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Violence as Secular Evil: Forensic Evaluation and Treatment of Violent Offenders from the Viewpoint of Existential Depth Psychology

Stephen A. Diamond[1,2,3,4]

Violence is the preeminent evil of our day. Though the causes of destructive violence in our society are complex, the troublesome human emotions of anger and rage play a central role in the genesis of violent behavior and psychopathology in general. In this paper, the author discusses forensic evaluation and psychotherapeutic treatment via "existential depth psychology"—a synthesis of Freudian, Jungian, and existential theory—focusing on the overlooked links between repressed anger or rage, pathological narcissism, antisocial personality, and violent behavior.

KEY WORDS: existential psychology; antisocial personality disorder; pathological narcissism; forensic evaluation; psychoanalysis; violence; evil; criminology.

Violence is the preeminent evil of our postmodern era. American culture is bedeviled by violence in its many manifestations. Indeed, violence is in certain ways condoned—even glorified—in our "civilized" society. Violence as entertainment is pervasive in America today, as attested to by the insatiable popularity of boxing, wrestling, football and hockey, as well as our graphically violent video games, television programming, and big-budget Hollywood action films. We are clearly a culture at once afraid of and fascinated by the evil of violence. But when violent behavior leaps suddenly from the safety of some movie, computer or television screen and occurs starkly

[1]Forensic Evaluator, Superior Court of Los Angeles County (Criminal Division).
[2]Assistant Clinical Professor, Pacific Graduate School of Psychology, Palo Alto, CA.
[3]Staff Psychologist, Block Medical Clinic, Los Angeles, CA.
[4]Correspondence should be directed to Stephen A. Diamond, Ph.D., Center for Existential Depth Psychology, 6535 Wilshire Boulevard, Suite 106, Los Angeles, CA 90048-4905. e-mail: dr_sdiamond@hotmail.com.

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in real life, it is shocking, repulsive, ugly, terrifying, and, in most cases—it is a crime.

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

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

By virtue of posing such subtle and far-reaching queries, our criminal justice system seeks to better comprehend the broad context and psychiatric precursors of the violent criminal behavior being alleged and prosecuted. It amounts to no less than a heroic human effort to comprehend evil. The very fact that our system permits such consultation with designated mental health experts indicates a significant level of psychological sophistication: the forensic psychologist and psychiatrist can and do directly imbue the legal process with valuable information regarding destructive human behavior and its psychology, including the phenomenon of evil. This is, in my view, an essential service for defendants, as well as for prosecutors, judges and juries, and tends to have a much-needed humanizing effect on a sometimes maddeningly rigid, oversimplistic, concrete, insensitive, cynical criminal justice system. But are the so-called experts depended upon by the system for illuminating such murky matters truly up to the task? How can the skilled forensic

evaluator be of assistance in explicating the causes of violence without first having carefully studied the psychology of evil?

THE PSYCHOLOGY OF EVIL

The term "evil" has historically been closely associated with the undeniably destructive aspects of anger, rage, and violence. But, due to its deeply rooted theological and religious or spiritual connotations, most modern mental health professionals feel uncomfortable using this judgmental language in describing malevolent human behavior. Nonetheless, as Jungian analyst Liliane Frey-Rohn (1967) rightly remarks,

> evil is a phenomenon that exists and has always existed only in the human world. Animals know nothing of it. But there is no form of religion, of ethics, or of community life in which it is not important. What is more, we need to discriminate between evil and good in our daily life with others, and as psychologists in our professional work. And yet it is difficult to give a precise definition of what we mean psychologically by these terms (p. 153).

A preoccupation with the perplexing problem of evil is not new to psychology—though it is certainly timely. Freud grappled with this formidable subject, as have many other prominent clinicians in this century, including Jung, Fromm, Frankl, May, Menninger, Lifton, and M. Scott Peck. [See also Goldberg (1995, 1997, 2000) and Diamond (1990, 1991, 1996).] Prefiguring Peck (1983), existential psychoanalyst Rollo May held that, here in America, we still comprehend little of evil's true nature, and are thus pitifully ill prepared to deal with it. Much the same may be said of that most glaring manifestation of modern day evil—violence—and the pathological rage and anger which tend to precipitate it. Yet, psychotherapists are increasingly required by society to evaluate and treat angry, belligerent, and destructively violent individuals. With escalating urgency, contemporary culture calls upon the mental health professional to do battle with this evil: to explain, control, or "cure" deeply troubled, hateful individuals who behave violently toward others and/or themselves. (Violence, after all, is not only directed outwardly, but is at least as often—and frequently concurrently—aimed inwardly toward the frail ego, in the form of self-loathing, mutilation, abuse, and, not uncommonly, suicide. Though, for purposes of this paper, our focus is limited to violence toward others.)

Consider the following factual cases: A thirty-year-old man viewing videos at home with housemates, arises slowly, calmly, silently and without any noted outward provocation, enters another room, and returns with a large, heavy hammer. Without so much as a word, he forcefully hits one of the men present in the forehead with the hammer, causing a serious (but

