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Editorial Opinion: What Are We Missing? Is There A Moral Judgment in Psychiatry as Well as Mental Illness?[abc]

Abstract[f]

This five-section paper approaches the neglected area of morality, particularly in the psychiatric and sociological context. The author introduces the Complexity and Perplexity surrounding Good and Evil (in S1), asks whether evil acts reflect mental illness or are just evil (in S2), tries to classify good and evil (S3), addresses Social responsibility and raises questions pertaining to fame and assassination, political correctness and relative versus absolute evil events (in S4) and then provides a perspective (S5). The author illustrates evil behaviors through 7 'epiphanies'. He suggests an independent 'DSM' Axis 6 of Good and Evil and recognizes this may be applicable to all individuals, not just the mentally ill. He discusses the psychopath, sociopath and antisocial behaviors, and differentiates these groups from the mentally ill DSM Axis 1 psychopathologies that only rarely reflect evil behaviors (e.g., in psychoses, paranoia and organic brain disturbances). Theological issues and spiritual growth, as well as legal implications are important topics. Social responsibility is also examined in the context of society providing fame for assassins, of what is relative to the times such as 'evil' based on political correctness. There is a difference between compliance with evil ('Evil Obedience'), inaction versus active opposition by good people against evil. The 8-tier ethicospirituobiopsychofamiliosocioethnicocultural systems approach may be useful in more broadly conceptualizing good and evil. The author guesstimates that only a small number of 'evil' doers (perhaps 5%) exhibit Axis 1 mental illness; he argues too that antisocial behaviors should not be condoned and classified as mental illness.

Keywords: Antisocial personality disorder, Assassination, Axis 6, Axis VI, Compliance, DSM-6, ethicospirituobiopsychofamiliosocioethnicocultural systems approach, Evil, Evil obedience, Fame, Good, Inactivity, Law, Medications, Medicine, Milgram, Neppe, Psychopathy, Psychosis, SCEAD, Spiritual cultural evil anomic derangement, Religion, Social responsibility, Spirituality, Theology

[f]It is unusual for an editorial opinion to have an abstract. However, the intention was to write an editorial of a thousand words. Given its length now, this is justified with the abstract in the third person.

Opinion

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Of Good and Evil: Complexity and Perplexity: Section1

What is 'good and evil'?

Several sudden moments of revelation- epiphanies-have guided my thinking about 'good and evil'. These left long-lasting impressions on me. Certainly, topics like Good and Evil can indelibly impress many of us, and the question of whether evil can be rationalized as "poor fellow he was mentally ill" is pertinent.

How can we more formally define good and evil? My esteemed colleague Stanley Krippner PhD has suggested to me "that something is 'good' if it is life-potentiating and helps people manifest the potentials with which they entered this world. Something is 'bad' if it is life-depotentiating and blocks their potentials. Of course, culture plays a critical role and often what is 'good' in one culture is 'bad' in another culture. Good and evil are seen and interpreted through the lens of culture. The variations in the applications of these terms certain shows a cultural influence. [g]"

Similarly, I have conceptualized these terms, and amplify Dr. Krippner's ideas further. Both 'good and evil' can be defined in terms of transcendence of self: 'good' implies spiritual growth for oneself and for others. To be 'good' refers to moral virtue, to growth for our world, to promoting what is right, to kind deeds

[g]I have informally quoted three of our referees in this article. All three emailed their opinions. Dr. Krippner's quotation is verbatim directly by e-mail. Thank you to them. This article was initially accepted in July 2017 in the JPCPY, and later some revised material published in IQNJ. The article was substantially then amplified in January 2018 for its final publication in this JPCPY.

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and contributing to others, and improving their lives and wellness. 'Evil' implies the converse qualities: Diminishing oneself and the world; profoundly immoral behavior, malevolence and deliberate harm. 'Evil' is undesirable and often has intent of destruction of what is 'good'. Conversely, 'good' can sometimes be not only the absence of 'evil', but the active working against 'evil'. Moreover, Good and Evil are not just concepts pertaining to individual behaviors, but can be conceptualized within multiple group concepts such as within the family, the society and the culture.

The first epiphany: Evil obedience: The Milgram research

The first epiphany occurred in my second year of college; in the late 1960s. I was randomly approached on the campus by some psychologists; to participate in an experiment called 'The Effect of Punishment on Learning'. Another volunteer and I were told that one of us would be the teacher; and the other would be the student. We drew lots; and I was the 'teacher': I was then instructed to 'teach the pupil' and to give the pupil electric shocks. I was then given a low-level shock to experience how the first shock felt. I learnt that the shocks would progressively increase. The experiment proceeded and after a few correct answers; the 'pupil' erred. I was told to shock him. This request to me was remarkable. I saw this as a moral dilemma. I caused consternation for the experimenters: I refused to perform-to deliver electric shocks to the pupil. This violated my agreement in the experiment.

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

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

I had an idea. I said to them; *"My friend Jim: I know he's a pacifist; and I know this might distort your work; but can I send Jim along?"* And so; Jim arrived (not very good random research subject selection but that's a different issue!); and an hour later; he came back. I had no doubt how this moral; kind individual would have reacted and so I said to him; *"At least now there are two of us."* And he looked at me and he said; "*What are you talking about? I gave those shocks!"* I was surprised; *"You did?"* And he replied; *"Yes! That was part of the experiment; I was asked to do so."* Then I said; *"What about the pain-the suffering; the torture? Maybe the death?"* and his comment was; *"Well; the student volunteered; so it's not my fault!"* I realized this was how the Nazis were able to cause the Holocaust and murder millions [1]. This might best be called; I suggest; 'Spiritual Cultural Evil Anomic Derangement' (SCEAD). This should *not* be elevated to the level of a medical disease process. But we could call it a 'cultural evil disease', thereby not extending to all perpetrators the excuse of mental illness but, at least, recognizing that the culture has induced aberrant behavior. That would imply possibly condoning psychopathology of a culture for one of the most reprehensible atrocities in the history of mankind. The great French Sociologist; Emile Durkheim described 'anomie' [2]. This refers to a normalization of a 'normlessness' and 'derangement' within the collective culture. The term 'spiritual' emphasized the abominable; profound compromise of ethical and spiritual standards.

But I realized; too; that there were a small number of resisters: These righteous; morally elevated individuals very likely might have and could have sacrificed their own lives. But they refused to go along with evil.

Of course; this broad story is a replication of the famous Stanley Milgram experiments and the theories behind them [3-5]. Stanley Milgram's classic experiments showed that; under orders; *"decent human beings will do anything."* Such is obedience [5]; and maybe lack of caring. And just to emphasize: Today; we could never do such studies. They would never pass Human Subjects Review committee scrutiny. Philip Zimbardo then created the well-known "Stanford Prison Experiments" on the psychology of incarceration [6]. This further led to many trying to explain such behaviors [7,8]. I call this *'evil obedience'*. The study I took part in; in Johannesburg; South Africa; was one of nineteen (!) replications world-wide of such obedience-eight studies in the United States and nine replications in European; African; and Asian countries from 1963 to 1985. Overall; roughly two- thirds complied and gave all the shocks. There is a wide difference in the range of overall analyses of studies. In some; as many as 40% of subjects did not obey the instruction to shock and in others only very few refused to comply. However; each study had its own special quality: I postulate this might conceivably be dependent on the exact details.

I propose that the cajoling and encouragement we received in the Johannesburg study I participated in would have markedly pushed up the proportional numbers of those who continued with the experiment. For example; the beautiful young lady in the study I was in; exhorted the 'teacher' to continue. How much more so if the whole culture insists on obedience to an idea and if the consequences of disobedience are profound? Milgram's underlying study motivation; was his attempting to understand the Nazi culture of obedience in the context of horrific evil [3-5].

So this first epiphany relates to a primary kind of evil *'evil obedience'* and it would be one subcategory in a proposed Good-Evil axis in DSM 6; recognizing that the DSM classification can be applied to everyone. In this instance; there might well be no psychiatric label for the first five axes [6].

Epiphany #2: Evil; in itself; is not mental illness. The high-grade; aggressive; criminal psychopath

"Let me not to the marriage of true minds admit impediments." [9] If you believe something; you may not change. But would this challenging true tale not lead many of you to become in favor of capital punishment?

It was 1976. I was training in psychiatry. And then I encountered the most evil individual of my personal life experience [6]. He told me very proudly about several of his murders. He had no remorse for these actions. He belonged in a gang: He not only murdered these individuals; he tortured them in the most atrocious ways. He would hang them in trees; and he would torture them; pulling out their toe nails one at a time. He would laugh before killing them: Nobody could quite get sufficient evidence to arrest him because his gang always provided alibis and aliases for each other.

