Gender, Madness and Crime: The Reproduction of Patriarchal and Class Relations in a Psychiatric Court Clinic

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This paper examines how forensic clinicians, particularly psychiatrists, help maintain the "constructed normality" of capitalist, patriarchal relations in contemporary liberal democratic states. The specific focus is a comparison of decision-making about accused women and men at a Canadian pre-trial clinic. Using quantitative and qualitative data, the authors argue that clinicians rarely express overt bias towards "clients", but their assessments for the courts are shaped by intertwined assumptions about class and gender embodied in familial ideology which condemn most of the assessees to negative outcomes. Thus, forensic psychiatrists make moral judgements about accused persons which are transformed by technocratic, medico-legal discourse into "scientific" ones. In this way, clinicians individualize and depoliticize the deviance of their "clients" and provide the rationale for decisions made by other carceral agents to sanction offenders.

INTRODUCTION

Since the early 1970s, a number of influential studies have focussed academic attention on the historical emergence of the "normalizing" society which exemplifies the contemporary liberal democratic form of state (Donzelot, 1979, 1980; Foucault, 1977, 1980; Garland, 1981, 1985; Rothman, 1971, 1980; Scull, 1977). As this cross-cultural research reveals, control of the underclasses in such societies is effected through a hybrid regulatory mode, variously described as "socialized justice" (Pound, 1943), the "welfare sanction" (Garland, 1981) and the "tutelary complex" (Donzelot, 1980), that grafts non-lawyer experts, discourses and methods onto existing legal structures and emphasizes case work rather than punishment. From the turn of the century, mental health professionals - psychologists, psychiatric nurses and social workers, and especially psychiatrists - have played an increasingly important role in state-sponsored "normalization" policies aimed at diagnosing and treating the delinquent and the criminal. In the aftermath of these historical convergences, forensic clinicians are now an integral component of the criminal justice process in Canada and other Western countries.

An extensive literature on forensic decision-making in the present context provides a wealth of detail about the contribution of these experts, not only to the ultimate disposition of accused persons, but also to the reproduction of class relations in capitalist, liberal democracies (Castel, Castel and Lovell, 1982; Ingleby, 1981; Menzies, 1989; Miller and Rose, 1986; Pfohl, 1978). Like probation officers and other non-lawyer professionals (Eaton, 1986), psychiatrists, and forensic clinicians generally, have been recruited into the criminal court system for a variety of reasons, but paramount among these is the mission to make sense of human deviance.

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Forensic authorities are enlisted to normalize and, hence, neutralize the words and deeds of defective, dependent and dangerous populations. They can exploit medical knowledge and discourse to explain, and explain away, the crimes and misdemeanours of legal subjects that might otherwise remain inscrutable, incomprehensible, and devoid of reason (Foucault, 1977, 1980; Miller and Rose, 1986; Pfohl, 1978; Robitscher, 1980). Operating within "the shadow of the law" (Mnookin and Kornhauser, 1979), they engage in discretionary legitimation work which helps police, prosecutors, and judges enforce the "constructed normality" (Bottomley, Gibson and Meteyard, 1987) of liberalism more effectively.

The specific assistance provided by forensic psychiatrists is the "scientification" of judicial judgments (Altheide and Johnson, 1980; Ericson and Shearing, 1986; Freidson, 1986; Gusfield, 1981). Through the routine classification of accused persons into recurrent diagnostic categories and criminal types, they identify the salvageable and the incorrigible among their "clients." In letters to the court, they then transform these value judgments into technical ones, using an established set of psychiatric labels—irresponsibility, incompetency, psychopathy, dangerousness, and so on—which merge with criminal ascriptions to individualize and decontextualize the behaviour of their subjects (Menzies, 1989; Pfohl, 1978; Turner, 1987; Warren, 1982). Beneath the technocratic veneer of scientific and moral neutrality that characterizes their assessments, forensic psychiatrists embrace a perspective which emphasizes the legal and moral culpability, criminal responsibility, and need for punishment of mentally disordered persons in conflict with the law (Menzies, 1987, 1989; Webster and Menzies, 1987). By patrolling the boundaries of sanity and criminality, mental health classifiers facilitate the censure and containment of psycho-legal rule-breakers. They simultaneously justify and de-politicize the decisions of police, prosecutors, judges and other carceral officials about a segment of the most marginal individuals in present-day capitalist societies, thereby helping to perpetuate the status quo.

