Conceptualizing good and evil in psychiatry and social groups [ab]

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Abstract [g]***:*** *The author provides complex illustrations of Good and Evil (in Part 1), and particularly in the context of whether or not mental illness is involved (Part 2).*

- *He refers to 'Evil Obedience' using the Milgram research as an example.*
- *In the second epiphany, he describes how a high-grade aggressive criminal psychopath modified the author's thinking.*
- *The theology of morality is then examined in the light of a very tragic multiple murder.*
- *Some conditions are misdiagnosed and labeled as 'Axis 2 disorders' when they do not reflect personality dysfunction. Yet, these are treatable organic brain conditions reflecting temporolimbic instability. These patients are not evil but have a treatable illness and the patients present for management.*
- *Good and evil in Psychiatry has largely been ignored. That makes the science problematic and does not allow any interface of medicine and psychology with spirituality.*
- *An Axis 6 in the Diagnostic and Statistical Manual of the American Psychiatric Association is suggested for DSM-6: Good and Evil*
- *The role of religion, law and evil is clearly relevant.*
- *The author introduces the idea of 'relative morality'.*

Key words: *Antisocial personality disorder, Axis 6, DSM-6, Evil, Evil obedience, Good, Law, Medications, Medicine, Milgram, Neppe, 'Organic / temporolimbic evil', 'Psychotic evil', Psychopathy, Psychosis, Relative morality, SCEAD, 'Spiritual Cultural Evil Anomic Derangement', Religion, Theology*

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[a] My grateful acknowledgements to the readers, editorial assistants, peer-reviewers, readers and referees. This includes Psychiatrist Dr Biagio Longano, who has made a truly remarkable contribution; renowned Humanistic Psychologist, Dr Stanley Krippner; and Jungian Analyst, Suzan Wilson. Also, thank you to (alphabetically) Shauna Mason, Stan Riha, Joseph Slabaugh, Jacqui Slade, and Erich Von Abele.

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[g] This rewritten article derives from a similar article for the Journal of Clinical Psychiatry and Psychology.

The Complexity Of Good and Evil: Part 1

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Several epiphanies—sudden moments of revelation—have guided my thinking about 'good and evil'. Initially, ironically, these epiphanies did not directly relate to mental illness, but they left long-lasting impressions on me. Others, too, may have epiphanous moments, and topics like Good and Evil can indelibly impress many of us. I present a few illustrations here of such personal insights and generalize to the broader world.

A. The context of Evil Obedience

1. Evil Obedience: A personal experience of the Milgram Research.

I had my first epiphany in my second year of college, in the late 1960s.

I was randomly approached on the campus by some psychologists, to participate in an experiment called 'The Effect of Punishment on Learning'. Another volunteer and I were told that one of us would be the teacher, and the other would be the student. We drew lots, and I was the 'teacher': I was then instructed to 'teach the pupil' and to give the pupil electric shocks. I was then given a low-level shock to experience how the first shock felt. I learnt that the shocks would progressively increase. The experiment proceeded and after a few correct answers, the 'pupil' erred. I was told to shock him. This request to me was remarkable. I saw this as a moral dilemma. I caused consternation for the experimenters: I refused to perform—to deliver electric shocks to the pupil. This violated my agreement in the experiment.

When I refused, the experimenters tried to encourage me: *"Please, you volunteered to participate: how can you not participate?"* This cajoling was repetitive. But I refused to go on: Then a beautiful young lady came along and in a sexy voice, and particularly attractively, said, *"Vernon, you've got to go on, you've got to give your shock. How can you not? You volunteered. You can't mess up the education lesson."* But I refused.

The chief experimenter looked at me and said, *"Thank G-d! You're the first of*

forty-nine people who has not gone through to give the student up to 750 volts of electricity." Of course, I was then told this was a sham experiment, something not shared with the prior 48 'teachers'. I learned how the other 'teachers' continued shocking their students even when the student would cry out in pain and later scream, *"You're killing me"* and then there would be silence. The experimenters said to me: *"At least you know how you reacted. We hope we would react like you, but based on our previous subjects, we cannot believe that we would."*

I had an idea. I said to them, *"My friend Jim: I know he's a pacifist, and I know this might distort your work, but can I send Jim along?"* And so, Jim arrived (not very good random research subject selection but that's a different issue!), and an hour later, he came back. I had no doubt how this moral, kind individual would have reacted and so I said to him, *"At least now there are two of us."* And he looked at me and he said, "*What are you talking about? I gave those shocks!"* I was surprised, *"You did?"* And he replied, *"Yes! That was part of the experiment, I was asked to do so."* Then I said, *"What about the pain—the suffering, the torture? Maybe the death?"* And his comment was, *"Well, the student volunteered, so it's not my fault!"*

2. Applying Milgram's work to our broader world.

Of course, this broad story is a replication of the famous Stanley Milgram experiments and the theories behind them. [1-3] Stanley Milgram's classic experiments showed that, under orders,*"decent human beings will do anything."* Such is obedience, [3] and maybe lack of caring. And just to emphasize: Today, we could never do such studies. They would never pass Human Subjects Review committee scrutiny. Philip Zimbardo then created the well-known "Stanford Prison Experiments" on the psychology of incarceration. [4-] This further led to many trying to explain such behaviors. [5] I call this *'evil obedience'*. The study I took part in, in Johannesburg, South Africa, was one of nineteen (!) replications world-wide of such obedience—eight studies in the United States and nine replications in European, African, and Asian countries from 1963 to 1985. Overall, roughly two-thirds complied and gave all the shocks. There is a wide difference in the range of overall analyses of studies. In some, as many as 40% of subjects did not obey the instruction to shock and in others only very few refused to comply. However, each study had its own special quality: I postulate this might conceivably be dependent on the exact details.

I propose that the cajoling and encouragement we received in the Johannesburg study I participated in would have markedly pushed up the proportional numbers of those who continued with the experiment. For example, the beautiful young lady in the study I was in, exhorted the 'teacher' to continue. How much more so if the whole culture insists on obedience to an idea and if the consequences of disobedience are profound? Milgram's underlying study motivation was his attempt to understand the Nazi culture of obedience in the context of horrific evil. [1-3]

Perhaps the Milgram research illustrates the cultural endorsements of obeying, for example. [1-3] Are the subjects distantiating their experiences from the real component of inappropriate, bullying, even violent behavior?

So this first epiphany relates to a primary kind of evil *'evil obedience'* and it would be one subcategory in a proposed Good-Evil 'axis' in the next manual of the American Psychiatric Association (APA), likely called 'DSM-6', recognizing that the DSM ('Diagnostic and Statistical Manual') classification can be applied to everyone. In this instance, there might well be no psychiatric label for the first five axes when referring to the psychopath. For clarification, for more than sixty years, the APA has been trying to classify mental illness and there are various dynamic and changing iterations involving five 'axes'. For many years, Axis 1 has been linked with psychopathological diagnosis, Axis 2 with personality disorder, Axis 3 with medical conditions, Axis 4 with psychosocial elements and Axis 5 with global level of functioning assessment. Currently, we are at DSM-5. [6]

3. Extending to a whole culture.

Could the concept of Milgram's obeying authority with evil acts be applied to a culture? It appears it could be.

Applying this Milgram research, I realized this was how the Nazis were able to cause the Holocaust and murder millions. [7] This might best be called, I suggest, 'Spiritual Cultural Evil Anomic Derangement' (SCEAD). This should *not* be elevated to the level of a medical disease process which we could the call '*cultural evil disease*', thereby extending to all perpetrators the excuse of mental illness. That would imply possibly condoning psychopathology of a culture for one of the most reprehensible atrocities in the history of mankind. The great French Sociologist, Emile Durkheim described 'anomie' [8] This refers to a normalization of

a 'normlessness' and 'derangement' within the collective culture. The term 'spiritual' emphasized the abominable, profound compromise of ethical and spiritual standards.

The most extreme case would be the Nazis. But there are many other regimes, Communist and dictatorial, which have been absolutely cruel and murderous toward their population and toward others. And even when they did not commit murder, the arrests, with or without sentence, may have led to imprisonment for long periods of time for what may be trumped-up charges or small areas of disagreement. Conversely, this is only part of the picture. There is an enormous amount of guilt as well, because many suffering or afflicted populations may experience significant guilt from disobeying any orders, or rebelling against those in positions of authority: the respect for such authority means that their orders must have been given for a reason and their culture may teach them that the leaders know best. [9] The fear of such repercussions, and the consequent inaction (even by verbalizing opposition) by the victims (who may be citizens of a country) may actually reinforce the victor's vile behaviors.