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

Yet; our society generally will show compassion: *"Shame; poor fellow! He had a bad home life. His environment was poor. He was molested. He was tortured."* This may or may not be so; and; if present; it could be argued that these might be mitigating factors; however; others survive such traumata; overcome them; and indeed; grow spiritually; actualizing and even transcending their traumata. At the end of it all; his atrocious actions; to me; are far; far more aggravating circumstances than the pale of a bad home life. In my opinion; this malevolent man's behavior was not induced by the mental illness per se; it was due to the pure evil. This is why; at the time; I went *beyond* official diagnostic labels and uniquely; called him at the time; a 'high-grade; aggressive; criminal psychopath' [6]. This meant I went beyond conventional psychiatric nomenclature; adding a legal component (criminal) and possibly a moral interpretation of degree (high-grade). In usual psychiatric terminology; this could mean a 'severe case of psychopathy'. But in the context of psychosocial behavior; I realized there was that extra level-a level beyond psychiatry.

I do not regard most psychopaths as mentally ill: I postulate that they constitute a significant subpopulation who manifest pure evil; instead [6]. This is not evil obedience; or organic illness; or psychosis; or reactions to paranoid misinterpretations. But those labels would only be excluded after a carefully considered medical opinion. This is where forensic psychiatry fits in. The 'evil' might be reflected in impulsive behavior and relate to manageable organic brain components. To me; that is not an Axis 2 disorder 'antisocial personality disorder' [10,11]. It is an Axis 1 condition reflecting Psychopathology; and in this instance possible temporolimbic instability; which is technically a bodily condition-the abnormal organic elements including brain firing - so Axis 3 [12-18]. Fortunately; these are treatable; so I've already developed a dichotomy here of 'legitimate mental illness' and 'legitimate evil'. Of course; those who are diagnosed with 'legitimate mental illness' could still have evil behavior; too.

So; what is a psychopath? Antisocial personality disorder (ASPD) in DSM-5; was previously termed 'sociopathy' or 'psychopathy'; or 'dyssocial disorder' in the International Classification of Diseases. ASPD is one of the 'Cluster B' Personality Disorders along with the other Cluster Bs: Borderline; Histrionic; and Narcissistic disorder. All of these are dramatic. ASPD is characterized by a long-term pattern of disregard for; or violation of; the rights of others. These people quite literally have a disorder of conscience. They have very impoverished moral senses and usually show a history of crime; legal problems; or impulsive and aggressive behavior. Some subtly differentiate the antisocial personality disorder; psychopathy and sociopathy. Invariably; the psychopath shows a pervasive pattern of disregard for; and violation of; the rights of others. Deviant events (evidence of Conduct Disorder) usually have occurred before or by the age 15 years. In both DSM-4 and DSM-5 nomenclatures; the antisocial personality must demonstrate three or more failures to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest (Table 1). They show deception as indicated by repeatedly lying; using aliases; or conning others for personal profit or pleasure. These people are commonly impulsive. They do not plan; and the psychopath does not learn from his/ her errors; repeating them again and again. They are irritable and aggressive; with reckless disregard for the safety of others and sometimes themselves. They are irresponsible; show lack of remorse and rationalize their immoral acts.

Table 1: Antisocial Personality Disorder in DSM 5.

According to DSM V; a person with Antisocial Personality Disorder must demonstrate at least three of seven characteristics:
Failure to conform to social norms with respect to lawful behavior
Deceitfulness
Impulsivity or failure to plan (not a characteristic of high-functioning psychopaths - my emphasis)
Irritability and aggressiveness; as indicated by acts of physical violence
Reckless disregard for safety of self or others;
Consistent irresponsibility;
Lack of remorse

Of course; such antisocial behaviors occurring only during Axis 1 psychopathologies such as acute manic or schizophrenic episodes are not regarded as part of the antisocial personality disorder [10,11]. The Axis I diagnosis technically provides an exclusion for Axis II though in reality we commonly use the Axis II antisocial diagnosis anyway.

Yet; I have met likeable psychopaths; but never good ones – although some can perform good deeds; at times; although the motivations may not be entirely pure! Applying this I argue for the removal of psychopaths from Axis II into Axis VI. Patients with Axis II disorders including Cluster B will remain on Axis II; but these are separate from the Psychopaths in Axis VI. We could retain the variants of 'Antisocial behaviors' on Axis II Cluster B; along with the borderline; narcissistic and histrionic; but the good-evil component would be in Axis VI and hence I still prefer the term 'Psychopath'. The Axis II emphasis here would therefore include the behaviors; separated from the listed Personality Disorders in borderline; narcissistic and histrionic.

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Implications of antisocial personality disorder and related conditions

Let's examine the implications of the anti-social personality disorder, also called the 'psychopath' [19-25]. In many legal systems, these patients' behaviors are somewhat condoned: If there is a death sentence, they might not be given the death sentence, because psychopathy is regarded as a 'mitigating factor'. In other settings, they might even end up in a mental hospital environment, because they are regarded as mentally ill. However, rehabilitation of such offenders might be more difficult, and in that context psychopathy is an aggravating circumstance [20,21,25-27]. In this article, I am suggesting a new Diagnostic and Statistical Manual (DSM) Axis, Axis VI, which relates to psychopathy and is likely not a Mental Illness (DSM-5 currently is multi-axial with 5 axes of different diagnostic psychiatric kinds [11]). Given this knowledge, psychopathy should not be a mitigating circumstance.

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

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

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

My intention here is not to debate causality. Are Antisocial behaviors purely constitutional and inborn and deterministic à la the famous 19th century criminologist Cesare Lombroso [28], who postulated the 'born criminal'? Today we would perceive this as very unlikely or certainly not a fashionable explanation. Or is it purely due to environmental causes? Most of us would perceive multifactorial reasons as pertinent, with environment impacting on the biological base. But that is a book of itself, and not being addressed here.

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

Do evil acts reflect mental illness or are they just evil? Section 2

Epiphany #3: The psychopathology of moral behavior: The patient's dilemma of Satan or God?

A caring school-teacher; devoted to her students; had her first baby. This was a routine; normal vaginal delivery. The mother; a religious and kind lady; was looking forward to her baby and was so proud. She lovingly was nursing her first- born in the nursery in the hospital. A day or so later; she suddenly awoke from her nocturnal sleep. She proceeded to strangle and murder several newborns. Mercifully; she was overpowered by several people but not before this carnage [6].

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

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

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

Epiphany #4: Real linkages of psychiatry and violence: Explosions in the brain

I have seen numerous patients with explosive disorders. These patients have extreme anger episodes; marked fluctuations of mood; and they can cause great damage to themselves and to others. These patients very often exhibit underlying organic brain disease; like mesial temporal lobe dysfunction [29-34]. There are some characteristic features: They have explosive anger episodes; they often have olfactory hallucinatory phenomena that are episodic or very short; classically with burning; or fecal smells. They might have episodes of blanking; and they might have mood swings over a series of seconds. These patients are often extremely intolerable to live with and to be around. They're often labeled 'borderline personality disorder' because of their rapid fluctuations. These are examples of patient subpopulations who are labeled 'mentally ill' or who are labeled 'psychiatric'. However; when you eliminate the abnormal electrical fires in their brain; with; for example; anticonvulsants like carbamazepine and lamotrigine; they become 'human' (their behavior is normalized from previously appearing like wild animals). Frequently; after medications; [12-15,18,35-37,17,18] we're able to meet new wonderful people; partly because the underlying problem in the brain has been corrected and possibly because they've learnt from their prior experiences when not under appropriate medication

control. Here is ostensibly evil behavior associated with mental illness. But this is not evil of itself; willful and deliberated wrong-doing; but a consequence of illness. In the properly assessed patient; we find their anger and aggression melts with medication. But the gratifying aspect is they almost always respond profoundly to anticonvulsants. This Axis VI diagnostic subgroup could be called *'Organic / Temporolimbic Evil'* [6].

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

My epiphany here was the revelation of the stark contrasts between these two groups; the treatable abnormal electrical firing patient who can be made whole rather easily; and the evil one feigning mental illness.

Epiphany #5: Ignoring a reality of good and evil: Where are the publications?

I had always assumed that there would be numerous papers on *good and evil in mental illness*. I was shocked to discover that it is extremely difficult to find even a single scientific publication on this topic! *"That's religion and belief; not science."* Of course; there are a few; but not many [38-43].

A best-selling layperson book by a psychiatrist; the late Scott Peck [44]; focuses on the presence of evil as a real force and gives case vignettes; but his orientation is more theological and not predominantly based on psychiatric nomenclature although he does recognize the need for modifying DSM; and distinguishes sociopaths; psychopaths and evil.

