Chapter 17

The Influence of Evil on Forensic Clinical Practice

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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
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 eschalon 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).

**Dramaturgical Trajectories**

Eradicating evil from drama would make the enterprise a bland affair. Dramaturgical approaches to understanding evil have centered 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 public.

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-
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, standardization, 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 pronominals of transition. By this, such conversion terms as mentioned above (i.e., “beyond,” “too far,” “beggar 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>
<thead>
<tr>
<th>Care plan no.</th>
<th>Sex</th>
<th>Diagnosis</th>
<th>Offenses</th>
<th>Length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>M</td>
<td>ppd/s/df</td>
<td>MS × 2/GBH</td>
<td>6 years</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>psd/df</td>
<td>MS × 1</td>
<td>17 years</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>ppd/s</td>
<td>AM/WI</td>
<td>4 years</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>ppd/df/as</td>
<td>M</td>
<td>7 years</td>
</tr>
<tr>
<td>22</td>
<td>M</td>
<td>ppd/mi</td>
<td>MS × 4</td>
<td>18 years</td>
</tr>
<tr>
<td>34</td>
<td>M</td>
<td>ppd</td>
<td>WI/A</td>
<td>14 years</td>
</tr>
</tbody>
</table>

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.
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. 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.

Table 2

<table>
<thead>
<tr>
<th>Problems identified</th>
<th>Suggested interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor attitude toward others</td>
<td>• Develop trusting relationship</td>
</tr>
<tr>
<td></td>
<td>• Feedback on others’ attitudes toward patient</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>• Refer to Alcoholics Anonymous</td>
</tr>
<tr>
<td></td>
<td>• Alcohol-related counseling</td>
</tr>
<tr>
<td>Reduced contact with mother</td>
<td>• Explore ways of increasing contact</td>
</tr>
</tbody>
</table>

*Care plan for patient with a diagnosis of psychopathic personality and a secondary diagnosis of schizoid personality with dissocial features.*

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).
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.”
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>
<thead>
<tr>
<th>Problems identified</th>
<th>Suggested interventions</th>
</tr>
</thead>
</table>
| 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 |

*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 legitimizid 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?
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 judgments 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 pretense 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-
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. 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.](image-url)
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 retreats 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
dull. In this sense, one does not have the capacity of choice and is unaware of higher eschalon 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

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**Fig. 3. Perceptions of rationality.**
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/
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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References