4. The Righteous Amongst Us.

Fortunately, there have always been a small number of resisters: These righteous, morally elevated individuals very likely might have and could have sacrificed their own lives. But they refused to go along with evil.

What about a theoretical consideration: If a Hitler, had been assassinated or murdered, would this be an evil action because killing somebody is an evil action? Or is it a blessing for others? Could it have changed the world for good? Our culture recognizes the dichotomy: Are these 'assassins' labeled 'freedom fighters' or 'terrorists'? The convention handling of a Hitler being caught would be appropriate court proceedings and trial. This happened in the Adolf Eichmann instance, execution [10]. Certainly, many would argue that is most appropriate.

B. Evil, in itself, is not mental illness

1. The high-grade, aggressive, criminal psychopath.

It was 1976. I was training in psychiatry. And then I encountered the most evil individual of my personal life experience. *"Let me not to the marriage of true minds admit impediments."* [11] Shakespeare had it right in this regard: If you believe something, you may not change. Even more so, at times, one may have fixed opinions, and it is frightening to change. And this is particularly so in the context of what I call 'relative morality': the context of what is good and what is evil. To begin with, is there such a thing as good and evil? And, if this is evil, do we justify it by blaming psychiatric illness, or psychopathology, or one's previous environment, or one's genetics? Or is evil 'something' where someone has not grown spiritually and has markedly diminished in stature on a supposed good-evil continuum of growth as a consequence of behavior that is unacceptable?

Now the test: Would this challenging true tale below not lead many of you to become in favor of capital punishment?

Early on in my professional career, I encountered the most vile, cruel individual. He told me very proudly about several of his murders. He had no remorse for these actions. He belonged in a gang: He not only murdered these individuals, he tortured them in the most atrocious ways. He would hang them in trees, and he would torture them, pulling out their toe nails one at a time. He would laugh before killing them: Nobody could quite get sufficient evidence to arrest him because his gang always provided alibis and aliases for each other.

Prior to this experience, I had been vehemently opposed to the death penalty. What moral right did we have, as a society, to take the precious life of another? And what if we were wrong? But, after experiencing this ogre, did this kind of individual deserve to live? Had he abrogated that right? This certainly would be an area for debate: The absence of remorse, and the extreme pleasure this vile youth in his late teens would obtain from his violent actions, was appalling and disgusting in the most extreme sense.

It could be argued that this individual deserves a humane practice of capital punishment.

Yet, our society generally will show compassion: *"Shame, poor fellow! He had a bad home life. His environment was poor. He was molested. He was tortured."*

And yet there are those who might have had a similar terrible home environment and grown bigger as a consequence. They would have encountered several rocks in their lives—sometimes real and unpleasant challenges. They could have used these

circumstances to trip over and deteriorate and attribute blame for their behaviors. Or they could have used that for support. The environment may or may not have aggravated depending on their responses. But if present, such life events could be argued to be mitigating factors. However, because others survive such traumata, overcome them, and indeed, grow spiritually, actualizing and even transcending their traumata, the result is potentially dichotomous and a whole range between.

At the end of it all, in this example, his atrocious actions, to me, are far, far more aggravating circumstances than the pale of a bad home life. In my opinion, this malevolent man's behavior was not induced by the mental illness per se; it was due to the pure evil. This is why, at the time, I went *beyond* official diagnostic labels and uniquely, called him at the time, a 'high-grade, aggressive, criminal psychopath'. This meant I went beyond conventional psychiatric nomenclature, adding a legal component (criminal) and possibly a moral interpretation of degree (high-grade). In usual psychiatric terminology, this could mean a 'severe case of psychopathy'. But in the context of psychosocial behavior, I realized there was that extra level—a level beyond psychiatry. Yes, there might have been a constitutional predisposition: He was born like that and "poor fellow those were his genes, and we must be sympathetic." But this does not condone evil, and few today would like to think people are 'born evil'.

2. Predestination: Constitution, environment, fate and free-will.

And if he were so unfortunate as to be born evil, should that still produce sympathy? Perhaps. But certainly, pragmatically, it could be argued that rehabilitation is much more difficult, at times, well nigh impossible. If his acts are vile, they deserve punishment. Such sentencing would reinforce the unacceptability for others for such terrible behaviors, would allow society not to condone such behaviors, and might, if prevented in time, act as a deterrent for that psychopath to act like that, as he might only be considering himself (but might not even be doing that). The cliché the *'punishment fits the crime'* might sound hard but even biblically, the context of pursuing justice with compassion, as necessary, is well known. Justice is not cruel: it is regarded as fitting the crime, and the pursuit of such justice is theologically appropriate. But again, such actions must be conceptualized within the cultural context including the laws of the country. Those controversies are largely peripheral to the 'good-evil' dichotomy. However, a more direct dichotomy below reflects how Segev [12], and Cashmore [13] (separately) express

views of not being responsible for actions as opposed to the perspective I'm expressing which does imply responsibility.

Certainly, the argument could be dichotomous. For example, the computational neurobiologist, Idan Segev of the Hebrew University of Jerusalem, argued that all behaviors are influenced by our environmental experiences and that we are not responsible for adaptation to such perceived emotions and their resulting actions. We should not be punished; we should be healed, as in synapses, neurons, and brains. [12] [13]

3. Free-will and responsibility.

The views of Segev and Cashmore above reflect the extreme viewpoint of inevitable predestination. It almost takes away from the idea of punishment, just emphasizing rehabilitation for those who could help themselves. It attacks the concept of any responsibility for actions in our society.

But this perspective is very different from how some would perceive such actions. I can only express my opinions, but Segev and Cashmore reflect that there are alternative ways of examining the same data.

With respect, these are the typical Segev and Cashmere comments are typical of materialists who perceive mankind as automatons, largely or completely without free-will, who cannot actualize or transcend themselves. This behaviorist approach mainly eliminates meaning. As I see it, the problem is the recent findings of consciousness research have totally refuted this argument but most scientists have simply not studied the area. [14, 15; 16, 17; 18, 19; 20, 21; 22]

With respect, this is a complex issue. I've spent four decades showing mankind is more than an automaton. I propose the fallacy these writers are applying, is refuted by 'consciousness' not being fully conceptualized [14]. I propose that these authors are missing a key element namely 'higher' ('external', 'cosmic', 'extracerebral', 'extended) consciousness. That makes for a far more versatile, dynamic approach to morality and good and evil and spiritual progression or regression. But that is another issue for discussion. To whet the appetite, I refer to our (Close and Neppe) discovery of 'gimmel', the third substance or third quality. [15; 16] Neppe and Close have shown there is substantial mathematical proof for this [17; 18], and that this finding is pertinent empirically [19; 20], not just a math operation [21; 22]. Gimmel is likely this consciousness I'm referring to, at least in part. So this is not just a belief, my

contention here about free-will is indirectly based on empirical math reasoning. [23]

Free-will is an enormously important concept meriting a separate paper. In this case, it reflects choice and freedom to do good and evil. The ostensibly all-embracing, complex scientific, mathematical and philosophical, so-called 'Neppe-Close TDVP model' [24] implies a limited freedom of choice. It is limited because we do not control all of reality. Only a divinity would. But, inter alia, we do have the opportunity to choose good from evil, action from inaction, spiritual progression from being stagnant or regressing.

4. Revisiting the 'psychopath' and responsibility

4.a. What psychopathy is not:

1. Psychopathology: I briefly outline here the concept of Axis 1 Psychiatric Disorders as in the Diagnostic and Statistical Manual V of the American Psychiatric Association. later, the first briefly, the second in some detail.

- Psychopathy too does not include the groups with organic illness due to abnormal brain functioning that leaves the patient not responsible for their evil', or 'psychosis', or 'reactions to paranoid misinterpretations". These conditions exist and would only be excluded after a carefully considered medical opinion—these patients are not psychopaths. This is where forensic psychiatry fits in. The ostensible 'evil' might be reflected in impulsive behavior and relate to manageable organic brain components.
- With great respect to any opposing views of 'antisocial personality labeling', in my opinion, these do not of themselves reflect an Axis 2 disorder 'antisocial personality disorder'. [25] [6] These reflect an Axis 1 condition reflecting Psychopathology, and in this instance possible temporolimbic instability, which is technically a bodily condition—the abnormal organic elements including brain firing - so Axis 3. [26-30] [31] [32] Fortunately, these are treatable, so I've already developed a dichotomy here of *'legitimate mental illness'* and *'legitimate evil'*. Of course, those who are diagnosed with 'legitimate mental illness' could still have evil behavior, too.