In this editorial; I'm not arguing whether or not evil as opposed to good exists; and certainly not whether it is a real force. Instead; I focus on evil (and good) *behaviors*; recognizing that those components might require a further psychiatric DSM classification [10,11]; namely a proposed DSM Axis-6 of evil behavior spectra in addition to the current five-axis DSM frameworks; which lack any mention of the good-evil spectrum.

Good and evil as a further axis in psychiatry does not currently exist. Somewhere along the line; mental illness has developed its own 'magisterium' [45]. If somebody acts; let us say 'abnormally'; in the theological sense in an evil way; and they then consult a psychologist or psychiatrist; they might not be regarded as evil. This is so as; in the mental illness sense, evil simply does not exist in our vocabulary. Consequently, that 'evil side' is regarded as relating to their supposed mental illness so that they are no longer 'evil' but 'ill'. It's remarkable that this occurs. I argue that we ought to be differentiating good and evil in psychiatry. We should have an Axis VI in the Diagnostic and Statistical Manual (DSM) formulations [10,11]. Good-Evil should have been a dilemma since DSM-1 was first conceptualized; and then incompletely formulated in the late 1940s; but it never was! [46] The Good-Evil dichotomy extends to ordinary people. Let us just say that some radiate kindness; but others do not. The latter might still be fine people but many of us may not regard them as such - quite justifiably [6].

Good and Evil: Can we classify it? Section 3

Epiphany #6: The Good and Evil Classification in Psychiatry: DSM 'Axis VI' perhaps?

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

If somebody commits a crime; sometimes very severe-such as murder or rape -- the person is often labeled as being 'mentally ill'. The Diagnostic and Statistical Manual in its various iterations; beginning with the aforementioned DSM-I in its more complete form in the early 1950s [46] through to the current DSM-5 [11]; has totally ignored this area. DSM-5; like its predecessors; is a multi-axial system; in which axis 1 reflects the psychopathology and mental illness diagnosis; axis 2 relates to personality disorder; axis 3 list the pertinent medical conditions; axis 4 describes the psychosocial elements; and axis 5 reflects the level of functioning the patient has. *Nowhere is there a mention of good and evil.*

It's important to know that the studies at this stage are not adequate to make judgments: People just write about the 'fact' that the mentally ill do not exhibit more violence than the general population as if it's definitely true; yet; inter alia; because the label of who is mentally ill is difficult; we cannot make such interpretations. By contrast; some of the lay-population assume that violence; even in psychopaths; must be due to mental illness. Certainly; it appears in my experience and in the experience of many people in the psychiatric and psychological professions; that many aggressive patients with Axis 1 and / or Axis 3 diagnosed psychiatric conditions can be treated and should be helped; often with medications that correct underlying biochemical electrical abnormalities. However; the same cannot be said for the evil individual who does not exhibit Axis 1 or Axis 3 pathology. The key difference here is detailed assessment and evaluation.

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

And yet; we have this conflation of two groups. We combine the general population of people who manifest evil; on the one hand. And we might not differentiate them from patients who

have Axis 1 psychopathologies and are therefore 'mentally ill' in the psychiatric sense. This lumps together the two distinct populations. What would be classified as 'good' Axis VI psychiatric patients-kind and sweet but with problems-are grouped with the evil ones; whom we respect because we don't have Axis VI and therefore regard only within Axis I or Axis II. *"Poor fellow he's a psychopath: He can't help it. He has a disorder of conscience."* It's remarkable how the magisterium of scientific mental illness completely ignores the other spiritual magisterium as part of reality [45]. As Steven Gould implies; they are *non-overlapping magisteria* - they cannot meet [45]. This attempt at applying both mental illness and good and evil sounds obvious; but is revolutionary to Psychiatry. Our growth as humans has been a growth of developing our good; collectively.

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

The 'not-good' people in the political sense of a Holocaust with atrocious actions at one extreme; have gradations of evil: Only a step down in importance is the people *who do not act when they should act.* This includes politicians who are often more interested in their own edification; and in their wealth and power accumulation; than in assisting populations and being kind; compassionate and yet just; moral human beings. These extremely evil individuals; irrespective of formal psychiatric history; are still part of the Axis VI of Good-Evil. That is therefore applicable to everyone who manifests evil.

However; possibly that new Axis VI of good and Evil should be elevated to Axis 4. It should precede functionality (Axis 5 currently) and psychosocial issues (Axis 4 currently); though it should be after the medical illness of Axis III.

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

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

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

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

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

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

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

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

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

Importantly; psychiatrists are not trained in good and evil; and have no specific knowledge of good and evil. In fact; this is outside their general magisterium—which is part of the problem. Psychiatrists and medical specialists could get further

background 'training' in good and evil in forensic specialties; in ethics training and in philosophy. Yet; physicians are often asked to make decisions about matters for which they have no training; and the absence or presence or the extent of evil is one of those areas. Our society requires them to have opinions. Even with their lack of training they cannot abrogate their responsibility to express opinions.

Table 2: The proposed Axis VI in DSM-6. Good and Evil.

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

Epiphany #7: Of religion; the law and evil. What is appropriate?

The neglect of concepts of good particularly; and of spiritual growth in our society is rather surprising; but not quite epiphanous for me. It's unexpected because growing up; as we have; in societies that are steeped in various religious cultures; the commonality of all of these cultures is good and evil.

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

Yet; theology; as a belief system; on the one hand; and medicine; psychology; and psychiatry as sciences; on the other

hand; regard the other as irrelevant: The one does not touch the other-the separate Magisteria; at this point; never meet. Therefore; if something wrong is done; the *law* might perceive this as transgressive; requiring appropriate *punishment*. *Theology* might describe the action as *evil*. Meanwhile; the psychiatrist might argue *"this is purely mental illness"* and want to emphasize rehabilitation and treatment. All these approaches reflect complex; multifactorial issues that must be dealt with individually [6].

Our common mythology is that the incidence of mentally ill patients committing significant crimes of violence is reasonably small; and speculatively not much more than the general population or sometimes even less. But we really do not know; because what constitutes mental illness? The underlying ideas behind these postulates are fascinating but not consistent. Who is doing the labeling? [7, 38, 40, 41, 43, 47-49].

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

Those who manifest Axis 1 mental illness who may for example; be acutely hallucinated or paranoid but show ostensibly evil behaviors are not a homogeneous group. It includes people who are under the influence of recreational agents (and therefore controllable and even though producing illness may be due to action); and they too may hear a voice or obtain a 'command' hallucination to act a particular way-although this is classically schizophrenic in nature [50].

Patients might also react to their own stimuli but less violently: For example; the 'command hallucination' involves hearing a voice commanding them to do something that our society would regard as inappropriate. The acting-out of a command hallucination is generally rare; because the patient will usually; if psychotic; be in their own world: Although hearing these things; they do not physically act out. But if they did act out; it would usually be self-directed acting out onto themselves. But most of the time; self-harm is not due to any psychotic delusion or hallucination; but linked with severe depression; anxiety or stressors in the environment. This is why the incidence of suicide is very high in the mentally ill patient compared with the general population; and this is particularly so if the patient has available a weapon of acute destruction [51-61].

However; weapons of acute destruction are very varied and usually easily available. We might try to restrict firearm availability in the mentally ill whom we consider the most vulnerable for self-harm. But firearms are not the only methods of successful suicide: For example; there is a relatively higher incidence of fatality not only with guns but also with jumping off buildings or bridges. Some other suicide attempts are relatively less fatal; such as overdoses; but some suicide attempts are particularly tragic such as carbon monoxide inhalation where those who survive might be brain damaged. Potentially patients commonly act against themselves not others; whether the technique of attempted suicide is violent (e.g.; firearms) or not (e.g.; overdose); but they do not generally act by harming others. These suicide attempts may be perceived as also harming family and friends because of the sad; unfortunate impacts and in that way may still be perceived as evil. But that is a very different kind of evil compared with attempted homicide. And such violent homicides are regarded as rare in the psychiatric population [6].

On the other hand; when we move from Axis 1 (psychopathology) to Axis 2 relating to personality disorder; then psychiatric classification becomes very different. These individuals can wreak havoc on others. This is the DSM-5 subpopulation of *Cluster B* patient. And *within* this so-called DSM 'Axis 2' are those who theologically may be regarded as 'evil': the exact terms have varied over time: Until recently; we used the term *'psychopath'*. Then *'sociopath'* became fashionable implying that society might have caused the behaviors-again; almost a way of partly condoning behaviors due to mental disorder: Some clinicians do not perceive the sociopath to be as evil as the psychopath; although the terms might; in actuality; be synonymous and just a different product of culture. The latest synonym is 'anti-social personality disorder'.