However, while the plethora of accumulated research reveals how class-related assumptions influence forensic decision-makers, it tells us almost nothing about the impact of gender-related beliefs on clinicians. Indeed, until recently (Allen, 1987a,b), even feminists have not considered this question worthy of any systematic investigation. Admittedly, compared with their male counterparts, very few women ever face criminal charges or undergo forensic assessment (Allen, 1987a; Gibbens, Soothill, and Pope, 1977; Webster, Menzies, and Jackson, 1982; Woodside, 1974). And, consequently, those who do may well be perceived to be irrelevant and/or uninteresting subjects for analysis.

Nonetheless, it is our contention that, by examining the manner in which forensic clinicians process women *vis à vis* men, we are addressing an issue of great importance: namely, how the work of mental health professionals both reflects and helps maintain patriarchal relations as well as class divisions in contemporary liberal democracies. The central focus of the paper, then, is to explain why and how forensic clinicians assess female "clients" in the way that they do. In developing the analysis, we begin with an overview of some major issues being debated in the literature on women, crime and mental illness. This discussion is followed by a brief delineation of context, method and a statistical comparison of the men and women who

underwent pre-trial assessment in one Canadian jurisdiction over a 12 month period. In the final section of the paper, we use qualitative data to explore how intertwined assumptions about class and gender structure the outcomes of clinical assessments for the courts.

GENDER, CLASS, MADNESS AND CRIME

It is difficult to explore the forensic assessment of female defendants without considering several more general questions about gender, mental illness and crime which have been, and continue to be, the focus of intense debate. First, there is the fundamental, and extremely contentious, question of whether more women than men become mentally ill. The prevalent belief that they do is founded primarily on official statistics relating to psychiatric hospitalizations and out-patient treatment, and secondarily on the results of a few community studies. Moreover, this literature tells us that, from the 1950s onward, the ratio of mentally ill women to men has increased (Busfield, 1983; Chesler, 1972; Gove and Tudor, 1973; Smart, 1976; Smith, 1975).

Attempts to explain the apparent gender imbalance revealed in the statistics generates a second question for researchers: is mental illness in women the functional equivalent of crime in men? (Smart, 1976: c.6; see also Barrett, 1988:c.7). After all, official *criminal* statistics reveal the same gender discrepancy in reverse. Perhaps when faced with similar crises or stressful situations, "normal" men and women adopt sex-specific forms of deviant behaviour which reflect their very different socialization patterns. Thus, the former become predators, and the latter retreat into themselves.

The functional equivalence thesis is very appealing, but it raises yet a third question: are women offenders more likely to be double deviants than men—both bad and mad? Certainly, the prevailing theories of female criminality, from Lombroso to the present, assume that women offenders are pathological individuals, driven by bio- and psycho-genetic forces. Three "facts" help sustain this view: the rarity of female criminals *vis-à-vis* their male counterparts; the almost exclusive perpetration of violent offences by women within a domestic setting; and the greater frequency of psychiatric records among female as opposed to male offenders (Anasseril and Harris, 1981; Gavigan, 1987; Heidensohn, 1985; Morris and Gelsthorpe, 1981; Rosenblatt and Greenland, 1974; Smart, 1976).

Given the historical tradition of theorizing about women who commit crimes, it is not surprising that a greater proportion of female than male offenders are subject to forensic assessment, at either the pre-trial or pre-sentence stage of the criminal justice process (Allen, 1987a,b; Dell and Gibbens, 1971). However, this raises a fourth question that has similarly triggered controversy: namely, when women and men charged with similar offences are sent for psychiatric evaluation, do the former ultimately receive less severe judicial dispositions than the latter? Some research on violent criminals lends support to the leniency thesis. For example, a recent English study (Allen, 1987a,b) revealed that men who committed serious crimes of violence generally received custodial sentences, whereas their female counterparts not only avoided institutionalization but in many cases were also accorded medical and social support in the community. Similarly, a group of American researchers (Rogers, Sack, Bloom, and Manson, 1983) found that, when women and men were hospitalized after a finding of incompetency or criminal insanity, the former spent less time in hospital and were discharged at a higher rate than the latter.

Hence, on the subject of women, crime and mental illness, the dominant perspective has been premised on the assumptions that more women become mad than bad, and that female offenders are therefore likely to be double deviants who need compassion and treatment rather than punishment.

However, these beliefs have not remained without challenge. Leaders of the anti-psychiatry movement (Laing, 1967; Szasz, 1963, 1970) and the societal reaction school in sociology (Becker, 1963; Goffman, 1961; Scheff, 1966, 1975), which emerged within the context of 1960s egalitarianism, reformulated the concept of deviance in a way that contradicts conventional wisdom about the origins of mental illness and crime. By shifting the focus away from the individual deviant and placing it squarely on those who make and mobilize deviant definitions, they argue that the generation and application of deviant labels are the prerogative of the powerful since the labelees are almost invariably unable to successfully resist or reject stigmatization.

