‘Does Evil have to exist to be real?
- the discourse of evil and the practice of mental health care’.

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Introduction

I have been much heartened by recent developments within the area of spirituality and mental health care. There is a growing body of literature that shows clearly the positive correlation between a person’s spirituality and their mental health, even in the context of severe mental health problems (Larson 2001). People are starting to see this area of care as significant in terms of research and practice and a number of positive spiritual strategies are beginning to edge their way into mainstream caring strategies. ‘Spirituality is good for your health’ the slogan goes. And it is. We are discovering that a healthy spirituality makes us happier, protects us from depression, makes us more secure, provides us with a stronger sense of self and, if our spirituality is manifested via religion, roots us firmly within a supportive community, which in turn has significant health benefits. All of this is exciting and challenging, and opens up new and relatively unexplored channels for caring and supporting people who are experiencing psychological distress. It is becoming more and more clear that spirituality sits at the heart of the enterprise of mental health care and that we most certainly need to reflect critically and carefully on its implications for our practice.

The rhetoric of love

At heart, spiritual care relates to the nurturing of that which is good, wholesome and health bringing. It is an approach to mental health and illness which is designed to enable carers to develop strategies to see and to treat patients as whole persons; as individual beings who require a sense of meaning, hope, purpose, relationship with God, Self and others and who, above all, require effective strategies which will enable them *to love and accept love*. There is a meaningful sense in which at the heart of the spiritual task of mental health carers lies the difficult objective of re-introducing the rhetoric of love and connectedness to the techno-scientific language of contemporary psychiatry.

The rhetoric of evil

Evil is the antipathy of love and goodness. A simple but not indisputable understanding of evil is that it is the power, be it internal or external, which seeks to destroy love in all of its diverse forms. It is senseless, meaninglessness, hopeless, violent and always results in the shattering of relationships. As such, one might think it worthy of serious reflection in relation to spiritual care within a mental health context. However, if we begin to explore the literature on spirituality and spiritual care, we will struggle to find any reference to the concept of evil. Consequently, despite frequent encounters with actions and persons often described as ‘evil,’ mental health carers are not presented with any therapeutic strategies or perspectives that might enable them to understand and deal constructively with evil. As we shall see, they may recognise its existence, sometimes in quite systematic ways, but there is no mechanism available which would enable them to work constructively with evil.

Losing our religion

Part of the reason for the absence of evil from the rhetoric of spirituality is that spirituality in its contemporary form is frequently stripped of its religious roots. I don't want to give an opinion on whether that is a good or a bad thing but it does leave a gap in our conceptual thinking in relation to spirituality. Many of the world's religious traditions acknowledge the reality of the dark side of human beings. Within these traditions the nurturing of a person's spiritual dimension is primarily aimed at moving them away from their perceived propensity towards evil and into the presence of 'the good' where they can find reconciliation, acceptance and the possibility of transformation. To enable this process, these traditions have rituals, rites of passage and spiritual practices, which enable people to make this transition and to sustain their lives in a way that emphasises good rather than evil.

They also have specific mechanisms to enable those who encounter evil to deal with it in constructive ways. For example, within the Christian tradition the dictum 'perfect love drives out fear' as it is embodied and worked out within the life of Christ, provides a significant paradigm for dealing with evil in a way that is compassionate and effective. Likewise such spiritual practices as prayer, forgiveness and reconciliation are effective and often therapeutic responses to evil and its consequences. When religions speak about spiritual care, they are talking very specifically about enabling people to live in ways that are considered good and to avoid that which is evil.

Forgetting about evil

Much of the contemporary discourse that surrounds spirituality and spiritual care has dissociated itself from any kind of formal religious foundation. Instead it tends to locate itself primarily within a very positive, humanistic worldview that focuses primarily on that which is good within human beings and human living. On reflection, it is clear that spiritual care and self-actualisation are closely connected within current approaches to spirituality. Spiritual care is designed to enable the actualisation of an assumed latent good within human beings. Thus, for the most part, spirituality is assumed to be *immanent*, emerging from within human beings and intended to enable self-actualisation. As there is no necessary transcendent dimension to spirituality, that is, no external powers to encounter or wrestle with, there is little need for the language of evil. Within this spiritual paradigm the concept of evil is neither desired nor required. In a real sense, evil is subsumed to the overwhelming quest for good and consequently falls out of the therapeutic equation. As a result of this, little reflection has gone into the possibility that an understanding of evil may be clinically significant and that developing effective strategies to counter evil within a therapeutic context may in fact be an important dimension of the care agenda.

