), paroxetine (Paxil), and escitalopram (Lexapro®) *(39)*. The action of this class of drugs is to block reuptake of the neurotransmitter serotonin from the synaptic cleft *(39)*. Other antidepressants that are nonselective serotonin reuptake inhibitors include nefazodone (Serzone®), venlafaxine (Effexor), and clomipramine (Anafranil®). SSRIs and nonselective serotonin reuptake inhibitors have documented ADRs including overstimulation, agitation, anxiety, and mania *(39)*. Breggin noted that all antidepressants can cause mania and that capacity is documented in the FDA-approved label for antidepressants *(39)*.

The ADRs associated with antidepressants range from mania to psychosis, which often commences with symptoms of insomnia, hyperactivity, nervousness, anxiety, and irritability and then can progress toward more severe aggression and agitation *(39)*. In some patients, the ADRs can be idiosyncratic with the psychosis lacking manic characteristics and being more paranoid in nature. The spectrum of ADRs considered frequent (1% or greater)

include mania/hypomania, insomnia, nervousness, anxiety, agitation, confusion, amnesia, depression, tremor, sweating, and heart palpitations *(39)*. Less frequent (between 0.1 and 1%) ADRs range across psychosis, euphoria, hostility, hallucinations, abnormal thinking, neurosis, paranoia, depersonalization, and lack of emotion *(39)*. The ADRs associated with SSRIs parallel effects often associated with other psychostimulant drugs, such as amphetamine and cocaine *(39)*. The analysis by Breggin *(39)* was based on re-analysis of data from CCTs published in refereed journals and does not necessarily account for the effects of wash out of subjects in studies who were eliminated because of a strong response to placebo or as a result of ADRs to the drug before the clinical trial commenced.

CCTs and application of animal models have limitations in predicting the risks associated with pharmaceutical intervention in psychiatry. CCTs are generally short-term studies (4–6 weeks) that are used for obtaining approval of drugs from regulating bodies such as the FDA. After approval, the drugs are often used for significantly longer periods than the CCT and can also be used in combination with other drugs leading to experimental polypharmacy. The desired effect of the polypharmacy is better functioning for the patient, however, the lack of adequate controlled research risks individual experimentation with combinations of drugs that could have a far higher rate of ADRs. It then becomes a scenario of risk–benefit analysis. But who defines and analyzes the risks and benefits?

There is increasing evidence that the SSRIs have ADRs that can cause or exacerbate a broad range of abnormal mental and behavioral conditions. The ADRs can effectively worsen an individual's functioning and can result in violence, criminal behavior, suicide, psychosis, or other extreme abnormal behavior. Recognition of ADRs is crucial to preventing potentially disastrous outcomes. Clear identification and analysis of ADRs in individual cases is critical for forensic application in criminal, malpractice, and product liability cases *(39)*.

Case reports have documented the capacity of SSRIs to result in mania sometimes associated with irritability and aggression *(24,39)*. Case reports have also indicated the potential for SSRIs to induce akathisia and aggression *(24,39)*. Akathisia has been reported as an ADR associated with antipsychotic tranquilizers including phenothiazines or reserpine *(25)*. Documentation of the rates of ADRs associated with SSRI use varies, however, overall the frequency is high enough to suggest that it is a common side effect *(25)*. With fluoxetine-induced akathisia, a review of the literature revealed rates from 9.7 to 25% *(39)*. Case reports have also suggested an association between SSRI use and obsessive suicidality and aggression *(24,25,39)*.

In 2004, Breggin formulated the syndrome of SSRI-induced obsessive suicidality and violence. SSRI-induced obsessive syndrome is characterized by the following:

- Sudden onset and rapid escalation of compulsive aggression.
- A recent initial exposure to medication, change in dose, or introduction or removal of another psychoactive drug.
- Presence of ADRs including akathisia or stimulation ranging from irritability and agitation to agitated depression and mania.
- Resolution of the syndrome after cessation of the medication.
- Violent or bizarre thoughts or actions.
- Obsessive thoughts or actions.
- Behaviors that have not been demonstrated previously in the patient's history.
- An alien or ego-dystonic behavioral or thought pattern determined through the patient's subjective views *(39)*.

Breggin suggested that patients fulfilling the eight characteristics detailed above, who commit suicide, become violent, or act criminally without previous history of criminal activity could be reacting to the effects of the SSRI drug. The review and analysis by Breggin *(39)* into sucidality, violence, and mania caused by SSRIs provided a strong basis for recognition of antidepressant-induced manic-like reactions and akathisa as frequent ADRs. In forensic medicine, the recognition of SSRI-induced ADRs can form a base to establish causality in malpractice, product liability, and criminal cases *(39)*.

In 1994, Breggin and Breggin were the first in the public sphere to detail the potential for SSRI-induced obsessive suicidality and violence. In their text *Talking Back to Prozac: What Doctors Aren't Telling You About Today's Most Controversial Drug,* press reports, clinical cases, and a re-analysis of the CCT data related to Prozac formed the basis for their theory related to SSRIs inducing aggression, suicide, homicide, and violence. The specific focus of the analysis was on the SSRI Prozac. The Breggin and Breggin text included a reanalysis of the FDA data, interviews with FDA officials, review and analysis of the literature, and review of a large number of media reports and of clinical consultations *(24)*. Also included in the analysis was a comparison of amphetamines and Prozac, as well as a reanalysis of efficacy data. Breggin and Breggin concluded that the drug had little, if any, beneficial effect and very significant risks, particularly in the initial stage of usage with a change in dosage or in withdrawal from the drug *(24)*.

Following concerns raised in Britain *(40)*, in a recent media release the FDA *(41)* noted that:

> *In letters issued today FDA directed the manufacturers of all antidepressant medications to add a 'black box' warning that describes the increased*

risk of suicidality in children and adolescents given antidepressant medications and notes what uses the drugs have been approved or not approved for in these patients. FDA's letters to manufacturers also discuss other labelling changes designed to include additional information about pediatric studies of these drugs. These labelling changes are applicable to the entire category of antidepressant medications because the currently available data are not adequate to exclude any single medication from the increased risk of suicidality.

What is unclear about the changes to warnings required by the FDA as well as the British Medical and Healthcare Products Regulatory Agency (MHRA) into the use of all SSRIs except Prozac for pediatric and adolescent use are the implications that this may have for use of the drugs in the adult population. The Breggin and Breggin analysis had a strong emphasis on adult risks. In addition, the FDA did not appear to address the potential ineffectiveness of the SSRI drugs for use in children and adolescents, nor potential issues of increased risk of hostility and aggression. This is in contrast to the MHRA's indication that only fluoxetine had demonstrated efficacy in the treatment of major depressive disorder (MDD) in children and adolescents and that with the other SSRIs sertraline, citalopram, escitalopram, fluvoxamine, paroxetine, venlafaxine, and mirtazapine the risk/benefit balance is unfavorable or non-assessable *(40)*. There appears to be a difference between the MHRA and the FDA responses, with the FDA being slower to respond to the issues, requiring a black box warning on all antidepressants for use in children and adolescents, including older types of drugs that do not appear to have the same degree of risk as SSRIs.

Ten years later, regulating bodies including the MHRA and the FDA have taken action to address aspects of the original Breggin and Breggin analysis *(40,41)*. In late 2003, the MHRA contraindicated the use of all SSRI drugs on children except for Prozac *(40)*. Their major concern related to increased suicidality and ideation of suicide in children and adolescents that was finally revealed through the meta-analysis of published studies as well as discovered data that had not previously been in the public sphere *(40,42,43)*. Almost another year later the FDA took action on the same issue and now requires a black box warning to be placed on all antidepressants *(41)*.

The time delay between the concerns raised by Breggin and Breggin in 1994 and the action of the regulating authorities raises serious questions as to their function in protecting human rights. In addition, given the original Breggin and Breggin analysis, only issues of use in children and adolescents have been the focus to date and potential issues of use in adults have not been adequately addressed. The FDA action in relation to a black box

warning on all antidepressants also raises another question. Why have the older types of antidepressants been required to have the black box warning when clearly the issue recently unearthed in research related specifically to SSRI drugs? Also, why has the FDA not followed the same course as the MHRA that had noted that only Prozac, on clinical data presented to date, had shown to be effective in the treatment of MDD in children and adolescents?

Breggin, as noted earlier in this chapter had been dismissed by promoters of biopsychiatry. However, it is now clear that if more attention had been paid to the concerns he raised in 1994 a significant number of lives of both children and adolescents may have been saved. The other paradoxical aspect of the SSRI crisis is that the original analysis by Breggin and Breggin *(24)* clearly highlighted issues related to the drug Prozac. The MHRA has continued to permit the use of Prozac for the treatment of children and adolescents for MDD *(40)*. Has there been sufficient analysis of the risks associated with the treatment of children and adolescents with Prozac? Has there been adequate detailed analysis of the risk and effectiveness of treatment with SSRIs in adults? It would appear on the surface that adequate risk analysis of the overall use of the class of drugs may not have occurred.

Pharmaceutical Companies, the Control of Academia, and the Construction of Knowledge

Foucault noted that knowledge is power and that the control of discourse in society forms the basis of governmentality. Through the control of discourse knowledge is constructed in a society through the regulation of experts who define fact and fiction. In risk society theory, the downplaying of risk and selective transmission of knowledge based on the consensus of experts becomes the central game in the transition towards the future. Dismissal of concerns raised by critics, as in the case of Breggin, often involves shooting the messenger. This is one example of governmentality in which the hegemonic view dismisses concerns raised by critics instead of attempting to investigate and resolve problems.

The *David Healy Affair* provides another example of governmentality in relation to biopsychiatry in action and the negative sum game of claim and counterclaim in relation to risk exemplified by the crisis surrounding the use, particularly the off-label use, of SSRI drugs in the United States and Britain. The controversy revolved around the withdrawal of a job offer following the delivery of a lecture by Dr. David Healy titled *Psychopharmacology & The Government of the Self* (44).

The lecture by Healy provided a historical review of the development of biopsychiatry and controversial claims in relation to the control of scientific findings. In the lecture, Healy's analysis is at its core based on concepts related to the risk society theory. Following the withdrawal of a position at the Centre for Addiction and Mental Health (CAMH), Healy's letter of compliant to the Chair of the Board of Trustees Ethics Committee in February 2001 delineated three claims that he perceived as central to the issue *(45)*. To quote from the letter:

> *On the evening of the 30th the CAMH had a gala meal. At this, I set up what I thought would be a simple conversation with Dr Goldbloom. He was too livid to engage in any constructive discussion. But he managed to say that people only remembered three things from a talk and all they would remember form mine were claims that Prozac could cause suicide, that Lilly knew about this, and that high dose antipsychotics had caused brain damage.* (45)

In his letter Healy stated, "On Dec 8th when I arrived home, I found an email from Dr Goldbloom telling me my job offer had been rescinded" *(45)*. Healy noted in his communication that the talk was a synopsis of a text to be published by Harvard University Press, noting that the back cover review would indicate that the text will be claimed to be the most important book on the history of psychiatry since Ellenberger's *Discovery of the Unconscious (45)*.

The statement by Healy in his lecture that may have been the key to the withdrawal of his job offer was:

> *I happen to believe that Prozac and the other SSRIs can lead to suicide. These drugs may have been responsible for 1 death for every day that "Prozac" has been on the market in North America. In all likelihood many of you will not agree with me on this—you haven't seen the information I have seen.* (44)

The lecture had a broader focus dealing with the history and changes in biopsychiatry over 50 years. However, the claim over concern of increased chance of suicide as risk associated with SSRI drug use appeared central to the attempt to control academic discourse. As noted earlier, this type of claim had been raised previously in the public arena by Breggin and Breggin *(24)* in the text *Talking Back to Prozac: What Doctors Aren't Telling You About Today's Most Controversial Drug.* The concerns raised in the Breggin and Breggin *(24)* text and also Healy's comments in the lecture appear to be somewhat endorsed given the restrictions related to all SSRI drugs, except Prozac, for use on children and adolescents in Britain and the recent requirement by the FDA of the inclusion of a black box warning label on antidepressants.

As noted, Healy's lecture detailed a brief comprehensive synopsis of the history of psychiatry and raised many issues in terms of the relationship between psychiatry and the role that the development of new drugs have in the modern era and their interaction with the social order *(44)*. He indicated that the development of not only psychiatric medications but also drugs including oral contraceptives, Viagra®, and other forms of medical intervention including cosmetic surgery are interacting with society and social constructs in ways that change the nature of society itself *(44)*.

Healy described the development of psychiatry in the modern era and highlighted that the critical turning point between the psychiatric and antipsychiatry movements of the 1960s, fueled by the works of psychiatrists or philosophers, including Foucault, Szasz, and others, as being replaced by a new form of psychiatry—corporate psychiatry *(44)*. In this regime, corporations work out what products they have to market and conditions the markets to purchase their products.

Core to Healy's analysis is the risk society theory. The modern, through seeking to control risks, creates unforeseen and unpredictable risks. As Healy stated:

> *This was not just the replacement of theology and philosophy—the qualitative sciences—by a new set of quantitative sciences. The new statistics set up something else. They set up a market in futures. A market in risks. We are on our way to becoming a Risk Society.* (44)

In psychiatry the drugs, particularly the SSRIs and the increased use of drugs such as Ritalin, have a risk discourse associated with their promotion within society. The use of SSRIs for the treatment of depression has been claimed to reduce the risk of suicide. With Ritalin and other drugs used for the treatment of ADHD, parents have been told that unless their child is treated she/he will have a risk of a poorer prognosis in adolescence and adulthood. This form of discourse, used to encourage reluctant parents to medicate their children, was first used in the late 1960s in the United States. It began with the use of the predescendant label of ADHD, hyperkinesis. In the period, parents were told their children had a risk of developing malignant personality disorder in adulthood unless they were treated *(33)*. However, as illustrated with the case of SSRIs possibly causing suicide, there is a counter-risk as detailed associated with biopsychiatric intervention in congruence with the analysis of Breggin *(25)* and Whitaker *(35)*: the risk that treatment worsens outcomes.

Some of the key issues of concern of the new corporate psychiatry Healy claimed are that *(43–45)*:

- A significant proportion of scientific literature is now ghost written.

- A large number of clinical trials are not reported if the results don't suit the pharmaceutical company.
- Clinical trials are multiply reported in different journals using different authors so any form of meta-analysis is difficult as a result of trying to conclude how many trials there have been.
- Important data such as quality of life scale results on antidepressants have been almost uniformly suppressed.

Healy indicated that this is not science and that this type of manipulation of science has been combined with market development plans that create patient lobby groups to lobby and promote new treatments *(43,44)*. This claim has a remarkable congruence with Breggin's construct—the psychopharmaceutical complex *(27)*. Combined with this is the increased, if not prolific, use of rating scales used in educational systems for identification of ADHD, depression, and other mental disorders. As children fall outside of the norms of the rating scale parents are encouraged, if not mandated, to treat children with drugs to minimize risk. Healy noted, again in congruence with the work of Breggin, that when we are treating children under the age of five with drugs like Prozac and Ritalin that we are not treating diseases as such *(27,44)*. Healy directly attacked the new cooperate psychiatry concluding that, particularly in the case of children:

> *The explosion of drug use in children is a manifestation of the force that makes markets, that underpins the market development of pharmaceutical companies and others. This is the force that creates pharmaceutical companies. The treatment effects from clinical trials have been taken to be findings that generalise across the community—they are taken to indicate that these agents will return children within the set of norms that will minimise future risks. What parent could not want to minimise future risks for their child.* (44)

Healy's analysis ends in a scenario of reform and scrutiny of corporate psychiatry or moving into a future in which the risks and potential threats to society "may not be as gentle and painless as we might once have expected" *(44)*.

In 2004, Healy presented estimates of the extent of the use of the new antidepressants in the United States. He noted that since the launch of Prozac in the United States in 1988, 50 million people have taken Prozac, Paxil, or Zoloft; approximately 16 million people have been prescribed Prozac, Paxil, or Zoloft annually; and approximately 30 million Americans have been prescribed an antidepressant annually *(43)*.

Chronic use of the medications, indicating the possibility of addiction to the SSRIs is also a significant risk not addressed by the MHRA or FDA.

Healy reported that this possibility was reflected by the 4 million Americans taking Paxil, Prozac, or Zoloft for more than 5 years; 6 million on Paxil, Prozac, or Zoloft for more than 3 years; and 9 million on Paxil, Prozac, or Zoloft for more than 1 year *(43)*. Healy also pointed out that this was for an illness that lasts on average 12–16 weeks. Healy claimed that since the launch of Prozac these drugs have caused somewhere between 20,000 and 70,000 excess American suicides *(43)*. His criticism of the oversight of medical practice is reflected in his claim that Americans track 100 times more accurately the fate of parcels put in the post than the fate of children and adults dying on these drugs *(43)*.

The social costs of Healy's analysis combined with the hidden risks of vast numbers of individuals staying on medications that effectively have no long-term research or even variable positive research outcomes in clinical trials in the short-term, creates a scenario where the prediction of outcomes for the society are unknown.

However, it is clear that there are significant risks to the individual under treatment and also to the pharmaceutical companies, research scientists, academics, and even prescribing medical practitioners as a result of widespread acceptance and use of the newer antidepressants supported by conflicting and, in some circumstances, manipulated selectively transmitted knowledge to regulating authorities and the society at large.

Litigation proceedings in the form of class actions, individual actions, and legal suits related to the withholding and/or suppression of data from clinical trials, illustrated by the potential legal case in which Britain's largest pharmaceutical company withheld important data from clinical trials regarding their SSRI drug *(46)*. The data reported as being withheld indicated an increased risk of suicide and "self-harm" if prescribed to depressed teenagers. Exposure of this presents significant financial and image risk to pharmaceutical company *(46)*. The same company is also under suit over the same matter by the New York Attorney General for the same reasons *(46)*. Legal suits in the forms of class actions, individual litigation related to suicide, the use of defenses related to criminal actions claimed to be a result of antidepressant drug treatments, and litigation as a result of ADRs are appearing in large numbers across the United States and other countries. No doubt, claims and counterclaims of scientific experts will be used to support or downplay risks. The uncertainty factor in relation to scientific evidence coupled with the claims that the treatments, as Geddes and Cipriani noted, for "one of the great health problems of our age" are necessary for the disorder and provides an avenue for possible defense of pharmaceutical company interests *(47)*.

Healy, in his letter to the FDA, provided specific detail of what in his analysis was the reasons for the apparent delay in the release of data and the use of coding to minimize negative results of drug tests. He referred in the letter to the operations of the Central Medical Affairs team, a division of SmithKline Beecham whose role is to manage issues across the company's pharmaceutical products *(43)*. Healy reported that in 1992 SmithKline was requested by the FDA to conduct studies of Seroxat®/Paxil on children as part of the approval process for adults *(43)*.

Healy detailed the results of Protocol 329, the largest trial of any SSRI on children. He claimed that the results were inconclusive; the drug did not work in general and in terms of hazards the results were conclusive—5 suicidal acts from 93 children on the drug vs 0 from 89 on placebo and 1 from 184 on imipramine or placebo *(43)*. In addition, approximately 10% of children had psychiatric side effects. He reported that the results of the study were published 5 years later in the *Journal of the American Academy of Child and Adolescent Psychiatry*, with an authorship including distinguished US figures in psychiatry *(43)*. The paper concluded that the drug was safe, effective, and well-tolerated in children. In the published study, suicidality was coded under emotional lability and aggressive events were coded under hostility *(43)*. Healy made reference to a Central Medical Affairs team document that indicated that another Protocol 377 was even more negative and there were no plans to publish the study. In addition, there were other studies, 511 and 716, not released *(43)*.

Healy's analysis regarding significant risks associated with SSRIs is in congruence with the analysis of the MHRA. Similarly, Mosholder in a memorandum to the FDA on February 18, 2004 recommended that:

> *Given the strength of the association shown by the present data, the clinical importance of the apparent effect (i.e., an estimated excess of one additional serious suicide-related event per 12 patient-years of active treatment), and the fact that the additional analyses are likely to take several more months to complete while considerable numbers of pediatric patients are being exposed to these drugs, I favour an interim risk management plan regarding use of these drugs in the pediatric population. … Specifically, I propose a risk management strategy directed at discouraging off-label pediatric use of antidepressant drugs, particularly the use of drugs other than fluoxetine in the treatment of pediatric MDD.* (48)

Healy reported that there is a crisis in scientific literature in that all published articles on randomized trials describe SSRI drugs universally as safe, effective, and well-tolerated in children and adolescents *(43)*. However, under closer scrutiny it is apparent that 13 of the 15 published trials the drugs were neither effective nor safe *(43)*.

In relation to the referred publications of these Healy stated that:

> *While it is not FDA's brief to regulate the academic literature, the possibilities of a close to fraudulent representation of the data and of extensive ghost writing does set up an argument that these apparently scientific articles are in fact infomercials rather that the real thing. If these articles are essentially advertisements, it is much less clear that FDA can throw their hands up and plead an inability to do anything about the production of such materials, when such materials have almost certainly in the case of study 329 led to a significant increase in off-label use of Seroxat/Paxil, while the company behind the article stalled on handing over data to FDA that had been generated in the first instance following an FDA request to have such data for safety purposes.* (43)

What is revealed in Healy's letter to the FDA is astonishing. Healy claimed that 10 days before the 2004 FDA hearing the American College of Neuropsychopharmacology (ACNP) Task Force released a report indicating that a possible reason that the academic literature was at odds with the raw data was possibly related to significant ghost writing input *(43)*. The ACNP Task Force reported SSRIs to be effective, safe, and well-tolerated, however, the authors claimed that this could be incorrect because they had not seen the raw data for the studies *(43)*. However, Healy observed that three of the authors on the ACNP Task Force were listed as authors in almost all of the randomized trials in addition to Protocol 329 *(43)*. He then asked the question, "How can they claim not to have seen the raw data?" In addition, two of the authors of the ACNP Task Force report were also authors of TMAP guidelines that had also implied that SSRIs are safe, effective, and well-tolerated in children *(43)*. The TMAP guidelines have been adopted in 13 states and, as noted earlier, in Texas alone have brought very significant financial returns to pharmaceutical manufacturers of the drugs concerned. The three authors Healy named in his letter are eminent academics at prominent universities in the United States. The review by Healy brings into question the operations of pharmaceutical companies, the academics involved, the role of the FDA, and the new science of corporate psychiatry. Healy's analysis and revelations further confirm the existence of the psychopharmaceutical complex as reported earlier by Breggin in 1998.

Concluding Remarks

The beneficiaries of corporate psychiatry are the pharmaceutical companies and academics receiving research grants, academic credit for ghost written literature, and subsequent acclaim from the community for their achievements. The losers are obvious—the children and adolescents, their parents, and families who have potentially suffered and even witnessed sui-

cide within their family, potentially caused by the medications prescribed for their treatment. Information relating to this risk appears to have been hidden or delayed in release for the purpose and profit of corporate psychiatry.

The black box warning requested by the FDA on the antidepressant labels is insufficient. The black box warning should be put on the operations of the FDA, corporate psychiatry and the academics who, if Healy's claims are accurate, ultimately should be made accountable for misleading, if not fraudulent and possibly even criminal behavior. The focus of this overall text is that of evil. Profit at the expense of potentially hundreds, if not thousands, of children's lives is evil.

However, the issues raised are not new to corporate psychiatry or to the role of the FDA. Similar problems were noted by Hughes and Brewin in 1979 *(49)*. Hughes and Brewin's analysis in *The Tranquilizing of America* resonates with Breggin's and Healy's analysis. Hughes and Brewin documented the proindustry bias of the FDA, an agency that is supposed to be responsible for protecting the public against unsafe or ineffective drugs. Hughes and Brewin concluded that particularly in relation to psychiatric drugs that the FDA acted in some cases as if "the public were the adversary and the industry the friend" *(49)*. These authors specifically detailed intimate relationships between the FDA and the pharmaceutical manufacturers evidenced by:

- Private meetings between the representatives of drug companies and the FDA that are held from public and media scrutiny.
- The lack of public voice in the FDA process.
- Professionals with the FDA attempting to take an advocacy position in favor of public safety being "systematically silenced."
- Advisory committees to the FDA containing members "who received a lot of money from drug companies for research," thus being in position of conflict of interests in decision making.
- Dismissals of panels of outside experts and appointments of new panels with a "more sympathetic" view of "drug therapy in general" *(49)*.

The manipulation of the FDA by the pharmaceutical industry was documented in the US Congress in an inquiry in 1974 chaired by Senator Edward Kennedy *(49)*. The summation of the findings of the inquiry indicated that in relation to the role of the professional reviewers for the FDA that:

- Recommendations for approval of drugs were never questioned, however, disapproval was "almost always questioned."
- Efforts by reviewers to reject drug approval applications resulted in "repeated harassment by FDA officials—that files were altered or modified."
- Industry pressure influenced the review process.
- Reviewers were removed from the process of review following disapproval of a drug.

- Reviewers who did not comply were "transferred out of their divisions, pursuant to efforts to get specific drugs approved" *(49)*.

The frightening aspect is that it is probable that Foucault's tenet of governmentality will prevail and the discourse will be controlled by the consensus of biopsychiatric experts, as it has in the past. Beck's tenet concerning the risk society of the claim and counterclaim played out in the public sphere will prevail with health professionals governed by the discourse of experts, recommending algorithm approaches to interventions such as TMAP for them to follow. Szasz's pharmacracy appears to be becoming a reality through recommendations for mass screening of citizens for mental health disorders, promoted ultimately by governments spurred on by campaign donations and the cry of the need to help those suffering in silence as a result of failure to diagnose their psychiatry disorder. This creates images of a risk society in which risks are controlled through chemical straight jackets and individual human rights disappear into the vacuum of individual immorality and corporate greed—the essence of modern evil.

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Chapter 4

Intention, Excuse, and Insanity

Tamas Pataki

Background

Culpable intent has been a central element of *mens rea* in systems of criminal law since early times, but absence of culpable intent has not featured explicitly in most insanity tests since the time of *McNaughtan*. Most tests since then have been based on two other traditional elements of excuse: ignorance and compulsion (or duress). This chapter briefly reviews the background of this development and the reasons why absence of intent has not figured more prominently as an excusive factor in insanity defenses. Given the character of the offenses, the presence of criminal intent often seems indefeasible. It is argued that although many intentions may appear to be present, it is far from evident that those intentions or reasons that do have an efficacious or motivating role in the defendant's actions, those reasons for which and those intentions with which the agent actually acted, are in fact criminal. For many relevant cases there is indeed intention that can account for the appearances and characteristics of intentionality in the defendant's actions, but the efficacious intention is unconscious and nonculpable, and therefore not criminal—both because it is unconscious and because, in most cases, it is not a culpable intention. If the argument can be sustained, then the emphasis in determining absence of *mens rea* in some cases of insanity should shift from what the agent didn't know or was (internally) compelled to do to what he intended; a position that seems more aligned with procedure in the ascertainment of legal responsibility elsewhere in the law.

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Actus non facit reum, nisi mens sit rea (The act does not make the crime, unless the intention is criminal).

Introduction

In most known systems of criminal law, a determination of criminal responsibility has required that the physical aspects of the offending act—the *actus reus*—must originate in culpable subjective conditions or states of mind referred to as *mens rea*. The most important of these conditions is the culpable intention, intent, or will to bring about the criminal act. Intentional action presupposes that there are reasons for which the agent acts, and that implies an aim (or aims) that the agent tries to achieve, as well as technical beliefs or knowledge or skills used to achieve the aim. It would also seem to require knowledge or awareness of what is being done at the time that it is being done, at least under the description that the act is intended. That is, intentional action is intentional also in the philosopher's technical sense of having an aim or object and that aim must be kept in sight during the performance of an action. Someone waving intentionally to a friend will know that he is doing so; if he cannot monitor his action his intention is likely to fail of its target. He may not know that he is also casting shadows and alarming the pigeons, though these are the very same act-event under different descriptions[1]. And, of course, if the agent does not know that he is alarming the pigeons he cannot be doing so intentionally. One might say that these are cognitive, or at least doxastic, conditions internal to the structure of an intentional act. Other elements of *mens rea* are concerned less directly with the intentional structure of the offending act. They focus on the degrees of circumstantial knowledge (or the absence of knowledge): what an agent knows, ignores, or should know of distal consequences and general norms regarding the act. These elements include recklessness, advertent or culpable ignorance, or negligence and inadvertent negligence. Recklessness may involve, for example, ignoring the possibility of an act's harmful consequences; some forms of negligence may involve not knowing matters that one is obliged to know, and so on. (There are other circumstances in criminal law in which knowledge of an act, even an act in which one does not have an agential role, can render an agent culpable, but such cases will not concern us.)

Contemporary systems of law recognize a range of justifications and excuses and (what is different) mitigations of liability for putatively criminal

[1] This way of individuating actions has been commonplace since G.E.M. Anscombe's Intention (Oxford University Press: 1957).

acts. It may perhaps be said in general that justifications (lawful self-defense is an example) negate the criminality of the act; mitigating circumstances, such as abnormal states of mind not amounting to insanity (a mind in the throes of ineluctable passion, for example) do not negate responsibility but may diminish it, and that excuses, although not rendering the offending act lawful, negate or qualify criminal responsibility by appealing to absence of *mens rea.* The excuses are a mixed bag. Absence of culpable intent, nonculpable ignorance, duress or compulsion, necessity or certain kinds of mistake or circumstantial ignorance may be invoked (although it is important to note that ignorance of the law, when the law is clear, is not an excuse). In these cases the *actus reus* is conceded but *mens rea* is denied. The excuses typically find application in cases involving the ignorant, the misled, the coerced, the insane, and the intoxicated. It has also been argued that there is another kind of excuse, or rather, a kind of foreclosure of responsibility, which is specific to the insane and children. It is claimed to be predicated not on absence of *mens rea* but on the absence of the status as a rational being that is presupposed in any judgment of legal responsibility *(1,2)*.[2]

The understanding that some types of mental illness should relieve a defendant of criminal liability is very old in Western thought. Notwithstanding the views just mentioned, the dominant approach has been to identify insanity as those forms of mental illness that excuse the agent from criminal (and other legal) liability. On this view, it is because legal insanity is characterized by the absence of one or more material elements of *mens rea* that it excuses, and is therefore akin to defense in law *(1)*.[3] Of course, the types of mental illness are many and the excuses relatively few. So it is unsurprising to see most of the diverse insanity tests formalized, from the time of *McNaughtan*, as attempts to retain the traditional framework of excuses by filtering out those features of mental illness that exemplify, or can be translated into, that framework. Thus, in relevant circumstances, a psychotic delusion may be under-

[2] For example, in Herbet Fingarette *(1)* and Michael S. Moore *(2)*. Fingarette writes: "Insanity and childhood both preclude responsibility status, and they therefore preclude moral judgements and legal judgements of criminality. In these conditions, questions of knowledge and appreciation of what one is doing or of its wrongness, or questions of voluntariness, self-control, or intent become beside the point " (p. 141).

[3] Chief Justice Weintraub: "although we sometimes speak of insanity as a defense, it is not a separate defense, as we lawyers use that concept, to a case that the state has otherwise established but, rather, it is essentially a denial of the state's main case, a denial of *mens rea*" (cited in ref. *1*, p. 130.)

stood as (causing) a mistake of fact or ignorance of some fact material to the act; impulsive or compulsive behavior may be interpreted on a model of internal duress or compulsion; psychotic confusional states may be understood as causing ignorance of the nature of the act or inability to appreciate its wrongfulness; and so on. Some tests, such as the American Law Institute's Definition of Legal Insanity in the 1950s ("A person is not responsible for criminal conduct if at the time of such conduct as the result of mental disease or defect he lacks substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of law") are framed in fairly general terms. However, even here the defense would ultimately establish the traditional excusive conditions, together with the fact that they were caused by specific features of the mental disease or defect.

Given its irreducibly normative character, it is hard to see how else the law could proceed on such fundamentals. That is not to say, of course, that there is no further scope for analytical refinement within the recognized excuses or that the legal process always succeeds in filtering out all those features from the immensely variegated range of mental disorders that do in fact excuse on traditional terms. Nor is it to suggest that the law is immune to conceptual shifts that may eventually undermine or attenuate its reliance on that paradigm of the law, the (more or less) integrated, rational, reasonable man. Since the 18th century, developments in philosophy and science and, more recently and dramatically in neuroscience and psychiatry, have been straining those very conceptions, which constitute the normative foundations of law. Increasingly, the more serious mental disorders are being conceptualized in neurobiological terms, which, on the surface, have nothing of the normative in them. Although I believe that these metaphysical issues do impinge on the subject at hand, I take the view (a) that the best understanding we have of the vast majority of mental disorders is still in terms of the extended common sense or folk psychology, which is the clinical language of psychoanalysis and its kin, and (b) that because of its irreducibly normative character, the judicial understanding of insanity will always require the translation of neurobiological characterizations of mental disorder into the common sense idiom.

The alternative approach of Fingarette *(1)* and Moore *(2)*, noted previously, opposes the supposition that if insanity exculpates it must be assimilable to one of the standard forms of excuse. The criminally insane in their view are neither innocent nor guilty: they are fundamentally irrational and therefore do not have responsibility status under law. They do not, says Moore *(2)*, have the status of persons. He writes, "the insane, like the very young, are not sufficiently rational to be fairly blamed or punished. If this is so, then

lawyers should give up the attempts to define legal insanity in a way that collapses into some traditional excuse. Crazy people are not responsible because they are crazy, not because they always lack intentions, are ignorant, or are compelled."

There is something right and something wrong about this. It is true that the insane are irrational, if that concept is given sufficiently broad extension, and therefore not subject to legal liability. But it is unclear how that condition either conflicts with or is antecedent to being under the sway of mad beliefs and desires, delusions and compulsions, the incapacity to form appropriate intentions and decisions, and so on: that is, the detailed substance of the traditional tests. Fingarette *(1)* says that "Conduct is insane, crazy, mad, irrational when it is not shaped in the light of certain norms. These norms are not only norms of correct inference or valid argument; they are norms regarding what emotions, or mood, or attitudes, or desires are in some sense suitable or proper with respect to certain other aspects of one's situation." And, he provides a definition of criminal insanity: "The individual's mental make-up at the time of the offending act was such that, with respect to the criminality of his conduct, he substantially lacked capacity to act rationally (to respond relevantly to relevance so far as criminality is concerned)." Similarly, to be grossly irrational and therefore mentally ill is, on Moore's *(2)* account, to be a very bad practical reasoner: such a person accepts irrational beliefs and desires as the premises of his practical syllogisms and presumably, though Moore does not spell this out, is unable to draw valid conclusions (i.e., form appropriate intentions, decisions, or proceed to apt actions). But, how is irrationality to be identified? Fingarette *(1)* says that "we have to do with the observed pattern of incapacity for rational conduct in the individual's life history. The specific issue faced by the trier of fact is not a causal one but is one of practical judgement in assessing a person. The question is whether it is fitting to view the offending act as belonging to such a pattern of irrational conduct." Moore *(2)* is in substantial agreement: "To be mentally ill is to be very seriously irrational" and "we predicate 'mentally ill' of a person whenever we find his pattern of past behaviour unintelligible in some fundamental way."

However, this is unhelpful. A pattern of conduct is not interpretable as either rational or irrational unless we know beforehand the agent's motivating desires, beliefs, and intentions, which reveal what is being done intentionally and what is not. Otherwise the pattern remains opaque. These precursors of action are precisely what the triers of fact will be considering in coming to a judgment about a defendant's state of mind and are nothing other than the material of the traditional tests. Moreover, it suggests that what is being tried in court is not the criminality of the offense but the character of the defen-

dant; not only one's state of mind at the time of the offense but one's state overall as this may be revealed by a larger pattern of conduct. I agree that the insane are irrational, in a sufficiently catholic sense, but for that notion to advance our understanding it must be unpacked in terms of irrational beliefs, desires, and the formation of intentions.

The Thesis

Culpable intent, I said at the outset, is the central element of *mens rea* and it reasonably could be expected that its absence would be the foundation of legal defense on grounds of insanity. I think that, by and large, the history of the defense satisfies that expectation, although not always on the face of it, and some scholars have asserted the historical priority and conceptual relevance of other conditions of excuse. Summarizing the history of insanity tests, Moore *(2)* notes that the earliest tests for insanity were based on analogies with children and animals and that from the time of *McNaughtan* there are "basically two kinds of traditional insanity tests: those based on ignorance of the mentally ill accused person and those based on some notion of his being compelled to act as he did." [4] This accent, first on irrationality—that is what Moore thinks the ancients adjudged the common characteristic between child and beast—and then on ignorance and compulsion *at the seeming expense of intention* seems to me mistaken both as to the understanding of the historical record and as to the proper appreciation of the excusive factors in a significant class of cases of insanity.

It is easy to see why absence of culpable intent could be seen as taking a back seat in defenses based on insanity: it appears obvious that in most relevant cases the complex sequence of action-events that constitute the *actus reus* are intended, organized toward a goal, sometimes planned over an extended period of time, and patently not in the same category of agency as sleep-walking or the motor movements in epileptic automatism or other neurological diseases. Moreover, the defendants themselves will frequently avow an intention that is criminal and on which they believed they acted.

It seems to me that although many intentions and reasons for acting, some of them perhaps criminal, may be present in the minds of some defendants at the time of the alleged offences, and that still other intentions may appear to be present (really only apparent intentions), it is far from evident that those intentions or reasons have an efficacious or motivating role in the defendant's actions; that is, those reasons for which and those intentions with

[4] Ref. *2*, p. 221.

which the agent actually acted are in fact criminal. I want to begin by showing that in many relevant cases there is indeed intention accounting for the appearances and characteristics of intentionality in the defendant's actions, but that the primary, efficacious intention is unconscious and nonculpable, and therefore not criminal—because it is unconscious and, in most cases, it is in itself not a culpable intention. If the argument can be sustained, then the emphasis in determining absence of *mens rea* in some cases of insanity should shift from what the agent did not know or was compelled to do to what he intended; a position that seems more aligned with procedure in the ascertainment of legal responsibility elsewhere in the law.

Some History

A sketch of some stages of the historical record may be useful. The idea that intention is a primary factor in determining guilt and assessing liability is very old in Western legal thought. Draco in the seventh century BC distinguished two categories of crime, the intentional and the unintentional, instances of the latter constituting lesser offenses *(3,4)*.[5] Four centuries later, Demosthenes elevated the distinction to natural law:

> *Among other people I find this sort of distinction universally observed. If a man has gone wrong wilfully, he is visited with resentment and punishment. If he has erred unintentionally, pardon takes the place of punishment. …The distinction will be found not only embodied in our statutes, but laid down by nature herself in her unwritten laws and in the moral sense of men.*[6]

In the 13th century the leading authority, Bracton, expressed the idea succinctly: "Remove will and every act will be indifferent. It is your intent that differentiates your acts, nor is a crime committed unless an intention to injure exists; it is will and purpose which distinguish *maleficia (3)*." [7]

A recent, representative statement also affirms the centrality of criminal intent, but then in a significant muddying of the waters, which by this time has considerable historical precedent, fails to explain whether the concepts of cognition and volition that are introduced beside intention are analysans of it or additional new elements.

> *The precise words of any formulation on criminal responsibility are not particularly important. The important thing that we must remember is that*

[5] Here I have relied principally on Daniel N. Robinson (ref. *3*) and J. M. Kelly (ref. *4*).
[6] Ref. *4*, p. 34.
[7] Ref. *3*, p. 100.

> *mens rea, criminal intent is the center of it. That is the inquiry the law is making, and any test or any formulation is adequate if it is based upon the concept of cognition, that is, recognition of the nature of the act and its wrongness, and volition or capacity to control conduct. …If [the standard] doesn't have those elements, it breaks continuity with all of the law of the past.*[8]

Ancient Greek and Roman law gave considerable statutory attention to matters of competence and the legal standing of minors and the insane. The general tendency was to regard insanity as a condition legally akin to infancy. The standard model for the insane appears to have been the *furioso*, the man who is so crazed or frenzied that he does not know what he is doing, what he is purposing, what he is about. There certainly are people who are like that, at least some of the time, and they ease the judge's task; but the ancient records also show more flexible and accommodating discriminations *(3)*.[9] Like infants, such people do not have the capacity to fulfill the duties of citizenship. They are irrational, a characterization that has many implications, the most important one being their incapacity to form and act on rational intentions (entering into contracts for example) in ways for which they can be held accountable. Medieval Christianity added little to Roman (and Germanic) law overall, but because it assimilated crime to sin and taught that possession by demons was voluntary and a sin and the cause of madness, the relatively humane treatment of the insane afforded by the ancients was considerably diminished where these elements of Christian teaching took hold.

When St. Augustine pleads for the insane, "For how can a man be called guilty who does not know what he has done?" he appears to privilege another element of excuse, ignorance, or the absence of knowledge of the act.[10] However, the context (these individuals have acted "unknowingly and not freely, but by the impulse of some force, I know not what") suggests that absence of intention is still the crux. A person who does not know what he has done can hardly have done it intentionally. If, for example, he does not know that he is scaring the pigeons (while waving to a friend) he cannot be doing that intentionally. He is, of course, unlikely to know all the descriptions under which his actions fall and therefore he will be ignorant of all that he does. But of what falls within the scope of his intention it seems he must, consciously or

[8] Warren Burger, Proceedings 10th Circuit, Appellate Court, District of Columbia, 1962 (cited in ref. *2*, p. 130).

[9] Ref. *3*, p. 28ff. Of course, the introduction of antipsychotic medication has done much to mitigate the manifestations of such states.

[10] Ref. *3*, p. 56.

unconsciously, know.[11] It follows that if he does not know, then he is not intending it.

In 1724, Edward Arnold shot and wounded Lord Onslow. Justice Tracy directed the jury.

> *That he shot, and that wilfully [is proved]: but whether maliciously, that is the thing: that is the question; whether this man hath the use of his reason and sense? If he was under visitation of god, and could not distinguish between good and evil, and did not know what he did, though he committed the greatest offence, yet he could not be guilty of any offence whatsoever; for guilt arises from the mind, and the wicked will and intention of the man. If a man be deprived of his reason, and consequently of his intention, he cannot be guilty. …[I]t is not every kind of frantic humour or something unaccountable in a man's actions, that points him out to be such a madman as is to be exempted from punishment: it must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast….*(3)[12]

Tracy enunciates the ancient principle that guilt arises from wicked will or intention and, on one reading, seems to suggest, though perhaps obscurely, the proposition that a person who does not know what he or she is doing cannot be intending it—that seems to be a natural understanding of the final two sentences taken together. With the qualifications noted above, this proposition is surely a fact. On a narrower reading of "a man be[ing] deprived of his reason, and consequently his intention," Tracy's madman seems incapable of even forming intentions. In both cases the primacy of wicked intent is affirmed. But the final summing up does not mention intention, only a radical ignorance or impoverishment of which even children and brutes barely could be examples. There is here an evident tension, and by the time of the classic McNaughtan case (1843), which resulted in the well-known eponymous test, culpable intention as a separate element drops out of the picture, explicitly at least.[13] The main part reads:

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[11] It may seem that a person could intentionally do something and not know it. For example, intentionally alert the residents of a house by ringing the doorbell but not know whether in fact he succeeds in alerting them. But this example trades on an ambiguity in the use of "alert" captured between "trying to alert" and "succeeding in alert(ing)." What he doesn't know isn't what he is intending.

[12] Cited in ref. *3*, p. 134.

[13] Some scholars have maintained that the McNaughtan rules were constructed deliberately around the excuse of ignorance of fact or law, but in light of the preceding discussion of the relations between ignorance and intent and the general primacy of intent in *mens rea* this contention seems questionable.

> *To establish a defence on the grounds of insanity, it must be clearly proven that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong.* (5)[14]

The Case of McNaughtan

Why has the well-tried excuse of absence of criminal intent disappeared explicitly from this test of insanity, and indeed from most of those that followed? Well, contemporary conceptions of mental illness have influenced the tests: the judges who fashioned the McNaughtan tests had a conception of mental illness as delusion foremost in mind; various psychodynamic and neuroscientific conceptions have been influential since Freud's time. Further, as we have seen, the excuses involving ignorance or absence of relevant knowledge can absorb some instances of absence of culpable intent, and it may erroneously be supposed that it can absorb all instances. Finally, it may be because, as previously mentioned, the presence of culpable intent seems all but indubitable in the majority of cases that get to trial; absence of culpable intent is a tough test to pass. We can see that from some comments Moore *(2)* makes *a propos McNaughtan.* In the course of arguing that none of the traditional elements of excuse capture the characteristic that relieves the insane of criminal responsibility he says:

> *First of all M'Naghten* [sic] *had the intent required for murder in England: He shot the gun with the purpose of killing another human being. True, he thought he was killing Prime Minister Peel when in fact he was killing Peel's secretary, Drummond. But such mistakes about the identity of the intended victim never excuse in law, as the doctrine of "transferred intent" has long established. In every ordinary legal sense of the word, M'Naghten (sic) intended the death of another. Similarly he knew the "nature and quality of his act;" he knew its wrongfulness; he "appreciated its criminality." He made no mistakes about what he was doing—he knew he was shooting, and he knew that he was killing—nor was he ignorant of the moral and legal prohibitions against killing. Finally there is no persuasive case for saying that M'Naghten [sic] was compelled to do what he did.*[15]

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[14] Cited from Richard Moran (ref. *5*, p. 169).

[15] Ref. *2*, p. 223. Similarly, Fingarette *(1)* on another classic case:
It is clear that in a plain and natural sense of the words Hadfield knew that he was attempting a kind of murder that is legally and morally condemned with peculiar intensity, namely, high treason…[H]e was engaged, *(Continued on next page)*

All of this I do believe, but only because I am persuaded by Moran's investigations, which reveal McNaughtan as a rational, paid assassin, albeit one evidently less motivated by money than by political aims and hatred of the Tories. McNaughtan was clearly a troubled man but he probably was not mad; it suited Peel's Government, however, to have him believed to be so. If McNaughtan was the mad being that subsequent legal history portrayed, then Moore's assertions appear to me less than certain. In particular, the conviction with which Moore imputes conscious intentionality to McNaughtan's act (and Fingarette to Hadfield's, *see* Footnote 15) seems unwarranted. It is not easy to defeat the imputation of culpable intent in any but the most extreme cases of psychotic disorganization. What follows is an attempt to outline the limited argument against such imputation adumbrated in "The Thesis."

The Argument

Daniel McNaughtan shot and killed Edmund Drummond, mistaking the secretary for the Prime Minister, Robert Peel, who was evidently the intended target. When asked to plead at his arraignment McNaughtan said only: "I was driven to desperation by persecution." Recounting the details of the crime at an earlier examination, one of the arresting officers recalled that on the way to the stationhouse the suspect said that "he" or "she," the officer was uncertain, "shall not destroy my peace of mind any longer." The officer also recalled McNaughtan saying after the arrest, "I know what I'm about." At that examination McNaughtan made a statement:

> *The Tories in my native city have compelled me to do this. They follow, persecute me wherever I go, and have entirely destroyed my peace of mind. They followed me to France, to Scotland…they follow me wherever I go. I cannot sleep nor get no rest from them…I believe they have driven me into a consumption. I am sure I will never be the man I was. I used to have good health and strength but I have not now. They have accused me of crimes of which I am not guilty, they do everything in their power to harass and per-*

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15 *(Continued from previous page)* at his own leisure and without compulsion, in a complex course of conduct which he himself planned and executed; he had a well-formed and specific intent, indeed a plainly criminal intent if one takes the words at their everyday face value. Thus, in any plain and straightforward use of language, he was not acting under an "irresistible impulse" nor was the "governing power of his will destroyed." What we have is irrational conduct, true enough, and based on an irrational belief. But the act was not involuntary, nor was Hadfield unaware of what he was doing (pp. 138–139).

secute me; in fact, they wish to murder me. It can be proved by evidence. That's all I have to say.[16]

His comportment at the trial, much of the evidence adduced there, and the considerations adduced by Moran suggest that McNaughtan was not insane, but let us assume that he was, as the defense argued, suffering delusional insanity; that he conceived the plot to murder Prime Minister Peel, carefully planned and prepared for it, and executed it with the avowed intention of striking at his persecutors.

It is understandable that McNaughtan's own account of his persecution and the constructions the defense based on it should have been taken at face value by his contemporaries. It is very strange that many of our legal contemporaries should accept it as the transparent account of what animated McNaughtan. We have, of course, no confirmable idea of the structure of McNaughtan's motivation, but we know from a psychoanalytic coign of vantage that his story cannot be the whole of it. Let us hypothesize a schematic psychodynamic account. It will be hopelessly oversimplified and incomplete, but its truth is of no importance for our purposes here, only the possibility of something essentially like it being true is. Suppose then that McNaughtan felt intolerably persecuted by an internal object, an aspect or part of himself identified with an object that had been earlier internalized and experienced as being persecutory (or had in the course of time become so), the sort of entity Freud referred to as the superego, or as a forerunner or component of the superego. Suppose further that McNaughtan's defense against this persecution was to externalize the object, to project and identify it with the despised man who was head of a government enforcing a very cruel policy. Killing that thing, which happened to be Peel, would then, in McNaughtan's mind, amount to ridding himself of his tormentor. Something like that could have formed part of the unconscious dynamics that motivated McNaughtan, if indeed he really was mad in the alleged way.

Although McNaughtan did not state that he had intended to murder Peel, much of what he did say before the trial, and his planned and determined conduct, would seem to imply it. However, if something akin to the hypothesized unconscious dynamics obtained, then space for a radically different possibility opens up: McNaughtan did not intend to kill Peel, he only thought that he did. What he intended was to destroy the object persecuting him, which through the mechanism of projective identification happened to be apprehended as the man, Peel. He may have known (almost surely he did) that he was kill-

[16] Excerpt abridged from ref. *5*, p. 10.

ing a man whom he thought was Peel, but it does not follow that he intended to kill that man. We do not, *pace* Bentham, intend all the known consequences of our acts; or, to put it another way, an act is not intentional under all the descriptions we know it under. This can be seen clearly if we formalize some relations between intention and knowledge noticed earlier: where "A" designates an act-event, then (a) if one is intentionally doing A it is true that one knows one is doing A (even when the intending and the knowing are both unconscious).[17] And (a) implies (b) if one does not know that one is doing A then one cannot be intentionally doing A. But (a) does not imply (c) if one knows that one is doing A then (necessarily) one is intentionally doing it. In fact, (c) is false and it is important to see that it is.

When I go running I know that I will erode the heels of my runners. "Running" and "eroding the heels" are different descriptions of the one act—what I do. But I do not wish, will, want, or intend to erode the heels. There is a sense in which the act of heel erosion is *voluntary*: I permit it, I could halt it if I wanted to. But though voluntary, it is not intended: there are no reasons that are my reasons for wearing down the heels: I can form no practical syllogism with a major premise stating a desire for the heel erosion and a conclusion that is an intention, decision, or action to do so. When there are no reasons for which I perform an act, I cannot be performing it intentionally. There are, in fact, several other kinds of action that are voluntary but not intentional. Shivering with cold is not actively willed or done intentionally, but it is usually something that could be halted by an act of will, and so is partly subject to will or *passively voluntary*, in the sense that it is permitted to continue. There is a large class of *expressive* actions, such as laughing, smiling with pleasure, and clenching one's fists in anguish that are passively voluntary, and not actively willed or intended. Indeed, when one tries to do them at will or intentionally they immediately lose their expressive force.

So McNaughtan may have known that he was killing (a man he thought was) Peel, without intending to, although he believed that he intended to do so and believed that he had good reason to do so. We are then confronted with a number of puzzles. The act that can be described as the supposed killing of Peel (or the pulling of the trigger) has many of the purposeful characteristics of intentional action, suggesting that it was intentional under at least one description.

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[17] The conception of unconscious knowledge or belief is, of course, essential to psychoanalytic understanding and demonstrable clinically. Particularly interesting is Karen Kaplan-Solms and Mark Solms, Clinical Studies in Neuro-Psychoanalysis (Karnac books: 2000): Ch. 8.

The description under which McNaughtan avowed an intention was killing this man (Peel, as he thought). How could McNaughtan go wrong about his intention? And if he was wrong, what exactly did McNaughtan do intentionally that lends the act its intentional character? Finally, even if McNaughtan did not kill this man intentionally, it appears that he still knew that he was killing the man he thought was Peel, so why should his responsibility for the killing be annulled or diminished? "Knowing the nature and quality of the act he was doing" is, after all, precisely what the McNaughtan test specifies for culpable acts.

First, it is necessary to show that an act can be intentional without its agent consciously knowing that it is. That happens when the intention with which the act is being done and the reasons for it are unconscious. But since the action *is* being performed intentionally it has some of the marks of its provenance. The following considerations suggest that the conception of *unconscious intentional action* is not only possible, but essential to the explanation of certain kinds of typical symptoms. In the *Introductory Lectures* Freud discusses a compulsive symptom in a 19-year-old girl.

> *The most important stipulation related to the bed itself. The pillow at the top end of the bed must not touch the wooden back of the bedstead. The small top pillow must lie on this large pillow in one specific way only—namely, so as to form a diamond shape. Her head had then to lie exactly along the long diameter of the diamond. The eiderdown had to be shaken before being laid on the bed so that its bottom end became very thick; afterwards, however she never failed to even out this accumulation of feathers by pressing them apart.…She found out the central meaning of the bed ceremonial one day when she suddenly understood the meaning of the rule that the pillow must not touch the back of the bedstead. The pillow, she said, had always been a woman to her and the upright wooden back a man.... If the pillow was a woman, then the shaking of the eiderdown till all the feathers were at the bottom and caused a swelling there had a sense as well. It meant making a woman pregnant; but she never failed to smooth away the pregnancy again, for she had for years been afraid that her parents' intercourse would result in another child and so present her with a competitor.* (6)[18]

Freud interpreted this ritual as a "magical" attempt to keep her parents separated, to prevent their sexual intercourse and to ward off anxieties connected with the birth of a competitor. In the course of her life the girl had contrived to achieve the separation in different ways and her symptoms were

[18] Sigmund Freud, Introductory Lectures on Psychoanalysis (ref. *6*, pp. 305, 307).

the latest expression of these aims. The ritual seems to be an intentional action but the girl could provide no reasons for doing it and initially found her own actions unintelligible. If we follow Freud's principal interpretation we can construct a practical syllogism, which may explain her behavior.

- Girl wants to separate mother and father.
- Girl believes that by separating bedstead and pillow she will separate mother and father.
- Girl (intends) effects separation of bedstead and pillow.

If the girl's action was in accord with this unconscious syllogism then it was intentional. The major premise, the girl's desire, is not in doubt but the minor premise expresses a "mad belief" and many commentators have questioned whether it was possible to hold such bizarre beliefs or to have them engage as motives to action. Moore *(2)*, for example, writes:

> *The problem with the Freudian account is...the evidence on the basis of which alleged unconscious attempts are verified. In the case of the obsessive nineteen year old girl the evidence for the crucial belief state consists of her associations between the parts of the bed and her parents.... [H]owever, one should question whether the association of one thing with another [her father with the bedstead] is evidence that the girl believes the two things to be the same....In addition, there is evidence to the contrary; unless she is more than neurotic, she would surely declare that she knows the difference between her father and her bedstead. Given the usual assumptions about the consistency of a person's beliefs, there is strong evidence that she does not believe that her father and her bedstead are one.* (6)[19]

Moore assumes that the girl could have held the belief expressed in the minor premise only if she believed that the bedstead was identical with her father (the pillows, her mother) and this he believes is unlikely on the basis of an expected denial, had she been asked, and the fact that the belief would be inconsistent with her conscious beliefs. He concedes, though, that the girl might have had the mad belief if she were more than neurotic. Even so, there are serious difficulties for the kind of position Moore represents. He holds that the "ritual is plainly an action of hers," by which he means that the action of separating the bedstead and the pillow is intentional. He follows "the law of torts and crimes in adopting Bentham's more inclusive definition of inten-

[19] Ref. *2*, pp. 335–336. It is odd that Moore does not readily countenance these beliefs since his identification of insanity as irrationality or unsound practical reasoning would seem to leave him with few other options. Elsewhere, however (p. 373), they appear to be accommodated, at least for the "seriously irrational."

tional [*sic*] as those actions done by an actor who knows he is performing them." [20] Because the girl knows what she is doing (i.e., separating bedstead and pillow), it follows on this criterion that she is acting intentionally. But then what is the practical syllogism that explains her action? If she is acting intentionally then there is a reason for her action. To deny that the action was intentional is a position that is defensible. But if intentionality is imputed then either a reason for acting—conscious or unconscious—had better be produced or, failing that, an argument that demonstrates that acting intentionally does not entail the having of efficacious reasons for acting.[21] Bentham's definition is flawed and Moore's use of it here, combined with his rejection of the unconscious syllogism, leads to the untenable position of affirming that the ritual is intentional without an explanation of how it can be.

The fact that the ritual is compulsive also raises questions about whether it can be consciously intended. It is a mark of conscious intention that it is sensitive to circumstance, that it can be withheld or modified in light of relevant rational considerations. These features, too, are lacking in the girl's ritual. So it seems that the act, under the description separating bedstead and pillow, is not intentional: there are no efficacious reasons for it and it is not vulnerable to rational revision. But the same act-event could be intentional under other descriptions. Several different practical syllogisms concluding with the required intention (or action) can be constructed. Moore seems to think that in order to arrive at the sort of practical syllogism instanced above the girl must have believed that the bedstead was her father. That is not implied in the material and it is not necessary for the girl to have believed it, though it seems to me possible that she may have believed it. What she appears to believe, unconsciously, is that if she separates the bedstead and the pillow she will have separated her parents. Believing this is not the same as believing that her parents were identical with the furniture. The distinction underlying the difference is between one thing symbolizing another and that thing being believed to be identical with the other. Both of these circumstances differ from a third, in which one thing is equated with another. In the case of the belief, if the girl believes unconsciously that the bedstead is her father (the

[20] Ref. 2, p. 79.

[21] That has been argued, for example by Sebastian Gardner in Irrationality and the Philosophy of Psychoanalysis (Cambridge University Press: 1993). I criticize several related arguments for intentional but non-rational action in "Freudian wishfulfilment and subintentional explanation" in M. P. Levine (Ed.) The Analytic Freud (Routledge: 2000).

pillows, her mother) then from the fact that she separates bedstead from pillow she will be able to conclude (unconsciously) that she has separated her parents. In the case of equation, what the girl does is to separate her parents when she separates the bedstead and pillow—as she apprehends it unconsciously. It is easy to find intention conferring reasons on either scenario. The practical syllogism set out above is an example using the sorcery-like belief ("if she separates the furnishings she will separate her parents"). This is an example for the equation:

- Girl wants to prevent the conception of a baby-competitor.
- Girl believes that by keeping her father (= bedstead) and her mother (= pillow) apart she could prevent that conception.
- Girl (intends) effects the separation of bedstead and pillow.

The equal sign here is not meant to indicate a belief; it is meant to indicate in the girl's mind the role of bizarre, fused objects.[22] I do not wish to suggest that any one of these syllogisms is the correct one. In fact, there is a variety of potential intentional structures, some not incorporating mad beliefs at all, that may account for the girl's unconscious action, but one or other unconscious structure seems to be necessary in any account that makes sense of the girl's compulsive ritual as an (unconsciously) intentional act.[23]

I think we can now see how McNaughtan's actions can be provided with an unconscious etiology of the hypothesized kind. McNaughtan's aim, on the hypothesis, was to destroy a persecutory object which he identified with Peel, or believed was in some magical way associated with Peel, or something to that effect. In any case, he apprehended the killing of Peel as the destruction of the object. This apprehension is supported by the peculiar fact that McNaughtan appeared to have believed that killing Peel would end his persecution, a most improbable outcome even on McNaughtan's own understanding of his situation. His unconscious intentions may have included, in addition to the intention to destroy the object, the intention to end the persecution, to defend

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[22] Consider Betty: "Around Easter, Betty came home from the park bringing two twigs which she arranged crosswise and then asked her mother what she thought this was. Her mother answered: 'I guess it is a cross.' Thereupon Betty began to whip her mother furiously, crying all the while that her mother deliberately hurt Jesus' feelings, that she ought to have acknowledged that it was the cross to which He was nailed and which, according to Betty, her mother knew" (Margaret Mahler, On Human Symbiosis and the Vicissitudes of Individuation; International Universities Press: 1968, pp. 6l–62).

[23] These matters are discussed in more detail in my "Intention in wish fulfilment," Australasian Journal of Philosophy (Vol. 74, No.1, March 1996).

himself, or (again) something to that effect; and each of these intentions was the conclusion of a piece of unconscious reasoning whose premises may have included one or another mad belief, trading, perhaps, on an equation of Peel and the internal persecutor. If that is right and McNaughtan did set out on some such unconscious but intentional project, then the sequence of actions that followed would in effect have been no different than if they had been motivated by an intention to murder Peel.

However, McNaughtan's case is different from the girl's in important respects. The girl has unconscious reasons for separating her parents but no conscious reason for separating the bedroom furnishings. McNaughtan not only appeared to have conscious reasons for killing Peel, but he also appeared to have formed an intention to do so, and seemed to avow that he acted on it. Does that not entirely undermine the relevance of the story about unconscious intent? I think it does not.

To begin with, first-person avowal indicates a certain kind of immediacy and privileged access to our own mental states, but it is not immune to error. We are not infallible guides to the content of our intentions, motives, beliefs, and attitudes. Particular instances of these states are frequently confabulated, distorted, or revised to achieve consonance with past actions and with other associated states of the agent. Examples of confabulated reasons for acting in posthypnotic suggestion have long been known. Recent studies of cognitive dissonance show the remarkable extent to which even in fairly ordinary situations we erroneously revise and invent reasons and attitudes in attempting to maintain consistency between our attitudes, beliefs, and actions. In psychoanalysis, of course, the patient's avowed motives and beliefs are rarely taken at face value, at least in the beginning of the process. The prevalence of self-deception (in others, if not ourselves) is not contested by anyone. It should not be surprising, then, if McNaughtan's avowals were founded on what were only apparent, confabulated, or factitious states of mind. A preponderance of such irrational phenomena is, after all, a mark of serious mental disorder. One can think of McNaughtan's conscious intentions as delusional, not in the sense that they were caused by delusion and had real, independent existence, but that they were the stuff of delusion.

Still, it may be insisted that McNaughtan did have a real intention to kill Peel. But even if that were so it does not establish *mens rea*. To establish *mens rea* would require a demonstration not just of the presence of intention but the presence of an efficacious intention, one on which the agent actually acted. The hypothesis about McNaughtan's illness suggests that his unconscious motives were sufficient for the act to take place, implying that the avowed intention had no necessary instrumental role. It is as if the act inter-

preted in terms of the avowed motives was just the shadow cast by the reality, like those shadows cast by puppeteers whose motives are, of course, quite different from those of the characters their shadow puppets portray.

But now it may be pressed that McNaughtan had an efficacious intention to kill Peel. One can accept some version of the unconscious dynamics and still maintain that conscious culpable intentions were present and had an instrumental role.[24] Intentions generate other intentions. It can be argued plausibly that although McNaughtan unconsciously intended to destroy a persecutory object (or had some similar intention), his targeting of Peel resulted from the emergence of fresh intentions created by his unconscious intentions through the prism of the projective or symbolic activities that we have hypothesized. The unconscious intention to destroy the persecutory object is converted in some way into the conscious intention to destroy Peel. There is, I think, a genuine question about whether intentions that have been, as it were, inserted into consciousness in this way, and not made intentions in the light of the agent's overall aims and deliberations are really his intentions. For something to be a conscious intention or reason for an agent it has to be formed or taken up by the agent and endorsed in a particular way. Leaving that difficult consideration aside, some such process certainly seems possible. It is not, however, an objection to the argument being explored here. I have been arguing only that such conscious intentions are not *necessary* to explain McNaughtan's conduct and that unconscious intentions, much like the 19-year-old girl's, may be sufficient.

These contentions imply that only in the case of inserted intention, a mental state whose agential role is, perhaps, problematic does the question of culpable intent and criminal responsibility arise. In the case of confabulated, inefficacious, and unconscious intentions the question of responsibility does not arise. In the first two cases, that is because there is an absence of intent; and in the latter case because actions performed while unconscious or for reasons that are unconscious do not (in general) attract legal liability.[25] The person who doesn't know why he acts doesn't know the act that he is doing, and is not able to morally assess what he is doing, and is therefore not accountable for that act (the act-event under a description of which he is unaware).

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[24] As does Gardner *op cit.* Ch. 6, in similar cases.

[25] "Criminal law and the law of torts have consistently held that sleepwalking, post-hypnotic and similar acts are examples of non-action. Case law, model codes and commentary uniformly classify unconsciously directed behaviour, or behaviour engaged in while unconscious as non-action" (*2,* p. 73). Here "non-action" means "not intentional under at least one description."

But may he not be responsible for his actions known to him under other descriptions? If Bentham were right, that we intend all those actions that we know we are performing (i.e., that our actions are intentional under all the descriptions that we know them), then the matter is easily settled. There would be intent and, therefore, responsibility. But we have seen that that is a mistake. A person can know that they are doing something without intending to do it. And that raises a further interesting question for the hypothetical model of McNaughtan's madness—and those cases that may be significantly similar to it. Even if McNaughtan didn't intend to kill Peel, still, he knew that he was doing so. He did not attempt to stop himself. His act was, as it seems, passively volitional. A person who knows that they are doing something but does not have a reason for doing it is in a very strange situation. The 19-year-old girl was in this situation. McNaughtan was not quite in this situation because he had reasons or, rather, confabulated reasons, and it's a fair surmise that the reasons were confabulated precisely to fill this gap between the actions he observes himself performing and the want of real reasons for performing them.

This strange situation suggests some concluding remarks. First, once we see that an agent's knowledge of an act of his does not imply that he intended it, the case for imputing strict criminal liability becomes less compelling. Other considerations of excuse or mitigation may well come to the fore. And that thought is reinforced by another. The situation of being, as it were, an observer of one's own actions without having access to the real reasons for which one performs them suggests a degree of alienation or dissociation very much of a kind with those serious forms of irrationality that many commentators have identified with legal insanity. It is one aspect of insanity partly unpacked. It may be that in practice juries will decide the guilt of defendants on more or less indefinite notions of intelligibility and gross departure from accepted norms of rationality. But that should not exempt us (or the judicial process) from trying to identify in the particular instance precisely if, where, and how rationality breaks down; and indeed where our understanding of it breaks down. I have been arguing that the place of intention in the insanity defenses may warrant re-examination.

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Chapter 5

An Archaeology of the Psychopath

The Medicalization of Evil

Tom Mason

Background

This chapter is concerned with the emergence of the psychopath as a psychiatric concept during the 19th century. It is argued that the reduction in medical credence in the notion of homicidal monomania resulted in a void in psychiatric expertise, which was ultimately filled by the medicalization of evil and the creation of the psychopath as a clinical entity. Through the transmission of philosophical and medical scientific theorizing, we can identify how issues of good and evil, right and wrong, and freewill and determinism allowed morality to become the major focus for the emerging psychiatric profession of that time. There is a wealth of literature both on moral philosophy and psychopathy that is not referenced in this chapter because (a) others have covered this in more detail elsewhere and (b) I merely wish to establish the overall principle of the possibility for the sake of argument.

Introduction

If one asks which authors have been the most conceptually influential on psychiatry in comtemporary times, it is highly likely that names such as Levi-Strauss, Szasz, Laing, and Foucault would be heard, among others. However, these authors have dealt mainly with the philosophical constructs underpinning their particular view of psychiatry and its implication for practice.

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Although many practitioners may not have read those authors in any great depth, nonetheless their ideas and concepts will more than likely have been discussed and debated in many arenas of mental health practice, raising issues and filtering through, causing some practitioners to ponder their clinical role and some educators to transfigure curriculum design. Needless to say, even when such eminent writers are dismissed as irrelevant, their work creates the stimulus for others to synthesize ideas and enable alternative interpretations and perspectives to be developed. Furthermore, as each generation emerges to re-evaluate previous great works, there is often a tendency for many of their concepts to be stretched, turned inside out, or re-interpreted. In any event, it is important to note their ability to influence the creation of new ideas.

Presumably throughout history, those teaching a particular topic in universities throughout the world teach what is considered to be the contemporary thoughts, latest research, and most recent knowledge of that topic. This may be related to a historical context, or it may be stated hermeneutically to offer a challenge, a critique, or a polemic, but it remains a central premise that current thinking in any field is the mainstay of such curriculum design and is that which is taught as contemporary knowledge on any particular course. By taught, it may mean formal lectures or informal seminars; suggested as reading on required, recommended, or further reading lists; or be part of the campus scene, common room argumentation, or bar room debate. Furthermore, challenging thought in one discipline would often have an impact in other professional areas, and in turn, affect the way in which thinkers in other sciences approach their work. For example, new work in physics may well influence thinkers in mathematics, oceanography, and medicine, but equally could influence workers in history, theology, or veterinary science by a reexamination of traditional ideological thinking. A recent example in the field of psychiatry is the emergence over the previous generation of study (approximately 30 years) of texts that have challenged traditional psychiatric orthodoxy, in both historical and practice terms. These texts have originated from fields such as anthropology, sociology, psychology, and philosophy. Indeed, it would be difficult to imagine that contemporary leading academics in the field of psychiatry are not familiar with names mentioned above (i.e., Levi-Strauss, Szasz, Laing, and Foucault) and have at least a passing knowledge of their work. The transmission of ideas is almost unstoppable for all but the most blinkered.

This chapter maps out the basic philosophical thoughts concerning good and evil, right and wrong, and the question of morality over an approximate period of 100 years during which the term *psychopath* emerged as a psychiatric concept. Alongside the work of the moral philosophers, the psychiatrists

encapsulated a/im-morality as medicalized concepts claiming a new domain through an explanatory framework of psychiatric discourse. The main landmarks are set out in Table 1. It should be emphasized that this chapter does not attempt to offer any developmental thought in relation to either moral philosophy *per se*, nor any histories of criminolegal psychiatry. Both of these fields are exhaustively referenced elsewhere and are beyond the scope of this current brief outline. Rather, an attempt to illuminate the relationship between philosophical thought and psychiatric developments in any given epoch will be undertaken. Although this is grounded in the scientific assumption of the transmission of ideologies between lay and professionals, and between professional groups, it is based on the work of social psychologists *(1)* and, it is argued, appears axiomatic.

Outline of the Argument

This work was carried out by employing a historical method that involved analyzing the philosophical and psychiatric texts originating in the period of time in which the notion of psychopathy was developed, not in an attempt to establish an explanation of current conditions, but to provide an understanding of historical ideas pertaining to morality, or the lack of—to paraphrase Foucault, "not to provide a history of the present but to offer a history of the past" *(2)*. That is, to examine how ideas rooted in the past caused and created other developments through the conflicts and tensions of that time. An examination was undertaken of some developments in moral philosophy and psychiatric explanation of this during the 19th century. Mainly, we analyzed the psychiatric accounts for elements of the medicalization process.