However; we cannot just restrict our 'evil' axis to the DSM Axis 2 subpopulation: How do we describe actions in large groups where such people might be drawn inadvertently to violence; but where the culture ultimately accepts this as rational; even admirable nationalistic behavior? For example; the Nazis imposed their belief systems on the population. This produced resulting national evil atrocities [6].

Separately; but in a related vein; Hannah Arendt; the Jewish anti-Nazi political philosopher who fled her native Germany in 1933; applied the phrase *"The banality of evil."* to the Eichmann context: [62] Whether this is appropriate use can be contextually debated; but I propose that it reflects; at least in part; a desensitization to the context of murders. That could *partly* explain; too; research results like the Milgram experiments [3-5]; *Obey because it doesn't count:* we're desensitized to reality. It could extend this 'banal perception of evil' to reflect the proposed DSM Axis VI 'good-evil' subgroup irrespective of mental illness. I have added it into the Table 2 subdivision: "Banality of evil-SEAD-Spiritual Evil Anomic Desensitization (may; at times; be part of #3 or #4 or both)"; because DSM studies are *provisional* and dynamic; always based on provisional empirical data for exploration of appropriateness for future classifications. Of course; in our previous psychiatric classifications (DSM 5 and before when applicable); some DSM Axes (such as Axis II or Axis III) may be deferred or not applicable. The same would now apply when using Axis VI labels in individuals who do not have Axis I, II or III diagnoses.

Again; we're not discussing here whether or not good and evil are actual forces; as in theological concepts; that can influence people and events. This is simply an objective look at behaviors and expressions of behaviors-not fantasies; not ideas; not thoughts-that are evil. These might cause not only deliberate self-

harm or ironically; deliberate self-gratification to themselves; but also result in major psychological traumata to family and friends as a consequence.

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

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

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

What benefit or change in society would occur if society agreed that good and evil behaviors exist? Would prediction of anti-social behavior be better as a result? Would treatment of the dyssocial; or would protection of our society be more effective as a result? Such questions do not relate to belief systems and theological backgrounds but we're examining here simply end-result behaviors. There is also frequently misrepresentation in the media [63]. But these questions are difficult to answer: They need empirical testing.

In this regard; Bastian and colleagues in Australia suggested the term '*moral vitalism*' [64] -the tendency to view good and evil as actual forces that can influence people and events. Bastian et al have also proposed a scale designed to assess the extent of good and evil *beliefs*; and the consequent *responses* and impacts on society these have. This moral vitalism would align with my proposed Good-Evil Axis VI of DSM-6. Such ratings would be based on self-rankings; ratings of first-degree contacts; and include histories of aberrant behaviors and also attitudes. But first; we must collect preliminary data and test the resulting classification.

Social responsibility: Modifying behaviors in regard to perceived evil: Section 4

The question comes up about social responsibility. I give two examples here of how society reacts to ostensibly evil actions, namely, firstly, assassination of famous people, and secondly, political correctness. We've mentioned that good and evil certainly have political and social consequences in terms of actions and decisions. There is something that is anomalous about our society, and that is, we sometimes glorify the perpetrator. This goes all the way back, to assassinations, for example of Abraham Lincoln, and onwards. And at this point in terms of political correctness, the current fashion is sexism, and this might reflect relative morality.

Fame and assassination

Many years ago, I wrote a letter to the editor about fame and assassination after a series of such attempted murderous actions on famous individuals—in this context, the Queen of England and Ronald Reagan [65]. I argued that assassins, or attempted assassins or criminal perpetrators, develop a vicarious fame ironically by their actions. Everyone knows about John Wilkes Booth of Lincoln fame, or about Lee Harvey Oswald of Kennedy fame, for example. There is some support for the idea that they were inspired to achieve long-lasting notoriety. Could this inspire other individuals to perpetrate such atrocities? Let us introduce a system of anonymity: One might want to give just an initial, it might even be incorrect initials -- "Y.Z." for example -- and all we would know is that "Y.Z. did it". Even better, what about numbers instead? Alternatively, "5-digit combination could allow for the labeling of 99,999 fame-seeking miscreants!"[h] That way there is no greater feedback to such a bizarre, inappropriate, and evil action. This can be our way of social responsibility. This is particularly important today, with Facebook and Instagram and other social media being easily accessible. And, of course, it's possible that one might make an error in attributing a crime to the innocent who has not yet (or ever) been found guilty. It would be safer having #46123 being erroneously accused than the real 'John Smith'.

Relative morality and political correctness

Sometimes issues have become ridiculous as well, from a social point of view, such that particular actions -- be they ethnic actions, be they gender actions, be they actions pertaining to the disabled -- are taken out of proportion for certain groups to find justification to act against individuals or other groups. Now this would be fine if this were completely moral. The problem is, it is sometimes moral and sometimes not. Usually there is a borderland area in between that one cannot decide about. And different individuals will have directly contradictory opinions about such 'right' and 'wrong'.

An example from today is sometimes called "politically correct" but may impact on what is interpreted as 'right and wrong'. We need to be particularly careful even with regard to habits that arise in the modern day: For centuries, the dating process has involved men in a chase– directed towards women— 'courtship' it was called. It appeared to be highly successful and endured. But today that fundamental behavior has been complicated: Let us imagine such actions go wrong. The dating breaks up. The woman does not like the man. Does this suddenly lead to a different way of conceptualizing of such actions? Does it suddenly become an action that is no longer a courtship, but some kind of sexual abuse? Is that now evil and no longer courtship with a break-up? Has society advanced such that we are now more socially aware,

[h]Thank you to another referee, Psychiatrist Biagio Longano, for suggesting this numbering

or are we ultimately potentially destroying society, possibly redefining actions that certainly involved acceptable behaviors for many years, but now conceived of as abuses, sometimes extreme abuse? This will extend, and has already begun to extend, beyond the male/female spectrum. The area is extremely complex. Abuse and occur if the relationship does not go wrong, to the extent even of marital rape. Others, such as Brigitte Bardot [66] and Catherine Deneuve, recognize that assault and harassment are clearly wrong, but that persistent amorousness is not. This is a work-in-progress as reflected even in the layperson literature [67,68]. One wonders where this will end. I am not raising this as an issue of what is right and what is wrong; I am reserving judgment, and just observing. All I am raising is the fact that societal change has produced a dynamic alteration of the structure of what is right and what is wrong. Clumsy courting was always unfortunate, but potentially forgivable. Pushing ahead without taking the trouble to ascertain consent was always wrong. Wrongful accusations have also always been wrong. I'd say that the right and wrong have not changed so much, but that the default submissiveness of women has been challenged and wrongs which were always wrongs have been re-examined. This is a relative phenomenon as opposed to a practical and actual phenomenon. It is no longer absolute and might have shades of gray. These extremes may turn out ultimately to be regarded as unfortunate. I predict that such extremes in terms of fashions cannot be maintained and that at some point, in a decade or two, such thinking will be ridiculed. There is a pendulum, and the pendulum swings back.

Not acting when one needs to act

Can one extend this concept of good and evil? I believe we can. First of all, one could debate whether or not evil actions *performed by ordinary people*, where there are no obvious psychiatric labels, should be extended in the domain of psychiatry to a psychiatric label. I regard this as a bad idea because it suggests that we are dealing with *mental illness*, when such actions are not mental illness at all, but extensions. It does, however, emphasize the need for sociological analyses of behavior that we would not term 'abnormal', but that we would term 'evil'. We should take into account *good behavior* as well.

The basis here may well be the question of inaction when activity is needed. *Can good people* just stand back and do nothing in the face of evil? Again, the example of the Nazis comes in. For example, surely Irina Sendler, Chiune Suhigara and Oskar Schindler should be regarded as exceptionally good, so to say in an Axis VI-G (for good)? They are the heroes and heroines, surely? Does this imply a new category of the ultimate social good? 'Heroism' could be one subcategory. But we are now dealing with a very, very complex political spectrum. It can sometimes be debated that the one side would argue that the other side is evil because they don't favor or believe in the same circumstances. But let us not look at these narrow areas of coloring either way; let's look at extremes.

Science, politics and evil?