2. Evil Obedience: Psychopathy also does not reflect 'evil obedience', as in the Milgram experiment and with the Nazis. These people are obeying authority, and certainly cannot be condoned but they reflect a high proportion of the population

based on the Milgram data that was replicated internationally.

4.b. What Psychopathy and Antisocial Personality Disorder are:

So, what is a psychopath? Antisocial Personality Disorder (ASPD) in DSM-5, was previously termed 'sociopathy' or 'psychopathy', or 'dyssocial disorder' in the International Classification of Diseases. ASPD is one of the 'Cluster B' Personality Disorders along with the other Cluster Bs: Borderline, Histrionic and Narcissistic disorder. All of these are dramatic. ASPD is characterized by a long-term pattern of disregard for, or violation of, the rights of others. These people quite literally have a disorder of conscience. They have very impoverished moral senses and usually show a history of crime, legal problems, or impulsive and aggressive behavior. Some subtly differentiate the antisocial personality disorder, psychopathy and sociopathy. Invariably, the psychopath shows a pervasive pattern of disregard for, and violation of, the rights of others. Deviant events (evidence of Conduct Disorder) usually have occurred before or by the age 15 years. In both DSM-IV and DSM-5 nomenclatures, the antisocial personality must demonstrate three or more failures to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest (Table 1).

Table 1: Antisocial Personality Disorder in DSM 5.

According to DSM V, a person with Antisocial Personality Disorder must demonstrate at least three of seven characteristics:

- Failure to conform to social norms with respect to lawful behavior;
- Deceitfulness;
- Impulsivity or failure to plan *(not a characteristic of high-functioning psychopaths – my emphasis*;
- Irritability and aggressiveness, as indicated by acts of physical violence;
- Reckless disregard for safety of self or others;
- Consistent irresponsibility;
- Lack of remorse.

They show deception as indicated by repeatedly lying, using aliases, or conning others for personal profit or pleasure. These people are commonly impulsive. They do not plan, and the psychopath does not learn from his/ her errors, repeating them again and again. They are irritable and aggressive, with reckless disregard for the safety of others and sometimes themselves. They are irresponsible, show lack of remorse and rationalize their immoral acts. Of course,

such antisocial behaviors occurring only during Axis 1 psychopathologies such as acute manic or schizophrenic episodes are not regarded as part of the antisocial personality disorder. [6; 25]

Yet, I have met likeable psychopaths, but never good ones – although some can perform good deeds, at times, although the motivations may not be entirely pure!

4.c. The variants: I've seen different ways of evil manifesting: Someone once told me "In the culture I live in, you don't kill; you're far more subtle, and you commit violations that cause harm such as computer hacking, or communicating information that can destroy lives." He added proudly: "That's the way I like it!"

Recognizing the variants, and the different degrees of callousness and consequent antisocial behavior, I argue for the removal of psychopaths from Axis 2 into Axis 6. Patients with Axis 2 disorders including Cluster B will remain on Axis 2, but these are separate from the Psychopaths in Axis 6. We could retain the variants of 'Antisocial behaviors' on Axis 2 Cluster B, along with the borderline, narcissistic and histrionic, but the good-evil component would be in Axis 6 and hence I still prefer the term 'Psychopath'. The Axis 2 emphasis here would therefore include the behaviors, separated from the listed Personality Disorders in borderline, narcissistic and histrionic.

5. Implications of antisocial personality disorder and related conditions.

Let's examine the implications of the anti-social personality disorder, also called the 'psychopath'. [33-39] In many legal systems, these patients' behaviors are somewhat condoned: If there is a death sentence, they might not be given the death sentence, because psychopathy is regarded as a 'mitigating factor'. In other settings, they might even end up in a mental hospital environment, because they are regarded as mentally ill. However, rehabilitation of such offenders might be more difficult, and in that context psychopathy is an aggravating circumstance. [34; 35; 39-41] And given that psychopathy by our classification at the Axis 6 level is not a Mental Illness, this should not be a mitigating circumstance.

Ironically, anyone can be labeled along a multi-axial psychiatric system. So for example, in Axis 2, one can write down 'no personality disorder' or 'no Axis 2 condition'. In the same way, the subpopulation of Nazi collaborators, for example, would be labeled along that Axis 6 component, and they would be regarded as evil.

Some may say—wrongly, I argue—that this framework of modern medicine and law seems to be saying that the mentally ill have no will, as though they are just being directed by their biochemistry like automatons. But in a way, don't these same scientists regard all humans, whether mentally ill or not, as basically purely motivated by their biochemical makeups? If so, on what legal basis would they have the capacity to distinguish right from wrong? Extending this idea, the theology concept of good and evil would necessarily be connected to the concept of free-will. My own attitude is that individuals are far more complex than that. Biochemical determinism may be relevant but this does not dictate their behaviors. Certainly, there are environmental influences which impact these behaviors. This also reflects their freedom of choice. This is a synthesis of genotype, phenotype and environmental influences. These together could imply ultimately an endpoint of learnt morality.

We could possibly call this proposed Axis 6 subgroup of Psychopath / Antisocial Personality as manifesting *Individual Evil.*

My intention here is not to debate causality. Are Antisocial behaviors purely constitutional and inborn and deterministic *à la* the famous 19th century criminologist Cesare Lombroso [42], who postulated the 'born criminal'? Today we would perceive this as very unlikely or certainly not a fashionable explanation. Or is it purely due to environmental causes? Most of us would perceive multifactorial reasons as pertinent, with environment impacting on the biological base. But that is a book of itself, and not being addressed here.

I do *not* regard most psychopaths as mentally ill:

In short, I postulate, instead, that psychopaths constitute a significant subpopulation who manifest pure evil.

6. Relative Morality

As an aside, I mentioned a different everyday context of 'Relative Morality': These are dilemmas we apply every day and everything discussed in this paper is relative to the framework of our socioculture.

First, I differentiate the similar sounding but very different but similarly worded concept of so-called 'Moral relativism' (MR). I use the term 'relative morality' (RM) because it is subtly, but very different from so-called 'Moral relativism' (MR)

in context, implications, and meaning.

MR may refer to any of many different philosophical positions about the differences in moral judgments across different people and cultures. This implies that right and wrong are not absolute values, but are personalized relating to circumstances or cultural orientation. It can be used, inter alia, to justify breaking the law or doing wrong. MR has a converse: moral absolutism refers to the constant values and rules irrespective of circumstances or cultural differences. [43] There are different subtypes of MR: 'Descriptive Moral relativism' argues that some disagree about what is moral; 'meta-ethical moral relativism' points out that, in such disagreements, no-one is objectively right or wrong; and 'normative moral relativism' maintains that we ought to tolerate the behavior of others even when we disagree about its morality because nobody is right or wrong. These subdivisions of MR are subtly different. Richard Rorty [44] argued that relativist philosophers believe *"that the grounds for choosing between such opinions is less algorithmic than had been thought"*, but not that any belief is as valid as any other. Moral relativism has been debated for millennia in diverse fields philosophy, science, and religion.

MR changes potentially over time and place. Encounters relating to individual moral practice and situations supposedly dictate the correct moral position, not anything fixed like good and evil. [45] As the great 19th century philosopher Friedrich Nietzsche[46], commented, *"You have your way. I have my way. As for the right way, the correct way, and the only way, it does not exist."*
The moral relativist (often a secular humanist who rejects God) has no good answer to the two-part question: Is there anything wrong with an action and, if so, why? [45]

The difference then with R*elative morality* is marked: RM focuses on actions relative to a specific event. It implies what is moral in one context may be completely immoral in another. It relates mainly to the good-evil continuum, recognizes the different natures of the same behaviors and in that way the morality can be different, and concerns circumstances relative to individuals.

Let's take a simple case in everyday life. I was recently faced, for example, with a choice about our extremely ill dog: The veterinarian had recommended, and, indeed, encouraged euthanasia. Termination of the dog's life was quite justified on 'objective' grounds. And yet, while in hospital, when he saw his 'parents' —us— visit, the dog wagged his tail and squeaked with delight. How does one go through with this sentence of the animal to death to alleviate his suffering when the dog

does not seem to be aware of his suffering and is still experiencing happiness? Now is it 'evil' to euthanize the dog? Or is it 'evil' to prolong suffering? To the vet it was easy: Euthanize: Morally it was appropriate. To us, it was easy: Don't euthanize: morally it was inappropriate. Is there any relative morality good-evil dilemma here, or is such an action (euthanasia) purely a pragmatic consideration?