The medicalization (or psychiatrization) process refers to the way in which a particular aspect of human structure, action, behavior, or thought is brought under the influence of medicine. There are five stages to the process, which also includes the mechanism by which it becomes socially legitimated in lay and professional terms. For this process to occur it requires that such a human structure, action, behavior, or thought is deemed to be abnormal, disordered, or out of balance with what is considered a typical human activity. Stage one is concerned with the identification of this difference, and once identified as such, stage two allows the human ailment to be classified according to a nosological framework, giving the appearance of it being "known" by medical expertise. From this, stage three produces a diagnosis, which locates it in terms of etiology and gives the appearance of it being "understood." In stage four, some form of medical intervention, however crude, must be offered in order to suggest that the condition or its effects are amenable to treatment. Finally, in stage five, for the process to be completed there must be a predic-

Table 1
Philosophical and Psychiatric Developments in Morality

Author	Philosphical work	Year	Medical theory
Kant	*Critique of Pure Reason*	1781	
Kant	*Prolegomena*	1783	
Kant	*Metaphysic of Morals*	1785	
Kant	*Religion Within the Limits of Reason Alone*	1785	
Schelling	*System of Transcendental Idealism*	1800	Forcault's thesis on the start of the first influential period of the "Dangerous Individual"
Schelling	*Of Human Freedom*	1809	Manie sans delire (Pinel)
		1812	Moral alienation (Rush)
		1835	Personality and morality (Pritchard)
			Forcault's end of the first period of the "Dangerous Individual"
		1838	Des maladies mentales (Esquirol)
Kierkegaard	*Either/Or*	1843	
Schopenhauer	*Basis of Morality*	1844	
		1845	First use of psychopathy but not translated to English for 40 years (Feuchtersleben)
		1885	Beginning of Foucault's second influential period
Nietzche	*Beyond Good and Evil*	1886	
Nietzche	*Genealogy of Morals*	1887	
		1888	Psychopathic inferiority (Koch)
		1910	End of Foucault's second influential period (Prinz's *Social Defence*)
		1912	Moral imbecile (Mercier)
		1913	Mental Deficiency Act

tion of the outcome of the disease in relation to the treatment, in the form of a prognosis. Thus, medical expertise is manufactured to convince society of its power. This is as true in Western medicine as it is in witchcraft.

An example of this is homicidal monomania, a fictitious condition created in the latter half of the 18th century by men of medicine in the battle with the institution of law. This condition, it was reported, was a single act of insanity, which was crime, and a single act of crime, which was insanity *(2)*. Without prodromal signs, a solitary act of murderous insanity was said to occur, which then dissipated leaving only an inexplicable entity that remained unfathomable to all. That is, to all except the men of medicine who claimed a knowledge of it, an expertise in understanding it, and of course, an ability to define, delineate, and circumscribe it with psychiatric discourse. Homicidal monomania as a clinical condition was the source of much debate for about 100 years but finally fell out of favor and ultimately disappeared as such towards the end of the 19th century.

The medicalization process depends to some degree on the transmission of concepts between varying groups. Billig et al. *(1)* showed how the ideologies of one group of people (professionals) could be transmitted to another group (lay) in which terminology and crude concepts were adopted and employed by the latter group. The transition of the professional concepts may take some time, and may even become distorted to some degree along the way, nonetheless, the passage was clearly evidenced in their research. It is this transition, however slowly, between the philosophical concepts to psychiatric discourse that lies at the core of the thesis outlined in this chapter. However, it is readily acknowledged that influential psychiatric accounts of human behavior and mental structures would also inspire philosophical thought, which indicates the strength of the two-way filtering process outlined by Billig et al. *(1)*.

Pre-Kant

It is clear that notions of good and evil, right and wrong, and morality have been the source of philosophical enquiry since early Greek times and in no way can it be suggested that their debate is merely a modern-day phenomenon.

For Augustine (354–430), the notions of good and evil were not questions of innate human absence or presence, in a relational balance where the less one is good the more one is bad, but more of a hierarchical ordering of duty or rightness. This can be translated into the concept of "ought" in which Augustine believed that higher order things ought to govern lower ones, that is, have power over them, and in the way in which the just world had been created this could not be reversed. Thus, evil was not merely the absence of

good but the expropriation of a good that ought to be present. In terms of causality, causal influences moved down the hierarchy and not up it. The natural way of the world according to Augustine was orderly, just, and proper; otherwise they were disordered, unjust, and improper. Such a latter state of affairs allowed lower things to have power over higher ones, which was evil. Therefore, evil was a disarrangement of the hierarchical ordering according to the way in which it ought to be structured. As before and after Augustine the paradox of the free will is never suitably resolved. However, he had an ingenious approach that involved establishing that God created the world in a just fashion involving the higher having power over the lower, and is therefore not responsible for creating evil. This act of creating evil is laid at the door of human free will to create the disordered imbalance of power. For Augustine, humans do not have power over God, but that they have power over human's priorities for good as arranged by God. Just people order their ultimate values to the higher, so that they are subject to striving toward those higher priorities. People in a state of evil thus prioritize those values incorrectly and allow lower things to govern them.

Anicius Manlius Severinus Boethius (480–524) was a Roman philosopher under the gothic King Theodoric, who later imprisoned and executed him for treason. However, during his imprisonment at Pavia he wrote his most famous text, *Consolation of Philosophy*, which in effect is a meditation on evil, with more than a hint of misfortune, particularly his own. As with Augustine, Boethius saw evil not as an entity in its own right, but an absence of good for which he holds free will responsible. However, although he covers this in depth in his treatise, he has another angle on it, which caused him some concern; namely, how is it that the evil people prosper and the good do not? If human free will is responsible for evil then Boethius needed to ensure that he could deal with the classic puzzle of God's foreknowledge of the future and the nature of free will. His answer was to recognize that it was not a question of causality, but merely a matter of logical relations. In effect, he placed God outside of time, as others had done before him, which allows God to see all events and their contingencies simultaneously without in any way interfering with them. Thus, evil action is not God's doing but human's doing alone, by choice.

A later German philosopher who dealt at length with the notion of evil was Gottfried Willhelm Leibniz (1646–1716), the son of a professor of philosophy at Leipzig University. In addition to being a philosopher, he was also a mathematician, historian, and jurist, and was offered, but refused, a professorship at the age of 21. We cannot deal with Leibniz's notion of evil outside of his general theory of monadology. Leibniz believed that all complex struc-

tures are made up of a multiple of simple substances, which he called monads. These in themselves are without parts; they are finite divisions of all material things and in themselves are immaterial and soul-like. Monads, having no parts, cannot grow or decay, and cannot be causally affected by any external creature. They may change within themselves, but these changes are internally driven and, because they have no physical properties, must be changes in perceptions. Each human being has one dominant monad (considered to be the rational soul) that not only has perception, but also apperception, that is, higher conscious reflection of the inner state. Its objective is good, and in this sense, we can interpret this as the soul acting on the body. Any created world is, thus, a system in which there is a surplus of good over evil. Although free will allows human action to engage in sin, it is better, for Leibniz, than a world in which there is neither free will nor sin. Thus, the evil in the world is no argument against the goodness of God.

There are, as stated above, many other philosophers who have contributed to the debate on good and evil through the notion of morality, but they have been omitted in this chapter on the grounds of shortage of space, and because others have dealt with them in far more depth, and the fact that they concerned themselves predominantly with other issues. For example, John Locke (1632–1704), the British philosopher who wrote on many issues such as the idea of experience and the nature of knowledge; David Hume (1711–1776), the Scottish philosopher and historian who wrote on human nature and understanding as well as morality and religion; Jeremy Bentham (1748–1832), who wrote on law, politics, and social reform as well as the principles of morals and legislation; and the Mills, James (1773–1836) and John (1806–1873), who published work on government and jurisprudence, and political economy and liberty, respectively.

The Rooting of Evil in Human Nature

It is the rise of psychiatry that underpins the medicalization of morality over the 18th and 19th centuries, and for this to occur it would require morals to be grounded within the human psyche as a structure of rational thought. As mentioned above, the medicalization process requires that an abnormality be identified, a difference established between one state and another, and that this difference can be classified into a nosological framework. Furthermore, a diagnosis must be achievable based on a causal inference within a grand theory of illness and that a medical (psychiatric) intervention can be undertaken. The final aspect of the process is that a prognosis or prediction can be undertaken as to the progress of recovery or otherwise. Over the period that is now being focused on, I argue that there was a crystallization of this

medicalizing process alongside the developments in the philosophy of morality that allowed psychiatry to acquire the notions of good and evil as medicalized entities.

At the rise of psychiatry a profoundly influential moral philosopher emerged. Immanuel Kant was born in Konigsberg, East Prussia in 1724 and died there in 1804, never having left his native province. Although he wrote throughout his youth and early middle age (in fact it was these writings that made him famous in his day), it was not until he was 57 years old that his acknowledged masterpiece *Critique of Pure Reason* was published in 1781. Although at first not well understood, and therefore not well received, 2 years later he published a condensed version containing the central tenets of his argument, which is usually referred to as the *Prolegomena.* Furthermore, in 1787 he made a substantial revision of this first critique, which has stood the test of time. Other great Kantian critiques followed: the *Critique of Practical Reason* in 1788 and the *Critique of Judgement* in 1790. During this prolific writing period he had also produced a small book *The Fundamental Principles of the Metaphysics of Ethics* in 1785, which, despite its unattractive title, has had a profound influence on moral philosophy since that time.

Kant was a systems-thinker who constructed the physical world according to the presupposition that every event was determined by preceding events. That is, every event had an antecedent that caused the event and thus what happened was the only thing that could have happened. In Kant there is a natural force (God) that determines everything; however, there is an inherent conflict in this system when we transpose the framework to a metaphysical one in which emanating from the physical structure of the human body, which is governed by the physical science of determinism, the human emotions can be under the influence of free will. That is, as humans we can choose between courses of action and therefore take responsibility for those choices.

Before Kant, the philosophy of morality, in terms of our moral convictions, was believed to require some form of metaphysical foundation, usually as a theological ethic. That is, questions of right and wrong were imposed on us, or transposed to us from a greater force than human nature—in other words, from outside rather than from within ourselves. Kant uprooted this hierarchy and inverted it. He saw moral conviction not as an entitlement to be bestowed on us, but as an inescapable primitive foundation, which was grounded in being part of human nature. Thus, morality originates within us and any appeal to a higher superstructure merely reflected another human need above and beyond the genealogy of morals. Locating the root of morality within the body and the mind as human nature, allowed medicine to acquire this site as an area of medical focus.

However, we need to look a little more closely at this sphere of medical moral operations. Kant claimed that in order for our moral convictions to have any validity they must have, to one degree or another, some element of freedom of choice, no matter how minute. In the binary oppositions of right–wrong, good–bad, ought–ought not, there must exist a space, albeit small, in which the human being exercises his or her discretion. If there is not, then an evaluation of moral propriety becomes meaningless. Should medicine decide that the mitigation of moral responsibility occurs as a result of a person being so afflicted by a disease of the mind that they cannot operate independently, at the behest of their own free will, then they are not culpable. Furthermore, they are not considered to be immoral.

Kant arrives at this position by arguing that any agent, in moral terms, must be rational—that is, capable of considering the reasons for or against a particular action, and having the volition to act on them. Although such ability to reason on the pros and cons of an action does not necessarily constitute a moral outcome if one also adopts the Kantian categorical imperative of acting only according to the maxim by which you can at the same time will that it should become a universal law, then it must by reason become a moral rule. Moving the argument forward, if all persons at all times cannot adopt such action, then it cannot be considered a universal moral rule. Here we see the social component of Kant's moral philosophy in that he suggests morality imposes on us a set of conditions of the community. Thus, to be immoral one must be rational, but choose that course of action.

Perhaps Kant's most central work on morality is set out in *Religion Within the Limits of Reason Alone* published in 1793 through the development of his notion of radical evil in human nature. Humans are the authors of good and evil and "nature is not to bear the blame (if it is evil) or take the credit (if it is good)" *(3)* . Having the capacity to be both good in some respects and evil in others allows the majority of humans to fall somewhere between the two extremes. The issue, for Kant, revolves around the extent to which people have the free will to choose one over the other, with this choice representing the incentive for people to incorporate it into their maxim, that is, making it the general rule by which they will conduct themselves. Although having the capacity to be both good and evil, we cannot be both at the same time, as being good in one way means that we have incorporated the moral law into our maxim, and being evil would mean the incorporation of that law into our maxim, which is clearly a contradiction. It is the fact that the propensities for good and evil lie in human nature and ultimately chosen through free will that ensures we become morally good or morally evil. Furthermore, Kant calls this evil radical because it corrupts the ground of all maxims and suggests

that it is to some degree an incurable state because "as a natural propensity [it is] *inextirpable* by human powers" *(3)*. Yet, it can be overcome because it is grounded in free will. (The debate on the treatability issue of psychopathy continues unabated to this day.)

From this perspective, it is difficult to see how psychopathy, as a conceptual term indicating immorality, could possibly have existed before Kant's grounding of moral philosophy inside human nature. By this, it is not offered that evil was grounded inside mankind for the first time, as others had previously argued (for example, Luther, Talmudic Rabbis). What is intended here is that as a consequence of the Kantian revolution in the domain of practical reason, which is usually not addressed, Kant for the first time argued that evil as such acquired a proper ethical code. "That is to say, with his idea of an 'original evil' inscribed into a temporal character of a person, evil becomes an affair of principle, an ethical attitude—'ethical' in the exact sense of an impetus of the will beyond the pleasure principle. …Evil is no longer a simple opportunist activity taking into account only 'pathological' motives, it is, on the contrary, an affair of the eternal and autonomous character of a person pertaining to his original, atemporal choice" *(4)*. Thus, coupling morality to a discourse on rationality Kant paved the way for those men of medicine to adjudicate on right and wrong, good and evil, and more profoundly to apportion blame.

Evil, for Kant, was the adoption of evil, *as evil* (radical), into the maxim of our incentives. The salvation, if any, pivoted on the disposition to the law, which in turn, revolved around the notion of innate guilt, said to be discernible in man at the earliest exercise of freedom. This guilt may be of several types, or stages; first, unintentional guilt founded on the frailty of the human will, second, unintentional guilt as a result of impurity, and third, deliberate guilt which displays an element of "*insidiousness* of the human heart, which deceives itself in regard to its own good and evil dispositions" *(3)*. In the latter stage, guilt is a deception and, in reality, one is unconcerned about it, and may consider themselves above the law or justified before it. Note that this too is a common feature of contemporary psychopathological traits theory in relation to psychopathic disorders. Furthermore, this explains, in Kantian terms, why so many evil doers consider what they have done as being beyond the law, that the law in their terms is not their supreme consideration, and that those who judge against them are deemed harsh. Again, this is resonant of the well-rehearsed psychopathic trait of an inability to learn from experiences. Finally, this deceptive guilt covers a veil of insincerity as they may even consider their evil actions as truly meritorious and regard genuine guilt as merely reflecting a weakness in others and a burden that they are not saddled with. If

they do not elude the consequences of their evil action, they consider guilt as misfortune, or bad luck, and not as a rational consequence of their behavior.

Between Subject and Object: Evil As a Precursor to Immorality

Friedrich Willhelm Joseph von Schelling (1775–1854) was the son of a Lutheran pastor, well cultivated, and an academic throughout his life. He is often regarded as the conduit between the ideas of Kant, Fichte, and Hegel, and the principal philosopher of the period of romanticism. His major work published in 1800 was his *System of Transcendental Idealism* in which he maintains that there must be two spheres of philosophy dealing with subject and object. In the former, we are concerned with the self and its freedom, whereas in the latter we must deal with phenomena of the natural world. Both spheres have a common source: the subject as transcendental being. In later writings, *Of Human Freedom* (1809), the transcendental subject is not an individual, but a universal spirit, which is will. In dealing with the freedom of the will, Schelling believed that an individual could only be truly free when he was aware of the constraints on his actions. Human drive was, thus, towards self-knowledge and the unification of that which was considered diverse (i.e., subject–object, self–other, spirit–matter). For Schelling, evil is the false unification of these modes. Specifically dealing with the origins of evil in Schelling's work, Zizek *(5)* notes "both Good and Evil are modes of the *unity* of Ground and Existence; however, *in the case of evil, this unity is false, inverted*." Zizek goes on to provide a contemporary example of this in our ecological crisis in which human is both a living organism (and part of nature) and a spiritual entity (and above nature). If humans were merely the former, they would be embroiled in nature's cycle as predators and pose no threat to it; if they were merely the latter, they would have a contemplative relationship with nature, having no need to actively intervene. What creates the explosive characteristic is the combination of the two, man as animal dominating the environment for survival and man raised to the power of spirit for absolute domination beyond mere survival. "Therein resides the true perversion of Evil: in it, the "normal" animal egotism is "spiritualized," it expresses itself in the medium of Word. We are thus no longer dealing with an obscure drive, but with a Will which, finally, "found itself"" *(5)*.

The Beginning of Foucault's "Battle Line"

It is interesting to note that Michel Foucault (1926–1984), the French intellectual historian of ideas, claimed that 19th-century psychiatry became

important because it initiated a new technological treatment of mental disorder, which empowered a policing of public hygiene through the judicial system. As mentioned elsewhere in this book (*see* Chapter 17), Foucault outlined a succession of serious offenses brought before European courts over a 35-year period between 1800 and 1835. Foucault argues that psychiatric expansion was evident in numerous domains with the "pathologization of the monstrous" being but one branch of medical discourse surrounding the "dangerous individual" *(2)*. Over this period, the issue of morality was at the forefront of philosophical and psychiatric debate, and it is this that for Foucault is the key to understanding the expansion of psychiatric power. Not because expansion of psychiatric power was merely a form of psychiatric colonization or a professional will to power, but because it functioned as a form of public hygiene of morality. During this intense intellectual period, morality as an aspect of society became a biologically functioning system, a social body, supervised and screened by psychiatry. The great psychiatrists were influential in this rising tide *(6)*.

The second period in Foucault's thesis is also particularly relevant to our typology. Claiming another fertile epoch for psychiatry's insertion into the dangerous individual, Foucault points us to the years between 1885 (in which the first congress of Criminal Anthropology took place) and 1910 (in which Prinz's *Social Defence* was published). He argues that homicidal monomania, with a few hesitations, was abandoned shortly before 1870. This would undoubtedly have left a scientific psychiatric void. The abandonment took place for two main reasons: first, because the idea of a focused insanity on one point of activity, the unleashing of a one-off act, was replaced by the idea that mental illness could attack the emotions and instincts, what was called moral insanity *(7)*; second, because of the development in the ideas of degeneration, that is, that mental disorder is degenerative at both the individual level and also across generations. Thus, psychiatry no longer narrowly focused on the single (mono) horrendous crime, purporting to be able to penetrate its depth, but now cast its gaze across a wide range of minor infractions whose analysis could remain superficial. This has serious consequences for the legal theory of responsibility, argues Foucault, for if in homicidal monomania there is no reason for the act, and it makes no sense, then the causal inconsistency established a non-responsibility. However, from the perspective of the new psychiatric gaze, a causal nexus could be provided to encompass all manners of conduct, criminal, delinquent, or otherwise. Philosophical questions would arise regarding the notion of free will and the extent to which determinism was bound within the confines of causality.

The shift in psychiatry, as well as in criminal anthropology, from the crime to the criminal, from the act to the actor, from past danger to future

dangerousness, and from punishment of the guilty to protection of the social body, brought about a change in the technical knowledge system "able to measure the index of danger present in an individual" *(7)*. This quest, 100 years later, is still being pursued. The corollary of this quest was that "hence the idea that crime ought to be the responsibility not of judges but of experts in psychiatry, criminology, psychology etc" *(7)*. By the second meeting of the Criminal Anthropology Association (1889) the psychopath was born as a psychiatric term *(8)* and then as an inferior being *(9)*.

For Foucault, it is the notion of risk that links this period with Prinz's *Social Defence*. Risk is assimilated through law by the idea of no-fault liability but that the medical professions assimilate "through imputability without freedom" *(2)*. Prinz is said to have coined the term *dangerous being* in 1905, relating it to everyday figures of degenerates, perverts, and the unbalanced and immature *(2)*. Not surprisingly, the moral imbecile was shortly to follow.

The Psychiatric Acquisition of Morality

Philippe Pinel (1745–1826) was the son of a physician whose first interests were in classical philosophy before later turning to science, mathematics, and physiology. He studied medicine at Toulouse and did postgraduate work at Montpellier. He was influenced by the writings of Locke, Condillac, and Voltaire, which clearly shows the heavy influence that philosophy had on his thinking. In fact, his strong leaning towards medical psychology can be seen in the preface of his work *Traite Medico-philosophique* (1809). Influenced by the prevailing spirit of rational inquiry, he dismissed physiological fictions such as hardening of the nerves as a causation of mental disorder, as well as interventions such as purging. He believed in the hereditary transmission and faulty education as causal factors of mental illness. He also believed that mental disorders could result from an impact on the emotional experiences and Pinel himself referred to his work as "moral treatment" *(10)*.

Three years later, in 1912, Benjamin Rush (1745–1813) developed the notion of moral alienation. The father of American psychiatry and a founding member of the University of Pennsylvania Medical School, Rush was also both active in politics and served in the armed forces. He wrote the first American textbook on psychiatry, *Medical Inquiries and Observations upon the Diseases of the Mind (11)*. He also wrote extensively on medical, sociological, political, and theological subjects, which would indicate that he would be at least conversant with the contemporary philosophical positions on morality during his time. A firm believer in virtue and moral standing, he fought long and hard to cure the insane, moral or otherwise, albeit by crude means. The notion of moral alienation is attributed to Rush, who believed that a per-

son could be afflicted by a disorder in which their ability to reason along moral lines could be affected. In Rush's work we see the notion of disorder influencing the extent to which the person would be deemed accountable for their actions. This idea brought the concept into conflict with those who considered the location of criminal responsibility as belonging centrally within the subject; suggesting that a moral insanity could diminish one's culpability would destroy the basis of law.

By 1835, morality was closely related to personality. James Pritchard (1786–1848) was a notable English psychiatrist who originated the term "moral insanity." He argued that in the same way that intellectual functions can become deranged, moral judgment may also become irrational *(12)*. The afflicted person can appear quite rational in some ways but is driven to commit crimes from this moral corruption. From the ensuing debate of Pritchard's writing the terms "psychopathic inferior" and "psychopathic personality" are said to have derived *(13)*. Pritchard came to believe in Pinel's descriptive accounts of the cases to which he referred to as moral insanity. However, both these authors in their descriptive accounts of what was to become psychopathy as we know it today, could not clearly delineate between morality and insanity and could only conceive of faulty morality as a form of insanity. However, moving from classification (clinical description) to psychiatric intervention, Pritchard clearly noted the extreme difficulties of treating this condition, "the prognosis in cases of moral insanity is often more unfavorable than in other forms of mental derangement. When the disorder is connected with a strong natural predisposition it can scarcely be expected to terminate in recovery" *(13)*. Now, as then, the difficulty of treating what is termed psychopathy is noted.

Morality Within the Self

Soren Kierkegaard (1813–1855) was a Danish philosopher and religious writer who has been described as an honorary German "fighting a battle which would be senseless without German romantic philosophy" *(14)*. Throughout the 19th century, the philosophy of morality became a question of spiritual demarcation, which involved a number of philosophers arguing either for a divine ethics of Christian faith or for a more secular psychology of good and evil. Kierkegaard, a guilt-ridden Christian, published *Either/Or: A Fragment of Life* in 1843 in which he attempted to show how it is possible to live one's life in accordance to moral duties. Interestingly, he suggests that there is no real rational choice of action between two options but that there is a command that we behave in a certain way. The only real choice for Kierkegaard was the choice of faith. Thus, in choosing against faith in religion was a "sick-

ness unto death" creating anxiety, despair, and horror. The other alternative, the opposite, became an inverse of good, and that faith equates with moral, whereas the opposite is immoral. In this way, guilt was a central tenet surrounding the choice to act in a certain manner, and without this guilt man was doomed. So, the middle of the 19th century located morality as a Christian ethic, until toward the end of the same epoch Nietzsche arrived on the moral scene.

Arthur Schopenhauer (1788–1860) was born in Danzig, now named Gdansk, and spent the majority of his life in independent study and writing in obscurity until after his death. His main works were his early books *On the Fourfold Root of the Principle of Sufficient Reason* (1813) and *The World as Will and Representation* (1818) rewritten and much extended in 1844. Schopenhauer is important to us in this project for a number of reasons. First, he originally developed his work from a Kantian perspective, thus providing a link and an extension across a generation of philosophy. Second, after his death his work gained popularity and influenced Nietzche in the latter half of the 19th century and Wittgenstein in the 20th century. Third, he anticipated much of what Freud was later to develop in terms of the inaccessibility of our own inner psychic life and motivations, and Freud, much later, built on what Schopenhauer had said. This latter point is an ideal example of the bridging of philosophy and psychology in a truly poignant way i.e., Schopenhauer being the epitome of a philosopher and Freud the founding father of psychoanalysis. Schopenhauer saw the dark side of human life, even to the point of pessimism, and he saw evolutionary biology as an example of nature's indifference to the individual. In human terms, this indifference was rooted in the will. For Schopenhauer, the will is in constant need to manifest itself and in its manifestation it reveals its life itself, and its resistance to death. The intellect overcomes the will's resistance to death, which clearly shows the psychic power structure of the death instinct that Freud would later make much of.

It was at this time that the first use of the term psychopathy, as the term is used today, can be traced to Ernst von Feuchtersleben (1806–1848) in *The Principles of Medical Psychology Being the Outlines of a Course of Lectures by Baron Ernst von Feuchtersleben* in 1845 *(15)*. However, an English translation was not written for 40 years, so it was much later that this work influenced the English and American notions of psychopathy.

As a Christian ethic, as a question of free choice, religious groups at this time began challenging the concept of moral insanity claiming that "the only disease to which the moral nature is subject is sin" *(16)*. The basis of the religious concern focused on a belief that a "class of modern German pagans who are trying with what help they can get in America to break down all the

safeguards of our Christian civilization, by destroying, if possible, all grounds for human responsibility" *(17)*. Not surprisingly, the controversy was brought into stark relief at the Guiteau trial following the assassination of President Garfield when the defense claimed exoneration on the basis of moral insanity. The philosophical battle was now raging on numerous fronts.

Beyond Good and Evil

It would seem that in philosophy, as in other human affairs, each generation reacts against the views and values that were held by the preceding generation. This results in it becoming faddish and fashionable to criticize the accepted beliefs of the previous generation. Friedrich Nietzsche (1844–1900) took this to the extreme. He was the son of a Lutheran pastor and following a strict theological upbringing fought a life-long battle against Christianity, ultimately claiming that God was dead. By this, he meant that humans should not need religion to rely on as a bolster and indeed claimed that Western man had largely come to this view with the move to atheism. If true, or if this was an accepted interpretation as Nietzsche did not believe in truths, then this would have serious implications for how we would need to view such concepts as morality. If there is no God, no other world, no transcendental dominion, then such notions as values, ethics, rationality, truth, norms, or standards cannot be prescribed from outside of humans but must be created by them. The creation of such notions is made to satisfy one's own needs both individually and collectively. Clearly, this places ideas of morality on the shifting sands of dominant ideologies and those more able to affect their will to power. Meaning and justification, thus, originates within them and exists on their own terms.

In dealing with the genealogy of morals, Nietzsche locates its roots in the relationship between the strong and the weak, the nobleman and the slave, the Ubermensch and the common, and the creditor and the debtor—that is, in the difference between these specimens. Deriving from this are two important themes. First, the promise that is inherent in the creditor and debtor relationship that "is as old as the concept of legal 'subjects' itself and which points back in turn to the fundamental forms of buying, selling, exchange, wheeling and dealing" *(18)*. On the break of this promise, guilt is formed in the debtor and the need to punish as redress by the creditor. Guilt and pain are woven together. This fracture of the pledge, the broken promise, is taken further to extend to the individual in relation to the community in the form of the criminal. The criminal (debtor) is punished by society (creditor).

The second theme to emerge is the will to power, which is central in Nietzschean thought. Whereas some previous philosophers regarded the human will

as the source of all evil, Nietzsche believed it to be people's greatest opportunity and strength. The drives to be oneself, to be strong, and to become who you are, are the supreme drives rather than to succumb to their opposites. Through this, mankind has set themselves aside and above other animal species. Believing this to be the case, Nietzsche claimed that the more the power of a community increased, the less seriously it took the misdemeanor of the individual, because he or she was less of a threat to the survival of the society. "The evil-doer is no longer 'outlawed' and expelled, universal fury is no longer given the same permission to vent itself on him without restraint. Rather, from now on the whole community will take care to defend and protect the evil-doer from this fury, and particularly from the fury of the directly injured party" *(18)*. A compromise is struck between the anger of the victim, the need to localize the crime, the requirement to relate it to equivalent events, and the will to accept every crime as in some way capable of being paid off. This leads, to some extent, in the separation of the criminal from his crime through lack of responsibity, culpability, or rationality. The causation of harm becomes fate, natural phenomena, environmental, or social structural in which punishing the individual becomes pointless. The wrongdoer does not feel guilt, rather he blames others; "for thousands of years, evil-doers, once their punishment has caught up with them, have felt...as regards their misdemeanours: something has gone unexpectedly wrong here, *not* 'I should not have done that'" *(18)*. Thus in 1887, at the *fin de siecle*, approximately 100 years after Kant, Nietzsche turned the concepts upside down; what was seen as good before could be re-interpreted as evil now, what was considered bad may well be the source for good, and badness itself became a form of madness.

The following year this inversion became fixed in psychiatric discourse. Psychopathic inferiority was a term coined in 1888 by Koch, who believed that the condition was a result of a constitutional predisposition, and that the person could not be held responsible for the disorder or the conduct emanating from it. Later constitutional psychopathy would gain popular usage. However, the term inferiority was not drawn far enough into the medical domain and it was left to Mercier to move it from inferiority to imbecility. Charles Mercier (1852–1919) wrote extensively on insanity, crime, and responsibility and focused on morality as a psychiatrized, and even psychologized, concept. In several texts over a period of years he set out what he saw as the differentials and linkages between crime and insanity, insanity and mental disorder, and conduct and personality. In his book, *Crime and Insanity (19)*, he distinguishes between insanity and mental disorder in a cursory way merely claiming that the former is "much more" than the latter and that mental disor-

der can occur without insanity. However, more importantly he elucidates more clearly his notion of insanity as disorder of the process in adjusting the self to the context or circumstances in which one finds oneself; a form of social element is thus required. For Mercier, it is not a disorder of mind, but a disorder of conduct *(20)*. He medicalizes this linkage through claiming that in the widest sense disorder of mind is always present in the case of insanity, but it does not always mean a disorder of the intellect. Mercier then identifies a number of disorders that he claims are not cases of insanity because the afflicted person recognizes that they are disordered, and such insight is testimony that they are not insane. For example, the agrophobic who knows that they are being irrational but cannot overcome their fear, and the devout person compelled to utter obscenities but unable to desist are but two Mercier outlines.

Thus, from insanity to disorder, and from disorder to conduct Mercier then stakes his claim: "there is also moral disorder, which is disorder of mind, and may account to actual insanity, but is unaccompanied by any delusion or by any discoverable disorder of intellect. In such cases, the intellect may be acute, and the reasoning power equal to, or above, the average; but the person affected has an incurable kink in his mind, which renders him insensible to the obligations of morality" *(19)*.

The Legal Legitimization

The rise of psychiatry at the turn of the 20th century became the added drive toward reforming the legislation surrounding mental disorders in the United Kingdom. It is not surprising that the emphasis on moral treatment and the acclamation of morality as a clinical focus should be reflected in the legislative framework that gives the medicalization of this concept the final stamp of approval. In an inverted sense, in the battle between psychiatry and law the latter gives credence to the former by providing the juridical sanction. The 1913 Mental Deficiency Act, with the official title "An Act to make further and better provisions for the care of Feeble-minded and other Mentally Defective persons and to Amend the Lunacy Acts" *(19)*, was testimony to the influence of several generations of psychiatrists and moral philosophers wrestling over the issues of good and evil. Through the notion of criminal responsibility, the definition of the clinical condition of psychopathy emerged amidst what was termed the moral imbecile. "That is to say, persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect" *(21)*. The psychopathic condition was now complete in philosophical, clinical, and legal terms.

Conclusions

Clinical psychiatric conditions can originate from a focus on human behavior, human difference, or human understanding, and through the medicalization process we can see how, in professional terms, they become legitimated maladies. At the forefront of psychiatric nosology lies philosophical discourse and unless this discourse is absorbed into psychiatric explanation, the full acceptance of a clinical condition is unlikely to be completed. In this chapter, I have argued that as homicidal monomania fell from use as a psychiatric term it was replaced by a focus on morality within the confines of criminal responsibility and that throughout the previous century the transition of philosophical concepts to psychiatric discourse paved the way for the medicalization of morality. Beginning with notions of good and evil, right and wrong, and freewill and determinism, the ground was set for the creation of the psychopath as a clinical entity. By the end of the 19th century and the beginning of the 20th century the law in the United Kingdom finally gave full sanction to the condition, through the definition of the moral imbecile. If the birth of the psychopath was through the caesuras and ruptures of philosophical and psychiatric discourse, then the 1913 Mental Deficiency Act may well have been its birth certificate.

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Chapter 6

The Comforts of Evil

Dangerous Personalities in High-Security Hospitals and the Horror Film

Mick McKeown and Mark Stowell-Smith

Background

This chapter reflects recent UK legislative proposals for the detention of dangerous individuals with severe personality disorder as a starting point for deriving insight into the deployment of the terminology of evil in everyday discourse. We concern ourselves specifically with the public safety role of high-security hospitals and consequent contribution to the assuagement of collective anxieties. This, in turn, is linked to Julia Kristeva's notion of the abject, with an analagous relationship to anxiety containment seen in people's encounters with horror movies.

Diagnostic categories such as dangerous and severe personality disorder (DSPD) and its forerunner, psychopathic disorder, have had their clinical value called into question. Arguably, such doubts over the practical use of these concepts can be accomodated if they are useful in other ways. We suggest here that one such ancillary function is the containment of anxieties connected with abjection. Abject entitities or experiences threaten the integrity of the self and engender feelings of horror, abomination, and revulsion. The containment of dangerous individuals in special hospitals both serves the purpose of establishing a physical separation from the public world and effects an alleviation of abject fears. This contribution to both physical and emo-

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tional security mirrors psychological processes at work in the consumption of horror films, wherein representations of the abject are safely projected onto the movie screen.

> *The history of the horror film is essentially a history of anxiety in the twentieth century.* (1)

Making Sense of Evil

References to evil abound in news stories and headlines that tell of terrible crimes committed by deranged individuals and international terrorists. The language of evil resonates with public abomination, horror, and terror in contemplation of such deeds. Although this deployment of the term evil may, for many, afford subtle interpretive nuances or elasticity of sense (meaning different things to different people), perhaps its most powerful significance is in exposing the hollowness of comprehension carved out by the acts in question. Thus, the marking out of behavior as evil indicates nothing less than our powerlessness to adequately explain: evil becomes shorthand for incomprehension.

It is our contention in this chapter, in exploring this hinterland in which impotence of understanding reigns supreme, to suggest that the social anxieties that must exist when faced with evil are to some extent minimized by the introduction of seemingly authoritative explanatory devices (such as psychiatric diagnoses) and the segregation of the perpetrators of gross anti-social acts into conditions of high security. Furthermore, popular coverage of this territory, notably in the horror movie genre, serves the same purpose and affords insight into the seeming paradox of mass revulsion co-existing with incessant fascination at horrific criminality.

As the mass media abound with sensational representations of horrifying human behavior, including the depiction of fictitious and actual events, the boundaries between entertainment and reportage become stretched and blurred. It is not uncommon for professionalized language to intrude, but often this is used loosely with casual regard to specificity in diagnosis: the psychotic and the psychopath become virtual synonyms, featuring as interchangeable entities in tabloid headlines or trashy drama scripts. Arguably, these popular accounts are indicative of wider cultural processes in the construction of difference, the distribution of social status, and the delimitation of relationships and lifestyle: the translation of representations of individuals as alien and other into the actual experience of exclusion and otherness *(2)*. General sensationalist media coverage, especially in the tabloid press but also including images in fiction and other forms of news reporting, can conflate all mental disorders

under the same umbrella and variously depicts individuals as monsters, homicidal maniacs, dangerous and in need of containment, presenting a risk to themselves and in need of asylum, narcisisstic parasites, open to ridicule, affording titillation, raving mad, bad, or absolutely evil *(3,4)*. In this sense, our focus in this chapter on dangerous individuals can be seen at the extreme end of broader social processes that construct difference for all people diagnosed with a mental disorder.

A link can be made with lay notions of evil. Evil can be seen as a term that serves to bring order and understanding to that which does not make sense. Diagnostic enterprises can, similarly, be viewed as achieving the same ends—a sort of scientific and moral certainty that results in assuagement of public anxiety. In this chapter, we suggest that the cinematic treatment of horror, and psychopaths specifically, offers insight into the psychological and social processes at work in the management of public fears. This becomes apparent in the obvious visibility of the segregation that occurs on psychiatric diagnosis and subsequent incarceration in high-security hospitals.

The Questionable Authority of Diagnosis

Mass media laxity in the employment of the lexicon of psychiatric and legal labels for individuals accused or convicted of sensational crimes is mirrored in scientific and academic debate over the credibility of these same diagnostic categories. Here we will specifically reflect on recent legislative proposals for the detention of dangerous individuals with severe personality disorder and the corollary public safety role of high-security hospitals. Medicolegal categories such as DSPD and its precursor, psychopathic disorder, are open to various criticisms, not least with regard to their clinical value. However, uncertainties over the use of such concepts might be superseded on the basis that they fulfill other functions. We argue in this chapter that one possible function is the containment of anxiety associated with the notion of the abject, a state defined by Julia Kristeva, which threatens established identity systems, particularly those surrounding the self. The containment of dangerous individuals in high-security hospitals serves the purpose of establishing a physical and psychological separation from the public, thereby alleviating some of these fears. This relationship mirrors one of the psychological processes at work in horror films, wherein the audience achieves a safe distance from that which is fear provoking (but also exciting) through its projection onto the movie screen.

In *The Powers of Horror,* Julia Kristeva *(5)* described the idea of the abject as an entity that lies outside of established systems of identity and in which meaning collapses. In her adaptation of Kristeva's work, Creed *(6)*

described the horror genre as, among other things, a way of dealing with anxieties associated with the abject. Creed also showed how the figure of the psychopath, as an exemplifier of this group, has insinuated its way into the genre. Historical and contemporaneous legal and clinical usage of categories such as DSPD and its predecessor, psychopathy, can be seen as a response to abject anxieties. Behaviors associated with these categories are often assaults on the boundedness of the self, striking at the "I"—a foundational construct within the Western symbolic order.

The diagnosis and institutional containment of individuals with DSPD functions in a way that establishes their behavior as "other," thereby restoring order to this framework. In this respect, categories of dangerous individuals are set apart as distinct and wholly different from a prevailing view of what constitutes normal and common humanity. That these dangerous "selves" are not like and are physically separate from "ourselves" furnishes comfort when faced with knowledge of their behavior and criminality. We argue here that this function parallels the containing process of expulsion and projection that Creed *(6)* ascribes to the horror film and, as such, serves to override doubts about the practical and conceptual value of such concepts as psychopathy and DSPD.

History and Development of Categories of Dangerous Personality in the United Kingdom

In the history of UK mental health services there has always been a concern to legislate for those people who do not appear to suffer from a recognizable mental illness yet exhibit gross forms of behavior apparently because of some other relatively intangible mental condition or disorder of mind. Latterly, such people have been deemed to be afflicted by a personality disorder, the most extreme examples being worthy of the appellation psychopathic disorder. Most recently, a new category of person, those with DSPD have been recognized in government policy, continuing the legal concern with extreme deviant behavior *(7)*. The notion of DSPD appears at the current endpoint of a distinct historical lineage of psychopathic individuals, and is virtually a synonym for the earlier medico-legal construct of psychopathy *(8)*. On reflection, the survival, in various incarnations, of a dangerous personality category appears somewhat remarkable given ambiguities in application and controversies over scientific credibility.

Arguably, both the putative bill to replace the existing 1983 Act and the earlier policy proposals regarding DSPD reflect the political imperative of containing dangerousness *(9–11)*. Beyond the specific proposals for contain-

ment, the very language of New Labor's modernization agenda for mental health services is replete with concerns for public safety *(12)*. This is most evident in the provision, ostensibly targeting "dangerous people with severe personality disorder" but potentially applicable to all mentally disordered persons, that would allow for their detention based on assessment of risk of offending rather than actual conviction for any offense. It is these elements of the legislative review that have caught the imagination of interested commentators, sparking off debate over the validity of the concept and the ethics of any new law *(9,11,13–18)*.

By the government's reckoning, the amount of people with DSPD in the United Kingdom is, at most, 2400 people, of which 1800 are already incarcerated either in prison or high-security mental hospitals *(7)*. The 400 detained in the high-security hospitals are assumed to be those admitted under the legal category of psychopathic disorder. The noted similarities between the two constructs suggests that the problems that have arisen in the use of psychopathic disorder as an organizing category for admission to compulsory treatment may be replicated in the future employment of DSPD.

Ramon *(19)* advances an argument that locates the development of psychopathy as a clinical construct in key social changes spanning the 19th and 20th centuries, especially gathering pace during and after the World War II. Although individuals who would latterly have attracted the label have probably always existed, a clinical concept of psychopathy only emerged alongside the 19th-century incorporation of psychiatry as a discipline within medicine. The first description of socially undesirable behavior as a category of mental disorder was advanced by Pritchard *(20)*, who described the concept of moral imbecility, the main indicators of which were the occurrence of irresponsible behavior in the absence of any discernable mental illness. The notion of psychopathy has been enshrined, and altered little, in successive mental health acts from The Mental Deficiency Act of 1913 through to the 1983 Mental Health Act in the United Kingdom.

Significantly, the term psychopathy has no place in either of the major diagnostic systems (*Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* [DSM-IV-TR], *International Classification of Diseases* [ICD]-10); however, it does have analogs in the category of antisocial personality disorder, as specified in DSM-IV-TR *(21)*, and in the ICD-10 category of dissocial personality disorder *(22)*. Influential elaborations of the psychopathy concept include Cleckley *(23)* and Hare *(24)*, who suggests that a common thread to run throughout this criteria is an absence of interpersonal warmth, a quality that Hare sought to identify in his own "psychopathy check list."

The social and political experience of world war and its aftermath were important for the growing acceptance afforded to both psychological explanations of mental distress and the provision of universal welfare. Soldiers who exhibited psychopathic behavior were treated in newly established therapeutic communities as an alternative to military prison or dishonorable discharge, affirming the identification of antisocial behavior as psychiatric distrurbance.

Ramon *(19)* sees this process as part of a wider expansion of the remit of psychiatry and psychology, constituting a psy-complex; with ever-increasing dimensions of human behavior coming under the remit of clinicians and open to clinical intervention. The growth of the psy-complex has taken place in a postenlightenment context that recognizes a particularly Western notion of the self that, among other functions, is highly compatible with a hegemony of science and capitalism. Geertz *(25)* described this dominant notion of the self, or "I", as a "...bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement and action, organized into a distinctive whole and set contrastively against other such wholes and against a social and natural background."

The infusion of modern psychiatry and indeed the wider social world with psychologized ways of making sense of events and circumstances has resulted in a proliferation of self-celebratory practices such as counseling. In part, this privileged version of the self arises, and is defined, through its relationship to its antithesis—something that embodies a sense of otherness.

After the war, the notion of psychopathy maintained its currency in offering a device for explaining forms of aggression and other undesirable traits that did not fit easily into the new structures for interpreting public behavior that accompanied the growth of the welfare state. If the poor were not to be blamed for their condition, and antisocial behavior was a product of social factors, then what was to be done about those individuals who appeared not to fit this role of passive victims of circumstances? For Ramon *(19)*, the answer was to enshrine the clinical notion of psychopathy into a distinct legal category of mental disorder, incorporated into the Mental Health Act of 1959.

Problems With the Concept of Severe Personality Disorder

Many criticisms have been made regarding the continuing usage of categories of severe personality disorder, with earlier critique focusing on the concept of psychopathy. Although broadly distinguished as either a medico-legal category or a type of abnormal personality, the term psychopath has had a number of different applications that have been formulated and described in a variety of ways. Coid *(26)* identified at least four uses of the term, including:

its use as a legal concept, a popular term of opprobrium, a single diagnostic category (e.g., the DSM and ICD categories of antisocial and dissocial personality disorder), and a "broad generic term to encompass a wide range of poorly delineated psychopathology exhibited by individuals with severe personality disorder who may exhibit antisocial or other dysfunctional social behaviour."

Perhaps common to all of these applications is an attempt to theorize a relationship between an abnormal mind, self, or personality and a propensity for grossly antisocial behavior. Such a relationship is strongly implied in the legal definition of psychopathy: "psychopathic disorder means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" *(27)*.

Common to all of these descriptions is a tendency to employ existing norms of socially acceptable behavior as a benchmark against which to measure or diagnose psychopathy. A problem with this is that it becomes difficult to disambiguate these norms from a particular personality type with which particular types of emotion and cognition can be associated. Internationally, the confusion that has arisen in the course of attempting to make sense of this relationship is something that led many countries to abandon the concept of psychopathy altogether on the grounds that it is beyond definition *(28)*. Within the United Kingdom, critics such as Blackburn *(29)* have pointed to the fact that countless studies have failed to identify a single type of abnormal personality that is prone to chronic rule violation and have repeatedly made the error of confusing social deviance with personal deviance. For various commentators, there are insufficient research findings to dispel the suspicion that categories such as psychopathy and severe personality disorder have been utilized as merely speculative constructs, casting doubt on the use of a categorical diagnostic system *(10,29)*. Correspondingly, Blackburn *(30)* concluded that "psychopathic disorder or anti social personality are simply umbrella terms which cover a mixed group of people who have in common only a history of socially deviant behaviour."

For Blackburn *(8)*, the employment of such global constructs, including the more recent DSPD, arise from ignorance about the notion of personality disorder, its treatability, and relationship to offending, and obscures the actual heterogeneity of such offenders. In the absence of clear etiological factors—no proven biological substrate exists and there is ambiguity as to the psychological causation *(29)*—a tautological inference occurs in which the disorder has come to be deduced from the very behavior it is supposed to explain. Chiswick concurs with this analysis, suggesting that the elasticity of the terminology allows almost any violent offender to slip into these categories, with

diagnosis being determined by such vagaries as to which prison the offender is remanded or by which psychiatrist he or she is interviewed *(31)*.

This problem has continued to dog psychopathy throughout its history. Levenson *(32)* highlights some of the absurdities to which this can lead, pointing out that, in practice, psychopathy is linked with socially deviant behavior and adds to this by arguing that social deviance is itself defined by a failure to conform to the prevailing social norms. Hence "opponents of Nazi rule in Nazi Germany, opponents of segregation in the American south and Apartheid in South Africa and, currently, Americans who are not devoted to increasing their consumption display...a psychopathic trend" *(32)*.

The lack of specificity in the legal definition of psychopathy was recognized by those charged with Ministerial reviews of the care of psychopathically disordered individuals in secure services *(33)*.

Treatability

Much of this uncertainty haunts the issue of helping or treating individuals with personality disorders, dangerous or otherwise, with a lack of evidence either way that personality disorder is treatable or nontreatable *(8,34,35)*. Collins *(36)* noted the vague, nonspecific way in which psychiatrists addressed treatment issues and Black *(37)* suggested that, on the basis of information available, any identified improvements in psychopaths' condition could not be related to specific inpatient treatments offered. One strain of opinion is that psychopaths are unable to make fundamental changes. Bailey and McCulloch *(38)* showed that psychopaths were significantly more likely to re-offend than a mentally ill group of offenders, and other commentators have hinted at the psychopath's facility to display a level of institutional adjustment that conceals their underlying propensity for further antisocial behavior. Faulk *(39)*, for example, discusses studies that have evaluated Grendon psychiatric prison (an institution that contains inmates broadly categorized as being psychopathically disordered). He suggests that when compared with a comparable prison population they showed a greater degree of adjustment and reduced neurotic symptomatology; however, levels of antisocial behavior—reflected in rates of re-offending, at both a 2- and 10-year follow-up showed no difference.

As an example of this, Roth *(40)* cites the case of Graham Young who poisoned three people and passed through Broadmoor, but soon after being discharged committed similar offences, this time poisoning a group of workmates; "At home were found Nazi emblems, drawings of graveyards and other objects affecting sadistic fantasies. In his many years of confinement in Broadmoor he had been quiet, inoffensive and well behaved."

Collins *(36)* suggests that lack of clarity surrounds psychiatrists' perception of treatability at the admission stage. Studies examining the effectiveness of treatments for people defined as having a psychopathic disorder are, in general, either equivocal or disappointing. Dolan and Coid *(34)* acknowledge this attitude but add that researchers have repeatedly failed to develop strategies for either proving or disproving the effectiveness of treatment with psychopaths. They suggest that scepticism about the treatability of psychopaths "may, in part, result from the professionals inadequate assesment in the first place, followed by an inability to develop, describe and research and adequately demonstrate the efficacy of treatment strategies."

Other studies have shown that, when assessed, little in the way of effective treatment is offered. Norris *(41)* suggests that traditional medical ideas about care, treatment, and cure are subordinate to control issues with psychopaths. She argued that length of stay in the high-security hospital correlated with severity of offending behavior, rather than psychological functioning *(41)*. Hence, the more severe the offense, the longer the treatment required. The control/treatment association has also been highlighted by Grounds *(42)* who studied the transfer of inmates from prison to high-security hospitals between 1960 and 1983. He noted that through the course of this period, sentenced prisoners were referred to the hospital at a point increasingly nearer to their earliest date of release. This trend suggested that the control and prolonged custody of the inmates, rather than their care and treatment was the prime consideration among both the referring agents and those institutions that received them.

A similar picture is developed by Dell and Robertson *(43)*, in their account of nonpsychotic (i.e., psychopathic) men in Broadmoor. This study showed that treatment appeared to be given a low priority with only a minority of men—35%—participating in any form of psychological therapy. The authors estimated that for the majority of their time in hospital, nonpsychotic men were engaged in no specific treatment. Second, an attitude of scepticism toward treatment was elicited from Broadmoor consultants. Consultants were often unable to define the specific help required by patients that they had admitted under the psychopathic category and, in only 38% of cases, was it expected that the provision of psychological treatment would make more of a difference than the passing of time. Third, despite the complexity of issues surrounding the discharge of patients from the hospital, one factor remained constant: no individual detained under this category was proposed for discharge before a period of 3 years after their admission had elapsed *(43)*.

Delland and Robertson *(43)* conclude from these facts that, although it might be officially denied, patients admitted to high-security hospitals under

the psychopathic category were expected to pay back "time for crime." Considered together these studies suggest that clinical treatment issues share at least an equal, if not subordinate status, to custodial and legal ones. Reporting on more contemporary work, Bowers *(44)* observes that in the absence of any consensus as to what works in treatment, the application of treatment in the high-security hospitals is variable and perhaps haphazard, dependent on prevailing beliefs and sympathies of individual professionals, care teams, or managers.

Critical Debate Concerning the Current Legislative Proposals

The government's proposals for preventive detention are arguably designed to side-step human rights legislation, designating a category of individuals of unsound mind to whom such measures can be legitimately applied *(45)*. Arguably, these proposals could result in indeterminate confinement because of the facility to repeatedly renew detention in a context of uncertainties regarding treatment effectiveness. Mullen *(9)* seriously doubts the ability of practitioners and services to fulfill the envisaged role of protectors of public safety in this regard, highlighting the impossibility of accurately predicting future risk of offending for any individuals on clinical grounds. The reality would be a circular process of reasoning whereby the propensity for further offending would be inferred in the knowledge of past offending, with mental health or personality variables likely to play a minimal role. Although the actual proposals frame the definition of mental disorder very broadly, with respect to DSPD, Gledhill *(13)* draws attention to the dangers of basing a system of indeterminate detention on an invented category of mental disorder. In this regard, he is skeptical that the coining of an acronym is designed to obscure the lack of credibility or clarity of definition in the DSPD category, seducing people toward a greater degree of confidence in its application than is actually warranted.

These critical readings of government policy have a number of themes in common. First is the opinion that the containment of dangerousness is disproportionately overemphasized, and that the focus on DSPD assists in supporting a form of public rhetoric that stresses the government's seriousness to tackle hard criminal justice issues, gaining cheap political capital in the process. This agenda is advanced in a context of maximized media exposure to serious criminal offenses committed by mentally disordered individuals, or where this is suspected, playing to the consequential public fears of such crime and expressed desires for retribution. Interestingly, the incorporation into the popular horror genre of fictionalized versions of actual crimes can be seen to contribute to the raising of public fears, which in turn plays into the hands of

those who would maximize public protection by ever more restrictive criminal justice measures *(46)*. From this perspective, various moral and ethical objections to the proposals emerge. The second strand of criticism is more concerned with the practical pitfalls that arise from critique of the practicality of framing policy around such a conceptually vague entity as DSPD.

Threats to Identity in Contemporary Culture

Over the years a variety of explanations have been advanced to account for the survival of psychopathy in the face of the extant criticisms. For example, Glenn *(47)* suggests that it survives as a form of cultural emblem signifying self-interest, superficiality, and shallowness, qualities that resonate with the framework of contemporary, postmodern culture *(32)*. Other theorists, such as Ramon *(19)*, have advanced the Foucauldian argument that the category of psychopathy should be viewed in the context of increasing medicalization, or, more appropriately, psychiatrization, associated with a psychological complex. Within the psychological complex, the category of psychopathy is yet another conceptual surface through which particular forms of subjectivity can be located and regulated.

Implicit in Kristeva's idea of abjection is the notion of the clean and proper self, a self that is whole, centerd, and fully constituted. Foucault *(48,49)* illustrated how this perspective on the self has come to attain a position of primacy within Western thinking. According to Foucault, although in traditional society only the monarch possessed true individuality, the transition to modern industrial society witnessed the self emerging as a mass phenomenon. The centrality of the self to Western culture is sustained through culturally pervasive themes concerning the hegemony of science, the inevitability of progress, and individual meaning vested in and arising from the human subject *(50,51)*.

Bauman *(52)* argues that such themes first emerge in the 16th century with the development of empirical science and can be seen as an attempt to impose order on a world dominated by magic and mysticism. Foucault's work suggests that these ideas were propagated in the form of a series of narratives, evoking rational, mechanical, and logical images, with humans rather than God, at the center of things. Levin *(53)* locates Nietchze's heralding of the "death of God" as the 19th century philosophical expression of this movement. Slugoski and Ginsberg *(54)* suggest that humanity's displacement of God at the center of things also coincided with the transition to capitalism, providing a functional set of values, focusing on the individual (personal responsibility, individual freedom), supporting the needs of the newly emerging economic infrastructure.

Drawing on Foucauldian theory, critical work within psychology *(55–57)* has examined how the boundaries of the self are defined and reproduced by a variety of lay and scientific theories. Such definitions arise within a set of modernist narratives about the individual, which incorporate a dominant perspective about the self while closing off alternative ways of viewing what it is to be "me" *(50)*. In this sense, Geertz's *(25)* definition can be seen to be an idealized version of selfhood; among other things, identifying the self, which is the archetypal subject of therapeutic intervention in modern psychiatry and psychology.

Recent debates, however, have described the contemporary cultural climate as one in which these discursive boundaries are increasingly under threat. Deconstructive and poststructuralist critiques of modernist epistemology have brought into question the reality status of the self, representing it as textually constructed *(58,59)* and decentered *(60)* in the symbolic order of language. Weatherill *(61)* sees the dissolution of boundaries around the integrated, Cartesian self of modernity as further expedited within a culture in which privacy is devalued in favor of qualities of openness—"of telling all, of sharing intimacies—preferably to a mass readership, or television or radio audience." Levin *(53)* describes the paradoxical way in which Nietzsche's heralding of the modernist *episteme* (with his pronouncement of the "death of God") also sowed the seeds for the postmodern "death of the subject." Levin shows how, in part, this transition is underpinned by Nietzsche's nihilism in which the death of God and the associated order of absolute morality and truth, suggests that there is "no meaning, at all in existence, as if everything were in vain" *(62)*.

Sass *(63)* discussed how for some, the anxiety provoked by the fictionalism and relativism (associated with this postmodern state of affairs) might prove unbearable. In his discussion of the impact of the postmodern on psychoanalytic practice, Sass argues that although for some there may be a curative value in embracing the idea of fictionalism and relativism, for others—those whose sense of self is already fragile or those for whom "the brute, undeniable reality of certain memories may make them less attracted to the idea of merely making up stories"— this might not be the case. Frosh *(64)* noted how more general ontological anxieties in the contemporary situation might be reflected in the increased attention given to particular types of self pathology, such as those most often identified with the diagnosis of personality disorder.

Psychopathy and the Abject

Arguably, another way of considering the continuing interest in the idea of psychopathy is that it helps us deal with anxieties associated with the abject.

As previously stated, Kristeva presents the abject as an entity that lies beyond meaning and signification and, crucially, "where 'I' am not" *(5)*. Abjection is defined as a state that does not "respect borders, positions and rules" and that corresponds to that which "disturbs identity, system, order" *(5)*. As such, we are compelled to defend ourselves from both the physical and emotional threat posed by the abject, which provokes "an extremely strong feeling which is at once somatic and symbolic, and which is above all a revolt of the person against an external menace from which one wants to keep oneself at a distance" *(65)*. Grant *(66)* argues that what Kristeva regards as abject phenomena correspond to Judaic notions of abomination. Central to this idea is the corpse, which represents a particular transgression beyond the symbolic system within which the "I" is realized. Whereas the living "I" expels wastes (faeces, pus, blood) "the corpse, that most sickening of wastes, is a border that has encroached upon everything. It is no longer 'I' who is expel. 'I' is expelled" *(5)*.

The corpse is abject and induces particular disgust and loathing because it lies beyond the borders of particular signifying systems within which is constituted the concept of the clean and proper self *(5)*. However, although transgression of these borders may be sickening, it also provokes fascination: "although the abject must be excluded it must also be tolerated for that which threatens to destroy life also helps to define life. Further the activity of exclusion is necessary to guarantee that the subject take up his/her proper place in relation to the symbolic order" *(6)*.

People find that which is abject both revolting and fascinating, yet, nevertheless, are drawn to contemplate its existence. Awareness of what is not abject presupposes awareness of what is, so that the act of exclusion necessitates the seeking out and active definition of that same entity. The implication here is that, for the subject to apprehend what lies within a system of signification they must also apprehend and revisit what lies outside of that system. Hence, the subject is compelled to revisit the border, and confront and exclude the non-human. This process of exclusion, in turn, recasts boundaries around the "I."

Abjection and the Movies

Creed *(6)* argues that the modern horror film is one means through which this project is achieved, first, through a confrontation with the abject and, second, through a process of expulsion in which abject phenomenon are projected on to a screen for an audience to view at a safe distance "When we say such-and-such a horror film 'made me sick' or 'scared the shit out of me' we are actually foregrounding [it] as a work of abjection…viewing the horror

film signifies a desire not only for perverse pleasure (confronting sickening/horrific images) but also a desire…to eject the abject (from the safety of the spectators seat" *(6)*.

In this way, horror films act as a kind of "modern defilement rite in which all that threatens the symbolic order, all that is Other, is separated out and subordinated to the existing symbolic order" *(66)*. Creed identifies a number of foci within this act of separation that include, among other things, an exploration of phenomena that are external to everyday systems of signification. In this respect, Creed *(6)* notes how images of bodily wastes, such as blood, sweat, and pus abound in the horror film along with the delineation of a border zone between the human and the non-human. Examples of the latter might comprise representations of the zombie ("the living corpse"), the vampire ("the body without a soul"), and the android *(6)*.

Along with the horror film, filmic representations of psychopathy often portray material that is not easily accomodated within established identity systems. However, whereas the horror genre explores an interface between an identity system centered on the clean and proper self and phenomena that lie beyond that, filmic depictions of psychopathy are more concerned with actions and behaviors that defy common sense understanding but which, in turn, often threaten the integrity of the self. Such overarching interpretations of the horror genre have been criticized by Tudor *(67)* as being reductive and lacking in specificity. Alternately, Valier *(68)* ranges widely in applying Kristeva's ideas to explore horror and gothicism in the nexus between the literary/visual and the law. For Valier *(68)*, "Gothicism narrates crime and punishment in a sensationalist manner, accomplishing its potent effects through titillated fascination and excited revulsion."

The Filmic Psychopath

Many of these themes are repeated in horror films that present images of the psychopath. The history of the filmic psychopath has been described by Wilson *(69)*, who argues that both in film and in popular culture psychopathy enjoys a "parallel life" to its scientific counterpart. This is a life not encumbered by the constraints of science but one which exploits the "semantic haze" surrounding the scientific concept of psychopathy to produce an array of different representation.

The historical development of these representations has been described by Hardy *(70)* who notes how, before the spread of psychoanalytic ideas to Hollywood in the 1940s, the tradition was to clearly distinguish between the normal and insane criminal. In this respect the origins of more contemporary filmic representations of psychopathy can be traced back to early mad char-

acters such as Lon Chainey's disturbed and disfigured *Phantom of the Opera* (1925) and Irving Pichel's drooling retard in *Murder by the Clock* (1931). Subsequent films such as *Little Caesar* (1930) and *Scarface* (1932) offer a more subtle portrayal of men who have been driven to criminal acts by a combination of avarice, social conditions, and mental problems. Greater ambiguity and blurring of boundaries is introduced through the *film noir* genre in the 1940s and 1950s in which ordinary men are frequently cast as sexually obsessed, introverted, weak, and desperate *(70)*. The violent, driven protagonist depicted by Humphrey Bogart in *In a Lonely Place* (1950) is representative of this less clearly differentiated picture of madness.

In part, however, the films of the 1940s and 50s demonstrate characters with no more than incidental symptoms of mental disorder. By contrast, *Psycho* (1960) develops a fuller, more complete representation of the psychopathic killer. Most famously, *Psycho* defines a relationship between a dominant, overpossessive mother and her son. The viewer is invited to make inferences about the effects of this relationship on the central character, Norman Bates. Bates' murderous behavior is described by Creed *(6)* as "the horror that ensues when the son feels threatened, physically and psychically, by the maternal figure. Norman Bates's desire to become the mother is motivated not by love but by fear: he wants to become the mother in order to prevent his own castration—to castrate rather than be castrated."

Hardy *(70)* also comments how *Psycho* is significant as the film that initiates a genre in which psychological disturbance in the criminal, usually homicidal psychopath, is central rather than incidental to character portrayal. A vast number of films follow this formula including, to name but a few, *Peeping Tom* (1960), *Boston Strangler* (1968), *10 Rillington Place* (1971), *Taxi Driver* (1976), *Manhunter* (1986), and the *Silence of the Lambs* (1991). Latterly, there has been a noticeable proliferation of such films dealing with both fictive and fact-based depictions of various serial killers.

A central feature to emerge within this genre is an attempt to explore the relationship between an abnormal mind and antisocial behavior. In part, this relationship is dramatized through the delineation of a type of border between normal and abnormal uses of violence. This can be seen in films such as *Cape Fear* (1961), *Badlands* (1973), *Blue Velvet* (1986), *Silence of the Lambs* (1991), and *Reservoir Dogs* (1992). In the latter the border emerges in the comparison between Mr. White's instrumental use of violence for criminal ends and the more dramatic, less easily viewed and understood sadism of Mr. Blonde. The behavior of Alex, the central character of Kubrik's *A Clockwork Orange* (1971) also shades into this not easily understood, abject form of violence. The absence of motivation is something that marks Alex's violence as abject.

Both the concern provoked by the apparent lack of motivation and the need to restore some form of meaning to his actions is reflected in the following speech by a family friend: "You've got a good home here, good loving parents, you've got not too bad a brain, is it some kind of a devil that crawls inside of you?" *(69)*.

Filmic representations of psychopathy often portray an ambiguous mixture of strong emotions that are aroused in spectators viewing the main protagonists from the safety of their theater seats. Banks *(71)* states "We secretly admire their disrespect for convention and guiltless flaunting of rules and laws in a manner that we find almost impossible to do. We enjoy their brave exploits and fearlessness. While we fear their predatory nature, yet we find in them a mixture of beauty and danger."

The huge number of films that either implicitly or explicitly take psychopathy as their focus suggests the popularity of this subject matter within wider culture. Perhaps this popularity can be partly linked to Creed's *(6)* suggestion that, as with the horror film, these sorts of films facilitate a process of expulsion, allowing dangerous, disturbing phenomenon to be projected on to a screen for an audience to view at a safe distance. More generally, Bowers *(44)* argues that this level of interest is also sustained within an "us and them" type dynamic in which "us," the public, seek to achieve moral and psychological distance from "them," the psychopaths; a group that invite a mixture of moral revulsion, fear, and excitement. Tithecott *(72)* observes that filmic representations of such individuals have reached the point where the serial killer is a superstar. It follows that the distinction between the movies and the depiction of actual crimes is increasingly blurred, with real-life killers achieving celebrity in a culture of "infotainment," reaching its apotheosis in the televising of the trail of Jeffrey Dahmer.

The Psychopathic Act and Abjection

Part of the fear generated by those identified as suffering from psychopathy or DSPD is that their actions often strike, both literally and symbolically, at the boundedness of the self. Coid and Khatan *(73)* report that of the 579 admissions to high-security hospitals between 1988 and 1994, 132 (23%) were admitted under the category of psychopathic disorder. Some 92% were admitted following criminal behavior, with the majority of index offences being crimes of serious personal harm. With reference to all categories of mental disorder, the most likely forms of criminal behavior leading to detention in a high-security hospital included homicide (32%), attempted murder or grievous bodily harm (28%), actual bodily harm or threats (17%), and various sexual offences including rape (19%). Similar proportions of offending

Table 1
Index Offense for All Individuals Currently Detained at Ashworth High-Security Hospital Admitted With a Primary Diagnosis of Personality Disorder

Index offense	No.	Percentage
Arson	9	7.50
Assault ABH	7	5.84
Attempted murder	4	3.34
Buggery or attempted; indecent assault on a male	4	3.34
Burglary or attempted; breaking or attempted; sacrilege	5	4.17
Gross indecency with a child	5	4.17
Indecent assault on a female	10	8.34
Kidnapping	1	0.84
Manslaughter [a]	25	20.84
Murder	8	6.67
Rape or attempted rape	18	15.00
Robbery or assault with attempt to rob	2	1.67
Theft, larceny	2	1.67
Threat or conspiracy to murder	1	0.84
Wounding GBH—other acts endangering life	12	10.00
Other indictable offences	7	5.84

Source: Ashworth Hospital Case Register.
Note: Admissions of such individuals to Ashworth ceased in 1998.
[a] Section 2 Homicide Act 1957 (diminished responsibility).
ABH, acute bodily harm; GBH, grievous bodily harm.

are reflected in the index offense figures for the current population of individuals diagnosed with personality disorder detained at Ashworth High Security Hospital (*see* Table 1). Coid and Khatan *(73)* contrast the offending behavior of people admitted to high-security settings with those admitted to conditions of medium security, more typically for property crimes or public order offenses, supporting a rationale for the continuing need for the containment function of the high-security hospitals.

Rose *(74)* argues that sexual offenses, such as rape, involve a violation of primitive defences that stand guard over a fundamental autonomy and unknownness. Weatherill *(61)* suggests that sex crimes attack the sense of privacy that has traditionally been associated with the Western sense of self. "It is sexuality that symbolizes our privacy (the genitals are our private parts), and it is around sexuality therefore that invasions—both psychic and physical—will occur in a culture of total openness."

Similarly, violent offenses attack both physical and psychical boundaries. Such offenses may puncture the skin, thereby making "visible the inside and outside," the wound acting as a reminder of the border between the real and the "Real" *(75)*. Such offences may also contain the threat of death and therefore, the possibility of the literal annihilation of self. This possibility attacks a primitive sense of omnipotence *(76)* leaving the victim feeling out of control and vulnerable and establishes a context in which the subject's sense of intactness is disrupted leading to feelings of violability and, in extreme cases, fragmentation *(77)*.

In the terms of reference used here, offenses associated with the idea of DSPD and psychopathy expose us to the abject by attacking and thereby making visible the fragile nature of boundaries around the "I." The violence and invasiveness of the psychopathic act raises questions about the integrity of such boundaries, thereby heightening anxieties that exist both internally and externally. Although not removing the possibility of the physical threat, we argue that the diagnosis and subsequent separation of the psychopath serves a symbolic purpose that renders the psychical threat more tolerable. The process by which this is achieved is analogous to the process of expulsion and projection that Creed *(6)* ascribes to the horror film.

Diagnosis and the Containment of Anxiety

Foucault provided historical illustrations of how diagnosis might reduce the experience of threat and anxiety. In his account of the evolution of the concept of the "dangerous individual" *(78)*, he describes how the category of homicidal mania—one of the forerunners to the contemporary idea of psychopathy—can be linked to the conceptual problems posed by a series of horrific offenses, occurring in the early decades of the 19th century. To give two examples of these offences:

> *In Alsace, during the extremely hard winter of 1817, when famine threatens, a peasant woman takes advantage of her husband's being absent at work and kills their little daughter, cuts off her leg- and cooks it in the soup.*
>
> *In Paris in 1827, Henriette Corniere, a servant, goes to the neighbor of her employer and insists that the neighbor leave her daughter with her for a time. The neighbor hesitates, agrees, then, when she returns for the child, Henriette Corniere has just killed her and has cut off her head which she has thrown out of the window.* (78)

These offences were problematic because of their severity and the fact that they could not be explained through reference to contemporary ideas of irrationality. Existing conceptions of insanity, for example, were based on

the notions of furor and dementia, conditions that were identifiable by their external manifestations (e.g., excesses of passion, rage, anger, and so on) and yet these offenses were said to have been perpetrated in the absence of such external indicators.

Using Kristeva's notion of the abject, one way of looking at the horror and anxiety provoked by these offences would be to see them as acts that are beyond signification and, therefore, occurring in "a place where meaning collapses" *(5)*. Meaning is restored, however, by the diagnostic criteria for homicidal mania, which suggests that the antisocial act might arise out of nowhere—from "the zero degree of insanity" *(78)*. The construction of this category, therefore, inscribes into the subject the possibility of dangerousness. "The fiction of 'homicidal mania' entails that the spectre of dangerousness permanently inserts itself into social life in that visible normality ceases to be a guarantee against the presence of a monstrous pathology" *(79)*.

The reworked version of the self implied here has a number of potential consequences. The insertion of the possibility of dangerousness in the absence of external indicators restores meaning to the type of aberrant act described by Foucault. The actor is now incorporated within a particular system of signification so that the act is no longer meaningless but can be explained by recourse to a medical frame of reference. This implicit explanatory model is perpetuated by contemporary legal and clinical applications of DSPD and psychopathy in which the notion of disability of mind explains the psychopath's hidden potential for dangerousness, thus permitting a post hoc reinterpretation of the abject act.

Additionally, the distinction between normal and abnormal, implied by the category of psychopathy, recasts boundaries around the established symbolic order. Acts inimical to that order (those which attack the boundedness of the self) are pathologized and separated out, much in the way that Creed describes the horror genre as expelling monstrous behavior through projecting it onto a screen. The modernist epistemological framework within which psychiatric diagnosis is traditionally grounded expedites this process. Cheung Chung and Jenner *(80)* argue that this equates to the type of logical atomism propounded by the early Wittgenstein *(81)*. Here language operates as a way of picturing and revealing the structure of external reality. In this way, the diagnostic criteria provided in DSM-IV and ICD-10 are held to depict the reality of knowable, external structures. Thus, categories such as dissocial and antisocial personality disorder are held to delineate types of "real" psychological structures. The flattening realism of this model, therefore, defines particular structures and constellations, which can be viewed as separate and distinct from other healthier structures.