Let us imagine situations where, for example, data might have been distorted by scientists to allow for major benefits for certain companies. One example would be vaccination. This is a complex area and outsiders, even MDs, are not privy to all the details. We know that vaccines have all but eliminated smallpox, polio and diphtheria, for example, and are remarkably effective in protecting the elderly in several conditions. The good done is astonishing. But those on a national policy-making committee tasked with determining the safety of vaccines and choosing the appropriate course of action do have dilemmas. If they discover that a particular vaccine for children is unsafe, and this is announced, there may be a nation-wide backlash that might cause an abrupt drop in childhood vaccinations, leading to the return of the specific disease. However, would researchers allow a great number of children to be vaccine-damaged, accepting this as 'collateral damage' because it is preferable to the return of a nightmare disease? Would concealing this fact be evil? There are also major potential financial implications in this multibillion-dollar industry and regulation of and tort actions for vaccines in the USA are different from other pharmaceuticals. One current recent example is the controversy on whether combining the measles-mumps-rubella (MMR) vaccine, particularly at the age of around one year old or in physically ill children, is appropriate, as there have been claims of this causing a profoundly increased incidence of autism. However, the data could be argued to be significant both pro [69] (for example, as in the movie 'Vaxxed') and con [70-77]. However, when one looks at the data statistically, and the controversy of whether such information has been appropriately collected, one at least, would wonder why the incidence of autism has apparently increased so profoundly. It could be due to other causes: Causality is different from correlation, and the history of science is rife with interpreting events that co-exist as being linked causally when they are not. But that's not the issue in this editorial: It's simply, if it is so that such data has been distorted, this would become a scientific distortion that could impact millions of children who then grow into adulthood, and surely the ordinary parent should have choices? [69-77]. Would this non-disclosure to the public, or not using another intervention (such as changing the age of MMR administration, or giving the measles, mumps and perhaps rubella immunizations at separate times) be regarded as evil behavior by these scientists? Sometimes such justifications are financial. I'm not saying it is, or is not, because we don't have all the data, but I am using it as an illustrative example of the complexity of issues. Invariably, in these instances there are approach-avoidance conflicts and the scientist and agencies must make balanced, informed decisions, where any malevolent intent may be balanced by benevolence. This makes good-evil discussions difficult in the real world.

The fusion of the politics and evil, also represents the medical and scientific components of good and evil. Action or inaction in vaccinations could be conceptualized in the good-evil context, since both courses could lead to all sorts of political consequences (e.g., draconian vaccination laws, or totalitarian tracking methods designed to ensure compliance). The only solution might be honest brokering performing the very best for the patient given the current state of knowledge and that to me would be the gold standard at this point.

Similarly, as another example, the medical reimbursement system might be contributing to diagnostic issues such as major depressive disorder or neurotic depression [78-80]. Insurance companies are more likely to pay for the more severe condition.

And then there is the example of a drug that was demonstrated to be unsafe when it was regarded as safe: Thalidomide was the drug of choice for nausea in pregnancy yet induced significant teratogenesis [81,82]. In retrospect, was there any deliberate hiding of cogent data? And in any event, in all controversial cases, how is outcome data, even in double blind studies, deliberately or inadvertently massaged [83-86]?

The *politicization of evil* is certainly something that is very, very relevant. And it's not only a case of 'evil obedience', where people just act as they think they should act because of appropriateness; it is a case of possibly inciting evil, or stimulating such aberrant group behaviors. A problem is the 'rock and hard place dilemma'.

One could conceive of a *spectrum of neutrality*, and in one way or another that neutrality would change. Again, this is relative morality to some, but I regard the signposts as more obvious: Sometimes, one has to choose between what from a logical, religious level would be regarded as positive transcendence and spiritually progressing or, on the other side, what the general population may regard as "I'm not getting involved".

A Perspective on Good and Evil: Section 5

To obtain a perspective, let's re-examine what we now know about evil.

Good is not just passively 'not being evil'

Evil can manifest in many ways. Society can manifest evil and we will do nothing about it, or we may decide to act. Good requires activity against evil, at times, or ensuring a positive qualitative moral difference such as kindness, virtue, respect, self-sacrifice, or righteousness.

Societal changes and relativity

We've recognized how perceptions of society can change in regard to good and evil: Certain aspects that were correct 50 years ago, in this second decade of the 21st century may be horrifying: Those individuals more senior in age will remember the days when children who were so to say 'naughty' got a smack of the hand or their glutei, and how this was a method of punishment for boys in the schools. The converse can apply to the extreme *laissez faire* of today and the different moralities. This is not a judgement, just an observation. There is a difference of relative perception and interpretations of what is good and what is evil and what is regarded as acceptable learned behaviors in our society.

The different interpretations of evil might apply culturally across cultures even in the same generation. Interpretations may be entirely different, for example, depending on the political stance: food and poison in different societies. Then there is, of course, the military aspect, where many behaviors are dichotomized simply into black and white. Consequently, we can certainly talk about how the *ethico-, bio-, psycho-, and the familio-*behaviors influence present and future behaviors. Some would argue that the influences of the family are possibly the greatest single factor that one learns at that good/evil continuum. But all these factors are profound.

This editorial began as an attempt to communicate that we cannot label aberrant behavior as simply psychiatric. "It's not their fault" so to say. Society has become a society of lack of responsibility. *"The patient is mentally ill; that's why he acts that way"* That is an insult to our psychiatric community. Let us re-examine this idea by trying to do a comparison.

Population demographic comparisons are unavailable

There are no statistics easily available to compare the 'ill' with the 'healthy' in regard to evil. The absence of available comparisons is because there has never been diagnoses of 'good and evil in psychiatry' so we simply must guess by experience! The tendency of our society has been to attribute evil behaviors to something pertaining to mental illness. I argue this must change. There are no statistics easily available to compare the 'ill' with the 'healthy' in regard to evil. In my experience of over four decades, and also incorporating the readings and knowledge of others, I would argue that *"95% of evil acts are not due to mental illness".* This is not to say that patients who are labeled psychiatric cannot be evil; indeed, I have argued that this is so, but rarely when acting-out events tragically manifest through psychosis, paranoia, episodic or impulsive disorders, for example. And when it does, these patients invariably in my experience also have, in addition, 'Axis II' DSM conditions such as borderline or antisocial personality disorders.

Axis VI

The limited mental illness component paradoxically of evil argues for a further multi-Axial component: Axis VI -- the Good/Evil Continuum. Only by having this, can we actually record events of evil and of violence and develop population statistics comparing 'healthy individuals who have not required psychological treatment' with those who have. This Axis VI would not imply mental illness. Importantly, if somebody has an Axis VI label, this would likely (based on my 95% estimate above) be quite independent of any other Axis labels: these 'healthy people' might not have an Axis I-V psychiatric diagnosis. Nevertheless, this is one way of placing abnormal behaviors that have a spiritual component onto a DSM Axis , but not as a mental illness label, just extending DSM nomenclature beyond the biopsychological to the familiosociocultural. And yet this still may incorporate Axis II conditions such as 'evil' behaviors in the psychopath and the sociopath into Axis VI. Axis VI then becomes the *expression of inappropriate evil behaviors* like profoundly immoral, malevolent deeds, or wicked, depraved, harmful actions. These still remain matters of interpretation of degrees of deviance within one's multiple cultures. We've seen that certainly these behaviors are not restricted to the psychiatric patient. Indeed, as guesstimated, the psychiatric population constitutes a tiny proportion of evil behaviors against others.

The evil psychiatric patient:

Let's now revisit specifically the concept of good and evil in psychiatry. Most psychiatric patients who even act violently, for example, act against themselves. This is a statistical reality across several cultures many fold at least four but likely a factor

of tens (although the data is still questionable) [87-89,90]: The mentally ill patient may act out, and they might commit suicide as a 'completed' action or they might attempt it, sometimes as a genuine failed suicide, other times as a so-called 'gesture'. This is an argument certainly for protection of the patient particularly against themselves, and it is a strong argument in relation to restricting methods of destruction -- such as firearms -- in those patients as despite several other ways of attempting suicide (e.g., jumping, carbon monoxide, strangulation, overdose) shooting oneself appears the most definitive frequent method [87-89,90].

Consequently, a major and valuable habit for anyone in the psychological professions is always to probe and ask about suicidality. Restricting firearms appears a logical idea . The most common diagnosis in these instances is 'agitated depression'. These patients are anxious and overwhelmed: The so-called 'retarded depressives' by contrast are too slowed or amotivated to act out.

But interestingly, when asking about potential to suicidality, something we routinely do in the mental health profession, we often discover something about good and evil. The most common preventive response I get is: *"Doctor, yes, I've even thought about suicide, but I would never do it. I'm religious, I'm spiritual, I realize it is wrong. And I would also never do it because it's wrong, and is unfair to my loved ones."*

What of Axis II diagnoses? I have argued that Axis II with the various subtypes of personality disorders should, as indicated, be separated out from psychopathic and sociopathic behaviors. Some personality dysfunctions are not manifesting evil. It is only that evil subgroup that should be in Axis VI, a subtle but important differentiation.