What is evil?

> *To be able to see fellow human beings as wholly evil…requires an imaginative capacity not found in other species.* (Storr 1991)

I now want to begin to develop a therapeutic perspective on evil that will enable us to understand the potential clinical significance of thinking about this area of care. I want to begin by exploring some of the dynamics that lie behind the *creation* of evil. Now I use the word 'creation' quite deliberately. For current purposes I want to avoid any deep philosophical or theological arguments about the existence or otherwise of evil. Personally, I am happy to acknowledge that evil may well have ontological significance; there may well be an external force of evil that

impinges upon human beings irrespective of their desires. However, I want to suggest that discussions over that possibility form only a part of the debate. (I suspect that the reason evil is easily discarded by many psychiatrists is because, when discussed at this abstract level alone, the clinical significance of evil can become confused and unclear).

For current purposes I want to take what we might describe as a pragmatic approach to evil. Such an approach assumes the *reality* of evil within a mental health context without necessarily arguing for its *existence*. Let me explain what I mean by this.

Social constructionist thinkers have taught us that things don't have to exist to be real (Berger 1966). Human beings are constantly exploring and interpreting their worlds, creating understandings, concepts, models, ideas which have no necessary ontological basis, understandings which are not factual in a scientific sense but when incorporated within our worldviews can be perceived in very real and tangible ways. Irrespective of their ultimate empirical status, these social constructions can impinge greatly on the way we experience the world and act towards it. I want to suggest that while evil *may* well have a supernatural dimension, it is *also* a powerful social construction, an explanatory framework that we use to grasp and make sense of that which appears unexplainable. Evil is a powerful interpretative label which, when ascribed to individuals, removes them from our therapeutic horizon and leaves them stranded, alienated and vulnerable to forms of treatment which are oppressive and dehumanising. When this happens, it is not only a tragedy for the individuals who receive this label, for in ascribing the label of evil and acting accordingly, *mental health carers can themselves become the perpetrators of evil.* The significance of this point will become clear as we move on.

Creating evil and battling with monsters

Within a mental health context, we constantly encounter human beings whose behaviours are bizarre, extreme and often inexplicable. Particularly within a forensic context, we are frequently faced with people who have committed acts that are abhorrent, frightening and degrading. How do we deal with that experience? When we encounter something we judge to be harmful or evil, there are two ways in which we can respond. We can respond by *objectivizing* and *distancing* ourselves from the evil act, evil person or evil process. Here we set up strategies either to battle against the evil, or to exclude it from our presence either physically via prisons or special hospitals, or psychologically through the process of labelling, distancing, and scapegoating. When this happens we turn *persons* into *monsters* and act accordingly.

When we consider the public profile of someone like Myra Hindley, we can see this process clearly at work. Hindley bears the label of 'the most evil woman in Britain' and there is a fresh public outcry each time there is talk of her release. As Hilary Brand correctly observes, despite the fact that her crimes took place over thirty years ago, we are frequently exposed to that same picture which freezes her in 1966 'a hollow-eyed, defiant 23 year-old, a sinister peroxide murderess. Its like we need her to be a monster in order that we can understand and make sense of that which is inexplicable'. But of course she is not a monster. 'She is a dark-haired 58-year old with arthritis, angina and a degree in humanities from the Open University' (Brand 2000).

Chilling as Hindley's crimes undoubtedly were, there is another dimension to her story that, in a sense, is equally as chilling. *'Before those horrific two years in which she lured five children to their deaths, she lived an exemplary life and was even in demand as a babysitter. Throughout her imprisonment she has shown no criminal tendencies, and experts are unanimous in the opinion that she poses no threat to society. The detective who took her confession in 1986 has no doubt. Had*

she not met Ian Brady and fallen in love with him, she would have got married and had family and been like any other member of the general public' (Brand 2000).