fortunately not fatal) gash and indentation of the skull. The young man is arrested and charged with Assault with a Deadly Weapon. Due to the strange circumstance, his Public Defender requests a confidential forensic consultation to aid in handling the case. A man in his late twenties stabs his roommate with a steak knife during an altercation. Another in his mid-thirties walks uninvited into a neighbor's apartment, rummages through the kitchen mumbling to himself, enters the living room wielding a sharp butcher knife, and proceeds to viciously stab the occupant repeatedly, all the while uttering the bizarre phrase, "I must feed." In an even more deadly murder case, the defendant deliberately steers his speeding vehicle into several unsuspecting pedestrians strolling at midday on a crowded city sidewalk. When asked why by police, he responded that these complete strangers were conspiring to kill him, and he felt irresistibly compelled to defend himself by attacking them with his moving vehicle. A young man angrily stabs his grandfather multiple times in the chest and abdomen with an ice pick; a decade later, he petitions the Court to be released from a state psychiatric hospital for the criminally insane. A thirty-seven-year-old, deeply depressed local television announcer with no previous history of violence (but suffering from violent headaches), viciously stabs to death his estranged wife, claiming later that "the Devil egged me on." A twenty-seven-year-old callously stabs his girlfriend and then refuses to help stop her bleeding, despite having previously attended and completed a Court-ordered anger management course for domestic violence. Still another furiously attacks his girlfriend with a chef's knife as she is packing her suitcase to leave him, like many batterers ranting, "If I can't have you, nobody can." Finally, a nineteen-year-old boy fiercely wields two sizable knives (one in each hand) at a half-dozen surrounding well-armed police officers, who wind up wounding him severely for refusing to relinquish the weapons. Another angry and rebellious youth is shot and almost killed after wildly assaulting officers with a long iron staff.

These are the kinds of cases commonly seen by forensic psychologists and psychiatrists. (Though all the above-cited cases involved male offenders, men being markedly the more physically aggressive of the sexes, females too commit violent crimes, most commonly against abusive spouses or lovers.) On their face, such alarming events may sound extraordinary; but in reality, they are ordinary, daily occurrences in our culture of violence. In another era, similarly bizarre, irrational, dangerous behavior would have undoubtedly been attributed to demonic possession. Today, we view such mystifying aberration through the prismatic lens of psychiatry and psychology. Instead of invading devils or demons, modern psychiatry's current culprit or "demon" *du jour* deemed most responsible for psychosis and many other debilitating mental disorders is the tiny neurotransmitter. By biochemically restoring the normal neurological balance of these unruly microscopic

"devils," mental illness may be finally defeated. Or so some still simplistically hope.

At all events, my point here is that how psychotherapists view evil in the twenty-first century depends very much not only on our historical or cultural context and religious background, but on the particular training, experience and theoretical orientation of the clinician. I was once asked by an astute Superior Court judge whether my own (partly Jungian) theoretical leanings influenced the way I interpreted and diagnosed a case. The answer is: yes and no. There is no denying that our theoretical paradigms strongly shape how we conceptualize such complex phenomena as aberrant human behavior, violence and psychopathology. The depth-psychologically inclined or existentially oriented (or, as in my case, that transcendent synthesis of schools I refer to as "existential depth psychology") practitioner's perspective as to etiology and significance of violent human behavior will differ dramatically from that of the cognitive-behaviorist or neurobiologist. Moreover, methods for acquiring data from the defendant (including whether or not psychological tests are utilized), as well as the specific aspects one tends to focus upon and emphasize clinically, can vary significantly. Nonetheless, there are certain issues that EVERY forensic evaluator must invariably address in assessing violent individuals. First and foremost, in my view, is diagnosis.

DIAGNOSING VIOLENT INDIVIDUALS

As a primarily phenomenological system of nosology, the DSM-IV (American Psychiatric Association, 1994, 2000) provides the standard criteria in this country for psychiatric diagnosis based on behavior, history, signs and symptoms. (In Europe and other parts of the world, the *ICD-10 Classification of Mental and Behavioral Disorders* [World Health Organization, 1992] has been the predominant diagnostic system.) When used properly, the DSM-IV is designed to provide relatively accurate, atheoretical, descriptive diagnoses. Thus, every evaluation of a violent offender must include a formal DSM-IV multiaxial diagnosis. Does or does not the violent offender meet the minimum diagnostic criteria for some sort of formal mental disorder? (Not all necessarily do.) If so, does the defendant suffer from some psychotic condition, or is he or she simply neurotic (i.e., nonpsychotic)? Is there an underlying or over arching personality disorder, involving chronic patterns of problematic behavior? Is the offender dependent upon or abusive of licit or illicit drugs? (Substance abuse is frequently found in violent offenders. For instance, according to DSM-IV[1994, p. 200], "more than one-half of all murderers and their victims are believed to have been intoxicated with alcohol at the time of the murder.") Might he or she suffer from some

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

Now, in order to arrive at a sound diagnosis of violent offenders, I find it best not to make assumptions about the individual being evaluated, but rather to remain open to who he or she is and where he or she has come from. This phenomenological approach, while long touted by existential analysts, is especially pertinent to forensic evaluations, in which the time spent with the offender is typically quite brief, and hence, of the essence. Preconceptions (or perhaps I should say unconscious or habitual preconceptions, since we all operate regularly with certain necessary preconceptions) are antithetical to a fair and unbiased forensic evaluation. And the various sorts of savagely violent criminal acts committed (or, in many cases, recommitted) by defendants can engender strong prejudices about who or what they are prior to ever meeting them. I have often been asked by friends, family and colleagues how I could tolerate working with seriously violent or other criminal offenders such as sexual predators. My answer is always the same: it is a deeply humanizing experience. A confession: At times, after reviewing the various records sent to me by the Court or Public Defender in advance of first seeing the defendant, documenting the reprehensible, sometimes repulsive acts this person supposedly committed, I have found myself momentarily feeling unwilling to sit in the same small, stark, windowless room with this as yet faceless alleged murderer, rapist or pedophile. It is a natural reaction, a pedestrian, instinctual response to what we—even as highly educated, well-trained professionals—perceive as evil. But then, I remind myself that I have a job to do, and overcome my temporary trepidation. And, in every single case I can recall, without exception, my initial reflexive preconceptions—of which I am keenly aware—dissipated upon actually meeting the flesh-and-blood human being sitting opposite me in the barren interview room. What comes across invariably is their raw humanity, their existential battle to be in the world, more or less masked by their maladaptive, injurious, and sometimes malevolent behavior. Theirs is a universal human struggle we all share, one which inherently includes the archetypal human capacity for evil: Thanatos and the "id" in Freud's schema; the "shadow" as C. G. Jung conceived it; or, to introduce to our discussion Rollo May's much

less familiar yet more than equally serviceable model, the "daimonic." May (1969) defined the daimonic as