In this view, women do not necessarily become mentally ill more often than men and the functional equivalence thesis does not hold. Rather, family members are more likely to identify and mental health experts to define certain behaviours by women as mental illness. Specifically, Laing and others suggested that girls and women who eschew their "natural", feminine roles as dependent daughters and wives/mothers within the family are considered pathological and in need of psychiatric treatment (Laing, 1967; see also Hudson, 1987; Showalter, 1985).

The insights of the anti-psychiatrists and societal reaction theorists have been pursued by feminists concerned about what they see as the historical trend for doctors and psychiatrists to pathologize and infantalize women (Ehrenreich and English, 1973, 1978; Showalter, 1985; see also Donzelot, 1980; Foucault, 1980). While some feminist writers have accepted the critique of official mental health statistics (Busfield, 1983; Smith, 1975), others have assumed their accuracy and offered a new interpretation. Taking the statistics, which revealed more married than single mentally ill women and the reverse for men, Chesler (1972) has elaborated a persuasive and extremely influential thesis about the social control of women through psychiatry and medicine (see also Barrett and Roberts, 1978; Hudson, 1987; Penfold and Walker, 1983; Procek, 1981; Smith and David, 1975). Women who contravene the assumptions about their "proper" role as caregivers, homemakers and faithful wives within the nuclear family, she argues, are labelled as mad and subjected to resocialization treatment, either as inpatients or outpatients, which is aimed at medicalizing them into submission (that is, willingness to assume an appropriate gender role). In short, psychiatrists step in when the informal, familial controls (economic and emotional) which keep women in line break down.

When feminists have turned the spotlight on female ***offenders***, they have reached similar conclusions. It is not that women who commit crimes are more likely to be mentally ill than their male counterparts, but rather that criminal justice agents and criminologists are more likely to explain female offenders in terms of bio- and psycho-genetic motivations which are premised on assumptions about inherent sex differences (Gavigan, 1987; Heidensohn, 1985; Morris and Gelsthorpe, 1981; Smart, 1976). In cases of serious inter-personal violence, for example, women are almost automatically viewed as "sick", a belief that is reinforced because their victims are usually children, spouses and other relatives (Allen, 1987a,b). However, even women

sentenced to prison for non-violent crimes are often considered abnormal, despite the absence of an identifiable mental illness, and are subjected to a regime of treatment and resocialization (Carlen, 1983, 1985; Dobash, Dobash, and Gutteridge, 1986; Edwards, 1984; Ross and Fabiano, 1986; Rowett and Vaughan, 1981).

Although feminists concur that criminal justice agents more frequently describe female offenders in terms of pathology compared with their male counterparts, they split over the question whether this translates into less severe dispositions for women *vis-à-vis* men. The only systematic comparison of women and men offenders remanded for psychiatric evaluation to date (Allen, 1987a,b)—a Foucauldian analysis of the medical and legal discourses employed in forensic decision-making—suggests that assessment outcomes are indeed consistently biased in favour of female offenders, particularly in relation to serious violent crime. This happens, Allen argues, because the gender-neutral provisions of the criminal law are undercut by the gender-specific assumptions about men and women to which psychiatrists adhere. Thus, on the one hand, forensic decision-makers routinely reduce or eliminate the legal guilt of violent female offenders by transforming them into pitiful victims who lack moral guilt and, on the other hand, find their male counterparts doubly culpable. Consequently, men who are described as mentally disordered by clinicians may still end up in prison, while women who are not can actually be returned home to the scene and victim(s) of their offence.

Although ground-breaking, Allen's research is also controversial. Her conclusions are based almost entirely on an examination of cases involving serious violence, which are atypical of the crimes committed by the majority of individuals who are forensically assessed (Dell and Gibbens, 1971; Menzies, 1989). Moreover, she ultimately adopts the same dichotomous approach to theorizing about women, crime and mental illness which she ostensibly rejects (1987a:9-13). Whereas Chesler (1972) and others speak about the oppression of women by men psychiatrists, Allen maintains that forensic decision-making consistently privileges the former as a group and discriminates against their male counterparts.

In contrast, some recent feminist research on women and crime suggests that legal decision-making reflects the ideologies and practices which are dominant at a given time in a particular form of political and social organization (Carlen and Worrall, 1987; Daly, 1987a,b; Eaton, 1986; Edwards, 1984, 1985a,b; Smart, 1976, 1985). It cannot be unraveled and comprehended using transhistorical, unitary categories, whether these be related to class, gender or race/ethnicity. Analyses of criminal law enforcement must be historically specific and account for similarities between, as well as differences within, offender categories.