Young *(75)* discussed how popular discourse about abject offenses seems to speak of a desire for a parental surrogate to appear in the form of a stern lawgiver. The task of the lawgiver is to re-establish identity and order through, among other things, the outlawing and exclusion of the perpetrators of the abject act. The categories of DSPD and psychopathy carry this potential, tidying up conceptual uncertainty and warranting, under certain circumstances, the separation and exclusion—in the form of long-term incarceration in a high-security hospital—of those identified as psychopathically disordered. Hence, a final consequence of the category of psychopathy or DSPD is that it provides a legal foundation on which a physical and psychical separation occurs: the segregation of psychopaths into a limited number of locations, such as high-security hospitals and medium security units, establishes a boundary that allows us to see psychopathy as Other. In so doing, this process of externalization "purifies and strengthens our attachment to a cleansed, imagined community in which we can re-experience the modernist desire for 'oneness and unity'" *(75)*.

Forensic psychiatric institutions, with their visible emphasis on security, exemplify this demarcation. Pilgrim and Rogers *(82)* suggest that the postwar trend towards desegregation of the mentally disordered in mainstream psychiatry was accompanied by a reluctance to admit people with a personality disorder or psychopathy diagnosis. Apart from the obvious fact that ordinary in-patient units are not best placed to address or contain extremely challenging behaviors, other factors contribute to this professional rejection of this client group as difficult patients. Hinshelwood *(83)* details the personal impact of caring for people with severe personality disorders in terms of potentially overwhelming disagreeable effects on practitioner's feelings, akin to a kind of abuse. Other commentators have highlighted the moral dimension to the application of personality disorder diagnoses *(10,29,84)* and the invidious status that this confers on people designated as patients by this route. For Pilgrim *(10)*, they fail to completely achieve a sick role, and are perceived of as having the same moral agency as nonpatients, "they are not pitied for their symptoms but condemned for their moral failings."

Forensic institutions, on the other hand, have continued to care for large numbers of such individuals, in effect mopping up those clients undesirable to the mainstream services because they had the "segregative means to effectively manage such deviance" *(82)*. Cawthra and Gibb *(85)* stronly argue that mainstream psychiatry is justified in turning its back on providing treatment for the severely personality disordered, suggesting that they ought to be the exclusive concern of forensic psychiatry, where there is the expectation of "appropriate physical containment in more secure environments."

Conclusions

We have argued here that an interest in the notion of DSPD and a tolerance of ambiguities in the structure and application of the category of psychopathy are maintained, in part, because they achieve a number of psychological purposes. Specifically, although the concepts of psychopathy and DSPD have failed to meet the supposed standards of exactness required by positivist psychiatry, their application has served a purpose by demarking particular zones and boundaries that reduce anxiety. The physical separation afforded by high-security psychiatric care is matched by the emotional security that arises from the conception of dangerous individuals as demonstrably and totally different from the rest of "us" in the general population. Deacon *(86)* offers a similar argument, stating that in a risk-obsessed culture, high-security hospitals appear to provide a sense of "safety in concreteness" by marking out a physical boundary between the dangerously mad (i.e., those incarcerated in a high-security hospital) and those not so defined (i.e., the wider society that lives without the walls of the hospital).

We suggest that, at the very least in terms of unconscious process, but possibly deliberately, the management of these anxieties plays a part in contemporary policy formulation regarding mental health. There are two reasons why we feel that this is a point worth making: first, there is a real danger of the extension of damaging discrimination and stigma to the majority of nondangerous individuals who happen to satisfy the various criteria for mental disorder; second, knowledge of the social and psychological processes that play a part in the formation and maintenance of categories such as DSPD, can help practitioners in their critical appraisal of current and future government policy and legislative review. Admittedly, such knowledge is of less immediate value in helping us determine what to do with those individuals who commit gross antisocial acts or exhibit seriously dangerous behavior. We would argue that recognition of the constructed nature of particular diagnostic or legal categories does not in itself trivialize or fictionalize this offending and the consequent need for services to effectively contribute to public safety. However, it may afford opportunities to pause and reflect on the possible consequences of such practices.

One consequence, as we have seen, is the demarcation of difference and the establishment of a sense of otherness. Deutsch *(87)* points out how cultural situations characterized by, among other things, threat and conflict can potentiate this polarization between versions of self and other. The process of splitting that occurs typically involves the denigration of the other, set in contrast to an ideal self, with those designated as other being viewed as somewhat less than human, and less worthy of humane responses: "those

contained within the walls of the high-security hospitals are visibly captive and available to receive such unconscious social projections, with little opportunity to accept or return them. As such they become powerful symbols of the evil in society, demonized in the press and collective unconscious" *(86)*.

The construction of groups of people as alien and other, often with accompanying demonization, is not restricted to consideration of the social situation of dangerous individuals. The social representation of mental health generally exhibits the same sort of processes and effects. Jodelet *(2)*, reflecting on social relations between residents of French communities, draws attention to patterns of social exclusion visited on those with defined mental disorder. The attendant social symbolism, redolent with fears of pollution and contagion, is resonant with Kristeva's focus on threats to the clean and proper self.

A notable point of relevance from the analysis presented here would be the extent to which it might allow us to deconstruct our representations of dangerous individuals and our relationship to them, opening up the possibilities of reclaiming their humanity. This approach, for instance, would be compatible with clinical approaches that involve attempts to understand the contributing social and developmental factors that might be implicit in individuals' offending, rather than being singularly concerned with physical containment.

Arguably, the knee-jerk adoption of loosely defined categories of dangerous individual into the operation of clinical services is unhelpful. Awareness of some of the psychological issues that we have described in this chapter may aid practitioners and the public in resisting woolly policy prescriptions and associated practice developments, and urge a greater concentration of thought towards more considered responses.

In an extensive survey of nurses working in the three English high-security hospitals, Bowers *(44)* described a range of attitudes toward individuals diagnosed with personality disorder, including those that emphasize notions of otherness, often mediated by a depiction of offending behavior in the distinctly nonclinical terminology of evil. Mercer and colleagues *(88)* outlined the operation of similar narratives of evil in a study of staff working at Ashworth High Security Hospital. In reflecting on his findings, Bowers *(44)* remarks on the apparent paradox of public revulsion at high-profile crimes and offenders coupled with a fascination with films and literature that cover the same ground. Perhaps in this respect the movies and high-security hospitals fulfill the same function: containing at a safe distance, physically and psychically, the objects of our horror.

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Chapter 7

Madness, Badness, and Evil

Deidre N. Greig

Background

The "mad" vs "bad" debate raises fundamental difficulties for the interaction of psychiatry and the law. In one sense the separation of these two states is quite clear. Those who are mad are not responsible for their actions committed as a consequence of their mental state and should be located within treatment parameters on the grounds that their behavior is unlikely to have been conscious, intentional, and voluntary. On the other hand, those who are bad are handled within the confines of the criminal justice system with the prime object being punishment for their transgressions. These boundaries are not as discrete as they might at first appear. Should behavior be excessively depraved and grossly cruel then there is a temptation to add "evil" to the mix, as if this is the unifying link between the two. Although this term is readily invoked in the public domain, both lawyers and psychiatrists cannot escape the influence of ordinary fears and perceptions, especially when behavior is intransigent and resistant to management strategies. It is this mad/bad/evil trajectory that is reviewed in this chapter.

* * *

Just over a decade ago the case of a man with a severe personality disorder posed acute difficulties for the criminal justice and mental health systems in Victoria, Australia, leading one psychiatrist to inform the Supreme Court that it was Garry David's perception of his own evilness that contributed to

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his isolation by fostering an exclusionary response from those prepared to assist him.[1] This therapeutic barrier added yet another facet to an already complex professional and community discourse about whether this man was bad, mad, dangerous, or possibly evil. (For a detailed analysis of the case, *see* ref. *1*.)

In this chapter, it is proposed to develop these themes as they pertained to David and consider the dilemmas that this important case posed for psychiatrists, lawyers, politicians, the public, and the treating staff who were charged with providing answers. This one man had an extraordinary ability to test the stability of the boundary between the criminal justice and mental health systems, which operate as separate arms of government with quite distinct aims and obligations. I argue that this boundary is not as discrete as it would at first appear, because extreme cases are usually ambiguous and their resolution depends on the contingency of circumstances and may initiate a highly contentious discourse between competing professional and public understandings. Rather than being viewed as an authoritative separation of two quite distinct states, the mad/bad divide has a tenuous and negotiable quality. As will be demonstrated, David himself was masterful in his own ability to expose the dilemmas arising when the boundary is breached, in his case often at a whim, and he created confusion for those prison and mental health staff involved in his management. The resultant border dispute was played out on many levels and it sorely tested political obligations to protect the community, just as it tested legal and psychiatric obligations to those with a severe personality disorder.

"Bad" and "mad" are deceptively simple words with quite different administrative and legal consequences. Those designated as bad are considered to have the capacity to freely choose their actions and, consequently, society may invoke the retributive powers of conviction and incarceration under the aegis of the criminal justice system. On the other hand, those deemed to be mad have a reduced capacity for free will and are more liable to attract a therapeutic response. This fundamental distinction is grounded in the legal concept of criminal responsibility, which requires that culpability is premised on those acts held to be voluntary, intentional, and carried out with a con-

[1] Garry (David) retains such an appalling self-image that he is indeed evil beyond comprehension, that when people respond positively to him he finds this very threatening, becomes so destructive in the relationship that eventually he frightens people, who have become revolted by him, and let him know this. (Dr. John Grigor, Second Hearing of the Community Protection Act 1990, Judgment, 15 November 1991, p. 19.)

scious awareness of their actual nature. Without these attributes the perpetrator cannot be considered to be morally blameworthy for criminal behavior that would otherwise be punishable by society.

It is obvious that there are few problems in translating the notion of badness into criminality, which has a legislative clarity and authority mirroring the community's sense of outrage about moral wrongdoing. However, the situation is rather different in relation to madness, for it is here that the law struggles to define aberrant mental states for legal purposes. In seeking to apply categorical forms of reasoning it can never allow for the diagnostic prevarication that is so much an integral part of the psychiatric process, nor does its template match the working knowledge of psychiatrists. Phrases such as "defect of reason" and "disease of the mind"—the core elements of the M'Naghten Rules[2]—are little more than legal artifices to bound otherwise incomprehensible behavior, yet they have remained resistant to reformulation for more than 150 years until the recent acceptance of "mental impairment" in many jurisdictions. This provides a more comfortable forum for psychiatric evidence, although it is situated within a legal, rather than a medical, framework. Although the legal use of "insanity" is becoming anachronistic, the law still retains "mental illness" as the core element of the civil commitment process, despite psychiatry itself relying on the broader concept of "mental disorder" as used in the clinical manuals *(2,3*; *see* refs. *4* and *5)*. Nevertheless, the process of reshaping mental health law that commenced in the 1980s has seen a greater accommodation between psychiatry and the law, and the legal parameters of mental illness are now far more workable for the treatment focus of the psychiatrist.

This brief overview of legal terminology surrounding the concept of madness suggests pragmatism rather than certitude. Because mental states are difficult to grasp with the clarity that the law ordinarily requires, it has little recourse but to define madness according to the purpose of the proceedings, whether this be for a defense of mental impairment, the test of testamentary capacity, fitness to plead, or civil commitment. If there is an underlying tension between the law and psychiatry in relation to legal designations of madness, then further irresolution is evident in the decisions about when, and in what circumstances, this label should be invoked. As a means of separating two different types of behavior, the mad/bad dichotomy is at best crude. Human behavior is complex and not all criminals have the capacity to exercise free choice, just as free will is not necessarily negated by the presence of mental disorder. On occasions, the two states appear to overlap, and the decision

[2] (1843) 10 Cl and Fin 200, 210, 8 ER 718.

about drawing on the procedures of the criminal justice system or those of the mental health system is indeed a difficult one, made even more so by the specter of future dangerousness that must always be paramount for the public and politicians. Cases with the dual elements of madness and badness are fraught with contention, and it is apparent that various professional groups draw on different understandings in seeking to resolve the quandary.

Such a territorial struggle came to public attention in Victoria, Australia, in early 1990 with media releases by the Premier and Cabinet members referring to the prisoner, Garry David, as being *the* most dangerous person in the state. The determination of the state government to intercede in the fate of one person due to be released was unprecedented, as were the lengths to which it was prepared to go in the ensuing years to ensure his continued incarceration.[3] In many respects this was surprising because Garry David was indistinguishable from other long-term prisoners except for the extreme nature of his disruptive behavior, and his penchant for self-publicity even when in the harshest areas of the prison. The characteristics of lengthy imprisonment were all too apparent in this case: he was severely institutionalized, suffered from a personality disorder, self-mutilated in custody, and issued innumerable threats to a broad range of people. But it was the tenor of the political declaration about his dangerousness that was unusual and triggered a lengthy saga involving lawyers, psychiatrists, and politicians in a bid to decide whether he could be deemed to be mentally ill, and thus involuntarily detained via the mental health route following his release from prison custody.

The debates occasioned by this one offender were often acrimonious and conducted at the highest levels of government and the courts. The timing was unusually sensitive because in the late 1980s Victoria, along with other jurisdictions, had expended much effort on separating criminality from mental illness in both a service-oriented and a conceptual sense, and these far-reaching changes were based on social justice principles. Psychiatrists, long stung by their critics' allegations of being "gatekeepers of social control," were eager to collaborate with lawyers increasingly attuned to the ramifications of involuntary commitment and the necessity of ensuring the protection of the mentally ill. In this, political support was forthcoming because the government had demonstrated its seriousness about providing for the rights of both prisoners and patients through legislation and funding. The underlying

[3] The tenor of these media statements is captured by the headline: "Crabb's Vow on 'Psycho'" referring to a statement made by the Honourable Stephen Crabb, who held the dual positions of Minister for Police and Emergency Services and Minister for Corrections in the Victorian Government (*The Sun*, January 8, 1990).

aim was that these two groups were to have access to any necessary treatment and be cared for in a community environment if at all possible.[4] Funds were made available for additional forensic services for mentally disordered prisoners, and the message that warehousing, or custody for convenience, was no longer to be regarded as appropriate in either the criminal justice or mental health systems was widely disseminated through policy initiatives and in the stated objectives of the relevant legislation (*see* ref. *1*, p. 32).

All these changes had the effect of clarifying and strengthening the boundary between criminality and mental illness in a way not previously envisaged, but it soon became obvious that little serious consideration had been given to the place of patients with severe personality disorders, either in terms of their management, or in the provision of suitable facilities. The fact that elements of both states may form part of the same behavioral pattern was often confusing to the professionals involved in decision-making, as was evidence of treatment resistance and the possibility of further intransigence. These aspects became all too apparent in the Garry David case. The fact that he had a severe antisocial personality disorder was beyond question, but did he fit within the paradigm of madness or badness, and was he dangerous, let alone evil? These questions generated an intense and financially costly discourse for nearly 4 years until his death on June 11, 1993.[5]

At the time, psychiatrists, in accordance with recent legislative changes, generally accepted that an exclusionary section of the Mental Health Act (1986) (Vic) prevented them from having the right to certify on the grounds of a diagnosis of antisocial personality disorder alone.[6] This Act was intended to be health-focused and confinement in a psychiatric institution could only be justified by the provision of the appropriate treatment and demonstration that

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[4] Section 8(1)(e) of the Mental Health Act (Vic) 1986 states that civil commitment requires treatment to be carried out in the least restrictive environment; while ss.47(d) and (f) of the Corrections Act (Vic) 1986 affirm the right of prisoners to "reasonable care and treatment" either inside or, where necessary, outside the prison.

[5] Around 1991, it was estimated that approximately 100 professionals were working on either some aspect of his management, or the preparation and presentation of court material. Official estimates cited a cost, at that stage, of between $9 and $12 million (*1*, pp. 156–157).

[6] There was some uncertainty about the interpretation of S. 8(2)(l) of the Mental Health Act (Vic) 1986 which prevented commitment of those "with an antisocial personality" on this basis alone. The omission of the word "disorder" suggested that this was a more ordinary usage of the key terms than that of a formal mental disorder diagnosis.

the principle of the least restrictive environment had been observed. There was little internal consensus that psychopaths were treatable and, therefore, civil commitment appeared to masquerade as unjust custody in these instances. Had the government not planned for Garry David's further detention in the absence of any declaration of criminality or mental illness, there may have been little pressure to identify just where the personality disorders should fit within the spectrum of madness and badness, nor would there have been any compromise of its own reform strategy with subsequent actions.

Just before his release date, and after lengthy incarceration within the prison system, David was certified on the grounds of mental illness, but at the same time he was encouraged to initiate an appeal against his further detention. Over the next 3 months, the Victorian Mental Health Review Board had the task of hearing this appeal, during which 11 psychiatrists engaged publicly in fine diagnostic discriminations in a manner alien to the more equivocal approach of clinical discourse.[7] Their lack of consensus regarding whether David could be held to be certifiable on the grounds of his personality disorder was immediately apparent. The Board ultimately, after a hearing of unprecedented length, gave its finding that his personality disorder did not come within the legislative meaning of mental illness when applying either the clinical standard, or that of the ordinary person (*see* ref. *4*, p. 207).

The Victorian government immediately exercised its own right of appeal, and took the extraordinary step of enacting special one-person legislation as a further backstop. This Community Protection Act (1990) empowered a Supreme Court judge to determine whether Garry David was a serious risk to the safety of any member of the public, or likely to commit an act of violence to another person, in which case that judge could then make an order for his preventive detention in a prison or a psychiatric facility.[8] This veneer of judicial discretion was immediately compromised in view of the stated intention of legislation that had the sole purpose of providing for "the safety of members of the public and the care or treatment and the management of Garry David." It is curious that the rationale for preventive detention was framed in this way, because at the outset it conjoins mental health and correctional objectives on the grounds that this particular person is likely to be a future danger to the community. At this point, the government's efforts at separating two distinct administrative spheres were manifestly crumbling under the recalcitrance of

[7] In addition, two medical practitioners from the prison and two psychiatric nurses from another security facility gave evidence.

[8] Community Protection Act 1990 (Vic) s.8(1)(a) and (b); and s.8(2).

one detainee with a severe personality disorder, who was putting at risk the newly implemented forensic strategies.

Many other jurisdictions have responded with similar vacillation about those recidivist offenders who appear to straddle the boundary between mental health and corrections. The late 1990s saw a spate of legislation in which past history became the trigger for personality disorder or mental abnormality constituting the risk justification for an application for preventive detention. Those held under such provisions are usually outside the ambit of the criminal justice system having completed their sentences, and beyond the reach of the more restrictive criteria of civil commitment; the normal safeguards of each process being no longer applicable.[9] This sentencing trend appeals to popular sentiment, but it adds further confusion to the border dispute and entails serious ethical issues for psychiatrists who are placed in the position of having to treat compulsorily those they may consider to be essentially untreatable, yet whose release will ultimately depend on a declaration of clinical improvement *(5)*.[10] At once it is apparent that legislation of this sort overrides the notion of therapeutic jurisprudence by attempting to combine a retributive, open-ended sentence with an expectation of effective treatment *(6–8)*.[11] In the Garry David case, the anomalous nature of the legislation he faced was so flawed on this and other grounds, that it was well beyond the safeguards of ordinary sentencing principles and brought with it a host of unanticipated problems that I have canvassed elsewhere.[12]

One aspect, rarely considered by legislators seeking to ameliorate the harshness of retributive aims, is the fact that management difficulties become even more acute in the absence of a definite release date. This was particularly notable in the case at hand, for David had a history of skillfully orchestrating high levels of tension in all those institutions in which he was placed,

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[9] *See* e.g., the Kansas Sexually Violent Predator Act 1994 (US); the Dangerous Prisoners (Sexual Offenders) Act (Qld) 2003; and the Mental Health Bill (UK) 2004 as salient examples of this current trend.

[10] It is interesting that a recent study in Victoria indicates that judges have generally declined to exercise their new powers of extending sentences for those deemed to be serious sexual or serious violent offenders under the Sentencing (Amendment) Act (Vic) 1993. *See* ref. *5*.

[11] The literature on therapeutic jurisprudence has proliferated in the past decade since the idea was initially publicised in the writings of David Wexler and Bruce Winick. For example *see* refs. *6* and *7*. Bruce Arrigo *(8)* provides a useful critical analysis of the concept in his recent (2004) article.

[12] Detail is provided in Chapter 6 of ref. *1*.

and he reveled in the resultant discord. For example, he used a myriad of techniques to challenge staff competence and expertise and, at the same time, he drew attention to inconsistencies in the dividing practices between correctional methods of control and the treatment rationale of mental health. An early memorandum written by the psychiatrist in charge of Forensic Psychiatric Services revealed the disillusionment and frustration involved in making decisions about such a fractious prisoner, when he noted the "further dissonance" arising between psychiatric and prison services, and admitted once again taking "the first steps of a macabre dance to his well-known tune." He further contended that "problems of this sort do not go away in real life as they do in a novel," and any transfer of the prisoner to another facility "does not close the book; it merely turns the page." [13] Not only was the prisoner intractable, but he also seemed to be controlling the mad/bad divide with disadvantageous consequences for all concerned. It became common knowledge throughout the institution that his management was often by "van therapy", or short-term removal to another facility for staff reprieve, despite the fact that the frequency of such moves thwarted carefully crafted management plans.[14]

In subsequent years, the problems compounded, and the management of David became extraordinarily difficult. His anomalous status as a detainee under the Community Protection Act (1990) meant that he was technically neither a prisoner in the criminal sense, nor was he an ordinary psychiatric patient. As one chief prison officer described the dilemma in one of the many Supreme Court hearings: "Prison officers always have to weigh up to themselves their responsibility to execute the law and look after a prisoner for whom they have no warrant."[15] David, on his part, refused to cooperate on the grounds that the legislation was an abuse of due process, but he was sufficiently contrary to demand disproportionate access to scarce psychiatric and psychological resources (*see* ref. *1*, p. 191). At the same time, the fact that much of his behavior gave rise to internal prison sanctions militated against

[13] Memorandum to Director, Mental Health Division of the Health Department of Victoria, January 9, 1985.

[14] This practice is described in the same internal memo of January 9, 1985, in which the chief medical officer of Pentridge Prison wrote the following: "The strategies used can be summarised by the term 'van therapy' which has involved moving the problem from place to place at intervals, which have remained largely under the control of the prison, but never actually achieving anything therapeutic. Indeed none has been forecast to my knowledge, and all that has been achieved has been deterioration."

the consistent application of any treatment program and substantiated his complaints about the neglect of his rehabilitative needs. Over time, disciplinary action became less frequent in order to avoid excessive confrontation, but this detainee's violent outbursts impacted on the morale of both patients and prisoners, who frequently succumbed to manipulative strategies that included the incitement of suicide and possible self-immolation (*see* ref. *1*, p. 44). David's flagrant security breaches in one maximum-security institution resulted in its closure and led the government to construct a number of special facilities at enormous expense. Each of these he rejected, tauntingly, as being akin to "a one-man prison grafted on to a one-person Act" [16] and, in a further disquieting allusion, he likened his experience to that of Hess in Spandau Gaol providing him with what he considered to be a lawful entitlement to resist.[17] There was an irony about this claim because, although Garry David vehemently argued that an oppressive state power was denying him his freedom, he was equally afraid of confronting the world outside and used strategies to ensure that his incarceration continued.

These few, of innumerable, examples suggest some of the many difficulties that may occur when a detainee has the capacity to challenge the legitimacy of the boundary between criminality and mental illness and thereby heighten professional uncertainties. David played on the confusion of his dual status by referring to himself as "a psychiatric prisoner" (*see* ref. *1*, p. 97)—a description unwittingly reinforcing the public's view that he must indeed be both mad and bad—and he refused to accept the ordinary conventions of either prisoner or patient status. At the same time, he exercised such a degree of control over his management that classification became a bargaining tool and staff members were increasingly demoralized by their sense of entrapment (*see* ref. *1*, p. 245). He derided therapists for their inability to assist him, often publicly mocking them for a lack of a duty of care, even when he aggressively refused treatment in life-threatening situations. On many occasions, threats led to escalating fears with consequent industrial unrest. Yet, at other times, his cooperation and charm were beguiling, and he dangled the hope of further therapeutic effort being worthwhile. But overall the institutional interaction with this one prisoner was more akin to a cat and mouse game with staff having to anticipate each unpredictable move. Garry David's resistive techniques were so various and so frankly calculated to thwart rehabilitative efforts, that he tested the efficacy of the government's ideological shift away

[15] Evidence given before Justice Hedigan, October 11, 1991.
[16] Ibid, May 29, 1991.
[17] Judgement, Community Protection Act 1990 (Second Hearing), November 15, 1991.

from warehousing, and placed himself beyond the reach of either correctional sanctions or treatment initiatives.

Ultimately, cases of this sort raise an important ethical issue: should therapeutic services be withheld in the light of substantive evidence of habitual resistance and demonstrably poor outcomes? In a forensic setting it is a question that is rarely articulated because it challenges the fundamental optimism of therapeutic knowledge, but it is one that is now resurfacing in a different context. The emerging emphasis on indefinite sentences with their hybrid combination of civil and criminal features charts a new direction for the expert psychiatric or psychological witness whose reconstruction of the personality in pathological terms effectively extends the domain of legal punishment. As Michel Foucault asserts, mental states can only be imprecisely related to offending, yet when the expert defines this relationship as the core element of a judicial inquiry the court's jurisdiction extends beyond the attribution of responsibility to that of dangerousness and the anticipation of cure (*see* ref. *9*, pp. 18–26). The expert's role is powerful in this context, because a judge has little recourse but to defer the basis of decision making to the professional who typically presents the court with actuarial or clinical assessments of risk and details the past offending history. The principle of sentencing proportionality with its accompanying protection of a time-based sanction is replaced with the promise of treatment, which on the surface appears to be a commendable alternative to retribution. Thus, there is little motivation for the court to question the professional's expertise and explore issues such as: the reality of treating or managing the seriously personality disordered or sexual recidivist during an indeterminate period; the impact on staff and other inmates; and the availability of suitably experienced therapists.

In brief, the more recent trend toward extended sentences that are so heavily dependent on psychiatric and psychological input, leaves in abeyance the role the professional *ought* to play in these instances, especially in view of the likely outcomes of enforced therapy and indeterminate detention. This transfer of power from the law to psychiatry has arisen because legislators have given way to public fears about the apparent convergence of madness, badness, and dangerousness in the case of some recidivist offenders, and moved to elevate the principle of community protection as the primary sentencing aim.[18] Foucault's summation of this shift is cogent: the court's focus on the

[18] This is particularly evident in the case of Victoria's Sentencing (Amendment) Act 1993 in which s. 5A(a) instructs the court to have regard to "the protection of the community" as the *principal* purpose of imposing a sentence in the case of the new category of a serious offender.

abnormal rather than crime *per se* is an adulteration of both justice and psychiatry and distorts the roles of each (*see* ref. *9*, p. 41).[19] In essence, psychiatrists and psychologists are drawn into providing a scientific facade for society's moral condemnation of those whose behavior defies ordinary understanding, yet who cannot be identified as having a mental illness *(10)*.[20] Or, in Foucauldian terms, a juridico-medical discourse has evolved around the phenomenon of the monster and opened the way for knowledge that relocates criminality within a paradigm of pathology and associated dangerousness, resulting in an effective disabling of the law in these instances (*see* ref. *9*, pp. 61–62).

The interpolation of evil into the discourse of madness and badness is decidedly awkward to explore, because the word has an elusive and pejorative quality that evades scientific objectivity. It cannot be readily grounded in mental health or criminal justice concepts, yet it has a subliminal relevance to both. The term is steeped in imagery that resonates in the public domain because it is entrenched in our cultural knowledge and expresses the intuitive fears that are held about those involved in both real and imagined depredations. We simply *know* that some people are evil; we can see their crimes visually and imaginatively, and from here it is but a small step to explain their inhumanity as stemming from some wellspring that acts as a marker for an intrinsic difference. "Evil" is, therefore, a nihilistic term expressing despair and incomprehension about depravity that cannot be encompassed within the confines of madness or badness, and it is difficult to imagine a stronger form of condemnation and exclusion.

In a framework that traverses these three elements—madness, badness, and dangerousness—it is not surprising that fantasy elements intrude, and this is especially evident in the depiction of the predations of psychopaths in film and literature. There is a fear that they cannot be contained and have such a practiced ability to hold others to ransom as to render ordinary constraints ineffectual. In similar vein, the media found Garry David's exploits

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[19] Foucault suggests that we need to confront the insidious nature of this intrusion because it does not come within the legality of the judicial institution nor the normativity of medical knowledge. Judicial power gives way to psychiatric knowledge constituting itself as the authority responsible for the control of abnormal individuals.

[20] Janet Ruffles in her 2004 article, argues that ASPD or psychopathy have become "legal synonyms" for evil and can therefore masquerade as a value judgment about an individual, enabling the courts to avoid direct usage of such emotive terminology (pp. 118–119).

so unfathomable and disturbing that he was depicted in media headlines as *Australia's Most Unwanted Man*[21] and *The Danger Man,*[22] and over a period of years these and other images served to reinforce the stereotype of a monster prepared to wreak vengeance on society by conducting an unbridled gun "killing spree." [23] There were two aspects to these images. On the one hand they were intensely visual, but they were also depersonalizing and used to confirm the urgency of the need for his segregation. By this means he was constructed as a symbolic focus for generalized fears of uncontrolled violence.[24] Other aspects of his personality did not emerge to mute this perception, such as his hopes, beliefs, desires, and passions, so that the mere mention of his name became synonymous with danger in the general view. It must be admitted that David himself acted perversely in fostering this reputation for dangerousness, and thus sowed the seeds of his own destruction. He was articulate, and reasonably drew attention to the injustice of his situation, although he chose to act in ways that would prolong his confinement. For example, he encouraged the idea that there was no limit to what he might do to express his anger, and he savored his reputation for violence, often indulging in games of extreme psychological cruelty to staff and inmates, including threats to them or their families. It was as if he were seeking approbation for an inverse status, and mocking those who tried to contemplate the possibility of his rehabilitation. In so doing, he used every opportunity to highlight the potential danger he appeared to represent, reinforcing this view with grandiose and wide-ranging threats against the community and public figures, and implying that he possessed both the capacity and desire to inflict boundless violence.

David's reputation for dangerousness gained further visual impact because of his willingness to violate physical limits with an almost primitive, visceral capacity for self-violence. Even in a setting where mutilation was rife, he confounded most people with his ability to withstand pain and inflict gross bodily injury. In due course this self-mutilation became a double-edged sword that guaranteed him notoriety in the prison population for unbounded defiance, yet at the same time instigated a sense of abhorrence that distanced him even further. In the prison he was admired as well as feared, as is clear from

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[21] The *Adelaide Advertiser*, May 19, 1990.

[22] *The Sun* (Melbourne), November 6, 1989.

[23] *The Age* (Melbourne), November 2, 1989 ("Prisoner Vows He'll Go on Killing Spree").

[24] Several large scale massacres on the streets on Melbourne in the late 1980s had led to fears about the possibility of unpredictable, random violence and, it was in this climate, that Garry David became the focus for community apprehension.

the words of a psychiatrist giving evidence to the Mental Health Review Board hearing of an appeal against his certification:

> *When he got to the point of slicing off his ears, his nipples and, ye Gods, his penis, that created in prison circles to this day an awe of Garry David, particularly in a very macho system…Senior prison officers have never seen anything like it and I think that he then achieved a status in the prison system…* [25]

Media portrayals gave weight to their depiction of his dangerousness by highlighting the grossness of his injuries with diagrams and a list of their frequency and location.[26] For the public, the visual reality of this raw psychological tactic of incessant scarring and destruction of body parts suggested the possibility of redirection to external targets, yet for David the endless cutting and disfigurements confirmed his autonomy in settings he perceived as being unjustly repressive. In view of his expressed desire for rehabilitation, there was an incongruity about using a tactic that demarcated him physically, and proclaimed his difference as an outsider, who could be accommodated neither in the prison, psychiatric hospital, nor in the community. The danger he appeared to represent gathered credence when David's self-mutilation was coupled with his own private listing of 49 grandiose, but chilling, threats against the community contained in a private document with the inflammatory heading of *Blueprint for Urban Warfare* (*see* ref. *1*, pp. 45–46, 214, for further discussion).

It is likely that the intensely visual components attaching to recurrent self-mutilation in this case did occasion an intuitive recognition that, in this man, there was some indefinable difference that set him apart from the usual connotations of mental illness or criminality. Even in parliamentary debates, some members were clearly influenced by the initial tenor of media coverage, and exaggerated the degree of danger that the prisoner appeared to present, with one suggesting that he would kill "20 or 30 times" were he to be released.[27] Of more, and unexpected, significance, were the intimations that many of those involved at professional levels in the discourse found David's disorder difficult to encapsulate entirely within professional terminology, and lapsed into the use of metaphor to suggest disturbing images of impending threat. As I have previously indicated, one psychiatrist described "the macabre dance"

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[25] Mental Health Review Board, *Statement of Reasons in GIPW*, May 9, 1990, p. 10.

[26] A body map depicting the nature and extent of Garry David's self-mutilations was published in *The Adelaide Advertiser*, May 19, 1990.

[27] Debates of the Victorian Parliament, *Hansard*, April 11, 1990.

in which staff were being led, and another conjured up the apparitions of "Angel of Death" and "Che Guevara." Lawyers joined in, with one drawing the court's attention to similarities with Tolkien's malevolent Gollum—"as dark as darkness, except for two big round pale eyes like telescopes in his thin face," —as if David were in possession of some innately sinister or evil predilection.[28] The Victorian Attorney General went a step further with the startling comparison to the flesh-eating psychiatrist, Hannibal Lecter, an image undoubtedly powerful in the public sphere, despite cannibalism not being one of David's physical excesses. [29] Journalists added to the hyperbole and one described his life as being an "amalgam of Dickens, Kafka and the Marquis de Sade." [30] Of course it may be unwise to place too much credence on the import of what were obviously literary indulgences, but their frequency and the overt expression of this underlying thread of some alien, sinister, unfathomable quality are rare in professional settings.[31] If David could not be situated within the confines of criminality or mental illness, and if he flouted his undoubted ability to treat legal and social rules with impunity, then for many these aspects were puzzling, and invited lapses into dramatic imagery. After all, this man had exposed the weaknesses in the construction of the mad/bad divide by implying that neither the punitive strategies of the justice system nor the treatment provisions of the mental health system were appropriate to his particular case, and he thereby sought to undermine the foundations on which both the law and psychiatry operate—a disquieting proposition for both professions.

There is a reluctance to acknowledge the utility of the term evil and it cannot be positioned in the behavioral sciences, yet it is unlikely to disappear from the public domain and is currently in vogue for specific types of offenders, notably pedophiles and predatory serial murderers. In relation to the latter, a Melbourne psychiatrist, Dr. Lester Walton, recently admitted that "psychiatry is quite limited in being able to provide some insight into this: you tend to fall back onto concepts like good and evil."[32] Used more broadly,

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[28] *The Age* (Melbourne), June 14, 1993.

[29] *The Age* (Melbourne) May 15, 1992.

[30] *The Age* (Melbourne) May 15, 1992.

[31] On occasions, judges may resort to the use of the term in sentencing remarks. For instance, in a recent Victorian case Justice Kaye told a serial murderer that his "disgusting display and loathing for (the victim) and contempt for her dignity… are an eloquent insight into the unmitigated evil which actuated you to kill MM and to behave as you did" (*The Age* [Melbourne] August 17, 2004).

[32] *The Age* (Melbourne), August 12, 2004.

evil is a rhetorical weapon in the hands of politicians, as we have recently witnessed in President George Bush's appeal to a collective, and ubiquitous, sense of fear and terror with his "axis of evil" reference.[33] These carefully chosen words were designed to tap into community apprehension and unify a response little different from the way in which the inquisition set about bolstering a belief in the perfidy of witchcraft in order to justify its campaign against creatures supposedly capable of instigating unimaginable horrors. The implication of evil, rather than a formal designation of criminality or mental illness is powerful politically, because it has the advantage of justifying a disproportionate reaction that may bypass the control and review mechanisms of the legal process, and yet not evoke significant public criticism. Judgments about evil are judgments about the extremities of human aberration, whether on an individual or global scale, and they are likely to trigger a more intrusive response than one emanating from dealing with either criminality or madness alone; and it is one that has features of being distancing, dehumanizing, and blind to the strains of normality that invariably coexist with evil (*see* ref. *10a*, *passim*).[34]

The term evil is just as enigmatic as those it attempts to characterize and leads to haunting questions that touch the very meaning we assign to human depravity and our understanding of responsibility. Gobodo-Madikizela identifies one of these in her analysis of the South African, Eugene de Kock (colloquially referred to as "Prime Evil"): how do we judge between those who commit evil acts without recognizing them as such, and those who know that their actions are indeed evil? *(11)*. After all, the latter may have a more normal moral compass, albeit one that he or she chooses to override. In transpos-

[33] In his State of the Union Address (January 29, 2002), George Bush explicitly linked impending danger and hatred with evil: "States like these, and their terrorist allies, constitute *an axis of evil*, arming to threaten the peace of the world. By seeking weapons of mass destruction, these regimes pose a grave and growing danger. They could provide these arms to terrorists, giving them the means to match their hatred. … In any of these cases, the price of indifference would be catastrophic."

[34] Hannah Arendt's *(10a)* reference to "the banality of evil" has crept into general usage as the struggle to understand that ordinary people may, under certain conditions, behave in extraordinary ways proceeds. More recently the general revulsion about the treatment of prisoners at Abu Ghraib prison in Iraq was tempered by the realization that the perpetrators were ordinary soldiers placed in a situation for which they were ill-prepared. Their behaviour would thus seem to be the result of ignorance and poor judgment in unusual circumstances, rather than motivated by evil intent.

ing this question to Garry David one should perhaps ask the extent to which he knew that he was being psychologically manipulative and destructive of professional reputations and consciously chose to pursue a cruel disregard of others; or the extent to which he set about reveling in the fear he incited in the community with his outrageous threats. In this, we have come full circle. The person with a severe personality disorder is marked by a status ambiguity that straddles the mad/bad divide. Certainly, prisoners are regarded as being responsible for their actions and therefore competent to exercise treatment refusal, whereas the psychiatric patient is regarded differently and may be the subject of enforced treatment, when this is considered to be necessary. Thus, if it is not possible to allocate the person with a severe personality disorder to one or other system with any degree of certainty, then the question of evil intent diminishes in force, because the elements of criminal responsibility cannot be clarified. This is an issue that undoubtedly will be the subject of further debate as the courts become more aware of research into the biological bases of psychopathic disorder and are forced to accommodate any possible implications of such studies for assessing the reality of free choice *(12,13)*.[35]

The answer to dispositional issues is not easy to encompass within either the ambit of the law's understanding of responsibility, or psychiatry's efforts to objectify dangerousness, because extreme cases such as that of Garry David expose the limits of each. It is not sufficient for the law to pass the buck to the behavioral expert, because the outcome may in fact be more draconian in terms of loss of rights and lengthier incarceration, as C. S. Lewis foreshadowed in a remarkable article written at a time when it was hoped that therapy offered the solution to the retributive orientation of the prison (*see* ref. *14*). His warning is still pertinent as the pendulum swings back towards community protection through incapacitation with the added, but often unrealistic, expectation of treatment. This is not to argue that the law and psychiatry are unable to come together in those few difficult cases that sorely test each system. Although the Community Protection Act (1990) had serious limitations, it had the advantage of being a wide-ranging inquiry that was able to expose Garry David's strengths, as well as the distress he had suffered over a lengthy period of time. It also demonstrated that the Victorian community had a paucity of facilities to deal with the severely personality disordered. An inquiry of this sort moves beyond an adversarial legal format and encourages a more realistic understanding of what psychiatry and psychology have to

[35] There is considerable body of empirical literature identifying frontal lobe dysfunction with the personality disorders.

offer in these circumstances. The responsibility of government should be at the level of providing more appropriate units for those whose offending behavior cannot be encompassed within the legal formulations of criminality or mental illness, and thus there can be a move away from such stigmatizing labels as "danger man" and "unwanted." [36] It is an approach that calls for cooperation between the professions, as well as for the development of a realistic dialogue and appropriate review process.

As for Garry David, his circumstances reflected the permeability of the boundary between badness and madness, and he was able to use this as an opportunity to identify some of the pressure points in the forensic interaction between psychiatry and the law. In relation to his evilness, there was evidence that his behavior was so perverse and contradictory that he could not be readily categorized, hence the temptation to draw on literary and other allusions to convey the impression that there was a qualitative difference about him as a person. As far as the public was concerned, it called for the line to be drawn at safe containment, and the mechanics of this process was of little interest because he appeared to be bent on casting a shadow of fear on the community. Garry David had become the outsider, who shored up his status by means that gave rise to an inference of evil simply because other explanations had failed in his case, and there was a temptation to draw on an evocative term that might perhaps provide the missing link in this particular jigsaw of understanding the human condition. As Solzhenitsyn lamented:

> *If only it were all so simple! If only there were evil people somewhere insidiously committing evil deeds, and it were necessary only to separate them from the rest of us and destroy them. But the line dividing good and evil cuts through the heart of every human being. And who is willing to destroy a piece of his own heart?* (15)

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[36] I note that, in her analysis of the use of evil in the courts Ruffles *(10)* also arrives at a similar conclusion in what she terms as a " needs-based" approach.

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Chapter 8

Destruction As a Constructive Choice

David A. Winter

Backgound

This chapter presents a personal construct theory view of serial killing and other acts of homicide and extreme violence. Such acts may be considered, as any others, a reflection of the individual's attempts to anticipate his or her world and are therefore, from the perpetrator's perspective, constructive choices. A personal construct theory taxonomy of these acts is illustrated by the narratives of serial killers and other violent offenders, as well as by case material and research findings. Particular attention is given to the writings of serial killer, Ian Brady. There is also a discussion of the construct of evil and of whether the personal construct theory perspective implies a position of moral relativism.

Introduction

Why do some individuals choose to engage in acts that are so destructive that they may be viewed as evil? When this label is applied to an act or its perpetrator, it is often also stated that the act is incomprehensible: "beyond belief," as Williams *(1)* entitled his book on the "Moors Murderers." In this chapter, it is argued that such acts may be comprehended if they are viewed from the perspective of those who commit them, and that one way in which this may be achieved is by the use of George Kelly's *(2)* personal construct theory. A brief introduction to the theory will be followed by an outline of how it may be applied in understanding acts of extreme destructiveness, and

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in particular homicide. Two contrasting examples of people who have committed homicide are discussed, and the chapter concludes with a reconsideration of the notion of evil.

An Introduction to Personal Construct Theory

Personal construct theory, like other constructivist approaches, views people as concerned with making sense of, and anticipating, their worlds. In Kelly's metaphor of the person as a scientist, this process was portrayed as one of constantly formulating hypotheses about, or constructions of, the world and if necessary reformulating these depending on whether they are validated or invalidated. Its building blocks are personal constructs, the bipolar distinctions each of us makes to discriminate between and predict events in our world, and that are structured in a hierarchical system in which some constructs are superordinate to others. In selecting courses of action, we choose those options that appear to offer greater opportunities for extending or defining our construct systems, and therefore for predicting our worlds.

However, for at least some of the time, most of us are imperfect scientists. Indeed, at times we may cling to a construction and use it repeatedly despite its consistent invalidation, this being Kelly's view of a disorder. We may also use various strategies in an attempt to avoid the risk of invalidation, which is involved in putting our constructions of the world to the test. For example, as in people who receive a diagnosis of schizophrenic thought disorder, we may loosen our construing, making predictions that are so vague that they are relatively invulnerable to invalidation; or, as in many people diagnosed with anxiety disorders or depression, construing may be tightened, so that predictions are very precise *(3)*. We may dilate our perceptual field, experimenting widely with new experiences in an attempt to develop new constructs that may allow better anticipation of the world; or, as in agoraphobia, we may constrict, delimiting our world to those events that we are able to predict. We may also attempt to make the world conform to our constructions of it rather than vice versa, this being what Kelly regarded as hostility. For example, people who have always seen themselves as rejected by others but who find themselves in relationships in which they are accepted, and even loved, may behave in such a way that ensures they are rejected again, thus validating their original construction.

Hostility is one of several emotional terms that Kelly defined in a rather unusual way. He differentiated it from aggression, which he viewed as involving the active elaboration of the person's construct system. Another emotional term that is central to personal construct theory is anxiety, associated by Kelly with awareness that one does not have the constructs that would

enable one to predict particular events. Our attempts to give meaning to our world are therefore essentially aimed at the reduction of anxiety. Another emotion we generally try to avoid is threat, defined by Kelly as awareness of an imminent comprehensive change in core structures, those superordinate constructs that are central to one's identity. Guilt, for Kelly, is the awareness of dislodgement from one's core role, or in other words finding oneself acting in a way which is inconsistent with how one has always seen oneself. McCoy *(4)*, extending Kelly's classification of emotions, distinguished between guilt and shame, in which one is aware of dislodgement from other people's view of one's core role.

From the personal construct theory perspective, every individual's construct system is unique, and to engage in an intimate relationship with another person one must see the world, in a sense, through their eyes, or show sociality. This credulous approach, in which the other person's views are taken at face value, is at the heart of the relationship between a psychotherapist and their client. As indicated in personal construct analyses of suicide and self-harm *(5,6)*, it may allow even the most apparently self-destructive behavior to be understood as the person's best available means of anticipating their world at that time. Elsewhere, I have explored the extent to which, in a similar manner, it is possible to adopt a credulous approach with the person who has committed offences of extreme destructiveness towards others *(7)*, and we now continue this exploration.

A Personal Construct Theory Analysis of Violence and Homicide

Acts of violence and homicide, like any other, may be regarded from a personal construct theory perspective as choices directed toward the better anticipation of the person's world. As has been suggested by the distinction between instrumental and reactive violent acts *(8)*, some of these choices are considered whereas others are more impulsive.

Homicide As a Considered Choice

Homicide As a Dedicated Act

In his taxonomy of suicide, Kelly *(5)* indicated that this may be a *dedicated act*, which is "designed to validate one's life, to extend its essential meaning rather than to terminate it." Destruction of others may similarly be regarded as a dedicated act for some individuals, and in some cases may be combined with self-destruction. Such acts are clearly considered choices. For example, Pierre Riviere, who killed his mother, sister, and brother because of

the way in which his mother treated his father, but then did not go through with his original intention of killing himself, described how "I thought that an opportunity had come for me to raise myself, that my name would make some noise in the world, that by my death I should cover myself with glory, and that in time to come my ideas would be adopted and I should be vindicated" *(9)*. Riviere's actions may be viewed as exemplifying what Katz *(10)* terms "righteous slaughter," other examples of which may be observed in the killing of potentially unfaithful partners. As Katz *(10)* describes such a killing,

> *From within the assailant's perspective, killing a deserting lover makes sense as a way of preserving a relationship that otherwise would end. If he leaves her or she leaves him, the relationship they had may well become, in both their romantic biographies, a relatively unremarkable chapter in a series of failed relationships. By killing her mate, Ruth made their relationship last forever; in the most existentially unarguable sense, she made it the most profound relationship either had ever had. …Killing him was her means of honouring and protecting the transcendent significance of their relationship.*

Suicide bombers also provide examples of destruction of others, as well as the self, as a dedicated act. As described by one such individual:

> *I know I cannot stand in front of a tank that would wipe me out within seconds, so I will use myself as a weapon. They call it terrorism. I say it is self-defense. When I embark on my mission I will be carrying out two obligations: one to my God and the other to defend myself and my country. …At the moment of executing my mission, it will not be purely to kill Israelis. The killing is not my ultimate goal though it is part of the equation. My act will carry a message beyond to those responsible and the world at large that the ugliest thing is for a human being to be forced to live without freedom.*

A similar message is provided by the last will and testament of one of the pilots who flew into the World Trade Center: "The time of humiliation and subjugation is over. It's time to kill Americans in their heartland. Lord I regard myself as a martyr for you to accept me as such." Such views are not restricted to those who have been construed as terrorists, as indicated by the following quote from a US marine in Iraq:

"The Iraqis are sick people and we are the chemotherapy. Wait till I get hold of a friggin' Iraqi. No, I won't get hold of one. I'll just kill him." It is of interest that a very similar justification was provided by James Vlassakis, one of a group of the most prolific serial killers in Australian history, for their murders of homosexuals, pedophiles, people with learning difficulties, and even fat people: "They were the disease and we were the cure" *(11)*.

Others who approach killing as a dedicated act by claiming to be doing the will of God may be considered to be deluded. For example, Peter Sutcliffe, the "Yorkshire Ripper," described how "The mission I'd been given was to kill all prostitutes. I was under God's protection" *(12)*. As is often the case in people who are labeled paranoid, dilation of the perceptual field occurred in that eventually "a woman only had to *look* like a prostitute in order to qualify as a victim" *(12)*. Responsibility for the murders was also transferred by Sutcliffe from God to the Devil.

Homicide As Escape From Chaos

Another of Kelly's *(5)* categories of suicide indicated that this may occur in conditions of chaos, when "everything seems so unpredictable that the only definite thing one can do is to abandon the scene altogether." Such a course of action was eloquently described by Antonin Artaud in his statement that "If I commit suicide, it will not be to destroy myself but to put myself back together again. … By suicide, I reintroduce my design in nature" *(13)*.

Ian Brady *(12)*, the notorious "Moors Murderer," indicated that murder may serve a similar purpose in his analysis of serial killing, which is based on interviews with several such killers. For example, discussing Graham Young, the "St. Albans Poisoner," whose ambition was to be "the greatest poisoner of all time," he stated that "The serial killer, essentially conceiving life as meaningless and death as nothingness, is consequently not afraid to die or kill in a final vainglorious attempt to introduce some degree of design."

Such an analysis may be applied to Dennis Nilsen, who murdered 15 young men, many of whom were homeless, and then kept their bodies, carefully washed and dried, "for company" for several days after killing them. Some of these murders appear to have allowed him to create a beauty and meaning in death out of people whose lives were chaotic. Thus, describing one of the bodies, he wrote that "He looked really beautiful like one of those Michelangelo sculptures. It seemed that for the first time in his life he was really feeling and looking the best he ever did in his whole life.…I just lay there and a great peace came over me. I felt that this was it, the meaning of life, death, everything" *(14)*.

The use of murder as part of a scheme of imposing meaning and order is most strikingly exemplified by "medical killers." Dr. Harold Shipman, who matched Nilsen in the number of murders for which he was convicted, but was suspected of being responsible for as many as 1000 more, was described by the coroner who investigated his case as someone who "enjoyed power and control" *(15)*. He is but one in a long line of health professionals who, to use one of Kelly's terms, has "slot rattled" from being a life saver to the

opposite pole of this construct, a killer. His suicide in prison may be regarded as a final act of power and control.

The chaos from which the perpetrator of homicide is attempting to escape may in some cases result from deficiencies in anticipating other people's construing and behavior. Such deficiencies have been found to characterize mentally disordered offenders diagnosed as psychopaths *(16)* and have also been considered typical of spouse batterers *(17)*.

Homicide As a Way of Life

Drawing on Kelly's view of psychological symptoms, Fransella *(18)* has indicated that these may provide the individual with a way of life that is chosen because it offers more structure, meaning, and possibilities of anticipating the world than do the available alternatives. For some individuals, such as those with careers in organized crime, violence may provide such a way of life, which may occasionally be expressed in homicide. This was so, for example, in the case of Reg Kray, whose last autobiographical account was entitled "A Way of Life" *(19)*, and for whom violence had been his profession *(20)*. As his wife described, "The past for Reg was a place of violence. As a young man he moved in unremittingly violent circles and answered like with like. It was a brutal way of life" *(18)*.

The more a particular violent identity is elaborated, as by the increasing media attention being given to the phenomenon of serial killing, the more attractive a choice it may become for the individual who has no other well-elaborated identity. Thus, for Paul Knowles, serial killing allowed him to become "the only successful member of my family" *(21)*. For Rudolf Pleil, who killed some 50 women, "Every man has his passion. Some prefer whist. I prefer killing people" *(21)*. In such individuals, killing may also develop an addictive quality *(12,15,22)*, perhaps similar to the combat addiction observed in some people who have had careers in legitimized violence, such as warfare, particularly if this has involved participation in atrocities *(23–25)*.

A similar analysis in terms of way of life is to view the killer as constructing a new narrative for himself or herself. Thus, Katz *(10)*, considering "senseless murders," views the perpetrators as having "reconstructed within the fatal scene a version of their lives. Essential to the motivation of these cold-blooded, "senseless" killers was a creative resolution of one of the many narrative possibilities they had been developing." For one of the men concerned, Gary Gilmore, this included exploiting his death "to make himself the moral tale of the year." Katz emphasizes the "edge" and "transcendent power" that deviance, expressed in a senseless killing, provides for such individuals, in contrast to the "moral dangers" of conformity. He views their acts in terms

of a "project of primordial evil that makes 'senseless killings' compellingly sensible to their killers." Similar points are made by Nowinski *(26)*, who writes that "People may, and sometimes do, willingly embrace an identity and choose a pathway that, when viewed from the outside, is dark and destructive. We need to understand the process by which individuals opt for a dark vision if we hope to prevent such choices and their consequences." In his view, which he illustrates by such cases as the Columbine High School killers, this process is one in which the dark vision may arise as a resolution to inner chaos and uncertainty.

Violence As a Shared Construction

Violence may be a particularly elaborated way of life in those individuals who, like Reg Kray and his brothers, were raised in a subculture of violence *(27)*, in which socially shared constructions produce a climate permissive of, and conducive to, violent acts. At a more micro level, families or couples may be regarded as having shared construct systems *(28)*, which in some cases may lead to acts of violence committed as a joint enterprise. This is so in those murders that have been viewed, somewhat inaccurately, as manifestations of "*folie a deux,*" for example, those committed by Ian Brady and Myra Hindley, and Fred and Rosemary West. The Wests, who were responsible for at least 10 sadistic murders, have been regarded as "a perfect textbook example" of this phenomenon *(21)*.

Homicide As Constriction

Kelly *(2)* viewed suicide as the ultimate constriction, the narrowing of the person's perceptual field to avoid inconsistencies in construing. Homicide may similarly be regarded as a constrictive act if it removes a person who causes one to experience such inconsistencies from the perceptual field.

Jean-Claude Romand was known by his family as an eminent medical researcher, who for years drove from his home in France every day to his office in the World Health Organization in Geneva. In fact, on most days he drove no further than the local forest, but made the occasional trip to the World Health Organization to pick up free pamphlets, which he scattered around the house. Eventually, as his web of lies began to unravel, he killed his wife, children, and parents rather than allowing them to discover his deceit. He now considers that "I have never been so free; life has never been so beautiful. I am a murderer, I'm seen as the lowest possible thing in society, but that's easier to bear than the twenty years of lies that came before" *(29)*. His story may be considered to illustrate a switch from dilation to constriction.

Emotions and Considered Homicide

In most of the prior examples, homicide may be viewed as reducing anxiety by increasing the perpetrator's ability to anticipate their world. However, other Kellian emotions may also be relevant to an individual's decision to kill. For example, homicide may serve to remove a person who is a source of threat in that he or she poses a major challenge to the killer's core constructs. As we shall see, the legalized killing of the death penalty may serve a similar purpose, as may less severe punishments.

More apparently paradoxical is that in some cases homicide may be a means of absolving oneself from guilt. In traditional psychiatry, psychopathy has been associated with an inability to experience guilt. However, from a personal construct theory perspective the individual who is labeled psychopathic is no less able to experience guilt than anyone else. It may be, however, that in such a person their core role involves, for example, being a sadist and the experience of acting humanely will therefore provoke role dislodgement and guilt, which may be reduced by further sadistic acts, including homicide. Kelly *(30)* indicates how a delinquent youngster may feel guilty when tricked into being good; whereas Pollock and Kear-Colwell *(31)* present two case examples of women who had stabbed their boy friends, and who both had histories of repeated abuse but perceived themselves as abusers, experiencing guilt when dislodged from this core role by, for example, therapists trying to persuade them that they were victims. The stabbings may have allowed them to revert to their core roles.

Homicide may also serve to reduce shame by making one appear more consonant with another person's construing of one's role. Although it can also be viewed in terms of constriction, Reg Kray's murder of Jack "The Hat" McVitie, a criminal associate of the Kray brothers, can be seen in terms of Kray reasserting his role as the gang leader who would brook no disobedience or disrespect. Freddie Foreman, who helped dispose of McVitie's body, explained why he "had to go" thus

> *there was so many things that he was doing wrong he was embarrassing them, cos he wouldn't take no notice of what they said. I mean, they've got to have a bit of respect. The man's got to do as he's told. But he disregarded everything they said. He was undermining them, he was making a fucking laughing stock, so they had to act, and the only way to hold credibility was to fucking do him.* (32)

It may seem tautological to state that homicide may at times involve hostility or aggression, but, as indicated above, these terms were defined in distinctive ways by Kelly. Thus, homicide involves hostility if, and only if, it is an attempt to make the social world fit with constructions that have previ-

ously failed. As Kelly *(33)* put it, "A man may commit murder to discredit what has proved him wrong." Doster *(34)* provides a similar explanation for episodes of marital violence, in which partners attempt to impose on each other constructs that have already been invalidated.

Similarly, homicide involves aggression, as Kelly defined this term if, and only if, it is an adventurous act associated with the elaboration of one's construct system. Ian Brady *(12)* described it thus, "sometimes it's a most stimulating experience to do something you don't want to do, don't approve of, and are legally proscribed from experiencing—just to discover new aspects of yourself and others."

Homicide As an Impulsive Act

Homicide As an Outcome of Tight Construing

There is some research evidence that people who construe in a tight, one-dimensional manner may be more likely to commit violent offences *(35–37)*. This may reflect the restricted options open to such individuals, who have been found to be characterized by various interpersonal difficulties, including deficiencies in anticipating the construing of other people, integrating conflicting information about others, and communicational ability *(3)*. People who construe tightly may also be particularly threatened by invalidation of their construing because their construct systems are brittle and vulnerable to structural collapse *(38)*. As Hallschmid et al. *(17)* described in discussing marital violence, they may therefore resort to violence, sometimes in an impulsive manner, to attempt to remove the threat posed by an invalidating person.

Homicide As Slot Rattling

People who construe tightly may be particularly prone to slot rattling *(39)*, a process in which the self, some other person, or an event is reconstrued at the opposite pole of a construct to that which was previously applied to them or it. Slot rattling may be associated with lopsided construing, in which people or events are not evenly assigned to the poles of constructs, and which has been found to characterize individuals diagnosed as primary psychopaths *(16)*. A similar pattern involving a positivity bias in the construing of others, and particularly their victims, has been demonstrated by Howells *(40)* in "one-off" violent offenders, whose offenses were characterized by extreme violence, often resulting in the death of the victim. These offences, typically committed by people who are generally overcontrolled *(41,42)*, may have been associated with temporary slot rattling in the offender's construction of the victim as a response to a major invalidation.

Homicide may also be a manifestation of slot rattling, sometimes accompanied by sexual arousal, from a view of the self as weak and impotent to one of the self as omnipotent. Such an analysis can be applied to the numerous examples of murderers with histories of sexual humiliation. For example, when interviewed on death row, Andrei Chikatilo described how "impotence has hounded me all my life" *(43)* and how "All my life, I've felt humiliated." His slot rattling from this position involved killing and mutilating over 50 people.

Homicide As Foreshortening of the Circumspection–Pre-Emption–Control Cycle

Kelly *(2)* viewed the optimal process of decision-making as one in which the individual *circumspects*, considering all of the constructs which are relevant to the decision, *pre-empts*, selecting the most salient of these constructs, and then takes *control*, selecting one or other pole of this construct to apply to the situation concerned. The person who acts impulsively tends to foreshorten this cycle by foregoing, or only minimally engaging in, its circumspection phase. In the view of Moser *(44)*, this was the case with Fred West, who tended to solve crises in his relationships with females by removing the female concerned, often by murder.

The Perpetrator's Reaction to Homicide

It will be apparent from this analysis of the features of construing associated with homicide that this offense may or may not be consistent with its perpetrator's view of him or herself and the world. Only when this consistency is lacking would the perpetrator be expected to experience negative emotions, such as guilt, following the offense. This is more likely to be the case in those whose action was impulsive than in those in which it was considered.

Some support for this view is provided by the finding that posttraumatic stress disorder (PTSD), which has been reported in as many as a third of violent offenders, is more pronounced in those who have committed reactive offenses than in those who have committed instrumental offenses *(45)*. This was the case with a man described by Harry and Resnick *(46)* who had killed a woman during an altered mental state, and who reported that "It took me years to reconstruct what happened." The perpetrator of a considered homicide may also occasionally experience such reactions if the killing does not go entirely as anticipated and as a result the perpetrator is forced to reconstrue the victim, perhaps by acknowledging, and being touched by, their humanity. For example, a terrorist who developed symptoms of PTSD after committing a planned murder, described how his victim "was crying, begging, talking

about his children…I was becoming more agitated listening to him, then I looked straight into his face and shot him in the head…blood spurted on my suit, he fell, I had to step over him and slipped in the blood and fell on top of him, I panicked and ran" *(47)*.

The professional killer's depersonalization of their enemy may allow such situations to be avoided. For example, the weapons officer who reduced to rubble a Bagdhad restaurant in which Saddam Hussein was reported to be eating, together with neighboring buildings, described his actions thus, "I did not know who was there. I really didn't care. We've got to get the bombs on target. We've got 10 minutes to do it. We've got to make a lot of things happen to make that happen. So you just fall totally into execute mode and kill the target."

Two Contrasting Killers

The Serial Killer As Constructivist

Ian Brady and his partner, Myra Hindley (the "Moors Murderers"), were vilified after they killed five children and young people in the 1960s. Brady may be considered to exemplify the instrumental offender in that the murders were planned, and regarded by him as an expression of a philosophical position of moral relativism, which he had held since the age of five (when at primary school he was the only child in the class to raise his hand when asked if anyone did not believe in God). His statement of this position in his book on serial killing *(12)* seems not inconsistent with constructivism. Thus, he writes "All matters turn not on reality but on perception of reality. A virtue or an evil is only as significant as one believes it to be." Also essentially constructivist is his view that serial killing generally involves a search for meaning, "…the serial killer *has* confronted the chaos or absurdity of existence…and is trying to impose upon it some meaning or order of his own."

Brady considers that the serial killer has made a choice not to "exist as a grey daub on a grey canvas" but instead "as an existential riot of every colour in the spectrum…action-painting with his knife on a human canvas, each slash-splash creating a unique masterpiece." In the first murder, "he is killing his long-accepted self as well as the victim, and simultaneously giving birth to a new persona, decisively cutting the umbilical connection between himself and ordinary mankind." In Brady's view, "the element of elevated aestheticism in the second murder" may signal "the onset of addiction to hedonistic nihilism." To use Kelly's *(2,48)* metaphor of the person as a scientist, if murder can, like any other behavior, be considered an experiment, serial killing as portrayed by Brady may be viewed as the killer's research program.

Not only is there a constructivist flavor to some of Brady's views, but his writing at times also bears a particularly striking resemblance to that of George Kelly. For example, compare "… law-abiding souls must have their victims too, experiencing no guilt at how pleasurable it feels to punish others for crimes they themselves have contemplated or succeeded in getting away with. Further, in punishing others for these crimes, they actually feel they are making retribution of some sort for their own" *(12)* with

> *People are threatened by "evildoers"…The "evildoer" exemplifies what we might do if we dared, or what we might be if we behaved childishly, or what we could have been if we had not tried so hard to do better. We dare not interact with him on common ground lest we slip back into the unwanted ways. In order to take protective steps against the threat that his presence arouses within us we take symbolic measures called "punishment" against him. By such measures we either destroy or symbolize the destruction of the core role relationship of the "evildoer" with ourselves…his behaviour has been threatening to those whose own morality is insecure; and as long as he is seen as having exemplified the tempting way of life, there are those who will need to punish him as a prophylaxis for their own temptations.* (2)

Compare also Brady's and Kelly's views of a person's moral judgments concerning their behavior. For Brady *(12)*

> *Absolutists are invariably absolute fools. And not least because they absolutely expect to be absolutely believed. As stated, all but the insane are well aware whenever personal actions conflict with their true beliefs, as opposed to their socially-conditioned responses. I believe every intelligent individual, whether predominantly good or evil, possesses a mostly idiosyncratic moral gyroscope which reminds him whether he is in conflict with his own moral and ethical convictions or merely those of others.*

In Kelly's *(2)* view,

> *Guilt refers to a condition of the person's construction system and not to society's judgement of one's moral culpability.…Perception of one's apparent dislodgement from his core role structure constitutes the experience of guilt.…Our proposed formulation is designed to free the research-minded psychologist from the absolutism of "evil" on the one hand, and from the anthropomorphism of the Freudian superego on the other.*

In view of the apparent similarity between Brady's and Kelly's writings, I wrote to ask Brady whether he had read any accounts of personal construct theory. He replied that he had not, but that he had "thought instinctively in terms of moral relativism" since his schooldays and that this belief "evolved by pragmatic observation and experience." In his view, "the 'paths' of moral relativism are individual," and he considers that the paths taken by criminals, presumably including himself, are trivial when compared with those of

> *American gangsters—not the Mafia but the Bush gang of ex-oil executives and their recent successful armed robbery in Iraq, the body count of innocent bystanders murdered or dismembered apparently not of sufficient public interest to be disclosed. Blair, a minor henchman and late-developed psychopath, who has bombed five countries in six years, is to receive American honours as a reward.*

In his view, "The emulation of American neo-conservatism in the UK will produce a similarly motivated neo-criminality/terrorism/racialism just as ruthless and pre-emptive."

Paradoxically, it is the knowledge that his "life is over," in that he will never be released, that has given Brady the freedom to express such views honestly and to write a book that "is not an apologia." "Unlike the merely *physically* free individual, no hellish circles of social graces and ersatz respect bind me to censor beliefs" *(12)*. It is also this knowledge, together with his concerns about the way that he has been treated in his current special hospital environment, that have led to his wish, denied for five years by force feeding, to starve himself to death. This would be what Kelly *(5)* would have termed a suicide under conditions of determinism, in which "the course of events seems so obvious that there is no point waiting around for the outcome."

A more fine-grained personal construct analysis of Brady's book has been achieved by converting it into a type of repertory grid *(49)* known as a textual grid *(50,51)*. In this method, all of the people or groups of people referred to in the book are listed, as are all the adjectival descriptions, or construct poles, applied to them. In Brady's book, 85 individuals or groups of people were described in terms of 424 construct poles. Table 1 indicates those construct poles that Brady applied to himself, from which it can be seen that philosophical beliefs concerning relativism and individualism represented core constructs, and that these beliefs were held with a certainty of conviction. His lack of any sense of obligation to please others and of faith in human nature presumably allowed the indulgence and freedom of expression reflected in these beliefs to be relatively unconstrained. However, he clearly considers himself to be not without moral scruples, and places considerable importance on loyalty and not corrupting others. Although the latter concern may seem inconsistent with his involvement of Myra Hindley and her brother-in-law in murder, Brady's *(12)* view is that "an individual can only be corrupted if the seeds of corruption are already within and predisposed to flower."

Nearly three-fourths of the construct poles that Brady applied to serial killers in general fell into four categories. Again, the largest single category concerned values and beliefs: for example, "regarding the willful destruction of others and self as comic," "believing in hell on earth," and believing in a

Table 1
Construct Poles Applied by Ian Brady to Himself

- Has relativistic thought processes/belief system
- Has certainty of belief
- Has freedom of thought/expression
- In accord with doctrine of original sin
- Believes supreme individualist should choose own life and moment of his death
- Would rather be dead than stare into abyss
- Afford opportunity to indulge natural urges
- Not under obligation to please
- Lacks faith in human nature
- Curious observer
- Has never set out to corrupt anyone
- Values personal loyalty and friendship
- Absence of personal ambition
- Has energy for criminal pursuits
- Has passion for travel
- Enjoys visiting art galleries and museums
- Can't get enough of people
- Can evaluate integrity within first 10 minutes
- Pragmatic

"personal philosophy." Also included in this category were choices that they had made, such as "choosing to live one day as a lion" and "choosing the path to perdition." Another category of construct poles concerned power and control, for example, "having to prove that they exist beyond the control of all." A further highly represented category was "high egoism," reflected in such construct poles as "superiority complex" and "morally superior." Not surprisingly, there were also a number of construct poles that might be categorized as "low tenderness" *(52)*, for example "regards people as obstacles to be surmounted by any available means," "misanthropic," and "architect of ruin." This last construct pole exemplifies a theme in the book concerning "destruction as an act of creation—an act of God" *(12)*.

The final textual grid is produced by excluding any construct pole that is applied to fewer than five people; any person to whom fewer than two construct poles are applied; and any construct poles and people that are used identically. This resulted in a grid consisting of 75 construct poles and 35 people, which was subjected to hierarchical cluster analysis and multidimensional scaling. The former analysis provided a dendogram of people, which indicated that Brady construed himself as similar to Stavogrin, the central character in Dostoevsky's *The Possessed*, whom Brady views as someone

who "cannot tolerate ordinary existence" and "turns life into a cartoon where everything is possible." He also appeared to dissociate himself from serial killers, his construing of whom seemed to be considerably more differentiated than his construing of other people.

A Case of Parricide

As part of the assessment process, the personal construct psychotherapist will often ask a client to complete an autobiographical sketch termed a self-characterization. That which was completed by Paul, who presented with symptoms of PTSD, was unusual not only in that he attached to it his curriculum vitae, but also in terms of its content. It began

> *Where do we start, how about birth, ok. I was born in Newtown on the 6th of February 1955. I don't remember the birth, perhaps I was too young or maybe I had my eyes closed, I don't know. I went to a nursery, then went to New Road primary school before going on to the local secondary school where my studies were interrupted by an unforeseen event. I killed my father. I don't really know why, my memory of the event has (sic) doesn't appear full. I was a little screwed up afterwards and probably still am today…*

It ended,

> *A foreboding has come over me that makes me nervous and distracted just thinking about this and the meeting tomorrow where I will have to talk about my Infamy and try to bring reason to it, where I know it is a painful subject that I can bottle up reasonably well with the odd histerical alcohol induced breakdown and odd week off due to an lethargic despondency that saps the will to due anything but read and sleep. I guess you need the full monty and replaying that record is not an easy thing to do at the best of times let alone trying to grasp it for reasoning. And it misses a lot.*

At his first therapy session, Paul said that he still did not know why he had done what he had and that he had "encapsulated it and put it on a shelf." I made it clear to him that it was entirely his choice whether we took what he called "the big event" down from the shelf and I suggested that we explore this choice using Tschudi's *(53)* ABC technique, which would allow tracing of the positive and negative implications of taking it off, and leaving it on, the shelf *(54)*. He used a computing metaphor to describe the advantages of taking it off the shelf, saying that he could thereby develop a "programming patch," rather than continuing to have "faulty reasoning." He anticipated that it would also make him more "proactive," in contrast to his present "directionless" life, which resulted from "a big block of bad goo sitting in my brain." However, the disadvantages of taking the event off the shelf included

his life reaching a "dead end," perhaps literally in suicide. After discussing these implications, he said that he still knew that he had to risk looking at the event.