Could it be that the thing that frightens us most may be the fact that despite the horrific nature of her crimes, in uncomfortable ways, she is really just like us!

Implications for mental health care

Within a mental health context such a response to extreme behaviours can have devastating consequences for the *personhood* of people with mental health problems *and* for psychiatrists and other mental health carers who struggle to offer authentic spiritual care. An interesting example of this is presented in the work of Dave Mercer, Tom Mason and Joel Richman on the discourse of evil in a forensic context. They carried out a fascinating piece of research at Ashworth hospital, which sought to explore the significance of the discourse of evil amongst forensic nurses (Richman 1999, Mercer 1999, Mercer 2000). They uncovered evidence that raised the possibility that within a forensic nursing context, the allocation of the label 'evil' could have significant implications for nurse-patient relationships. They noted that the term 'evil' is quite regularly used within the 'lay' nursing discourse (i.e. the day-to-day language used by nurses as opposed to the professional language of psychiatry or law). Interestingly, while there was a good deal of tolerance for people who were 'classically' mentally ill (psychotic, bipolar disorder etc.) those with a diagnosis of 'psychopath' or 'personality disorder' were frequently labelled evil and in significant ways written off as fully human beings. Interestingly, the allocation of the label 'evil' was neither random nor a purely pejorative act. Rather it reflected what the researchers described as a 'formulation of a rule-structured taxonomic ordering' (Mercer: 16).

A Taxonomic Ordering of Evil in Nursing Discourse

- *Absence of medical descriptors*: Evil was only employed if there was no evidence of physical or psychiatric symptoms.

- *Nature of the attack:* To qualify as evil, the nature of the attack or assault had to be seen as deliberate, planned and purposeful.

- *Extinction of moral bonding*: Evil was linked to the transgression of practical and abstract boundaries, implying free will, choice, intelligence, and unrestrained 'instinct'.

- *Adjacent pairing of opposites:* Evil was associated with offences where there was a generational gap between victim and perpetrator, for instance, rape of children or the elderly.

- *Reality testing:* Acts were more likely to be described as evil if a pattern of 'deviant' behaviour had been established over time, and 'tested out' in the world (Mercer 1999:15).

The label of evil was applied when the person was deemed to be aware, reasonable and morally responsible for the particular actions he or she participates in. Significantly, psychiatric diagnosis appeared to 'expurgate the demons' and free the person from the accusation of being evil. Thus, such language as 'an evil no hoper', 'this one is beyond help', 'just rotten through and through', 'evil, pure evil' and 'the only way out for this man is in a box (coffin)', sat in uneasy tension with the expressed clinical aims such as caring, developing self-esteem, and enabling meaningful relationships (Mercer 1999:16).

The researchers end their report with this rather unsettling statement: 'these perceptions conceptually move the patient beyond the possibility of rehabilitation or, at least, beyond the ability of psychiatry to effect a cure' (Mercer 1999:17). The perception is that psychiatry can no longer help these 'evil creatures'. The evil person is judged 'untreatable' and in a sense 'untouchable' and particular strategies are employed to move him or her out of the world of persons and therapeutic intervention and into the realm of lepers, monsters and 'untreatability'. Such a discourse not only degrades the patient, it also forces the mental health carer into a position where the danger of inhumane practices becomes a real possibility. You don't treat monsters as humans!

There is another dimension to this process that is equally as crucial and must not be forgotten. If we take seriously Scott Peck's definition of evil as *"that force residing either inside or outside of human beings that seeks to kill life and liveliness* (Peck 1988:43), 'creating monsters' in response to evil acts not only destroys the liveliness of the patient, it also destroys the liveliness of the carer and can become an evil in itself; an insidious form of evil which in the long-term makes all of us less than human. If that is the case, then the spiritual stakes are high.