Inside the ordering practices of the liberal democratic state, what contributes most to maintaining the capitalist, patriarchal status quo is not overt oppression of certain groups, but rather the indirect influence of ideologies on decision-makers, including those who enact and administer the law (see also Barrett, 1988; Bottomley, Gibson and Meteyard, 1987; Gavigan, 1988). Of particular significance are the class and gender norms encapsulated in familial ideology (Barrett, 1988; Barrett and McIntosh, 1982; Thorne and Yalom, 1982; Zaretsky, 1976). For example, the previously cited studies of women and crime reveal quite clearly that both legal and non-legal

criminal justice agents judge their "clients" in relation to the (usually) implicit standards of appropriateness associated with the nuclear or bourgeois family model based on a heterosexual marriage relationship and the sexual division of labour. Thus, convicted persons who contravene the dictates of familial ideology routinely find themselves subject to intensified regimens of regulation and treatment that recurrently transcend categories of class, gender and race/ethnicity (Daly, 1987a,b; Eaton, 1986; Edwards, 1985a).

At the same time, the "constructed normality" which familial ideology reflects is unremittingly white, patriarchal, and bourgeois. The offenders who are assessed most harshly overall by criminal justice personnel are the double, triple and multiple failures—the women and men who have not negotiated the class, gender and racial/ethnic "deals" which are characteristic of "normal" people (Carlen, 1987). They eschew the discipline, deferred gratification and hard work which are the assumed prerequisites for achieving economic security in a capitalist, market society. They have not assumed their proper roles as wives/mothers and husbands/fathers in a nuclear family unit. They are physically unattractive, verbally inarticulate and socially inept misfits living on the marginal edge.

We found the theoretical framework elaborated in recent feminist literature on women and crime most persuasive and relevant to our own analysis of forensic decision-making: a study which focuses on the routine processing of routine cases involving petty property and public order offences, as well as the more sensational, and rare, crimes against the person examined by Allen (1987a,b). In the everyday ordering of pretrial forensic subjects, medico-legal authority articulates with gender and class according to complex and mutually elaborative patterns. It would be erroneous to suggest that forensic classifiers are knowingly engaged in a crude or conspiratorial coercive enterprise. On the contrary, the unexamined assumptions about normality underlying the medico-legal discourse and practices of clinicians are rarely, if ever, explicitly stated. Forensic authority is instead deeply rooted in the power of therapeutic discourse and the hegemonic features of scientific knowledge systems. It is through their role as mediators between the mechanisms of medical and legal order—and in their ability to deflect political, structural or cultural explanations in favour of theories grounded in personal pathologies—that clinicians exercise and justify state control over marginal citizens. It is here that they most clearly contribute to the maintenance of gender and class inequality.

CONTEXT AND METHOD

The cohort of women who comprise the focus of this paper were assessed at the Metropolitan Toronto Forensic Service (METFORS). Founded in 1977 with the objective of providing both single-day and protracted clinical evaluations for the Toronto criminal courts, METFORS consists of a Brief Assessment Unit (BAU) and a 23-bed Inpatient Unit; the former delivering multi-disciplinary evaluations of criminal defendants under conditions of maximum security, and the latter designed to accommodate forensic subjects for extended 30 to 60 day remands under the terms of the Canadian Criminal Code or the Ontario Mental Health Act. Over the first decade of its existence, METFORS has furnished court reports on 600 to 800 defendants each year in the BAU, and on another 200 to 300 persons in the Inpatient Unit (Menzies, 1989; Webster, Menzies and Jackson, 1982).

Our research at METFORS has been concentrating on the medico-legal careers of more than 500 accused persons over the course of a six-year period following their initial BAU assessments in 1978 and 1979 (McMain, Webster and Menzies, 1989; Menzies, Webster and Sepejak, 1985a,b; Webster and Menzies, 1987). In this present study, we look specifically at a sub-group of 57 women defendants, and we focus on their assessments at METFORS during the first year of the agency's operation in 1978. We incorporate both statistical and qualitative documentary analysis of the extensive medical profiles that were compiled on these subjects throughout their remands in the BAU and Inpatient Units. These documents include the reports of arresting police officers; the medical files generated by all participating METFORS classifiers (including psychiatrists, psychologists, social workers, nurses and correctional officers); court letters written by the presiding psychiatrists; intake, progress and discharge notes from the inpatient ward; and statistical summary sheets completed for each assessment. For purposes of comparison, we drew a random systematic equivalent sample of 57 men who were evaluated during the same time frame. The following quantitative and illustrative probing of METFORS documents enlists both an intensive scrutiny of materials generated about the 57 women, and a relational analysis that compares the experiences of female and male defendants.