As a preliminary step in exploring the big event, we completed two repertory grids. One of these required him to consider people in his life, and indicated that his construing of himself and members of his family was unelaborated, apart from a very negative view of his father. The other grid required him to consider life events, and indicated that his construing of the big event was also unelaborated, a pattern which has been associated with PTSD *(55)*.

In order to address gaps in his memory of the big event, he agreed to talk to a childhood friend, to look at newspaper cuttings of his trial, and to read the court file of his case. The file included a mention of an incident on the day of the big event that he had forgotten, and that might have been the missing precipitating factor for his actions in that it might have evoked memories of his father's violence towards him.

Although he appeared somewhat disappointed that his emotional reaction to reliving of the big event was not more intense, this reliving enabled us to explore issues concerning guilt and enabled him to talk about the event with a friend. Over the course of therapy, he made major life changes, suggesting that taking the event off the shelf had indeed allowed him to become more proactive. Repetition of the life events repertory grid indicated that the big event had become better integrated in his construct system.

Reflections on Evil

Judged on the basis of their crimes—the killing of children and a parent—our two examples of people who have committed homicide might be seen to embody the popular notion of evil. We live in times when we are constantly bombarded with images of evil and are told in no uncertain terms what evil is, where it may be found, and how it should be eliminated. Views on this matter may differ markedly, indicated by comparing the "axis of evil," as defined by George Bush (who has spoken about evil in 30% of his speeches *[56]* in justifying his "war on terror") with the notion of the "Great Satan," a term first applied to the United States by the Ayatollah Khomeini and still used to justify acts of terror. This example clearly indicates that good—evil is a construct, and one that may be shared by people with contrasting views on how the construct is applied. It is also a construct on which people's positions may slot rattle, illustrated by the US government's construal of some regimes as evil, which they previously supported, and presumably therefore construed as good.

Evil is rarely indexed in psychology texts *(57)*, but was not ignored by Kelly. He regarded the construct of good vs evil as so perplexing that people use various devices to avoid "the awful responsibility for distinguishing good from evil amidst shifting circumstances, and then making a firm choice between them" *(30)*. As illustrations of such devices, he cites psychologists who pretend to avoid making moral judgments about clients by making medical judgments instead; people who regard absolute permissiveness as the basis for a democratic society; those who advocate complete self-acceptance; and others, such as Nietzsche, who attempt to reduce the good–evil construct to obsolescence by devising a principle that transcends it. When the individual does face up to the good–evil construct, he or she, in Kelly's view, may use the strategies of laws ("handrails for the morally nearsighted") to distinguish good from evil; submission to an authority who makes the distinction for one; conscience, which may represent no more than the authority of one's parents; and "purpose." Elaborating on the latter, he remarked that

> *If we decide what kind of world is scheduled to appear in the future, we can say that anything we can do to hasten it is good, and anything we do to delay it is evil. Everything hinges on making progress toward Utopia. It is fatal to change one's mind about the nature of that Utopia or to admit that one's efforts have been extended in the wrong direction.*

Although Kelly considered that such a morality was rarely seen "on this side of the Iron Curtain," he might have taken a different view were he to live in the world of today.

Kelly clearly regarded consideration of good and evil as central to the task of the psychotherapist. Thus, discussing this task, he stated that

> *The important thing to remember is, despite all the blatant claims that are made on every hand, no one has yet constructed the final answer of what is good and what is evil, and that the moment man gives up the enterprise he is lost. The psychologist who attempts to assist his fellow man should keep this truth central to his system of practice. The task is to assist the individual man in what is singularly the most important undertaking of his life, the fullest possible understanding of the nature of good and evil.* (30)

It may be surprising that his own understanding of this construct was not without indications of an absolute notion of what constitutes good and evil in that, for example, he stated that people may differ in how well they make this distinction. However, perhaps it is understandable that someone with a father who had been a Presbyterian minister could not entirely free himself of such an absolute view. It is a paradox that was taken up by one of Kelly's students, Rue Cromwell, in correspondence with him. Thus, Cromwell (personal communication) asked: "Were you actually suggesting that the future represents a

'quest for the Holy Grail (of what is good as opposed to evil)' or is there not the possibility of erecting a new and better system of constructs to replace the ones which have existed with us for so long?" Kelly's reply was,

> *It is true that there are many events with which man has dealt in terms of good vs. evil that might well be treated in terms of other constructs. But I am not one for abandoning the construct of good vs. evil. I would still give it a very wide range of convenience, though I should add that one needs to be prepared continually to revise his judgement about particular events. Thus, while I agree with you that we need to continue to look for more complex and adequate ways of construing these events, I'm inclined to believe that we should retain the construct of good vs. evil as a superordinate construct—just as scientists retain truth vs. falsehood as an important superordinate construct governing their lives.*
>
> *In implying that we should continue the use of the good vs evil construct, I don't think I am departing from the position of the psychology of personal constructs. Good vs. evil is still a construct invented by man. What I am saying is simply that I still think it is a useful construct, even though we have to keep it under continual revision. It is the construct of good vs. evil which I would advocate retaining during the foreseeable future, not the absolutistic labels that have been traditionally placed upon particular events. Let's continue to use the construct as a superordinate value in our lives but let's also elaborate and re-examine what falls under it.*

Kelly *(33)* restated this position in a paper given 2 years after the correspondence with Cromwell:"Any assumptions we make about what is good, or what is evil, or what will open the door to the future, are best regarded as only temporary, and any conclusions we draw from our experiences are best seen as approximations of what we may eventually understand."

In taking Kelly's advice to re-examine what falls under the good–evil construct, one also needs to examine how the construct is applied. This is often in the fashion that Kelly described as "preemptive," for example, the media portrayal of Ian Brady as an evil monster and nothing but an evil monster. How can this view be reconciled with the fact that Brady, a friend of whose had been helped by a blind stranger, transcribed books into Braille for Schools for the Blind for 20 of his years in prison? As he has remarked, "Serial killers, like it or not, can possess just as many admirable facets of character as anyone else, and sometimes more than average" *(12)*. This is graphically expressed in the writings of Dennis Nilsen, a former soldier and policeman:

> *I like to see people in happiness.*
> *I like to do good.*
> *I love democracy.*
> *I detest any criminal acts.*

I like kids.
I like all animals.
I love public and community service.
I hate to see hunger, unemployment, oppression, war, aggression, ignorance, illiteracy, etc.
I was a trades union officer.
I was a good soldier and N.C.O.
I was a fair policeman.
I was an effective civil servant.
STOP. THIS ALL COUNTS FOR NOTHING when I can kill fifteen men (without any reason) and attempt to kill about nine others—in my home and under friendly circumstances.
Am I mad? I don't feel mad. Maybe I am mad. (14)

Another example of the difficulty in reconciling the good and evil aspects of an individual is provided by Francois Bizot's *(58)* account of Douch, the Khmer Rouge official who had been his captor in Cambodia and had been responsible for saving him from execution when he realized the falsity of the accusation that Bizot was a CIA spy. Douch was later to become commandant of S-21, the notorious interrogation center in which 14,000 people were imprisoned but only seven survived. As Bizot remarks, "I could not bring myself to identify the man I had known, who so loved justice, with the principal torturer of this vile gaol, responsible for these atrocities." As has been illustrated in a contructivist analysis of the television series, *Buffy the Vampire Slayer (57)*, postmodern literature and art often provide similar challenges to the polarization of good and evil, and encourage the replacement of the preemptive use of this construct by one that is more propositional, acknowledging that the person who is construed as evil may also be viewed as having various other characteristics, some of which may be not undesirable.

It is not only personal construct theorists who have viewed, and written about, good–evil as a construct. For example, Ian Brady *(12)* considers that "the polarised values of good and evil constitute a paradoxical interdependent unity, an indivisible entity of internally-opposing tensions which constitute the vital essence of life: contrast and variety." Responding to my invitation to him to elaborate his view of evil, he wrote "A definition of evil? What pretty well forges the grapeshot of banalities—war, tyranny, greed, corruption, etc. —into a comprehensive ball?"

His answer to this question was "Ignorance (lack of knowledge/understanding). Logically, the best-educated, upper/middle ruling classes are the architects of all the evil/good qualities as well as the inequalities in every society."

As discussed previously, Brady's position of moral relativism could be viewed as uncomfortably similar to that of personal construct theory, especially when, as in this chapter, the theory is used to take a credulous approach to perpetrators of homicide, just as when such an approach has been taken to pedophiles *(59)*. Stojnov *(60)* considers that personal construct theory is relativist in content but universalist in form in that the importance attributed to sociality and to propositional construing provide the basis for a Kellian ethics. However, a capacity for sociality is as much a qualification of an effective sadist, designing ever more fiendish methods of torture, as of a saint. As Warren *(61)* points out, the difficulty is that some personal construct theory views of optimal functioning are presented so neutrally that they might even seem to regard the serial killer as functioning optimally if his or her actions are in the service of elaborating the construct system. His solution is to introduce as one aspect of optimal functioning an egalitarian outlook, in which others are seen as equals and there is an attempt to understand, and show tolerance of, their view of the world. As Green *(62)* has described, offending behavior, by contrast, may be viewed as involving "a lack of responsibility and respect for the construing of others." Raskin *(63)*, similarly, sees constructivism as being committed to an ethics of tolerance, in which "Even when an opponent's view is deemed evil…dialogue aimed at exposing the opponent to alternative constructions is at least as likely to succeed as alienating, dismissing, or actively seeking to destroy said opponent." In Butt's *(64)* view, there is no need to apologize for being a moral relativist, for this is "a vital corrective to moralism, a moral certainty that too often leads to the most appalling moral transgressions." As he vividly puts it, "No one has been burnt at the stake by relativists." In considering Butt's views on moralism, one might reflect on statements by leaders in current world conflicts, for example Tony Blair's justification of his decision to go to war in Iraq in terms of the need to advance essentially Western values "within a framework that recognises their universality" *(65)*.

The question of whether personal construct theory encourages an anything goes form of moral relativism was not ignored by Kelly himself. He presented the dilemma thus: "how to protect human audacity from human audacity without stifling human audacity" *(33)*, and in an illustration of this with relevance to current world events, "how do you give political sovereignty to a people, or a state, bent on suppressing its minorities?" His solution draws on his distinction between aggression and hostility, the latter clearly being viewed in a more negative light. His description of hostility again has current relevance,

> *Hostility is, in a personal construct theoretical system, an extortional undertaking designed by the person to protect a heavy investment in his own*

> *construction of life. And if, perchance, his hostility proves destructive of others, then that, unfortunately, is the way it must be. The economy must be preserved; the fact that the elderly starve in India or on the other side of town is incidental. Heresy must be controlled; too bad that intellectual curiosity on the campus must be denied. Bombs must be dropped: to be sure, children will die, but who can say it was we who put them in the target area? From our point of view, it is a precious way of life that we defend—Cadillacs and all. But what the hostile man does not know is that it is he who is the eventual victim of his own extortion.* (33)

Examples of hostility abound in the war in Iraq, from the extortion of evidence for the existence of weapons of mass destruction to the willingness of Americans to defile holy sites, provoked by the launching of attacks on American troops from those same sites.

To conclude, personal construct theory allows us to understand destructive choices, including those involving killing, in terms of the construction processes of their perpetrators. However, this will not involve condoning such choices as long as we hold to an ethics of egalitarianism and tolerance, and a distaste for expressions of hostility that involve destructiveness towards others. Perhaps the major obstacle towards adopting such an approach is that, in viewing acts of destruction as expressions of normal processes of construing, and in adopting a more propositional use of the good–evil construct, it requires us to acknowledge that, just as a killer is not necessarily entirely evil, neither are we necessarily entirely good. Chandler *(66)*, writing about the Khmer Rouge interrogation center, concludes that "To find the source of the evil that was enacted at S-21 on a daily basis, we need look no further than ourselves." As Katz *(10)* has pointed out, the threat of catching our own reflection and the anxiety caused by apparent chaos may lead us to take comfort in positivist approaches to the understanding of destructive acts rather than the less comfortable, but ultimately more productive, approach of viewing these acts "from the inside."

As a final reminder of the wisdom of taking a cautious approach to judgments concerning good and evil, it is worth considering the afterword to Ian Brady's book written by George Sotos, which is essentially a critical rant. He states that "This, then, can't be a book on serial killing.…This, then, is child pornography" *(67)*. One might think that these are the words of a good man, incensed by evil. But now consider the fact that Sotos has been charged with the possession and distribution of child pornography; that he edits a magazine that has been described as an "unhypocritical adulation" of violence and power; and that typical of his views is that "Females are dogs whose only worth is as pawns for my pleasure. Almost exclusively, this involves physical violence" *(68)*.

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Chapter 9

Violence As Secular Evil

Forensic Evaluation and Treatment of Violent Offenders From the Viewpoint of Existential Depth Psychology

Stephen A. Diamond

Background

Violence is the pre-eminent evil of our postmodern era. Although the causes of destructive violence in our society are complex, the troublesome human emotions of anger and rage play a central role in the genesis of violent behavior and psychopathology in general. This chapter discusses the forensic evaluation and psychotherapeutic treatment of violent offenders from the perspective of existential depth psychology—a psychodynamic fusion of Freudian, Jungian, and existential theory—focusing on the overlooked links between repressed rage or anger, pathological narcissism, antisocial personality, and violent behavior. This chapter stresses the importance of accurately evaluating and diagnosing potentially dangerous individuals, encourages the clinical prognostication of violence, and elucidates the pragmatic pertinence of existential depth psychology in effectively evaluating and treating pathologically angry or aggressive patients.

Introduction

Violence is the pre-eminent evil of our postmodern era. America is particularly bedeviled by violence in its various aspects. Indeed, violence is in

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certain ways condoned—even glorified—in our so-called civilized society. Violence as entertainment is pervasive today, as attested to by the insatiable popularity of brutal spectator sports such as boxing, wrestling, football, and hockey, as well as graphically violent video games, television programming, and extravagant Hollywood action films. We are clearly a culture at once afraid of and fascinated by the evil of violence. But when violent behavior leaps suddenly from the safety of some movie, computer, or television screen and occurs starkly in real life, it is shocking, repulsive, ugly, terrifying, and in most cases, it is a crime.

Here in the United States, the violent offender, once apprehended, is typically arrested, charged and incarcerated until trial. It is often at this point in the criminal process that the forensic psychologist or psychiatrist is consulted by either the alleged offender's defense counsel or directly by the court. Some of the questions commonly posed are as follows: Is the defendant competent to stand trial? Does the defendant have a mental disorder? And if so, does the mental disorder, disease, or defect amount to legal insanity? Or, could these psychiatric problems have directly affected the defendant's ability to form the requisite intent for having committed the crime? Finally, if a mental disorder does exist, what is the recommended treatment and prognosis?

Although not ostensibly stated, these seemingly straightforward legalistic questions run deep, touching inevitably on the profoundest of philosophical and sometimes even theological ponderings. What the attorneys, judges, juries, and the public really wish to know, whether consciously or unconsciously, is: How can we make sense of senseless violence? What caused this particular person to commit this brutal crime? Is he or she evil? What is evil? Where does evil originate? Is the defendant mentally ill? If she or he is not evil, but rather mentally ill, what causes such illness? Can it be treated and cured and if so, how? What is the likelihood of this individual's destructive behavior recurring in the future? Should this person be held fully responsible for his or her violent behavior? And if so, what is the appropriate punishment? These, then, are precisely the myriad musings that must be adequately addressed—directly and indirectly—during the forensic evaluation of each and every violent criminal defendant.

By virtue of posing such subtle and far-reaching queries, our criminal justice system seeks to better comprehend the broad context and psychiatric precursors of violent criminal behavior being alleged and prosecuted. It amounts to no less than a heroic human effort to comprehend evil. The very fact that our system permits such consultation with designated mental health experts indicates a significant level of psychological sophistication: the forensic psychologist and psychiatrist can and do directly imbue the legal process with

valuable data regarding destructive human behavior and its psychobiology, including the enigmatic phenomenon of evil. This is, in my view, an essential service for defendants as well as prosecutors, judges, and juries, and tends to have a much needed humanizing effect on a sometimes maddeningly rigid, overly simplistic, insensitive, cynical criminal justice system. But are the so-called experts depended on by the system for illuminating such murky matters truly up to the task? How can the skilled forensic evaluator be of assistance in elucidating the causes of violence without having first scrupulously studied the psychology of evil?

The Psychology of Evil

The term *evil* has historically been closely associated with the undeniably destructive aspects of anger, rage, and violence. But, because of its deeply rooted theological and religious or spiritual connotations, most modern mental health professionals feel uncomfortable employing this judgmental language in describing malevolent human behavior. Nonetheless, as Jungian analyst Liliane Frey-Rohn rightly remarks:

> *Evil is a phenomenon that exists and has always existed only in the human world. Animals know nothing of it. But there is no form of religion, of ethics, or of community life in which it is not important. What is more, we need to discriminate between evil and good in our daily life with others, and as psychologists in our professional work. And yet, it is difficult to give a precise definition of what we mean psychologically by these terms.* (1)

A preoccupation with the perplexing problem of evil is not new to psychology—although it is certainly timely. Freud grappled with this formidable subject, as have other prominent clinicians in this century, including Jung, Fromm, Frankl, May, Menninger, Lifton, and M. Scott Peck (*see also* Goldberg *[2–4]* and Diamond *[5–8]*). Prefiguring Peck *(9)*, existential psychoanalyst Rollo May held that, especially here in America, we still comprehend little of evil's true nature, and are thus pitifully ill-prepared to deal with it. Much the same may be said of that most glaring manifestation of modern day evil—violence—and the pathological rage and anger that tend to precipitate it. Yet psychiatrists, psychologists, and psychotherapists are increasingly required by society to evaluate and treat angry, belligerent, and destructively violent individuals. With escalating urgency, contemporary culture calls on the mental health professional to do battle with this evil: to explain, control, or "cure" deeply troubled, embittered, hateful individuals who tend to behave violently toward others and/or themselves. Violence or aggression, after all, is not only directed outwardly, but is at least as often, and frequently concurrently, aimed

inwardly toward the frail ego in the form of self-loathing, self-inflicted physical abuse, and suicidal behavior. Indeed, in 2001, for instance, there were more than 30,000 successful—and a far greater number of attempted—suicides in the United States, almost twice the total homicides. Although at least some suicidal acts can be perceived as hostile, angry expressions of indirect or—as in the case of the prevailing plague of fanatical suicidal bombers in America, Europe, and the Middle East—direct violence against others, the focus of this chapter is almost exclusively on externalized violence.

Consider the following forensic cases:

Case 1

A 30-year-old man viewing videos at home with housemates, arises slowly, calmly, silently, and without any noted outward provocation, enters another room, returning with a hammer in hand. Without so much as a word, he strikes one of the unsuspecting men present in the forehead with the hammer, causing a serious (but fortunately not fatal) gash and indentation of the skull. The young man is arrested and charged with assault with a deadly weapon. Because of the strange circumstance, his public defender requests a confidential forensic consultation to aid in handling the case.

Case 2

A fellow in his late 20s stabs his roommate with a steak knife during an altercation.

Case 3

Another male in his mid-30s walks uninvited into a neighbor's apartment, rummages through the kitchen mumbling to himself, enters the living room wielding a butcher knife, and proceeds to viciously stab the startled occupant repeatedly, all the while chanting the bizarre phrase "I must feed."

Case 4

An agitated driver deliberately steers his speeding vehicle into several unsuspecting pedestrians strolling at midday on a city sidewalk. When asked why by police, he responds that these complete strangers were conspiring to kill him, and he felt compelled to defend himself by attacking them pre-emptively with his vehicle.

Case 5

An adolescent angrily stabs his grandfather multiple times in the chest and abdomen with an ice pick. After a decade of incarceration, he petitions

the court to be released from a state psychiatric hospital for the criminally insane.

Case 6

A deeply depressed, middle-aged local television announcer with no previous history of violence (but suffering from violent headaches), viciously stabs his estranged wife to death, claiming later that "the Devil egged me on."

Case 7

A 27-year-old man callously stabs his girlfriend and then refuses to help stop her bleeding, despite having previously attended and completed a court-ordered anger management course for domestic violence.

Case 8

In another extreme case of domestic violence, the abuser furiously attacks his girlfriend with a razor-sharp chef's knife as she is packing her suitcase to leave him, like many batterers ranting "if I can't have you, nobody can."

Case 9

A 19-year-old boy fiercely wields two sizable blades (one in each hand) in a tense confrontation with a half-dozen well-armed police officers, who wind up wounding him for refusing to relinquish the weapons.

Case 10

Another rebellious youth is shot and almost killed after furiously assaulting officers with a long iron staff.

* * *

These are the kinds of cases commonly seen by forensic psychologists and psychiatrists. Although cases 1–10 involved male offenders, men being markedly the more physically aggressive of the sexes, females also commit violent crimes, most commonly against abusive spouses or lovers. On the surface, such dramatic events may sound extraordinary; but in tragic reality they are ordinary, mundane, daily occurrences in our culture of violence. In another time not so long ago, similarly bizarre, irrational, dangerous behavior would have undoubtedly been attributed to demonic possession. Today, we view such mystifying aberration through the prismatic lens of psychiatry and psychology. Instead of invading devils or demons, modern psychiatry's current culprit or "demon" *du jour* deemed most responsible for psychosis and other debilitating mental disorders is the tiny neurotransmitter. By biochemi-

cally restoring the normal neurological balance of these unruly microscopic "devils," mental illness, and its sometimes violent sequelae, may be finally conquered—or so some still quixotically hope.

At all events, the point is that how mental health professionals view evil in the 21st century depends very much not only on our historical or cultural context and religious background, but also on the particular training, experience, and theoretical orientation of the clinician. I was once asked by an astute Superior Court judge whether my own (partly Jungian) theoretical leanings influenced the way I interpreted and diagnosed a case. The answer is: yes and no. There is no denying that our theoretical paradigms strongly shape how we conceptualize such complex phenomena as aberrant human behavior, violence, and psychopathology. The depth or psychodynamic psychologist (e.g., Freudian or Jungian), existential psychotherapist, or adherent to that transcendent synthesis I refer to as *existential depth psychology (7)*, will bring divergent perspectives as to etiology and significance of violent human behavior in comparison to those of the cognitive-behaviorist or neurobiologist. Moreover, methods for acquiring data from the defendant (including whether or not psychological tests are utilized), as well as the specific areas and aspects one tends to focus on and emphasize clinically, can vary significantly. Nonetheless, there are certain issues that every forensic evaluator must invariably address in assessing violent individuals. First and foremost, in my view, is diagnosis.

Diagnosing Violent Individuals

As a primarily phenomenological system of nosology, the *Diagnostic and Statistical Manual of Mental Disorders 4th Edition Text Revision* (DSM-IV-TR) *(10)* provides the standard criteria in this country for psychiatric diagnosis based on behavior, history, signs, and symptoms. (In Europe and other parts of the world, the *ICD-10 Classification of Mental and Behaviorial Disorders [11]* has been the predominant diagnostic system). When used properly, the DSM-IV-TR is designed to provide relatively accurate, atheoretical, descriptive diagnoses. Thus, every evaluation of a violent offender must include a formal DSM-IV-TR multiaxial diagnosis. Does the violent offender meet the minimum diagnostic criteria for some sort of mental disorder? (Not all necessarily do.) If so, does the defendant suffer from some psychotic condition, or is he or she simply neurotic (i.e., nonpsychotic)? Is there an underlying or overarching personality disorder, involving chronic patterns of problematic behavior? Is the offender dependent on or abusive of licit or illicit drugs? Substance abuse is frequently found in violent offenders. For instance, according to DSM-IV *(10)* "more than one-half of all murderers and their victims are believed to have been intoxicated with alcohol at the time of the murder." Are there

underlying or latent neurological or other medical conditions (e.g., epilepsy, delirium, dementia, thyroid dysfunction, cerebrovascular disease, encephalitis, diabetes, etc.) that could conceivably cause or contribute to aggressivity? Each of these are fundamental questions demanding the best and most complete answers we can muster. For these questions bear heavily not only on how we technically diagnose the defendant, but also on how we ultimately understand and interpret his or her destructive behavior, decide what the appropriate treatment and/or consequences should be, and opine as to how favorable or unfavorable the prognosis.

Now, in order to arrive at a sound diagnosis of violent offenders, I find it best not to make any assumptions about the individual being evaluated, but rather to remain open to who he or she is and where he or she has come from. This phenomenological approach, although long touted by existential analysts, is especially pertinent to forensic evaluations, in which the time spent with the offender is typically quite brief, and hence, of the essence. Preconceptions (or perhaps I should say unconscious or habitual preconceptions, since we all operate regularly with certain necessary preconceptions) are antithetical to a fair and unbiased forensic evaluation. Moreover, the various sorts of savagely violent criminal acts committed (or in many cases, recommitted) by defendants can engender strong prejudices about whom or what they are before ever meeting them.

I have often been asked by friends, family, and colleagues how I can tolerate working with seriously violent or other criminal offenders, such as sexual predators. My answer is always the same: it is a deeply humanizing experience. A confession: at times, after reviewing the various records sent to me by the court or public defender in advance of first seeing the defendant, documenting the reprehensible, sometimes repulsive acts this person supposedly committed, I have found myself momentarily feeling hesitant to sit in the same small, stark, harshly lit, windowless room with this as yet faceless alleged murderer, rapist, or pedophile. It is a natural reaction, a pedestrian, instinctual response to what we—even as highly educated, well-trained professionals—perceive as evil. But then, I remind myself that I have a job to do, and overcome my temporary trepidation. Furthermore, in every single case I can recall, without exception, my initial reflexive reactions—of which I am keenly aware—dissipated on personally coming face to face with the flesh-and-blood human being sitting opposite me in the close confines of the cold, impersonal interview room. What comes across invariably is their raw humanity, their often blundering but impassioned existential endeavor to be in the world, more or less eclipsed by their maladaptive, injurious, and sometimes malevolent behavior. Theirs is a universal human struggle we all share, a striv-

ing inextricably intertwined with and confounded by the archetypal human capacity for evil: *Thanatos* and the *id* in Freud's schema; the *shadow* as C. G. Jung conceived it; or, to cite Rollo May's much less familiar yet more than equally serviceable model, the *daimonic*. May *(12)* defined the daimonic as:

> *any natural function which has the power to take over the whole person. Sex and eros, anger and rage, and the craving for power are examples. The daimonic can be either creative or destructive and is normally both. When this power goes awry, and one element usurps control over the total personality, we have "daimon possession," the traditional name through history for psychosis. The daimonic is obviously not an entity but refers to a fundamental, archetypal function of human experience—an existential reality.*

For both Freud and Jung, and later, May, violence stems from the running amok of denied impulses from (respectively) the id, shadow, or daimonic. Each of these three classic concepts are myths of the unconscious. Psychology and psychiatry—much as they may pride themselves on being scientific—are rife with myths. Myths express existential truths that defy logical or rational explanations. A myth is one way we give meaning to our existence—no myth, no meaning. What we have come today scientifically to call models or paradigms are actually myths: cognitive constructs we create in an effort to better comprehend our universe and ourselves. In the case of these three aforementioned myths (the id, the shadow, and the daimonic), each evolved from and addresses the problem of evil from a particular psychological perspective. And each, although distinctive, is basic to understanding deeply (i.e., truly *diagnosing*, the etymology of which suggests the ability to profoundly know or see clearly through a problem) the evil deeds of violent individuals. They go far beyond the useful but limiting labels derived from traditional diagnostic systems, and are exceedingly helpful in making some sense of so-called senseless violence. Central to this essentially psychodynamic comprehension of violence is a requisite reckoning with the long-neglected yet primal problem of pathological anger or rage.

Antisocial Personality, Pathological Narcissism, and Other Rage-Related Mental Disorders

Whether we are willing to admit it or not, we live not only in an "age of anxiety" as W. H. Auden, Paul Tillich, Rollo May, and others observed, but in an age of rage as well. It is also, as I have elsewhere argued *(5–7)*, this pandemic, subterranean anger or rage that breeds not only the bulk of hostile, hateful, violent behaviors, but also most serious mental disorders in general, including some of the psychoses. It is no mere coincidence that what we sci-

entifically term *psychosis* is colloquially called madness. Addressing the "primacy of psychic structure and aggression in determining psychopathology," *(13)* psychoanalyst Otto Kernberg *(13)* explicitly recognized that "hatred derives from rage, the primary affect around which the drive of aggression clusters," and that this hatred is "the core affect of severe psychopathological conditions, particularly severe personality disorders, perversions, and functional psychoses."

It surprises some today to find that Freud initially, and for two decades, paid so little attention to the role of repressed anger and rage in psychopathology. Before the early 1920s, the Freudian root of all evil was seen as the repression of instinctual sexuality or *libido*. It was not until the advanced age of 64, in *Beyond the Pleasure Principle*, that Freud first posited what came to be called Thanatos, the "death instinct." Freud stated that the death instinct *(14)* would express itself "as destructive or aggressive impulses." Because Freud seems seldom to have spoken specifically or extensively about anger or rage before 1920 and even beyond, just where these elusive "aggressive impulses" were secreted during the course of countless earlier Freudian analytic treatments is a true mystery; and many of his more faint-hearted followers rejected this belated addendum to Freudian theory. Freud's former protégé Carl Jung also all but circumvented the subject of anger in his own otherwise sweepingly prolific writings spanning some 20 volumes in his *Collected Works.* What I find especially fascinating is that the primal passions pervading the Freud–Jung partnership (1907–1913) and finally precipitating their rift—resentment, anger, and rage—found so trifling a place in their theories and treatment of the psyche. They went largely unrecognized by either savant, even though it must have been clear to many following the first World War that these emotions were the most salient modern dynamic of the daimonic. Indeed, the proper place of anger and rage remains to this day a sphere of significant clinical confusion, with far-reaching implications and challenges for all current theories and therapies.

Consider the following infamous cases:

Case 1

An idolized professional football star and affable international celebrity stands trial twice (criminally and civilly) for a brutally bloody double murder in Los Angeles.

Case 2

Several years earlier, in that same great city, two bright and attractive young brothers from Beverly Hills stand trial twice for the chilling murder by shotgun of their millionaire parents.

Case 3

In northern California, 39-year-old drifter and career criminal Richard Allen Davis randomly kidnaps and kills 12-year-old Polly Klaas, snatching her from the supposed safety of her suburban bedroom.

Case 4

The wholesale slaughter at a San Francisco law firm leaves eight dead and six wounded by an irate gunman, who, for his unoriginal finale, wields his weapon against himself.

Case 5

In Atlanta, another angry man, Mark Barton, murders his wife and two children before killing nine and wounding a dozen others after losing money in the stock market.

Case 6

In New York City, Colin Ferguson, a deeply disturbed middle-aged Jamaican immigrant, embittered by what he deemed to be America's rampant racism, deliberately and methodically opens fire on unsuspecting passengers on a crowded commuter train, killing 5 and wounding 18.

Case 7

In one of a stunning wave of similar incidents, two adolescent boys, Eric Harris and Dylan Klebold, kill a dozen fellow students and a teacher before taking their own lives at Columbine High School in Colorado.

* * *

What sorts of psychopathological conditions predispose people to commit such heinous crimes? Who perpetrates violence? It is true that violent crime is frequently committed by so-called sociopaths: manipulative, criminally inclined yet typically socially charming individuals meeting (and often exceeding) the minimum diagnostic criteria for the DSM-IV-TR diagnosis of antisocial personality disorder (APD). *I propose here that APD is fundamentally an anger or rage disorder.* This pathological anger is hinted at in the very aggressive term antisocial (i.e., against society). According to the DSM-IV-TR *(10)*, "individuals with APD tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including beating their spouse or children)." Indeed, aggressiveness is one of the prominent diagnostic criteria for this severe personality disorder. Dyssocial

personality disorder or APD generally involves a chronic and pathological anger, rage, and resentment toward others since childhood: parents, teachers, employers, supervisors, and other symbolic authority figures, such as police. Sociopathy centers around a deep-seated hostility toward family, culture, world, destiny, fate, God, reality, indeed, toward life itself. This immense rage remains largely dissociated in APD, expressing itself unconsciously, rebelliously, destructively, negatively, violently, nihilistically, cynically, cruelly, vengefully, sadistically, and malevolently. Certainly, antisocial behavior almost always contains narcissistic components, emanating from a central core of narcissistic wounding. So, if we wish to better understand the antisocial personality, we must turn our attention to the problem of neurotic narcissism.

Psychoanalysts such as Winnicott *(15)*, Fromm *(16)*, Kohut *(17)*, and Kernberg *(13)* have related the problem of hostility, anger, and rage to an underlying matrix of malignant or neurotic narcissism. Pathological narcissism is surely one of the most pervasive, insidious human evils, and is closely correlated with rage. We now know that pathological narcissism stems from inadequate, insufficient, or traumatic parenting (or surrogate parenting) before 5 years of age, during the pre-Oedipal period; and that deprivation or emotional trauma during this delicate developmental milestone renders severe psychic wounding in children, resulting in distorted perceptions of both themselves and the world. According to D. W. Winnicott *(15)*, when we experience our parents or caretakers as unloving, rejecting or hostile, we respond by concealing our true self, replacing it with what we sense they want us to be, thereby creating a false self. To cite psychologist Stephen Johnson *(18)*, "even though narcissism comes from the Greek myth superficially understood to represent self-love, exactly the opposite is true in the narcissistic personality disorder or narcissistic style. The narcissist has buried his or her true self-expression in response to early injuries and replaced it with a highly developed, compensatory, "false self."

This perfectly describes the rigid defensive persona of the patient with APD; it is pathological narcissism in *extremis*. A great deal of what neurotic narcissism disguises—and few if any of us are fully free from it—is our unresolved infantile anger, resentment, and rage. Karen Horney *(19)* noted that despite the pain and anger about not being loved (or, at least, never being as well loved as one would like) children dare not demonstrate their rageful feelings for fear of further frustration, rejection, or retribution in the form of physical and/or psychological abuse. This vicious cycle can be repeated throughout one's life, engendering and reinforcing a noxious neurotic condition characterized by compensatory grandiosity, hypersensitivity, exaggerated sense of entitlement, and a long-simmering pathological rage. The commonly well-

camouflaged yet touchy, intense, and overreactive anger of the narcissistic character is aptly referred to as *narcissistic rage*. Narcissistic rage, writes Kohut *(17)*:

> *Belongs to the large psychological field of aggression, anger, and destructiveness …and occurs in many forms; they all share, however, a specific psychological flavor which gives them a distinct position within the wide realm of human aggression. The need for revenge, for righting a wrong, for undoing a hurt by whatever means, and a deeply anchored, unrelenting compulsion in the pursuit of all these aims, which gives no rest to those who have suffered a narcissistic injury—these are the characteristic features of narcissistic rage in all its forms and which sets it apart from other kinds of aggression.*

Neurotic narcissism is a perverted caricature of normal narcissism. It starts out as normal, healthy infantile narcissism, but, because of a hostile, inadequate, rejecting, or indifferent environment during infancy and childhood, the individual is so deeply injured that he or she reacts angrily. This utterly comprehensible, natural, appropriate anger is, in turn, rejected, repudiated, and customarily, punished—as are the developing child's normal narcissistic needs for love, acceptance, and admiration. The child is thus forced to repress not only his or her healthy narcissism, but also the healthy (or ontological) outrage and anger about being injured, insulted, or rejected, spawning the rage-soaked seeds of future neurosis or psychosis. For, at bottom, pathological narcissism is a tragic tale of rejection, and the indelible pain and bitterness of being rebuked.

Indeed, neurotic narcissism, as Rollo May *(20)* reminds us, "has its origin in revenge and retaliation." It is rooted in anger, rage, and resentment—the normal human response to disappointment, hurt, rejection, betrayal, abuse, or abandonment. Paradoxically, the devastating sequelae of neurotic narcissism include, in adulthood, the completely unconscious, compulsively self-defeating inability in the present to accept (and repeated antagonistic refusal of) the love, warmth, affection, understanding, and approval so painfully lacking during childhood, thus recapitulating and reinforcing both the wounding and the resulting rage. Hence, the familiar sporting aphorism, "the best defense is a good offense" may be said to characterize accurately the pathological personalities of gravely violent individuals.

A sense of narcissistic entitlement is characteristic of both narcissistic personality disorder and APD. In the case of APD, manipulative, hurtful, and aggressive behavior serves the subconscious purpose of causing others to experience the same feelings of fear, rejection, victimization, terror, and betrayal, as did the perpetrator during childhood. It is a sadistic sort of *projective identi-*

fication, an unconscious or only semiconscious acting out of pent up anger towards parents, world, God, and self. The rapist, the stalker, the serial killer: judging by their behavior, each of these criminals ostensibly shares a conscious belief that they have the absolute right to thrust themselves uninvited into other people lives, and to selfishly exploit others for their own ends. But in reality, this perception presumes a level of conscious awareness which in most cases is simply not present. They do, however, have in common a distinct lack of empathy with their fellow man, being unwilling or unable to feel compassion toward, or identify with, the basic emotions, rights and needs of others. Such grossly inhumane attitudes and behaviors stem mainly from a combination of compensatory grandiosity and a schizoid-like detachment from their own feelings.

It could be sensibly said that the primary difference between narcissistic personality disorder and APD is one of degree, differentiated largely by the relative strength or weakness of what Freud called the superego, as well as by the severity or intensity of past traumatic narcissistic wounding. The boundary between these two contiguous diagnoses is somewhat tentative. Kernberg *(13)*, for example, describes certain destructively aggressive patients manifesting combined traits of narcissistic, paranoid, and antisocial personality as suffering from "the syndrome of malignant narcissism." What these and most other character disorders—and, for that matter, the mass of all mental disorders—share in common is the pervasive, pernicious presence of repressed rage. I have never met a patient with APD who had not suffered severe narcissistic wounding and subsequent narcissistic rage. I doubt one truly exists.

Violently antisocial individuals are mainly made, not born. I assert this to be true even though it has been observed that APD apparently occurs mostly in men, more commonly among first-degree biological relatives than it does in the general population, and that these patients in general "often show abnormal EEG results and soft neurological signs suggestive of minimal brain damage" *(21)*. It should also be equally well-noted, however, that both adopted and biological children of antisocial parents have an increased risk of developing this disorder *(10)*. There is no question that despite predisposing neurological or genetically inherited traits typical to sociopaths, family environment (or lack thereof) plays a vital role regarding the genesis of psychopathic behavior. The "bad seeds" germinating in this perverse scenario are not necessarily neurological or genetic, but more importantly, the poisonous pestilence of pathological narcissism: a process the insidious development of which is so culturally embedded and, therefore, profoundly threatening to our own personal and collective narcissism, as to all but obscure it from incisive objective study.

It has been suggested and substantiated by research that those suffering from APD (particularly what is termed *primary psychopathy*) seek extraordinary levels of stimulation and seem not to learn from experience. Regarding the latter trait, I would argue that this can be said of all neurotic conditions: neurosis is, by definition, a state in which one cannot learn from experience because one is not fully conscious of that which is being experienced. It is a state of unconscious acting out, which is itself a defense mechanism (a *repetition compulsion*, as Freud called it) for avoiding consciousness of that which drives it. So long as the underlying affects, complexes, and conflicts remain unconscious, the neurotic behavior repeats itself *ad infinitum*. Regarding the sociopath's seeking stimulation beyond the norm, I believe this is owing to, at least in part, a chronic depressive condition, concealed and warded off by a defensive *reaction formation* (i.e., the sociopathic persona or false self). In order to avoid sinking into this perennial depressive quicksand, constant intense stimulation is required, including the addictive excitement and adrenaline rush of breaking laws, taking risks, acting out sexually, intoxication, enragement, and violence.

Finally, it has long been presumed that the individual with antisocial personality—the psychopath—subsequent to having committed a crime, has no real sense of conscience or guilt, owing perhaps to some genetic anomaly or insufficient superego. But I would again underscore the fact that although extreme psychopathic behavior may seem monstrous to us, at bottom, sociopathy is a human affliction, manifested in a suffering fellow human being, not some inhuman monster. Our equally human, archetypal tendency to demonize individuals who commit horrifically violent acts is a psychological defense, a desire to disassociate ourselves from evil and from our own vehemently denied shadow side. I would argue that these deeply damaged individuals do indeed have guilt: not neurotic guilt, but, rather, ontological or *existential guilt.* Whenever any human being commits some act that violates his or her primary values or fundamental nature; when we somehow dishonor or desecrate our own being or the being of others; whenever we vainly or naïvely deny our potentialities for both good and evil; or slough off our inborn responsibility to direct our daimonic impulsions as constructively as possible, there develops—often subconsciously, buried deep in the psyche of even the most seemingly conscienceless criminal—a natural, existential anger with one's self; an inner outrage at failing to follow our most noble, not basest, impulses. Existential philosopher Jean-Paul Sartre *(22)* has spoken of such states of self-betrayal as *mauvaise foi* (bad faith). We have sinned or missed the mark, and at some level, we know it, have inwardly registered it, and roughly reproach ourselves for it. In the hardened heart of every sinner, no matter how evil, the capacity

(perhaps even an abysmally imbedded proclivity) for good endures, despite the habitude toward evil. And, it is precisely this innate inclination toward good that, when thwarted, generates guilt feelings: painful gnawing guilt feelings, which the antisocial personality promptly dissociates from consciousness in remarkably efficient fashion. But, as Freud discovered, the successful repression of such feelings does not negate their existence. Beneath the tough exterior and well-disguised depression dwell these unredeemed, potentially humanizing demons of guilt, and, with them, the entombed, archaic, ghostly spirits of galling narcissistic injury. The psychotherapy of sociopathy, as we shall see, requires the systematic, painstaking excavation of these haunted, shadowy ruins by deliberately dismantling the armoring barriers erected precisely to deflect any such illuminating penetration.

However, having now discussed sociopathy at length, I submit that the bulk of violent behavior is not engaged in by individuals meeting the current diagnostic criteria for APD. Psychopathy is but one of many anger disorders, though the majority of these disorders remain—with the exception of DSM-IV-TR's intermittent explosive disorder—officially unrecognized. Who really perpetrates violence? According to the *Synopsis of Psychiatry (21)*:

> *The differential diagnosis of violent behavior includes psychoactive substance-induced organic mental disorder, antisocial personality disorder, catatonic schizophrenia, cerebral infection, cerebral neoplasm, decompensating obsessive-compulsive personality disorder, dissociative disorders, impulse control disorders, sexual disorders, alcohol idiosyncratic intoxication, delusional disorder, paranoid personality disorder, temporal lobe epilepsy, bipolar disorder and uncontrollable violence secondary to interpersonal stress.*

The authors neglect to mention schizoaffective disorder, schizophreniform or brief psychotic disorder, intermittent explosive disorder, major depressive disorder with or without psychotic features, borderline intellectual functioning, attention deficit hyperactivity disorder, conduct disorder, alcohol or other substance abuse or dependence, paraphilias, pyromania, narcissistic, schizotypal or borderline personality, as well as other pathological conditions frequently found in violent individuals.

Thus, the evaluation of violent individuals is no meager matter, always posing a major diagnostic challenge. Any attempt to conduct such an evaluation must take myriad data into account. To begin with, the violent behavior itself must be objectively considered as to actual content, context, severity, brutality, premeditation, spontaneity, intent, motivation, remorse, and so forth. A serious inquiry into any previous violence must be undertaken, as must be done regarding the offender's psychiatric history. A typi-

cal forensic evaluation explores, at the very minimum, psychiatric history (including whether the defendant is currently taking psychotropic medication and whether such medications were being taken as prescribed around the time of the crime), criminal history, psychosocial history, and substance abuse history, as well as present circumstances and current mental status. For purposes of assessing the individual's current level of mental functioning, I employ and recommend a formal mental status examination. In addition, any neurological or other specific or general medical conditions, which could have played any part in the person's violent comportment, must be carefully considered. For this reason, I recommend that some form of medical and neuropsychological screening be included in every forensic evaluation of violent offenders. Neurological deficits resulting from previous head trauma, anoxia, fetal alcohol syndrome, systemic disease, chronic substance abuse, or other conditions, can directly impact critical functions such as reality testing, judgment and impulse control, contributing to (if not causing) violent behavior.

Generally speaking, as a forensic psychologist, one attempts also to reconstruct the circumstances leading up to, at the time of, and immediately following the violent act, as well as tries to determine what the defendant's state of mind might have been during this crucial period. This is no easy task, nor is it anywhere near foolproof, demanding a peculiar fusion of psychology, divination and dogged detective work. Nevertheless, it is imperative to venture an educated guess, especially in cases that could invoke an insanity defense.

Competency, Legal Insanity, and Mitigating Circumstance

Legal insanity refers to a defendant's state of mind at the time of the crime. In the state of California, where I practice, the test for legal insanity is whether a criminal defendant can prove by a preponderance of the evidence that he or she was incapable of knowing or understanding the nature and quality of his or her act and of distinguishing right from wrong at the time of commission of the offense. Recent legislation limits the use of the insanity defense by declaring that this defense shall not be based solely on a personality or adjustment disorder, a seizure disorder, or an addiction to, or abuse of, intoxicating substances. A person is considered not guilty by reason of insanity if he or she was unable to distinguish between right and wrong at the time of the crime's commission and was unable to appreciate the nature and quality of his or her actions, so long as this state of mind was not solely attributable to any of the above-mentioned disorders.

Underlying the insanity defense is the existential query regarding personal responsibility. Traditionally in this country, it has generally been pre-

sumed by the average citizen that we are morally and ethically responsible for our actions, and that those individuals who insist on behaving badly must be held responsible for their criminal or immoral acts. However, psychiatry and psychology have been permitting, for some time now, individual responsibility for one's behavior to be slowly eroded. Each time a new psychiatric "designer defense" is desperately advanced to defend or excuse evildoing—as for instance, in the Menendez brothers case, Lorena Bobbitt's castration trial, or the proposed but never realized "black rage" defense of mass-murderer Colin Ferguson—we run the risk of taking yet another dangerous step down the slippery slope of nihilism, chaos, and anarchy. We remove the admittedly onerous burden of responsibility from the bowed back of the individual—a cumbersome but indispensable personal cross we each must be willing to bear—and deem the violent individual not guilty of behaving as she or he did because of some diagnosable mental disorder or other surmised psychological syndrome. Or, we come to view such individuals as hapless victims of circumstance: bad genes, dysfunctional families, physical or sexual abuse, spousal abuse, alcoholism, drug addiction, poverty, racism, and so on. Consequently, we collectively hold them to a lower standard of responsibility than others presumably less encumbered by such biopsychosocial baggage. Either we believe their violent behavior to be justifiable by the special circumstances surrounding it; or we deem their responsibility diminished because of some presumed mental or medical disturbance. (Remember, for example, the infamous "Twinkie defense" of double-murderer Dan White in San Francisco, which later resulted in the abolition in California of the formal diminished capacity defense.) As one outspoken Lutheran theologian soberly observes, "as a society, we seem to believe that if our behavior is biologically determined, then the genes we inherit—not we ourselves—can be held responsible for what we do. Confronted by moments of moral crisis, we are often quick to scapegoat our genes" *(23)*. With steadily mounting emphasis being placed by science on biological over psychological and social factors in human destructiveness and violence, we shall soon from all quarters hearken the plaintive cry: "My genes made me do it!" Indeed, this troubling trend has already commenced in courtrooms throughout the country.

But, on the other hand, the insanity defense can, in certain cases, be quite appropriate and humane. The perennial philosophical problem of personal responsibility is brought into sharpest and most vivid focus in the criminal justice system. Assuming that individuals do, as a rule, bear responsibility for their behavior, might there be exceptions to this rule? And, can there be such a thing as differing degrees of personal responsibility? Moreover, what is

society's (including parents' and caretakers') responsibility in the creation of violent individuals? And, what of fate or destiny?

Consider the self-defense of Oedipus—a patricidal mass-murderer by modern day standards—against the harsh condemnation of Creon in the Greek classic *Oedipus at Colonus*:

> *Tell me now, if an oracle had prophesied a divine doom coming upon my father, that he should die by a son's hand, how could you justly reproach me with it, me who was then unborn, whom no sire had yet begotten, no womb conceived? And if when born to woe—as I was born—I met my father in strife and slew him, all ignorant of what I was doing and to whom, how could you justly blame the unknowing deed?* (24)

Can mere unconsciousness exculpate responsibility? And what about external circumstance? Undoubtedly, there is strong literary and legal precedent for considering the presence of mitigating circumstances in determining an individual's personal responsibility and guilt. For instance, "crimes of passion" tend to be treated somewhat less severely by juries than "cold-blooded," premeditated acts of violence. Orestes, another famous Greek protagonist, was found not guilty in a trial by jury of matricide, despite the fact that he had deliberately murdered his mother. His acquittal hinged on the special circumstances justifying his action: namely, that his mother, having slain his father, also intended to kill him, and that he—according to the god of truth, Apollo, his divine defense counsel—had been impelled by Zeus himself to avenge his father's wrongful death. And, had Hamlet lived long enough to be charged and tried for murder, similar questions of justification (and sanity) would have inevitably arisen.

Can a person suffering from documented mental retardation, grave medical illness, or disabling neurological damage be held fully responsible for an act of violence? (For example, in March 2000, a man violently attempted to force his way into the cockpit of a commercial jetliner while in flight, jeopardizing the lives of all aboard. It was later reportedly determined that he was suffering at the time from acute encephalitis.) What of the schizophrenic or manic patient? Or the intoxicated drug abuser or alcoholic? Or the adult victim of child sexual, emotional, or physical abuse? These are precisely the esoteric questions confronting our criminal courts each and every day, and, in turn, being ever more frequently referred to forensic psychologists and psychiatrists for expert consultation.

Yet another conundrum for the forensic evaluator is determining a violent defendant's competency to stand trial. Unlike legal insanity, which is concerned with the individual's state of mind at the time the crime was committed, competency focuses almost exclusively on the person's current, here-and-now func-

tioning. In California, a defendant is deemed mentally incompetent if, as a result of mental disorder, he/she is unable to understand the nature of the proceedings taken against him/her and to assist counsel in the conduct of a defense in a rational manner. Can we as a society ethically place on trial and possibly convict violent individuals who, because of some mental or medical disorder, cannot adequately comprehend what is currently happening to them nor participate rationally in their own defense? Our system judiciously allows for a forestalling of the trial of such grossly deranged individuals until such time that they are deemed competent to stand trial subsequent to intensive psychiatric treatment.

Competency evaluations are considered by some psychologists and psychiatrists to be relatively simple, easy, and straightforward procedures, because only present mental status is at issue. But they are not. For one thing, the motivation to simulate incompetence or insanity may be high, in hopes of avoiding facing trial or conviction. Moreover, it is extremely difficult to distinguish between "faking bad" (exaggerating or fabricating symptoms) or "faking good" (some defendants don't wish to be seen as incompetent or insane, as, for instance, in the case of convicted "Unabomber," Ted Kaczynski) without taking a detailed psychiatric and psychosocial history. Factors like judgment and memory impairment loom large, because substantial cognitive deficits can significantly limit defendant's ability or willingness to cooperate constructively with defense counsel as can psychotic symptomatology such as auditory hallucinations, paranoid delusions, or severe depression, mania, or impulse control problems. In evaluating violent individuals for competency to stand trial, they must therefore be able to demonstrate, among other things, a minimal or rudimentary grasp of the legal charges facing them, the gravity of those charges, the consequences of conviction, their possible legal defenses, how the legal system operates (e.g., the roles of judge, jury, public defender, prosecutor, etc.) and show some capacity to trust in and cooperate closely with defense counsel.

Of course, malingering is an ever-present pitfall in the practice of forensic psychology and psychiatry. Most clinicians rely heavily on their extensive training and experience (and typically on the results of standardized psychological tests like the Minnesota Multiphasic Personality Inventory-2) to detect the presence of faking, manipulation, lying, amplification, and the like. For me, the most important clues to whether someone suffers from a legitimate mental disorder or is feigning or exaggerating his or her condition come from a composite of history, current context, and clinical presentation. Major mental disorders such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, antisocial personality disorder, and

so on, seem to stem in part from archetypal patterns of potentiality embedded innately in the human psyche. In this rather Jungian view, these mental disorders each have their archetypal or universal patterns of behavior and experience, notable cultural differences notwithstanding. With sufficient practice evaluating and treating severe psychopathology, clinicians become familiar with these common patterns, and can compare the individual's complaints, behavior, and history with what they know to be typical in such cases. Although mental illness can certainly manifest in idiosyncratic ways, any gross or even subtle deviation from these archetypal patterns is suspect. Hence, we want to know: When did the person's illness begin? How persistent was it? What was its course? Has the defendant ever been psychiatrically hospitalized or treated? How debilitating were the symptoms on his or her ability to function normally? Is there any known family history of mental illness? Have there ever been suicide attempts or previous episodes of violence? How many times have they been arrested? On what charges? How much time cumulatively have they spent incarcerated? How did they do in school? Have they been able to sustain reasonably long periods of employment or meaningful interpersonal relationships?

It is true, of course, that any defendant can falsely report hearing voices or having paranoid ideation, or attempt to simulate multiple personalities in hopes of sounding insane. (Recall, for example, the case of Kenneth Bianchi, the so-called Hillside Strangler.) But a carefully elicited, detailed study of these classic signs and symptoms can be quite revealing to the seasoned forensic evaluator, especially in light of a defendant's known psychiatric history as well as other available data addressing associated features (including specific culture, age, and gender differences), prevalence, typical course and familial patterns of various mental disorders.

Prognosticating Violent Behavior

Is it possible for mental health professionals to predict violence? Once more, my answer must be equivocal. If by predict one means to foretell the future to some statistical certainty, then naturally, the answer is no. But, if by prediction one means to make an educated guess as to the future probability of violent behavior in a particular individual, I would say that this is not only possible, but absolutely necessary. Moreover, it is something we clinicians do every day. Each time we permit a patient, perhaps an irate patient, to leave our consulting room to return home or to work, we are predicting that he or she will not behave violently in the immediate future. Were this not so, we would be legally constrained to have the patient placed on an involuntary psychiatric hold as a possible danger to others. Should this same patient have

actually spoken to us convincingly about visiting violence on some specific victim, we would additionally be obliged, as per the Tarasoff ruling, to notify the intended victim(s) as well as the police *(21)*. My point is that if we believe that a patient may imminently do violence to others (or to self), we are legally and ethically bound to intervene. In such cases, we are, for all intents and purposes, predicting or prognosticating violent behavior.

Prognosticating is the term I prefer to predicting. Each time we formally diagnose a patient, we are also prepared to provide some prognosis regarding the future. That prognosis is based on both research findings and clinical experience. Regarding violence, the best predictors of potential violent behavior according to Kaplan and Sadock *(21)* are "(a) excessive alcohol intake, (b) a history of violent acts with arrests or criminal activity, and (c) a history of childhood abuse." In addition to these factors, I would include evidence of recent or historic impulsivity, poor judgment, the presence of paranoid ideation and/or command hallucinations, previous or present disinclination to regularly take prescribed psychiatric medications, any history of suicidal behavior, current substance abuse in general, recent indications of extreme anger or rage, severe current psychosocial stressors, and the refusal to preclude violence as a specific, situational solution—all data to be carefully considered in the evaluation of violent (or potentially violent) individuals in forensic or therapeutic settings.

I am convinced by close to 30 years of clinical practice that much of the violence committed by patients who seek psychiatric or psychotherapeutic treatments can be averted by circumspect and conservative prognostication of violent behavior. This is clearly one area in which the rapidly accelerating social evil of violence can—indeed must—be slowed by mental health professionals. But to successfully do so demands that we first become more willing to recognize and confront the potentiality for evil when we see it. We cannot luxuriate in the blissful ignorance of pseudoinnocence. *Pseudoinnocence*, as conceived by Rollo May *(25)*, consists of an incapacity to perceive the possibility of evil in ourselves and others, and stems from a fundamental denial of the daimonic. Repeated failure to identify (and take aggressive steps to obviate) dangerously violent tendencies in patients is tantamount to being blind to the reality of evil. This is a childish naïveté we clinicians can ill afford, because such unenlightened disavowal inevitably eventuates our unwitting, perilous complicity with evil. Hence, the vital importance of having keen eyes for veiled evil (as well as for appreciating positive human potential, goodness, beauty, intelligence, grace, charm, and creativity), conceding that these seemingly contradictory characteristics paradoxically can, and do, commingle in each of us to some degree.

Treating the Violent Individual

To the extent 21st-century psychotherapy persists in demonizing and subjugating the daimonic, it cannot be curative, but remains instead one more contributing factor to the current epidemic of violence. There are, to be sure, certain individuals who have such difficulty controlling their destructive impulses that immediate, active, and aggressive psychiatric intervention (including involuntary hospitalization, physical restraint, and medication) may be required to prevent them from harming themselves or others. However, in my view, it is preferable, whenever possible, to resist any therapeutic techniques, interventions, or responses that tend to relieve patients of their responsibility for themselves and their own behavior. Mental health professionals have today grown far too reliant on psychotropic drugs to supplant what we have failed or fear to do psychotherapeutically with violent patients: namely, facilitating the requisite task of consciously acknowledging and constructively redirecting their anger and rage. This exacting though irreplaceable enterprise can be accomplished in brief or open-ended, inpatient or outpatient, individual or group therapy, privately or institutionally; but in any case, we clinicians had better reassess our stance toward the daimonic, and, rather than striving solely to psychopharmacologically suppress it, learn to harness the latent healing power of rage and anger in our treatment efforts. This approach in no way makes the utilization of modern psychiatric medications and the sort of psychotherapy I am proposing mutually exclusive. Indeed, judicious use of psychotropics in adjunctive support of such a therapeutic stance toward the daimonic can be extremely beneficial, and in certain cases, indispensable.

In most of the forensic cases I see involving violent behavior, I typically recommend psychotherapeutic treatment for the offender. This is not merely some rote prescription: I firmly believe that psychotherapy—not just any therapy, but one capable of valuing, confronting and redirecting the daimonic—can assist habitually violent individuals to face and channel their rage more constructively, and prophylactically avert violent behavior in patients susceptible to it. The crucial therapeutic task in treating violent individuals is accessing and addressing their rage and its roots directly, without the emotions being deleteriously acted out. *Acting out* is a potent defense mechanism almost always present in pathological violence. It is a way of utilizing violent action, behavior, or even vocalization to avoid the direct, conscious experience of anger or rage, as well as that which underlies or is linked to these powerful passions. Were violent individuals to cease acting out their destructive impulses, they would be inevitably faced with the volcanic resentment, anger, and rage that fuel such behavior, as well as that to which the anger is a response: narcissistic wounding, existential frustration, neglect, abandonment, fear, meaninglessness, pre-

vious verbal or physical abuse, sexual molestation, and so on. The mistake most psychotherapists make in treating not only seriously violent offenders but so many other patients as well, is attempting to address the underlying emotional pain without first fully acknowledging and dealing directly with (rather than complicitly circumventing) the rage.

The daimonic passions of anger and rage pose a perennial problem for psychotherapists of all persuasions. There is precious little agreement today among the many divergent schools of psychotherapy as to how—or, for that matter, even whether—to deal with these explosive emotions. So much depends on the specific orientation subscribed to by any given therapist, as well as his or her own personal and cultural complexes surrounding rage and anger. When it comes to addressing our patients' wrathful feelings, most psychotherapists tend to take one or more of the following tacks: dissuade the overt expression of anger or rage; simply ignore it; intellectually analyze it, reducing it to an artifact of neurosis or transference; promote its physical and/or verbal ventilation in order to extirpate it; rationalize or cognitively restructure it; try to behaviorally modify it; and, in virtually all cases currently treated, employ sundry psychoactive medications to biochemically limit the experience and expression of anger or rage. This latter approach—the suppressive psychotropic therapy of the daimonic so prevalent in mainstream psychiatric treatment today—is particularly problematic, and, not infrequently, iatrogenic: the daimonic can be drugged, denied, or dampened for only so long before tending to return with a destructive vengeance. Although medications that stabilize mood and inhibit aggressiveness can certainly play a positive part in the chronic management and acute treatment of violent individuals, they are no substitute for real psychotherapy. The ultimate task of effectively treating violent or, for that matter, any other psychologically disturbed individuals, is to systematically and deliberately conjure up the "demons," not put them conveniently to sleep. Naturally, this is a scary prospect for therapists working with this notoriously intimidating, dangerous population. Precautions must always be taken, and the very real risks of injurious acting out carefully anticipated, controlled for, and minimized. But to paraphrase C. G. Jung, some risk is always required for the efficacious treatment of serious psychopathology. And, to cite May *(26)*:

> *I think there is just as much daimonic wrath in any kind of psychotherapy—except as it is avoided by the therapist. In terms of technique, those clinicians who are aware of the daimonic normally confront violence and rage no differently from the Freudians, Jungians, or other kinds of psychodynamically-based therapists. The crucial difference is that they can get at the anger and rage more constructively, because they can recognize its valu-*

able aspects. What we try to do is to shift or redirect the anger and the rage into those positive pursuits that the person has been omitting from his or her life. I do not believe in toning down the daimonic. This gives a sense of false comfort. The real comfort can come only in the relationship of the therapist and the client or patient.

On the question of just how to respond to (rather than dodge) the choleric patient's blatant or sometimes deceptively well-disguised aggression, May *(26)* equally decried (although not without sparse exception) the perceived need by some practitioners to forcibly stimulate, expose, or induce this daimonic emotion, noting that "in most therapy, however, one rarely deals with maximizing the head-on confrontation with repressed anger and rage: the daimonic has plenty of power in its own right, and the therapist need not be concerned, except rarely, with 'maximizing' the rage." In conducting psychotherapy with angry and violent individuals, all that is really required is a courageous willingness to acknowledge and openly address the daimonic as it arises spontaneously during treatment rather than recoiling from, denying, or dancing delicately around it. This unflinching sensitivity to and valuing (vs rejection of) the patient's "badness," his or her horrific, even murderous rage that both society and patient consider evil can, in my estimation, make a major difference in treatment outcome, though I am unaware of any specific research currently being conducted in this critical area.

Another central aspect of treating violent offenders regards the issue of imposing appropriate consequences for their actions. Our criminal justice system typically deems punishment in the form of incarceration the most apropos consequence for criminally violent behavior. But we must make a distinction between punishment and what I would call *penance*: unlike punishment, penance is a psychological sacrament, a symbolic act of contrition and self-absolution. Applying the appropriate penance is of the utmost importance in sentencing guilty violent offenders. In the Roman Catholic and Orthodox Churches, penance consists of a sacrament such as confession, absolution, or an act of penitence imposed by a priest. We would do well to remember that the traditional term for penal institutions designed to house and rehabilitate criminal offenders is *penitentiary*. Mere prolonged imprisonment is probably not the most appropriate penance for the multitude of individuals convicted of committing a violent crime. There can be no true atonements, absolution, or rehabilitation without proper penance. Punishment is, for most prisoners, a more or less meaningless form of penance: without some personal meaning, there can be no real rehabilitation, recovery, or transformation. To be truly therapeutic, penance (or effective punishment) must be chosen, accepted, actively willed, and consciously submitted to rather than merely imposed on one from

without. As for the assertion by some that treatment of violent perpetrators should include efforts to address the damage done to victims and/or their families, this too could be considered a fitting form of penance: consciously choosing to make reparations to surviving victims or families is a way of acknowledging the transgression and attempting to atone for it. But simply ordering or insisting that such reparations be made is relatively ineffectual, serving to heal neither perpetrator nor victim. Penance, to reiterate, must be willingly embraced by the guilty party; only then can it truly be a meaningful and deeply restorative ritual.

One of the most moving portrayals of appropriate penance in recent memory can be found in the disturbingly beautiful film *The Mission* (1986), starring Jeremy Irons and Robert De Niro. De Niro plays a hot-headed South American mercenary, who murders his brother in a fiery fit of jealous rage. Following the murder—for which there are no clear legal consequences owing to circumstance—he withdraws from the world in a state of inconsolable depression, guilt, and remorse. His fate is turned over to a saintly Jesuit missionary (Jeremy Irons), who strives to save this tortured, suffering soul. As part of his penance, the murderer must tow the tied-up trappings of his violent life—armor, sword, guns, and so forth—behind him as he and the priest ascend the sheer (but spectacularly breathtaking) cliffs and waterfalls separating the primeval rain forest (and the far-flung Jesuit mission of the film's title) from so-called civilization. The contrite soldier accepts his Sisyphus-like penance with a vengeance, purging his sin, jettisoning his former persona, and becoming initially a nonviolent—but, ultimately, true to form, militant—Jesuit monk, an equally impassioned defender against evil. Even the most appropriate penance (or potent drug) is powerless to permanently obviate, obliterate, or negate the daimonic. Hence, the far more realistic treatment goal is to redirect rather than try futilely to eradicate or eliminate the violent patient's immanent daimonic tendencies.

Eradication of the daimonic was the goal of the totalitarian society depicted so graphically in *A Clockwork Orange* (1971), another sublime but unsettling film by director Stanley Kubrick, based on the brilliantly prophetic novel by Anthony Burgess *(27)*. Ultraviolent offenders like Alex and his "droogs" were experimentally "treated" and reduced to pitifully passive creatures unable to muster any aggression at all, whether it be for self-motivation or self-defense—a sort of high-tech behavioral lobotomy. The ubiquitous psychotropic drugs being overprescribed by psychiatrists and increasingly relied on by society to control violent individuals can have similarly dehumanizing, castrating consequences. Creativity is yet another indirect casualty of these well-intentioned but misguided efforts to depotentiate rather than redirect the

daimonic, as I have discussed in detail elsewhere *(7)*. Though sorely tempting for a culture fed up with and terrorized by violence and those who commit it, these desperate measures are cynical solutions to an age old problem: human evil. But evil, like the daimonic, can never be completely eliminated. Nor can evil be conveniently projected on and attributed to one specific subgroup, personality type, or mental disorder, as psychiatrist M. Scott Peck *(9)* so precariously proposes. Evil is an ever-present possibility in each of us, even the most pious, well-adjusted, law-abiding, and good. Given the right (or wrong) set of circumstances, anyone is capable of evil, including the radical evil of violence. The appalling events in Nazi Germany less than six decades ago, as well as shocking experimental findings of psychologists such as Milgram and Zimbardo, make clear the universal human capacity for violence and evil lurking—like Dr. Jekyll's compensatory Mr. Hyde—just beneath the mask-like social veneer Jung dubbed the *persona*. But much the same may be said of redemption. Redemption must always remain in our minds and hearts an ever-present (albeit sometimes highly unlikely) human potentiality. "Let he (or she) who is without sin cast the first stone," was how Jesus sagely expressed the pitfalls of pharisaical or legalistic judgment, and the diabolic hypocrisy of collective condemnation.

Lastly, it must be admitted that the evil of violence stems not only from the individual and his or her personal history, but also from the transpersonal, mass psyche as well (i.e., our *collective shadow* as Carl Jung called it). Hence, no comprehensive psychotherapeutic treatment of violence can ignore the need to address systematic causes. Until we confront and remedy the latent sources of violence in our culture, we will continue to see and treat only the symptomatic outbreaks instead of the systemic disease. Individual violence can be viewed, to some extent, as vicarious, isolated discharges—warning flares—of a festering collective rage. We live in a society that unwittingly fosters and subtly supports violent behavior because it consistently denies and devalues the daimonic, and offers scant sanctioned rites or rituals permitting and encouraging the constructive expression of anger or rage. Judging from the burgeoning frequency and severity of violent eruptions in the United States spanning the past few decades, it can be inferred that the American shadow is riddled with rage. We have also, both here and abroad, recently witnessed and stand painfully reminded of the destructive, virulent, vehemently violent dark side of radical religious fundamentalism, another deadly detonation of roiling collective madness.

Radically altering our attitude toward the daimonic—from disdain and derogation to one of respect and valuation—involves an existential encounter with the Sphinx-like puzzle the daimonic poses. The Sphinx was a savage, rapacious creature that would lay in wait for unsuspecting travelers on the

road to Thebes. Petrified victims were posed a riddle none could answer, for which their punishment was a violent death. Such is the sorry state we find ourselves in today. Our land is being ravaged by the destructive aspect of the daimonic. America, like the ancient city of Thebes, is in a violent state of siege. Anger, rage, and violence are rampaging across the realm. Every man, woman, and child is at risk. But, reading on, we learn that Thebes survived the Sphinx's murderous reign of terror. Our old friend Oedipus worked out the riddle's solution. The Sphinx self-destructed in a fit of mortification and rage. The Thebans were saved. Today it is we, like young Oedipus on his way to Thebes, who are met with a similar riddle to solve, a riddle requiring a right response, and rather quickly—lest we too be consumed piecemeal by this beastly, barbaric, carnivorous demon of violence. The fateful decision our situation demands is whether we, as mental health professionals and as a culture, will ally ourselves with the collective forces serving to suppress the daimonic, or choose instead to work toward the redemption of our devils and demons (our repressed rage and anger) as constructively as we can—to learn to creatively live with the daimonic or be violently devoured by it. That is the question. We will decide our own destiny. Let us choose wisely.

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Chapter 10

Scapegoat, Spectacle, and Confessional

Close Encounters With Sex Offenders and Other Species of Dangerous Individuals

Dave Mercer and Joel Richman

Introduction

> *It was a contamination. Like something out of* The X-Files. *Vampire perverts hunting in packs.* (From *Acid Row* by Minette Walters) (1)

The recent novel *Acid Row*, by popular crime fiction writer Minette Walters, is a story of mob hysteria and escalating violence in response to rumors that a known pedophile has been rehoused on a deprived estate in southern England. Although it is fictional entertainment, the book represents part of a growing body of literature (*see also* Wallis Martin *[2]* and Rankin *[3]*) within popular culture that retells and recreates a narrative of public fear focused on mediated representations of child offenders and their victims. A common feature of populist, professional, and political discourses is the use of metaphoric language of a medieval hue such as "witch hunting," "vampire perverts," and "plague." This chapter reviews sociohistorical literature with regard to mental health and deviance, suggesting that the complex discursive issues offer insight into the demonization and scapegoating of the "other." The role of secure psychiatry is discussed in terms of the containment and treatment of the dangerous individual, in which the science of sex offender treatment reflecting the rationality of modernity seems bedeviled by the pessimism of the postmodern condition.

From: *Forensic Psychiatry: Influences of Evil*
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It has been suggested that forensic psychiatry was birthed in the rationalist spirit of modernity, and the optimism that science would replace superstition in explicating the universal laws governing both the physical and social worlds. Despite an assortment of definitions and dates in attempting to define the term *postmodernity*, one common characteristic is the collapse of grand theoretical schema, or metanarratives, and singular claims to the truth about any social fact. No longer confined to the academic world, the concept of a postmodern society has become a feature of popular and mediated discourses about the present. Within the fields of medicine and health care, generally, the theoretical linguistic turn has generated an expanding body of literature focused on the sociocultural construction of health and illness *(4)*. More particularly, in the psycholegal domain of forensic mental health, the influence of the French philosopher of ideas Michel Foucault (1926–1984) has witnessed a critical intellectual assault on the primacy of psychiatric explanations in terms of knowledge, power, and truth. In crude terms, his voluminous output can be situated in three broad areas: mental illness *(5)*, criminality *(6)*, and sexuality *(7)*. It is thus an apposite starting point for any challenging discussion of the contemporary mentally disordered sexual offender, because an individual whose identity as a sexual deviant is an amalgam of psychiatric and legal expertise. One key paper that focuses on the origins of the dangerous individual in 19th-century legal psychiatry *(8)* attempts to identify the historical point at which the medical gaze enters the domain of the courtroom in laying claim to the soul of the offender. Today, these same issues continue to vex politicians, policymakers, and the public, generating controversial debate about criminal responsibility, the diagnostic category of personality disorder, and preventive detention in the medico-legal management of dangerousness *(9)*.