Battling with monsters and resurrecting persons: sitting with evil in the hope of reconciliation

I have already suggested that one way of dealing with evil is through confrontation and distancing. However, there is another way that we can respond to the presence of evil. Christian psychiatrist James Mathers (1979), in his exploration of the nature of evil, highlights the life of Jesus as a paradigm for dealing with evil within a therapeutic context. Whereas our natural tendency is to adopt an aggressively exclusionist stance towards evil, Mathers highlights the fact that that time and time again when confronted with evil, Jesus took a different approach. Rather than isolating or excluding evil, (although at times he certainly did adopt this position) his overall tendency was to sit with those whom civil and religious society deemed to be evil in the hope of reconciliation. When he encountered demons, barbarians and madmen, Jesus sat with them, ministered to them and in so doing resurrected their personhood and destroyed the evil persona. This approach to evil was costly, dangerous and ultimately fatal; it required integrity, courage and love but it offered a response to evil that was radically effective and which I believe is highly pertinent to the contemporary practice of mental health care. I want to suggest that this model of sitting with evil in the hope of reconciliation is a helpful spiritual paradigm for addressing the types of problems highlighted thus far.

A return to the virtues?

How then might we begin to learn to sit with evil in the hope of reconciliation? I want to make a tentative suggestion that one way in which we can counter the type of evil I have been describing is by reflecting thoughtfully on the role of *the virtues* in the practice of mental health care. While the virtues may not command a great deal of attention within contemporary mental health car practices, they nonetheless have the potential to add a significant dimension to our caring practices when we are faced with evil.

Aristotle described virtue as a state of excellence or disposition whose aim is the highest good (Ross 1998). The term 'virtue' means that which causes a thing to perform its function well (eye-seeing; knife-cutting edge; horse-running etc.) *Human virtue is that which causes us to fulfil our function in a way that is appropriate for our status as human beings.* Virtues such as love, goodness, mercy, trust, courage and hope are not things that are grasped and learned with the intellect alone. Rather, they are *habits* that, when practiced regularly, result in a new and virtuous way of

being. Practicing the virtues leads to the development of a form of character that will enable individuals to act according to what is good within their particular encounters. Virtues therefore aim to move a person towards the good, and away from that which is bad or evil. As such, they would appear to be a perfect counter to the types of negative social constructions of evil that have been outlined thus far. Within the confines of this paper is it not possible to develop this approach as fully as might be required to make the case. Nevertheless, in order to offer some pointer towards my thesis, I will highlight four virtues that are of particular relevance to mental health professionals and reflect briefly on how they might function in the overcoming of evil.

Respect and Honesty

The first stage in battling with evil relates to re-conceptualising what it means to be human. In order to do this we need to be totally *honest* about what human beings are. I have already suggested that the current emphasis on spiritual care tends to assume an inherent goodness within human beings. There is much goodness in the human race. But history and common experience tells us that human beings are a strange mixture of touching goodness and terrifying badness. We live our lives in a strange tension between the compassion of mother Teresa and the horror of Auschwitz. On one level we are profoundly relational creatures-persons-in-relationship, as John MacMurray (1995) puts it. *The primary spiritual need that all of us have is for relationship and reconciliation.* From the cradle to the grave we are dependant on love to survive. We become who we are not by isolating ourselves from one another but by relating with one another in a myriad of different ways. The very fabric of our Self is relational. I cannot be a husband without a wife; I cannot be a father without children; I cannot be a teacher without having pupils and so forth. Paradoxically, this is what makes us vulnerable to pain, hurt, suffering and forms of emotional damage that can, to a greater or lesser extent, determine the trajectory of our lives. Ironically, it is our need to love and to relate which is one of the primary causes of human suffering. These inherent relational dynamics form the basis for our respect for one another and our understandings of personhood. No matter how damaged we may be, no matter how heinous our actions may be, we remain persons-in-relationship and retain the need to be treated and understood as fundamentally relational beings.

There is no doubt that human history is marked by tremendous acts of love, compassion and altruism. And yet, there is another side to being human which is much darker. For example, if we take the Holocaust, which most of us would think of in terms of the darkest form of evil, there is a dimension that is often overlooked. William Styron, in his novel Sophie's Choice, makes a simple but poignant observation.