The non-psychiatric patient

We now move away from psychiatry and in that move away, recognize the same consideration. First the psychopath and sociopath may think or manifest their non-caring callous aspects: But it is the evil parts of those antisocial labels that fit Axis VI. And these people may never present to the psychiatrist, though often do to the legal system. As indicated, some would regard psychopathy and sociopathy as identical; I do not. I still find the Lombroso model of the inborn evil of the psychopath [28]. But I recognize that the psychopathic condition is a rarity. Far more common may be the sociological model of the 'learned evil' of the sociopath. Some would regard this only as a relative difference, with sociopaths possibly not being as severely ill. And it provides again the fertile imagination of the contrast between genetic and environmental factors: Commonly, there may be combinations of both. This introduces the social side and a new way of conceptualizing our experiences.

'Ethicospirituobiopsychofamiliosocioethnicocultural': A Legitimate Approach: Section 6

For me, the most important word in all of the social sciences may be a rarely used one, but not surprisingly liked by me, as I developed the term! It is *'ethicospirituobiopsychofamiliosocioethnicocultural'* or if preferred, combining the ethicospirituo-, simply *'ethicobiopsychofamiliosocioethnicocultural'* [91].

In essence, "we can be completely devoid of any DSM diagnosis of mental illness or some degree of neurosis and still have a diagnosis of Evil or Good. There are the extremes, the ends of the bell curve in both areas. For example, on the Good side, someone who doesn't lie, doesn't steal or never thinks negative thoughts about others (totally against everything Jungian, which deals with Shadow!). And on the other side, someone, with or without a conscience or perhaps consciousness, would cut you to the quick without some much as a thought about right or wrong, good or evil."[i]

Clearly, ethics are fundamental reflecting the morality of behaviors. After *ethico-* in this compound word comes the *spirituo-* which some would regard as part of the ethico-: They're certainly related? One phrase in theology is that *"nobody is an angel"* and there are all sorts of concepts pertaining to an 'evil eye' and 'Satan'. The bottom line here is ethical behavior might be a manifestation of the spiritual but that we are likely all imperfect.

We therefore may need to move away from these concepts in our scientific analyses. First, there is the Kabbalic concept of the 'Benoni': ordinary individuals with faults. Most times people are somewhere in between - they're not perfect they're Benonis. We expect no human to be absolutely morally perfect individuals who do not do wrong things are starting point is the majority: Most are Benonis: [92-94]. This does not mean the Benoni is evil or good: They're ordinary and trying and not Axis VI. The Benoni represents almost everyone in between Good and Evil, but hopefully, mainly Good.

Second, of course, with all these theological components, we can introduce repentance-and that introduces a movement towards good from the evil. The *ethicospirituo-* components are quite literally reflecting the ethics, and this is what good and evil is all about. If one were to conceive of it, it would be an *Up/down Axis of spirituality*, of behaviors that allow one to transcend oneself and grow, and to contribute to society -- or the reverse. The common conceptualization of Hell/Heaven, with a throw-in of Purgatory may be useful; these are potentially not real concepts, but they are concepts that we don't fully understand. And we would only label extremes of Evil on Axis VI, though we could possibly for our statistical analysis have an additional sub-Axis VI.G. of good, which would even harder to score even ordinally (good-better-best so to say).

Given that we know now that almost all evil is not psychiatric, we can nevertheless apply such evil at a multi-axial level and introduce the new multidisciplinary DSM classification of an Axis VI. And we can apply it, too, in psychiatry. We must recognize that people are not labeled Axis VI -most people, or the 'Benonis', are in between, but are attempting to grow higher and in a more spiritual way. This to me is the most important aspect of life: the transcendence of self, the growth to a higher spiritual level, the expression of this spirituality in our own physical world.

There may be no special point of differentiation just as we qualitatively must judge whether a specific psychopathology is

[i]From another referee, Suzan Wilson, Jungian Psychoanalyst.

worthy of an Axis I Psychiatric label. Axis VI could work both ways Axis VI-E (evil) and Axis VI-G (good). But the diagnostic labels could be limited to the most extreme directions of Evil and even include extreme Good including moral virtue, kindness, humanity, righteousness, and spiritual growth.

Axis VI is in a psychiatric classification only because there is no other place for it. It is actually an *'ethicospirituobiopsychofamiliosocioethnicocultural classification'.*

We continue to examine the *'ethicospirituobiopsychofamiliosocioethnicocultural'*. The bio -- the biological component is interesting introducing part of the constitution-environment label again: possibly the Lombroso idea of the psychopath, of being "born evil", is an extreme example [28]. However, biological 'constitutional' origins -genes and the environment in the womb—again reflect something very important, that people might start off differently, just as they start off differently with predispositions toward different kinds of mental illness such as depression, anxiety, and psychosis. And the biological elements can be modified throughout life both with illness. Today we have the know, at least a little, of the abilities to express or not express our genes—sometimes due to modifications through the environment so-called 'epigenetics' [95-101]. In good and evil, people can learn from their environment. There are extremes in terms of psychopathic and the learned sociopathic behavior. At that bio level, the biological level, we have the base.

We move to the *psycho-*, the psychological level. There are multiple different ways to interpret elements pertaining to underlying psychodynamics in terms of how people respond. We can be Freudian in this regard [102]. Or we can apply several hundred different models. For example, we can extend beyond the unconscious behaviors and move towards collective consciousness and collective awareness -- the kind of aspects we see at a Jungian level: the awareness of a certain growth [103,104].

And this introduces the socio component, or in this instance, the sociocultural component which impacts the spirituo-, the spiritual, component. Culture is clearly a determining factor for what is regarded as acceptable behavior. It is the way to understand moral relativism [6], but with great assists from *society* and our families and our *microculture*. Good and evil are obvious components that are learnt.

Because all is unified, I strongly argue in favor of this Systems Approach in the context of our many experiences including the *good-evil spectrum*. Indeed, with my colleague, Dr Edward Close, I have introduced the very broad concept of the *'individual-unit'* [105]. Individual-unit refers to the emphasizing that everything is related: Multiple levels manifest together, most overtly in individuals, but the units can be familial, group, ethnic, cultural, social, and species linked (acronym: 'GIFECSs'). For many years I used the relatively short (!) 29-letter term we introduced, namely *'Biopsychofamiliosociocultural'* approach, too [91-106] This term is useful but misses key components in the good-evil spectrum namely ethicospirituo-. Everything is related. We can even include *physico-, astronomico-, and geologico-*. Certainly *militaro-* is important, too. But while I emphasize these components, there's an even broader framework.

This unity is well illustrated by that still complex but comprehensible term that we've discussed like the 50-letter, 8-tier compound word *'ethicospirituobiopsychofamiliosocioethnicocultural'* systems approach [105]. But that too is insufficient. Perhaps militaropolitico- is important too? And then so is our physiology, and our environment, and our relationship with our world. This led us to develop a monster term, all of which are applicable through our special unification model called 'TDVP' (short for a new theory of everything called the 'Triadic Dimensional Vortical Paradigm'). TDVP recognizes a complete unification of everything [105]. Hence, we proposed the 'monster' 300-letter noun (with -ness or -ity depending on the context, or in other forms –al as an adjective and only 298 letters, or ally as an adverb) that easily reflects the logical theme of 38 related components [105] in our book, Reality Begins With Consciousness: A paradigm shift that works. Here it is and I don't expect anyone to remember it!

'Mathematicoinfinitofinitovorticospatiotemporoconscioquantomic Romacroplanetoastronomocosmicophysicochemicoelectricometeor Ologicoinanimatoanimatogeneticoenvironmentobiophysiologicops Ychopharmacofamiliosocioethicopoliticomilitarogeographicoecon omophilosophicospirituomysticoethnicoevolutionoculturalness [105].

We point out that: *"Superficially, this may appear to be a meaningless compound word. But it is anything but a meaningless compound word: It is truly unified and meaningful. It reflects the unification of sociocultural and evolutionary systems theory and of several key sciences and philosophy."* [105].

We want to ensure that the ultimate unification of all of reality is understood as extraordinarily important. Everything animate and inanimate interfaces and interacts with everything else. All events impact and strengthen or weaken oneself or the individual-unit.

Why is this relevant to good and evil? Because systems theory includes profound impacts of the environment and of genetics: These must all be accounted for and included in a comprehensive systems approach. This way we recognize that our ethics, biology, psychology, family, society, spirituality and culture are all intertwined in a profound environment where all things animate and inanimate, infinite and finite, are continually in a complex interaction. In fact, in what way could one portray cosmic unification better?" [105].

We are all one. And everything enhances or diminishes our world and ourselves. Good and evil are not just concepts that can be looked at individually. Good makes our world better; and evil makes it worse.

And so, what are we missing? Is there a moral judgment in 'Good and Evil'? How does this apply to mental illness?