But what of evil? The concept, and its use, appears strangely out of place in discussions about mental health and criminal justice at the start of the new millennium. The plea for forensic psychiatry to embrace the psychology of evil is not new *(10)*, and recognition of the way that some individuals are demonized through professional disassociation offers the potential to locate understanding and intervention in an existential framework *(11)*. Research undertaken recently, outlined in Chapter 17 (*see also* Mercer *[12]* and Richman *[13]*), revealed that evil retained currency in the discourse of forensic mental health nurses. Typically, this was in relation to offenders diagnosed as psychopathic or personality-disordered, and in particular where the offense was of a sexual nature. The fundamental dilemma for the staff that were interviewed resided in the medical management of moral issues, such as rape or child abuse, and the sense of professional impotence this

generated. We return again to this theme in this chapter, traversing a dangerous territory where the taken-for-granted world must be held up for closer inspection. One early commentator *(14)* noted that a "sociology of evil" had been slow to develop. A more recent addition to the social science literature claims that "ideas are cheap but facts are precious," urging us to avoid fiction and focus on "true stories" *(15)*. Indeed, the opening lines of this chapter offer a cautionary reminder of how easy it is to outrage the sensibilities of others in attempting to understand the moral dimensions of those who perpetrate evil acts: "A consequence of this approach is that the considerable emotional, political and ideological baggage that attends our cultural views of evil must be thrown overboard, at least temporarily, and the resulting analysis may offend people" *(14)*

Mindful of the problematic nature of any social fact, and the contested nature of truth, we therefore conclude with a number of reflective anecdotes derived from lengthy careers as practitioner and researcher in secure settings. It is anticipated that this move from theoretical perspective to personal narrative will bring the reader closer toward understanding the lived experience *(16)* of spending time with incarcerated offenders and the institutions that house them. In so doing we raise a series of fundamental questions that, like the concept of evil, are seldom addressed in the literature of the scientific community: Why choose to do this sort of work? What do we achieve as professionals or academics? How are we affected by the experience?

Witchcraft and Psychopathology: Scapegoats and Rule-Playing

> *Once a person is caught committing a crime, he should be tried and if guilty punished....The criteria for incompetence should have nothing to do with mental illness or psychiatry. If a person is competent enough to rob and mug and murder, he is competent enough to be punished.* (17)

The above extract summarizes the long-held and widely criticized *(18)* perspective of Thomas Szasz, noted for his vehement attack on institutional psychiatry as a vehicle of social control. His unorthodox and controversial work, challenging the biological basis of mental illness has been adopted as a model for understanding the manufacture of otherness and the accompanying social processes of persecution, scapegoating, and exclusion. There have been many stories in history in which such singular grand claims are dismissed with the recognition that a more temperate interpretation is required. It is thus noted that "there was no clear dividing line between 'mystical' and medical explanations for, and the treatment of 'insanity'; both attitudes and activities

held sway and to think otherwise is to denigrate the complexities of history" *(19)*. In the tradition of the great man theory of progress, psychiatric historians prior to the 1950s relied on formal treatises and biographical studies *(20)*. Much less attention was devoted to exploring the historical and intellectual context in which the discourse and practice of psychiatry developed. This failure to engage with primary source materials has meant that, to the present, discussion of medieval psychiatric thought has been dominated by demonology. The classic text *A History of Medical Psychology (21)*, portraying mental illness as an exclusively theological matter during the Middle Ages and Renaissance, has received little critical attention. Instead, a negative assessment of these periods has entered orthodox accounts, where reliance on supernatural events takes precedence: "Not all accused of being witches and sorcerers were mentally sick, but almost all mentally sick were considered witches, or sorcerers or bewitched" *(21)*.

Until the end of the 17th century, torture and exorcism, it is suggested, were the main forms of treatment for the insane, only declining with the emergence of an enlightened and rational embryonic mental health movement *(22)*. On a global scale, similar identifiable stages have been identified in the progress of psychiatric knowledge: primitive, rational, religious, somatic, and lastly, harmonization *(23)*. Others posit that, as humanity distances itself from the natural environment, collective, mythological, and religious ideas are challenged and "the psychiatrist is occasionally called upon to adjudicate in an area where mental illness, superstition and reality may overlap" *(24)*.

Although agreeing with traditional medical historians that the decline of witchcraft persecution coincided with the development of psychiatry, Szasz *(25,26)* explains this in terms of analogous ideologies of intolerance. Here, inquisitorial authority and institutional psychiatry are invested with the same logical and empirical status, sharing common moral and political functions. Thus it is noted: "The end of one ideology is thus the beginning of another; where religious heresy ends, psychiatric heresy begins; where the persecution of the witch ends, the persecution of the madman begins" *(26)*. Influenced by positivism, 19th-century physicians such as Pinel, Esquirol, and Charcot applied a psychopathological perspective to human difference and located deviance at the level of the individual—a focus on the victim rather than the persecutors.

Understanding how societal belief in magic developed into the social movement of a witch craze only after the 13th century is, for Szasz *(26)*, located in an analysis of politics, power, and ideology. Evolution of a feudal contract, an emerging middle class, contact with alien cultures, and the development of science threatened the nonreciprocal social relations of Divine Law

and church supremacy. The genocide of the burning times can be seen as a ritual and symbolic act, sacrificing the other to purify society: "in short by playing the religious game." Witchcraft, in this sense, is the historical precursor of modern beliefs about mental illness: false explanations for complex moral problems, and equally destructive of personal dignity and political liberty. The status of heresy or madness are ascribed, by inquisitor or psychiatrist, and justify their own brand of treatment: "This totalitarian definition of what constitutes 'therapy' and of who is a 'therapist' has persisted to our day with respect to all involuntary psychiatric interventions" *(25)*. Nowhere, it is concluded, is the relationship between witchcraft and mental illness better illustrated than in contemporary forensic psychiatry. Like the witchcraft statutes, protective mental health legislation and the enforced treatment of sexual psychopaths have gained popular acceptance. Given his voracious and sustained attack on institutional psychiatry, as a latter day witch hunt, it was in the forensic sphere that Szasz *(26,27)* should find the ultimate exemplar of a relationship between stigma, discriminatory legislation, and the deprivation of liberty: "However, to speak of criminal motivation in terms of 'aggression,' 'hostility,' 'pregenitality,' 'lack of sublimation,' and so forth…does not carry us beyond the ancient moral view of the problem, which attributed crime to man's evil nature" *(27)*.

It is posited by Russell *(28)* that witchcraft studies have seldom borrowed from a genealogical analysis, which is surprising given Foucault's "explicit concern with the 'history of the modern soul on trial.'" One trial in early 17th-century Germany is reconstructed as the site of struggle (and resistance) rather than domination in the micropolitical negotiation of power, in which the voices of those silenced for centuries are at last heard. Traditional historians, it is argued, have replicated the diminution of subjugated, nonelite, and feminine knowledges. It is thus observed: "And the central notions employed by all parties in the trial process, including those such as 'witch,' 'witchcraft,' 'God,' 'evil,' 'justice,' 'Christian,' and 'truth' were, and are, highly unstable, powerful, highly charged and capable of deployment for a wide variety of strategic purposes in a complex interplay of wills and power" *(28)*. One might note how current UK reporting of public outrage and mob violence towards those charged or convicted of offenses against children seems to offer a grass-roots challenge to psycho-legal arrangements for disposal. Interestingly, though, critical discourse analysis of anti-pedophile protests *(29)*, described in newspaper headlines as a latter day witch hunt, permits understanding of the ideological function of media language in pathologizing crowd protest, and delegitimating all forms of collective political action.

The Special Hospitals and the Science of Sex Offender Treatment

> *By virtue of posing such subtle and far-reaching queries, our criminal justice system seeks to better comprehend the broad context and psychiatric precursors of the violent criminal behavior being alleged and prosecuted. It amounts to no less than a heroic human effort to comprehend evil.* (11)

It is perhaps appropriate to borrow the Foucauldian concepts of "a history of the present" *(30)* and an "archaeology of knowledge" *(31)* in attempting to unravel, rather than document, the complex institutional formation of the English special hospital system. For more than 140 years, these monolithic establishments have occupied a pivotal position and a strategic function, at the interface of medicine and law, in the psychiatric enterprise of dealing with individuals deemed to be both mad and bad. They are at once very public and very private places. If their stories have often been told through the sensational headlines of a media spotlight, this has only added to a macabre fascination with what is usually depicted as a shadowy and sinister world. Despite major changes in the policy and practice frameworks of mental health service delivery, the special hospitals have survived as Goffmanesque *(32)* relics of the asylum era and the total institution. If numerous attempts have been made at organizational and managerial change, and the Victorian construct of the criminally insane usurped by the euphemistic figure of the service user, the controversies of the past show little sign of abating. There is a need to critically explore the structure of high-security forensic provision in the context of the political and ideological management of medicalized offending.

There is a paradox surrounding the history of the special hospitals. In some ways it is largely untold. There has not, for instance, been any attempt to distil, from what must constitute a vast archival resource, one single volume or text that details their origins and development. Conversely, much has been written about them in relation to their unique role and function at a systems level. The bulk of this commentary, it is suggested, tends to fall within two broad categories *(33)*. The first of these comprise an essentially defensive and descriptive output from clinicians working within the special hospitals. The second is a largely dismissed body of critical thought expressed by external observers and, to a lesser extent, official reports. In rhetoric style it is posited that marginalizing the opinion of outsiders as unreliable and ill-informed is a strategy of protection and preservation: "This defence may not be particularly valid but it is intelligible and therefore has to be acknowledged as part of the problem of having a free and open debate about a system which is manifestly a victim of its own history" *(33)*. There are, though, many

primary and secondary sources of information that can be drawn on in attempting to assemble a version of the special hospital history. Such materials would include legislative and policy documents, internal publications, autobiographical works from significant personnel, survivor testimonies, and a massive collection of mediated accounts in the professional and popular press. In reviewing this diverse array of published literature, one is reminded of the fundamental philosophical challenges facing the historian *(34)* and the political, polemic, and partisan functions of language in retelling and reconstructing the past. Most standard texts dealing with the history or role of psychiatry will include a chapter focused on forensic psychiatry, or the treatment of disordered offenders, as a specialized field of mental health practice. These potted histories typically adhere to the Whig tradition of viewing the past as a chronological and evolutionary map of progress, advancement, and reform punctuated by important names and dates.

The special hospitals were formally constituted under Section 97 of the Mental Health Act *(35)*, later repealed by the National Health Service Act *(36)*. This legislation requires the Secretary of State to provide and maintain special hospitals "for persons subject to detention…who in his opinion require treatment under conditions of special security on account of their dangerous, violent and criminal propensities." However, the starting point is more usually taken to be the opening of Broadmoor Hospital in 1863. Indeed, it has been noted *(37)* that much of special hospital history was recorded by two authors, Allen *(38)* and Partridge *(39)*, who took Broadmoor as their particular focus. Situated at Crowthorne in rural Berkshire, Broadmoor Hospital, or the "big house" as it became colloquially known, was the first asylum in England designed and built to house the criminally insane. If the Act for the Better Provision for the Custody and Care of the Criminal Lunatics *(40)* provided legislative authority to construct a criminal lunatic asylum, it represented also a triumph of Victorian optimism and faith in the newly developing science of psychiatry. Initially intended to accommodate 400 men and 100 women, physical conditions at Broadmoor were seen to represent a vast improvement to those in gaols and prisons around the country from which the first inmates were transferred. Likewise, the philosophy of the institutional regime, premised on the notion of moral therapy, emphasised a rehabilitative or restorative role in contrast to the harsh existence of prison life. Commenting on the Victorian attitude toward the criminal lunatic, Cohen *(41)* comments: "Most had committed violent crimes but they were not held morally responsible since they did not really know what they were doing. A humane society had to recognise that this made them less culpable and it had to provide for them. Certainly, they should not be allowed to endanger others but they needed asylum and, as far as pos-

sible, treatment." This duality of function between caring and custody has remained to the present as a fundamental and problematic feature of secure psychiatric services. Despite savage criticism *(42,43)* they now proclaim themselves to be an integral component of the modern health care system.

The central and defining foundation stone of forensic psychiatry, and thus of all other professional groups working in the field, is the medico-legal construct of dangerousness. If language changes have transformed the criminal lunatic into the mentally abnormal, and latterly, mentally disordered offender, these descriptors are all variants of the 19th century dangerous individual. The concept of dangerousness still resides at the heart of mental health legislation and dictates the disposal of offenders, and symbolizes a chief ingredient of forensic mental health practice in terms of the assessment and management of risk. Without any solid evidence base and fueled by tabloid sensationalism, public opinion in the 1990s elevated a general concern about violent crime as a product of mental illness. It is noted: "A 'risk' climate tends to propel the social control functions of mental health legislation into greater prominence" *(44)*. In an early paper, Bluglass *(45)* locates the development of forensic psychiatry as part of the wider effort to establish a scientific criminology. This important connection between attempts to explain and predict criminality, and the operational mechanisms of criminal justice, has fuelled a critical sociological engagement with the institutional apparatus of state institutions in terms of power, control, and ideology *(46–48)*. Significantly, these critical treatises, though accounting for the shift from medicine in prison to medicalized prisons, have focused on the penitentiary as the focal point of state power. Again, secure psychiatry, and its "medical hostages" *(49)* remain hidden from view. It is unsurprising that many of the inhabitants of the special hospitals lack the glamour of the "romantic deviant, and in academia as well as professional practice disordered offenders might well be described as "people nobody owns" *(50)*.

It is not the intention here to review historically the variety of treatment approaches that have been directed at the sexual offender. Textbooks *(51,52)* and manuals are plentiful. Do-it-yourself packages, often linked to training courses and workshops, are highly marketable commodities in what Caputi *(53)* has described as the "age of sex crime." Rather it is to draw attention to the faith that is invested in the idea that "science" has a role to play. Whether the solution has been sought in physical methods, antilibidinal medication, behavioral conditioning, or relapse prevention programs, they are essentially underpinned by a universal ideology that fixes, and then explains, sexual crime at the level of the individual offender. It is comforting because it directs attention away from structural/gendered inequality and the endemic nature of sexu-

ally abusive behavior as a sociocultural issue *(54)*. The discursive resources of men, in positions of power, who assess sexual assault as part of the legal process, compound the power disparity further *(55)*. One forensic psychiatrist in recognizing that "the profiling of rapists only deals with the individual consequences of a male-dominated society but not with the fundamental, underlying causes of rape," can still offer only "incarceration and treatment" *(56)*. With a book title promising to "illuminate the darker side of human behavior," he only manages to cast a light across the trap into which we inevitably fall. The 19th-century alliance between sexology and criminology *(57)* has proved remarkably resistant; diagnostic typologies and criminal identities merge in the construction of noncitizens, such as the sex offender and other subspecies of being *(6)*. In the shadowy world of the psychiatric Bastille, these are the real and imagined monsters that haunt our worst nightmares. The body (treatment) and mind (therapy) are the site of regulation, control and surveillance, and "the forensic care plan is one strategy aimed at the protection of the self and soul" *(58)*.

Inside the Sadeian World of the Special Hospital

> *Before playing the tape Tim introduced it: "The thing I find most evil about it, and evil's the only word, you know is the apparent normalness, for want of a better expression. He comes across as an intelligent, logical, normal sort of person. But he's evil isn't he?"* (A police officer describing a taped telephone call between a pedophile and a young girl *[59]*.)

A strange irony lies at the heart of forensic nursing, that branch of the profession charged with the responsibility of caring for the mentally disordered offender. This rapidly expanding component of contemporary mental health provision, with international variations in scope and practice, in essence combines the traditional values of caring with a custodial function. Although much has been written on the complexity of balancing, or reconciling, therapy and treatment with security and containment *(37,60)*, there are few personal accounts of a job that might be described as the devil's advocate. This is essentially a shift from the cerebral to the visceral, and involves a consideration of the lived experience of working with detained and dangerous individuals. This section draws on a reflective narrative that attempts to capture the unseen (and probably unknown) costs of engaging—as practitioner or researcher—with those who attract the labels of other and evil. It is autobiographical. It is a confessional. For those who might rebuke these observations as unsystematic, nonstandardized, and therefore trivial or invalid, we would offer a counter suggestion. In the tradition of the critical incident *(61)* these data fragments

are parts of the research biography. Or, borrowing from the perspective of Levi-Strauss *(62)*, they provide a telescope for focusing on the inner and outer cultures of an organization. In contrast to official versions of the truth, the ideological apparatus of the special hospital system is exposed as a socially sterile, centralized, and bureaucratic command structure. It is a reminder that forensic (office) psychiatry has always operated with a narrow and restricted agenda; a prescriptive, not analytic, concern with risk and dangerousness that is devoid of the cultural sensitivity of fieldwork. What is not seen cannot be discussed. Until 1989, all members of staff working in the special hospitals were bound by the Official Secrets Act (usually reserved for areas of national security) in a legislative control of what could and could not be spoken about.

A large amount of my clinical practice as a nurse working in a high-security hospital involved therapeutic work with sex offenders. These men had committed serious, serial, sexual violence against women and children, and had all spent long periods of time in penal or secure environments. I was one of a number of multidisciplinary colleagues involved in setting up a cognitive-behavioral group-treatment approach based on the fashionable model of relapse prevention. My own interest in the sexual offender and the pedophile as the subjects of psychiatry, however, has a longer history, rooted in social science, that predates any therapeutic involvement. Indeed, my academic background in sociology had prepared me with a critical perspective that problematized the whole idea of medicalizing criminal behavior, in particular sexual violence. A majority of the tutorial staff contributing to the undergraduate sociology curriculum in the late 1970s had been active in the turbulent political struggles of the 1960s. Civil rights and social justice were central elements of a discipline that championed the rights of minority groups oppressed by a "power elite" *(63)*. Labeling theory and Marxism provided new ways of explaining deviance, and explicating the class-based function of medicine, psychiatry, and the law as repressive agencies of social control. It represented a refocus on the abuse of the vulnerable and the crimes of the powerful, and targeted welfare agencies as one of the props of the capitalist economy. Instead of biological pathology, mental illness could be reconstructed as a product of economic exploitation *(64)* or the skewed interpersonal dynamics in that most sacred of institutions, the family *(65)*.

Alongside challenges to the social relations of production (capitalism), the second wave of feminism contributed an influential critique of the sexual relations of reproduction (patriarchy). Particular attention had been directed at male violence against women. In opposition to "malestream" ideology, rape was viewed as an expression of male power as "nothing more or less than a

conscious process of intimidation by which all men keep all women in a state of fear" *(66)*. The agenda was a sexual political one *(67)* that located, and established, sexual violence and abuse within a structural and cultural context *(68–70)*. In a now famous campaigning statement the radical feminist Robin Morgan *(71)* was to make explicit the connections between mediated misogynistic representations of women and their violent subjugation: "Theory and practice: pornography and rape." Recognition of the gendered and material construction of sexualities evidenced the emergence of campaigns to acknowledge the rights and citizenship *(72)* of those outside of the heterosexual norm. Eschewing the constraints of biological determinism, the erotic self could be understood in the discursive domain as a sociocultural negotiation of sexual stories and scripts *(73,74)*. It was in this context of resistance to the "psychiatrization of perverse pleasure" *(7)*, and parallel to the voice of the Gay Liberation Movement, that Tom O'Carroll *(75)* published a brave manifesto for adult–child sexual relations, *Paedophilia: The Radical Case*. In briefly reviewing this recent history of the search for sexual freedoms and identities, alliances emerged that in the current climate would be seen as contradictory, even unthinkable. One illustration of this is the distribution of materials issued by the Paedophile Information Exchange and Paedophile Action for Liberation through an alternative bookshop in Liverpool, organized as a radical feminist collective (e.g., *76,77*). Some 20 years later, the campaign for the sexual privacy of pedophiles as a civil right continues, albeit in a less public forum *(78)* in which the rights of the child seem to be less important than those of offenders and potential offenders. Reasserting his case, O'Carroll *(78)* adopts the imagery of evil to condemn the language of law enforcement as a threat to freedom: "It is the language of demonization, in which the word 'paedophilia' has popularly come to symbolize pure, undiluted evil, with the implication that nothing must be allowed to stand in the way of a ruthless war to bring about its extirpation." At almost the same point in time the unholy trinity of pedophile, personality disorder, and child pornography were to emerge as critical issues in the beleaguered history of the special hospital system *(79)*.

The above is a truncated, and possibly sentimental, account of the optimism and spirit that informed an intellectual and pragmatic assault on injustice at a particular point in time, where the personal became the political *(80)*. This was to provide a theoretical starting point for working with offender-patients that was at variance with the institutional discourse and practice of institutional psychiatry that constructed the forensic nursing role when I began working in one of the English special hospitals in the mid-1980s. This was shortly after qualifying as a registered mental nurse, which I had been strongly advised not to do—with the suggestion that it was a dead end to any career

prospects. At the time, these large-scale institutions were centrally administered, sharing more in common managerially with the penal system than the National Health Service (NHS). Those nurses who trained outside the special hospital system were commonly referred to as county staff (local provision). This marked one as an outsider and acceptance or survival involved a lengthy initiation in which the most important test was how one responded to the first incident (act of aggression requiring physical intervention) on a ward. The words that greeted me when I arrived are hard to forget. It was a direct question from one of the staff nurses: "Welcome to the special hospitals, the Foreign Legion of the NHS, so what skeletons have you got in your cupboard?" The implication was that one was hiding, or escaping from, something. My response was "None." "Don't worry," he replied, "you soon will have."

Shortly after this incident a charge nurse informed me, in deference to the role of the state as paymaster, that I was a civil servant. This bizarre interpretation of the job of working with offender-patients precluded any therapeutic challenge—it was my duty to serve those people. In many ways this summarized the prevailing philosophy of care. A more generous choice of words might be milieu therapy and the belief that there was something inherently restorative simply by being resident in a hospital setting. Elsewhere this has been referred to as the illusory journey of rehabilitation aboard a ship of fools *(81)*, with the nurse assuming the task of entertainment's officer and filling a time vacuum with something *(82)*. A handful of counselors, traveling between wards, may well have dispensed talking therapy (though staff on the wards were never privy to the content of these sessions) with their captive clients, but with detained sexual offenders this was an invitation to collusive and counterproductive relationships. Likewise, it can be argued that the psychotherapeutic enterprise in closed institutions is compromised by the inequity of power relations and conflicting role responsibilities *(83)*. From the perspective of this chapter, though, there is a bigger difficulty in enacting reciprocal and facilitative therapeutic relationships with sexual offenders. Put simply, the inability of a humanistic paradigm—rooted in a model of human goodness and the potential to self-actualize—to embrace behaviors that might be seen as bad, wicked, or evil. The ideal of treatment further relies on the patient agreeing to take part in the process of change, but this is an equally naïve assumption. Indeed, for a person detained—without limit of time—the confessional of therapy can be far from attractive. Conversely, there is much to be gained from silence *(84)*. The more one talks about oneself the more dangerous one can become in a system that is predicated on the assessment and management of risk with regard to public safety. This can be wrapped up in the psycho-speak of denial, but experience suggests that there is a stronger

motive in manufacturing the persona of political prisoner and killing time (an apt metaphor!) in the hope of eventual transfer or discharge.

The principles of cognitive behavioral work *(85,86)* are not without critical interrogation, despite the mantra-like status that has been achieved in the precious world of sex offender treatment. In running such a group we discovered that our participants presented a much greater risk than was indicated in the initial selection assessments. But other concerns arose—though I do not know whether these were shared by fellow facilitators—notably expressed through language. It was not uncommon when interviewing a prospective group member to be interrupted with "Aren't you going to ask about my distorted thinking, offense cycle or triggers to offend?" Perhaps it is a cynical assumption that people can learn a way of speaking that has powerful and persuasive clinical currency in the discourse of the therapeutic state. Still, one has to consider the extent to which these ways of talking about the world (in this case, women and children) actually affect the thinking and behavior of those who articulate them so well. In an earlier appraisal of this experience *(87)*, I borrowed the words of the novelist Helen Zahavi from her book about a young woman terrorized by a serial rapist. Now, several years later they are worth repeating: "They come out with all the jargon. They tell you in that Grendon whine about the therapy they've had, how they've talked it through, how they've come to terms with what they did. And running through it all, bubbling away beneath the surface, you hear the self-justifying snivel of the unrepentant rapist" *(88)*. This quote will certainly not win over fans from those who retain a zealous faith in offender therapy. I would not suggest that it is anything other than a very personal statement. But, it does get closer to the real experience of sitting and conversing in a therapeutic group with extremely abusive and violent men than many of the texts and manuals available to practitioners in the field. I recall a sobering incident when one member of the group with a horrific catalog of offenses leapt to his feet and denounced the group and its members. He proclaimed vociferously the pleasure principle of being a sadist, a refusal to play the game, and a renunciation of his fellow patients for their self-motivated complicity in learning the language that other people want to hear. At the time I can recall feeling a grudging respect at this outburst, not for the content but for the honesty of his words. He concluded by stating that he would rather serve a longer period of time than surrender his passions. It was a dialog reminiscent of de Sade:

> *This manner of thinking you find fault with is my sole consolation in life; it alleviates all my suffering in prison, it composes all my pleasure in the world outside, it is dearer to me than life itself.... If then, as you tell me, they are willing to restore my liberty if I am willing to pay for it by the*

sacrifice of my principles or my tastes, we may bid one another an eternal adieu, for rather than part with those, I would sacrifice a thousand lives and a thousand liberties, if I had them. (89)

It is also likely that each suffered a similar fate.

Outside of the imperative to confess and the spectacle of group therapy are other stories that rest uneasily beside the sanitized language of the clinical case studies or professional publications of the scientific community. Both authors have many spent many years, often on collaborative projects, attempting to unravel the cultural constituents of the special hospital world. Yet, ultimately, there are limitations on what is said, as well as limitations on what can be said. For instance, a recently published methodology paper, in *Nurse Researcher (90)*, was deemed to be unsuitable for the readership of the journal because of the inclusion of a vignette that outlined a case of child murder and possible necrophilic abuse. Admittedly a distasteful and distressing topic, current newspaper reporting of sex crime for the consumption of the general public is a good deal less circumspect. The implication is that the work of forensic personnel, valorized in generic health policy, should somehow remain hidden behind its walls.

Others who have spent time in penal and custodial establishments will doubtless recognize the distinction between official and unofficial discourses of both staff and inmates. Thus co-author Joel Richman recalls attending a patient care team meeting as part of an ethnographic study of ward culture. This ceremonial occasion was presided over and conducted by a charge nurse, who would replace his usual pair of glasses with a monocle, in the pseudointellectual style of an Oxford seminar. One elderly patient, resident in the hospital for many years, was being considered for review. When asked what he would do if released he replied, "Become a railway clerk and kill my mother." The psychiatrists present, programmed to respond to dangerousness, failed to question whether this woman was still alive. He was officially beyond redemption. Further, the nurse who had prepared a progress report for the patient had copied previous submissions—changing only the dates! This account also exposes the failure of the remedial philosophy, and the idea of a ward trajectory in which the patient's career is measured in progress from high- to low-dependency environments. This man was described in the meeting as the "best kitchen boy" the ward ever had, and this proved one good reason to retain (and detain) his services. In a tragic turn, the patient showed Richman his diary. For the whole year it recorded only one entry: an appointment with a specialist to review the patient's nocturnal enuresis.

Moving from the surreal to the sinister are those encounters that cannot be neatly caricatured in the conventional language of mental health care. Such

are moments when those we know well as patients, through regular and mundane interactions, reveal another aspect—one very different from the everyday presentation of self. An example of this would be when on one occasion I was in the kitchen area of one of the wards, kneeling down, and out of the view of a couple of patients sitting in the adjacent dining room. From this position I was easily able to overhear, though not intentionally, the conversation between the two individuals, both of whom had committed sexual offenses. The patient who was speaking was describing details of his offense against a young girl, in a way that can only be described as chilling. It was boastful and needlessly graphic. At this point I made them aware of my presence. The discussion stopped. Many times before this, and afterward, the same patient had expressed remorse for his crimes as part of a prolonged appeal for freedom. This took place many years ago, but the words still haunt me. Likewise, in a more direct exchange, another patient with a history of sexually motivated serial murders talked casually about his crimes. I had asked whether he regretted his actions and how he now felt about his victims. The shock that accompanied his reply was in the complete dispassion in his voice as he told me, "Why should I, they were all homeless, nobody will miss them." Textbooks can break down the features of the psychopathic personality into tidy taxonomies, but there is no way that they can convey the human experience of confronting the unfeeling and remorseless killer.

From the perspective of doing research, Richman experienced this same cold rationality during one of the interviews. After the standard questions to promote discussion, the focus was shifted toward the patient's offending behavior and he was asked why he had stabbed people. The answer was unsettling in its directness and logicality: "I wanted to see what would happen." Similar research on a ward for young psychopaths revealed the skill with which the patients were able to manipulate the treatment model in the pursuit of gratification. To qualify for therapeutic intervention for their sexual offending, patients had to undergo an assessment that involved penile plethysmography. In a standard procedure (e.g., *see* ref. *91*) the patients would be shown sexual images, and their levels of arousal measured in terms of penile tumescence. The patients, though, had a completely different reason to take part in this: they wanted to see the dirty pictures. One young man explained how this had been achieved by his refusing ground parole, an extremely unusual course of action given the privileged status and greater freedom of movement it afforded. When asked why he would decline parole he informed the care team that he was unsure how he would react if he encountered a woman in the grounds of the hospital, and what he might do to her. In so doing he made himself dangerous and he challenged the organization to assess his risk. This was achieved

and he was enlisted into the treatment group, the second stage of which involved a variant of masturbatory reconditioning. The homework included the keeping of a fantasy diary. The psychologists running the program had no idea that the diaries were written as a group exercise—with guidance from the more experienced members of the ward community in terms of what was appropriate material to offer up as disclosure.

One of the high-dependency wards Richman was researching on was commonly referred to as the pit, the sink, or the punishment block (for both the staff and patients). The daily life of those who worked or lived on it were regimented by an unvarying timetable of rules and rituals. The patients all had diagnoses of mental illness, yet the staff would speak to them without any consideration of their symptoms. But, if the special hospitals are controlling institutions, in which members of staff can feel as disempowered as the patient population, there are pockets of resistance. I remember one enterprising young charge nurse arranging a sports day for the ward, with cigarets as prizes (health promotion was not big on the agenda). As javelins or the discus were unsuitable for a secure psychiatric unit, patients took part in events such as tossing the Wellington boot. The final competition was a tug-of-war between the staff and the patients. At first, the staff took a strong lead and looked likely to win. But, this suddenly changed, and the change was symbolic. The patients stood fast, immovable, and determined. Their recognition of this seemed to promote a sense of strength and purpose; they had a sense of power, and possible victory, which was completely alien to their normal routine and highly regulated lives. As they pulled harder they began to drag the staff team forwards, and there was a sense among onlookers of an awakening. Nor was this climate change missed by the charge nurse, who immediately shouted out "Tea time now, game over, everyone's a winner!" The day concluded with the two sides hugging each other and celebrating their successes. In sharp contrast to this collective sense of coming alive is the example of a patient who, because of his assaultative behavior, had been placed in seclusion. Each time the psychiatrist visited to review the seclusion regime the patient would protest loudly that he was persecuted by voices instructing him to "Kill, kill, kill." With each of these clinical consultations the patient's antipsychotic medication was increased, but without any changes in the ideation or behavior of the individual. At one point, exceeding all pharmaceutical recommendations, the patient was receiving 360 mg of Haloperidol and 1400 mg of Chlorpromazine daily without any noticeable impact. At each visit by the psychiatrist the patient would beg for higher dosages, shouting "The voices are getting worse, if you don't help me I'll kill someone." The doctor was disarmed and helpless. His armory of medications proved worthless. He could only inform the patient that further increases

of medication could be life threatening. At an individual level the patient had enacted a resistance strategy, challenging the profession and authority of psychiatry. He had taken the humanitarian ethic of helping and turned it into the means of his own destruction.

Whether a practitioner or a researcher, one feels a sense of comfort or safety behind the walls of an institution. The dangerousness of patients is somehow diluted by the elaborate mechanisms of security and surveillance. But there is a thin divide between this world and the outside world. This fragility reveals itself in different ways, but it must be a common experience for many people. Reflective practice, critical incident analysis, and clinical or academic supervision are vaunted as safeguards. Sometimes, though, the risk or fear of harm can feel much more tangible and closer than one would want. Whatever evil is, it can reach out and touch us from a distance. I find it hard to forget the promise made to me by a very dangerous psychopathic sex killer: "I'll enjoy looking you up when I get out of here, I'll take you out and buy you a drink." Hard to construct it as an act of generosity, equally difficult to describe the menace with which the words were uttered. My son, when he was about 10 years old, did not arrive home from school at the usual time and was missing for several hours. He had stopped at a friend's house and lost track of time while playing a computer game. But, as we searched for him, with assistance from the neighbors, my mind was a frenetic explosion of images and sounds, as it replayed over and over again the words of a sadistic pedophile killer I had interviewed shortly before. This is probably the fear of most parents, where stories of child destruction surround us. At that point, I knew too much—and always will. Similarly my co-author can recount the time he was approached at a train station by a vaguely familiar man, who then revealed himself as a patient from a secure hospital. When asked what he was doing there he proclaimed, "I've escaped, I'm on the run." What happened next has an almost comic twist, but this is only knowable in retrospect. Forcing a very worried man along the platform so that the two appeared to be traveling together, the patient climbed aboard the train without paying and sat next to him for the journey. Only some time later did he laugh and cry out, "Had you fooled there, I've been released." Whatever the motive, the experience generated incredible unease and a constant sense of nervousness that persists to the present.

Reflection and Reflexivity: Some Closing Thoughts

You asshole. Why is it I get the feeling you're a fucking paedophile at heart. Have you got ideas of touching little children? Don't ever get the idea of

> *coming to Liverpool to give one of your sick speeches, as it will be your last. Assholes like you should be executed on the spot.* (Fax from a member of the public to a University Faculty of Law and Social Sciences concerning research into pedophilia *[92]*.)

This has been a difficult chapter to write. Not because of the topic—after 20 odd years of involvement in forensic mental health it is an all too familiar territory. The challenge is in looking back, and asking "why" and "what"? Why did we choose to spend so much of our lives inhabiting a world that for most people is visited only through the prurient thrill of movies or novels? And what did we achieve, what was it all for? Research data and publications have been abundant. Conference presentations and invitations to speak around the world are not without kudos. There has been professional recognition and career rewards, and for this one is appreciative. But at a deeper and more fundamental level, we have failed. The end product has to be about more than self-interest—or we are just another dimension of the problem? Very seldom do researchers and writers explain their choice of subject matter; it is taken for granted. In reminiscing about the lives of detained patients there is the realization that many were beyond our help, some may not have warranted it, but there are others who we could have spoken for in a louder voice. We have been threatened, we have been frightened, but we have also been saddened. One can feel contaminated by contact with individuals who have been the cause of great hurt and loss for others, but also corrupted by a system that promises much and delivers little.

Spending long days, over extended periods of time, as an ethnographic researcher (JR) on the wards in a special hospital is a taxing and tiring experience. After leaving the hospital at the end of the day, I would sit until three in the morning transcribing field notes and recording observations. But the strain is an emotional as well as physical one. At 68 years of age, I repeated this type of research in a prison. It was another closed off and silent world. But the things that I saw, and the stories I heard cannot be relegated to a printed page and forgotten: they are enduring images and they cut deep into the soul and the conscience. They produce sleepless nights or troubled sleep. For many years these stark and brutal institutions became my field, my area of interest, and my intellectual territory. If asked why, I could draw on a number of commonly cited reasons for undertaking any kind of academic inquiry. From a sociological perspective the special hospitals were frontier territory, it was like walking on the moon. No one had done this kind of work before and it was exciting. Other colleagues in the faculty also envied it, and I admit to holding on tightly to it as something that belonged to me. But now, at the close of a career, I find myself doubting all of this, and searching for an

answer that will make sense to me, not to others. It is easy to feel guilt for the times when an action on my part might have relieved or consoled the suffering of another human being. There is some small degree of comfort though in knowing that others—who should have done much more—did less. Consultant psychiatrists, I recall, collected patients like rare specimens on their fishing trips to the prisons. Those individuals who could be turned into a profitable case study were highly prized. They translated their legal guardianship of others into a marketable item on their curriculum vitae. My invitation to do anthropological research on the ward of a particular psychiatrist was a gift for giving him a new interpretation of the ward to present to an international audience in Canada *(93)*. One becomes the war correspondent, presenting images of the exotic or unknown, recording events for others—standing at the front lines but taking no action.

As someone (DM) who has spent many difficult hours listening to the accounts of sexual abusers and murderers, I am not immune to the sense of disgust and disbelief that comes from family, friends, and colleagues. For a number of years now I have been involved in research for a PhD, exploring the accounts of pornography given by staff and personality-disordered sexual offender-patients in a high-security psychiatric hospital. Distinct from the large amount of experimental data that seeks to demonstrate a measurable correlation between sexually explicit imagery and harm, the intention is to explore how desire is constructed, and how people's collective ways of talking—discourses—relates to their understanding of sexual violence and abuse. Although the project has been academically well received, and will make a contribution to forensic nursing knowledge/practice, I have encountered the same hostility echoed in the quote that introduces this section. Outside of work, I seldom advertise my chosen line of practice or research, it attracts either the wrong kind of interest or contemptuous comments. The question that I have been asked most often is "How could you do that for a living?" My undergraduate students on an adult nursing course at the University of Liverpool tell me, "But that's not nursing." My mother before she died telephoned me to say, "I've just found out what you do, I don't understand you." My retort has always been that you "do it for all those people out there who could become a victim." And this is an honest answer, albeit an overly optimistic one, that is little more than an insurance salesman's promise of damage limitation. Figures on recidivism are fickle, but to do nothing can only be worse. As for whether looking after serial killers, child torturers, and rapists is nursing, I remain uncertain. The reality is that in an imperfect world, within existing legal frameworks, someone will always have to undertake this task. And my respect for those who do is immense, as I know that there is a price to pay.

This has been our attempt to set the record straight. Nothing changes by the telling. There is no salve. There is no redemption.

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Chapter 11

The Vilification of Victimized Children in Historical Perspective

Victoria Van Slyke

Background

This chapter explores the vilification of psychiatric patients with childhood histories of sexual victimization or exploitation by the "medical men" and social workers who shaped the emerging specialty of psychiatric social work in the United States during the early decades of the 20th century. It examines conceptions of evil that converged in diagnostic constructions of these patients, all of whom were involuntarily hospitalized at Boston Psychopathic Hospital and who exhibited seemingly irrepressible sexual behavior, regarded as deviant by society.

Introduction

The revulsion engendered by the sexual assault of children was a potent counterpoint to the scientific objectivity espoused by psychiatric social work—an emerging specialty within an emerging profession—during the earliest decades of the 20th century. Such revulsion was consonant with the notion of evil, which comprised the central organizing framework for the formulation of psychiatric social work by its acknowledged co-founders, neuropathologist Dr. Elmer Southward and social worker Mary Jarrett. Together they co-authored *The Kingdom of Evils: Psychiatric Social Work Presented in One Hundred Case Histories Together with a Classification of Social Divi-*

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sions of Evil, which was published in 1922 *(1)*. The case histories for this book were chosen to exemplify the typology of evils with which psychiatric social workers, and society, were confronted.

The Kingdom of Evils was intended as the text for the scientific training of psychiatric social workers as well as a Progressive treatise on the etiology and eradication of social evils. The publication of *The Kingdom of Evils* commanded national attention, inspiring a full-page review in the *New York Times Book Review* that concluded, "America lost its most gifted psychiatrist and promising mental hygienist" when Southard died 3 years before the book's publication *(2)*. Following Southard's death, Mary Jarrett, assuring her influence in case presentations and interpretations, completed the remaining work on the book. Although psychiatric social worker Bertha Reynolds, among the first class of students to receive college-based training for this practice specialty, wrote of this era that, "We wanted no return to moralistic social work and wanted to keep the scientific outlook which dominated this period" *(3)*, this conviction was belied by the persisting preoccupation with the moral dimensions of psychopathology delineated in *The Kingdom of Evils*.

Because the sexualized behavior that was sometimes a sequelae of childhood sexual assault evoked moral outrage, it provided a revealing test of the new objectivity that scientism was intended to introduce into social work practice, a scientific objectivity perceived as crucial to professional credibility. Yet such moral outrage constituted an alluring inducement to vilify psychiatric patients with histories of childhood sexual victimization, and to expunge evidence associated with it *(4)*.[1] Although Mary Jarrett expressed optimism that the subjective could be readily distinguished from the objective, the acute ambivalence surrounding sexual violation of children and its conscious acknowledgment confounded this anticipated clarity: her insistence that "…social work must be free from prejudice, if it is to take its place among professional and scientific endeavors" *(5)*, was contradicted by the psychiatric case record narratives analyzed in this study.

This chapter explores the vilification of psychiatric patients with childhood histories of sexual victimization and exploitation by the medical men and social workers who shaped the emerging specialty of psychiatric social

[1] History archivist Kenneth Foote observed that nations, or whole communities, may conspire to destroy, expunge, or ignore evidence of repellent events, thereby effacing historical memory: "A society's need to remember is balanced against its desire to forget, to leave memory behind and put the event out of mind. Few events produce such strong ambivalent feelings as acts of violence" (*see* ref. *4*, p. 385).

work in the United States, and examines conceptions of evil that converged in diagnostic constructions of these patients. Based on an extensive examination of the medical records of a purposeful sample of Boston Psychopathic Hospital patients treated between 1913 and1918, which are also among those cases summarized in *The Kingdom of Evils: Psychiatric Social Work Presented in One Hundred Case Histories*, this chapter highlights selected findings from that study *(6)*.

The Boston Psychopathic Hospital records examined here have not been archived; they continue to be administered by the medical records department of what is now called Massachusetts Mental Health, formerly Boston Psychopathic Hospital, which is housed in the original facility. In the larger study the medical records of seven Boston Psychopathic patients, containing more than 1000 typewritten pages of psychiatric social work case narrative, psychiatry notes, documents authored by patients, extensive verbatim transcripts of case staffings, and interagency and collateral correspondence were systematically analyzed and compared with the same patients' case summaries published in *The Kingdom of Evils*. Some of the most compelling findings to emerge from this research involved segments of medical record narrative, which had been intentionally expunged from presumably verbatim reproductions, as well as published commentary which contradicted the primary source records.

Relevant historical documents drawn from three archival collections were also analyzed, including Dr. Elmer Southard's unpublished papers and narrative lecture outlines for psychiatry classes he taught at Harvard Medical School[2] and the Mary C. Jarrett Papers at Smith College Archives. Many faculty who taught in the first college-based training program for psychiatric social workers at Smith College in 1918 were also physicians on staff at Boston Psychopathic Hospital, participating in case staffings and treating patients whose cases were analyzed in this investigation. Unpublished student lecture notes and recollections provide a revealing window to examine their constructions

[2] These archival collections include the Mary C. Jarrett Papers at Smith College and archived documents from graduates of the first Smith College training program for psychiatric social workers in 1918; the Elmer E. Southard Papers in the Francis Countway Library of Medicine Archives at Harvard University Medical School; and the American Association of Psychiatric Social Workers Papers in the Social Welfare History Archives at the University of Minnesota were also consulted. The published professional literature of the historical period also constituted a primary data source in this study.

of culpability and morality as they pertained to sexual assault. Some of these Smith students interned at Boston Psychopathic Hospital, which was regarded as a "plum placement." Primary source documents also included professional literature of the era.

Attacking Evil Through "the Psychiatric Perspective"

The Kingdom of Evils delineated a psychiatric stance intended to expose and extinguish social evils. Neuropathologist Southard, who was a member of the Harvard Medical School faculty and a prominent leader in the new US mental hygiene movement—which advanced "the psychiatric perspective" as remedy for a profusion of alarming social problems—advanced his formula for "eradication of evil" in his address to the 1919 National Conference of Social Work: "Go to! Let us attack evil in every form, both crude and insidious, both material and spiritual, both environmental and personal," he admonished attendees *(7)*.

Southard explicitly proposed that psychiatry assume the role of moral arbiter: "We try to train for the moral life or to reform the immoral," is how he articulated psychiatry's function with regard to the vices and bad habits which might afflict patients.[3] Such powers of moral discernment were to be exponentially increased by the application of the psychiatric perspective. The new "social psychiatry" pioneered by Dr. Southard aimed to expand psychiatry's diagnostic domain to the largely unauthorized social sphere, and in *The Kingdom of Evils* he probed and interpreted the psychopathic causes of many social problems, such as labor unrest in the United States and the rise of Bolshivism in Russia. The cultural anxiety over morality in the Progressive Era—the immorality of female sex delinquents or of "poor stock" immigrants, for example—was transposed into a search for links between the psychiatric construct of personality and the formation of character, between psychiatric treatment and the exercise of moral influence. Psychopathology assumed ubiquitous proportions in the general population as the distinction between normality and mental disease became increasingly blurred, and social problems linked to individual deviance were construed as a threat to the prevailing social and economic order.

Evil provided the ethos and intellectual scaffolding for conceptualizing psychiatric social work. This 1500-bed Harvard-affiliated teaching and research hospital became the laboratory in which psychiatric social work evolved. Dr.

[3] Manuscript, "Dr. Southard's Plans," Southard Papers, GA81, Box 8, Countway Library of Medicine Archives, Harvard Medical School.

Southard was its medical director and Mary Jarrett was his chief of social services. Southard maintained that it is easier to perceive evil than it is to conceive of good, that human beings are by nature predisposed to destroy rather than to create, and that the most salient approach to the problem of evil, therefore, is to effectively harness this innate human tendency toward destruction in the service of destroying evil. He was convinced that human nature could be best understood by studying disease and maladjustment—that "evil gets more clearly into the mind than does good.…They [evils] attract our attention more readily.…We see evil all about us. We do not need to make elaborate conceptions or interpretations of the evil that is at hand," Southard asserted (*1*, p. 428). The five categories of evil delineated in *The Kingdom of Evils* were diseases and defects of body and mind; educational deficiencies and misinformation; vices and bad habits; legal entanglements; and poverty and other forms of resourcelessness.

The conviction that evil would be perceived if only one looked—that social evils were plainly fathomable rather than obscured or concealed from the psychiatric eye, and that they required no unusual measures beyond the psychiatric perspective to ascertain—reinforced the confidence that they would be recognized, if only enlightened eyes were turned on the social landscape. This presumption constituted a kind of perceptual tautology: evil could be seen if it was there, and if it wasn't seen, it wasn't there. The outlines of what was seen, however, were drawn and shaded by cultural ideology, especially the imperatives of female virtue, male privilege, and sexual normalcy. These were the prerequisites of family stability envisaged by the dominant culture of the era.

Irrepressible Sexualized Behavior As a Basis for Vilification

Seemingly irrepressible sexual behaviors in children evoked especially potent expressions of vilification by psychiatric professionals and their collaborators. Children's Aid Society founder Reverend Charles Loring Brace's conceptualization of this behavior was published in *The Dangerous Classes of New York and My Twenty Years Work Among Them* in 1872, four decades before any of the psychiatric patients discussed in this chapter were hospitalized. It is steeped in the biological determinism that formed the foundation of the eugenics movement, and the social Darwinism that supported its practice. Its emphasis on matrilineal transmission of defect complimented the gendered conceptions of psychiatric professionals:

> *I have known a child of nine or ten years, given up, apparently beyond control, to licentious habits and desires, and who in all different circum-*

stances seemed to show the same tendencies; her mother had been of similar character, and quite likely her grandmother. The "gemmules" or latent tendencies, or forces, or cells of her immediate ancestors were in her system, and working in her blood, producing irresistible effects on her brain, nerves, and mental emotions, and finally, not being met early enough by other moral, mental, and physical influences, they have modified her organization, until her will is scarcely able to control them and she gives herself up to them. (8)

There was no explicit link made between sexual victimization and such sexualized behavior in any of the cases analyzed in this research, and few such links had been made early in the 20th century. One of the most significant was the finding by social workers Sophonisba Breckinridge and Grace Abbott in 1912 that 47 out of 157 delinquent girls in the State Training School in Chicago had been sexually assaulted by a family member *(9)*. In the Progressive era, most girls were committed to such institutions for sexual delinquency *(10)*. But even though Breckinridge and Abbott's study was published several years before the admission of the patients to be discussed here, there is no evidence that their disturbing finding about the prevalence of sexual assault among delinquent girls influenced the disposition of these cases.

Although sexual acting out behavior does not necessarily demonstrate that a child has been sexually victimized, it is sometimes observed in children who have been traumatized by sexual assault *(11)*. The eminent child psychologist Dr. William Healy actively collaborated with social work leaders in the early decades of the 20th century while conducting research to identify a particular sex trauma in the histories of delinquent children that could explain the deviant sexual behavior they exhibited *(12)*. Still, like Brace, Healy perceived this deviance as ultimately intrinsic and irreversible, and continued to construct childhood sexual victimization in fundamentally moralistic terms:

When it comes to the actual immoral practices which occasionally spring up in the household the situation is desperate. Incest and other evil practices leave ineradicable stains. It may be contended that early teaching of this kind must fall on fertile ground to produce long enduring vicious results.…Very many times in our studies of the genetics of a delinquent career we have ascertained that the earliest beginnings were connected with illicit sex practices. There seems to be little reason for the individual pursuing any paths of rectitude when the most intimate relations of life are morally awry. (*see* ref. *12*, p. 410)

Similar presumptions dominated the case narratives of three Boston Psychopathic Hospital patients with histories of sexual victimization and seemingly irrepressible sexualized behaviors: Alice Nardini, Theresa Beauvais, and

Dora Hadley, whose cases are profiled in this chapter. The covert and explicit ways in which Alice and Theresa were vilified in the medical record narrative was unparalleled in its potency among cases analyzed in the larger study, from which this chapter is derived. In each case, the patient exhibited a pattern of behavior that blatantly violated the norms demarcating sexual decency.

The ambivalence about the moral stature of sexually victimized girls persisted even when their assaults involved brutal force and no possibility of escape, or the virtual captivity associated with childhood dependency. At best, these girls were not blameless; at worst, the purity and innocence reserved for their sex had been irreparably defiled. Girls determined to be "sex delinquents" were regarded as a serious threat to the institution of the family, and a scandalous inversion of women's assigned role as sexual standard-bearers. Social constructions of female sexual desire, which construed "hypersexual" behavior as inherently predatory, figured prominently as an obstacle to perceiving females as victims.

The heading on Alice Nardini's published case summary in *The Kingdom of Evils* is *Syphilitic Deliquent* in which she is described as "one of those persons who are always on the verge of association with the court":

> *When Alice was three years old she was taken by the court from her parents, both of whom were alcoholic and sexually delinquent, and placed in the care of a children's agency. She was boarded in homes of the best sort, and given up by one after another because she was troublesome. When she was about thirteen her parents kidnapped her. They became drunk and quarreled, and the father after having the mother arrested took the child to a shack in the country where he practiced incest. She was rescued by the police and committed to an industrial school as "a wayward child, growing up in circumstances exposing her to lead an immoral, vicious, and criminal life"…she would do almost anything to attract attention.*
>
> *In childhood she had fits of temper when she would scream for an hour at a time. She showed such a tendency to vulgarity that she could not be allowed to play with the neighbor's children in the respectable homes where she was boarded. If crossed she became sullen, refused to eat, threatened to kill herself, and finally got into a state of nervous excitement that alarmed her friends. A physician who saw her thought that she should be kept under restraint for the public safety.…When she was allowed to leave the industrial school to do housework in private families she used obscene language and was lewd in her manner with men upon the street.*

In this published construction it is Alice's life, rather than her environment, which is ultimately vilified as "immoral, vicious, and criminal." There was no evidence in the case summary that the objectivity attributed to the

new scientism altered this condemnatory view of victims of childhood sexual assault. There is a conspicuous absence of the psychiatric point of view and its psychopathologizing language throughout the Nardini case summary. The basis of Alice's "criminality" remains dubious, other than her having been committed to an industrial school following her rescue by police by reason of her sexual victimization. There was no evidence suggesting any specific criminal charges against her. Given that Progressive era juvenile courts tried girls almost exclusively for moral offenses *(10)*, this may well be the nature of circumstances that brought Alice "on the verge of" association with the criminal justice system.

Eroticized behavior in the child and adolescent Alice, which would now probably be regarded as traumatic re-enactment, appears to have been viewed as a genetically predisposed moral debasement with little likelihood of reversal. In this view, the culpability of the perpetrator was eclipsed: not by defining the residual effects of sexual trauma as psychopathology and attributing them to a disturbance of the psyche, or by denying altogether the reality of childhood sexual victimization and reconfiguring it as wishful fantasy. Instead, the culpability for Alice's early misfortune came to be attributed to the victim herself: in the process by which Alice's sexual victimization became a distal cause, her now-intrinsic immorality—as demonstrated by latent tendencies and irrepressible eroticized behavior in childhood and adolescence—came to be regarded as the ultimate cause of her problems. The following construction, with its telling juxtaposition of bad and unfortunate, reveals the disproportionate weight assigned to the aversive impact of heredity compared with presumably unlucky environmental factors. The vague and value-neutral language of early experiences minimized the import and veiled the nature of Alice's blatant victimization compared with her inferior lineage: "Considering her bad heredity, and unfortunate early experiences, and her unstable character, we did not expect as much stability as she has developed (*1*, p. 171).

Interpretive commentary from a psychiatric perspective was notably absent in the Alice Nardini case summary. A rationale for this exclusion may be inferred from the statement that, "…the psychopathic aspects of her quick-tempered, moody disposition were less conspicuous in her case than her unreliable conduct." Although as a child Alice was observed to have had "fits of temper when she would scream, for an hour at a time," would "do almost anything to attract attention," refused to eat, threatened to kill herself, and "got into a state of nervous excitement" of sufficient severity that "a physician who saw her thought she should be kept under restraint," nonetheless it was her "immoral, vicious, and criminal" conduct rather than "the psychopathic aspect" of this case which was most "conspicuous," that is, which domi-

nated the logic of problem attribution and intensified the vilification. Because much of Alice's troublesome behavior was conspicuously sexualized, and because she was also female, the tendency to perceive her behavior in moralistic terms appears to have been significantly increased.

During Alice's second psychiatric hospitalization she was tested for syphilis, with the conclusion that "the positive Wasserman test [was] probably due to congenital syphilis…As the mother had syphilis, the presumption was in favor of the opinion that Alice was a case of congenital syphilis" (*1*, p. 168). Once again, the pattern of attribution is matrilineal transmission of defect, even when other evidence countermands this conclusion. Despite the acknowledged sex delinquency of her father, who "took the child to a shack in the country where he practiced incest" with her, the possibility of acquired syphilis was not even entertained. This permitted psychiatric social workers and physicians to avoid the more repellent prospect that Alice had contracted the disease directly from her father's sexual victimization. Their conclusion was also consistent with Taylor's historical study, which found that acquired syphilis was rarely diagnosed in children in this era: even in the face of overwhelming evidence, extraordinarily convoluted explanations were introduced to favor congenital syphilis, or acquired syphilis transmitted in such a way that any possibility of child sexual assault was ruled out *(13)*.

The bold, denigrating heading at the top of the Theresa Beauvais case is "Child of a Thief and a Prostitute; Brought up by Charity." Psychopathia Sexualis. The published case summary states:

> *Theresa's father was a professional thief and her mother had been a prostitute. Theresa herself had already entered upon this life and was in the poor house when her townswoman found her. When Theresa at fourteen had learned the dangers of pregnancy, she had stopped promiscuous intercourse and begun masturbation. Theresa never tried to conceal her life or habits and a psychoanalyst who saw her said that as there was nothing repressed, psychoanalysis was superficial.…She said that she could not control herself with respect to sex relations. (There was a period of absolute promiscuity for a period of some three months before admission to the hospital.)*

Theresa was found to have syphilis, and the case summary also documents, "She said she had been living as a street-walker and resorting to masturbation constantly."

Although psychoanalysis was tried with Theresa—undoubtedly by the then-resident Freudian at Boston Psychopathic, Dr. Emerson, who had requested that Theresa be hospitalized for a 10-day observation—this approach was intended to uncover and relieve internal psychological conflicts, which origi-

nated in warring instincts, not in actual sexual victimization or the complex effects engendered by conscription into childhood prostitution. Because she appeared to have good recall of the sexual exploitation that had dominated her young life, a psychoanalytic approach was judged to be of no help to Theresa, because her sexual victimization was an objective fact rather than a subjective response to wishful fantasy or desire.[4]

In the early decades of the 20th century, new psychodynamic theories laid the framework for understanding nymphomania as a symptom of a disordered psyche rather than as an inheritable biological disease *(14)*. Such causal constructions did not sweep away the vilification that seeped into explanations intended to reflect progressive thinking, nor did they provide room for the possibility that one of the conceivable effects of childhood sexual victimization was an irrepressible eroticism. An appreciation that such a seemingly irrepressible eroticism might arise not from sexual desire, but rather from sexual compulsion, would have required a radical transformation of the social construction of female sexuality. The historical constructions of Theresa Beauvais's "hypersexuality" reflect the intersection of this cultural template for female sexuality with the crosscurrents shaping psychiatric social work.

The Beauvais medical record contained a lengthy and provocative verbatim transcript of a staffing of this case in which Mary Jarrett participated. Because Theresa was drawn into prostitution during her childhood, perhaps through her own mother's involvement as a prostitute, her case offers a window through which to examine perceptions of juvenile prostitution held by staff of Boston Psychopathic Hospital. She was hospitalized at least three times during 1917, and again in 1918 in a distraught condition, when she had asked police to bring her to Boston Psychopathic Hospital. Dr. Lawson G.

[4] After Freud abandoned his trauma paradigm in the 1890s, a theory based on actual childhood seduction, he developed a new theory which re-established internal causes as the epicenter of all subsequent constructions. Drive theory was intrinsically psychological, based as it was on attributed meaning and internal mental processes. Drive theory was the predominant Freudian formulation during the historical period of this investigation, and the psychoanalytic orientation at Boston Psychopathic Hospital when Therese was admitted. The previous seduction theory was never very psychological in that etiology derived from external events rather than internal operations. In this way, drive theory validated psychiatry's predisposition to minimize or ignore corroborated accounts of sexual victimization. It also had the unwitting effect of reinforcing the vilification of psychiatric patients like Alice Nardini and Therese Beauvais by the professionals in charge of their care.

Lowery, one of Boston Psychopathic Hospital's most eminent psychiatrists, conducted Theresa's mental and physical examination and documented their poignant exchange about the moral implications of her actions in his case notes, which are excerpted here:

> *Says she used to have an uncontrollable impulse for sexual relations and masturbation, but that now that has disappeared and sexual relations disgust her.…She is very dramatic in telling her story, puts her head down, sobs a great deal when pressed at all about her sexual life, but stops this very easily on command. She seems not to have a proper appreciation of the moral situation involved. Asked if she knew it was wrong to do these things, she said yes. Asked why it was wrong, said "I don't know." Asked if she personally saw anything wrong with it, said, 'no,' but she knew how people looked at it.*

The conflation of immorality with psychopathology in the constructions of Theresa's troubles permeates the case narrative, despite Southard and Jarrett's avowed commitment to view Theresa as sick instead of morally depraved. Their causal constructions in the published case summary implicated Theresa's constitutional disposition, and such constitutional explanations were often linked back to moral defect:

> *Her promiscuity is to be considered rather as a symptom of a disease than as a pure moral deflection. With a background of exceedingly poor heredity (father a professional thief, mother a prostitute) and as vicious an early environment as could be conceived, one is justified in expecting a rather poor social result.*
>
> *One cannot avoid the assumption that it would take more than the ordinary amount of will-power to overcome the sexual desires of such a hypersexual individual, and one would be expecting too much if one hoped for a great deal of steadying in such a person after adult life had been reached and many pernicious habits had been formed in youth, but one should have sympathy for this girl as a victim of disease rather than as merely vicious. One arrives at this conclusion from a psychiatric study of the whole life of the patient.* (*1*, p. 490)

In this revealing case commentary, the causes of Theresa's conduct are ultimately endogenous, blending the "mental causes of conduct" emphasized by the psychiatric point of view with constitutional defect. The independent influence of environment was not implicated in any causal construction. Southard and Jarrett were unequivocal in their conviction that it was their "psychiatric study of the whole life of the patient" that allowed them to perceive Theresa as a "victim of disease," a construction that should engender sympathy instead of moral condemnation, they argued.

But contrary to their assertion, there was no actual study of Theresa's "whole life." Instead, a plethora of facts were collected that were ultimately bent to accommodate preconceived endogenous causes and diagnostic biases, or were disregarded as irrelevant. The application of the psychiatric perspective in Theresa Beauvais's case not only emphasized "mental causes of conduct" and constitutional factors such as heredity; it virtually eclipsed the causal potency of any external influence. It is not surprising that Dr. Lawson Lowrey, who led the Beauvais staffing and posited a series of alternative explanations for her disturbing behavior, did not include Theresa's sexual victimization among them. In the following year, it was Dr. Lawson Lowrey who instructed Smith College psychiatric social work students on gathering information related to sexual experience when taking a patient's personal history. Student Rose Hahn's precisely scribed class notes of Dr. Lowrey's lecture specified the following subjects of inquiry: "sexual relations—free and promiscuous, or confined to one person? Excessive or normal? Homosexuality? Masturbation?"[5]

The exclusion of sexual assault or other forms of victimization from this enumeration can hardly be attributed to sexual reticence, as deeply sensitive subjects of a sexual nature were legitimized by Dr. Lowery for professional probing by the typically genteel young women in training. Sexual victimization, or any language that might intimate it, did not appear elsewhere in the expansive range of subjects to be covered in such history taking. Such a stance was consistent with its exclusion from the possible explanations Lowery proposed during the Beauvais case psychiatric staffing, during which he stated:

> *This is another of those complicated cases of sex delinquency with an emotional condition which some might term hysteria. She can't be regarded as a normal person; she has enough intellect but has a decided defect in emotions and will; I think she belongs to the group of psychopathic personalities. We have to determine whether her conduct is the expression of underlying feeble-mindedness or underlying psychosis, or whether she represents a case of character anomaly; or whether we are dealing with a normal person in a vicious environment or a normal person without any particular excuse. The indications are in this case for character anomaly with emotional and volitional defect of the type we call psychopathic personality.*

Lowery did posit one possibility, however, that was an extraordinary rarity in the pathology-focused milieu of psychiatric practice documented in

[5] Manuscript, Rose Hahn-Dawson, Individuals A-D, 1918-1919, 60.GW, Box 1283, Folder 92A-13, Smith College Archives.

the larger study: that Theresa was a "normal person in a vicious environment." Ultimately that explanation appears to have been posed as a rhetorical one, as Theresa's case was portrayed as sexual delinquency, not sexual victimization, despite what was known about her induction into child prostitution. There is no evidence to suggest that any of the professional staff involved viewed juvenile prostitution as a form of sexual exploitation or victimization. By vilifying Theresa as a sex delinquent it was society that was victimized by Theresa, a conviction obviously shared by Dr. Hudson when he declared in the staffing, "I think she should go to some institution as a protection to society." Dr. Lowery agreed with his peers that "the problem of training them for an unsupervised life is almost hopeless."

Theresa's sexual victimization as a child prostitute was not entertained as even a distal cause of her "hypersexuality," nor was her childhood induction into prostitution ever construed as victimization. Exposure to such a vicious environment was not explicitly proposed as an explanation for Theresa's deficient moral training even though it was clear from the psychiatric examination that Theresa did not know why her sexual behavior was deemed offensive to others. A social learning interpretation of Theresa's sexual behavior was never posed by any member of the staff, even though important deficits in her knowledge and understanding had already been identified that would invite such an explanation. Given her mother's involvement in prostitution, and Theresa's own early induction into this life, it might have been reasoned that she had not ever been taught why such behavior was wrong.

That Theresa's "living as a streetwalker and resorting to masturbation constantly" is construed as sexual desire rather than sexual compulsion is consistent with the presumption that voracious sexual appetite was thought to drive such oversexed women *(14)*. Beneath the presumption of Theresa's insatiable sexual desire was the conviction that she was somehow feeding her voracious sexual appetite by such behavior, rather than being compelled to perform often irrational and ultimately unsatisfying sexual acts by relentless impulses she could not fathom.

Significantly, there was only one case in the larger study sample in which the concept of compulsion is explicitly linked with sexually deviant behavior, and in which a patient's perceived moral deviance is reframed as a pseudo issue: that case involved the only male patient in the study sample. Similar sexual behavior by Alice Nardini, Theresa Beauvais, and Dora Hadley was vilified as morally debased, and was not diagnosed as compulsive. Compulsion placed the behavior beyond the volition of the individual to control it, thereby neutralizing culpability. Students in the Smith College program for psychiatric social workers were presented with a psychoanalytic interpreta-

tion of compulsion, which presumably emanated from instinctual drives, the "expression of unexpressed tendencies or desire breaking through cultural structures (*see* footnote 5, p. 242).

The acrimony that characterized psychiatry's stance toward Theresa during the patient interrogation—a customary element of psychiatric case staffings—may have been evoked by her open admission that she masturbated constantly and was at a loss to control her sexual impulses or behavior, and her history as a child prostitute. The gendered underside of that acrimony was recorded in the following exchange:

Question: What did you want your aunt for?
Answer: I wanted to see some one that cared enough about me to be interested; Miss Hanson didn't care where I went.

Question: Why do you weep now?
Answer: It makes my head feel better.

Question: Is that why women weep?
Answer: They weep for the same reason men swear, to relieve their feelings.

Question: What makes you feel badly?
Answer: That you don't any of you understand me.

Many of the questions Theresa faced in this rather public inquisition were leading, hostile, or even threatening, including being asked if she wanted to be sent to a work colony for mental patients for 10 years.

Protective Effects of Social Class in Psychiatric Vilification

Case record documents indicate that Dora Hadley was hospitalized twice at Boston Psychopathic Hospital during 1915, when she was 19 years of age. The first admission was involuntary, following a suicide threat and attempt; she was persuaded by her social worker to accept voluntarily rehospitalization 7 months later when she experienced severe pelvic pain, suicidal depression, and general physical debilitation following weeks of increasingly frequent sexual activity with a succession of different men.

Dora's case stands apart from the others discussed here in that she was characterized as being of respectable family of fairly good New England stock, and the fact that case record documents revealed no explicit history of early childhood sexual exposure. The extent to which Dora's sexually delinquent behavior violated the feminine virtues of chastity and purity extolled by traditional culture was an overriding professional concern of her exclusively female psychiatric social workers. These professional women had been socialized into the Victorian cult of domesticity of the late 19th century, which was predicated on the moral superiority of women. Their ambivalence toward Dora, with her

vehement declarations of independence and her disdain for the sexual double standard, surfaced throughout the social service case narrative.

The systematic and deliberate exclusion of significant medical record data from the lengthy published summary of the Dora Hadley case is revealing. The expunged narrative would have allowed the reader to apprehend the compulsive nature of Dora's sexual behavior, and the despair and desperation she experienced over her repeatedly failed attempts to stop it. Neither was there any mention that Dora broke off her engagement with the kind, affectionate, Harvard-educated man she loved because her promiscuous sexual behavior was so hopelessly out of control.

There were several factors in Dora's case that, taken together, would suggest the possibility of sexual abuse to the contemporary clinician, including her involvement in prostitution during adolescence and the compulsive quality of her sexual behavior around the time of her hospitalizations. Psychiatric social worker Helen Anderson documented Dora's pattern of sexual promiscuity in the case record, noting her unsuccessful attempts to "swear off" future sexual forays:

> *She has had intercourse with four different men and admits as often as three or four times a week and does not deny more than once an evening. They take rooms at the beach places mostly. Patient has not taken money or clothes and has been out little to dinners with these men. She is fond of them and likes to have them make love to her. She does not, however, love them and still is most interested in her fiancé who is different from any of these. One of these made her promise she would not do this any more with him or others, but she went out the next night with another man and forgot all about her promise. After she comes home she cries a great deal to think she has acted so, but continues the next night. She cannot give any reason for her conduct. She is out every night.*

Shortly before her second hospitalization at Boston Psychopathic Hospital Dora expressed her desperation and disgust with herself over her sexual "acting up," and her inability to control it, in one of her letters to Miss Anderson:

> *I don't get any sleep. I'm a sight. My face has grown very thin. I have lost eighteen pounds. It hurts to breathe and my chest hurts most times.... I'm so miserable I'd just as soon die, and my conscience bothers me. I have been acting up considerable since I left the hospital, and when I think of J. [her fiancé] grow sick at heart, and try to get up courage enuff to get rid of myself. I go out all the time and try to forget everything, but when I come back, I've done something I wouldn't want friends to know and then I'm miserable. I hope you understand. I don't know who to go to. I feel as though*

I should see a doctor, and see what he can do for me, but what I need most is talk.…I wish you would tell me what to do.

With severe abdominal pain and expressing the wish she were dead, Dora was persuaded by Helen Anderson to be rehospitalized. During her second hospital stay, Mary Jarrett and Helen Anderson warned Dora she was "on the way to prostitution."

Ultimately Dora became so discouraged with herself and her inability to control her sexual behavior that she broke off her engagement to her fiancé, a Harvard student of Norwegian descent who had always treated her with kindness and affection. She again confided in Miss Anderson via letter:

Dear Miss Anderson,

I am writing what I can't say to you…I haven't thought much of the things I have done in the last two weeks, because the thoughts drive me nearly insane. No one knows how awful I feel, how sorry I am. There's no excuse of course, except the old one, that we don't know what we do, in that condition. I have to have someone all the time to know me, and sometimes I get so excited, that I don't know what I do, and its then that I do the things I do and have done. You may think that I don't care, but Miss Anderson, my heart is broken. I don't want J. [her fiancé] now. I love him, but I don't want him or anyone else. Dora

This was not the voice of a young woman relishing the sexual liberties increasingly claimed by working-class girls in the early 20th century. Instead, it expressed the guilt, shame, and despair Dora internalized over what would now be recognized as sexually compulsive behavior.

Dora's letter to Miss Anderson persuasively contradicted Dr. Schorer's evaluation that she "has no real regret for what she has done," and might have led the professionals in charge of her care to ponder why she would be so driven to do things that caused her such demoralizing shame and guilt. Despite Dr. Schoer's earlier acknowledgment that Dora was unable to "resist temptation," she did not diagnose her sexual behavior as compulsive. Like Theresa Beauvais, Dora Hadley's sexual behavior was construed in moral terms.