But that moral dilemma might become more stark with the approach- avoidance conflict of wanting to benefit an individual, yet putting the society at risk or the converse (e.g., release from incarceration of a dangerous offender): Life generally does not involve simple black-white decisions. There are often dilemmas in interpretation of actions, in which different people can justify in polar ways.

6. The not psychopathy psychiatric group: Real psychopathology and organic illness:

I contrast the Psychopath with another superficially similar group: These patients ostensibly cause trauma to others or themselves, sometimes while acutely suffering. They are inherently good at that theological level, and will not do harm to others. These are ill individuals, who might look antisocial until they are treated, and then what appeared to be Axis 2 behaviors are redefined as organic illness in the brain.

6.a. Tragedy in psychiatry: The psychopathology of moral behavior: The patient's dilemma of Satan or God?

I now portray one of the saddest cases I've seen in my career.

A wonderful school-teacher, devoted to her students, had her first baby. This was a routine, normal vaginal delivery. The mother, a religious and kind lady, was looking forward to her baby and was so proud. She lovingly was nursing her first-born in the nursery in the hospital. A day or so later, she suddenly awoke from her nocturnal sleep. She proceeded to strangle and murder several newborns. Mercifully, she was overpowered by several people but not before this carnage.

She was described by nursing staff as: *"It's as if she was possessed! As if she was so powerful, nobody could restrain her."* And then came the remorse and weeping of the poor lady: *"What have I done? I cannot remember any of it. I know I heard the voice of God who told me to do this, but I now know this was the voice of the Devil."* This was a very tragic epiphany for her. She cried out in profound distress:

"It was Satan; not God. Look what I did."

She was charged with murder and, of course, found not guilty by reason of insanity, for her condition would broadly fit into the category of 'Post-Partum Psychosis'. She ended up in a mental hospital. So here is an example, indeed, of mental illness. A very strange case, the only case of this specific kind that I've seen in four decades: A mental illness causing the most terrible of crimes.

This Axis 6 subgroup could be called the 'Psychotic Evil'.

6b. Explosions in the brain: Psychiatry linked with violence

I now discuss a common occurrence in my neuropsychiatric practice. I have seen numerous patients with explosive disorders. These patients have extreme anger episodes, marked fluctuations of mood, and they can cause great damage to themselves and to others. These patients very often exhibit underlying organic brain disease, like mesial temporal lobe dysfunction. [47-52] There are some characteristic features: They have explosive anger episodes; they often have olfactory hallucinatory phenomena that are episodic or very short, classically with burning, or fecal smells. They might have episodes of blanking, and they might have mood swings over a series of seconds. These patients are often extremely intolerable to live with and to be around. They're often labeled 'borderline personality disorder' because of their rapid fluctuations. These are examples of patient subpopulations who are labeled 'mentally ill' or who are labeled 'psychiatric'. However, when you eliminate the abnormal electrical fires in their brain, with, for example, anticonvulsants like carbamazepine and lamotrigine, they become human. Frequently, after medications, [26-29; 32; 53-55 31 32] we're able to meet new wonderful people, partly because the underlying problem in the brain has been corrected and possibly because they've learnt from their prior experiences when not under appropriate medication control. Here is ostensibly evil behavior associated with mental illness. But this is not evil of itself, willful and deliberated wrong-doing, but a consequence of illness. In the properly assessed patient, we find their anger and aggression melts with medication. But the gratifying aspect is they almost always respond profoundly to anticonvulsants. This Axis 6 diagnostic subgroup could be called *'Organic / Temporolimbic Evil'*.

Importantly, if these patients commit a crime, and are charged forensically, in my opinion, they are not regarded as 'insane' and they are almost always still

responsible. They are still aware of their actions and the so-called ‘irresistible impulse’ does not apply. But their abnormal electrical brain firing might diminish their responsibility and provide a mitigating circumstance. Again, this is tragic because after treatment (e.g. with anticonvulsants like lamotrigine or carbamazepine, and with the serotonin neuromodulator, buspirone) these patients often blossom and become wonderful individuals. *“I can now control myself, doctor”.*

6.c. Malingering and psychopathy.

In contrast, another group exists: These are criminals charged with violent crimes or murder, who claim explosive outbursts for which they are allegedly amnesic. But they don’t have that symptomatology. I remember one such case, who insisted he was innocent and did not remember any actions. After conviction, he insisted on seeing me: *“I just want to tell you doctor, that I remember it all. I killed him, and I enjoyed it. And I would do it again.”* He was not mentally ill, just plain ‘individual evil’. Again, this would be a case of ‘individual evil’ in the proposed DSM Axis 6, with the other Axes being ‘deferred’ or ‘condition not present’.

The revelation of the contrasts between these two groups—the treatable abnormal electrical firing patient who can be made whole rather easily; and the evil one feigning mental illness—is stark. The treatable patient is suffering and utterly distressed to the extent that these patients are high suicide risks. The malingerer, by contrast, is there entirely for self-gain and to abrogate responsibility.

Are evil acts just evil or do they reflect mental illness? Part 2

Vernon M Neppe MD, PhD, FRS(SAf), DFAPA

1. Ignoring the reality of good and evil: Where are the publications?

I had always assumed that there would be numerous papers on *good and evil in mental illness*. I was shocked to discover that it is extremely difficult to find even a single scientific publication on this topic! *"That's religion and belief; not science."* Of course, there are a few, but not many. [56-61]

An important reason for the limited publications in this area, is the careful regulatory control over acceptable research today. Milgram's work would never be approved by a Human Subjects Committee today: It would be deemed "barbaric" (which, frankly, it likely was).

A best-selling layperson book by a psychiatrist, the late M. Scott Peck [62], focuses on the presence of evil as a real force and gives case vignettes, but his orientation is more theological and not predominantly based on psychiatric nomenclature although he does recognize the need for modifying DSM, and distinguishes sociopaths, psychopaths and evil.

In this editorial, I'm not arguing whether or not evil as opposed to good exists, and certainly not whether it is a real force. Instead, I focus on evil (and good) *behaviors*, recognizing that those components might require a further psychiatric DSM classification [6; 25], namely a proposed DSM Axis-6 of evil behavior spectra in addition to the current five-axis DSM frameworks, which lack any mention of the good-evil spectrum.

Good and evil as a further axis in psychiatry does not currently exist. Somewhere along the line, mental illness has developed its own 'magisterium' [63]. If somebody acts, let us say 'abnormally', in the theological sense in an evil way, and they then consult a psychologist or psychiatrist, they might not be regarded as evil. This is so as, in the mental illness sense, that evil simply does not exist in our vocabulary. So

that evil side is regarded as relating to their supposed mental illness. It's remarkable that this occurs. I argue that we ought to be differentiating good and evil in psychiatry. We should have an axis 6 in the Diagnostic and Statistical Manual (DSM) formulations. [6; 25] Good-Evil should have been a dilemma since DSM-1 was first conceptualized, and then incompletely formulated in the late 1940s, but it never was! [64] The Good-Evil dichotomy extends to ordinary people. Let us just say that some radiate kindness, but others do not. The latter might still be fine people but many of us may not regard them as such – quite justifiably.

2. The Good and Evil Classification in Psychiatry and for Human-kind: DSM 'Axis 6' perhaps?

The classical descriptions of mental illness in psychiatry, and in psychology, have been formulated to completely ignore the role of good and evil. For many mental health professionals, everything is subsumed under the medical model of illness: If a patient acts in an aberrant way, this is not his fault generally, but attributed to his mental illness.

If somebody commits a crime, sometimes very severe -- such as murder or rape -- the person is often labeled as being 'mentally ill'. The Diagnostic and Statistical Manual in its various iterations, beginning with the aforementioned DSM-I in its more complete form in the early 1950s [64] through to the current DSM-V [6], has totally ignored this area. DSM-V, like its predecessors, is a multi-axial system, in which axis 1 reflects the psychopathology and mental illness diagnosis; axis 2 relates to personality disorder; axis 3 list the pertinent medical conditions; axis 4 describes the psychosocial elements; and axis 5 reflects the level of functioning the patient has. *Nowhere is there a mention of good and evil.*

It's important to know that the studies at this stage are not adequate to make judgments: People just write about the 'fact' that the mentally ill do not exhibit more violence than the general population as if it's definitely true, yet, inter alia, because the label of who is mentally ill is difficult, we cannot make such interpretations. By contrast, some of the lay-population assume that violence, even in psychopaths, must be due to mental illness. Certainly, it appears in my experience and in the experience of many people in the psychiatric and psychological professions, that many aggressive patients with Axis 1 and / or Axis 3 diagnosed psychiatric conditions can be treated and should be helped, often with

medications that correct underlying biochemical electrical abnormalities. However, the same cannot be said for the evil individual who does not exhibit Axis 1 or Axis 3 pathology. The key difference here is detailed assessment and evaluation.