We're missing an awareness that we must speak of good and evil behaviors. There is a need to recognize morality even if judgment in Good and Evil is relative. And this does apply to mental illness but only in a tiny proportion of our population, though the DSM (Diagnostic and Statistical Manual) may ultimately allow us to classify Good and Evil as another systems approach Axis of Axis

VI that applies to our whole population not just the mentally ill.

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Conflict of Interest

None.

References

1. (2013) Anonymous: Could it be that Eichmann and his million accomplices in the Holocaust were just following orders? Could we call them all accomplices?, Google Books, USA.
2. Durkheim E (1897) On Suicide. Penguin Classics 2007, USA.
3. Milgram (1963) Behavioral study of obedience. Journal of Abnormal and Social Psychology 67(4): 371-378.
4. Milgram S (1974) Obedience to authority; An experimental view. Harper Collins, USA.
5. Milgram S (1965) Some conditions of obedience and disobedience to authority. Human Relations 18(1): 57-76.
6. Neppe VM (2017) Conceptualizing good and evil in psychiatry and social groups. IQNexus Journal 9(3): 7-37.
7. Zimbardo P (2007) When good people do evil, Yale Alumni Magazine, USA.
8. Blass T (1991) Understanding behavior in the Milgram obedience experiment: The role of personality, situations, and their interactions. Journal of Personality and Social Psychology 60(3): 398-413.
9. Shakespeare W (2018) Sonnet 116: Let me not to the marriage of true minds admit impediments." Poetry Foundation, USA. pp. 1564-1616.
10. (1994) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). (4th edn), American Psychiatric Publishers, USA.
11. (2013) Diagnostic and Statistical Manual of Mental Disorders. (5th edn), American Psychiatric Association, USA.
12. Neppe VM (2015) Paroxysmal disorders: What is epileptic and non-epileptic? (Part 4) Journal of Psychology and Clinical Psychiatry 3(5): 00165.
13. Neppe VM (2015) Management of Paroxysmal Neurobehavioral Disorder (PND) Part 3 Journal of Psychology and Clinical Psychiatry 3(5): 00165.
14. Neppe VM (2015) Paroxysmal Neurobehavioral Disorder: The episodic brain condition (Part 2). J Psychol Clin Psychiatry 3(5): 00165.
15. Neppe VM (2015) Paroxysmal Disorders in Neuropsychiatry: Why episodic disorders must be accounted for. J Psychol Clin Psychiatry 3(5): 00165.
16. Neppe VM (2015) Temporal lobe epileptic and brain related déjà vu experiences (Section 11)-The special subtypes of déjà vu (Part 3). J Psychol Clin Psychiatry 2(6): 00113.
17. Blumer D, Neppe V, Benson DF (1990) Diagnostic criteria for epilepsy-related mental changes Am J Psychiatry 147(5): 676-677.
18. Neppe VM (2015) The INSET as an important historical and diagnostic screen in paroxysmal disorders (Part 8) Journal of Psychology and Clinical Psychiatry 3(5): 00165.
19. Lynam DR (1997) Pursuing the psychopath: capturing the fledgling psychopath in a nomological net. J Abnorm Psychol 106(3): 425-438.
20. Lynam DR (1998) Early identification of the fledgling psychopath: locating the psychopathic child in the current nomenclature. J Abnorm Psychol 107(4): 566-575.
21. Endres J (2004) The language of the psychopath: characteristics of prisoners' performance in a sentence completion test. Crim Behav Ment Health 14(3): 214-226.
22. Furnham A, Daoud Y, Swami V (2009) How to spot a psychopath". Lay theories of psychopathy. Soc Psychiatry Psychiatr Epidemiol 44(6): 464-472.
23. Genter R (2010) We all go a little mad sometimes": Alfred Hitchcock, American psychoanalysis, and the construction of the Cold War psychopath. Can Rev Am Stud 40(2): 133-162.
24. Calzada-Reyes A, Alvarez-Amador A, Galan-Garcia L, Valdés-Sosa M (2013) EEG abnormalities in psychopath and non-psychopath violent offenders. J Forensic Leg Med 20(1): 19-26.
25. Maibom HL (2014) To treat a psychopath. Theor Med Bioeth 35(1): 31-42.
26. Day R, Wong S (1996) Anomalous perceptual asymmetries for negative emotional stimuli in the psychopath. J Abnorm Psychol 105(4): 648-652.
27. Edens JF, Marcus DK, Vaughn MG (2011) Exploring the taxometric status of psychopathy among youthful offenders: is there a juvenile psychopath taxon? Law Hum Behav 35(1): 13-24.
28. Lombroso C (1885) Criminal Man. Duke University Press Books, Canada, pp.1-448.
29. Neppe VM (1981) Non-epileptic symptoms of temporal lobe dysfunction S Afr Med J 60(26): 989-991.
30. Neppe VM (1981) Symptomatology of temporal lobe epilepsy. S Afr Med J 60(23): 902-907.
31. Neppe VM (1982) Differing perspectives to the concept of temporal lobe epilepsy. The Leech 52(1): 6-10.
32. Neppe VM (2014) Utility, applications, validity and reliability of the Inventory of Neppe of Symptoms of Epilepsy and the Temporal Lobe (INSET) compared with ambulatory electroencephalographic parameters, longitudinal clinical features, anticonvulsant responsiveness, and the SOBIN (Subtle Organic Brain Inventory of Neppe).
33. Neppe VM (2015) Which patients respond to anticonvulsants? The role of mesial temporal lobe firing (Part 10) Journal of Psychology and Clinical Psychiatry 3(5): 00165.
34. Neppe VM (2015) Taming the temporal and frontal lobes of the brain by applying higher brain function structured inventories-"The Inventory Of Neppe Of Symptoms Of Epilepsy And The Temporal Lobe" (INSET) and the "Subtle Organic Brain Inventory Of Neppe" (SOBIN) together with ambulatory electroencephalography parameters, and clinical anticonvulsant responsiveness.
35. Neppe VM (2015) Paroxysmal disorders: electrical firing and systems diagnoses (Part 7) Journal of Psychology and Clinical Psychiatry 3(5): 00165.

36. Neppe VM (2015) Paroxysmal disorders: Are these seizures or electrocerebral firing? (Part 11) J Psychol Clin Psychiatry 3(5): 00165.

37. Neppe VM (2016) Analysis of symptom clusters involving episodic disorders including Paroxysmal Neurobehavioral Disorder (PND) in neuropsychiatry, USA.

38. Mercer D, Mason T, Richman J (1999) Good & evil in the crusade of care. Social constructions of mental disorders. J Psychosoc Nurs Ment Health Serv 37(9): 13-17.

39. Ulrichsen J, Ulrichsen M (2006) The good and the evil recovery]. Ugeskr Laeger 168(3): 299-301.

40. Abdel Rahman R (2011) Facing good and evil: early brain signatures of affective biographical knowledge in face recognition. Emotion 11(6): 1397-1405.

41. Tice LF (1952) Education, for good or for evil? Am J Pharm Sci Support Public Health 124(11): 360-362.

42. Parker WL, Trifunov J (1960) The sport of amateur boxing--good or evil? Can Med Assoc J 83: 432-435.

43. Gillon JJ (1962) The good and evil of bibliography. Concours Med 84: 2897-2898.

44. Peck MS (1997) People of the lie: The hope for healing human evil. (2nd edn), Simon and Schuster, USA.

45. Gould SJ (1997) Nonoverlapping magisteria. Natural History 106: 16-22.

46. Grob GN (1991) Origins of DSM-I: a study in appearance and reality. American Journal of Psychiatry 148(4): 421-431.

47. Altschule MD (1972) Beyond good and evil, or how to create the dark in which to whistle. J Med Assoc Ga 61(5): 162-172.

48. Gutt RW (1977) Every evil may eventually beget some good..(on the 150th anniversary of Ludwig van Beethoven's death. Arch Hist Med (Warsz) 40(2): 219-228.

49. van der Does de Villebois AE (1979) Children: the touchstone of good and evil. Rev Med Univ Navarra 23(1): 63-69.

50. Neppe VM (1982) Schizophrenia: a guide to clinical diagnosis. South Afr J Hosp Medicine 8(4): 88-92.

51. Hamel R (1998) A better approach to care of the dying. Catholic healthcare and the Catholic community can present an alternative to physician-assisted suicide. Health Prog 79(5): 54-59.

52. Kalischuk RG, Davies B (2001) A theory of healing in the aftermath of youth suicide. Implications for holistic nursing practice. J Holist Nurs 19(2): 163-186.

53. Kolves K, Milner A, Varnik P (2013) Suicide rates and socioeconomic factors in Eastern European countries after the collapse of the Soviet Union: trends between 1990 and 2008. Sociol Health Illn 35(6): 956-970.