Although it was known that Dora experienced the exploitation intrinsic to adolescent prostitution, there was no evidence that members of the psychiatric staff considered the possibility that Dora's irrepressible sexual promiscuity might be linked with a history of sexual victimization. Although psychiatric social workers at Boston Psychopathic Hospital went to extraordinary lengths to vigorously investigate and document suspected breeches of sexual morality by young female patients who had been labeled sex delinquents, there is no evidence that Dora's possible sexual victimization was

investigated at all, despite the fact that Dora's parents were "known to" the Northhampton Branch of the Society for the Prevention of Cruelty to Children (SPCC) for 5 years, when Dora was between the ages of 13 and 18. The reply Miss Anderson received from Miss Carrie Gauthier, special agent for the society, clearly stated, "I do not consider my work with Dora a thorough trial, nor have I made a thorough investigation of her case or attempted to verify any of her stories." The nature of Dora's "stories" to her worker at the SPCC were never investigated or "verified," and there was no reference to them in the social service notes.[6] Dora became "hysterical" at the psychiatric social worker's insistence that her father be informed of her whereabouts or that she have any direct contact with him.

Dora's case was ultimately construed as "predominantly a moral problem with a train of legal entanglements" (*1*, p. 122). but without the stigma of a constitutional origin. Her social class appeared to insulate her from the more blatant vilification that psychiatric labeling accrued to Alice and Therese. Dora's brief involvement in prostitution at age 16 never earned her the label of "degenerate" by the staff of Boston Psychopathic Hospital.

Conclusion

This analysis has explored the tenacious persistence of a moralistic perspective in cases of childhood sexual victimization by the emerging specialty of psychiatric social work—especially when patients exhibited behavior perceived as sexually deviant—despite its declared allegiance to "the scientific perspective," with its purported objectivity and freedom from moral bias. The tendency of psychiatric professionals to vilify victims appeared to be as irrepressible as the sexual behaviors they found most disturbing in patients with histories of childhood victimization.

Although Smith College psychiatric social work students received significantly more exposure to psychiatric theory than did Harvard medical students,[7] it did not equip them to navigate the highly gendered and volatile terrain of diagnostic labeling, a terrain from which they were officially barred.

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[6] Efforts by this investigator to obtain Dora's SPCC case record to ascertain what "stories" Dora had told to Miss Gauthier were unsuccessful, as the archivist at the Massachusetts Mental Health Institute in Cambridge, the agency that had received and archived extant SPCC case records, verified this particular record had been destroyed.

[7] Manuscript, Southard Papers, Countway Library of Medicine Archives, Harvard University, Cambridge.

The language of psychopathology, when it was used at all, was amenable to conveying covert expressions of vilification. Although "the psychiatric perspective" was extolled as the lens through which seemingly inscrutable human motives and actions could be detected and laid bare by experts, its actual application was riddled with ideological exigency.

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Chapter 12

Evil

A Clinical Perspective

J. David Kinzie

Background

This chapter describes several historic, illustrative cases of refugees who have survived torture and severe trauma. From a clinical perspective, these patients represent severe cruelty and evil inflicted on them. In addition to their clinical symptoms of prolonged posttraumatic stress disorder (PTSD) and depression, they raise the disturbing question regarding why evilness occurs. For most therapists, there was nothing in their education to prepare them for such disturbing human tragedy. At a philosophical or religious level, there is no adequate explanation or understanding for this personalized evil. As the events in Iraq demonstrate, no country, and perhaps no individual, is totally immune from committing atrocities. The author suggests honesty as well as empathy and professional commitment in caring for traumatized patients and offers suggestions for therapists to keep their sense of balance while performing their professional responsibilities.

Introduction

For more than 25 years, I have been evaluating and treating refugees from conflicts, wars, and ethnic cleansing throughout the world. The stories these refugees tell are of unspeakable brutality and torture, as well as their own severe human suffering. These stories tell of man's inhumanity to man, as well

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as raising the problems of evil in human life. Following are three representative cases, certainly not the worst of those from three different areas of the world.

Cambodia

When first seen, the patient was a middle-aged, married Cambodian man who had previously suffered a brutal head beating that resulted in a personality and intellectual change. More recently, he had undergone a craniotomy for hematoma at a local hospital; however, there was no change in his functioning. He presented as sad and hopeless, with complaints of headaches, frequent nightmares, and intrusive thoughts. He was described as being slow, withdrawn, speaking very little, and unable to do even minimal tasks in his house. He was born in a rural area of Cambodia and his parents died of old age before the Pol Pot regime took power in 1976. He had no education. At the time Pol Pot took over, he was married and had an 8-month-old daughter. During the Pol Pot regime, he lived in a concentration camp with stark conditions in which starvation was rampant. Forced labor was considerable, often 15 hours a day, 7 days a week. Both of his brothers and his sister died of starvation. His wife apparently died alone and their baby starved to death soon after. Many times, he was starving and unable to work. At one time when he was unable to work, the cadres beat him severely about the skull. He thought he was going to die several times and even wished that they had continued with a few more blows. After one beating, he was left unconscious, after which he experienced a change in his personality. The Vietnamese invaded Cambodia in 1979 and he escaped to Thailand and later to the United States. He appeared to be psychomotor retarded, hard of hearing, and had difficulty cooperating in the interview. He spoke only when spoken to and usually questions had to be repeated several times. He seemed to lose his concentration during long questions; he did not know the date or the country in which he currently lived. Throughout the following 20 years in treatment, he has remained intellectually impaired but his depression has improved somewhat.

Guatemala

The patient is a 29-year-old male of Native American ancestry from Guatemala. He has multiple symptoms, but most of his concerns are worries about his family in Guatemala. He wakes up with nightmares and startles easily. He finds himself preoccupied with events in Guatemala and his own concentration is quite poor. At times, his thoughts are flooded with atrocities he has witnessed and finds himself crying unpredictably. He is sad much of the time and has very little enjoyment.

The patient is the youngest of six children. His father left the family when the patient was 6 years old. He had a stepfather for a period of time, who also left after being in the army. Another man who was described as angry and mean and actually threatened the patient's life when he was trying to protect his mother, fathered the final half-sibling. They lived in a rural area in Guatemala, which was contested by guerrilla and government military. The family saw much fighting and fear, which occurred when the patient was between the ages of 12 to16 years. These incidents included a bomb blast that killed his best friend's mother. During this particular incident, bullets were fired for 2.5 hours and, unable to get help, his friend's mother died. The patient also saw the military bring in captured guerrillas who were tortured and killed as an example in front of the village. He was taken by both sides at different times and beaten. He was once kidnapped for 7 hours by government forces. He felt his life was in constant danger. At age 16, he was going to be recruited in the military by both guerrillas and the government forces. He left home at age 16, working at various places in Mexico, and then came to the United States. His mother, for whom he still grieves, died of cancer 5 years ago. He appeared sad, thoughtful, and struggling for words as he described the atrocities in Guatemala. He also cried as he described his mother's death. There was some improvement in his effect over 3 years follow-up with active treatment. Many of his symptoms, however, remained persistent.

Somalia

This example is of a 37-year-old Somali male who had multiple symptoms of headaches, confusion, and anger outbursts, which have existed for about 12 years. These anger attacks occur primarily when his family calls him from Kenya and he recognizes that he is unable to help them. He feels like striking out but in fact, he has not done this. He has periods of confusion; headache and back pain have existed for 12 years since the episodes of the beatings in Somalia. He has felt weakness in the legs and burning in his hands. He claims he has no energy and feels depressed that life is not worth living. He has many intrusive thoughts about the events in Somalia that he is unable to stop. He is startled by sudden sounds. He has lost 20 lb in the last year because of a very poor appetite.

The patient had a very complicated history. His father was a farmer and businessman. At age 10, the patient went to live in an orphanage but had ongoing contact with his family. He attended 8 years of school and learned how to read and write. At age 23, he married; the marriage had been going well until recently when it came under much stress. In 1991, the war hit his area. He seemed very reluctant to talk about it and gave few details. He was separated

from the rest of the family working in a farm area surrounded by rebel militia. His father went out to meet them and was killed. The patient remained inside, but was continually shot at and, although he was not hit directly, has wounds all over his body from explosive particles. When the rebels came into the house, he and a friend were beaten, particularly severely on his back. When the rebels left, he received some help and minor medical treatment from villagers. He walked for 28 hours back to his town but could not find any family. He described seeing a 100 dead bodies and going without food for a long time. He finally arrived in Kenya and was reunited with members of his family. They were not safe in the refugee camp, as they were often beaten and robbed and had little food or water. His wife was robbed when she was by herself. The patient is a very thin-looking Somali man who appeared intense, pressured, and agitated: he was ill at ease most of the time as he described his experiences in a vivid way. There was some improvement in his agitation and PTSD symptoms over the next 4 years of treatment.

Therapist Reflections

How are we to think and feel about survivors of such atrocities? How are the psychiatrists and therapists who treat people to think about their work and the complicated feelings that are brought forward? How is one to understand those who commit such acts? What is one to understand about the inhumanity to humans, the evil one does to another? More directly, is it within all of us to do unspeakable atrocities under certain conditions?

The Patient Survivors

I have been a psychiatrist for survivors of several conflicts: Indochina, Bosnian wars, Somalia, and the various guerrilla activities in Central America. The reactions from these desperate regions and religions seem quite similar. The refugees who suffer from losses of homes, family, country, and livelihood are now living as refugees in a foreign Western society. Not only losses, but also severe trauma and torture characterize these people. Cambodians under Pol Pot who experienced the "killing fields" of the concentration camps, ethnic cleansing in Bosnia, tribal clan warfare in Somalia, and the civil wars of Central America demonstrate violence, brutality, and murder that is often indiscriminate and random. The clinical effects are quite similar. Seventy to 90% will often present with PTSD and depression. Some are diagnosed with psychosis and others have brain damage from beatings. Most have a sense of hopelessness, poor sleep, nightmares, intrusive thoughts, startle reactions, irritability, and anger outbursts that lead to a sense of going "crazy." The clinical course is long and often chronic, made worse by the loss of social support in their

cultures. Furthermore, many of the traumas are culturally shamed, such as rape and sexual torture, and cannot be admitted to, perhaps to even to oneself. With treatment, there is often some relief of symptoms, but they are subject to return under remembered traumatic stress, such as the bombing of the World Trade Center on September 11, 2001. A unique aspect is very little drug or alcohol abuse especially in the Muslims and Buddhist cultures. There is also very little Axis II to pathology, such as manipulation or unstable personality traits. There is surprisingly little rage against the perpetrators of these crimes. The patients seem too self-absorbed, preoccupied with current stresses and trying to survive in this new environment, to display anger. There is little questioning of their religious beliefs. A few Cambodians have asked if Karma is correct, if the bad seem to survive and the good die. Muslims and Christians will sometimes mention that if God is merciful or good, how could this have happened? Most do not question their belief and many find new solace and companionship in their religious communities.

The Psychiatrist and Therapist Reactions

These are difficult stories to hear. Experience is required for the right combination of empathy, quiet listening, gentle probing, and direct questioning. The patients subtly test if the therapist can handle the reports of brutality. Indeed, there is a sense of wanting to run away, by avoiding the difficult stories or belittle the experience with trite psychological platitudes. The therapist is not a passive spectator as in Susan Sontag's *(1)* description in viewing pictures of cruelty because the therapist's duty is to help and relieve suffering. Here one can reduce symptoms with medication, provide psychological support, and help plan for social services. Doing something relieves the ongoing vicarious stress of the therapist, but it does not take it away.

There is a burden on the therapist who, over time, burns out or suffers "empathetic strain"—a term introduced by Wilson and Lindy *(2)*. In a survey of four psychiatrists working in our clinic in 1993 found there were some common reactions *(3)*. We all at one time experienced sadness and depression, irritability, hyperarousal, and excessive identification with the patients. It also spilled over in our other clinical work where we felt less tolerance for the "minor" suffering and stress of other "ordinary patients."

There is also something more profoundly disturbing at these encounters. Medically trained therapists have a sincere belief in the scientific approach starting with the Age of Enlightenment. We trust the human mind to make sense of the world, accept the evolving nature of truth, and are socially optimistic and confident of progress *(4)*. Nothing in my (and probably most psychiatrists') undergraduate or medical school of psychiatric training suggested that

such evil events existed or prepared me to make sense of them. It is as though the educational system overlooked, or was blind to, the atrocities of the world. It wasn't that we didn't know—after all, the Holocaust and dropping of the atomic bomb on two Japanese cities were well known. One seemed like the unique aberration of the power madman and the other justified as a way to end the war quickly and save more lives. In the *Diagnostic and Statistical Manual of Medical Disorders* (DSM-1) there was a psychiatric diagnosis of gross stress reaction to describe such conditions that the Holocaust victims suffered, however, it was removed in DSM-II. It has been suggested that the Holocaust was an aberration of human history and would not be repeated. Now we see (primarily through television) the effects of wars and torture worldwide with terrorism and counterterrorism techniques used for political advantage and revenge, while the number of victims and survivors increase.

It is as if we as a culture, and as an educational system, forget—or have repressed—the prodigious amount of human suffering that humans are capable of inflicting. In a vague and perhaps irrational way, I felt deceived by the belief in progress, which ignored the very believable evil that we can cause. My patient's stories surprised and dismayed me. To be fair, although my medical training did not prepare me for such victims, however, it did develop in me a continued commitment to my patients. Thus I (and my colleagues) have persisted.

A Philosophical Reflection on Evil

For Christians, the problem is a difficult one: "How could an all-powerful yet benevolent God let such evil happen?" Either God is not all-powerful or all good. The typical answer "God's will but not ours will be done" and "God works in mysterious ways" seems too slick and facile and even suggests that we cannot attempt to understand God. It is off limits. For Christians, a related question is put forth by Nozick *(5)*, when Christ died for our sins did he really have the Holocaust, or for that matter Pol Pot camps, Rwanda massacre, or Bosnia ethnic cleansing (and the list goes on) in His mind? It does not seem to match up. Forgiveness is not the right action, but it is unclear what is.

A persistent assumption from Augustine to the enlightenment was that evil was God's punishment for sin. Rousseau (1712–1778) changed the connection between sin and suffering.[1] Our misery requires no intervention from God. Our misery results from our sins. Every sin contains its own penalty as a natural consequence. Kant (1724–1804) broke up this connection even more.

[1] Much of the historical aspects of evil is drawn from S. Neiman *(6)*, to whom I am indebted.

For example, the statement that an injury (sickness or death) should not happen to a nice (beautiful, young) person relates happiness and virtue. The righteous deserve good and the wicked deserve to suffer. To Kant (and modern observers) this is clearly false: happiness and virtue are not systematically connected.

Voltaire (1694–1778) went even further: "there is evil as well as good on the earth and no philosopher has ever been able to explain the nature of physical evil." Reason is unable to explain the world and its evils. Nietzsche (1844–1900) felt evil is a problem that humankind brought on itself by creating ideals that put life in the wrong. The problem of evil is meaningless suffering. We took the blame for suffering on ourselves to give life meaning. We invented sin and redemption. Even martyrdom could be a search for meaning (to use a contemporary example). It is difficult to find meaning under conditions of torture and death camps, although Viktor E. Frankl tried in his book *Man's Search for Meaning (7)*. A view from an Auschwitz survivor resonates more with my experience with patients. "We did not become wiser in Auschwitz—nor did we become 'deeper' in the camps, insofar as that fatal death is a definable spiritual dimension at all. That we did not become better, more human, and morally mature need not, I believe in argued in" (7, p. 266).

The paradigm for modern evil has been Auschwitz during the Holocaust. It was destabilizing because it showed a possibility of human nature that we tried not to see. Technology created the ability for human's burden to be greater than ever imagined before. Auschwitz threatened the course of secular faith, enlightenment, and the advances of freedom and knowledge. Death camps revealed the nightmare of contingency (rationality to survival) in ordinary life. People could be shot for either doing their work or not.

The face of Auschwitz is often described as quite banal—faceless bureaucrats merely mechanically doing a job of destruction. We seem to forget that this facelessness only too readily resurfaced during the slaughter in Vietnam, on all sides. Perhaps the face of evil took on a more personal note with the bombing of the Twin Towers of 9/11—well planned and well coordinated to kill and strike terror in the Western world. It seemed purely demonic and was described as such by politicians. There can be no justification or rationalization for the blunt slaughter of nearly 3000 people.

As I think of these events, there seems to be no answer that religion, psychology, or similar philosophical concepts can provide. We see no relationship between virtue and happiness. We no longer see that reason and rationality leads to progress. Social democracies and awareness of human rights do not equate to a world without violence. Evil, random and arbitrary, on the just and unjust is an unpleasant fact. It is a fact for my refugee patients here

and those in many parts of the world and even in Western countries. Our own assumptions of a safe predictable world have been shaken—both for the patients and for those treating them. As our therapy reconstructs broken lives and spirits, we at least can take comfort in relieving the suffering of some even if we cannot answer their unspoken questions of why?

Thoughts on Abu Ghraib

As I write this, the abuses and torture of the American imprisonment in Iraq have become public knowledge. These abuses and even murders have apparently occurred in other prisons in Iraq and Afghanistan and probably other unknown places. Government documents, thus far revealed, indicate legal opinions on why such behaviors may not violate International treaties or even why there may be a legal basis for such type of detainees. Nothing can hide the fact that Americans have been involved in torture. There has always been a certain self-righteousness in America—we are morally superior, we play fair and by the rules. We seem to have forgotten Vietnam. I was a civilian doctor there in the 1960s and saw first hand what atrocities we were capable of. We seem to learn this every generation. It is not that evil is out there (i.e., in other people). It is here within our own culture and us—probably even in most of us. The demons are close to home.

The doctor in me cries out, "Don't you know what you are doing to the Iraqi prisoners—abuse, humiliation, and torture? That the emotional and psychiatric scars will last a lifetime?" Aside from murder, what else can you do to derogate and humiliate Muslim men? I remember the words of Nietzsche *(8)*, "Whoever fights a monster should see to it that in the process he does not become a monster."

Thoughts for Professionals to Live Responsibly in a World of Evil

It is difficult to keep one's perspective and sense of balance in a world in which our patients describe (and we see first hand) acts of cruelty and brutality. Nevertheless, it is important not to be overwhelmed or appalled so one cannot perform his or her professional responsibilities to patients, and to others, who rely on psychiatrists for help and treatment.

Below are some of my suggestions to help keep a sense of balance and yet perform our responsibilities.

1. Recognize realities of evil and inhumanity in our world. There is enough information available both from our patients and from the news media to overcome any moral naïveté that we may have. We now know that good intentions and good people cannot always prevent these acts from occurring. In addition, we know that unintended consequences, such as "collateral damage" from war, can have devastating effects.

2. Recognize that the effects of these brutalities can be prolonged, intense, and extensive for individuals, family, societies, and even whole countries. This can include despair and hopelessness as well as the destructive thoughts with plans of revenge.
3. Keep focused on helping patients. Provide competent compassionate care as our first responsibility.
4. Be aware of countertransference or "burnout," for these feelings, particularly those of anger and irritability, may compromise our ability to care.
5. Lead a balanced life with time off, satisfying leisure, and recreational activities and most importantly, good friends, family, and colleagues who provide healthy relationships.
6. Feel free to engage or not to engage in social activism. Many find activism helpful and provide a voice for the inhumanity that is observed. Others find activism can develop a life of its own and distracts from professionalism. Many of us, myself included, feel that we cannot do both. It just takes too much energy to be a full-time citizen promoting a belief in social justice and democratic values and at the same time do the intense therapy that is required of us to work with traumatized patients. I feel that time away from this intense activity is needed and I would not encourage people to engage if they already feel overwhelmed by their professional work.

With my reflections on evil, I have to admit I do not understand it. None of the answers: religious, psychological, social, or philosophical seem satisfactory. With my patients, I find no words except to say, "What happened to you is very bad. It should not have happened to anyone. I will be with you together as we help you live your life with all the pain and sorrow." It is not particularly insightful but it is honest and that is a good place to start.

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Chapter 13

Capacities and Dispositions

What Psychiatry and Psychology Have to Say About Evil

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Introduction

Psychology and psychiatry have an important social role in naming and describing deviance from group and individual norms. Traditionally, the mental health sciences have taken the lead in taking potentially harmful or unusual mental states and behaviors out of a moral discourse of "good" and "bad," and into a health discourse of "ill" and "well." In this chapter, I argue that there are valuable insights from psychology and psychiatry that can help us in understanding how people come to do that which is morally repugnant, or "evil." I conclude, however, that the concept of evil has a moral and cultural significance that is distinct from health and disease; and as such, the role of mental health is limited.

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A capacity for good and a capacity for evil are one and the same capacity. To realise the good, dispositions are necessary.[1] (1)

Background

This chapter examines what psychology and psychiatry tell us about the problem of evil. We need not expect psychology and psychiatry to reveal much about the classic problems of evil: how God allows evil to exist in a loving, good, and godly world; nor about the distinction between human and natural evils or the problem of free will. However, there is an expectation that the mental health sciences will be able to explain extremes of behavior, especially evil behaviors that scare people. A relative of one of Dr. Shipman's victims was quoted thus after Dr. Shipman committed suicide: "I thought that once he was in prison that the psychiatrists would have a good go at him, and then we would understand.…Now we will never know" *(2)*.

I chose the quote from Aquinas to begin because it is extraordinarily psychologically astute. Normal mental functioning is best understood as a series of capacities and potentialities. The mind does not function as a series of brain events, like light switches that turn on and off; rather, it seems to function more as a constant process, of waxing and waning complexity *(3)*. For example, we do not love as an event; we have a capacity for loving that may be activated or deactivated, depressed or heightened, regulated or unregulated, partially or fully expressed. *Dispositions* might be understood as personality traits and dimensions that interact with psychological capacities to bring about thinking, feeling, believing, and acting.

Psychiatry and psychology clarify personality functioning and capacities to carry out certain psychological tasks. Psychology is the study of normal states of mental functioning and the measurement of mental function. Psychiatry is the study of abnormal mental functioning: the consequences of disease processes on normal function and the treatment of those consequences. This chapter shows how and what these approaches say about evil.

The Medicalization of Evil

Nieman *(4)* suggested that a turning point in the philosophical study of evil was the distinction between natural evils, for which no one was respon-

[1] It is surely of human interest that I first obtained a copy of Aquinas Volume 22 when I found it in the patients' library on a ward in Broadmoor, during a ward round.

sible, and human evils, which arose out of human agency. The point was that evil was something chosen by the actor; it was not caused by natural events. At the heart of evil is the notion of free will, because it is essential for the concept of evil that a choice is made by an actor free to choose. There is almost a sense that people who choose to do evil things allow us to identify the virtuous who choose to do good.

Any deterministic account of human action undermines the concept of evil, because it undermines accounts of humans making free choices. Many psychological theories of mind did just this by suggesting that human intentions and actions were caused, for example, by unconscious drives or conditioned behavioral responses. In response to criticisms that such theories undermined accounts of free will and responsibility, psychologists could argue that they were able to show that a pathological process caused many abnormalities of mental functioning. The subject, who did not choose to have these problems, could not then be characterized as evil.

In fact, both psychiatry and psychology has prided itself on its nonjudgmental approach to abnormal behaviors; an approach that is also considered to be nonjudgmental insofar as it is scientific, and therefore value-free. Although most philosophers (and practitioners) would acknowledge that the practice of science is not remotely value-free, it is still a cherished belief in medicine that diagnosis and clinical decisions are made descriptively, not prescriptively *(5)*. Those who define themselves as mental health scientists have therefore had important social roles, not only as confessors, but also as those who exculpate and ameliorate those who act in way that might otherwise be judged as morally repugnant. It is not that behaviors or mental states are no longer evaluated negatively, they are still seen as bad and undesirable. However, they are taken out of the moral realm of moral judgment and into the scientific realm of pathology.

Obvious examples of this process can be seen first in relation to addiction, second in relation to erotic object choice. To be addicted to alcohol or drugs used to be evidence of a vicious nature, and of moral failure to make a choice of abstinence. Psychiatry and psychology provided an account of addiction as a disease, over which the addict has no control, and which cannot be said to be a function of choice. The addict is first excused from moral judgment by mental health scientists and then offered therapy. Similarly, with homosexuality, which was deemed to be evil insofar as it was a deviance from the moral norm that was chosen by the individual. Mental health science then judged it not to be evil (chosen) but a disease that needed treatment. Gay men and women were not judged as evil, but they were judged as sick and in need of treatment *(6)*.

The issue here is how differences between persons is explained and understood. The biological sciences have tended to make use of group norms

to establish the status quo from which an individual differs, so that in medicine, disease is that which differs from the group norm, and causes damage. Illness, on the other hand, involves the subjective experience of the individual, and refers back to that individual's own personal norm. Medical science (including psychiatry and psychology) involves the study of disease, which requires knowledge of group norms, and this knowledge is presumed to be available to be known and measured objectively. Furthermore, there are no social consequences of differing from the group norm for most diseased people; for example, social groups will not exclude those with very high or very low blood sugars. Finally, it is assumed that persons do not choose their diseases, and have no control over them.

However, as Szasz and other critics of psychiatry have pointed out, social groups may experience individual difference from any group psychological norm as a threat, and react accordingly to exclude the individual. The "normal" mental state and behaviors of any social group changes over time, and is as much political as it is psychological. Those who choose to dissent from the group are likely to be punished, especially if their choice of action appears to cause harm to others; arguably, one of morality's functions is to protect group cohesion as well as individual conduct *(7)*. Groups may prefer to see someone who is different from the group norm as ill rather than dissident, as a way of avoiding political challenge.

When psychiatry and psychology claim to be scientific endeavors, which are objective in their assessment of human behavior and mental function, they are claiming to be both morally neutral endeavors, and morally beneficent practices that promote social welfare. However, the example of homosexuality shows that there is indeed an important moral aspect to the mental health sciences because they can determine what is and what is not disease. If a disease causes a behavior, then the disease and not the actor is responsible for that behavior; the actor is a patient, not a morally repugnant person. Only people who choose to do or think things that are morally repugnant and hurt the community will be deemed to be evil, as opposed to diseased; and psychiatry claims to be able to make this distinction. Psychiatric and psychological practice also acquires a positive moral valence by offering to remove harmful thoughts and behaviors with treatment, the traditionally beneficent identity of the healer. Small wonder then that no textbooks of psychiatry or psychology offer accounts of evil.

The Normally Abnormal: Moral Insanity

It was easy for mental health sciences to reclaim many abnormal behaviors and mental functions as illnesses and not evil. It was indeed a turning

point when psychotic phenomena were reclassified as natural disasters, caused by brain malfunction, and not evidence of evil choices or possession by evil forces. The distress, suffering and self-defeating nature of many mental illnesses made it clear that the language of evil was inappropriate to describe many people who were violating moral norms *(8)*.

However, all the early psychiatrists and psychologists recognized that it might be difficult to distinguish caused abnormality of behavior from chosen deviance. The term *moral insanity* was first used by Prichard to describe individuals who seemed to be persistent social norm violators, but did not seem to be ill in other ways. It was the persistency that seemed to indicate illness; similarly, *manie sans delire* was a term devised by Esquirol to describe those who caused consternation to others, but were not themselves deranged *(9)*.

In 1941, Hervey Cleckley *(10)* published what has become one of the most important books about a most troublesome group of people: those called psychopaths. Cleckley's contention was that a group of people exist who repeatedly violate moral and legal norms and cause distress to others. They appear to be indifferent to the distress they cause, and do not change nor appear to want to change. However, they do not appear to be ill in any conventional sense; they can make choices and appear to do so. Cleckley argued that they seem to be unable to recognize the distress of others, what he called a type of agnosia.

The point about Cleckley's work is that it started a discussion about whether persistent callous, remorseless rule-breaking behavior was chosen or caused. If caused, then it could be understood as a natural disaster that did not involve human agency, and could not be deemed as evil. Interestingly, the term *evil* does not appear in the index of the book, and Cleckley specifically states that few of his psychopaths were ever violent to others.

Hare Psychopathy: An Index of Evil?

What if persistent moral rule breakers were not only callous and remorseless, but also violent? Robert Hare developed Cleckley's ideas and applied them to people who violate moral and legal norms in egregious ways. He developed a checklist of personality traits and interpersonal behaviors, with which he seeks to classify individuals in terms of their capacity to act as psychopaths. Using the Hare Psychopathy Checklist (PCL-R), he found that about one-third of violent recidivist offenders in prisons scored 30 or above out of a possible 40 (i.e., that there was something about these offenders that was quantitatively different from the others who scored much lower) *(11)*. Not every criminal is a Hare psychopath, but those that are present more risk to the community when they are released *(12)*.

Table 1
Personality Characteristics Measured by the Hare Psychopathy Check List

Factor 1
• Glibness and superficial charm
• Grandiose sense of self worth
• Pathological lying
• Cunning/manipulative
• Lack of remorse or guilt
• Shallow affect
• Callous/lack of empathy
• Irresponsibility
• Failure to accept responsibility for one's own actions
Factor 2
• Need for stimulation/proneness to boredom
• Parasitic lifestyle
• Poor behavioral controls
• Promiscuous sexual behavior
• Early behavior problems
• Lack of realistic long-term goals
• Impulsivity
• Many short-term marital relationships
• Juvenile delinquency
• Criminal versatility [a]
• Revocation of conditional release [a]

From ref. *11*.

[a] Not scored. Subjects are rated as 0 (trait/behavior not present), 1 (trait/behavior somewhat or uncertainly present), or 2 (trait/behavior present).

The PCL-R provides a measure of interpersonal traits (Factor 1 [F1]) and a measure of criminal rule breaking tendency (Factor 2 [F2] (*[13]*, *see* Table 1). In Western cultures, criminal rule breaking is common, and although undesirable, is not seen necessarily as evil. Despite the fact that criminal behavior is by definition chosen, it is not likely to attract the term evil unless it is extreme in terms of harm and suffering both intended and/or caused. It is F1 that looks a bit more like a list of evil characteristics, especially the items about remorselessness, callousness, and exploitation of the vulnerable. Deceitfulness and persistent dishonesty is listed as well as denial in the form of refusing to take responsibility for one's actions.

To be a Hare psychopath, one needs to score highly on both F1 and F2. The F1 items only account for 16 of the possible 30 points needed to be rated as a psychopath. Of course, the threshold could be lowered or the items weighted differently. However, if this group is already criminal then we know they are dangerous to others, or at least we will not be completely surprised if they are. What we might be more interested in are those people who only score highly on F1, but are not necessarily criminal. They might, however, cause all sorts of problems for others if they have such an unpleasant psychological disposition. Hare discusses this issue in a book for the lay public in which he offers advice about how to identify the psychopath in the office *(14)*. Perhaps high F1 scorers can turn their capacity for cruelty into an advantage if it is combined with intelligence, wealth, and the buttressing of social class; they might be effective in big business as corporate asset strippers or in dictatorships or in invading small neighboring countries.

Measuring Evil

Michael Welner further developed the psychological assessment and measurement of evil by developing a Depravity Scale *(15)*. This is still in development as a tool, but Wellner sees it as a way to "diagnose evil." The impetus for its development comes from US law, which states that extreme penalties (such as capital punishment) may be applied to those crimes that "heinous or atrocious." The courts then require some index of heinousness or atrocity with which to make this crucial deliberation.

Wellner developed his Depravity Scale by re-examining criminal cases that had been adjudicated as heinous or depraved. He developed a 26-item scale, which addresses intentions, attitudes, and consequences of an action. Presently, he is attempting to collect a big enough data set to allow him to calibrate his scale properly. (Readers are invited to go to the Web site and contribute: http://www.depravityscale.org.)

Calibration may seem like a neutral scientific term. Actually, it is a crucial issue, given the purpose for which this tool is likely to be used. An individual who is rated highly on the Depravity Scale either may be given an extremely long sentence or may be executed. Given that there must be a subjective quality to any evaluation of an act (for this is what valuing means), in order for the Depravity Scale to be just, it must be based on the biggest possible data set. In order to measure evil in any meaningful sense, one would have to know the extent of the empirical field. What might seem depraved to one person will not to another, which might be relevant if either of those people is a judge in a capital case.

What many people have argued of course is that measuring evil is at best misguided, and at worst, a morally reprehensible activity in itself, especially when presented as the work of mental health professionals. Some have argued that Hare's PCL-R is just dressing up moral judgment with numbers, which gives it a pseudoscientific quality *(16)*. Welner's concept of the diagnosis of evil seems incoherent, given that one of the features of evil is that it is a separate domain from illness or disease, because it is chosen, not caused.

The Evil Brain: The Neuroanatomy of Moral Choice Making

The counterargument is the one from beneficence put originally by psychologists; namely, that actions or attitudes that have been called evil are actually natural disasters that should invite concern, not condemnation, and might yet be susceptible to treatment. Recent research in neuropsychology and psychiatry has addressed the brain structures involved in making moral choices, the implication being that those who make wrong moral choices may have abnormal brain function in those areas.

Of course, this approach is not new. In the 19th century, both Lombroso and Galton suggested that the brains of criminals could be reliably distinguished from the brains of noncriminals. Current approaches to research can make use of the latest developments in neuro-imaging, especially those scanning devices that give a picture of function rather than structure. Raine *(17)* studied the brains of subjects who had committed homicide and found abnormalities of function in the prefrontal cortex. The risk of violence was increased if subjects with such brain damage had also been exposed to poor care as infants. Similarly, Caspi et al. *(18)* found that violent rule breaking was more common in boys who had a genetically acquired neurochemical deficiency combined with an experience of maltreatment as children. Anderson and colleagues *(19)* describe the case of a young woman who showed persistent unempathic rule-breaking behaviors, apparently caused by a minute injury to her right orbito-frontal cortex.

The neuroanatomical structures involved in normal moral choice making are also the subject of current study. Spence and his group *(20)* showed that the parietal cortex is crucial to the experience of agency and choice, and the ventromedial prefrontal cortex is involved when subjects tell lies. Dolan *(21)* has shown that the amygdala is involved in fear reactions, often involving anger, and that input from the amygdala needs to be modulated to prevent extreme behavioral reactions. Singer *(22)* found that empathy for others' distress is mediated through the thalamic structures that respond to

pain (i.e., that it is possible for us to feel the pain of others in some real sense).

Of course, what we do not know is whether any of this interesting data helps us to understand evil. To apply the data sensibly, we would have to know that we are all using the same definition of evil, and as discussed elsewhere in this book, defining evil is a complex task. Evil goes beyond criminality; it may not even be synonymous with violence. It goes beyond some boundary of rule breaking: it implies choice, planning, cruelty, despite for others' distress, and a lack of pity. It may or may not be instrumental; some acts acquire the label evil when great cruelty is done to no purpose (as in Levi's *[23]* notion of "useless violence"). Not all homicides are the same in terms of their evil quality; thus a study of murderers may tell you something about people who have been episodically and fatally violent, it may not say much about evil.

Equally, we do not know if those who carried out evil acts, or who have been in persistently evil states of mind have defective thalamic tracts or unmodulated amgydalae. It seems hard to argue that those who perpetrated atrocities such as My Lai or in Nanking did so because their brains were defective. Those men, who met at the Wannsee Conference in 1941 to plan the destruction of millions of people, simply because they were Jewish, probably did not have defective brains; in fact, they were powerful successful men who were functioning well psychologically.

Even if they did have abnormal brains, what then? The subjective experience of those who perpetrate evil acts is that they do have choices, and they are often very aware of the moment when they made the choice that brought about an evil thing. Some have described the process of doing something cruel as a psychological experience; the doctors involved in selections at Auschwitz needed two bottles of vodka a day to numb themselves enough to survive the experience *(24)*. Even if some of the perpetrators of atrocities in the Holocaust did have abnormal brains, there would almost certainly be some who did the same things and did not so have; how would the argument be formulated that would justify treating them differently, given that the social context and the institutional intentions were exactly the same for both?

Trauma and Evil: "Those to Whom Evil is Done, Do Evil in Return"

The above is a quote from Auden's *(25)* poem, *September 1st 1939*, written as another war was about to break out. The psychological study of the sequelae of traumatic events has indicated that in some individuals, the expe-

rience of trauma can put an individual at increased risk of acting in morally or legally rule-breaking ways. This may be a result of acquired irritability, hypervigilance, and anxiety, or it may be because the individual (especially if they have been the victim of some moral violation) feels cut off from the moral community to which they used to belong. The victim becomes a perpetrator, and as such, moral responsibility is reduced. The less responsibility and agency for an evil act, the less we may want to call the actor evil.

Most research, however, has concentrated on developmental trauma, and the long-term effects of child maltreatment. Physical abuse and neglect of children affect the development of the brain, especially the right orbito-frontal cortex (which was already implicated in moral choice-making function discussed). The brains of maltreated and neglected children have reduced synaptic connections, leading to impoverishment of responses to interpersonal stimuli. Maltreated children have reduced capacity for naming their own feelings, and those of others, have reduced empathic response to others' distress, and have less sense of identity, in terms of a personal selfhood *(26)*. Individuals with disorganized attachments to others are at increased risk of acting violently and cruelly, especially to attachment figures *(27)*.

However, all the same caveats apply to these theories as were raised about abnormal brain function. It is not clear that everyone who does evil things has had these awful experiences in childhood. It is clear that most people who are maltreated in childhood do not act violently to others. The experience of childhood trauma may increase the risk of acting violently in adulthood, but it does not explain it. Nor, to be repetitive, is violence the same as evil; they may have overlapping features but they are not the same.

Evil: A Kind of Necessity?

Psychiatry and psychology have a great deal to say about the capacities and dispositions of those who perpetrate antisocial, violent, and evil acts. It seems unremarkable to find abnormalities of brain function in some rule breakers; we need our brains in order to have our minds, and for some, abnormalities in brain function will be a complete explanation of abnormal states of mind. Similarly, our dispositions and interpretations of the world will be influenced by all our experiences, including those of childhood: maltreatment will undoubtedly be influential for some evildoers.

What seems clear to me is that evil has not yet been tidied away completely as a natural disaster without any moral weighting at all. Many of the people I speak to in my work have done evil things, and they speak of them as evil. They are not satisfied with the explanation that they were ill at the time;

many, if not most, tire of claiming that they were possessed by evil. They want to understand how they came to be in evil states of mind and want to retain evil as a particular type of moral judgment for a particular type of event. The data about the internal and external psychological underpinnings of moral choice making and moral rule breaking seem to me to be indications of how complex moral identity is.

Unlike Morrow *(28)*, I do not think that evil is essentially inexplicable. The question is what we use our explication of evil for. I have a sense that the concept of evil exists as a way for us, either as individuals or in a group, to express our outrage at something. It is a performative word, which carries a feeling of an active judgmental process; it is also a call to action.

Psychiatry and psychology can tell us a great deal about the internal and external worlds of human experience, but there is a level of moral analysis, in terms of the relationship between the group and the individual, that is beyond their reach. However, to work therapeutically with people who have done evil things makes an engagement with this type of analysis inevitable, in my view. My work with forensic patients has made me thoughtful about what it is to get into an evil state of mind. In this state of mind, disconnectedness and alienation are crucial; Tillich *(29)* gives an account from theology of how unbelief, pride, and desire interfere with our power to be all that we can be. Evil is a failure, not so much of the ordinary psychological self, but the moral identity that we aspire to, so that evil makes us less than we are or can be. We want to be more than we are, sometimes we have a sense that there is more than the here-and-nowness of life, and that we could reach it if we only knew how, perhaps best described by Wordsworth:

> *...something far more deeply interfused,*
> *Whose dwelling is the light of setting suns,*
> *and the round ocean and the living air*
> *And the blue sky, and in the mind of man.* (30)

I see our moral identity as a particular sort of "I-ness," which is part of our total autobiographical narrative. This could be linked to notions such as the ego-ideal, or the super-ego. Whatever the wording, it is hard not to think, as Isaiah Berlin *(31)* suggests, that the splitting of the self into higher and lower is a profound conceptual development in the Western history of ideas. Where there is a failure to develop a moral identity, or in those situations where the moral identity is undermined, diminished or abandoned, there will be what Midgley *(32)* calls "the empty centre," or, as one my patients called it, "a dark space." This dark space has echoes of C. S. Lewis's description of nothingness:

And Nothing is very strong... strong enough to steal away a man's best years, not in sweet sins but in a dreary flickering of the mind over it knows not what and knows not why... (33)

My late and much missed colleague, Murray Cox, suggested in his 1990 Foulkes Lecture *(34)* that psychotherapists need more dialogue with the theological realm of discourse, which explores ideas of transcendental development. He called it a luxury, but I suspect it may be a kind of necessity. This phrase mirrors that used by Day Lewis, who called love, "a kind of necessity" *(35)*. Given the ubiquity and apparent inevitability of human cruelty (which must surely be a defining feature of evil), we will need all the theoretical tools at our disposal if we are to keep hope and resistance to evil alive.

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Chapter 14

Should Radical Evil Be Forgiven?

Marguerite La Caze

Background

Is evil an absolute difference that we must respond to with horror? Or is evil an aspect of humanity that we must approach with understanding? How we answer these questions partly determines how we should answer the question of whether we should forgive evil, particularly radical evil. *Radical evil*, as it is used it here, can be understood as evil that is not motivated by understandable human motives. Hannah Arendt argues that one cannot forgive radical evil because such acts completely transcend the human realm. Radical evil seems to be beyond our understanding. By contrast, Jacques Derrida argues that true forgiveness has nothing to do with measuring the extent of guilt, wrongdoing, remorse, apology, or healing. True forgiveness in this view involves forgiving the unforgivable, so forgiveness must be possible even in the most extreme cases, such as those of radical evil.

Although Derrida's view may be an accurate account of the logic of pure forgiveness, I argue that we need not take the further step of expecting forgiveness in cases of radical evil. Although the attempt to forgive in many cases is contributory to human good, a person who acts in evil ways cannot expect forgiveness but must work toward reconciliation.

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Should Radical Evil Be Forgiven?[1]

Should one (indeed, can one) forgive the unforgivable, radical evil being an exemplary case of the unforgivable? If we take Hannah Arendt's account of radical evil as incomprehensible or without ordinary human motivations seriously, radical evil seems to pose particular problems for the possibility of forgiveness, because there are no explanations, justifications, or excuses for radically evil actions. In all other cases, evil can be accounted for partly by human weakness or passions, and our general susceptibility to these weaknesses provides the obvious basis for forgiveness. Arendt's argument that because radical evil transcends human concerns it is beyond human forgiveness is challenged by Jacques Derrida's view that forgiveness essentially involves forgiving the unforgivable, in other words, the forgiveness of radical evil. Although Derrida does not explicitly state that we should forgive the unforgivable, my reading of his work on this point is that he implicitly sanctions such forgiveness. Derrida's view of forgiveness focuses on the logic of forgiveness, whereas Arendt focuses on the politics of forgiveness and by implication, the psychology of forgiveness, and this shift of focus affects a shift in our expectation of forgiveness, the implications of which are outlined in this chapter.

Arendt on Forgiveness: The Impossibility of Forgiving Radical Evil

Throughout her work, Arendt is concerned with understanding the nature of evil, specifically as exemplified by the concentration and extermination camps in Nazi Germany, and in the Nazi and Stalinist regimes. For Arendt, the totalitarianism of those regimes represents a particular kind of evil—radical evil. She touches on the question of whether we should forgive such evil in a number of texts. For example, Arendt discusses the concept of forgiveness in *The Human Condition (1)*. She says that the "faculty" of forgiving allows for the possibility of redemption from "irreversibility" *(1)*. Furthermore, Arendt believes that forgiveness is essentially personal, although not necessarily private and individual, because we forgive a person for what they have done *(1)*. My interpretation of this idea is that when we forgive, we always forgive a person their actions and we may do this in a public or collective way.

[1] My thanks go to participants in the UQ-UNE weekend and at the *International Association of Women Philosophers* conference, and to Damian Cox for comments on an earlier version of the paper.

The origin of the concept of forgiveness, like the concept of evil, can be located in religious ethical traditions, a connection that makes some philosophers skeptical about their usefulness for contemporary ethics or psychology. For example, Simone de Beauvoir claims in *Oeil pour Oeil* ("An Eye for an Eye") that forgiveness is a resort of the religious, not of atheists *(2)*. However, although Arendt traces the understanding of forgiveness to a religious tradition, she sees no difficulty in understanding forgiveness in a secular way *(2)*.[2] Similarly, I argue that although we should be aware of the particular origins of certain concepts, we are able to rework them in a contemporary context and should not dismiss them out of hand. Forgiveness between human beings does not have to have a religious basis. Furthermore, the concept of forgiveness does work that other concepts, such as reconciliation, cannot do.

A number of philosophers also believe that the concept of evil, even more so radical evil, belong to the sphere of religion and have no place in secular discussions of ethics or psychology. Alain Badiou, for example, claims that because radical evil invokes a measure that cannot be measured, it must be abandoned as being essentially religious *(3)*.[3] By "measure" he means to make commensurable and he claims that theorists of radical evil, using the Shoah as their paradigm example, are involved in incoherence. Badiou argues that the Shoah is used as the exemplar of radical evil, saying "the Nazi extermination is radical Evil in that it provides for our time the unique, unrivalled—and in this sense, transcendent, or unsayable—measure of Evil, pure and simple" *(3)*. Badiou says that these thinkers maintain that the Shoah is incommensurable with other evils and yet constantly compare other evils to it (e.g., when political leaders compare Nasser, Saddam Hussein, and Slobodan Milošovíc to Hitler). There are two problems with Badiou's analysis. One is that the claims of political leaders do not necessarily imply that there is a difficulty inherent in the concept of radical evil itself. Second, if we focus only on the issue of whether the Shoah can be compared to other evils, there is no incoherence in claiming that it is both incommensurable and a limit below that which other evils can be compared to each other. One could argue that all other evils are measurable in a way that the Shoah is not. Certainly, the concept of evil should not be abused or too broadly applied. There is also a danger of attributing monstrosity and perversely glorifying criminal acts.[4]

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[2] Papastephanou *(24)* points out that a view of 'forgiveness with repentance' is evident in the literature of Ancient Greece (pp. 517–519).

[3] "Extreme evil" is Badiou's preferred term for the Shoah (p. 66).

[4] For example, Card *(25)* says that her understanding of diabolical evil comes closer than Kant's "to the classic view of Satan as a corrupter" (p. 212) although her intention is certainly not to glorify evil.

Nevertheless, as we shall see, radical evil delineates a category of evil and does not have to be tied to a religious tradition. Arendt appears to tie forgiveness to wrong actions that have been committed "unknowingly," *(1)* a characterisation that suggests forgiveness is only appropriate for a small subset of actions. However, she bases her view on the thought that "crime and willed evil are rare" *(1)*, so most wrongs deserve forgiveness.[5] These wrongs are just part of the unpredictability of human life. "Radical evil," Arendt says, can neither be forgiven nor punished in her view, because it completely transcends the human realm *(1)*. Her formulation presents the essence of the question: is radical evil beyond the human and therefore beyond the possibility of forgiveness?

Kant is credited with introducing the concept of radical evil in "Religion Within the Limits of Reason Alone" *(4)*. His account of evil is as perversity, in which human beings put the principle of self-love and of non-moral motivations above that of duty *(4)*. By "radical" he means that evil is a deeply rooted human propensity, although always one that we can choose against. In that sense, Kant sees radical evil as fundamentally human, although blameworthy, so that there is potential for forgiveness. He does not say in this essay whether we should forgive radical evil, or rather the actions done out of radical evil. However, in *The Metaphysics of Morals* he says that it is a duty of human beings to be forgiving, which is not to be confused with "*meek toleration* of wrongs" or "renunciation of rigorous means (*rigorosa*) for preventing the recurrence of wrongs by others" *(5)*. Forgiving is part of the conditional duty to be sympathetic rather than malicious to others.[6] Such a duty does not imply that one must forgive every harm committed. Use of the term radical evil has altered since Kant.

In her writings, Arendt shifted from the language of radical evil, referring back to Kant, to the language of the banality of evil.[7] Arendt discusses radical evil in her early essay "The Concentration Camps" *(6)*. This radical evil, which she also refers to in *The Origins of Totalitarianism*, is incomprehensible *(7)*.[8] In the former paper, she describes the processes involved in this

[5] By contrast, Derrida claims that "Forgiveness has nothing to do with knowledge" (ref. *12*, p. 70).

[6] Thus, for Kant, forgiveness is a conditional duty of love, rather than an unconditional duty of respect.

[7] Allison *(26)* argues that, despite appearances, Kant's and Arendt's views on the nature of radical evil are remarkably similar.

[8] Bernstein *(10)*, after a very comprehensive discussion of theories of radical evil, concludes that "evil is an excess that resists total comprehension" (p. 227).

particular form of radical evil developed through the concentration and extermination camps. Radical evil involves treating human beings as superfluous, meaning that the treatment goes beyond even treating others as mere means to one's own ends. The obvious example of such evil is the Nazi treatment of Jewish people and others who they murdered when their work could have contributed to the war effort.[9] People were murdered simply because of who they were.

Radical evil or absolute evil differs from other kinds of evil in that it cannot be explained by evil motives. "Ordinary" evil has some explanation, such as greed, status, anger, hatred, or revenge that account for the motives of the perpetrator. Radical evil is evil in which there seems to be no benefit to the perpetrator. The way people are treated is characterized by "antiutility," Arendt argues *(6)*.[10] This point raises a difficult question. Does this lack of motive make what the perpetrator has done more or less forgivable? One could say that their actions cannot be forgiven because there are no humanly understandable motives, such as selfishness, greed, fear, or even cruelty to explain what they have done. Or one could say, implausibly, that it is more forgivable because it was not carried out for venal reasons. Undoubtedly, Arendt takes the first view—that because the motives of those in the concentration and

[9] The paradigmatic nature of the Shoah has led some philosophers to the view that radical evil is constituted by genocide. For example, Alessandro Ferrara, after mentioning these paradigm examples of radical evil concludes that "Constitutive of radical evil seems to be the unleashing of violence on a victimized group unable to adequately react—targeting the individual only insofar as she is part of that group. Radical evil also seems to have to possess a characteristically systematic quality which episodic violence—for example, lynchings and pogroms—does not possess" (ref. *19*, p. 183). However, although genocide is the most obvious example of radical evil, I believe that the definition of radical evil is independent of it. Radical evil could be episodic, it could fall short of genocide or attempted genocide, and it could focus on a group that is not weak or victimized. Ferrara also gives a more general definition of radical evil as evil that we cannot bear to have connected with human life in any way, even as an emblem of what should not be done (ref. *19*, p.186).

[10] Arendt *(6)* adds further on in the article that this antiutility is only apparent, because the existence of concentration camps and people's treatment within them serves the purpose of keeping the population terrified (p. 760). However, this argument cannot apply to the camps, particularly extermination camps, during world war two, in which enlisting the aid of people in the camps could have helped the Nazi's war effort. Fine emphasizes the point that it is *difficult* to understand what happened in the Shoah within standard rationalistic frameworks (ref. *19*, p. 133).

death camps are not those of wrong or evil actions generally, there are no possible grounds for forgiveness, or for punishment. On her account, we cannot connect such actions with the usual human weaknesses and passions that we all share. Forgiveness is seen as a human concept and radical evil goes beyond the human.

As we have seen, in *The Human Condition* Arendt refers to Kant's concept of radical evil as if she is using the same concept *(1)*. Later, after the Eichmann trial in Jerusalem, Arendt distinguished between radical evil and extreme evil. After reflecting on Eichmann's appearance in the court, Arendt holds the view that evil cannot have the depth required to call it radical *(8)*.[11] Rather, it is like a fungus that spreads over the surface of things. Richard J. Bernstein points out that "Insofar as 'radical' suggests digging to roots that are hidden, she no longer believes that evil is radical in *this sense*" *(9)*. He also argues that Arendt shifts in her thinking from the concept of superfluousness to that of thoughtlessness to explain evil *(10)*. She emphasizes Eichmann's lack of thought and reflection in carrying out the work of extermination.

Yet, I argue that these two concepts are compatible in that one focuses on the way perpetrators treat the victims (rendering them superfluous) and the other emphasizes the condition of the perpetrator (their state of thoughtlessness). Both conditions are relevant to understanding radical evil. The perpetrators do not reflect on their actions, and their actions have the result of rendering others superfluous. Bernstein concludes that "radical evil is compatible with the banality of evil" *(9)*. He sees Arendt as shifting her focus to the intentions of the perpetrators, but still presupposing that the evil is radical. Bernstein insightfully observes that Arendt's theory splits apart the evilness or wickedness of the intentions or motives from the evilness or monstrosity of the deeds. Monstrous actions can be committed from the most banal and trivial of motives, such as the petty ambition that appears to have motivated Eichmann.

However, not all radical evil is also banal. Some people, such as Hitler, commit incomprehensible crimes out of monstrous motives.[12] Radical evil

[11] Arendt *(8)* makes this point in a letter written in 1964.

[12] Bernstein *(10)* notes this possibility: "The banality of evil is a phenomenon exemplified by only *some* of the perpetrators of radical evil—desk murderers like Eichmann" (p. 222) Geddes *(27)* also notes that Eichmann is one example of one kind of evil (pp. 108–109) However, Allison (*26*) argues that Arendt implies that such motivelessness characterizes the Nazi regime as a whole. He believes that Eichmann constitutes a limiting case of Kantian evil, because of his extreme neglect of the morally relevant features of his actions, rather than a different kind of evil (p. 99). I believe Arendt could hold that many of the Nazi perpetrators were "ordinary people" and that there are other kinds of evil.

can be committed from a variety of motives or no motive at all. What seems to distinguish radical evil is the attitude the perpetrator takes to the victims. One could also argue that the explanation banality gives of evil is a very inadequate one. There is a large gap between the triviality of the motives and the horror of what they have done, but it is not completely incomprehensible. What the explanation does not explain is how, from a psychological point of view, such banal motives could have been thought to justify such monstrous deeds. Whether it is called radical or banal, such evil involves utter lack of consideration of the individuality, culture, or perspective of the victims.

The incomprehensibility of radical evil and the relative inexplicability of banal evil implies that the acts of the perpetrators are beyond forgiveness. In Arendt's view, forgiveness is a human thing and we cannot forgive the inhuman. Perhaps what Arendt leaves out is a leap to forgive that which goes beyond understanding of motives. This leap appears to be exactly what Jacques Derrida is suggesting.

Derrida on Forgiveness: Forgiving the Unforgivable

Derrida takes up the question of forgiveness in "On Forgiveness" *(11)* and "To Forgive: The Unforgivable and the Imprescriptible" *(12)*. Just as he argues that true hospitality is unconditional and limitless, Derrida maintains that we can only truly forgive the unforgivable crime or harm *(11)*.[13] He also compares forgiveness (*le pardon*, *un pardon*) to the unconditionality of the gift, but notes that forgiveness is related to the past, so cannot be reduced to the gift *(12)*. True forgiveness is unconditional and not premised on an understanding of the evil committed, so it includes forgiveness of radical evil. Pure forgiveness is aneconmic; it is beyond repentance, atonement, or any account of the weight of the crime, Derrida says. Once we begin to think of repentance and negotiation, healing and reconciliation, Derrida claims that we have entered the realm of impure or conditional forgiveness that is too simple. True forgiveness is a kind of madness, beyond such considerations. True forgiveness is forgiveness of the "*guilty as guilty*" *(11)*. In his view, forgiveness cannot be of those who have atoned, because then they are no longer guilty.

Furthermore, conditional forgiveness does not exemplify the open generosity of true forgiveness. Such forgiveness is "corrupted" by the calculation of the value of the crime and of repentance *(12)*. Derrida traces the idea of unconditional forgiveness to what he calls the Abrahamic religious tradi-

[13] Other authors, such as Garrard *(18)* argue that we should forgive the unforgivable, such as the crimes of the Shoah.

tion in order to include Judaism, Christianity, and Islam, yet argues that such forgiveness goes beyond that tradition, in so far as the tradition contains the contradictory or auto-deconstructive call for forgiveness only in proportion to repentance *(11)*. He concludes that the unconditional and conditional forms of forgiveness are heterogenous, irreducible, yet nonetheless indissociable, as are unconditional and conditional hospitality *(11)*. Unconditional forgiveness includes forgiving the unforgivable, a possibility that other moral philosophers, such as Arendt, reject.

Although Derrida briefly refers to Arendt's view of forgiveness (to note she does not claim that forgiveness has a juridical dimension, although it is correlative to punishment), he considers Vladimir Jankélévitch's argument that the perpetrators of the Shoah cannot be forgiven because "forgiveness died in the death camps" *(13)* in some detail in both "To Forgive" and "On Forgiveness" *(11,12)*.[14] Jankélévitch first published his essay "Should We Pardon Them?" in 1966, when there was debate concerning the decision in France in 1964 not to have statutory limitations on crimes against humanity (e.g., the deeds of Nazis). The essay was republished in English in 1996. Jankélévitch argues that there should not be any legal statute of limitations on those crimes: they are imprescriptible. One reason he gives is that any particular cut-off point in time is arbitrary. Another is that the full horrors of the crimes are not realized immediately, but over time. More importantly, they are crimes against humanity, and are therefore on a different scale from ordinary crimes and should be regarded differently. Jankélévitch says that it contradicts morality to consider pardoning such crimes *(13)*.

Furthermore, these crimes are so great they cannot be redressed: they are "inexpiable" and for the inexpiable forgiveness can have no meaning. Jankélévitch's argument here is similar to Arendt's, in that he believes that if punishment cannot be proportionate and is almost irrelevant, the crime is inexpiable *(13)*. He is clearly thinking of the crimes of the Shoah as radical evil. Jankélévitch says that the Shoah is a "crime out of all proportion to everyday wrongdoing" and "an unnamable, unmentionable, and terrifying thing" *(13)*. He also refers to "ontological wickedness" or "the most diabolical and gratuitous wickedness that history has ever known" *(13)*. Because their crimes were unmotivated, he says, the perpetrators were monsters. The crimes of the extermination camps are different from other war crimes, such as terror bombing, because of their "directed, methodical, and *selective* character" *(13)*.[15]

[14] Vladimir Jankélévitch (1903–1980) was Professor of Moral Philosophy, University of Paris.

[15] Jankélévitch *(13)* refers to the "refined sadism" of the perpetrators of the Shoah (p. 563), but Arendt *(6)* argues that even sadism was usually not a motive for the crimes (pp. 758–759).

The unforgivability proceeds from the knowingness of the criminal acts. Moreover, no one ever asked to be pardoned, so they should not be.[16] Jankélévitch argues that a pardon could only be justified by the "distress and dereliction of the guilty," but he finds them complacent and unconcerned *(13)*.

Derrida counters Jankélévitch's claim that there is a need for forgiveness to be asked in "To Forgive" by saying that there is

> *in the very meaning of forgiveness a force, a desire, an impetus, a movement, an appeal (call it what you will) that demands that forgiveness be granted, if it can be, even to someone who does not ask for it, who does not repent or confess or improve or redeem himself, beyond consequently, an entire identificatory, spiritual, whether sublime or not, economy, beyond all expiation even.* (12)

The notion of forgiveness here is one of reaching out to the other, extending our forgiveness, without being asked to do so or expecting anything in return.[17] Derrida says it is hard to follow Jankélévitch's logic and is surprised that he has changed his mind from an earlier work, *Le Pardon (14)*, in which he was more sympathetic to the idea of unconditional forgiveness.[18]

The gaps Derrida sees in Jankélévitch's logic are between the inexpiable and the unforgivable and between finding a crime unforgivable and concluding that we cannot forgive it. For Derrida, one cannot arrive at this conclusion because the unforgivable calls for our forgiveness and "because this logic continues to imply that forgiveness remains the correlate of a judgment and the counterpart to a *possible* punishment, to a possible expiation, to the 'expiable'" *(11)*. Derrida questions such a correlation because he sees punishment and forgiveness as quite separate and distinct, and does not view forgiveness as being tied to judgment.[19] He finds the idea of the imprescriptible

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[16] Jean-Luc Nancy *(28)* also argues that evil is "unbearable and unpardonable" (p. 123) and defines evil as "*the hatred of existence as such*" (p. 128).

[17] Dooley characterizes Derrida's view thus: "To have a passion for the impossible or the unconditional means that you desire what you know to be impossible—due to the claim which language and tradition make upon you—so as to prevent the conditional from becoming *too* conditional" (ref. *12*, p. 143). There is something worrying about having a passion or desire for the impossible because the impossible, as Derrida describes it, is dangerous and undesirable. In the case of hospitality and forgiveness, they are ideals of self-destruction.

[18] Light *(29)* claims that Jankélévitch's view is that the imprescriptible is of a different and worse, order, than the unpardonable, but he does not provide textual evidence (p. 54).

[19] One exception that Derrida *(11)* notes is the *right of grace*, where a sovereign can pardon a criminal, in other words forgive them in a way that goes beyond the law (p. 46).

points beyond the law to the concept of the unforgivable, and therefore, true forgiveness *(11)*. Furthermore, Jankélévitch is only alleging that pardon has not been asked for *(11)*. What Derrida finds most problematic in Jankélévitch's account is the idea that "*forgiveness must have a meaning*" *(11)*. He finds no reason to assume that forgiveness depends on a human possibility. Derrida challenges both Arendt's and Jankélévitch's view that forgiveness is "a human thing" or on a human scale *(12)*, suggesting that pure forgiveness somehow goes beyond the human. What he perhaps has in mind is that a God seems able to forgive because such a being would be beyond the particular entanglements of guilt and harm *(12)*. Derrida implies that forgiveness points beyond the human.

Derrida questions the idea that forgiveness cannot be a response to radical evil or the inexpiable in the name of a hyperbolical ethics, an ethic that is exaggerated and goes beyond an exchange of demands and expectations. The unforgivable is radical evil for Derrida or perhaps even something worse (if possible). He says that such evil involves "an absolute hatred" and "destructive hostility" *(11)*. This ethic "therefore, [that] carries itself beyond laws, norms, or any obligation. Ethics beyond ethics, there perhaps is the undiscoverable place of forgiveness" *(11)*. According to Derrida, Jankélévitch's view concerning the unforgivability of the Shoah falls into the economic logic of exchange. By contrast, hyperbolical ethics concerns itself with the impossible, therefore the unforgivable.

Surprisingly, Derrida "privatizes" forgiveness even more than Arendt, because Arendt connects forgiveness with judgment and punishment *(1)*, whereas Derrida argues that pure forgiveness has nothing to do with judgment. For him, forgiveness is between two people only: the victim and the perpetrator *(11)*. He accepts that some people cannot bring themselves to forgive and that such a decision is a private matter, citing the example of a woman who said at the Truth and Reconciliation Commission in South Africa that only she, the victim, could forgive and she was not ready to forgive. Derrida's idea is that a "democracy to come" would allow for the secret and the inaccessible, and experiences such as those of the Truth and Reconciliation Commission demonstrate the importance of allowing for such secrets *(11)*. It is important that there is a space for private decisions concerning whether or not and when to forgive. However, there is a strain in Derrida's thoughts on forgiveness that goes against his acceptance of non-forgiveness.

Although Derrida's account of true forgiveness may be of a forgiveness that does not, or cannot, exist, he claims it is essential to provide us with a means to think about the nature of forgiveness, to understand acts that fall short of forgiveness. The impossibility of pure forgiveness should guide our

thinking about forgiveness based on repentance, mourning, and exchange. Ultimately, we will negotiate between pure forgiveness and its impure forms. Derrida's characterization of forgiveness addresses the logic of forgiveness, rather than the ethics or psychology of forgiveness. He does not make a claim as to when we should forgive and when we should not.[20]

However, I argue that we must read his view of forgiveness as implicitly arguing for the madness of pure forgiveness, for two reasons. First, Derrida's criticisms of Jankélévitch and Arendt suggest not only that their account of forgiveness is conditional, but also that their particular views about whom and when we should forgive are objects of his criticism. For example, Derrida seems scandalized by Jankélévitch's angry tone in writing about the Shoah and his remarks concerning Martin Heidegger.[21] Derrida quotes a passage from Jankélévitch's essay, and then warns "What follows are remarks of such polemical violence and such anger against the Germans that I do not even want to read them or cite them" *(12)*. Of Jankélévitch's view of Heidegger, Derrida writes "And a little further on, as often elsewhere, Jankélévitch violently attacks Heidegger" *(12)*.[22] Jankélévitch does make a number of remarks about Heidegger, for example "The pedantic tone of German racism reminds me of…the gibberish of Heidegger" *(13)*. These remarks are certainly unsympathetic to Heidegger, but there are several rather than many and the reference to "violent attacks" presents Jankélévitch as an irresponsible writer, at least in this piece.

Furthermore, Derrida links Jankélévitch's waiting for a word of sympathy from the perpetrators and his criticisms of Heidegger with Paul Celan's poem, *Todtnauberg*, often interpreted as an expression of disappointment that Heidegger did not ask for forgiveness. He quotes the first verse from the poem: "Arnica, eyebright, the /draft from the well with the starred die above it, / in

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[20] Because Derrida defines forgiveness as forgiving the unforgivable, Papastephanou *(24)* appears to assume that he believes we should forgive the unforgivable (p. 507). Oliver *(30)* argues that we can only supply the constant interrogation of the search for pure forgiveness by taking into account the unconscious. Borradori *(31)* claims the conclusion "is that the meaning of forgiveness remains enigmatic" and ineffable (p. 144).

[21] Heidegger was a German philosopher (1889–1976) who was, notoriously, involved with the Nazis in the 1930s.

[22] There is a disturbing note in Jankélévitch's *(13)* essay when he says that juridical norms such as human rights can be dismissed when considering capturing and punishing Eichmann (p. 557) One could argue that just as one should not trample the rule of law no matter what the crime, one must not forget ethics, no matter how radical the evil.

the / hut, / the line/ —whose name did the book/ register before mine?—, / the line inscribed/ in that book about/ a hope, today/ of a thinking man's coming/ word/ in the heart, […] *(15)*. Derrida sets aside the question of the poem's interpretation and makes the point that Celan's poem itself is a gift, an expression of forgiveness: "*Todtnauberg* remains thus to be read, to be received—as gift or forgiveness themselves, a gift and a forgiveness which are the poem before being, possibly, its themes or the theme of the poet's disappointed expectation" *(12)*. (Apparently, he sent it to Heidegger, who loved it *[16]*.) This interesting interpretation contrasts Celan's generous forgiveness (he was not asked for forgiveness by Heidegger) with Jankélévitch's view that without a request for forgiveness he cannot and should not forgive. Implicitly, Jankélévitch is unfavorably compared to Celan because he is less forgiving.

Second, Derrida's positive account of true forgiveness implies that it is an ideal that we should try to live up to insofar as it is possible. We should aspire to true forgiveness, that is, to forgiving the unforgivable. He uses normative language in defining pure forgiveness, for example, "Forgiveness is not, it *should not be*, normal, normative, normalizing. It *should* remain exceptional and extraordinary, in the face of the impossible: as if it interrupted the ordinary course of historical temporality" *(11)*. Derrida also says that a hyperbolical ethic "would command precisely…that forgiveness be granted where it is neither asked for nor deserved, and even for the worst radical evil" *(12)*. Conversely, Derrida's association of impure forgiveness with calculation and corruption implies that we should avoid this impurity by not considering the conditions for forgiveness, such as repentance and atonement *(11,12)*, although he notes that once we have to make a decision in a particular case, forgiveness must "engage in a series of conditions of all kinds (psycho-sociological, political, etc.)" *(11)*.

In the sense of holding out impossible ideals, Derrida is a stern moralist. When exactly Derrida believes we should give way to the madness of pure forgiveness is another question. His remarks concerning the South African Truth and Reconciliation Commission accord with Jankélévitch's point that others cannot forgive on behalf of the dead: "The survivor is not ready to substitute herself, abusively, for the dead" *(11,12)*. Here the impossibility of forgiveness is a pragmatic one, in that the victim is not in a position to forgive. Derrida also says that "I always risk perjuring myself by forgiving, of betraying someone else by forgiving, for one is always doomed to forgive (thus abusively) in the name of another" *(12)*. However, it appears that he is willing to accept that risk in the name of forgiveness.

In an echo of his discussion of hospitality, Derrida says "It is between these two poles, *irreconcilable but indissociable*, that decisions and respon-

sibilities are to be taken" *(11)*. However, there is an important difference between Derrida's accounts of unconditional hospitality and forgiveness. Both are impossible, but in the case of hospitality, Derrida warns of a number of specific, catastrophic dangers of hospitality: the visitor can become an invader or colonist, conquest is an abuse of hospitality, and so on. However, there is no correlative list of pure forgiveness' dangers, of the harms that might arise from its untrammeled progress. Derrida makes one point concerning the possible arrogance and assertion of sovereignty in presuming to forgive *(11)*;[23] not everyone wishes to be forgiven. Nevertheless, he adds that forgiveness that is unconditional but without sovereignty is possible. Another difference is that Derrida speaks of the right to hospitality, but he does not speak of a right to forgiveness or a duty to forgive.[24] I believe that is appropriate, but perhaps lurking there is a tension in that Derrida takes supererogatory concepts and pushes their logic, suggesting an implicit expectation that if forgiveness is an ideal, then it is a good that we should expect of ourselves and that others may expect of us.

A possible implication of Derrida's account is that we should be less forgiving of the unforgiving, for they do not aspire to true forgiveness, a paradoxical outcome. He quotes Hegel as saying that "all is forgivable except the crime against spirit, that is, against the reconciling power of forgiveness" *(11)*. Derrida's view seems to imply that the perpetrators must be forgiven, no matter what the crime. Furthermore, his account of forgiveness puts the onus on the victims to forgive rather than on the oppressors to atone. This point could be a little unjust, as Derrida says that his concern is what he calls the comedy of forgiveness and what he has in mind are those who presume to forgive on behalf of others, such as heads of state *(11)*.[25] Ultimately, he claims he remains torn between the purity of forgiveness and the pragmatism of reconciliation. However, the weight of his argument lies on the potential forgivers. This presumption adds a further burden to the victims of radical evil, and

[23] Derrida even says we may have to be "forgiven forgiveness" because of that assertion (ref. *12*, p. 22).

[24] The concept of a "duty to forgive" would imply that all evil acts should be forgiven.

[25] Papastephanou *(24)* observes that "there is no compelling argument supporting the view that forgiveness conditional on repentance is inescapably or exclusively committed to this kind of strategicality and exchange" (p. 515). On the contrary, the victim's struggle to decide whether to forgive is independent of any strategic maneuvers, as Derrida himself implies by separating forgiveness from justice and politics.

cannot constitute an ethical injunction in every case.[26] Nevertheless, Derrida's idea that there is a call for forgiveness is an appealing one. What would an ethic of forgiveness that takes into account both these insights and difficulties look like?

Why Might We Forgive?

A gap in both Derrida and Arendt's accounts of forgiveness is a precise characterization of the psychological nature of forgiveness. Their views certainly provide hints of what such an account might look like, providing constraints on the account, for example, by saying whether forgiveness is "a human thing" or not, and whether it involves forgiving the unforgivable. Forgiveness is generally opposed to resentment, so we might say that forgiveness involves the giving up of resentment, or as Uma Narayan says, giving up "our sense of grievance" *(17)*.[27] Giving up that grievance does not mean that one has to trust again or deny the original wrong. Narayan notes that we may feel a range of emotions toward the offender, including moral anger and hurt. *Hurt* may seem an inappropriately trivial term to use in the context of radical evil, but I believe that it can be a component in our response to extreme racism and anti-Semitism, for example, as such treatment can be experienced as a betrayal. Letting go of these particular feelings does not entail forgetting of the original offense or excusing it, but a willingness to think of that person as other than an enemy or wrongdoer.[28] The nature of the relationship between victim and offender will of course affect the nature of forgiveness. Unilaterally forgiving a person whom one does not interact with is a very different affair from forgiving a former friend or neighbor. The consequences and the feelings of both the victim and the perpetrator will be very different when they live or work together.