> any natural function which has the power to take over the whole person. Sex and eros, anger and rage, and the craving for power are examples. The daimonic can be either creative or destructive and is normally both. When this power goes awry, and one element usurps control over the total personality, we have "daimon possession," the traditional name through history for psychosis. The daimonic is obviously not an entity but refers to a fundamental, archetypal function of human experience—an existential reality (p. 123).

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

ANTISOCIAL PERSONALITY, PATHOLOGICAL NARCISSISM, AND OTHER RAGE-RELATED MENTAL DISORDERS

Whether we are willing to admit it or not, we live not only in an "age of anxiety" as W.H. Auden, Paul Tillich, Rollo May and others observed, but in an "age of rage" as well. And it is, as I have elsewhere argued (Diamond, 1996), this pandemic, subterranean anger or rage which underlies not only the bulk of hostile, hateful, violent behaviors, but most serious mental disorders in general, including some of the psychoses. It is no mere coincidence that what we scientifically term "psychosis" is colloquially called "madness." In a relatively recent book addressing the "primacy of psychic structure and aggression in determining psychopathology," Otto Kernberg (1992, p. viii) clearly recognizes that "hatred derives from rage, the primary affect around

which the drive of aggression clusters," and that this hatred is "the core affect of severe psychopathological conditions, particularly severe personality disorders, perversions, and functional psychoses" (p. 21).

It surprises some today to find that Freud initially paid so little attention to the role of repressed anger and rage in psychopathology. Prior to the early 1920's, the Freudian root of all evil was seen as the repression of instinctual sexuality or libido. It was not until the advanced age of sixty-four, in *Beyond the Pleasure Principle*, that Freud first posited what came to be called Thanatos, the "death instinct." The death instinct, said Freud (1959, p. 135), would manifest itself "as destructive or aggressive impulses." Since Freud, prior to 1920 and even beyond, seems seldom to have spoken extensively about anger or rage specifically, just where these elusive "aggressive impulses" were hiding during the course of countless earlier Freudian analytic treatments is a mystery; and, many of his followers rejected what seemed to them this anticlimactic, metaphysical outgrowth of Freud's theory. Freud's former protégé Carl Jung also pretty much circumvented the subject of anger in his prolific writings. What I find especially fascinating is that the primal passions pervading the Freud-Jung partnership (1907–1913) and finally precipitating their rift—resentment, anger and rage—found so insignificant a place in their theories and treatment of the psyche. They went largely unrecognized by either savant, even though it must have been evident to many following the First World War that this was the most salient modern dynamic of the daimonic. Indeed, the proper place of anger and rage remains to this day a sphere of serious clinical confusion, with far-reaching implications and challenges for all current theories and therapies.

Consider the following infamous cases: An idolized professional football star and affable international celebrity stands trial twice for a brutal, bloody double murder in Los Angeles. In that same city, two bright and attractive young brothers also stand trial twice for the chilling, premeditated murder by shotgun of their millionaire parents. Thirty-nine-year-old drifter and career criminal Richard Allen Davis confesses to randomly kidnapping and killing twelve-year-old Polly Klaas, snatching her from the supposed safety of her suburban northern California bedroom. The wholesale slaughter at a San Francisco law firm leaves eight dead and six wounded by an irate gunman, who, for his unoriginal finale, wields his weapon against himself. And, in New York, a deeply frustrated middle-aged Jamaican man from a privileged background, embittered by what he believed to be American racial discrimination, deliberately rises from his seat on the Long Island Railroad and methodically opens fire on unsuspecting passengers. What sorts of psychopathological conditions predispose people to commit such heinous crimes? Who perpetrates violence? It is true that violent crime is frequently committed by so-called sociopaths: manipulative, criminally-inclined, yet

sometimes socially charming individuals meeting (and often exceeding) the minimum diagnostic criteria for the DSM-IV diagnosis of antisocial personality disorder. I propose here that antisocial personality disorder is fundamentally an anger or rage disorder. This pathological anger is hinted at in the very aggressive term "antisocial," i.e., against society. According to DSM-IV(1994, p. 646), "individuals with Antisocial Personality Disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of of physical assault (including spouse beating or child beating)." Indeed, aggressivity is one of the prominent diagnostic criteria for this severe personality disorder. Dyssocial or antisocial personality disorder generally involves, since childhood, a chronic and pathological anger, rage and resentment toward others: parents, teachers, employers, supervisors, and other symbolic authority figures such as police. Sociopathy centers around a deep-seated hostility toward family, culture, world, destiny, fate, God, reality, and indeed, toward life itself. This immense rage remains largely unconscious in antisocial personality disorder, expressing itself rebelliously, destructively, negatively, violently, nihilistically, cynically, cruelly, vengefully, sadistically, and malevolently. Certainly, antisocial behavior almost always contains narcissistic elements, and emanates from a central core of narcissistic wounding. So, if we wish to better understand the antisocial personality, we must first turn our attention to the problem of neurotic narcissism.