> *Real evil, the suffocating evil of Auschwitz- gloomy, monotonous, barren, boring was perpetrated almost exclusively by civilians. Thus we find that the roles of the SS contained almost no professional soldiers but were instead composed of a cross-section of German society. They included waiters, bakers, carpenters, restaurant owners, physicians, a bookkeeper, a nurse, a fireman; the list goes on and on with these commonplace and familiar citizens' pursuits.* (Styron 1992:204)

There is ample evidence within the literature to suggest that when ‘ordinary’ human beings for whatever reason become disinhibited, they have a propensity to act in ways that can only be described as evil. There is thus a strange tension between the human propensity towards relationships and love and the tendency to stumble into an abyss of darkness and evil. Those who cross the line from light into

darkness more obviously than the rest of us in fact simply reflect in a concentrated form a darkness that abides, all be it uncomfortably, in all of us.

As we think about and reflect on spiritual care and its implications for our practice, we need to develop *honesty* with regard to the true state of human beings. It is when we act dishonestly and pretend that the evil embodied in certain individuals is radically *other than* the evil encompassed within ourselves that problems begin to emerge. Effective spiritual care that desires to deconstruct monsters and resurrect persons only begins when we start to reflect on the possibility that those who appear radically 'Other' may in fact be persons like us.

Courage and Compassion

I was very much struck by an essay by Bob Johnson (2001) in the recent Church of England Board of Social Responsibility report *Personality Disorder and Human worth*. I have been disturbed by some of the rhetoric surrounding the discussions about recent legislation focussing on how we should deal with people who are violent and have personality disorders. The rhetoric of evil frequently appears in the political and social discourse around this topic and much of what I have said thus far could equally be applied to dimensions of that debate.

Johnson recognises the inherent forces of depersonalisation and dehumanisation that are present in certain approaches to dangerous and severe personality disorders. His paper is an attempt to draw psychiatry back to its central focus on easing suffering and enabling people to live meaningful and hopeful lives. He describes people with dangerous or severe personality disorders as 'modern day lepers'. With *compassion* he lays out a case supporting the humanity of a group of people who are frequently assumed to be less than human. As one reads Johnson's account, it becomes clear that the label of 'untreatable' can function in a very similar way to the label of evil as it has been described in this paper, leaving a person isolated and alienated from the medical system and with no hope of redemption through the standard psychiatric avenues. If a person is considered 'untreatable', yet is still suffering the effects of profound emotional trauma in their earlier years, where do they go for help? Johnson reveals the way that the label 'untreatable' assumes that the only legitimate treatment is that which can be offered by current standard psychiatric interventions. Yet the boundaries of treatment are narrowed in such a way as to exclude a section of the population who are frequently broken, vulnerable and in need of *persistent relationships*. Importantly, Johnson calls mental health carers in general and psychiatrists in particular to be *courageous* in their defence of the humanity and spirituality of those who are dehumanised by the label of untreatability. He draws on the analogy of lepers in the ancient world to make his point.

> *'Six hundred years ago lepers were exiled, cut off from the normal social intercourse in case they infected everyone else. A few dedicated people worked with them, improved their standard of living and long before anti-leprous drugs were available, enabled them to live longer. The optimum treatment for this dread disease, then as now, was human comfort. How can we do less to our own mentally ill, merely because the current dominant section of the psychiatric profession has determined that personality disorders are as 'untreatable' as leprosy once was? Isn't it time to apply other criteria?'* (Johnson 2001:20)

Johnson calls for psychiatrists to be both courageous and compassionate in their dealings with those whom others seek to reject, stigmatise, alienate and marginalize. In defending those who are assumed to be evil, the virtues of courage and compassion are fundamental in deconstructing evil and resurrecting persons.

The friendships of Jesus – sitting with evil in the hope of reconciliation

How then might we embody these virtues? One way they can be embodied is within another vital virtue, that of *friendship.* Friendship is a primary unit of human relationship and as such is a major conduit for the development and maintenance of spirituality. It is through our friends that we gain value, meaning, purpose and transcendence, (the latter through our friendship with God). More than that, friendship is an expression of love. Friendship is the particular relationship that can be utilised to sit with evil in the hope of reconciliation, one that 'treats' loneliness and hopelessness, and deconstructs evil. If we return to the example of Jesus that I highlighted previously, it is clear that the form of friendship that spiritual carers might find most useful is very different from the cultural norm. Within Western culture we tend to develop relationships based on two principles: the principle of social exchange and the principle of like attracts like.