In Derrida's account, the idea of repentance or apology is left out of the process of forgiveness, and this is one area in which I disagree with him. I argue that there is an important, if complex, relationship between repentance

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[26] Potter *(32)* notes that often the oppressed are expected to forgive the oppressors (p. 145).

[27] *See* my paper *(33)* "Envy and Resentment" for a discussion of ethical forms of resentment.

[28] Narayan *(17)* notes that we may still have negative feelings towards the offender, perhaps because we had negative feelings towards them prior to the offence, or our trust may be lessened, even though we have forgiven (p. 171). *See* Hampton and Murphy *(34)* for the distinction between forgiveness and justification, excusing, and being merciful (p. 506).

and forgiveness. It appears that just as one can forgive without being asked to, one can offer an apology and repent without expecting forgiveness. As we have seen, Jankélévitch argues that we cannot forgive the perpetrators of the Shoah because they have never asked for forgiveness, and Derrida counters with his view that true forgiveness does not depend on apology. During his visit to Australia in 2000, Derrida was asked by a journalist whether he thought the Australian government should apologize to Aboriginal people for past injustices, particularly the involuntary removal of Aboriginal children from their families. Although he was reluctant to give advice, when pressed he said "Yes, the government should apologize because that would be a promise to improve the situation, to change a terrible situation" *(12)*. To be fair to Derrida's view, it should be noted that an injunction to forgive without apology does not correspond to an excuse for not apologizing.[29] However, I would take this point further, and say that victims should not be blamed for wanting or even expecting an apology.

Another central question concerning forgiveness is whether it is essentially personal. There may be some exceptions to the rule that we can only forgive what has been done to us personally. Although Arendt is extremely critical of the notion of collective guilt, saying "When all are guilty, nobody in the last analysis can be judged" *(8)*,[30] she accepts collective responsibility and collective harm, arguing that the Shoah was "a crime against humanity on the body of the Jews" *(8)*. If that interpretation is correct, it appears that others may be able to forgive the perpetrators of the Shoah and other crimes against humanity (provided they are considered forgivable at all). Eve Garrard *(18)* argues that this aspect of the Shoah makes it possible for everyone to be hurt by the crime and therefore in a position to consider forgiving that crime. Derrida implies we can forgive such crimes, arguing that there is no conceptual limit to forgiveness, in that we all inherit crimes against humanity *(11)*, although he also says that we cannot forgive on the behalf of victims. There is not neces-

[29] In *Totality and Infinity*, Emmanuel Lévinas *(35)* discusses apology as a "primordial phenomenon of reason" where one justifies oneself before the other by apology. He says further "Apology does not blindly affirm the self, but already appeals to the other" (p. 252). It is as if we must all apologize for our very existence. Derrida takes up this theme, stating we will find in "Kant, Hegel, Nietzsche, and Heidegger" as well as Lévinas, a problematic of guilt for merely existing, a guilt which is of course unforgivable and unexpiable, although we may hope for forgiveness *(12)*. Such an idea of fundamental guilt again emphasizes the religious aspect of apology and forgiveness.

[30] Jankélévitch also says "if everyone is guilty, no one is guilty" *(13)*.

sarily an inconsistency here, as Arendt means that we forgive a particular person for what they have done, even though they have not done it to us specifically. Perhaps we could forgive in the sense that an action is a crime against humanity but not assume that we are forgiving particular actions against individuals and families—that we are forgiving in place of particular others.

Nevertheless, the final decision concerning when and whether to forgive is a personal one in the sense that only victims and those very close to them have directly suffered harm. I believe Derrida is right to separate forgiveness from juridical and political considerations. We cannot expect or demand forgiveness as a right. We can only hope for it or try to bring about the conditions for it. Toward the end of his essay, Jankélévitch says there can be no reparations for the Shoah *(13)* and although it is an understandable view, the offering of reparations is still an essential expectation of the perpetrator, even if they are refused.

Some philosophers believe there are other difficulties with forgiving radical evil. Carlos Pereda warns of the dangers of what he calls "forgiveness and oblivion" in a political context *(19)*. Although he believes we need to forsake revenge, he argues we need warnings for the future, and must remember the atrocities of the past. His view emerges from the commonly made connection between forgiveness and forgetting.[31] However, these two acts can be separated. Forgiveness is perfectly compatible with continuing to remember the wrongdoing.

There is an interesting connection between the idea that we should forgive the perpetrators of horrible crimes because of their common humanity with us, and the contrasting view that they are so utterly different from ordinary people, so evil, that they should not be forgiven. Arendt argues that the basis for forgiveness is respect rather than love: "Respect, at any rate, because it concerns only the person, is quite sufficient to prompt forgiving of what a person did, for the sake of the person" *(1)*.[32] Garrard also argues that forgiveness, even of the unforgivable, must be based on respect or our common human nature *(18)*. This idea of the respect owed to all members of the human community may seem to be undermined by acts of radical evil because the acts put the perpetrators outside the human community. However, if we take the

[31] Paul Ricoeur *(36)* refers suggestively to a "duty to forget" described as a "duty to go beyond anger and hatred" (p. 11). The duty to forget is important and not the same as an injunction to forgive. Nietzsche writes that one cannot forgive if one forgets, and that strong natures are likely to forget in this way (pp. 23–24).

[32] It should be noted that Kant *(37)* thought that being forgiving is a form of the duty of love (p. 578).

basis of respect to be common human freedom, particular acts, no matter how abhorrent, do not have this effect of placing evil people outside the community. Gitta Sereny found that Franz Stangl could come to feel the enormity of what he had done and could experience remorse *(20)*.

Nevertheless, respect provides only the preliminary basis for forgiveness, and does not mean that we must forgive. Garrard concedes that our common human nature provides a weak reason to forgive *(18)*.[33] However, it is not only weak, it simply is not enough. If respect were a sufficient reason to forgive, our decision to forgive should be universal: either we should forgive all wrongdoers or we should forgive none. The actual decision to forgive is more like an act of love, because it is and must be voluntary. Respect, then, is necessary, but not sufficient for forgiveness. Perpetrators differ in their actions, choices, and motivations, but share other features with everyone. The crime of treating some others as beyond the pale cannot be met with the same response as lesser acts.

However, if forgiveness is related to the acknowledgment of responsibility for one's acts and genuine regret and remorse, then forgiveness may only be possible in very rare cases. In Simon Wiesenthal's *The Sunflower (21)* he describes how a dying SS man, Karl, asked him for forgiveness for his participation in atrocities against Jewish people. Wiesenthal silently listens to the man's confession and then leaves the room. Later, after the war, he visits Karl's mother and does not tell her about Karl's murderous actions. Wiesenthal invited a range of theologians, philosophers, and psychologists to read his memoir and to ask themselves what they would have done in the same situation. The responses divide between recommending forgiveness and rejecting the idea, primarily depending on how they interpret the SS man's attitude. If commentators see his remorse as genuine, they are likely to suggest forgiveness as at least possible, but if they interpret his behavior as arrogant, denying Simon Wiesenthal's humanity and not fully recognizing the wrongs of his own actions, they dismiss the idea of forgiveness.[34] On the one hand, Karl is repentant, but on the other hand, he had called for "a Jew," any Jew, to be brought to his bedside to hear his confession and he says that the people he killed "died quickly, they did not suffer as I do" *(21)*. Even in this very rare circumstance of a direct request for forgiveness from a perpetrator,

[33] Potter *(32)* says that the "background condition" for forgiveness is that "it must be compatible with self-respect, respect for others as moral agents, and respect for the moral community" (p. 139).

[34] In Card's *(21)* discussion of Wiesenthal's dilemma, she accepts his non-forgiveness of Karl, but not his failure to tell Karl's mother about his actions (p. 185).

it seems unjust to expect forgiveness or to criticize Simon Wiesenthal for withholding it.

Forgiveness may be worthwhile for the victim because it shows they are coming to terms with the past. However, no one can dictate the terms under which someone should reach the point of forgiveness. Forgiving may be a good, but it is not one that can be forced on people, nor should we judge others for not being forgiving enough. We might say that they are being impractical or making things worse for themselves by not forgiving, but we should not condemn them by holding them to impossible ideals. That said, forgiveness is a valuable ethical action, as long as it does not entail condoning evil.[35] Lack of forgiving as a consistent trait is problematic, but not any particular instance. In the end, forgiveness is a leap even when it is related to repentance and apology. This would also be true even in the cases of mutual forgiveness that Trudy Govier *(22)* alerts us to because both parties would need to reflect on the possibilities and reasons for forgiveness.

For perpetrators, there is also the problem of forgiving oneself. Although it might be thought that perpetrators are far too ready to forgive themselves, the possibility that it could be harder than forgiving others must be conceded. Perhaps forgiving yourself involves generosity or proper self-respect. Unlike some other philosophers, for example, Narayan *(17)* and Robin S. Dillon *(23)*, Arendt does not believe that one can forgive oneself, because she sees forgiveness as based on the plurality of the human condition and on the experience that only others can have of us. However, I contend this claim puts too stringent conditions on the basis of forgiveness. Although we cannot see ourselves as others see us, we can experience our past actions as surprising, wrongful, and harmful to ourselves when we reflect on them. Asked whether we can forgive ourselves, Derrida gives a very interesting answer: "There is in me someone who is always ready to forgive and another who is absolutely merciless, and we are constantly fighting. Sometimes I can sleep, sometimes I cannot" *(12)*. The suggestion is that there is a barrier to self-forgiveness, not the barrier of lack of otherness that concerns Arendt, but the barrier of pluralism within the self that blocks complete self-forgiveness. Perpetrators of radical evil may be able to forgive themselves if they were able to both understand what they have done and to see a change in themselves.

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[35] *See* Boss' *(38)* argument that it is morally wrong for women to forgive perpetrators of domestic violence in the context of ongoing abuse. Hampton and Murphy *(33)* also argue that forgiveness can be a vice if it implies lack of self-respect (p. 17).

In many cases, forgiveness of radical evil may be too much too expect. Reconciliation may be easier than forgiveness because reconciliation is about pragmatically working together rather than requiring a change of heart and repentance from the perpetrator and a change in the victim's attitude. Derrida claims that "There is always a strategic or political calculation in the generous gesture of one who offers reconciliation or amnesty, and it is necessary always to integrate this calculation in our analyses" *(11)* . To describe an act as strategic and calculating sounds derogatory, but at times such strategy is preferable to an unbending unwillingness to compromise. He admits that "no one would decently dare to object to the imperative of reconciliation. It would be better to put an end to the crimes and discords" *(11)*. Refusal to apologize, properly express regret, and the denial of responsibility is what halts or slows the process of reconciliation. There may be something problematic about the notion of reconciliation being used in cases of radical evil because it implies fault on both sides, so atonement may be an even better concept. Atonement is the acknowledgment of guilt and attempt at reparation without expectation of forgiveness or reconciliation.

It is possible to forgive radical evil, but such forgiveness cannot be demanded or expected. Radical evil's lack of comprehensibility does not place it in a different category of evil or wrongdoing with respect to forgiveness although forgiveness in such a case is more complex and difficult. More important than the lack or inadequacy of motivation as an explanation for radical evil is the subsequent attitude of the perpetrator. Only their humanity, repentance, and finally, the victim's response can provide a basis for forgiveness. Derrida's view of forgiveness focuses on the logic of forgiveness, which nonetheless has ethical implications, whereas Arendt focuses on the politics, psychology, and ethics of forgiveness. In this shift of focus from logic to psychology and ethics there has to be a shift in our expectation of forgiveness. Derrida states that forgiveness is forgiveness of the unforgivable or radical evil, and as I argued, implies that we must forgive the unforgivable. Arendt puts the unforgivable or radical evil beyond the human and finds it truly unforgivable. In my judgment, although it is not ethical to demand or expect forgiveness from victims, it is a human response that may be worthwhile for both victim and perpetrator even in extreme cases. Forgiveness is asymmetrical in that although the perpetrator cannot expect forgiveness, the victim can have reasons for trying to forgive, both as part of their own process of healing and in attempting to see a connection between humanity and those who commit evil actions. In the end, the decision whether to forgive is one that only the victim can make. Conversely, the perpetrator can only attempt to atone or bring about the conditions for reconciliation or forgiveness.

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Chapter 15

Mad, Bad, and Evil

Psychiatry, Psychoanalysis, and Evil

Michael Levine

Background

Why has the term *evil* become so common in the theory and practice of disciplines in which the term—as a morally loaded religious notion—has no natural grounding? There are overlapping but also different reasons why the notion of evil—and not only the word evil, as if it could be divorced from its connotations—is used in psychiatry, psychoanalysis and other psychotherapies, and jurisprudence. In each case it points to a reflexive uneasiness and insecurity about the foundations of these disciplines, and nowhere more so than in psychiatry. More is at stake in using the term evil than may seem evident at first. The issue has little to do with merely proscribing usage. I argue for three interrelated claims: (a) It is not possible to naturalize the term evil, (b) the attempt to naturalize the term is undesirable, and (c) psychiatrists, psychoanalysts, and lawyers should avoid using the term evil.[1] These disciplines have commitments that are incompatible with the conceptual frameworks in which evil has interpretive or descriptive relevance. The view that these disciplines should be committed to eschewing the notion of evil in their professional discourses has been given short shrift in recent literature.

[1] My thanks to Psychoanalytic Studies (Carfax publishing) for permission to use material in Levine *(10)*.

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The prevalent view, which ignores etymological and methodological considerations, is that one uses the term naturalistically.

Introduction

Freud rarely used the term evil—and I will endeavor to show that this was for good reason.[2] The prevalent view is that one can use the term naturalistically, more or less as one wants to, with little consideration of why it might not be possible to naturalize evil (*see* Alford *[1]*, Grand *[2]*, and Reznek *[3]*).[3] Why is it that despite these claims for a naturalistic application of the term evil, many find it jarring and inappropriate when a judge, or even worse, a psychiatrist, describes an individual or act as evil? The reason is not difficult to uncover. Although the concept of evil is actively used in contemporary culture, it is not an idea relevant to the practice of psychiatry, psychology, psychoanalysis, or law.

More is at stake in using the term *evil* than may seem evident at first. The issue of usage is itself indicative of wider problems and concerns. Analogies can be drawn between Ronald Reagan's and George W. Bush's uses of evil in "evil empire" and the "axis of evil," respectively. There too, there is an offloading of responsibility in seeing evil as something wholly other—as metaphysical and religious rather than political in nature—and as demanding destruction.[4]

Let me hypothesise on how the usage of the term evil in psychiatry points to a deeper problem in the field. The reader can substitute psychoanalysis and jurisprudence (albeit not quite *mutatis mutandis*) and construct similar arguments. Psychiatry is now, as it has been for its entire history, a field in crisis.

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[2] In the general subject index to the 24-volume *Standard Edition* of Freud's works there is one reference to the problem of evil (S:E. 17: 62–3); one to Evil Eye (S:E. 17: 240; 243 n. 2); and one to Evil Spirit (S:E. 22: 166). I found no references to evil in the indices to the works of Melanie Klein, and there is no entry for evil in Rycroft *(11)*.

[3] Also *see* Altman and Tiemann *(12)* who try to integrate the religious and psychoanalytic perspectives. If the thesis of this paper is right then their task is hopeless.

[4] The attitudes of Reagan and Bush bear more than a superficial resemblance to what Melanie Klein *(13)* calls the "Paranoid-Schizoid Position." This is "a psychic configuration…in which the individual deals with his innate destructive impulses by (a) SPLITTING both his EGO and his Object-Representations into Good and Bad parts, and (b) projecting his destructive impulses onto the bad object by whom he feels persecuted. …The 'Depressive Position' describes the position reached…by the infant…when he realises that both his LOVE and Hate are directed towards the same object—the MOTHER." Charles Rycroft (11; pp. 111–112, 132).

Unsure of the nature of mental illness, and confused about what is cause and what is effect, it has for the most part reduced itself in practice to dispensers of an ever-increasing array of psychotropic drugs that alter behavior and feelings. Psychotherapy in any form, not only psychoanalysis, has an ever-decreasing role to play in treatment, especially among public patients. Some will dispute this claim, but psychiatrists mostly dispense—some would say push—drugs meant to alleviate symptoms, which they may claim are really causes of mental illness or other psychological problems, such as depression. Patients at public clinics will see their psychiatrists for prescription renewal every few months and nothing, or nearly nothing, else. This is a cause for concern. If that is the whole of psychiatric practice, then those who are mentally ill are not being treated adequately, unless one thinks medication is the sole treatment. Furthermore, psychiatrists should be questioned insofar as they claim to be doing something more than dispensing what they regard as appropriate drugs. It may be that psychiatrists at public institutions do not have time for psychotherapy. If that is so, it raises fundamental questions about health care and the state's duty and willingness to provide adequate care. These issues are crucial, but beyond the scope of this chapter except to offer a partial explanation of why psychiatrists have come to use concepts like evil.

The attempted justification for this move to drug "therapy" by psychiatrists relies, as we will see, on a scientistic and reductionistic view about the nature of mental illness. However, the turn to terminology and concepts such as evil that are irreducibly value-laden and religious suggests dissatisfaction with their own understanding and treatments, and the offloading or projection, for the usual defensive reasons, of such problems and concerns to the realm of the mysterious, transcendent, and religious.

Some contemporary psychiatry's view of mental illness is that it is largely organically based. It is a view that has filtered down from neuropsychiatry, pharmacology, and more generally from those with a biochemical and neurophysiological view of mental illness, and has become common among non-professionals. The common idea among those who read *Scientific American*, the *New York Review of Books,* or watch American Broadcating Company and British Broadcasting Company science shows, is that the various mental disorders are owing to, and so can be explained in terms of, chemical imbalances, neurophysiological damage, and so on, all of which require physical and chemical intervention. Furthermore, despite the fact that this view of mental illness has met with many objections from within and outside psychiatry, its appeal and fact that it remains widely held has not been diminished. It is after all, a view that is easily understood—if not overly simplistic. It puts the blame or responsibility for such illnesses not on agents or

those they are involved with, but on something physical and beyond their control. In effect, this view diminishes or obliterates blame.[5]

This is contrasted with a view rooted in folk psychology and psychoanalysis that sees mental disorders largely (but not exclusively) in terms of those mental categories of self-understanding involving conscious and unconscious beliefs, desires, wishful thinking, fear, envy, fantasy, and so on. This latter view of mental illness suggests that various kinds of psychotherapies are appropriate responses to most mental illnesses and problems, rather than psychotropic drugs and neurophysiological intervention. This view places the responsibility for such illnesses primarily with agents and not, for the most part, reducible to physical and chemical causes.

There may be some common ground between the two sides of this divide, but when it comes to the hard issues in terms of etiology, classification, and treatment of mental disorders, all rooted in quite different understandings of what mental illness is, the divide is enormous and important. The neurophysiological and biochemical view of mental illness is largely a mistaken and damaging one for rather simple reasons. These reasons have nothing to do with supporting some outmoded metaphysical dualism, though they do rely in various ways on aspects of subjectivism, the idea that there is something more to consciousness and personal experience than mental content that can be objectively reduced to (e.g., physical processes). Freud thought that one day a complete neurophysiological account of mental functioning and disorders might be possible. He also thought that such an account would be compatible and consonant with the truths he saw psychoanalysis as uncovering. In his early work, he believed in the principles for a scientific psychology, but later abandoned the idea because science was not sufficiently developed to make the project practicable.

The fact that symptoms and behavior can be altered, even permanently, through physical and chemical intervention does not entail that the causes or problems are themselves fundamentally physical or chemical in nature, even though in some cases there may be neurophysiological and chemical concomitants to mental illness. Are the various psychological states associated with mental illness causes or consequences? Biological and neuropsychiatric purists are reductionistic and argue that the states are always and only consequences, but this is far from clear and there is evidence that contradicts this view.[6] Pataki *(4)* cites claims from other psychiatrists and researchers who

[5] For a philosophical critique of this view of mental illness, *see* Pataki *(4)*.
[6] *See* Pataki (*4*; pp 59–60).

claim that "impressive data [indicates] that there is no such thing as depression that occurs solely from biological causes" and that "cognitive psychotherapy and a mixed psychodynamic interpersonal modality were equally effective as antidepressant drugs."

The neurophysiological view of mental illness is largely a mistaken and damaging one not only because it has one looking in the wrong place for causes of most mental illness, but also, as already noted, because through that misplacement there is a concomitant abrogation of responsibility and the need for the insight, understanding, and reflection that traditional psychoanalysis and therapy calls for. It removes or mitigates the pressure, responsibility, and guilt associated with parenting or even self-examination—but at what price?

Evil in Context

Because the problem of evil is inextricably embedded in particular world views, there can be no problem of evil apart from such contexts. In the philosophy of religion, the problem has to do with the compatibility of an omnipotent, omniscient, and omnipresent God with the existence of evil. Why would such a God allow any evil to exist, let alone the types and amount of evil that do exist? Can this problem be suitably translated into secular terms? When the psychiatrist, psychotherapist, or judge speaks about a problem of evil what they mean, or should mean, if they remove the notion of God from the discussion but retain the notion of evil, is very different. They are asking: "Why do people commit particularly horrendous immoral acts—acts that reflect a particularly aberrant, anti-social, psychopathic character and lack of conscience?" or "Why do some commit evil acts and others do not?" These questions are not to be taken in the larger philosophical or reflective sense of why any evil exists at all. Their professional focus should be on the cause and prevention of such actions—although often their assertion that an act or person is evil is a straightforward extra-clinical or judicial judgment. Their professional concern is not with moral condemnation but with issues such as the circumstances under which perpetrators of such acts can be held responsible and/or punished and treated. When is treatment appropriate and therapeutic, and what kind of treatment is best?

David Parkin *(5)* describes talk about evil as part of "the broad discourse on human destructiveness and suffering." Similarly, C. Fred Alford *(1)*, who gives a psychoanalytic account of evil, defines evil (one of his many definitions or descriptions) "as a discourse about the meaning of suffering, malevolence, and loss." The claim that talk about evil has no place in psychiatry or psychotherapy and should not be used by judges is based on two prior views.

First, that it is extra-psychiatric to talk about suffering and destructiveness in ways that presuppose or allude to extra-clinical discourse suffused with religious and quasi-religious meaning. Second, that such allusions cannot be avoided by fiat—by declaring the term evil naturalized. The same is true of law, moral philosophy, and psychoanalysis.

The traditional problem of evil has no bearing on these questions as secularly conceived. Of course, psychiatrists, jurists, psychoanalysts, and psychologists need not deny that actions and people are heinous, harmful, repugnant, immoral, and unjust. However, to discuss the actions of a person, or a person themselves, in terms of evil rather than psychoses, neuroses, the legality or morality of the action, or any other categories available that are not linked to the notion of evil, conveniently obfuscates and mystifies the professional tasks at hand. It is a giving up on, or renouncing of, those tasks. The psychiatrist, qua psychiatrist will identify the psychopath as a psychopath, but there is no point in further describing a psychopath as evil. Religiously speaking, evil is to be identified, (e.g., as sin) and redressed theologically (e.g., in terms of redemption and salvation). Secularly, however, crime, immoral acts, and mental illness must be identified and redressed by means ingredient to the relevant discipline considering them. The issue is not merely verbal because identification, treatment, or judgment hang in the balance. What needs to be shown is how and why this is so.

The etymology of the term evil is part of the substantial account of why the term is inseparable from religious contexts, those such as Alford *(1)*, Goldberg *(6)*, Reznek *(3)*, and Grand *(2)*, who explicitly or implicitly claim to naturalize the term pay no attention to the term's etymology. Grand *(2)* gives no account of the etymology of evil and no explanation of what she means by evil. How is it different from moral wrong doing? Is the difference etiological, substantive, or rooted in something else? Forgoing any discussion of the nature of evil, Grand says *(2)* her book "inquires into the memory of annihilation, and asks how that memory is lived, shared, and silenced in the relational nexus of evil…I am preoccupied with the way annihilation's memory is transmuted into the perpetration of evil." Although Grand *(2)* does not reduce the explanation of evil to a single type as Alford *(1)* and Goldberg *(6)* do, he writes, "I do not presume that all evil is rooted in a history of trauma survival," she goes on to say "I propose that this traumatic history finds a singular articulation in the interpersonal and intrapsychic operations of evil." She does not mean that this "singular articulation" is manifest in the same way across all who suffer from such trauma, nor presumably that the etiology of the "perpetration of evil" resulting from the trauma are identical. Grand recognizes that there are many different ways in which the immoral

and horrible actions a person later performs are rooted in earlier traumatic experiences (real or imagined).

Arguably, all attempts to naturalize the term evil, such as those cited previously, fail. Insofar as evil is being used in an extra or ultra-moral sense, it is used with religious or quasi-religious connotations. Grand *(2)*, for example, says "we know that as we draw closer to malevolence, its secrets will allude us. We can investigate evil and retain evil's raw edge: that which cannot be known, articulated, or forgiven." She goes on to quote Baudelaire: "It is the devil's cleverest guile to convince us that he does not exist." At the very least, and without acknowledgment, Grand is mixing ethics and theology with psychotherapy. At the worst, she has abandoned psychotherapy as naturalistically conceived.

Others, however, do pay attention to the etymology of the term evil and its implications. David Pocock *(7)* says:

> *According to the Oxford English Dictionary (OED), the word "evil" in the adjectival sense is little used in modern colloquial English, "such currency as it has being due to literary influence" and "in quite familiar speech" it is "commonly superceded by bad." The dictionary tells us that the substantive is "somewhat more frequent, but chiefly in the widest sense, the more specific senses being expressed by other words, as harm, injury, misfortune, disease, etc." In the positive sense of "morally depraved," "bad," "wicked," the usage is said to be obsolete as applied to persons.*

Pocock disagrees that the usage as applied to persons is obsolete, but Macfarlane *(8)* does not. Macfarlane *(8)* says: "The disappearance of evil as a concept is one of the most extraordinary features of modern society. That it is no longer generally possible to conceive of an abstract force of evil is clearly of great interest to historians and anthropologists."[7] Of course, Pocock's *(7)* claim that evil as applied to persons is not obsolete does not necessarily undermine the view that evil has unavoidable religious connotations. It is this latter claim that is central to this chapter rather than the view that it is obsolete. Reznek *(3)*, Alford *(1)*, and Goldberg *(6)* mistakenly believe nothing substantive is at stake in their application of evil to persons and their actions. However, given the etymology of evil the way they use the term not only begs important questions, it also undermines naturalistic understandings, approaches, and solutions to the problems associated with such actions and people.

What is described as evil is not susceptible to the kinds of scientific, socio-scientific and humanistic discourse that, by their natures, psychiatry,

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[7] *See* Macfarlane *(8),* for further discussion of the etymology of "evil," and Taylor *(14)* for the theological roots of the term *evil*.

psychoanalysis, and the law are, or should be, self-reflectively committed to in contemporary secular society. That is why evil is otiose and anachronistic when the actions and people to which the term is applied are conceptually configured in contemporary moral, legal, psychoanalytic, and psychiatric discourse. This is not to say that religion is incompatible with psychiatry, psychoanalysis, and the law, although there probably is an incompatibility between aspects of each. It is to say that certain categories are moribund and harmful in disciplines in which practitioners fail to see that they have no justifiable context. There are, for example, different ways of dealing with or punishing evil people than there are mere criminals.

Consider the relationship between mental illness and the human capacity for so-called evil. The idea is that some mental illness may lead to actions or character traits that are evil. Having its roots in a religious or magical worldview, "evil" has connotations that are neither scientific, legal, nor moral. Evil cannot represent a problem for a science because it is, by its nature, extrascientific. The debate about whether evil is intrinsic to humans does not take on scientific or non-religious philosophical coherence by reference to the possible origins of evil in abnormal brain function and damaging life experiences. On the contrary, the claim that immoral and destructive behavior is owing to abnormal brain function or damaging life experiences eliminates the need for an account in terms of evil. Evil is not what originates in abnormal brain function or damaging life experience, but in conflict with God, or a state of affairs, such as original sin, that is essentially religious. Religious perspectives on evil, on the nature and source of immorality generally, are qualitatively different than the kinds available to socio-scientific and secular accounts generally.

Is the Dispute Merely Verbal?

The idea of ridding psychiatric, psychoanalytic, and legal discourse of the term evil is not a trivial verbal point meant to be wholly prescriptive. Natural disasters are devastating, but one rarely hears them described, as the Lisbon earthquake of 1755 was, as evil. Calling them natural disasters reflects a change in how such disasters are regarded. In the context of a religious worldview, they were understood in a nexus of religious concepts. Causally, they are now understood in terms of laws of nature. Contrast this with Alford's *(1)* account of evil. Although it is fundamentally psychoanalytic, he directly links it to metaphysics and ontology. He says *(1)* that "evil is not a psychological category but a metaphysical one, about why men and women suffer so much. It is not a question that psychology alone can answer." However, the metaphysical question of why evil exists, as opposed to the question of how

to reduce instances of psychological suffering or prevent people from committing certain types of action, is not one that psychology can or should attempt to answer. What resources could psychology (psychoanalysis, psychiatry, or law), naturalistically conceived, have to address such a question? Alford's view is that moral evil is rooted in the experience of dread and anomie (meaninglessness and chaos). Doing evil is, in effect, a strategy for dealing with such experience.[8] Despite his nod towards metaphysics, there is little, if any, recourse to extra-psychoanalytic categories in Alford's account of evil.

Alford *(1)* says "A man with a method is like a baby with a hammer. Everything looks like a nail." He hopes to avoid methodological malfeasance, and yet his own reductionistic account of evil is generated by a lone idea. It is not his psychoanalytic account in terms of dread that is wholly mistaken.[9]

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[8] Alford (*1*: p. 53) says: "One's doom is one's death; dread is abstract doom—pain, abandonment, and loss, as well as their existential correlates, meaninglessness and nothingness. Dread is fear of a living death." Alford *(15)* inexplicably claims that my earlier article (ref. *10* was about his 1997 book *[1]*). Alford *(1)* is used as an example in that article, but that is all. The essay is about the larger issue of how the term is inappropriately used.

[9] *See* Alford (*1*; pp. 38–43 for his account of Thomas Ogden on the austistic-contiguous position; how it relates to Melanie Klein's account of the paranoid-schizoid and depressive positions, as well as to evil. Alford says, "the autistic-contiguous organization of experience, [is] the most fundamental and primitive mode of being. It is called austistic-contiguous because the state it represents is not of two skins or surfaces touching, but one that is two, two surfaces whose contact creates one reality, shared skin. …At its best, autistic-contiguous experience expresses a profound rhythmic contentment with the world. …[However] it may become transformed into dread in an instant, the experience of loss of self…anxiety experienced as a feeling of leaking or dissolving, disappearing or falling into shapeless unbounded space. …In the autistic-contiguous position there is no symbolization. Bodily experiences, impressions of shapes, forms, and rhythms take the place of symbols…*evil is a paranoid-schizoid attempt to evacuate the formless dread* [experienced in the autistic contiguous-position] *by giving it form via violent intrusion into another, the other's body giving presymbolic form to the dread that is evacuated there.* …Destroying the other, we destroy our dread (or so the fantasy goes), separating from it after having given it protosymbolic form in the body of another…paranoid-schizoid anxiety expresses and defends against autistic-contiguous dread...avoiding evil depends on the ability of symbolized dread. Symbolization is the realm of the depressive position." There is a connection here with Clifford Geertz's *(16)* account of religion as a way of dealing with and avoiding the one thing that human beings cannot cope with—anomie or chaos.

On the contrary, to one positively disposed to psychoanalytic theory it seems quite plausible that such an account, or some related account, might provide an explanation for some types of hideously immoral actions. However, the idea that all the actions and people that Alford describes as evil can be accounted for in terms of a response to dread is as counterintuitive as it is contrary to clinical practice. Actions that Alford describes as evil are accounted for in many different ways, just as, for example, racial prejudice has various sources rooted in ego defense (*see* Young-Bruehl *[9]*). It is not Alford's method *per se* that leads him astray, at least not where the method is conceived as he himself conceives it—a psychoanalytic approach informed by interviews, discussions, and questionnaires. Rather it is his procrustean approach to general data that leads him to an overwhelming reduction. More to the point of the thesis of this chapter, Alford's account of evil also leaves one in theoretical and practical limbo. Who do we see about this dread—the priest or the practitioner? As we will see, his reductionism is indicative of an unwanted connection between, on the one hand, his naturalistic account of evil as rooted in dread, and on the other, religious and metaphysical accounts that are also reductionistic. The attraction of reductive accounts is their simplicity and mysterious concreteness. Evil, for example, is neatly accounted for by disobedience to God or an evil force. It is ontological.

In allegedly using the term evil naturalistically, not only are unwanted meanings inadvertently retained, but distinctions that rely on non-naturalistic meanings can also be undermined. Entertaining problems associated with evil to which non-naturalistically conceived meaning is ingredient is made difficult. Secularly, it is moral evil (the evil that people do) rather than natural evil (such as earthquakes, diseases, and mental illness) that is problematic and for which naturalistic, but not wholly physical, explanations are sought. (Some psychiatrists do look for wholly neurobiological and chemical explanations.) Earthquakes and the like are the result of natural causes and have wholly scientific explanations. Any broader and more ultimate explanations are seen as supplementing rather supplanting these. In religious terms, however, the more basic problem, particularly in contemporary analytic philosophy of religion, is often regarded as natural rather than moral evil.[10] The free will defense

[10] Traditionally, as in Job and Dostoyevsky (*see* Ivan in *The Brother's Karamazov),* moral evil is regarded every bit the problem, indeed the same problem, as natural evil—namely, "Why does God allow it?" The alleged freewill defence is not seen an acceptable solution to the problem of moral evil as it is by contemporary Christian analytic philosophers of religion. Such philosophers thus misrepresent the traditional problem of evil in more ways than one.

to the argument from evil against the existence of God claims that people, rather than God, are responsible for evil. God allows people to freely perform evil acts because any restriction on free will would be a greater evil than permitting them to perform such acts. Granted then, that people rather than God are responsible for moral evil, and that it is good that people can commit evil though not that they actually do, the question that remains for the religious is how natural evil is to be accounted for. It seems that God is responsible for earthquakes and disease although he is not directly responsible for the immoral actions of free people. There are a host of strategies for dealing with this, including the view that natural evil is subsumable under moral evil in that it is the devil that is free and hence responsible for natural evils. Nevertheless, natural rather than moral evil is regarded as the fundamental problem for the believer. The claim then, is not only that it is not possible to stipulate a wholly naturalistic use of the term evil, but that the posing of certain questions about evil requires non-naturalistic meanings.

How Psychiatrists, Psychotherapists, and Judges Honor Evil

The idea that some immoral acts reflect more than moral failing—that they are evil—is often, and maybe always, an attempt to emphasize condemnation by recourse to metaphysical or religious categories. To label someone or something as evil is to condemn them in a special way, to split them off from ordinary moral categorization. For example, the Nazis were not merely brutally immoral, but evil; evil not because what they did was so bad but because what they did was so bad as to be categorically different or other than the merely immoral. Describing a person or action as evil is an attempt to deny that they are best understood, or can be understood at all, as immoral (as morally bad or mentally ill), drawing a qualitative distinction between immorality, or actions that result from illness on the one hand, and evil on the other. Evil is thus an honorific title or description. It is not only worse than immorality but different in the way that the sacred is different from the profane. Given evil's religious connotations, it is a kind of sacred and mysterious immorality.

The distinction between evil and the immoral only has purchase in the context of religious and metaphysical commitments that are implied in predicating evil. Can naturalistically conceived psychiatry, psychoanalysis, or legal theory and practice recognize such a qualitative distinction? The connotations involved in such recognition have implications for theory and practice that are antithetical to the fundamentals of psychiatry, psychoanalysis, and law. Those who regard religious/metaphysical suppositions as unacceptable and inherent in any alleged qualitative distinction between evil and immorality will reject

such a distinction. When these suppositions are denied, as they are by those claiming to use a naturalized notion of evil, the alleged qualitative distinction is reduced to an honorific quantitative one. It emphasizes the scope or special cruelty of the actions, and sometimes their uniqueness, though claims to uniqueness are also honorific.

The emphasis on an alleged qualitative distinction between evil and immorality is often made in connection with large-scale evil. Alford *(1)* says "Large-scale evil…is explained by the conjunction of human maliciousness with the failure of cultural containment, as well as the ability of society to draw upon and use people deficient in symbolic resources of their own but not so crazy as to be unable to use the culture's scapegoats as their own." Whether he is correct in claiming that the ability of individuals to do horrific things is to be explained in terms of the specific psychoanalytic account he gives (i.e., the inability to use symbolic resources to express the dread inherent in the autistic-contiguous position) is an interesting question. Psychoanalysis sees some kind of psychoanalytic account as necessary.[11] However, the uniqueness of large-scale evil is not a function of a mysterious qualitative distinction setting certain horrendous acts apart from others. It is the historical particularity along and the means and scope of the conjunctions and abilities Alford cites that guarantees uniqueness.

Evil and Reductionism

As already noted, Alford's account of evil is reductionistic. The view that horribly immoral actions are always rooted in the experience of dread rather than, at times and in complex ways, based in fear (i.e., a simpler type of fear than dread), psychoses, a myriad of psychological difficulties, and defensive strategies, is too simple. It discounts a range of social forces, personality characteristics, and physiological causes. For Alford, social and cultural forces play a role only insofar as they fail to provide symbolic resources that enable individuals to manifest harmlessly their experience of dread.

Although Alford's reductive account and others, such as those that explain evil wholly in physiological or chemical terms, are not directly linked to attempts to employ the term evil naturalistically, there are indirect connections. Consider briefly what Alford's account of evil suggests concerning his alleged naturalization of the term. Alford *(1)* disputes the standard interpretations of the much discussed Milgram experiments as a "story about being placed in a ter-

[11] *See* Moss *(17)* for a range of essays on forms of hate and their causes with varied explanations.

rible bind in which there is so much pressure to conform and obey that decent people do awful things." His view is that people perform evil because they want to and they like it. In the case of the Milgram experiment *(1)*, "they find themselves in a situation that absolves them of responsibility for their sadism." He says *(1)* "Evil is pleasure in hurting and a lack of remorse" and "In the precategorical experience of evil the intensity of the experience dissolves normal distinctions between subject and object, inner and outer. …Evil is what threatens to obliterate the self, overcoming its boundaries."[12]

Alford criticizes Zimbardo's interpretation of an experiment Zimbardo claims supports Milgram's results. Zimbardo says (Alford *[1]*)

> *Our results are…congruent with those of Miligram who most convincingly demonstrated the proposition that evil acts are not necessarily the deeds of evil men, but may be attributable to the operation of powerful social forces. …The inherently pathological characteristics of the…situation itself…were a sufficient condition to produce aberrant, anti-social behavior.*[13]

Alford interprets the experiment differently. He says *(1)* "The assumption that normal men might be evil is the hidden variable, the most straightforward and obvious explanation of all. …People like to hurt one another, obtaining great pleasure and satisfaction from doing so." However, neither Zimbardo's interpretation nor Milgram's experiment directly support Alford's suppositions. Why is the assumption that "normal men might be evil" (i.e., that they like hurting one another) any better supported by the experiment than

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[12] Alford says (*1*; p. 50) "Dissolution, corruption, and decay…have nothing to do with evil, except in the biblical sense of misfortunes that plague us all. This, though, may be what evil is really about, the fantasy that the misfortunes of old age and death can be inflicted on others to save ourselves." He says (p. 52) "Evil inflicts pain, abandonment, and helplessness on others, so that the evildoer will not have to experience them himself" (p. 66). "Evil is a way of talking about profound and puzzling experiences of existence, particularly those precategorical experiences of dread, badness, malevolence, and loss whose locus is unclear" (p. 71). "Evil is the special quality of badness called envy, the desire to destroy the innocence and goodness for its own sake, because the very existence of innocence and goodness outside the self is an intolerable insult to the grandiose but empty self" (*see* pp. 119–120).

[13] Alford says (*1*; p 29) "The statement is nonsensical. Zimbardo cannot mean that these conditions were sufficient by themselves. If so, then there were no human beings involved." Of course, Zimbardo does not mean these conditions were sufficient in themselves. He means that in the circumstances, with a group of more or less ordinary people, they were sufficient. After setting up a straw man, Alford acknowledges that this is what Zimbardo means.

Zimbardo's own conclusion that "The inherently pathological characteristics of the…situation itself…were a sufficient condition to produce aberrant, antisocial behavior?" It is only in the context of accepting Alford's account of evil that his assumption becomes more plausible, in which case the experiment is superfluous. At any rate, despite what Alford apparently thinks, the two conclusions are neither incompatible nor even clearly inconsonant.

Zimbardo's conclusion, if correct, may sometimes mitigate the moral or legal responsibility of people who commit immoral acts in such circumstances. However, this is also true of Alford's conclusion and thus cannot be used to differentiate the accounts.[14] Furthermore, Alford's explanation of evil as stemming from a failure to negotiate one's experience of dread through symbolization fails to support, in an obvious way, his further view that people are inherently evil or that they obtain "great pleasure" from hurting one another. In the present context, however, my concern is not with Alford's insightful account of evil, but with what the reductive aspect of that account reveals.

Alford's *(1)*, Goldberg's *(6)*, and Reznek's *(3)* tendency towards reductionism—evil as rooted in dread, shame, and character defect respectively—would be odd even if they acknowledged irreducible religious meaning in the term evil. In religious contexts, evil has various meanings and causes but in one way or another, it is related to God. An evil action, for example, is contrary to God's commandments. However, reduction is more peculiar, in which evil is allegedly divorced from religious connotation and can no longer be rooted, for example, in a turning away from God. How can one plausibly see all the different kinds of immorality, all the bad people do, as traceable to a single source? Nothing in the attempt to naturalize the term evil implies such a reductive understanding. On the contrary, the attempt at reduction is rooted in a metaphysical or religious way of regarding and explaining evil—univocally and simply. Looking for a single cause of evil is like looking for a single

[14] The extent to which Alford allows a role for "powerful social forces" as a contributing factor to people's immoral actions is unclear. In this discussion of Zimbardo he appears to reject it altogether—claiming it is a result of people being intrinsically evil and liking evil. But in explaining large-scale horrors like the holocaust he allows that culture and particular historical circumstances play a large role. Culture appears to play a vital role even in regard to small "evils" that people commit. People commit evil because the cultures in which they live do not provide them with the symbolic resources necessary for the harmless dissipation of impulses and experiences responsible for evil. Thus, on his own account, Alford is misleading in suggesting that social forces—forces that bound up with culture in various ways—play little role in relation to people's wrong harmful acts.

meaning of life. It is a sign that one is in the grip of a theory and reveals the extent to which theory can inform observation.

The fact that those claiming to use evil naturalistically also tend towards reductive accounts indicates that the allegedly naturalized is incomplete at best. The idea that evil is a singular type of force, caused by one or few types of causes, is a religiously grounded notion. (According to Aquinas, evil is not real but is lack or deprivation of Being.) It is an idea that is contrary to the various psychiatric, physiological, psychoanalytic, psychological, political, sociological, and common sense views that see the reasons and causes (the sources, kinds, and degrees) of immorality as complex and multifarious. Goldberg *(6)* and Alford *(1)* couple their reductive accounts of evil with reductive solutions: the overcoming of shame and non-harmful ways of expressing one's experience of dread respectively. In a sense, judges too couple their categorization of people as evil with reductive solutions. Evil people are beyond the pale. Any punishment the law can mete out is not only too good for them, in a way, it is also inappropriate. Their just desserts await them elsewhere.

Conclusion: What is at Stake?

To the extent usage allows, an individual can use a term as they see fit. One can attempt to naturalize the term evil. But if evil connotes bad or wicked in religious contexts, chances are it will be a religiously loaded term in secular contexts. The secular overlaps with the religious when it employs notions such as evil and it is not possible, and probably not desirable, to naturalize terms whose ordinary usage has other connotations and implications.

Despite Alford's alleged naturalistic use of the term evil, he says that, especially for youths, the vampire has taken over from Satan as a leading symbol of evil and he goes on to discuss vampire fantasies and impulses. Are vampires also to be understood naturalistically? The association of evil with vampires suggests that evil still has the kinds of other worldly connotations that those whose disciplines commit them to a naturalized world view, should reject. If the participants in Alford's discussions on evil use the term to refer to vampires or feelings described as indicative of the non-natural, then Alford's use of the term must be similarly constrained, not because he believes in the supernatural, but because those whom he is talking to do. Embedded in a web of non-naturalistic meaning, evil is used in ways that cannot be contravened by fiat. When journalists, lawyers, psychiatrists, and moral philosophers talk about evil readers, juries, and clients think "God, Satan, and vampires." Even those who are avowedly non-religious, are constrained by usage so that their allegedly innocuous use of evil will carry non-naturalistic meaning.

Psychiatrists and judges should avoid the term evil because using it results in extra-psychiatric and extra-judicial considerations playing a role in disciplines that committed to regarding such considerations as irrelevant. In their explanations or consideration of excuses, let alone in treatment and sentencing, psychiatry and law do not countenance supernatural factors, the devil, spiritual darkness, or the idea of another moral realm (*see* Macfarlane *[8]*). As Pocock *(7)* says, "the evil act itself is beyond the comprehension of human justice and invites unspecified, inhuman penalties" (e.g., "hanging is too good for them"). In psychiatry or psychoanalysis describing an act or person as evil may likewise imply a call for unspecified extra-judicial or clinical means of understanding and modes of treatment. However, the denial of such means, and the need for means, is essential to judicial and clinical practice. In accounting for the demise of the concept of evil, Macfarlane *(8)* says that "increasing security, arising from greater control over the natural world…frees men from terror and hence from evil."[15] Not only natural science, but also psychiatry, psychoanalysis, and a non-theocratic judicial system provide security and control because they are naturalistic disciplines. Employing a notion of evil in these disciplines is thus regressive. Furthermore, if my earlier hypothesis is right, it points to inadequacies and more severe problems with the theory and practice of the disciplines themselves.

Reznek's *(3)* and Goldberg's *(6)* attempts to employ evil naturalistically are as unsuccessful as Alford's. The title of Reznek's book *Evil or Ill?* is flash. However, he never notes that in his mass of quotations from judge's, philosophers, and psychiatrists remarking on points of law and particular cases, there is an almost total lack of the use of the term evil. Reznek uses the term as a matter of course, but the lawyers and psychiatrists he refers to rarely do.[16] This indicates where the burden of proof lies concerning the claim that evil can be used naturalistically. Reznek *(3)*, Alford *(1)*, Goldberg *(6)*, and Grand *(2)* must ask themselves why the term evil is not used as they say it can be used.

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[15] Macfarlane (*8*; p. 61) claims this view "lies behind Keith Thomas's two major works …" (Thomas *[18,19]*).

[16] Reznek (*3*; p 95) says, "Many conditions have allowed defendants to be excused on the basis of automatism—somnambulism, concussion, hypoglycaemia, dissociation, and epilepsy (Fenwick *[20]*). The Mental Test tells us that these are excuses—they make a person less blameworthy because they are features of his mental state showing he is not as evil as the person doing the same degree of harm intentionally." But does Fenwick describe the issue in terms of evil, or only Reznek? *See* Fenwick *(21)*. The Mental Test states (Reznek [*3*: p. 42]) "If the mental state of the defendant is critical in determining whether the defence succeeds, it is an excuse."

It is not part of a psychiatrist's, psychoanalyst's, or judge's duty to pronounce a person as evil, and outside of their professional competence to do so. Quasi-religious terminology should be set aside for secular terms, albeit not always scientific ones. It would be a mistake to see this chapter as an attempt to stipulate ordinary usage. It attempts to show what is at stake in conceptualizing problems in certain ways. Unlike those who do not have incompatible professional commitments, psychiatrists, psychoanalysts, and judges who may want to evaluate and condemn people on clinical and moral grounds should follow Freud and steer well clear of pronouncing a person or action as evil.

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Chapter 16

Talking About Evil, Even When It Is Not Supposed to Exist

C. Fred Alford

Background

Several years ago, as part of a study of what some Americans think about evil, I spoke with a number of imprisoned rapists and murderers, comparing their answers to questions about evil with those of free citizens. The biggest difference is that inmates are far less imaginative about evil. After completing this research, I took my project east to Korea and Japan, for half the world does not believe in evil, and I wondered why. Evil, I concluded, is a disorder of the human web, the delusion that we can get other humans to do our suffering for us. Evil is a disorder of human distance, the delusion that we can be shriven of unbearable feelings by finding someone else to hold them for a while. Evil, from this perspective, would be the perversion of what Winnicott calls holding. This is not the Eastern view, but it is how the Eastern refusal to see evil has influenced me. Evil is not what puts people outside the human web, but how the perverse cling to it.

Introduction

In the *Phaedrus,* Socrates begins by praising a calm, rational, orderly love. Halfway through the dialogue, he changes his mind, as though to say "What am I saying? I am sounding like a philosopher. It's the madness of love that makes love interesting." I am going to make a U-turn about a topic

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almost as interesting as love, evil. The difference is I am going to tell you in advance. First, I am going to tell you why I find evil a useful concept in helping us understand some of the terrible things that people do to each other. Then I am going to tell you why the Eastern half the world does not find evil a useful concept. I conclude that although I find the Western concept useful, it does not appear essential in making sense of the world.

It is important that those of us who live in the middle, so to speak—that is, those who stand back and study the concept of evil—remain reflective about the concept. It is only ironic when scholars, philosophers, and others who make it their profession to think deeply about these things decide that evil must or must not exist, can or cannot be used as an explanation. Evil loves to divide things into two; there is no reason our thinking about evil should follow this pattern.

Evil West: Satan and Vampire

Anyone who seeks to explain evil runs the risk of justification by means of explanation. To understand all is to forgive all, or so the saying goes. I do not know that this risk is any greater when the explanation of evil is psychological or psychoanalytical, but the risk takes on a special character, in which understanding the psychological sources of evil leads one to see evil as a pathology or disorder. If evil is a disorder, then it is the human disorder par excellence, one that has been with us for more than 3000 years.

Several years ago, as part of a study of what some Americans think about evil, I spoke with a number of imprisoned rapists and murderers, comparing their answers to questions about evil with those of free citizens. I will refer to this experience along the way. I spent a lot of time with the inmates, more than 150 hours during a period of about 15 months, and grew fond of many of them, sometimes finding myself eager to forget the terrible things they had done, and the suffering of their victims. Eventually, I came to think of evil as a force that transfixes its perpetrators and victims alike. That this force originates within and is part of our psychological makeup, makes less difference than one might suppose. This force is dread.

The Middle English word *dread* frequently translates the German *angst*. Both connote not only awe-filled terror, but also anticipation. “An apprehension of the future, a presentiment of something which is nothing,” is how Kierkegaard *(1)* describes it in *The Concept of Dread* (Angst). Dread is primordial, the terror of human limits, of living and dying in a single human body. Above all we dread being human. For Alfred North Whitehead, the two sources of evil are that “things fade” and that “alternatives exclude”—another way of saying that evil is what reveals to us the limits of being human *(2)*.

We dread what it is to be human not only because we will soon die, but also because the limits revealed to us by our choices make it so hard to find meaning in anything. In *The Symbolism of Evil*, Paul Ricoeur *(3)* writes of ethical dread, terror at the inability to love or care, and despair at the incapacity to invest the transitory world with value. He equates this experience with evil. *Kakía*, the New Testament term we translate as "evil," has a similar sense, as Elaine Pagels *(4)* argues in *The Gnostic Gospels.*

At this point, the thoughtful reader may be thinking to him or her self something like this. "Ok, I accept that dread has something to do with evil, but it's not the same as evil. Evil has to do with malevolence, with the infliction of suffering and pain and the lack of remorse."

The reader would be correct, but not simply correct. Today the Holocaust is the leading image of evil. It was not always so. For more than a century, the Lisbon earthquake of 1755 was the paradigm of evil. Tens of thousands perished, Voltaire wrote *Candide*, and the issues of God's justice and theodicy were debated as never before. Consider how differently people must have understood evil then: not as what humans do, but as what we suffer. The Old Testament's concept of evil is similar. *Ra*^{c} is anything bad, displeasing, or harmful to man (Isa. 45.7; Jer.4–6; Amos 3.6; Mic. 2.3; Eccles. 1.13; Job 2.10). "The ethical order of doing ill is not distinguished from the cosmo-biological order of faring ill," says Ricoeur *(3)*. Let us consider the possibility that this failure to distinguish between doing and suffering represents not only the immaturity, but also the insight, of the species.

I asked both inmates and free informants to tell me a story about evil. The most common story was the experience of going down into the basement as a child, feeling that something dark and dangerous was about. "I felt evil" is how several informants put it. "Do you mean that you felt that you were evil, or that you felt that evil was around you?" I asked *(5)*. None of the informants were able to make sense of the distinction. At the time of the experience they were operating, I believe, in the autistic-contiguous position, as Thomas Ogden *(6)* calls it. In this position, there is no inside and outside, no you and me. There is only feeling.Ogden calls it the autistic-contiguous position because the state it represents is not of two skins or surfaces touching, but one that is two, two surfaces whose contact creates one reality, shared skin. Imagine that sitting in your chair you feel neither the chair nor the pressure on your buttocks. Instead of the chair or buttocks one feels simply an "impression," a feeling with no inside, no outside, and no locus. That is autistic-contiguous experience *(6)*. Its paradigm is the mother–infant relationship, the infant unaware of where his surface ends and his mother's begins, aware only of a boundary that is not so much boundary as experience, an experience

of the other that is at once an experience of itself, an impression, a shape without a frame.

Autistic-contiguous experience is not just the realm of dread. It is also a realm of meaning and immediacy beyond, or beneath, words. It is the realm of the reality of bodily experience so immediate and so real that the distinction between bodily and symbolic experience is transcended, or perhaps undermined would be a better term. If we did not have autistic-contiguous experience to draw on for the rest of our lives, there would be something hollow and missing in life, a world of symbols whose connection to meaning would be obscure.

Although autistic-contiguous experience is not only the realm of dread, it may become transformed into dread in an instant, the experience of oneness becoming an experience of loss of self in the blink of an eye. Autistic-contiguous anxiety is experienced as a feeling of leaking or dissolving, disappearing or falling into shapeless unbounded space. It should be called formless dread, in which boundaries fail and things that should be separate flow into each other. For more than 3000 years evil has been understood as a form of pollution, dirt, or matter out of place. This is the primordial experience of evil, and autistic-contiguous experience is its source.

Writing in the tradition of Melanie Klein, Ogden argues that the autistic-contiguous position precedes the paranoid-schizoid and depressive positions, but not by much, and sequence is not really the point. The point is the way in which the three positions need each other, each one acting to temper the other two. It is the force field among them that counts. Psychopathology is the result of the collapse of the richness of experience generated by the three poles. Collapse toward the autistic-contiguous pole is marked by imprisonment in the tyranny of sensational experience, which must forever be indulged in order to escape the terror of formless dread. Collapse toward the paranoid-schizoid pole is marked by imprisonment in sequences of thoughts and feelings that simply happen, and cannot be analyzed or interpreted. Collapse toward the depressive pole is marked by isolation from the immediacy of lived experience, leaving one devoid of spontaneity and aliveness *(6)*.

Although Ogden uses the term "dialectical" to characterize the proper relationship among the three positions, it may be more helpful to conceptualize the relationship among the three positions in terms of a triangle whose form stems from the tension created by the three angles.

The dread that leads to evil takes place along the left side of the triangle, the side that connects autistic-contiguous with paranoid-schizoid experience. In fact, one might argue that dread transforms an equilateral triangle into an acute one, the left side becoming shorter as these two positions collapse into one. From this perspective, evil is a paranoid-schizoid attempt to evacuate formless dread by giving it form via the violent intrusion into another, the other's body giving presymbolic form to the dread that is projected into it. As one inmate who had committed murder said, "I just had to make somebody feel what I was feeling. I couldn't bear to be alone with the feeling any longer." Ogden refers to a patient who mimicked his every gesture, using Ogden's body to experiment with what it might feel like to be alive. Ogden was touched, as he should have been. It was a type of love, imitation the sincerest form of the autistic-contiguous position. However, Ogden should also have been worried, and so should we all. Here too is the ground of evil, using others' bodies to give shape to our own formless dread. Putting our dread into the other by terrorizing and victimizing him, we give form to our dread. It is as though the other were the frame for the picture of our dread, a picture that must be framed before we can paint it, and destroyed immediately afterward, lest it remind us of our dread.

Destroying the other, we destroy our dread (or so the fantasy goes), separating from it after having given it protosymbolic form in the body of another. The process applies not only to physical violence, but also to the cutting remark, the hurtful gesture, and perhaps even the purposeful neglect of the humanity of others, as though some must lose their humanity for others to possess it.

From a strictly theoretical perspective, it might be useful to ask whether the evil act stems from a position closer to the paranoid-schizoid angle of the triangle than the autistic-contiguous angle. Violence, whether physical or mental, that has the quality of evacuative attachment, in which one connects with the other in order forcibly to share an unbearable feeling so as to at once communicate and be rid of it, and would thus come closer to the paranoid-schizoid position. One informant, in recounting what she regarded as an act of evil, said, "I made him love me and then left him so that I would know that at least one person in the world knew the hurt I feel every day of life." I think she was right about hers being an evil act, though one would have to ask if she knew this at the time, and if she felt regret afterward.

Violence that seeks to create an edge or boundary, as though to say that one must suffer and die so that another can live, would come closer to the autistic-contiguous position: violence as a defense against the wished for merger. In general, however, the dread that motivates evil operates through both positions at once, and it is not terribly important to sort them out. The

principle is important, the way in which paranoid-schizoid anxiety expresses and defends against autistic-contiguous dread.

Dread is normal. Dread is what it is to be human. "Full humanness means full fear and trembling, at least some of the waking day," is how Ernest Becker *(7)* puts it. From this perspective, evil is cheating. Evil seeks to possess the vitality of existence without experiencing the dread that goes with it. Evil pretends that vitality need not have the same roots as dread, that one can know the joy of living without the dread of dying. Evil pretends that one can split the autistic-contiguous position, taking the vitality for oneself while leaving the dread for others, or rather inserting it there.

One might argue, much as Socrates does (*Meno* 77b-78b, *Protagoras*, 353d-58e), that the evildoer is evil out of ignorance, failing to understand that inflicting dread on others cannot bring him to life. If this is so, the ignorance will not be corrected by information, not even psychological theories about dread. It is a matter of teaching people how to symbolize their dread, so that they may contain it in more abstract and knowable forms than wounded bodies. It is an education that begins with mother and baby and ends with our culture's finest achievements, such as art, religion, and music. In between is the art of everyday living with our dread, the most important space of all. In the absence of symbolization, evil becomes lodged in the body, acted out rather than expressed in more abstract, less destructive forms.

I have not said much about the difference between the prison inmates (murderers and rapists) and free citizens as far as their experiences of evil are concerned. The biggest difference is that inmates are far less imaginative about evil. Many free citizens told elaborate and fanciful stories about evil. Not a single inmate did, and with many inmates I spent more than 100 hours. They would have if they could. Conversely, inmates were much more likely to say that thinking evil is almost as bad as doing it. For inmates, the idea is already the act, or should I say vice-versa. For some inmates, I had the impression that doing evil was a way of bringing the idea to life.

Consider the possibility that an imagination for evil is the alternative to doing it. Certainly, evil and creativity come awfully close together, which is why we admire characters like Faust or Milton's Satan. Like evil, creativity plays with limits, subverting, obliterating, restoring, and subverting them all over again. Creativity is evil that submits to the requirements of abstract form. Instead of expressing our doom in and through the bodies and minds of others, we express it in abstract media, in words not deeds, in images not actions. An implication is that Kleinians, such as Hanna Segal *(8)*, are mistaken to hold that art is an expression of the depressive position, an act of symbolic reparation. This is only half the story, as I argue elsewhere *(9)*.

Art is the submission of paranoid-schizoid destructive impulses to the requirements of abstract form. Shape, texture, and rhythm are the artistic forms of the autistic-contiguous position. Art is an act of paranoid-schizoid destruction that submits to reality: the reality of morality, consequences, love, and above all otherness. Art is not only an act of reparation, but also the struggle between destruction and reparation. Behind every work of art, including the art of creative living, lies the narrowest of victories over evil.

Evil and creativity come so close that it is important to grasp the crucial difference. Torture is a good place to start, particularly because torture is frequently couched in the language of drama, a work of art. The torture chamber is called the "production room" in the Philippines, the "cinema room" in South Vietnam, and the "blue lit stage" in Chile *(10)*.

In fact, torture is the reverse of drama. In drama, a transformed larger world is acted out on a small stage. In torture, the world is reduced to the body of the victim, the difference between creativity and evil in a nutshell. Torture understands creativity backwards. In a creative work, the body is projected into an artifact, where it can be transformed, enhanced, played with, even used ruthlessly because it is not really the human body, but a body of work. In creation, we animate the world, bringing the dead material world to life with the spirit of mind.

Torture is reverse animism. It reduces the world to the human body. Rather than non-body symbolizing body, body comes to symbolize a world reduced to its bare essentials, pain and power. "Symbolize" is a misleading term, however, suggesting a degree of abstraction not present. It is not that the body comes to symbolize the world; the body becomes the world, it is the world. In symbolism, we spare the body. "Symbol formation derives from the need of the child to protect his object, or parts of the object, from the effects of his attacks," says Janine Chasseguet-Smirgel *(11)*. In torture, we deny the world.

If creativity and imagination are alternatives to evil, then we should want to know whether our culture is providing these frames and forms. Culture is about the meaning of life. Or rather, it is about the meaning of life in the face of death, the doom that confronts us all. It is that simple, and that complicated. Culture is of no value when it mirrors the experiences that terrify us. When it does, culture is talking the language of the autistic-contiguous position, imitation without understanding or integration. The evening news is not culture, though it is the number one source of free informants' examples of evil; nor are most movies culture. A meaningful culture stands at a distance, connecting with our experiences but not mirroring them.

Much of what passes for popular culture today has more the quality of a mirror than a frame and form. We learn some things from mirrors, but we do

not learn to frame and form our dread—that takes a container with more depth. Vampires are a good example of shallow containers. Among younger informants, vampires are the leading icons of evil. For every informant under 30 who referred to Satan as symbol of evil, three referred to vampires. It is not necessarily progress. Satan wants your soul. More than that, Satan wants you to want to sell it to him for worldly power. The vampire only wants to suck your blood, melding with your life force for a little while. With the vampire, a whole inner world has disappeared in favor of primitive images of regression. (Interestingly, inmates are not the least bit interested in vampires.) Satan has more to teach about evil than vampires, although the regressive truth of the vampiric impulse must be taken seriously as a source of evil.

Evil East: Bombing the Fish

During my research, I became more aware that half the world, the Eastern half, doesn't believe in evil. Not only that, but most who live in China, Japan, and Korea find evil a dangerous concept, an instance of the Western tendency toward dualism, dividing the world in two, making compromise impossible *(12)*. Let me tell you a story that illustrates my experience. My experience was a semester spent in Korea talking with people about why they did not believe in evil. (If you think it is difficult getting people to talk about evil, try getting them to talk about something that is not supposed to exist!) The story comes from a Westerner living in Japan, but about the concept of evil there is not much difference between these two Eastern nations. It is not a story about blurred boundaries and dread. It is a story about how a group of children are inculcated into a world in which pleasure in hurting, what many in the West call evil, cannot exist. These children live in a different world than many in the West, but not necessarily a poorer one. I call the story "bombing the fish," and it is from Catherine Lewis *(13)*.

Several boys were gathered around a fish tank at a Japanese preschool. Each time one dropped a small clay pellet into the tank, they would cry out in unison "Bombs away!" The teacher told them this might harm the fish, but she did not stop them, and they continued to bomb the fish. Later she raised the issue in class discussion, asking "What does everyone think about this behavior?" Several students said it sounded like fun; most were worried about the fish. The teacher guided the discussion in such a way that the boys' bad motives never came up.

The boys might have mistaken the clay for food, or they might have not thought about what they were doing, but the possibility that the boys might have wanted to hurt the fish was never confronted. "Bombs away" was never mentioned. Interviewed at the end of the day, the teacher denied that she even

privately thought the boys meant to hurt the fish. They were deficient in empathy for other living things. Once it was explained to them that they might really hurt the fish, they would not want to do it again.

For one with an interest in psychoanalytical theory, the teacher seems misguided. If we ignore children's aggression, we only heighten their tendency to deny it while they continue to behave aggressively. We only increase children's inclination to split good and evil, fostering their tendency to attribute their own malevolence to others. Better to gently interpret the aggression, so the child might come to own that part of him- or herself, rather than alienating it in others. Such interpretation might also bring to light the unconscious identification with the victim that lies behind much aggression. No people have suffered more from the consequences of "bombs away!" than the Japanese.

The Japanese teacher, like virtually all the Koreans I interviewed, could not imagine (or at least could not say) that some people might get pleasure from hurting others. Not only that, but Japanese and Koreans frequently suggest that if we recognize the existence of truly malevolent motives, we actually make it more difficult for people to feel empathy and connection with others, because we create a world in which others are indeed like we secretly know ourselves to be: filled with malicious and destructive impulses. Better not to hold up that mirror in the first place.

One might respond that Japanese and Koreans create their web of empathy only by demonizing the other. It is a fine theory, but the practice of Koreans, at least, does not support it. Koreans are almost as reluctant to demonize others, even North Koreans. Doing so would open the door of the world to an intrusion of otherness so alien, dreadful, and inhuman that it must herald the end of the world, or so a number of Koreans said to me.

Perhaps there is no answer; perhaps the creation of evil with our concepts is as filled with tragedy as it is denial: the tragedy of creating "evil empires" that must be destroyed on the one hand, the tragedy of denying the human pleasure in destruction on the other. With such a dangerous concept, we should at least consider the possibility that its denial serves humanity better in the long run than its creation. This is what my research in the East taught me.

But is it really denial, the reader may ask? If an entire culture does not believe in the existence of evil, then how can it be denial? "Metaphysical incredulity" might come closer to the mark. For the culture that has no place for evil, evil does not exist. Perhaps. Certainly, I went to Korea expecting to find that in the absence of the concept of evil they would have more difficulty finding places to locate their dread. Lacking the projectively created container for their dread called evil, Koreans would be filled with a more diffuse

angst. Though these things are difficult to measure, Koreans did not seem filled with angst in comparison with those who had the concept of evil available to them. The reason, presumably, is that there are lots of things to do with one's dread, and lots of places to put it.

In the West, we often take comfort in locating evil in the alien other, such as President Reagan's designation of the Soviet Union as an "evil empire." For Koreans, alien others, repositories of our dread, are no comfort, for it is alien otherness that is the most dreadful thing. One can speculate endlessly about the sources of this difference. *Amae* is one way to account for the difference.

An intense relationship of mutual dependence, amae, or skinship as it is sometimes called, is fueled by the close physical contact between mother and child. Mothers and young children spend most hours of the day in close physical contact, sleeping together, bathing together, and nursing. In the Japanese view, the mother's job is to erase the gap between the infant and herself, drawing the child into a social relationship so rewarding it will encourage the child to seek out social relationships modeled on amae for the rest of his or her life. Amae rests on the satisfactions of the autistic-contiguous position, even as it supports mature relationships.

If this is so, then evil—the worst thing—would be otherness, whatever falls outside the fleshy web of skinship. Evil is that which cannot be named, because to name it is already to know it. We are back to evil as dread, the presentment of something that is nothing, our doom. In the West, we make this nothing into something: we give it a name, sometimes even a body (the Soviet Union, Satan, Hannibal Lecter). In so doing, we find a certain relief. In the East, to call something or someone evil is to place them beyond the fleshy human web, an act so terrifying that it can barely be contemplated. To imagine that the little boys wanted to hurt the fish would be to place them beyond this web.

Place of Evil

I often talk about evil to various groups, from the Rotary to religious organizations. A frequent and disappointing experience is to have lectured about evil for an hour or so, taken a few questions, and then be asked, "Now that you are an expert on evil, tell us, does it really exist?" The listener has missed the point, the main point I was trying to make: evil is not a thing; it is a concept that some people find useful in trying to make sense of the absurdity, horror, sadism, and pain they find in the world. Intellectuals, therapists, and others who are convinced that evil has no place in the modern world make a similar mistake, assuming that evil has essential quality that can be

expressed in a valid, theological definition, which is why therapists and judges should refrain from using the term.

Legislating how evil must be understood would prevent us from knowing not only the way in which the premoral experience of evil as dread infiltrates our wide-awake everyday world, but it would also prevent us from seeing and understanding the way in which half the planet constructs its world so that evil cannot exist. Why bother to ask this question if one has already legislated the term out of existence? I am quite content if some readers conclude that this premoral experience of evil so clouds the moral meaning as to render the concept of evil dangerous or inchoate, especially when used in psychiatry and law. What does not make sense is to argue that one should not think or study any further about the term evil.

I think that evil is a useful term, precisely because it captures a world that is not clearly divided in two, a world in which the sacred and secular meet and mingle almost every day, and certainly every night, of our lives. It is this that explains why it is so hard for most people to experience evil as a moral concept: whereas morality is about knowing right from wrong, evil expresses the dissolution of meaning, boundaries, and sense. In this way, evil challenges the very existence of moral categories. It is this phenomenon that I studied. I have used evil to try to make sense of the way people inflict their horror and dread on others. I find evil a useful concept because it evokes not only sadism, but also an absence of boundaries, helping to explain the pleasure in inflicting pain on others, the pleasure of evacuation and control. The pleasure stems from the re-establishment of boundaries with me on the inside, my pain on the outside, in you, at least for a moment. However, it is not essential that this be called evil, only that the process be recognized.

To many in the West, evil adds a richer understanding of this experience, I believe, because the concept of evil calls on a tradition in which badness is a boundary-violator, creeping up on us, appearing in places we least expect it, such as ourselves and our loved ones. I thought the East would be bereft in the absence of this experience. It turns out there are other ways to order the world, the denial of evil (if that is what it is) having the great advantage of placing no one, not even the most hostile and hateful parts of ourselves, outside the fleshy human web that holds us all.

As part of my prison research, I became involved in the prison's psychopathy identification program. Aimed at excluding psychopaths from the prison's psychological treatment program on the grounds that there they would only learn better how to feign normality (i.e., become more efficient psychopaths), the program involved training in the Psychopathy Check List, devised by Robert Hare, and other screens. Even after considerable training, I simply

could not see the psychopaths I interviewed, or whose interviews I watched on video, as unattached or unrelated. Crazily attached, bizarrely related, needing fusion and total control at the same time: that I could see. But not unrelated or unattached, not outside the human web. That we need such unattached beings in order to explain evil perhaps says more about us than the psychopath, more about the Western way of life than we know. That, at least, is something I have come to think more about since returning from the East.

Evil is a disorder of the human web, the delusion that we can force other humans to do our suffering for us. Evil is a disorder of human distance, the delusion that we can be shriven of unbearable feelings by finding someone else to hold them for a while. If D. W. Winnicott *(14)* is correct, then perhaps we can, but only when the partners are in tune. Evil, from this perspective, would be the perversion of what Winnicott calls holding. This is not the Eastern view, but it is how the Eastern refusal to see evil has influenced me. Evil is not what puts people outside the human web, but how they perversely cling to it.