Psychoanalysts such as Winnicott (1958), Fromm (1973), Kohut (1978) and Kernberg (1992) have related the hostility, anger, and rage to an underlying matrix of neurotic narcissism. Pathological narcissism is surely one of the most pervasive, insidious human evils and is highly correlated with rage. We now know that pathological narcissism stems from inadequate, insufficient or traumatic parenting (or surrogate parenting) prior to five years of age, during the pre-Oedipal period; that deprivation or emotional trauma during this delicate developmental milestone renders severe psychic wounding in children, resulting in distorted perceptions of both themselves and the world. According to D. W. Winnicott (1958), when we experience our parents or caretakers as unloving, rejecting or hostile, we respond by concealing our so-called "true self," replacing it with what we sense they want us to be, thereby creating a "false self." To cite psychologist Stephen Johnson (1987, p. 39), "Even though narcissism comes from the Greek myth superficially understood to represent self-love, exactly the opposite is true in the narcissistic personality disorder or narcissistic style. The narcissist has buried his (or her) true self-expression in response to early injuries and replaced it with a highly developed, compensatory, 'false self'."

This perfectly describes the antisocial personality disordered individual's rigid defensive persona; it is pathological narcissism in extremis. A great deal of what neurotic narcissism disguises—and few if any of us are

fully free from it—is our unresolved infantile anger, resentment and rage. Karen Horney (1937) noted that despite the pain and anger about not being loved—or, at least, never being as well loved as one would like—children dare not demonstrate their rageful feelings for fear of further frustration, rejection, or retribution in the form of physical or psychological abuse. This vicious cycle can repeat itself throughout one's life, sometimes causing a severe neurotic condition characterized by compensatory grandiosity, hypersensitivity, exaggerated sense of entitlement, and a long-simmering pathological rage. The typically well-camouflaged, yet intense and overreactive anger of the narcissistic character is aptly referred to as narcissistic rage. Narcissistic rage, writes Kohut (1978),

> belongs to the large psychological field of aggression, anger, and destructiveness . . . and occurs in many forms; they all share, however, a specific psychological flavor which gives them a distinct position within the wide realm of human aggression. The need for revenge, for righting a wrong, for undoing a hurt by whatever means, and a deeply anchored, unrelenting compulsion in the pursuit of all these aims, which give no rest to those who have suffered a narcissistic injury—these are the characteristic features of narcissistic rage in all its forms and which sets it apart from other kinds of aggression (p. 652).

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

Indeed, neurotic narcissism, as Rollo May (1981, p. 145) reminds us, "has its origin in revenge and retaliation." It is rooted in anger, rage and resentment—the normal human response to disappointment, hurt, rejection, betrayal, abuse or abandonment. Paradoxically, neurotic narcissism and its sometimes devastating expressions, includes the compulsively self-defeating, bitter rejection in adulthood of the love, warmth, affection and acceptance so painfully lacking during childhood, recapitulating and reinforcing both the wounding and the resulting rage. Hence, the familiar sporting aphorism, "The best defense is a good offense," may be said to characterize accurately the pathological personalities of seriously violent individuals.

A sense of "narcissistic entitlement" is characteristic of both narcissistic and antisocial personality disorder. In the case of antisocial personality

disorder, manipulative, hurtful and aggressive behavior serves the subconscious purpose of causing others to experience the same feelings of fear, rejection, victimization, terror and betrayal, as did the perpetrator during childhood. It is a sadistic sort of projective identification, an unconscious or semiconscious acting out of anger toward parents, world, God, and self. The rapist, the stalker, the serial killer: judging by their behavior, each of these criminals ostensibly shares a conscious belief that they have the absolute right to thrust themselves uninvited into other peoples lives and to selfishly exploit others for their own ends. But, in reality, this perception presumes a degree of conscious awareness which in most cases is simply not present. They do, however, have in common a distinct lack of empathy with their fellow man, being unwilling or unable to feel compassion toward, nor identify with, the emotions and needs of others. Such grossly inhumane attitudes and behaviors stem mainly from a combination of compensatory grandiosity and a schizoid-like detachment from their own feelings.

It could be sensibly said that the primary difference betweeen narcissistic and antisocial personality disorder is one of degree, differentiated largely by the relative strength or weakness of what Freud called superego, as well as by the severity or intensity of past traumatic narcissistic wounding. The border between these two contiguous diagnoses is somewhat tentative. Kernberg (1992, p. 23), for example, describes certain destructively aggressive patients manifesting combined traits of narcissistic, paranoid and antisocial personality as suffering from "the syndrome of malignant narcissism." What these and most other character disorders—and, for that matter, the overwhelming majority of all mental disorders—share in common is the pervasive presence of repressed rage. I have never met an antisocial personality disordered patient who had not suffered severe narcissistic wounding and resultant narcissistic rage. I doubt one truly exists.

Violently antisocial individuals are mainly made, not born. I assert this to be true even though it has been observed that antisocial personality disorder apparently occurs in men, more commonly among first-degree biological relatives, than it does in the general population, and that these patients in general "often show abnormal EEG results and soft neurological signs suggestive of minimal brain damage . . ." (Kaplan & Sadock, 1991, p. 532). It should also be equally well noted that both adopted and biological children of antisocial parents have an increased risk of developing this disorder (DSM-IV, 1994, p. 648). There is no question that despite predisposing neurological or genetically inherited traits typical to sociopaths, family environment (or lack thereof) plays a vital role regarding the development of psychopathic behavior. The "bad seeds" germinating in this twisted scenario are not necessarily neurological or genetic, but more importantly, the poisonous, insidious pestilence of pathological narcissism: a process, the perverted development

of which is so culturally pervasive and, therefore, threatening to our own personal and collective narcissism, as to all but obscure it from objective study.