Psychiatrists often argue that psychiatric patients are at no greater risk to commit evil acts than the rest of the population. In fact, some experts postulate such patients might be at *lesser* risk, because many of their difficulties are internalized and not outwardly actively expressed and often not communicated: Moreover, if they act out, they will most often act out towards themselves, for example, by suicide or by 'suicide gestures'. Such behaviors are invariably linked with DSM Axis 2 behaviors, sometimes also with Axis 1 Psychopathologies. But that does not make them Antisocial or Psychopathic. This is another reason why Axis 6 is needed. It fills a void.

And yet, we have this conflation of two groups. We combine the general population of people who manifest evil, on the one hand. And we might not differentiate them from patients who have Axis 1 psychopathologies and are therefore 'mentally ill' in the psychiatric sense. This lumps together the two distinct populations. What would be classified as 'good' Axis 6 psychiatric patients—kind and sweet but with problems—are grouped with the evil ones, whom we respect because we don't have Axis 6 and therefore regard only within Axis 1 or Axis 2. *"Poor fellow he's a psychopath: He can't help it. He has a disorder of conscience."* It's remarkable how the magisterium of scientific mental illness completely ignores the other spiritual magisterium as part of reality. [63] As Steven Gould implies, they are *non-overlapping magisteria* —they cannot meet. This attempt at applying both mental illness and good and evil sounds obvious, but is revolutionary to Psychiatry. Our growth as humans has been a growth of developing our good, collectively.

We need to have a separate axis in psychiatric classification: This Axis 6 should relate to a good-evil continuum. This is quite separate from any other mental illness axes, though, at times, they're related. This becomes clearer at times after appropriate treatment. There are good people, and there are not good people, some 'very not good'—an extreme we call 'evil'.

The 'not-good' people in the political sense of a Holocaust with atrocious actions at one extreme, have gradations of evil: Only a step down in importance are the people *who do not act when they should act.* This includes politicians who are often more interested in their own edification, and in their wealth and power

accumulation, than in assisting populations and being kind, compassionate and yet just, moral human beings. These extremely evil individuals, irrespective of formal psychiatric history, are still part of the Axis 6 of Good-Evil. That is therefore applicable to everyone who manifests evil.

However, possibly that new Axis 6 of Good and Evil should be elevated to Axis 4. It should precede functionality (Axis 5 currently) and psychosocial issues (Axis 4 currently), though it should be after the medical illness of Axis 3.

These evil actions of all kinds are far, far more common than in the mentally ill. This division of the two types of people might imply that the ones who don't have the 'excuse' of mental illness have perhaps a spiritual problem or cultural influence. Is this something to apply at a moral level still? We cannot label the immoral and the evil persons as *"just having mental illness"*. That's not fair to our mentally ill, in fact, it's an insult.

And so we have this question: *Should we have a further dimension in our diagnostic system in psychiatry—in DSM 6 as the next iteration: Good and Evil as an Axis 6?* This is important. And should we even be labeling it in a Psychiatric Axis, because surely if most of these perpetrators are not perceived as mentally ill, it would be unfair to even contaminate the poor mentally ill with such insults? At the judicial level, should those who are evil be condemned and sentenced more heavily, because it may be that they are less rehabilitatable, as opposed to being habilitatable? We can debate this issue, but it cannot be ignored.

This opinion has been directed towards one kind of evil: The evil of violence. There are numerous other more subtle Axis 6 Good-Evil behaviors. There are those who show a callous disregard for others by inappropriate economic behaviors. There are those who ostensibly have disorders of conscience and wreak havoc on societies. Some of these individual are politicians. But the focus in this lengthy Editorial has been on the violent behaviors as opposed to the more subtle.

I propose now a very provisional classification of the Good and Evil DSM Axis 6. The most obvious dichotomy is separating out Axis 1 conditions that are directly responsible for ostensibly evil behaviors, compared with that absence of Axis 1. There is a very large gray zone: Many patients have Axis 1 disorders but cope in society and do not disrupt at the ethicobiopsychofamiliosociocultural level. And many such behaviors are not dramatic, but subtle, and far less substantial—there are economic components, or political ones, or the person in lay terms is just not a nice person, and uncaring. But the extremes portrayed here are a start. Table 2 is a

provisional beginning.

Table 2: The proposed Axis 6 in DSM-6. Good and Evil
Group A: *Disorders of conscience. The Good – Evil Axis in the absence of officially diagnosed Axis 1 Psychopathology.* 1. Individual deliberate antisocial behavior disorder 2. Cultural or group collective antisocial behavior 3. Evil obedience in groups 4. SCEAD—Spiritual Cultural Evil Anomic Derangement (may, at times, be part of #3) 5. Other disorders of conscience. 6. Not otherwise specified 7. Combinations of the above, with or without other Axes 1 to 5 involved. Subdivision A: Violent Subdivision B: Evil, disruptive non-violent Subdivision C: Directly or indirect complicit or both Subdivision D: Unclassified Subdivision E: Combinations of A to D (please specify)
Group B: *No disorder of conscience. Good – evil axis in the presence of Axis 1 Psychopathology with or without Axis 3 (Medical conditions) and Axis 2 disorders (Personality disorders or dysfunctions)* 1. Paranoia 2. Psychosis 3. Organic (for example, temporolimbic instability) 4. Other psychopathology disruptive behaviors resulting in evil. 5. Not otherwise specified 6. Combinations of the above (please specify), always with Axis 1 and with or without other Axes 2 to 5 involved, and potentially including any of Group A 1-4 conditions. Subdivision A: Violent Subdivision B: Evil, disruptive non-violent Subdivision C: Directly or indirect complicit or both Subdivision D: Unclassified Subdivision E: Combinations of A to D (please specify

The essence is *responsibility must be taken*: *Mental illness is not a cop-out for bad behavior.* There are evil individuals and there are good people, and there's a range in between. Axis 6 is not only for the mentally ill but can be applied to everyone.

Group A includes Disorders of Conscience. I am not calling these individuals 'Antisocial Personality Disorders'. I have moved ASPD from Axis 2 where other personality disorders exist. These are Psychopathic behaviors in Axis 6.

This is a preliminary evaluation report of an idea pertaining to a multi-axial system. It is necessarily controversial, and necessarily will require some repetitions.

In Table 2, we have sub-classifications of Axis 6, as well. To illustrate: The Nazis applied cultural *'evil obedience'* behaviors. That obedience of itself could not, in any event, be condoned. But we've differentiated this evil obedience from the spiteful, cruel, vicious, inhumane individual who would torture his victims. That reflects active vile behavior. But there are subtypes: We could argue a relatively small number of those patients are mentally ill and could not control their actions. An example was that tragic postpartum case of the patient who murdered infants. She could be regarded as psychiatrically ill on Axis 1 and exhibiting evil behavior relating to temporary psychosis on Axis 6.

For perspective, the fact that the *content* of the delusional idea of the postpartum psychosis patient related to 'Satan' or 'G-d' was not the pertinent component. Ultimately, we would construe such behaviors as tragic, and yet evil at that moment. The behavior *process* is what is relevant, not whether it is 'G-d' or 'Satan' or other delusional ideas. Therefore, if the individual is evil, but does not manifest evil behaviors, that would not be regarded as an Axis 6 condition. In law very often, the requirement is action: It is neither thought to action, nor contemplation. That contemplation might be an active event itself, but unless publicly stated, there is no difficulty.

Importantly, psychiatrists are not trained in good and evil, and have no specific knowledge of good and evil. In fact, this is outside their general magisterium—which is part of the problem. Psychiatrists and medical specialists could get further background 'training' in good and evil in forensic specialties, in ethics training and in philosophy. Yet, physicians are often asked to make decisions about matters for which they have no training, and the absence or presence or the extent of evil is one of those areas. Our society requires them to have opinions. Even with their lack of training they cannot abrogate their responsibility to express opinions.