The principle of social exchange presupposes that we gauge our relationships according to what we can get from them. Thus I enter into a relationship with another person with the hope that I will get particular things back that will satisfy me and encourage me to stay within the relationship. There is not inherent moral obligation other than the quest for personal satisfaction. Consequently, if I am not getting what I want from a relationship, I will move on to one within which I can feel more fulfilled and satisfied.

The principle of likeness assumes that friendships are constructed between individuals who have particular things in common. Thus our friendships tend to be based on the idea that like attracts like. However, the friendships of Jesus are based on a very different principle: the principle of love/grace (Swinton 2000). Jesus sat with those who were radically unlike him; tax collectors, sinners, those considered religiously unclean and women, and in so doing resurrected their personhood in and through the relationship of friendship. His friendships were open, unbounded by culture and particularly available to those whom society marginalized, stigmatised and considered evil. It strikes me that this model of friendship provides a useful corrective to modernist ideas of health care as a distanced, objectified and 'non-committed' enterprise and draws us back to the reality that all mental health care is profoundly personal and in one sense deeply counter-cultural[1].

Of course, an immediate reaction to the suggestion that the mental health carer has a role as the friend of the patient might be to begin to highlight the dangers of losing boundaries, becoming overly enmeshed, the importance of professional distance and other such defences that the medical model has taught us to use to protect ourselves from 'over-involvement.' As clinicians we are trained to think clinically, detachedly and to be wary of so called 'non-therapeutic' relationships. Yet there is evidence to suggest that friendship is a fundamental human requirement and a primary channel for the working out of human spirituality and mental health, even in the context of profound mental illness (Swinton 2000). Friends accept one another for what they are and seek to offer support and guidance in times of happiness and brokenness. Friendship embodies community and acceptance and can provide a safe space for growth and change. Friendship mediates love and perfect love drives out all evil.

As Johnson quite correctly warns us, 'being sociable to anti-social individuals carries a potential risk, just as befriending lepers did in the middle ages'. But if we don't offer it, who will? Whilst acknowledging the very real dangers of over-involvement, manipulation, loss of security and the importance of effective risk

[1] Bearing in mind the negative attitudes that society often has towards people with mental health problems in general and in particular those considered 'evil' in the ways that have been described, the idea of spending your whole career offering love, compassion and support to such people seems unusual to say the least!

assessment, it is nonetheless vital that we do not feel compelled to cloak our essential humanness in such a way that we can no longer function towards patients as fellow human beings. We must begin to think seriously about the implications of incorporating friendship into our role as professionals and start to utilise the spirituality and re-humanising power that is inherent within the relationship of friendship. It may be that this particular role, when developed and worked through within the psychiatric context, could prove to be a primary means of re-humanisation which can take us beyond evil and onwards towards a new way of looking at professional relationships and a revised model of spiritual intervention.

Conclusion

Evil does not have to 'exist' to be real. It is alive, well and being enacted and acted upon daily within our perceptions and within our daily practices. The solution? Love. It is only perfect love that can drive out fear and it is only love that can truly conquer evil in all of its diverse forms. The values perpetuated by the virtues are deeply spiritual and relate closely to the types of spiritual understanding and care which are becoming prominent within contemporary practice. Importantly, the virtues can be taught and learned by being with someone who is virtuous. As such, they hold the potential to offer a practical, therapeutic approach to the type of evil that has been highlighted. When learned and expressed, the virtues are one possible way of countering evil within a clinical context. They enable us not simply to carry out spiritual care that counters evil but more importantly, they allow us to become the kind of people whose thoughts, actions and influence are so profoundly impacted by love that evil cannot exist in our presence. For now, the primary task for mental health care givers is to become the kind of people whose thoughts, words and actions are imbued with love.

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