54. Lindqvist AS, Moberg T, Ehrnborg C, et al. (2014) Increased mortality rate and suicide in Swedish former elite male athletes in power sports. Scand J Med Sci Sports 24(6): 1000-1005.

55. Rafnsson V, Gunnarsdottir OS (2013) All-cause mortality and suicide within 8 days after emergency department discharge. Scand J Public Health 41(8): 832-838.

56. Rostila M, Saarela J, Kawachi I (2013) Suicide following the death of a sibling: a nationwide follow-up study from Sweden. BMJ Open 3(4): e002618.

57. Saint Onge JM, Krueger PM, Rogers RG (2014) The Relationship Between Major Depression and Nonsuicide Mortality for U.S. Adults: The Importance of Health Behaviors. J Gerontol B Psychol Sci Soc Sci 69(4): 622-632.

58. Sommer-Rotenberg D (1998) Suicide and language. Cmaj 159(3): 239-240.

59. Stiel M, Madea B (2002) Satanism and suicide in adolescence--2 case reports. Arch Kriminol 210(3-4): 76-82.

60. Vidal CE, Gontijo EC, Lima LA (2013) Attempted suicide: prognostic factors and estimated excess mortality. Cad Saude Publica 29(1): 175-187.

61. Wahl CW (1957) Suicide as a magical act. Bull Menninger Clin 21(3): 91-98.

62. Arendt H (2006) Eichmann in Jerusalem: A report on the banality of evil. Penguin Classic, USA. pp. 1-336.

63. Fawcett K (2015) How mental illness is misrepresented in the media: Insidious portrayals on TV shape perceptions about real-life people with psychological disorders, USNews, USA.

64. Bastian B, Bain P, Buhrmester MD, Gómez Á, Vázquez A, et al. (2015) Moral Vitalism: Seeing Good and Evil as Real, Agentic Forces. Pers Soc Psychol Bull 41: 8; 1069-1081.

65. Neppe VM (1981) Fame and assassination. S Afr Med J 60(9): 346.

66. Pulver A (2018) Brigitte Bardot: sexual harassment protesters are 'hypocritical' and 'ridiculous'. The Guardian News and Media Limited, USA.

67. Barmak S (2018) How to have sex now: Love in the age of consent; plus the myth of shared workspaces. The Walrus.

68. Bydlowska J (2017) Am I complicit in my own #MeToo? How I played the game of sexual harassment to get ahead—but lost myself in the process, The Walrus.

69. Wakefield A (2016) Vaxxed: From Cover-Up to Catastrophe (documentary DVD).

70. Napier G, Lee D, Robertson C, Lawson A, Pollock KG (2016) A model to estimate the impact of changes in MMR vaccine uptake on inequalities in measles susceptibility in Scotland. Stat Methods Med Res 25(4): 1185-1200.

71. Jain A, Marshall J, Buikema A, Bancroft T, Kelly JP, et al. (2016) Correction of Description of MMR Vaccine Receipt Coding and Minor Errors in MMR Vaccine and Autism Study. JAMA 315(2): 202-204.

72. Mormann M, Gilbertson C, Milavetz G, Vos S (2003) Dispelling vaccine myths: MMR and considerations for practicing pharmacists. J Am Pharm Assoc 52(6): e282-e286.

73. Maisonneuve H, Floret D (2012) Wakefield's affair: 12 years of uncertainty whereas no link between autism and MMR vaccine has been proved. Presse Med 41(9 Pt 1): 827-834.

74. Brown KF, Long SJ, Ramsay M, Hudson MJ, Green J, et al. (2012) U.K. parents' decision-making about measles-mumps-rubella (MMR) vaccine 10 years after the MMR-autism controversy: a qualitative analysis. Vaccine 30(10): 1855-1864.

75. Rao, TS, Andrade C (2011) The MMR vaccine and autism: Sensation, refutation, retraction, and fraud. Indian J Psychiatry 53(2): 95-96.

76. Poland GA (2011) MMR vaccine and autism: vaccine nihilism and postmodern science. Mayo Clin Proc 86(9): 869-871.

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77. Deer B (2011) How the vaccine crisis was meant to make money. BMJ 342: c5258.

78. Xhenseval B (1985) New proposals for the development of the concepts of neurotic anxiety, major depression and panic attack. Acta Psychiatr Belg 85(4): 480-508.

79. Zimmerman M, Coryell W, Stangl D, Pfohl B (1987) Validity of an operational definition for neurotic unipolar major depression. J Affect Disord 12(1): 29-40.

80. Fanous A, Gardner CO, Prescott CA, Cancro R, Kendler KS (2002) Neuroticism, major depression and gender: a population-based twin study. Psychol Med 32(4): 719-728.

81. Scott WJ, Fradkin R, Wilson JG (1977) Non-confirmation of thalidomide induced teratogenesis in rats and mice. Teratology 16(3): 333-335.

82. Vargesson N (2015) Thalidomide-induced teratogenesis: history and mechanisms. Birth Defects Res C Embryo Today 105(2): 140-156.

83. Dossey L (1998) On double-blinds and double standards: a response to the recent New England Journal editorial. Altern Ther Health Med 4(6): 18-20.

84. Neppe VM (2016) How much do we rely on double-blind medical studies? Section 2, in Logical prescribing in psychiatry and medicine. IQ Nexus Journal 8(2): 17-24.

85. Neppe VM (2016) Are we blind to the limits of double-blind medical studies? J Psychol Clin Psychiatry 5(6): 00311.

86. Neppe VM (1990) Ethics and informed consent for double-blind studies on the acute psychotic. Medical Psychiatric Correspondence: A Peer Reviewed Journal. Model Copy 1(1): 44-45.

87. Panczak, R, Zwahlen, M, Spoerri, A, Tal, K, Killias, M, et al. (2013) Incidence and risk factors of homicide-suicide in Swiss households: National Cohort study. PLoS One 8(1): e53714.

88. Adinkrah M (2014) Homicide-suicide in Ghana: perpetrators, victims, and incidence characteristics. Int J Offender Ther Comp Criminol 58(3): 364-387.

89. Lester D (1988) Firearm availability and the incidence of suicide and homicide. Acta Psychiatr Belg 88(5-6): 387-393.

90. Tiret L, Garros B, Maurette P, Nicaud V, Thicoipe M, et al. (1989) Incidence, causes and severity of injuries in Aquitaine, France: a community-based study of hospital admissions and deaths. Am J Public Health 79(3): 316-321.

91. Neppe VM (1999) Cry the beloved mind: a voyage of hope. Brainquest Press, USA.

92. Scholem G Kabbalah (1974) Jewish Publication Society, USA.

93. Kaplan A (1990) Inner Space: Introduction to Kabbalah, Meditation and Prophecy. Moznaim Publishing Corp, USA. pp. 254.

94. Wolf L (1999) Practical kabbalah. Three Rivers Press, USA.

95. Kaminsky, Z, Petronis, A, Wang, SC, Levine, B, Ghaffar, O, et al. (2008) Epigenetics of personality traits: an illustrative study of identical twins discordant for risk-taking behavior. Twin Res Hum Genet 11(1): 1-11.

96. Ogren MP, Lombroso PJ (2008) Epigenetics: behavioral influences on gene function, part I. Maternal behavior permanently affects adult behavior in offspring. J Am Acad Child Adolesc Psychiatry 47(3): 240-244.

97. Crews D (2010) Epigenetics, brain, behavior, and the environment. Hormones (Athens) 9(1): 41-50.

98. Champagne FA, Rissman EF (2011) Behavioral epigenetics: a new frontier in the study of hormones and behavior. Horm Behav 59(3): 277-278.

99. Roth TL (2012) Epigenetics of neurobiology and behavior during development and adulthood. Dev Psychobiol 54(6): 590-597.

100. Narain C (2012) Changing behavior with epigenetics. Nat Neurosci 15(10): 1329.

101. Szabo PE (2016) Response to "Variable directionality of gene expression changes across generations does not constitute negative evidence of epigenetic inheritance" Sharma, A. Environmental Epigenetics, 2015, 1-5. Genome Biol 17: 105.

102. Freud S (1953) The Standard Edition of the Complete Psychological Works of Sigmund Freud. Hogarth Press, UK.

103. Jung C (1978) Jung on synchronicity and the paranormal. Princeton University Press, USA, pp. 184.

104. Jung CG (1991) The Psychogenesis of Mental Disease. Routledge, UK.

105. Neppe VM Close ER (2014) Reality begins with consciousness: a paradigm shift that works, (5th edn), Brainvoyage, USA.

106. Neppe VM (1990) Innovative Psychopharmacotherapy. Raven Press, USA. pp. 1-223.

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