3. Evil, Religion and The Law.

The neglect of concepts of good particularly, and of spiritual growth in our society is rather surprising for me. It's unexpected because growing up, as we have, in societies that are steeped in various religious cultures, the commonality of all of these cultures is good and evil.

In fact, fundamental to religion is the idea of spiritual growth and goodness. This is one of the common features of these traditions. Among these common features, are dyadic opposites—*God and Satan*; the idea of the *'evil eye'* and *'lucky charms'*; the idea of a '*fight between good and evil'*. When do we say to another *"I wish you spiritual growth"* but we will always wish people *"happiness"*. We don't easily consider the good-evil, moral transcendent continuum, just the day-to-day pleasures.

However, though we speak of religion, and sometimes perceive it as synonymous with 'elevation of spirituality', this, of course, is not always so. ISIS members behead people in the name of religion, and the inquisition was not a time of peace certainly.

Yet, theology, as a belief system, on the one hand, and medicine, psychology, and psychiatry as sciences, on the other hand, regard the other as irrelevant: The one does not touch the other—the separate Magisteria, at this point, never meet. Therefore, if something wrong is done, the *law* might perceive this as transgressive, requiring appropriate *punishment*. *Theology* might describe the action as *evil*. Meanwhile, the psychiatrist might argue *"this is purely mental illness"* and want to emphasize rehabilitation and treatment. All these approaches reflect complex, multifactorial issues that must be dealt with individually.

For example, one could argue, that a 'constitutionally-impelled offender, not acting out of free will', is by definition incorrigible. Incarceration in that case is not retributive, but actually preventative, in that it is certain that the person will re-offend. But of course, is there such a person as a 'constitutionally-impelled offender, not acting out of free will' and this introduced the complex area of the 'punishment fits the crime' That is a different debate, indeed, it is complicated by 'crimes' that are no longer crimes: There is currently great upheaval in, for example, the USA, Canada and South Africa, about disproportionate incarceration

for crimes that are relative (e.g. possession of marijuana). But this is not pertinent to our 'good-evil dichotomy'.

Our common mythology is that the incidence of mentally ill patients committing significant crimes of violence is reasonably small, and speculatively not much more than the general population or sometimes even less. But we really do not know, because what constitutes mental illness? The underlying ideas behind these postulates are fascinating but not consistent. Who is doing the labeling? [4; 56; 58; 59; 61; 65-67].

This then can add a further legal component. If an act occurs which in law is perceived as 'transgressive', that same act may be interpreted as 'evil' in theology, and in psychiatry as 'mental illness'. Terms such as *'irresistible impulse'* (or their equivalent where the patient is not regarded as guilty by reason of not being able to control his/ her action) at times may be used: *"The patient could not control himself and irresistibly acted out in a violent, aggressive manner."* At that point, forensic psychiatrists are asked, *"Was this irresistible?"* And, if so, the patient may be committed to a psychiatric hospital instead of a prison.

Those who manifest Axis 1 mental illness who may for example, be acutely hallucinated or paranoid but show ostensibly evil behaviors are not a homogeneous group. It includes people who are under the influence of recreational agents (and therefore controllable and even though producing illness may be due to action), and they too may hear a voice or obtain a 'command' hallucination to act a particular way—although this is classically schizophrenic in nature. [68]

Patients might also react to their own stimuli but less violently: For example, the 'command hallucination' involves hearing a voice commanding them to do something that our society would regard as inappropriate. The acting-out of a command hallucination is generally rare, because the patient will usually, if psychotic, be in their own world: Although hearing these things, they do not physically act out. But if they did act out, it would usually be self-directed acting out onto themselves. But most of the time, self-harm is not due to any psychotic delusion or hallucination, but linked with severe depression, anxiety or stressors in the environment. This is why the incidence of suicide is very high in the mentally ill patient compared with the general population; and this is particularly so if the patient has available a weapon of acute destruction. [69-79]

However, weapons of acute destruction are very varied and usually easily available. We might try to restrict firearm availability in the mentally ill whom we

consider the most vulnerable for self-harm. But firearms are not the only methods of successful suicide: For example, there is a relatively higher incidence of fatality not only with guns but also with jumping off buildings or bridges. Some other suicide attempts are relatively less fatal, such as overdoses; but some suicide attempts are particularly tragic such as carbon monoxide inhalation where those who survive might be brain damaged. Potentially patients commonly act against themselves not others, whether the technique of attempted suicide is violent (e.g., firearms) or not (e.g., overdose), but they do not generally act by harming others. These suicide attempts may be perceived as also harming family and friends because of the sad, unfortunate impacts and in that way may still be perceived as evil. But that is a very different kind of evil compared with attempted homicide. And such violent homicides are regarded as rare in the psychiatric population.

On the other hand, when we move from Axis 1 (psychopathology) to Axis 2 relating to personality disorder, then psychiatric classification becomes very different. These individuals can wreak havoc on others. This is the DSM-5 subpopulation of *Cluster B* patient. And *within* this so-called DSM 'Axis 2' are those who theologically may be regarded as 'evil': the exact terms have varied over time: Until recently, we used the term *'psychopath'*. Then *'sociopath'* became fashionable implying that society might have caused the behaviors—again, almost a way of partly condoning behaviors due to mental disorder: Some clinicians do not perceive the sociopath to be as evil as the psychopath, although the terms might, in actuality, be synonymous and just a different product of culture. The latest synonym is 'anti-social personality disorder'. However, we cannot just restrict our 'evil' axis to the DSM Axis 2 subpopulation: How do we describe actions in large groups where such people might be drawn to violence, but where the culture accepts this as rational, even admirable nationalistic behavior? For example, the Nazis imposed their belief systems on the population. This produced resulting national evil atrocities.

Hannah Arendt, the Jewish anti-Nazi political philosopher who fled her native Germany in 1933, expressed this tragically: *"The banality of evil."* [10] This is another reason why another DSM Axis 6 'good-evil' might be useful for everyone. It is not limited to our focus on the classification of mental illness. In psychiatric classifications, some DSM Axes (such as Axis 2 or Axis 3) may be deferred or not applicable. The same applies when using Axis 6 labels in individuals who do not have Axis 1, 2 or 3 diagnoses.

Again, we're not discussing here whether or not good and evil are actual forces, as in theological concepts, that can influence people and events. This is simply an objective look at behaviors and expressions of behaviors—not fantasies, not ideas, not thoughts—that are evil. These might cause not only deliberate self-harm or ironically, deliberate self-gratification to themselves, but also result in major psychological traumata to family and friends as a consequence.

Clearly, there are times when electrical firing in the brain, such as in temporal lobe disease, can cause explosive anger, and this can be controlled with appropriate medication. Is evil more common in psychiatric patients? It does not appear to be so but we really don't know because 'evil' is often labeled as 'illness'.

When we examine the published literature, we discover that there are basically no publications, for example, in PubMed, in this area—very, very little is written. It is politically inappropriate to discuss good and evil in mental illness. And yet, that compromises the patient, because our society often says, *"They must have been mentally ill to have done such things."* This is why our society links up psychopathy with illness sometimes calling it 'antisocial personality disorder and regarding it as a mental illness) when psychopathy, to me, is not mental illness. Psychopathy may best describe pure evil, and by calling it only 'antisocial personality disorder,' society may be trying to make it sound more clinical, even more acceptable, and avoid the more disturbing language of 'good and evil'. Examining behaviors that our society would regard as evil, we frequently leave out the politics, and unfortunately even the evil actions, in the name of religion. This is quite different from the organic brain syndrome component, in which specific cerebral damage leads to behaviors that are unacceptable, and which can be appropriately alleviated.

But what about the theological concept of the human propensity toward evil? Why would fundamentally good people sometimes do evil? Perhaps religion treats that as a mystery, whereas modern science in its quest for knowledge (and rejection of the 'supernatural') eliminates the mystery element.

What benefit or change in society would occur if society agreed that good and evil behaviors exist? Would prediction of anti-social behavior be better as a result? Would treatment of the dyssocial, or would protection of our society be more effective as a result? Such questions do not relate to belief systems and theological backgrounds but we're examining here simply end-result behaviors. There is also frequently misrepresentation in the media. [80] But these questions are difficult to

answer: They need empirical testing.

In this regard, Bastian and colleagues in Australia, suggested the term '*moral vitalism*' [81] —the tendency to view good and evil as actual forces that can influence people and events. Bastian et al have also proposed a scale designed to assess the extent of good and evil *belief*s, and the consequent *responses* and impacts on society these have. This moral vitalism would align with my proposed Good-Evil Axis 6 of DSM-6. Such ratings would be based on self-rankings, ratings of first-degree contacts, and include histories of aberrant behaviors and also attitudes. But first, we must collect preliminary data and test the resulting classification.