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

Finally, it has long been presumed that the antisocial personality—the psychopath—subsequent to having committed a crime, has no real sense of conscience or guilt, owing perhaps to some genetic anomalie or insufficient superego. But, I would again underscore the fact that while extreme psychopathic behavior seems monstrous to us, at bottom, sociopathy is a human affliction, manifested in a suffering fellow human being, not some inhuman monster. Our equally human, archetypal tendency to demonize individuals who commit horrific, violent acts is a psychological defense mechanism, an attempt to disassociate ourselves from evil and from our own denied shadow side. I would argue that these profoundly damaged individuals do indeed have guilt: not neurotic guilt, but, rather, ontological or existential guilt. Whenever any human being commits some act which violates his or her own values or fundamental nature; when we somehow dishonor or desecrate our own being or the being of others; whenever we vainly or naively deny our potentialities for both good and evil, or slough off our inborn responsibility to direct our daimonic impulsions as constructively as possible, there develops—often subconsciously, buried deep in the psyche of even the most seemingly conscienceless criminal—a natural, existential anger with one's self; an inner outrage at failing to follow our most noble—not basest—impulses.

Existential philosopher Jean-Paul Sartre (1953, 1962) has spoken of such states of self-betrayal as *mauvaise foi*, or "bad faith." We have "sinned"

or "missed the mark," and, at some level, we know it, have inwardly registered it, and bitterly condemn ourselves for it. In the hardened heart of every sinner, no matter how evil, the capacity—perhaps even an abysmally imbedded proclivity—for good endures, despite the habitude toward evil. And it is precisely this innate inclination toward good which, when thwarted, generates guilt feelings: painful, gnawing guilt feelings, which the antisocial personality promptly dissociates from consciousness in highly efficient fashion. But, as Freud discovered, the successful repression of such feelings does not negate their existence. Beneath the tough exterior and well-disguised depression dwell these potentially humanizing demons of guilt, and, with them, the entombed devils of ancient narcissistic injury. The psychotherapy of sociopathy, as we shall see, requires the systematic, painstaking excavation of these ruins by deliberately dismantling the armoring barriers erected precisely to deflect any such penetration.

However, having now, at length, said all this about sociopathy, I submit that the bulk of violent behavior is not engaged in by individuals meeting the current diagnostic critieria for antisocial personality disorder. Psychopathy is but one of many anger disorders, though the majority of these disorders remain—with the exception of DSM-IV's "intermittent explosive disorder"—officially unrecognized. Who really perpetrates violence?

According to the *Synopsis of Psychiatry* (Kaplan & Sadock, 1991),

> "the differential diagnosis of violent behavior includes psychoactive substance-induced organic mental disorder, antisocial personality disorder, catatonic schizophrenia, cerebral infection, cerebral neoplasm, decompensating obsessive-compulsive personality disorder, dissociative disorders, impulse control disorders, sexual disorders, alcohol idosyncratic intoxication, delusional disorder, paranoid personality disorder, schizophrenia, social maladjustment without psychiatric disorder, temporal lobe epilepsy, bipolar disorder, and uncontrollable violence secondary to interpersonal stress (p. 561)."

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

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

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

Generally speaking, as a forensic psychologist, one attempts also to reconstruct the circumstances leading up to, at the time of, and immediately following the violent act, as well as trying to determine what the defendant's state of mind might have been during this crucial period. This is no easy task. Nor is it anywhere near foolproof, requiring a strange brew of psychology, divination, and detective work. Still, it is nevertheless imperative to venture an educated guess, especially in cases which might invoke an insanity defense.

COMPETENCY, LEGAL INSANITY, AND MITIGATING CIRCUMSTANCE

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

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

presumed by the average citizen that we are morally and ethically responsible for our actions, and that those individuals who insist on behaving badly must be held responsible for their criminal or immoral acts. However, psychiatry and psychology have for some time now been permitting individual responsibility for one's behavior to be slowly eroded. Each time a new psychiatric "designer defense" is inappropriately advanced to defend or excuse evil-doing—as for instance, in the Menendez brothers case, or Lorena Bobbitt's castration trial, or the proposed but never realized "black rage" defense of mass murderer Colin Ferguson—we run the risk of taking yet another dangerous step down the slippery slope of chaos and anarchy. We remove the admittedly onerous burden of responsibility from the bowed back of the individual—a cumbersome personal cross we each must be willing to bear—and deem the violent individual not guilty of behaving as she or he did due to to some diagnosable mental disorder or other surmised psychological syndrome. Or, we come to view such individuals as hapless victims of circumstance: bad genes, dysfunctional families, physical or sexual abuse, spousal abuse, alcoholism, drug addiction, poverty, racism, etc. Hence, we collectively hold them to a lower standard of responsibility than others presumably less encumbered by such biopsychosocial baggage. Either we believe their violent behavior to be justifiable by the special circumstances surrounding it or we deem their responsibility diminished due to some presumed mental disturbance. (Remember, for example, the infamous "Twinkie defense" of double-murderer Dan White in San Francisco, which later resulted in the abolition in California of the "diminished capacity" defense.) As one outspoken Lutheran theologian (W. Thorkelson, 1994, p. 10c) solemnly observes: "As a society, we seem to believe that if our behavior is biologically determined, then the genes we inherit—not we ourselves—can be held responsible for what we do. Confronted by moments of moral crisis, we are often quick to scapegoat our genes." With mounting emphasis being placed on biological over psychological and social factors in human destructiveness and violence, we shall soon from all quarters hearken the plaintive cry: "My genes made me do it!" Indeed, this troubling trend has already commenced in courtrooms throughout the country.