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Chapter 17

The Influence of Evil on Forensic Clinical Practice

Tom Mason, Joel Richman, and Dave Mercer

Background

This chapter reports on research carried out in a high-security psychiatric establishment in the United Kingdom. Data were collected from primary nurses and care plan documentation on patients who were considered to be evil. The results indicate that nursing staff employ medical discourse in an attempt to understand index offenses up until they consider the patient's actions evil, and beyond help, then they employ lay language as a means to understand such behavior. The care plans reveal a lack of cohesive treatment strategies regarding this group of patients and suggest an absence of credible therapeutic approaches. A model of motivation is set out in which, depending on the nurses' interpretation of the patient's ability to manage the values underpinning right and wrong, their free will, and their subsequent choice of action, they can be located as Akratic, Brutish, or medical forms.

Introduction

For some, the notion of evil sits comfortably within ideological and illocutionary frameworks, whereas for others the idea is a disagreeable concept causing distaste and avoidance. Both, however, give credence to the idea of evil through their respective treatment of, and response to, the concept. In the former, there is an explicit acceptance of evil as an explanatory term to

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denote a clear distinction between behavior deemed to lie within the confines of understanding and behavior that is somehow beyond comprehension. In the latter, there is an implicit acceptance of the possibility or potential of evil, made real by its circumvention based on the fear of addressing its use. This is not dissimilar from those who claim a disbelief in a spirit world but who refrain from playing an Ouija board. What is important is the extent to which the concept of evil is capable of producing a set of emotions relating to the context in which the term is employed. It is the power of this production that establishes the root of all evil in the various perspectives in which it is utilized.

The diverse contexts in which evil is operated can include its employment by the tabloid press in the form of sensationalist headlines to mirror society's abhorrence of a heinous act. Additionally, judges are often quoted in the press as stating that a particular offender, or offense, brought before them is "evil." Theologians may employ the concept to depict the dark side, the opposite of good, to invoke the listener to guard against the forces of evil. Politicians are fond of using the term evil to denote the severity of the enemy in order to legitimate a particular governmental action. Philosophers debate the concept of evil as a state of human affairs and anthropologists may employ it as a parameter of cultural analysis. What all these contexts share is the use of evil in relation to the society in which it is set. Put another way, evil is used as a mode of production of a repertoire of emotional responses based in the social values of the particular culture in which it is grounded.

One area in which evil is located is the intersection between mental disorder and offending behavior, madness and crime, or what is now known as forensic psychiatry. In this fertile field, which first proclaimed itself a pathology of the monstrous *(1)*, there is a rich source of human potential for the extremes of aberrant behavior. At this juncture between psychiatry and the law lies the indecipherable monstrous act in which madness and badness become enmeshed as illness, and where this sickness transcends the boundaries of "beyond" to become evil. In this domain, the lay socialized codes of evil fuse with the professional ethics of illness to confuse and confound the ideologies on which each are based *(2)*. As forensic professionals attempt to deliver care from this latter ideological basis, the lay concepts of evil contaminate their paradigm, creating conflict and contradictions, as evidenced in the dilemmatic nature of forensic discursives *(3)*. In this tension-driven sphere of forensic professional practice, aspects of health care delivery, such as assessments, planning, and interventions, must be operationalized, and it is the impact that the concept of evil has on this delivery that this current research is focused.

Literature Review

Although the focus of this chapter is concerned with the relational influence that the concept of evil may have on care planning within forensic psychiatry, for the purposes of unraveling the theoretical background we will deal with the literature in two distinct sections.

On Evil

At its simplest level, bad is the binary opposition of good and binary oppositions are said to be an inherent aspect of human nature *(4)*. Binary oppositions such as right-wrong, sad-happy, up-down, and divine-secular are trajectories of human life that are formative of the parameters within which humans operate, or deemed ought to. Evil as a term, however, is commonly, but not exclusively, employed to denote a state beyond these human rules of engagement, popularly expressed in the term *beyond the pale*, and is used to express something or somewhere that lies outside of this demarcation of being human. We would like to address this metaphysical (or metapsychological) nature of evil in relation to human affairs along a number of trajectories that make the concept of evil relevant to our species alone in the animal kingdom. However, we would also like to point out that these trajectories are not clearly delineated—they do, in fact, intersect and overlap in certain areas.

Philosophical Trajectory

Philosophers throughout the centuries have been concerned with the structural ordering of evil in relation to its formation rather than its existence as an ontological entity. Augustine (354–430) believed that evil was created by man (generic) through the disordering of God's pre-arranged hierarchical structure of causality. For Augustine, in the correct state of human affairs the higher eschalons have power over the lower, with evil being the inversion of this order. Here we see two important elements to the notion of evil: (a) the disordering component and (b) the element of power. Other philosophers dwelling on the concept of evil also located its creation as a human endeavor. Boethius (480–524), a Roman philosopher under the Gothic King Theodoric, saw evil as a problem of human free will in creating an absence of good. Leibniz (1646–1716) felt that any created world must be a system in which there is a surplus of good over evil, the choice of the latter, again, being a question of human free will. From a philosophical point of view, this perspective is based on good and evil existing in the world and the choice of human free will is one over the other. However, another philosophical perspective to arise suggests that evil is rooted within human nature itself.

Perhaps the most influential philosopher to deal with this issue was Immanuel Kant (1724–1804), who discussed the notions of good and evil within the concept of morality. Kant grounded morality within human nature, suggesting that individuals have the capacity to be both good and evil, but not at the same time. Thus, again there is the notion of free choice of human action to adopt one over the other, and Kant regards the choice of evil for evil's sake as radical evil *(5)*. Locating evil as the false unification of human drives between binary oppositions such as subject-object, self-other, and spirit-matter, Schelling (1755–1854) believed that both good and evil exist within the combinatory force of these opposites. Finally, moving beyond, Nietzsche (1844–1900) inverted the concepts of good and evil to show that good could be weakness and the evil man's greatest opportunity and strength. Although locating both good and evil within the human, he also believed that humans needed a relational position to the social, to the Other. Thus, in philosophical terms, evil has trajectories that emanate from within the human, either as free will or in the absence of good.

Mythological Trajectory

Mythological literature is replete with references to evil, almost irrespective of the cultural or ethnic group from whose myths one is referring *(6)*. For example, in Piaroa mythology, ethical standards are governed according to good equating with clean, aesthetically pleasing, and showing restraint, whereas bad is evidenced by dirt, ugliness, and excess. Thus, a balance is observed between these forces. Evil, in Piaroa mythology, emanates from the immoderate heat of light of the life-giving sun; too hot or too cold, too bright or too dark, equate with monstrous, madness, and excess *(7)*. Depicted in the wild and dangerous figure of Kuemoi, a tyrannical madman, the myth equates the loss of mastery over one's desires as poisonous, and that which will be mocked. This is a controlling force on socialized behavior for the Piaroa because they know that signs of their own excess will, in turn, be mocked. In Japanese mythology, Amaterasu, the Sun Goddess, was used to shine light on the dark places in which evil spirits dwelled *(8)*. In Irish mythology, Dagda was the chief of a people who were constantly at war with Fomorii, a race of evil beings *(8)*. Finally, in Iranian mythology, only Mithra knew how to avert evil and keep the dark powers of Ahriman, the spirit of wickedness, at bay.

What is important in the mythological trajectory of evil for this chapter is the structural account by which myths influence human thought and behavior. It ought to be stated from the outset that structural analyses of mythologies have their critics; for example, Girard *(9)* claimed that structuralism was a clumsy framework with which to interpret myths because it lacked the sophis-

tication and sensitivity to interpret at the simplest level narrative accounts of, for example, the comic and the tragic. Needham *(10)* also criticized structuralism as "detached and abstract, and it is this detachment that leads to the neglect of concerns of any moral and metaphysical interest." However, moving beyond surface-level interpretations, Levi-Strauss *(11)* observed that the important point of structuralist accounts of myths is to show how they operate in the minds of men without their being aware of the fact. Levi-Strauss suggested that we understand "the total body of myth belonging to a given community as comparable to its speech" *(11,12)*. Thus, it is the unconscious laws of the myth that influence the behavior of men (this may well prove to be significant for the construction of care plans for forensic patients).

Anthropological Trajectory

The main, and simplest, difference between mythological and anthropological trajectories of evil concerns the former being deified creations, whereas the latter tend to be more secular-orientated. Although the former may influence human behavior through the unconscious laws mentioned earlier, in the latter anthropological trajectories of evil the influence on human action is more direct and perceived as more explicit. A good example of this is the work by David Rheubottom who studied Skopska Crna Gora, a rural area in Yugoslav Macedonia *(13)*. Although Crna Gorci evil (*los*) is rooted in religious ethics, it is manifested through the weak will of humans. In this trajectory certain tribes, clans, villages, and even neighbors may harbor hostile intent on the individual Crna Gorci family and it is the extent to which their enemies' hostility is allowed to attack the family that exemplifies the evil. Rheubottom shows that these trajectories of evil have a complex sphere of operations in which possessions, property, and persons can become the target of evil intent. It is not only a question of the power of the force of others' evil, but also the extent of their own weakness in resisting it that confuses the picture. Blame, guilt, and paranoia are common features of the interplay of these dark forces of evil. Thus, in anthropological terms, the trajectory of evil is grounded firmly in the everyday sphere of human operations influencing everyday living and governing social responses to neighbors and networks *(14)*.

Dramaturlurgical Trajectories

Eradicating evil from drama would make the enterprise a bland affair. Dramaturlurgical approaches to understanding evil have centerd on its root as the fundamental attack on the fabric of society. Witches, gypsies, Jews, and freemasons, to name but a few, have all been coined as evil, not so much for being what they are but for their undermining of society. Within the trajec-

tory, the forces of good and evil not only battle each other as distinct entities attempting to occupy the same ground, but also conjoin to become one. In this sense, drama deals a double hand, with the power over each other becoming one single entity in which good and evil cannot be distinguished. This can be seen in Shakespearian characters such as Hamlet, Brutus, Prospero, and Macbeth in which decisions regarding moral standards become blurred and in Milton's *Paradise Lost* in which good and evil are both separate and the same *(15)*. There is an abundance of evidence within Greek drama regarding this tension between forces of collision, with Aristotle openly accepting the existence of "mixed actions" that cannot be clearly classified either as good (*agatha*) or as bad (*kaka*). In drama, they are complicated by the intrusion of misunderstanding, ignorance, emotion, or external constraint *(16)*. Nonetheless, it is the fact that this conflict is played out as representations between *praxis* and *ethos* that go some way to explain the tragic action of evil *(17)*.

Theological Trajectories

In most theological frameworks, there are the eloquently expressed binary oppositions of God and the devil, and heaven and hell, both representing the distinction between right and wrong, good and evil. In Christian eschatology, it is the relationship between these binary oppositions that is the most interesting. When the belief system involves the notions of the devil and hell, they are the greater sanctions over behavior than their opposites *(15)*. More rituals are said to exist in religious systems to protect against evil than for any other reason *(18)*. It is the permanency of the threat of evil that gives it force and requires a constant guarding against it. In Christian mythology, Satan (adversary) loosely equates with the later emergent [d]evil as a wicked serpent *(8)*.

Criminological Trajectories

Very few, if any, academic texts on criminology mention, let alone deal with, the notion of evil. Yet, it is in the heinous criminal act that evil finds popular usage. It is when children, the elderly, or other vulnerable groups have been hurt that the label of evil is readily applied. Judges are fond of using the term when sentencing criminals who have undertaken particularly wicked acts and media headlines readily employ the word to evoke the strength of abhorrence from societal members. What seems to be important in these evil trajectories is the grounding of the motivational force for such a criminal act and its relationship to the extent of free will that is apparent within the criminal. Should the motivation be considered perverse, then evil is often evoked as its accompanying state, which indicates that sense of beyond; that is, entering the darker side of human nature.

On Care Planning

Again, little has been written on the systematic application of care planning in forensic psychiatry. However, it is certainly the case that in the event of serious incidents occurring and the response of subsequent inquiry reports, there is a greater focus on what is done with the mentally disordered offender. What we do know about forensic care planning is that there is a discrepancy between the assessed need and the level of service provision in terms of security systems in force *(19)*. Part of this difficulty is the fact that risk assessment in this branch of psychiatry is notoriously difficult to undertake with any workable degree of accuracy *(20)*. Achieving targets such as 50% accuracy remains a professional objective *(21)*. Merely knowing that, statistically, a group of patients who are compulsorily detained are safe to be released, but without knowing exactly which patients they are, is unhelpful.

A major component of a care plan will refer to the professional theory that is relevant for this specific target population known as forensic psychiatry. However, questions remain unanswered relating to whether a unique body of knowledge exists that is constitutive of forensic psychiatry specifically, or whether general psychiatric principles apply to this patient population. This raises a series of further questions relating to the medicalization of criminology, which have been covered elsewhere and we will not dwell on here *(22)*. Suffice to say that merely attempting to ignore the problem by reducing the debate to a sterile silence will not satisfy the demands of science. In terms of planning care for patients who are compulsorily detained and forced to receive treatment that they do not wish, it would seem a central ethical issue that the focus of that treatment is clearly delineated and understood.

Irrespective of the niceties of the care plan, the focus on risk assessment, dangerousness, and recidivism clearly indicate the major concerns of the public through professional accountability. This brings into stark relief a further question relating to the extent to which planned care ought to be concerned with offense-specific issues and if identified aspects of the care plan should show the relationship between it and offending behavior. For example, if an identified problem with the care plan referred to poor social skills, then it would seem relevant to be able to construct a logical pathway between increasing the patient's social skills and non-re-offending. It is clearly no longer acceptable to produce a menu of treatments that bear little resemblance either to the skills of the practitioners in applying the intervention or their availability in real terms. Certainly, the comments of one clinician sums up this unacceptable position: "the care plans are like the menus—full of stuff they never get" *(23)*.

Aims of the Study

The aims of the study fell broadly into two areas. The first was concerned with establishing whether forensic practitioners operating within a medicalized framework employed the concept of evil. This, in turn, meant identifying if and when, psychiatric concepts were abandoned in favor of lay notions of badness and what factors of offending behavior contributed to this altered cosmology. Second, if the first objective produced the evidence in support of this state of affairs, then a major concern would relate to its impact on the forensic therapeutic enterprise. This would involve its effect on planning mental health care delivery as well as on interactive frameworks on a day-to-day basis. Therefore, the second aim related to identifying if the motivational structure of evil in relation to the assessed patient and their offense, as perceived by the staff, influenced their approach to the therapeutic endeavor.

Method

The method was simplistic in its construction but more complex in both its operationalization and its analysis.

Setting

The study took place at a high-security psychiatric hospital in Merseyside, UK, which caters to patients detained compulsorily under mental health legislation for involuntary treatment on account of their being deemed to be "dangerous, violent or having criminal propensities" *(24)*. There are approximately 500 patients in the hospital, the majority having committed a criminal offense, with an average length of stay between 7 and 8 years *(25)*. The staff groups are comprised of a nursing staff, with recognized national training certificates in mental health nursing, unqualified nursing assistants, as well as psychiatrists, psychologists, social workers, and occupational therapists. There are no specialized security personnel, with this function being devolved to all staff, nurses bearing the brunt of most security procedures. Care delivery is set within a multidisciplinary team framework with each discipline geared specifically toward their own ideological or epistemological perspective. Ostensibly, the main ethic of the establishment is focused on treatment, but this is framed within a priority of protection of the pubic.

Data Collection

Data collection was undertaken in three phases. First, a series of semistructured interviews were conducted with those of the nursing staff who

constructed care plans for forensic patients. They were presented with a series of vignettes, which represented various offenses, including buggery, murder, and child torture *(3)*. The interviewees were asked for their comments regarding the rationale for the offenses and then asked to discuss a care plan on the basis of their explanatory framework. The comments were recorded on an audiotape and later transcribed for analysis. Second, data were collected from care plans held on the wards, and the identified problems and the clinical interventions were extrapolated. These care plans were representative of the cases within the vignettes. Third, a group of nurses who had constructed a care plan from which data had been collected were interviewed in relation to the rationale underpinning the identification of problems. These interviews were recorded on audiotape and later transcribed.

Data Analysis

The data from the first phase of the study took the form of thematic analysis following compilation of categories from statements within the narrative accounts. Terms were located that referred to psychiatric concepts, such as diagnostic labels and psychopathological explanatory frameworks, and were noted as they appeared in responding to the vignettes. A second set of terms were identified that referred to lay notions of evil including "bad," "rotten," and "sick" (this latter term usually denoting badness rather than ill health). These, again, were noted as they occurred within the text. Switch or linkage terms between the two cosmologies of psychiatric and evil were identified and these included phraseology referring to transcendence, such as "beyond," "too far," "incomprehensible." "inexplicable," and "beggaring belief."

The third phase data were analyzed through an ethnomethodological three-tier procedure, which is rooted in Schutz's common sense knowledge of social structures of everyday activities, practical circumstances, and practical reasoning *(26)*. In this first-tier approach, the professional (expert) members' sets of alternative explanations provide (a) the circumscription of their cultural knowledge; (b) methods of assembling, testing, and verifying the known "facts"; (c) methods of providing accounts of choices; and (d) methods for "assessing, producing, recognising, insuring, and enforcing consistency, coherence, effectiveness, efficiency, planfulness and other rational properties of individual and concerted actions" *(27)*. The notion of cultural member refers to the person who has mastered the natural language of that professional group. This means that they speak, hear, and witness a discourse that objectively produces and displays common sense knowledge of their everyday practices *(28)*.

The second tier involves analyzing the formal structures of the foregoing practical reasoning by attending to the formal accounts of evil (as rela-

Table 1
Patients Considered Evil

Care plan no.	Sex	Dianosis	Offenses	Length of stay
2	M	ppd/s/df	MS × 2/GBH	6 years
4	M	psd/df	MS × 1	17 years
6	M	ppd/s	AM/WI	4 years
8	M	ppd/df/as	M	7 years
22	M	ppd/mi	MS × 4	18 years
34	M	ppd	WI/A	14 years

ppd, psychopathic disorder; psd, personality disorder; s, schizoid disorder; df, dissocial features; as, antisocial; MS, manslaughter; GBH, grievous bodily harm; ABH, actual bodily harm; AM, attempted murder; WI, wounding with intent; M, murder; A, arson.

tional to the motivation). This entails suspending all judgments of adequacy, value, importance, necessity, practicality, success, or consequentiality of statements as practical accomplishments. This is referred to as ethnomethodological indifference; that is, indifference to value judgments. Given this procedure of indifference, we can view practical accomplishments of everyday activity (in relation to evil and care planning) in terms of: (a) their properties of uniformity, reproducibility, repetitiveness, standardardisation, typicality, and so on; (b) that these properties are manifest across the cultural knowledge group; (c) members recognize these properties independently of the cohort that are currently producing them; and (d) the recognition of their independence is a situated accomplishment *(27)*.

The final tier of analysis employed the identification of indexical expressions relating to indices of evil and pronomals of transition. By this, such conversion terms as mentioned above (i.e., "beyond," "too far," "beggaring belief," and so on) are understood to be native of the users of that natural language and are known by them. Although in philosophical terms, indexical expressions have elements to them that remain a nuisance *(29)*, they are, nonetheless, unavoidable *(27)*.

Results and Discussion

The results from the first-phase data have been published elsewhere *(30)* and it is the second and third phases of the research that we will focus on here. The care plan data (second phase) produced six cases that were similar to the vignettes, in that the primary care staff considered them as evil. Table 1 shows the six cases in relation to their gender, diagnosis, index offenses, and

Table 2
Care Plan 2[a]

Problems indentified	Suggested interventions
Poor attitude toward others	• Develop trusting relationship • Feedback on others' attitudes toward patient
Alcohol abuse	• Refer to Alcoholics Anonymous • Alcohol-related counseling
Reduced contact with mother	• Explore ways of increasing contact

[a] Care plan for patient with a diagnosis of psychopathic personality and a secondary diagnosis of schizoid personality with dissocial features.

length of time in a high-security psychiatric establishment. We note that all the cases were male and had some degree of psychopathic or personality disorder as a primary diagnosis. Homicide, actual or threatened, featured in all but one of the cases and the length of stay ranged from 4 to 18 years.

What is interesting to note is that the primary care staff considered these six cases as representing the epitome of evil and considered them beyond psychiatric help. Therefore, when exploring the actual care plan construction within the patient's file, we were able to establish the following formats.

Care plan 2 (Table 2) is of a male with a diagnosis of psychopathic disorder (despite the fact that it is not a clinical entity but a legal one) and a secondary diagnosis of schizoid personality with dissocial features. Schizoid features of personality include emotional coldness, limited capacity to express warmth, apparent indifference to praise or criticism, and almost invariable preference for solitary activities *(31)*. Dissocial features include callous unconcern for the feelings of others, gross and persistent attitude of irresponsibility, and disregard for social norms, rules or obligations, incapacity to maintain enduring relationships, incapacity to experience guilt, and marked proneness to blame others *(31)*.

Care plan 4 (Table 3) involved a male who was diagnosed with personality disorder with dissocial features, and who had committed manslaughter after sexually abusing a young boy. He showed a distinct lack of remorse, was considered cold and callous, and carried the label of evil. Care plan 6 was concerned with a male having a personality disordered with schizoid features, and was viewed by the primary care staff as a "psycho" who had little hope of ever being released (Table 4).

Table 3
Care Plan 4[a]

Problems identified	Suggested interventions
Institutionalization	• Encourage off-ward activities • Discuss life outside of hospital • Rehabilitation trips
Acts in unacceptable manner	• Discuss reasons for anger • Discuss consequences of inappropriate actions • Discuss more suitable ways of dealing with anger
Needs understanding of index offense	• Develop trusting relationship with staff • Develop awareness and feelings toward index offense • Offer support when necessary

[a] Care plan for patient with a diagnosis of personality disorder and a secondary diagnosis of dissocial features.

Table 4
Care Plan 6[a]

Problems identified	Suggested interventions
Low level of self-confidence	• Build a trusting relationship • Role play to explore feelings
Needs to build quality personal relationships	• Explore and discuss issues relating to relationship formation • Allow patient necessary time to explore feelings • Support and encourage self-awareness
Maintain patient's progress	• Discuss and review progress • Support as needed • One-on-one sessions with case manager

[a] Care plan for patient with a diagnosis of personality disorder and a secondary diagnosis of schizoid personality.

Care plan 8 involved a sex offender diagnosed with a psychopathic disorder with both dissocial and antisocial features (Table 5). He was considered an extremely dangerous individual, even within the confines of a high-security psychiatric hospital, and showed a callous disregard of others' feelings. He was a recidivistic sex offender and labeled by staff as "just plain evil."

Table 5
Care Plan 8[a]

Problems identified	Suggested interventions
Patient and staff unknown to each other	• Spend more time with patient • Understand individual needs
Sexual abuse	• See a psychologist • Supportive sessions by a primary nurse
Lack of environmental stimulus	• Set up a program • Promote quality of life • Attain more life skills
Has difficulties with anger	• Promote positive feedback • Address issues in counseling

[a] Care plan for patient with a diagnosis of psychopathic disorder with dissocial and antisocial features.

Table 6
Care Plan 22[a]

Problems identified	Suggested interventions
Epilepsy	• Educate and heighten awareness • Reinforce staff knowledge • Record all episodes
Needs ongoing rehabilitation	• Assess patient needs • Ensure all identified areas are dealt with • Organize rehabilitation trips
Risk of violence	• Maintain close observations • Provide support and reassurance.
Risk of self-harm	• Maintain observations • Provide support and understanding • Utilize diversional therapy

[a] Care plan for patient with a diagnosis of psychopathic disorder with a mental illness overlay.

Of the final two care plans to be considered here, plan 22 related to an individual with a personality disordered with a mental illness overlay and who had committed four manslaughters through excessive outbursts of violence (Tables 6 and 7). He was viewed by staff as a "bad" man who manipulated his epilepsy to acquire sympathy. Plan 34 related to a man with a psychopathic disorder who showed scant disregard for his fellow humans. He was said to enjoy the pain of others.

Table 7
Care Plan 34 [a]

Problems identified	Suggested interventions
Arson	• Needs to develop relationships with staff • Discuss whatever patients wishes to
Depression	• Regular reviews • Antidepressants • Reassure
Anxiety	• Discuss reasons for anxiety • Draw up a program
Stress management	• Liase with Art and Design workshop • Write down feelings when stressed
Aggression	• Keep up observation • Staff to adopt consistent approach • Explore and assess mental state

[a] Care plan for patient with a diagnosis of psychopathic disorder.

The six care plans represent a complex picture in which badness and madness are interwoven to highlight the difficulty in distinguishing when one has precedence over the other. There is a constant emergence of one descriptor through the fog only to disappear again for another to give form. A closer examination of the motivational forces of perceptions of evil was required to understand its influence on the care plan construction, and this formed the basis of the third phase of this research.

In this third phase of data collection, primary care staff were asked to account for the relationship between the constructs of the care plan and identification of the label evil that was attached to the particular patient. In the first level of analysis, we observed the tensions between the explanatory frameworks, which were often resolved by the rational construction and verification of the motivational structures of the perceived evil person. The following narrative illustrates this:

> *I: Can you explain why you have identified the problems that you have in this case and perhaps say something about what you will do about them?*
>
> *N: Well...I suppose…this guy has got a serious attitude problem. It's not one that is subject to psychological testing…it's sort of…bad news. He had a shit awful upbringing and most of the family couldn't care less about him…but…I suppose…he needs…help…well…he certainly needs* something.

I: Like what?

N: Something for his alcoholism. He hit the pop (alcohol) in a big way, probably depressed or something…he ought *to be, considering what he did. I mean, he knew what he was doing (motivation). He did it because he wanted to do it. All that crap about his upbringing being responsible…just doesn't wash. He was able to understand right and wrong and…he did it anyway. Bad bastard. He knew what he was doing, all right.*

I: And the care plan?

N: Well…we have to go through the motions don't we, you know, to protect ourselves (insurance) if we don't…well…they'll have you. There's not much you can do with this man, we can give him a bit of this and a bit of that, but in reality it's Old Father Time (rational plan) that will take the wind out of his sails. Meantime, we just go through the motions…it's all the same (reproducibility).

As an example, this account shows several features of the rational construction of perversity. First, there is the external vs internal motivational force that creates a tension for the staff in relation to perceived fault. If the focus is on an external drive that creates the motivation for evil action then that constitutes some degree of mitigation. Therefore, the switch to a rationalized account that is attributable to an inner zone of the person is undertaken, which then becomes identified as guilt. This blames the person for his action and allows for no intrusion of mitigating factors, which then sets the scene for any operation towards him that is legitimized by cultural sanction aimed at his total responsibility. In short, evil was perceived as within him, he is evil.

We were now concerned with examining the formal structures of evil and began to search for evidence that the practical management of this concept, as an accomplishment, was universal to the cultural formation that engaged in this behavior. This narrative manifests such an example:

I: So, would you agree or not that there is a discrepancy between your care plan (22) *and your account of the person?*

N: He's dangerous, he's deadly…irrespective of what you call him. Would you…I mean…really…can you see any chance for him whatsoever? We (culture) see this all the time (repetitiveness), we know (cultural knowledge) this inside out, they're all the same (standard). In fact they know each other better than we do, that's why they hate each other, they can see themselves in the other pervert's mirror.

I: What about treatment?

N: Treatment? Treatment is management. Keep them (typicality) under tabs (observation), away from the vulnerable, away from the weaker ones. He'll prey on them and rip them apart. A risky man. A bad *man.*

I: What about rehabilitation?

N: Rehabilitation: What about it? I mean…come on…you're not really serious are you?

I: Well, in the care plan…(interrupts)

N: In the care plan? No one takes the care plans seriously. They are there for the commissioners (official body) that's all. No one takes them seriously. Everyone knows they are meaningless, a front, that's all.

This narrative shows that, taken at face value, the comments regarding the everyday activity are in themselves practical accomplishments of fulfilling the task of managing the perverse person. That the care plan is, and is known to be, a level of falseness throughout the cultural sphere, is clearly seen. This fact transcends this cultural cohort that we were interviewing and is known throughout the system of forensic care. Throughout this narrative and many others, there is a recognized tier of meaning for those socialized in the cultural knowledge, which appears as common sense to them and yet, possibly, incomprehensible to others. If we bracket our own value system, or are indifferent to value judgemnts in ethnomethodological terms, we can see that such statements, as seen in the aforementioned narrative, indicate disbelief on their part that we cannot appreciate the "real" level of meaning. The subjects are almost incredulous that we appear unable to "see" what lies beyond the facade of the care plan. It is the account of evil, badness, that the participants are signposting, and it is the practical everyday accomplishment of managing that perversity within the framework of "forensic" that is their achievement. Through indifference, in fact, we can appreciate that their accomplishment of this management within what they perceive as a false therapeutic enterprise with the evil person is a greater achievement than either a management without this pretence or, indeed, a simple operation within the therapeutic enterprise alone. Their major accomplishment is the management of evil within the therapeutic pretence.

In the third-level analysis, the indexical expressions relating to the transition between psychiatric and evil cosmologies were explored to reveal both the conflict between explanatory perspectives and the abandonment of the former cosmology in favor of the latter. This highlights the influence that this transition has on the care planning. In the first-phase research, we noted the following theme:

I: Can you explain this?

N: If you look at it from just the medical point of view he attacked older women in some way for his mother not protecting him from his father. This fellow just didn't attack the women; he entered their territory to get them. He is not robbing the women and going in and out. But this is just an evil attack. Yes, definitely evil. If you are going to break into someone's home you rob them and you beat them up. To do what he did was evil. It's gone beyond that barrier. A lot of people don't believe in the concept of evil, but evil is evil. You cannot even justify him entering any of these homes. As if he hadn't done enough damage to her, he had the nerve to assault her afterwards…As if he hadn't done enough damage to her. There was no need for it. He's gone over that boundary. To me that is evil. No justification.

From this third-phase research, again, we observe the boundary violations in this short extract.

I: How do you account for the behaviour of this patient (care plan 8)?

N: Erm…he was sexually abused himself as a child. Therefore, I suppose…he has been made that way…well…some would say that…I suppose. He's had a bad upbringing. It could be environmental. He loses it (temper) sometimes…and when he does he shows another side to him. He's a manipulative sod (derogatory term) and couldn't give a shit for anyone. What he did was inexplicable…its not madness…he's just…well…we could, and have, tried to fathom it out but in the end, well, there's no explanation. He's just rotten. No good. No amount of treatment will have any effect on him. He's gone too far. *It was just bad for bad's sake. He never shows any remorse or sadness for what he did. In fact, come to think of it, he never shows any pleasure either. The only time he laughs about it is when he gets a bad reaction from staff. He gets his kick from it then. Yeah…bad for bad's sake. This man is evil, terminally evil.*

We can now formulate a general illustration outlining the perception of the evil person that has emerged from the narrative accounts surrounding offending behavior and the construction of care (Fig. 1).

In this scheme there is a logical flow of consideration that involves the person viewing the motivation for the action of the evil as lying outside of the individual, which mitigates, to some degree, responsibility. However, when the motivation lies within the doer of the evil, the perception changes to blame. From this, the perceiver of the evil person must consider the question of whether they knew the values by which they should have acted and consider the extent to which they knew that to transgress them was wrong. Put another way, the perceiver deals with the rational nature of the doer, not only in rela-

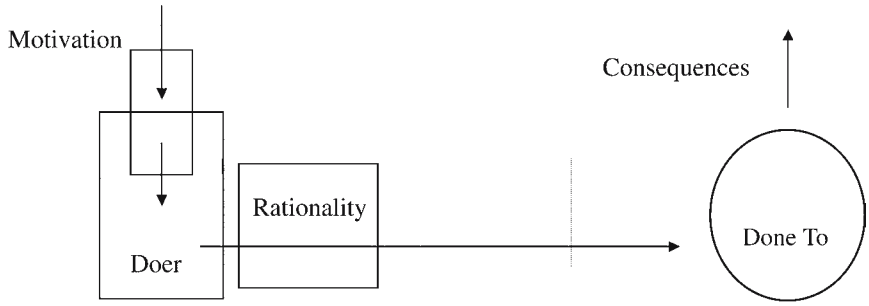

Fig. 1. Airaksinen model of perversity, which states that the perverse person does what he should not, simply because he should not do it. He or she needs to know values in order to transgress them.

tion to the external socialized normative prescription but also in relation to a perceived inner process of knowledge of right and wrong, and responsibility for their actions. There is then a focus on the person, or thing, done to which also involves a hierarchy of values. For example, when a rapist rapes there is a strong element of sympathy for the victim, and the act may be considered evil. However, should the rapist, in turn, be raped in prison, the level of sympathy is lessened. Finally, there is a focus by the staff on the extent to which they believe the evil person considered the consequences of their action. This basic structure is examined in more detail in Fig. 2.

Working from the *oeuvre* of Edgar Allan Poe, Airaksinen *(32)* outlines four main "sets" of motivation for perverse action, which we have displayed in the four individual doers described earlier (A, B, C, and D). The perception is again of an evil person; that is, the doer, and his or her relationship to the motivation for such action. In the first, A, the doer knows what he or she ought to do and, in fact, wishes to do it; however, he succumbs to the temptation to cause shock, pain, irritation, and does the opposite—bad. In this motivation set there is knowledge of the value of good but a stronger urge to do bad, thus it is seen as a weakness of will. In another sense, there is a power struggle between good and bad in which the latter wins, through the flaw of the doer. It is the doer's weakness, and thus his or her fault. This motivation set was a common finding in our study and was often referred to as "he knew what he was doing" and psychopathologized repeatedly as "seeking immediate gratification."

In the B motivation set the doer is negligent. One knows what the values of doing good are and knows that one should do them; however, he or she

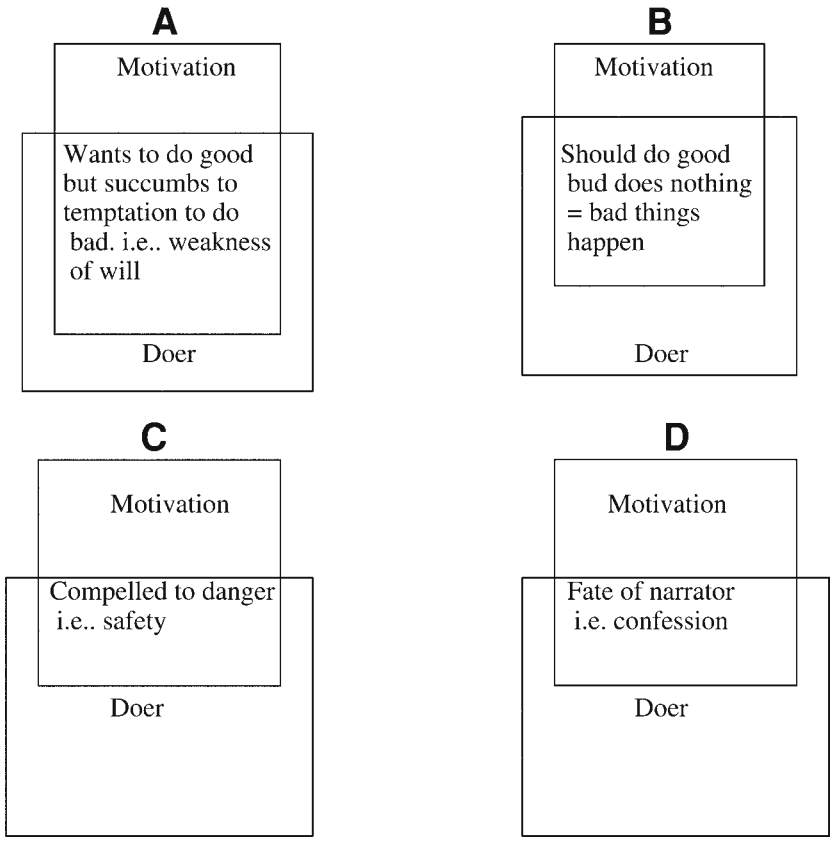

Fig. 2. Four motivational frameworks.

chooses to do nothing and, as a result, bad things happen. When this motivation set is perceived by the person, the doer is seen as cold and callous because they stood by while harm befell others. By doing nothing, the individual is viewed as evil through a portrayal of heartless inertia coupled with a perceived hidden pleasure in the occurrence of the bad things happening. We noted in the study that this motivational set was usually referred to as a form of abandonment of good values rather than an acceptance of bad ones. However, the level of evil was often expressed as particularly reprehensible because such abandonment was viewed as cold and calculating, with a view that the self of the doer received some benefit from such abandonment.

The C motivational set is concerned with the setting of a trap in order that bad things happen. In this framework, there is an anticipation of danger,

which is viewed as excitement by the perceiver, and the doer is considered to be gaining something from this. That "something" may be perceived as pleasure, excitement, sexual gratification, and so on, and is created by the anticipation of bad action caused by the doer initiating the possibility through doing something. Airaksinen *(32)* offers the removal of a safety barrier as a good example, in which the doer then awaits the calamity of the unsuspecting victim. In the forensic domain, arson fits neatly into this set as the fire-setter retires to a safe distance while causing others to be the target of danger.

The final perverse motivation set, D, concerns the doer as the focus of bad action. In this, one's bad deed results in harmful things happening to oneself, but with the intention of causing shock, pain, anguish, and so on to others. Airaksinen *(32)* provides us with the example of the confessor wishing to break the status quo of success and well-being confessing to murdering a rich relative after being condemned to death. The confession is an expression of hate to create anguish, "he confessed just because he wants to confess" *(32)*. The narrator, in effect, states "Yes, I did it, and I am glad that I did it." An extreme example of this form of perverse motivation is the suicide in which the doer enacts this final tragedy in order to cause the pain of loss and guilt for those left behind. Self-harm also falls within this perverse motivation set when the injury is intended to evoke emotional responses in another.

We can now address the question of rationality within the Airaksinen model and reformulate the perception of evil according to how a doer is perceived to reason the bad action. This reformulation entails the three constructs of akratic, brutish, and medical explanatory frameworks. In all three constructs, there is a perception of the balance between the extent to which there is a causal mechanism influencing the doer and the extent to which the motivation is a fully-fledged intentional action. This pivots on the notion of choice; that is, the extent to which the doer can operationalize his action based on knowledge of values and range of responses (Fig. 3).

In the akratic framework, which involves the weakness of will and the succumbing to stronger drives, we have already noted that the doer knows the values of right and wrong actions. However, knowing that he or she ought and even desiring to do good, yet choosing bad, demonstrates an ignorance of the value of values. The doer is perceived as evil because he or she shows a devaluation of good through the choice of bad. The does must therefore be ignorant of the true value of good. In the akratic frame, the corrective force may be viewed as educative if considered at all possible.

In the brutish framework, the doer of evil is considered to be inferior in a developmental or animalistic hierarchy. In this frame, the doer is said to be unaware that his or her motives lead to evil acts and may be viewed as morally

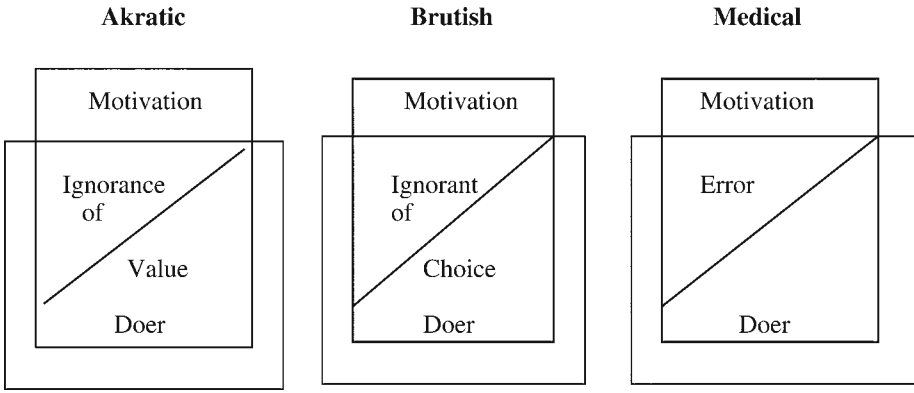

Fig. 3. Perceptions of rationality.

dull. In this sense, one does not have the capacity of choice and is unaware of higher eschalons of righteousness. He or she is considered an "animal," a brute. As Aristotle outlined a brutish person, "we call the lower animals neither temperate nor self-indulgent except by a metaphor, and only if some one race of animals exceeds another as a whole in wantonness, destructiveness, and omnivorous greed; these have no power of choice or calculation, but they are departures from the natural norm…" *(33)*.

Finally, we have the medical framework in which the doer of evil is considered such, or at the least, incapable in a rational sense, and cannot prevent oneself from undertaking bad action. The doer is considered to be suffering from an incapacity and therefore is not free to operate according to intentions or values of society. He or she is not viewed as responsible, yet is not totally blameless because the inability to control him- or herself is often perceived as the doer's fault. The important factor in this medical model is that it allows society to dispose of the "sick" person to an array of "mental" options according to the degree of perceived evil, and this is very much offense-related rather than referring to any notion of sickness in a pathological sense.

Despite our separation of the akratic, brutish, and medical frameworks, there is a degree of overlap of all three because the weakness of will (lack of control) is interwoven within the no-fault, but inability-to-control-oneself, medical framework. As Airaksinen *(32)* points out the response, of course, is very different because "an akratic needs education, whereas both a brute and a Freudian patient need a cure."

Having examined the constructs of our Airaksinen model (Fig. 1) from motivations (Fig. 2) and rationality (Fig. 3), we undertook a further level of

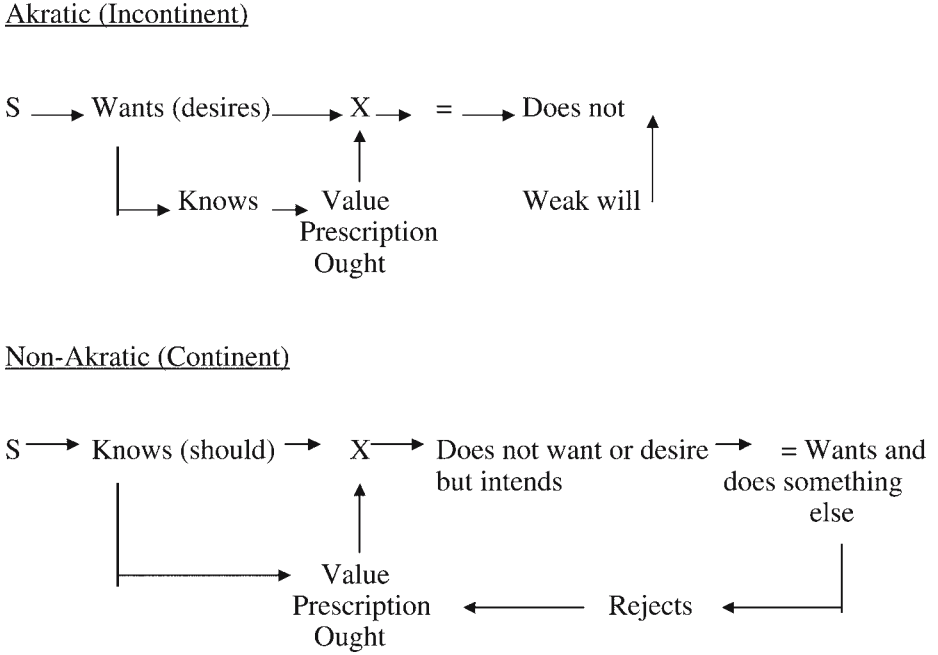

Fig. 4. Weakness of will and preference.

analysis of the data in relation to perverse action as preference, negligence, and weakness. We noted from the data that when staff considered the doer of evil as akratic, there was a distinction drawn between those who were perceived to be weak in the sense of being overcome by stronger drives and those who merely rejected the values attached to good action. In both, the doer of evil knows what ought to be done but, in the former, his or her resistance is overcome through a weakness of will, whereas, in the latter, any intention to do what ought to be done is rejected because of the stronger urge to do bad (Fig. 4).

Here the subject (S) wants and desires to do something (X) and the wish to do this is based on knowing the value of this action. The action (X) is prescribed as desirable and carries the duty of "ought" to do it. For example, to use Airaksinen's exemplar, a person promises to go home at noon, and wants to do this as the individual knows the value of keeping one's word. However, in the akratic (incontinent) adaptation the individual does not go home because of weakness of will and, instead, stays with friends. Note in this formula there is no intention to go home, merely that he or she wishes/

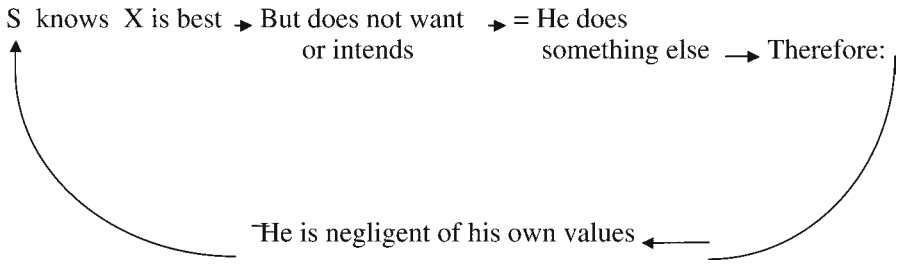

Fig. 5. Negligence.

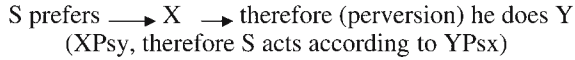

Fig. 6. Perversity and subversive motivation (this is an infinite regression).

desires to; therefore, the higher pleasure is not to go home despite the fact that one's wishes and desires are overridden. In the non-akratic (continent) adaptation the subject intends to do X even though he or she does not wish it. However, the subject rejects the value of doing X because he or she wants to do something else. Therefore, the individual is in control of his or her will and actively rejects the value of X. In short, the preference is not to do X.

The data revealed a more basic perception of an evil doer as outlined in Fig. 5. The doer (S) knows that a particular act is the correct one but does not wish or desire to do it. Moreover, the subject does not form the intention to do the good act and, in actuality, does a bad one. Therefore, the individual is negligent (or guilty) on two counts. First, because he or she does not form the intentions of a good act prescribed by society and, second, because he or she knows that X is the best option and by doing something else is negligent of his or her own values. We noted this frequently in the staff's perceptions of the evil doer who was considered "in their right mind," and "knowing what they did." The doer was viewed as knowing right from wrong and could rationalize action according to good and bad, and in the end chose to be evil. When this state of affairs existed, there was a perception that this constituted a cold and callous position, which was beyond the treatment sphere and considered "pure bad." This lay outside the sickness model (Fig. 6).

Borne out of akrasia and negligence, this final perverse construct was identified in the research data and refers to an extra dimension (Fig. 6). In the original Poe-perversity frame, a person does evil merely because he or she

should not. However, this does not explain the motivation that underscores this statement in relation to: (a) the pay-off for not doing good or (b) where one's preference actually resides. From the research, when the staff observed that a doer committed an evil act, not out of weakness (akrasia) nor negligence nor "sickness," but out of sheer pleasure of being evil, they pointed towards another level of interpretation. This involved not so much an enjoyment of an evil act, but pleasure of the harm that it causes and, again, not so much in terms of the direct harm to the target of the evil act but harm to others. We were led into thinking here that the doer undertook evil to cause harm to other members of society in terms of creating shock and horror, a sort of attack against the social body rather than the individual. However, this was only part of the picture, because this too did not explain either motivation or preference.

The Airaksinen answer is that the harm in this scenario is directed at the self. One does evil because the individual wishes to harm him- or herself. However, this harmful intention cannot be a stronger, better value because this would lead to the doer doing what is considered the better good and, therefore, would not be evil. Through the doer identifying what he ought to do and then choosing to do something else, he or she makes this alternative action of greater value (to oneself). Therefore, as a perverse person, he or she should not do this something else and should do something else instead. However, this in turn becomes higher value and as a perverse person he should not do this...and so on. This is an infinite regression. Clearly, the model of evil requires another aspect to ground this perversion and to provide the motivation and the preference factors. This additional dynamic is something akin to pleasure. At the center of evil, or as Airaksinen prefers, core-perversity, there is a performance of self-harm in which obedience to the habit provides the pleasure of transgression.

During the present study's research, when this pleasure principle was perceived, this factor appeared as the root of evil in that staff abandoned medical discourse and turned to lay badness as beyond help. The fact that no reference, in the present study's data, to the principle of self-harm was noted in any level of analysis required further thought and exploration. However, as a final comment, we have observed in the high-security hospital in which this study was undertaken, a relatively high number of persons perceived as evil but also a relatively high number of self-injurious behaviors, although the two groups are not viewed in similar terms.

Conclusions

From previous studies we have conducted in a forensic clinical setting we were aware that the notion of evil operated within the perceptions of offending

behavior *(30)* and that, to some degree, there was an impact on the planning of care *(3)*. However, we were less sure as to the precise nature of this impact or how clinical staff constructed evil in relation to perceptions of the doer of evil action. The present study attempted to unravel this complexity and to provide a schema of perversity in relation to offending behavior and the construction of care. During sociological inquiry, we are often asked to provide some answers to the question, "So what?" and, in conclusion, we would like to offer a few suggestions as to why we should undertake this project and to identify the impact on practice.

The impetus for the project is that in forensic practice we are sometimes swamped by therapeutic optimism at a superficial level that is difficult to manage in everyday practice in high-security psychiatric services. Not that this therapeutic enterprise is not signed up to, but that its critical appraisal, production of alternative perspectives, and grounded realism tends to be in short supply, or viewed as heresy. The importance of the project is to raise the awareness of socialized values on professional practice and to indicate the limitations of forensic psychiatry in the face of lay conceptual frameworks relating to evil, badness, and perversity. The impact on practice, we hope, is to provide a springboard for others to incorporate this analysis in constructing approaches to care delivery. For example, as clinicians we have often heard a patient referred to as evil without any understanding of the construction, or constituent parts, of this concept. Once we are aware of the impact of evil on constructing care, we can begin to address the issues within the overall model. Through this, patients considered evil, bad, and beyond, may receive a different approach to care delivery by those who otherwise may have given up on assisting them. This surely must be better than ignoring the problem or dismissing it out of fear.

Acknowledgments

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Chapter 18

Hope in the Face of Evil

Geri Miller and Ron Hood

Background

This chapter focuses on how counselors can maintain hope in the face of evil. Beginning with a brief philosophical discussion of evil, the chapter presents a framework for understanding the concept as it presents itself in client's stories of human suffering, and focuses on approaches counselors can use to maintain hope for both themselves and their clients.

Introduction to Evil

"What is evil?"

"How do we recognize it?"

"Is it normal for the human condition?"

These are the types of questions that arise when a discussion of evil begins. Waller *(1)* states that although every human culture has a word for evil, there is no acceptable definition. Although the September 11 events resulted in the use of the word in daily conversations, academics have tended to avoid defining evil because there is no neutrality with the word; the definition of evil reflects the perception of the individual defining it. Waller *(1)* references Susan Sontag as saying, "'We have a sense of evil,' but we no longer have 'the religious or philosophical language to talk intelligently about evil'." Although it is important that we understand evil in others and within ourselves, ordinary language does not explain it well: evil is intimate and indescribable—people who have

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been tortured know it exists, but have difficulty finding words to express it *(2)*. For example, the following folk tale articulates the dynamics of evil yet still does not providing a precise definition for it:

> *A Native American elder once described his own inner struggles in this manner: "Inside of me there are two dogs. One of the dogs is mean and evil. The other dog is good. The mean dog fights the good dog all the time." When asked which dog wins, he reflected for a moment and replied, "The one I feed the most."* (Native American folk tale)

Within these constraints, then, we, as authors, provide a definition of evil that is inherently based on our perceptions. To echo the words of Faiver, Ingersoll, O'Brien, and McNally *(3)*, we find it necessary to address the concept of evil in part because our clients use the term in sessions. Additionally, we have personally and/or professionally experienced evil in our own lives and those of our clients. Therefore, it is impossible not to discuss evil and how it operates. Therefore, we must begin with a definition of evil in order to elucidate our non-neutral perspective on evil to the reader.

Definitions of the Term Evil

What draws us to use the term *evil*? Why do we even find it necessary to use it? Historically, evil was sometimes used to describe what we now know to be mental health problems. For example, psychosis was seen as possession by the devil. What happened to shift our language from the use of the word evil to describe these problems to the use of the term *mental illness*? Was it that our knowledge base grew and from this more informed knowledge base we developed a framework for labeling and treating the dynamics of the process we once called evil? If this is true, then perhaps this shift in ideologies is what we are currently living within when we use the term *evil*. We may use the term to describe a process or dynamics that are unknown, mysterious, frightening, awful, incomprehensible, overwhelming, and powerful—just as we used the term when describing mental illness in the past. The use of the term may flow out of our ignorance, limited experience, cultural and social prejudice, and our inability to understand the components and dynamics of whatever "it" is that we have labeled evil. Evil perhaps does not exist in any inherent, fixed modality, mental state, or specific atrocity, but continues to exist in a social, cultural, value-laden context. Evil may arise from the magical hope of resolving insurmountable difficulties from an individual or group perspective.

Perhaps, then, the use of the word evil is important and necessary for us in the process of understanding a phenomenon by providing us with a "box"

that contains the dynamic we experience and are unable to explain, thereby making it more manageable. This may be a necessary developmental stage in the journey of understanding an unknown individual difference or social, religious, and cultural differences. With this possible caveat of the use of the word evil, we will now explore definitions used to explain this concept.

Waller *(1)* defines evil as that which involves humans deliberately hurting another human. This perspective means that evil is not judged by intention, motivation, or accidental/unintended harm. It is simply evil because another human being is hurt. Faiver et al. *(4)* state: "Evil is reserved for actions and intentions that inflict needless pain and suffering on others." The video, *Faith & Doubt at Ground Zero*, defines evil as when we lose the sense of a human being as a human being. "Evil is a certain lack, limitation, or distortion of good" *(7)*. Zimbardo *(8)* discusses a "creative evil" in describing the 9/11 attack on America: intelligence was used in well-organized violence toward others. Miller *(9)* labels the 9/11 attacks on America as evil and defines evil as pain and suffering caused by someone who feels pleasure or no remorse for having taken such action. The definition of evil used in this chapter is a compilation of these definitions: evil is behavior that causes suffering in others whether it is intended, motivated, or accidental, and the perpetrator of the evil action has lost the sense of humanness in oneself and others. This reflects the perspective, then, that all humans have the capacity for evil action and does not attempt to label the person, but rather label the act, as evil.

Framework for Evil

Rosenbaum *(4)* suggests careful use of the word is required so it is not devalued and further indicates that evil has hierarchies and degrees. Hierarchies and degrees provide a framework to separate natural evils from human-made evils, within which there are distinctions for the person committing the act. These distinctions are: (a) one believes one is doing something good in committing the evil act or (b) one is knowingly committing an evil act. In Rosenbaum's view *(4)*, degrees of evil are distinguished by two variables—the consciousness of the person and the scale of the evil act.

Russell *(5)* provides three categories of evil that may assist us in the discussion of evil. These categories are metaphysical (the presence of evil means a lack of perfection in creation), natural (suffering occurs as a result of nature), and moral (one knowingly inflicts suffering on others). Counselors may address evil with regard to all three categories, but more often than not, a counselor must address the suffering caused by moral evil. Therefore, we see evil as evidenced in natural disasters; however, our main counseling focus explores the presence of moral evil in our clients' lives. For an excellent,

succinct summary of Western psychology's examination of evil *see* Faiver et al.'s *(3)* review of the works of James, Freud, Jung, Goldberg, Fromm, Lifton, Menninger, and Peck.

Counselors should examine whether or not they believe in any of these three categories of evil and the possible impact of countertransference issues of these beliefs in the counseling process. For example, counselor and client may differ in terms of the interpretation of an experience as evil or they may agree that evil is present in the client's situation. Whatever the level of agreement or disagreement on the perception, the counselor needs to be aware of possible countertransference and foster a therapeutic alliance while working with the countertransference and appropriately addressing the welfare of the client.

Miller *(6)* describes countertransference as biases that emerge from professional experiences related to education, training, or supervision. They also emerge from personal experiences or a combination of professional and personal experiences. For example, they can be related to the counselor's and/or client's different religious backgrounds or personal reactions to existential life themes. Additionally, these biases about evil may impact assessment and treatment, cause avoidance of the topic, and/or lead to inappropriate disclosure or intervention. Miller *(6)* discusses countertransference and its possible ramifications within a spiritual context, which can be applied to these same concerns when working with the concept of evil in the counseling setting.

If a counselor does not believe that evil exists, the counselor may not experience fear in addressing its presence. Being attentive to countertransference, the counselor will simply need to work with what might be the client's fearful reactions to evil. If the counselor does believe that evil is impacting the client's life, then the counselor may need to work through his/her countertransference and fears regarding evil in addition to working with the client's reactions.

Counselors open to the concept of the presence of evil may need to develop a "sense" for evil. That way, if it emerges through the suffering of the client, the counselor will not miss it. This sense development can be done by educating oneself about evil (reading, attending workshops/trainings/classes), being mentored by counselors who have worked with evil, developing a framework that helps sort out evil from other possible influences, and knowing ourselves and our own personal experiences with evil.

Response to Evil

In responding to evil, Adams *(10)* states that we can try to prevent it, stop it, make good on it, balance it, or defeat it. Faiver et al. *(3)* report that

evil is a "rebellion against truth (that which is real)," therefore, one fights it by being committed to truth, facing oneself, and being educated about it. One "fights the good fight." These various authors provide specific guidelines counselors in responding to evil. First, acknowledge its presence, name it, and make a commitment to truth that includes thoughts and actions by the counselor. Second, develop support networks, a sense of community for oneself and one's client that encourages love and strength. They state that the presence of love and strength is critical in addressing evil because evil encourages isolation and weakness. Zimbardo *(8)* stresses that counselors explore evil through situations that give birth to and maintain evil while holding on to our value of human life. These dual tasks allow the counselor to stay connected with the force of goodness in an attempt to "oppose evil with tolerance, compassion, justice, and love." Finally, the third guideline is to use hope, virtue (which is based in a sense of power), a sacred space, polarity (a stance of fighting), self-confrontation, a practice of compassion and love, and meaning that allows suffering to be transcended. Miller *(9)* suggests that counselors recognize the presence of evil in their clients and their lives in order to hold the clients (and/or others in their lives) accountable for an evil action and help the client experiencing its presence in his or her life develop coping responses to such evil.

Hope is a core concept in responding to evil. Yahne and Miller *(11)* state that counselors do not necessarily give clients hope, but can help them find it. They state that hope is a central part of the healing process of suffering and is an important part of treatment effectiveness. Two descriptions of hope they provide are *hope as a way* and *hope as an action*. As a *way*, hope is placed in something outside of oneself, a connection with a higher power resulting in a source of transcendent, spiritual hope. They also describe hope as an *action*, in which one shows integrity in life by choosing actions against the evil rather than in spite of its presence. Finally, they use the word *esperar*, the Spanish verb for hope that also means "to wait" to say that the process of hope is sometimes waiting with our clients; we can provide hope in hopeless situations by simply being willing to stay with clients on the journey.

There are specific approaches the counselor can take in response to evil that stem from the core source of hope. These approaches may focus on hope as a way, as an action, or learning to wait with hope in the presence of evil.

Approaches in Response to Evil

Hope has never trickled down. It has always sprung up. That's what Jessie de La Cruz meant when she said, "I feel there's gonna be a change, but we're the Ones gonna do it, not the government. With us there's a saying, '*La*

esperanza muere última. Hope dies last.' You can't lose hope, you lose everything." *(12).*

In training as counselors, O'Halloran and Linton *(13)* state that the focus is on caring for others and not on our own needs. Yet as Miller *(14)* states, counselors are continually exposed to the dysfunctional behavior of others. We see and hear hard stories, re-experience them with clients as witnesses of their pain. Although this is a generally taxing aspect of the work, it is especially difficult when hearing stories that embody the essence of evil. In these instances, our sense of a just world can be very disturbed and force us to face the existential questions of life and its meaning, the goodness of human beings, and the cause of incomprehensible behavior.

Counselors must maintain a sense of hope that can be passed on to our clients in their suffering. Hope is critical for the therapeutic alliance. We are telling clients that we believe in them, that we believe we can be helpful to them. Hope is a gift from one human being to another who is currently struggling with suffering in his/her life. Hope allows the client to feel connected with another and be more open to the possibilities of change and improvement. Hope evolves from realistic and thoughtful planning regarding change in a collaborative effort between the counselor and client. Fostering hope also requires attention to present activities with realistic hope directed toward the future.

For hope to be passed from counselor to client, the counselor must possess a capacity for happiness and self-care. Myers *(15)* describes two factors—relationships and religious faith—that seem to contribute to happiness: relationships in the sense of meaningful relationships that provide social support, and religious faith that may be related to social support, meaning and life purpose, and hope in facing existential questions related to death and suffering. Miller *(16)* integrates these two factors by recommending that counselors create social supports for themselves that are real, genuine, and spontaneous, looking for natural healers and good matches in their lives as well as finding ways to keep their spirit "alive." This process of self-care by counselors can result in our clients "catching" happiness from us and increasing their sense of hope.

Miller *(9)* describes this interactive process of happiness, self-care, and hope as an American Red Cross Disaster Mental Health counselor in New York City in response to the 9/11 disaster. She worked on two Red Cross assignments: one 2-week assignment over Thanksgiving and another 2-week assignment over Christmas.

Miller *(9)* described the need for, and nurturance of, hope in herself in order to work as a counselor. First, she reported maintaining hope by holding tight to the value of human life that was reinforced by almost every survivor

saying to her, "But, Geri, I am alive," after telling his/her story. Second, she maintained hope by watching the resilience and goodness of other volunteers as they tried to make the world a safer place, viewing the pyramid of support in each volunteer's life that allowed them to be at the disaster site. Third, she maintained hope by working on a team of mental health professionals. Here, she stated that no one person was designated as strong or weak all of the time, but an assessment was done as to who was strong enough in a moment to handle the situation that was presented. She provided the metaphor of responding to evil like passing a baton in a relay: one goes as far as one can and then passes it on to another. Finally, she maintained hope in the face of evil by practicing self-care that included exercising, responding to bodily needs, playing, using humor, living in the present moment, making friends with strangers, taking breaks, talking with loved ones, and following a spiritual practice. This sense of hope described by Miller *(9)* emerges from the components of supportive relationships (a team of professionals) and spiritual faith (a value for life and a view of humans as good) in the context of self-care actions. Self-care is the epicenter of hope.

When discussing self-care actions in response to evil some specific components must be examined. Initially, consider one's counseling philosophy. Miller *(14)* discusses two slogans from American self-help programs: "Progress, not perfection" and "Be responsible for the effort, not the outcome." These maxims may assist the counselor in examining his or her counseling perspective.

"Progress, not perfection" urges the counselor toward self-improvement. Yet, this personal and professional self-improvement must be accomplished realistically, avoiding discouragement by one's human fallibility. In other words, although the counselor tries to improve, he or she also practices self-forgiveness when the improvement is less than desired.

The second slogan, "Be responsible for the effort, not the outcome" helps the counselor also stay in balance. The counselor, although focusing on the welfare of the client, needs to assess where and how a realistic impact can be made with the client and let go of what cannot be impacted. In the first author's work as a 9/11 Disaster Mental Health counselor, a new mental health team counselor asked her at the end of her first 12-hour day, "How do you know if you are making a difference here?" The first author responded in the face of the overwhelming number of clients and their needs, "We don't. But that's not our job. Our job is to do the best we can—to make the best effort possible." Both of these maxims can guide self-care and feed the source of hope and happiness that counselors pass on to their clients. However, when addressing evil, these concepts become especially important to the health of our clients

and/or their lives. The counselor must have realistic goals for client improvements or change, knowing that the work is only one effort against a larger evil, not the solution!

In specific application to self-care, Miller *(14)* outlines the importance of working with the mind, body, and spirit. Regarding to *mind self-care*, people usually drop leisure and creative activities during stressful times *(17)*. Ironically, these are the very activities that help us relax at the moments when they are most needed. The message, then, is to work hard to maintain these activities in spite of a tendency to say, "I don't have the time, energy, and/or money to do them."

Csikszentmihalyi *(18)* talks about the concept of *flow*, an activity that he describes as involving "skills, concentration, and perseverance." These are the activities where one "loses oneself" in enjoyable activities that involve novelty and accomplishment. These can happen in professional and personal lives. For example, the counseling process may provide a way to lose track of time because the art and healing of the work with clients becomes redemptive. Personally, a counselor may find gardening or running offers a way to forget about worries, problems, or time constraints. Counselors must discover and maintain activities in their lives that are healing to the mind—activities that provide a sense of leisure, creativity, and flow. Such activities can create a break from the "horribleness" of the evil they hear or see.

Counselors also need to practice *body self-care*. As Miller *(14)* discusses, the body does not lie. Counselors who listen and respond to their bodies can use it as a gage to guide their self-care. Another American self-help group acronym is HALT (Hungry, Angry, Lonely, Tired). This acronym offers a quick "check-in" with the body for the counselor to determine what personal needs should be met to bring the self into balance. This self-care check can be done during actual counseling work. For example, the counselor may be hearing a client tell a horrible, torturous story of evil. While listening, the counselor can self-examine with the HALT checklist to determine if some personal intervention needs to be done during the counseling session (e.g., drinking some water) or following the session (e.g., "As soon as this session ends, I need to go outside and take a walk").

Each counselor needs to learn how and where he/she puts stress and struggle into the body and how to respond effectively to that stress. It may be helpful for the counselor to visualize the stories of evil as poisons, not that the client is a poison, but that there is a poison in the story that is being absorbed by the counselor through the empathic, therapeutic alliance. The counselor can look at the body as a sponge absorbing these toxins through the process of listening.

The counselor must find ways to "detox" or "wring out" the poisons in the sponge,developing a knowledge of how and where such toxins are stored in the body to know one's own personal "continuum of poison absorption" to determine how to effectively process them out of one's system. If the counselor can distinguish low to high levels of "toxicity," he or she can then discern how much and what type of self-care to practice. Physical activities that encourage this detoxing will be idiosyncratic for each counselor. Some counselors may regularly have a massage or work out in a gym. Whatever the activity, the counselor needs to know the level of "toxicity" being experienced in order to determine how urgent it is to address it and how intense the self-care response must be. For example, a counselor may have been considering taking a vacation in a couple months, but realizes, after listening to his/her body stress, that the vacation needs to be as soon as possible, creating a "mini-vacation."

Psychological and emotional needs also fit into the mind/body arena *(14)*. As stated earlier with flow, activities for oneself that are enjoyable, human ("being where we are"), and self-focused can provide a great relief for the counselor. The human component means that the counselor is allowed to be a person and experience whatever is being felt without judgment or expectations from self or others.

The last component, *spirit*, is an important part of self-care. As Richards and Bergin state: "people can understand and regulate their lives through spiritual means" *(19)*. Here, as Miller *(14)* states, look at what keeps our spirits alive, keeps us believing in a just world, and gives us hope and enjoyment. This may be a philosophy of living or certain people, activities, or rituals that keep us believing in our goodness and in the goodness of others, as the Native American story earlier in this chapter so aptly outlined.

It is necessary for the counselor to determine what these sources of self-care are and then make sure to practice them. Illusions of "If only I had more time, money, or energy" need to be wrestled. Focus on how such components can be included in life by setting off a chain reaction *(14)*. This means that you use whatever time, energy, and money available to practice self-care. This could simply mean wearing some comfortable clothes, carrying a meaningful, reassuring token, holding a necessary meeting in a more comfortable place. But whatever the self-care practice, finding a way to give oneself some "room," a chance to relax, to feel encouraged, energized, and hopeful. As one mental health counselor stated with regard to self-care during the response to 9/11, "We all had our rituals." Each counselor found some way, some routine that was reassuring and practiced that routine. It might be as simple as drinking a diet soda each night and watching television or it could be attending a religious service.

It may also be helpful to the counselor to practice self-care through the senses *(14)*. Here one uses reassuring smells, sounds, tastes, touch, and sights, and incorporates them in daily work in the context of evil. For example, the first author, in initially working with severe trauma survivors, began to collect art books of impressionist works to look at after an intense session of trauma work with a client. These visual images calmed her and reassured her about the presence of justice and goodness in the world.

Self-care is especially important when confronting evil. To restore and maintain hope in oneself that can then be passed on to clients, the counselor may need a repertoire of self-care options as well as a flexibility in trying different options to stay in balance physically, mentally, and spiritually. The counselor also needs to remember that some stories are simply harder to hear and re-experience with clients because of a similarity in one's own experiences with evil, one's own human vulnerabilities (it may be harder to work with evil at some points in our lives than others), or the awfulness of the stories. Counselors need to respect their own limitations—their own humanness in facing evil with clients—and understand that a "quick fix" or even a "foreseeable fix" to such awfulness may not exist. Rather, they may need to do what Yahne and Miller *(11)* suggested for such situations, wait for a sense of hope to return.

For example, one of the authors had a counseling session in which the evil in the story almost seemed palpable in the room. Later in the day, this seasoned counselor vomited without cause (there was no eating disorder present) except for the poisonous nature of the story. The other author of this chapter heard a story of racism that had irreparably destroyed the client's life options, filling the counselor with an experience of powerless rage. Both authors had to practice self-care while they allowed themselves slowly to heal from the evil inherent in their clients' stories. Our psyches need to rest as our bodies do.

The American Psychological Association *(20)* presented the concept of resilience in individuals as critically important in responding to disasters. Their brochure, a part of a packet, *Aftermath: The Road to Resilience*, contains 10 ways to build resilience in individuals, counselors as well as clients. These 10 suggestions are:

1. Make connections.
2. Avoid seeing crises as insurmountable problems.
3. Accept that change is a part of living.
4. Move toward your goals.
5. Take decisive actions.
6. Look for opportunities for self-discovery.

7. Nurture a positive view of yourself.
8. Keep things in perspective.
9. Maintain a hopeful outlook.
10. Take care of yourself.

Additionally, the American Psychological Association's *(21)* pamphlet on practitioner resilience in response to 9/11 encourages increased self-monitoring by the counselor regarding body nurturance, stress levels and expression, relationship focus, spiritual needs, and balanced activities to work. These 10 suggestions for building resilience and increased self-monitoring are actions the counselor can take in responding to evil.

Summary

This chapter discussed the concept of evil and presented a framework for defining and addressing it. The chapter focused on using hope, stemming from actions of self-care by the counselor, as a main source of energy in responding to the presence of evil. The counselor who practices self-care lives in a world of hope that "contagiously" passes on to clients. This hope reflects a deep compassion for the human struggle shared by the counselor and the client; a hope that allows for the suffering experienced from the presence of evil to be lived through, and ultimately transformed and transcended.

There are a number of recommendations that can be made to counselors based on this chapter. First, counselors must examine their perspective on evil through education on the topic, mentoring by other counselors experienced in this area, developing a framework for understanding evil, and knowing oneself and one's life experiences as they relate to evil. Second, counselors must develop a hopeful approach to responding to evil by creating a wide repertoire of self-care approaches. An understanding of the concept of evil in combination with a hopeful response means that counselors can effectively address evil as it arises in their lives and those of their clients.

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