We could and should apply classifications to good and evil. This paper provokes ideas, many of which create the ambivalences of 'approach-avoidance conflicts'. There are seldom pure black- white choices, just a coloring between. It's important for commentators to conceptualize the whole balance, understand the opposing views of actions that might be motivated differently, sometimes oppositely, and involving profound psychodynamics and ethicoethnicopsychofamiliosociocultural overtones: What is perceived as evil in one can be a blessing for another.

4. Perspective

There is far more in the context of good and evil than the psychiatric context and its classifications of moral behavior. We have alluded to the theological, as well as the medicolegal context, and these three together—psychiatry, forensic and theology—constitute most of the context of moral judgment. Of course, the term 'theology' here is something of a misnomer—it includes the morality of our godless brothers, as well.

All these considerations are aspects to consider in any kind of evaluation of this sort. They reflect dilemmas one has to look at, and there is no easy answer to the good-evil dichotomy and controversies of relative morality. We end as we began: if one is not hard-hearted and if one does not want to contemplate such matters, that is comprehensible. On the other hand, the trauma of good and evil may afford people opportunities to grow or even avenge deep-lying conflicts —if only 'virtually' in one's dreams, for example—without repercussion. But such feelings too can be positively redirected and impact oneself or others in their immediate or long-term futures.

References and Bibliography on Conceptualizing good and evil in psychiatry and social groups (Part 3)

Vernon M Neppe MD, PhD, FRS(SAf), DFAPA

1. Milgram S: *Behavioral Study of Obedience.* Journal of Abnormal and Social Psychology 67:4; 371-378, 1963.
2. Milgram S: *Obedience to Authority; an Experimental View*. New York: New York: Harper Collins, 1974.
3. Milgram S: *Some Conditions of Obedience and Disobedience to Authority.* Human Relations 18:1; 57–76, .doi:10.1177/001872676501800105, 1965.
4. Zimbardo P: When Good People Do Evil, *Yale Alumni Magazine.*, January/ February 2007, 2007.
5. Blass T: *Understanding Behavior in the Milgram Obedience Experiment: The Role of Personality, Situations, and Their Interactions.* Journal of Personality and Social Psychology 60:3; 398-413. doi:310.1037/0022-3514.1060.1033.1398, 1991.
6. Committee APA: *Diagnostic and Statistical Manual : DSM 5*. Washington , D.C.: American Psychiatric Association, 2013.
7. Anonymous: *Could It Be That Eichmann and His Million Accomplices in the Holocaust Were Just Following Orders? Could We Call Them All Accomplices?* In USA, Google Books, 2013.
8. Durkheim E: *On Suicide*. New York: Penguin Classics 2007 (original 1897)
9. Segev T: *Soldiers of Evil: The Commanders of the Nazi Concentration Camps*. New York, NY: McGraw Hill, 1988. (Tom Segev)
10. Arendt H: *Eichmann in Jerusalem: A Report on the Banality of Evil*. New York: Penguin Classic, 1963 (reprinted 2006).
11. Shakespeare W: *"Let Me Not to the Marriage of True Minds Admit Impediments."* Sonnet 116. Stratford on Avon, circa 1564 - 1616.
12. Segev I: *Synapses Neurons and Brain,* in Coursera August 2015. 2015 (Idan Segev)
13. Cashmore AR: *The Lucretian Swerve: The Biological Basis of Human Behavior and the Criminal Justice System* http://www.pnas.org/content/107/10/4499.f. 2010.
14. Neppe: *Good and Evil in Psychiatry and Theology.* *J. Clin Psychiatry and Psychology*, 2017 in press.
15. Close ER, Neppe VM: *Putting Consciousness into the Equations of Science: The Third Form of Reality (Gimmel) and the "True" Units (Triadic Rotational Units of Equivalence) of Quantum Measurement* *IQNexus Journal* 7:4; 7-119, 2015.
16. Close ER, Neppe VM: *Speculations on the "God Matrix": The Third Form of Reality (Gimmel) and the Refutation of Materialism and on Gluons.* *World Institute for Scientific Exploration (WISE) Journal* 4:4; 3-30, 2015.
17. Close ER, Neppe VM: *The Role of Mathematics in Investigating the Nature of Reality (Part 4).* *IQNexus Journal* 7:4; 22-26, 2015.
18. Close ER, Neppe VM: *Translating Fifteen Mysteries of the Universe: Nine Dimensional Mathematical Models of Finite Reality, Part Ii.* *Neuroquantology* 13:3; 348-360, 2015.
19. Neppe VM, Close ER: *A Data Analysis Preliminarily Validates the New Hypothesis That the Atom 'Contains' Dark Matter and Dark Energy: Dark Matter Correlates with Gimmel in the Atomic Nucleus and Dark Energy with Gimmel in Electrons.* *IQ Nexus Journal* 8:3; 80-96, 2016.
20. Neppe VM, Close ER: *The Fourteenth Conundrum: Applying the Proportions of Gimmel to Triadic Rotational Units of Equivalence Compared to the Proportions of Dark Matter Plus Dark Energy: Speculations in Cosmology.* *IQNexus Journal* 7:2; 72-73, 2015.
21. Close ER, Neppe VM: *Understanding True Units and Gimmel as Part of TDVP: Chapter 7* *IQ Nexus Journal* 8:4 — V6.122; 97-106, 2016.

22. Close ER, Neppe VM: *Why True Units Have to Be Correct: The Mass in the Proton: Re-Affirming the Truth of Triadic Rotational Units of Equivalence. Chapter 6* IQ Nexus Journal 8:4 —V6.122; 70-96, 2016.
23. Neppe VM, Close ER: *Free-Will: A TDVP Perspective (Part 13 I).* IQNexus Journal 7:3; 135-136, 2015.
24. Neppe VM, Close ER: *Fifty Discoveries That Are Changing the World: Why the Triadic Dimensional Distinction Vortical Paradigm (TDVP) Makes a Difference.* IQ Nexus Journal 9:2; 7-39, 2017.
25. American, Psychiatric Association and Committee *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-Iv)*. Washington, DC: American Psychiatric Publishers, 1994.
26. Neppe VM: *Paroxysmal Disorders: What Is Epileptic and Non-Epileptic? (Part 4)* Journal of Psychology and Clinical Psychiatry 3:5; 00165 8-11, 2015.
27. Neppe VM: *Management of Paroxysmal Neurobehavioral Disorder (PND) Part 3* Journal of Psychology and Clinical Psychiatry 3:5; 00165 6-8, 2015.
28. Neppe VM: *Paroxysmal Neurobehavioral Disorder: The Episodic Brain Condition (Part 2)* Journal of Psychology and Clinical Psychiatry 3:5; 00165 4-6, 2015.
29. Neppe VM: *Paroxysmal Disorders in Neuropsychiatry: Why Episodic Disorders Must Be Accounted For.* Journal of Psychology and Clinical Psychiatry 3:5; 00165 1-28, 2015.
30. Neppe VM: *Temporal Lobe Epileptic and Brain Related Déjà Vu Experiences (Section 11)—the Special Subtypes of Déjà Vu (Part 3).* Journal of Psychology and Clinical Psychiatry 2:6; 00113 00116-00119/00115, 2015.
31. Blumer D, Neppe V, Benson DF: *Diagnostic Criteria for Epilepsy-Related Mental Changes* Am J Psychiatry 147:5; 676-677, 1990.
32. Neppe VM: *The Inset as an Important Historical and Diagnostic Screen in Paroxysmal Disorders (Part 8)* Journal of Psychology and Clinical Psychiatry 3:5; 00165 16-19, 2015.
33. Lynam DR: *Pursuing the Psychopath: Capturing the Fledgling Psychopath in a Nomological Net.* J Abnorm Psychol 106:3; 425-438, 1997.
34. Lynam DR: *Early Identification of the Fledgling Psychopath: Locating the Psychopathic Child in the Current Nomenclature.* J Abnorm Psychol 107:4; 566-575, 1998.
35. Endres J: *The Language of the Psychopath: Characteristics of Prisoners' Performance in a Sentence Completion Test.* Crim Behav Ment Health 14:3; 214-226, 2004.
36. Furnham A, Daoud Y, Swami V: *"How to Spot a Psychopath". Lay Theories of Psychopathy.* Soc Psychiatry Psychiatr Epidemiol 44:6; 464-472, 2009.
37. Genter R: *"We All Go a Little Mad Sometimes": Alfred Hitchcock, American Psychoanalysis, and the Construction of the Cold War Psychopath.* Can Rev Am Stud 40:2; 133-162, 2010.
38. Calzada-Reyes A, Alvarez-Amador A, Galan-Garcia L, et al.: *EEG Abnormalities in Psychopath and Non-Psychopath Violent Offenders.* J Forensic Leg Med 20:1; 19-26, 2013.
39. Maibom HL: *To Treat a Psychopath.* Theor Med Bioeth 35:1; 31-42, 2014.
40. Day R, Wong S: *Anomalous Perceptual Asymmetries for Negative Emotional Stimuli in the Psychopath.* J Abnorm Psychol 105:4; 648-652, 1996.
41. Edens JF, Marcus DK, Vaughn MG: *Exploring the Taxometric Status of Psychopathy among Youthful Offenders: Is There a Juvenile Psychopath Taxon?* Law Hum Behav 35:1; 13-24, 2011.
42. Lombroso C: *Criminal Man*. Seattle: Amazon Kindle Edition, 1885.
43. Anonymous. (2017). *Relative Morality*. Retrieved 29 August 2017, from http: //legal-dictionary.thefreedictionary. com/Relative+Morality
44. Rorty R: *Consequences of Pragmatism*. Minneapolis University of Minnesota Press, 1982.
45. Schumacher R. (2017). *What Is Moral Relativism?* , from https: //carm. org/moral-relativism
46. Nietzsche F. (Circa 1875, quoted in 2017). *Quotation*. www.brainyquote.com/quotes/quotes/f/friedrichn159194.html