But, on the other hand, the insanity defense can, in certain cases, be quite appropriate and humane. The philosophical problem of personal responsibility is brought into sharpest and most vivid focus in the criminal justice system. Assuming that individuals do, as a rule, bear responsibility for their behavior, might there be exceptions to this rule? And can there be such a thing as differing degrees of personal responsibility? Moreover, what is society's (including parents' and caretakers') responsibility in the creation of violent individuals? And what of fate or destiny? Consider the self-defense of Oedipus, a patricidal mass murderer by modern day standards, against

the harsh condemnation of Creon in the Greek classic *Oedipus at Colonus* (Sophocles, 1982):

> Tell me now, if an oracle had prophesied a divine doom coming upon my father, that he should die by a son's hand, how could you justly reproach me with it, me who was then unborn, whom no sire had yet begotten, no womb conceived? And if when born to woe—as I was born—I met my father in strife and slew him, all ignorant of what I was doing and to whom, how could you justly blame the unknowing deed? (p. 244)

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

Can a person suffering from mental retardation, serious medical illness or disabling neurological damage be held fully responsible for an act of violence? (For example, in March, 2000, a man violently attempted to force his way into the cockpit of a commercial jetliner while in flight, jeopardizing the lives of all aboard. It was later reportedly determined that he was suffering at the time from acute encephalitis.) What of the schizophrenic or manic patient? Or the intoxicated drug abuser or alcoholic? Or the adult victim of child sexual, emotional or physical abuse? These are precisely the esoteric questions confronting our criminal courts each and every day, and, in turn, being ever more frequently referred to forensic psychologists and psychiatrists for expert consultation. Yet another challenge for the forensic evaluator is determining a violent defendant's competency to stand trial. Unlike legal insanity, which is concerned with the individual's state of mind at the time the crime was committed, competency focuses almost exclusively upon the person's current, here-and-now functioning. In California, a defendant is deemed mentally incompetent if, as a result of mental disorder, he/she is unable to understand the nature of the proceedings taken against him/her and to assist counsel in the conduct of a defense in a rational manner. Can we as a society ethically place on trial and possibly convict violent individuals who, due to some serious mental or medical disorder, cannot comprehend what is currently happening to them nor participate rationally

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

Of course, malingering is an ever-present pitfall in the practice of forensic psychology and psychiatry. Most clinicians rely primarily on their extensive training and experience (and typically on the results of standardized psychological tests like the MMPI-2) to detect the presence of feigning, manipulation, lying, amplification and the like. For me, however, the most important clues to whether someone suffers legitimately from a serious mental disorder or is feigning or exaggerating his or her illness, come from a composite of history, current context and presentation. Major mental disorders such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, antisocial personality disorder, etc., seem to stem in part from archetypal patterns of potentiality embedded deeply in the human psyche. In this rather Jungian view, they each have their archetypal or universal patterns of behavior and experience, notable cultural differences notwithstanding. With sufficient experience, clinicians become familiar with these common patterns, and can compare the individual's complaints, behavior and history with what they know to be typical in such cases.

While mental illness can certainly manifest in myriad idiosyncratic ways, any subtle deviation from these archetypal patterns is suspect. Hence, we

want to know: When did the person's illness begin? How persistent was it? What was its course? Has the defendant ever been psychiatrically hospitalized or treated? How debilitating were the symptoms on his or her ability to function normally? Is there any known family history of mental illness? Have there ever been suicide attempts or previous episodes of violence? How many times have they been arrested? On what charges? How much time cumulatively have they spent incarcerated? How did they do in school? Have they been able to sustain reasonably long periods of employment or meaningful interpersonal relationships?

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

PROGNOSTICATING VIOLENT BEHAVIOR

Is it possible for mental health professionals to predict violence? Once more, my answer must be equivocal. If by "predict," one means to foretell the future to some statistical certainty, then, naturally, the answer is no. But if by prediction we mean to make an educated guess as to the future probability of violent behavior in a particular individual, I would say that this is not only possible but absolutely necessary. Moreover, it is something we clinicians do every day. Each time we permit a patient, perhaps an irate patient, to leave our consulting room to return home or to work, we are predicting that he or she will not be behaving violently in the immediate future. Were this not so, we would be legally constrained to have the patient placed on an involuntary psychiatric hold as a possible danger to others. Should this same patient have actually spoken to us convincingly about visiting violence upon some specific victim, we would additionally be required, as per the Tarasoff ruling (see Kaplan & Sadock, 1991, p. 822), to notify the intended victim(s) as well as the police. My point is that if we believe that a patient may imminently do violence to others (or to self), we are legally and ethically bound to intervene. In such cases, we are, for all intents and purposes, predicting or prognosticating violent behavior.

"Prognosticating" is the term I prefer to "predicting." Each time we diagnose a patient, we are also prepared to provide some prognosis regarding

the future. That prognosis is based on both research findings and clinical experience. As regards violence, the best predictors of potential violent behavior according to Kaplan and Sadock (1991, p. 561) are "(1) excessive alcohol intake, (2) a history of violent acts with arrests or criminal activity, and (3) a history of childhood abuse." In addition to these factors, I would include evidence of recent or historic impulsivity, poor judgment, the presence of paranoid ideation and/or command hallucinations, previous or present refusal to regularly take prescribed psychiatric medications, any history of suicidal behavior, current substance abuse in general, recent indications of extreme anger or rage, severe current psychosocial stressors, and the refusal to rule out violence as a specific, situational solution—all data to be carefully considered in the evaluation of violent (or potentially violent) individuals in forensic or therapeutic settings.

I am convinced that much of the violence committed by patients who seek psychiatric or psychotherapeutic treatment can be averted by careful and conservative prognostication of violent behavior. This is one area in which the social evil of violence can be mitigated by mental health professionals. But, in order to do so, we must first be willing to recognize and confront the potentiality for evil when we see it. We cannot afford to be pseudoinnocent. Pseudoinnocence, as defined by May (1972), consists of an inability to perceive the possibility of evil in ourselves and others, and derives from a denial of the daimonic. Repeated failure to recognize prospective violence in patients is tantamount to being blind to the reality of evil. It is a childish naiveté clinicians can ill afford, and can tragically result in our unwitting, perilous complicity with evil. Hence, the importance of having eyes for evil as well as for beauty, charm, intelligence, grace, creativity and goodness, recognizing that these daimonic qualities can and do paradoxically coexist in each of us to varying degrees.

TREATING THE VIOLENT INDIVIDUAL

To the extent twenty-first century psychotherapy persists in demonizing and subjugating the daimonic, it cannot be curative, but remains instead one more contributing factor to the current epidemic of violence. There are, to be sure, certain individuals who have such difficulty controlling their destructive impulses that immediate, active and aggressive psychiatric intervention (including involuntary hospitalization, physical restraint, and medication) may be required to prevent them from harming themselves or others. However, generally speaking, it is preferable, whenever possible, to resist any therapeutic techniques, interventions or actions that tend to relieve patients of their responsibility for themselves and their own behavior. We have today

grown far too reliant on psychotropic drugs to supplant what we have failed or fear to do psychotherapeutically with violent people: constructively confronting and redirecting their anger and rage. This task can be accomplished in brief or open- ended, inpatient or outpatient, individual or group therapy, privately or institutionally; but in any case, we mental health professionals had better reassess our stance toward the daimonic, and, rather than striving solely to suppress it, learn to harness the healing power of rage and anger in our treatment efforts.

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

The mistake most psychotherapists make in treating not only seriously violent offenders but so many other patients as well, is trying to address the underlying emotional pain without first fully acknowledging and dealing directly with (rather than circumventing) the rage. The daimonic passions of anger and rage pose a perennial problem for psychotherapists of all persuasions. There is precious little agreement today among the many different schools of psychotherapy as to how—or, for that matter, even whether—to deal with these explosive emotions. So much depends on the specific orientation subscribed to by any given therapist, as well as his or her own personal complexes surrounding rage and anger. When it comes to addressing our patients' wrathful feelings, most psychotherapists tend to take one or more of the following tacks: dissuade the overt expression of anger or rage; simply ignore it; intellectually analyze it, reducing it to an artifact of neurosis or transference; promote its physical and/or verbal ventilation in order to get rid of it; rationalize or cognitively restructure it; try to behaviorally modify it; and—in the vast majority of cases currently treated—employ sundry psychoactive medications to biochemically control the anger or rage. This

latter approach—the suppressive psychotropic therapy of the daimonic—is particularly problematic, and, not infrequently, iatrogenic: the daimonic can be drugged, denied or dampened for only so long before tending to return with a destructive vengeance. While medications which stabilize mood and inhibit aggressivity can certainly play a positive part in the chronic management and acute treatment of violent individuals, they are no substitute for real psychotherapy. The ultimate task of effectively treating violent or any other disturbed individuals for that matter, is to conjure up the "devils," not put them conveniently to sleep. Naturally, this is a scary prospect for therapists treating this notoriously dangerous population. Precautions must always be taken, and the very real risks of destructive acting out carefully anticipated, controlled for and minimized. But, to paraphrase Jung, some risk is always required for the successful treatment of serious psychopathology. And, to cite May (1996) on this subject:

> I think there is just as much daimonic wrath in any kind of psychotherapy—except as it is avoided by the therapist. In terms of technique, those clinicians who are aware of the daimonic normally confront violence and rage no differently from the Freudians, Jungians, or other kinds of psychodynamically-based therapists. The crucial difference is that they can get at the anger and rage more constructively, because they can recognize its valuable aspects. What we try to do is to shift or redirect the anger and the rage into those positive pursuits that the person has been omitting from his or her life. I do not believe in toning down the daimonic. This gives a sense of false comfort. The real comfort can come only in the relationship of the therapist and the client or patient (pp. xxi–xxii).

On the question of just how to elicit (rather than avoid) the patient's frequently well-disguised anger or rage, May (1996, pp. xxii) equally eschewed the clinician's perceived need to somehow forcibly stimulate, expose or induce this daimonic emotion: "In most therapy, however, one rarely deals with maximizing the head-on confrontation with repressed anger and rage: the daimonic has plenty of power in its own right, and the therapist need not be concerned, except rarely, with 'maximizing' the rage." In doing psychotherapy with angry and violent individuals, all that is really required is a courageous willingness to acknowledge and directly address the daimonic as it arises spontaneously during treatment rather than recoiling from, denying or dancing around it. This unflinching sensitivity to and valuing (versus rejection of) the patient's "badness," his or her horrific rage which both society and patient consider evil, can, in my estimation, make a significant difference in treatment outcome—though I am unaware of any specific research currently being conducted in this critical area.