47. Neppe VM: *Non-Epileptic Symptoms of Temporal Lobe Dysfunction* S Afr Med J, 60:26; 989-991., 1981.
48. Neppe VM: *Symptomatology of Temporal Lobe Epilepsy.* S Afr Med J, 60:23; 902-907, 1981.
49. Neppe VM: *Differing Perspectives to the Concept of Temporal Lobe Epilepsy.* The Leech 52:1; 6-10, 1982.
50. Neppe VM: *Utility, Applications, Validity and Reliability of the Inventory of Neppe of Symptoms of Epilepsy and the Temporal Lobe (Inset) Compared with Ambulatory Electroencephalographic Parameters, Longitudinal Clinical Features, Anticonvulsant Responsiveness, and the Sobin (Subtle Organic Brain Inventory of Neppe).* https://live.blueskybroadcast.com/bsb/client/_new_default.asp?action=SEARCH&Client=418883. 2014
51. Neppe VM: *Which Patients Respond to Anticonvulsants? The Role of Mesial Temporal Lobe Firing (Part 10)* Journal of Psychology and Clinical Psychiatry 3:5; 00165 22- 25, 2015.
52. Neppe VM: *Taming the Temporal and Frontal Lobes of the Brain by Applying Higher Brain Function Structured Inventories—"the Inventory of Neppe of Symptoms of Epilepsy and the Temporal Lobe" (Inset) and the "Subtle Organic Brain Inventory of Neppe" (Sobin) Together with Ambulatory Electroencephalography Parameters, and Clinical Anticonvulsant Responsiveness* http://neuro.psychiatryonline.org/toc/jnp/27/2. 2015
53. Neppe VM: *Paroxysmal Disorders: Electrical Firing and Systems Diagnoses (Part 7)* Journal of Psychology and Clinical Psychiatry 3:5; 00165 15- 16, 2015.
54. Neppe VM: *Paroxysmal Disorders: Are These Seizures or Electrocerebral Firing? (Part 11)* Journal of Psychology and Clinical Psychiatry 3:5; 00165 25-28, 2015.
55. Neppe VM: *Analysis of Symptom Clusters Involving Episodic Disorders Including Paroxysmal Neurobehavioral Disorder (PND) in Neuropsychiatry.* http://neuro.psychiatryonline.org/toc/jnp/27/2. 2016
56. Mercer D, Mason T, Richman J: *Good & Evil in the Crusade of Care. Social Constructions of Mental Disorders.* J Psychosoc Nurs Ment Health Serv 37:9; 13-17, 1999.
57. Ulrichsen J, Ulrichsen M: *[the Good and the Evil Recovery].* Ugeskr Laeger 168:3; 299-301, 2006.
58. Abdel Rahman R: *Facing Good and Evil: Early Brain Signatures of Affective Biographical Knowledge in Face Recognition.* Emotion 11:6; 1397-1405, 2011.
59. Tice LF: *Education, for Good or for Evil?* Am J Pharm Sci Support Public Health 124:11; 360-362, 1952.
60. Parker WL, Trifunov J: *The Sport of Amateur Boxing--Good or Evil?* Can Med Assoc J 83432-435, 1960.
61. Gillon JJ: *[the Good and Evil of Bibliography].* Concours Med 842897-2898, 1962.
62. Peck MS: *People of the Lie: The Hope for Healing Human Evil* 2 Edition. New York: Touchstone (Simon and Schuster), 1997.
63. Gould SJ: *Nonoverlapping Magisteria.* Natural History 106:March; 16-22, 1997.
64. Grob GN: *Origins of DSM-I: A Study in Appearance and Reality.* American Journal of Psychiatry 148:4; 421–431, 1991.
65. Altschule MD: *Beyond Good and Evil, or How to Create the Dark in Which to Whistle.* J Med Assoc Ga 61:5; 162-172, 1972.
66. Gutt RW: *[Every Evil May Eventually Beget Some Good... (on the 150th Anniversary of Ludwig Van Beethoven's Death)].* Arch Hist Med (Warsz) 40:2; 219-228, 1977.
67. van der Does de Villebois AE: *[Children: The Touchstone of Good and Evil].* Rev Med Univ Navarra 23:1; 63-69, 1979.
68. Neppe VM: *Schizophrenia: A Guide to Clinical Diagnosis.* South Afr J Hosp Medicine 8:4; 88-92, 1982.
69. Hamel R: *A Better Approach to Care of the Dying. Catholic Healthcare and the Catholic Community Can Present an Alternative to Physician-Assisted Suicide.* Health Prog 79:5; 54-59, 1998.

70. Kalischuk RG, Davies B: *A Theory of Healing in the Aftermath of Youth Suicide. Implications for Holistic Nursing Practice.* J Holist Nurs 19:2; 163-186, 2001.
71. Kolves K, Milner A, Varnik P: *Suicide Rates and Socioeconomic Factors in Eastern European Countries after the Collapse of the Soviet Union: Trends between 1990 and 2008.* Sociol Health Illn 35:6; 956-970, 2013.
72. Lindqvist AS, Moberg T, Ehrnborg C, et al.: *Increased Mortality Rate and Suicide in Swedish Former Elite Male Athletes in Power Sports.* Scand J Med Sci Sports, 2013.
73. Rafnsson V, Gunnarsdottir OS: *All-Cause Mortality and Suicide within 8 Days after Emergency Department Discharge.* Scand J Public Health 41:8; 832-838, 2013.
74. Rostila M, Saarela J, Kawachi I: *Suicide Following the Death of a Sibling: A Nationwide Follow-up Study from Sweden.* BMJ Open 3:4, 2013.
75. Saint Onge JM, Krueger PM, Rogers RG: *The Relationship between Major Depression and Nonsuicide Mortality for U.S. Adults: The Importance of Health Behaviors.* J Gerontol B Psychol Sci Soc Sci, 2014.
76. Sommer-Rotenberg D: *Suicide and Language.* Cmaj 159:3; 239-240, 1998.
77. Stiel M, Madea B: *Satanism and Suicide in Adolescence--2 Case Reports.* Arch Kriminol 210:3-4; 76-82, 2002.
78. Vidal CE, Gontijo EC, Lima LA: *[Attempted Suicide: Prognostic Factors and Estimated Excess Mortality].* Cad Saude Publica 29:1; 175-187, 2013.
79. Wahl CW: *Suicide as a Magical Act.* Bull Menninger Clin 21:3; 91-98, 1957.
80. Fawcett K: *How Mental Illness Is Misrepresented in the Media: Insidious Portrayals on TV Shape Perceptions About Real-Life People with Psychological Disorders.*, USNews, April 16, 2015, 2015.
81. Bastian B, Bain P, Buhrmester MD, et al.: *Moral Vitalism: Seeing Good and Evil as Real, Agentic Forces.* Pers Soc Psychol Bull 41:8; 1069-1081, 2015.