Another central aspect of treating violent offenders regards the issue of imposing appropriate consequences for their actions. Our criminal justice system typically deems punishment in the form of incarceration the most apropos consequence for criminally violent behavior. But we must make

a distinction between punishment and what I would call penance: unlike punishment, penance is a psychological sacrament, a symbolic act of contrition and self-absolution. Applying the appropriate penance is of the utmost importance in sentencing guilty violent offenders. In the Roman Catholic and Orthodox Churches, penance consists of a sacrament such as confession, absolution, or an act of penitence imposed by a priest. We would do well to remember that the traditional term for penal institutions designed to house and rehabilitate serious criminal offenders is "penitentiary." Mere prolonged imprisonment is probably not the most appropriate penance for the multitude of individuals convicted of committing a violent crime. There can be no true atonement or absolution or rehabilitation without proper penance. Punishment is, for most prisoners, a more or less meaningless form of penance; and without some personal meaning, there can be no real rehabilitation, recovery or transformation. To be truly therapeutic, penance (or effective punishment) must be chosen, accepted, actively willed, and consciously submitted to rather than merely imposed on one from without. As for the assertion by some that treatment of violent perpetrators should include efforts to address the damage done to victims and/or their families, this too could be considered an appropriate form of penance: consciously choosing to make reparations to surviving victims or families is a way of acknowledging the transgression and seeking to atone for it. But simply ordering or insisting that such reparations be made is insufficient, serving to heal neither perpetrator or victim. Penance, once again, must be willingly embraced by the guilty party; only then will it truly be a meaningful and healing ritual.

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

redirect rather than eradicate or eliminate the violent individual's daimonic tendencies.

Eradicating the daimonic was the goal of the totalitarian society depicted so graphically in *A Clockwork Orange* (1971), another sublime but disturbing film by director Stanley Kubrick, based on the brilliantly prophetic novel by Anthony Burgess (1963). Ultraviolent offenders like Alex and his "droogs" were experimentally "treated" and reduced to pitifully passive creatures unable to muster any aggression at all, whether it be for self-motivation or self-defense—a sort of high-tech behavioral lobotomy. Creativity is another tragic casualty of depotentiating the daimonic. The powerful psychotropic drugs being over utilized by psychiatrists and increasingly depended upon by society to control violent individuals can have similarly dehumanizing, castrating consequences. Though sorely tempting for a culture fed up with and terrorized by violence and the troubled individuals who commit it, these desperate measures are cynical solutions to an age old problem: human evil. But evil, like the daimonic, can never be completely done away with. Nor can evil be conveniently projected upon and attributed to one specific subgroup, personality type, or mental disorder, as psychiatrist M. Scott Peck (1983) precariously proposes. Evil is an ever-present possibility in each of us, even the most pious, well adjusted, law-abiding and good. Given the right (or wrong) set of circumstances, anyone is capable of evil—including the radical evil of violence. The appalling events in Nazi Germany less than six decades ago, as well as shocking experimental findings of psychologists such as Milgram and Zimbardo, make clear the universal human capacity for violence and evil lurking—like Dr. Jekyll's compensatory Mr. Hyde—just beneath the mask-like social veneer Jung termed the persona. But much the same may be said of redemption. Redemption must always remain in our minds and hearts an ever-present (albeit sometimes highly unlikely) human potentiality. "Let he [or she] who is without sin cast the first stone," was how Jesus sagely expressed the pitfalls of pharisaical or legalistic judgment, and the diabolical hypocrisy of collective condemnation.

Lastly, it must be admitted that the evil of violence stems not only from the individual and his or her personal history, but from the transpersonal, mass psyche as well, i.e., our collective shadow as Carl Jung liked to call it. Hence, no comprehensive psychotherapeutic treatment of violence can ignore the need to address systemic causes. Until we confront and remedy the latent causes of violence in our culture, we will continue to see and treat only the symptomatic outbreaks instead of the systemic disease. Individual violence can be viewed, to some extent, as vicarious, isolated discharges—warning flares—of a festering collective rage. Judging from the burgeoning frequency and severity of violent eruptions in the U.S., it can be inferred that the American shadow is riddled with rage. We live in a society which

unwittingly fosters and subtly supports violent behavior because it consistently denies and devalues the daimonic, and offers scant sanctioned rites or rituals permitting and encouraging the constructive expression of anger or rage.

Radically altering our attitude toward the daimonic—from disdain and derogation to one of respect and valuation—involves an existential encounter with the Sphinx-like puzzle the daimonic poses. The Sphinx was a savage, rapacious creature who would lay in wait for unsuspecting travelers on the road to Thebes. Petrified victims were posed a riddle none could answer, for which their punishment was a violent death. Such is the sorry state we find ourselves in today. Our land is being ravaged by the destructive aspect of the daimonic. America, like the ancient city of Thebes, is in a violent state of siege. Anger, rage and violence are rampaging across the realm. Every man, woman and child is at risk. But, reading on, we learn that Thebes survived the Sphinx's murderous reign of terror. Our old friend Oedipus correctly guessed the riddle's solution. The Sphinx self-destructed in a fit of mortification and rage. The Thebans were saved. Today it is we, like young Oedipus on his way to Thebes, who are met with a similar riddle to solve, a riddle requiring a right decision, and rather quickly—lest we too be consumed piecemeal by this beastly, carnivorous demon of violence. The fateful decision our situation demands is whether we, as mental health professionals and as a culture, will ally ourselves with the collective forces serving to suppress the daimonic, or choose to work toward the redemption of our devils and demons—our repressed rage and anger—in any constructive ways we can. To learn to creatively live with the daimonic or be violently devoured by it. That is the question. We will decide our own destiny. Let us choose wisely.

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