THE AGGREGATE PROFILES

The METFORS women represented 9.6 per cent of the subject population during the year of the study. In the aggregate, their statistical profiles revealed recurrent patterns of socio-economic and institutional exclusion based on gender and class. These female recipients of forensic classification were almost universally drawn from the ranks of the disenfranchised urban underclass: the culturally marginal, the chemically dependent, the mentally and criminally suspect, the under- and unemployed, the homeless, the reliant, the solitary and the poor. Among the group of 57 women, seven were married or cohabiting at the time of their assessment. Nine had received a high school education, four had a job, 20 lived alone, and two were institutionalized. Forty-four of 57 had a prior criminal record, 21 had been in prison, and 34 had spent time in psychiatric hospital. Nearly half (25) had attempted suicide. Twenty-five and 18 women respectively were heavy abusers of either alcohol or other drugs. Following the METFORS brief assessments, the BAU psychiatrists categorized 23 of the women subjects as mentally disordered, 19 as psychotic, 18 as behaviour disordered, 19 as dangerous to others, 14 as dangerous to themselves, and 9 as unfit to stand trial. And when they were returned to court, 18 of 54 were sentenced to prison, and another 22 received a term of probation.

The aggregate comparison between the 57 women and their male counterparts disclosed a complex and contingent relationship between gender and class in the ordering practices of forensic authorities. On most biographical, socio-legal and clinical measures, the two genders were strikingly similar. The shared socio-economic, medical and legal subjugation of women and men seemed to permeate their existence and galvanize their institutional treatment. Bivariate statistical analyses demonstrated no significant female-male differences in age, race, place of origin, education, residence, marital status, court record, prison record, psychiatric history, drug consumption, or precipitating criminal charges. The METFORS classifiers

did not apparently distinguish women from men in their depictions of mental disorder, fitness to stand trial, dispositional recommendation, or dangerousness to self and others. Nor were there any variations by gender in the distribution and intensity of subsequent criminal court sanctions.

On the other hand, significant gender differences did emerge along a few dimensions where the sex-specific experience of women forensic subjects was clearly transcendent, and in particular where the medico-legal ordering of women was associated with elements of familial control, economic disempowerment, and violence. First, 41 of 54 female defendants for whom data were available, in contrast to 27 of 55 males, had not lived with both biological parents to age 16 ($X^2 = 7.26$, $df = 1$, $p = .007$). Second, even more women than men (53 and 40 respectively) were unemployed at the time of their METFORS assessment ($X^2 = 8.41$, $df = 1$, $p = .004$). Third, although general criminal histories were indistinguishable, women were decidedly less violent toward others; their mean incidence of 0.39 prior violence convictions was scarcely more than one-third the 0.96 average for men ($t = 2.65$, $df = 111$, $p = .009$). Fourth, it was women subjects who were significantly more likely to have attempted suicide, with a frequency of 25 or 44 per cent, in contrast to an incidence of 14 or 25 per cent among men ($X^2 = 3.90$, $df = 1$, $p = .05$).

These statistical comparisons plainly show the mutual infusions that prevailed between the gender-specific experiences of women and men at METFORS, and their parallel placements in the lower reaches of the hierarchical political and economic order. Neither patriarchy nor social class was by itself a sufficient explanation, or a unilateral propellant, for the institutional careers of forensic subjects and the decisions of their examiners. Instead they elided and divided in a variety of contradictory ways. Such a recursive pattern of convergence demands a fully reflexive and multi-dimensional approach to the study of gender, class and forensic discretion. And this, in turn, necessitates a closer look at the how and why of clinical decision-making through the enlistment of a qualitative documentary analysis of discursive practices. In what follows, we attempt to unravel some of the organizing assumptions and activities through which the METFORS professionals classified, and contributed to the sanctioning of, the 57 female defendants and their male counterparts. Our specific concern is to illustrate how the intertwined assumptions about gender and class that are encapsulated in medico-legal ideology impacted on the forensic assessors, and shaped their official ascriptions of mental disorder and criminality among both women and men.

FORENSIC FORMULATIONS OF GENDER AND CLASS

No analysis of psychiatric assessments for the criminal courts can proceed without an understanding of the critical impact of class differentials between clinicians and patients. Nor can a one-sided contrasting of men and women (compare Allen, 1987a,b) capture the complex interactions among gender, class, and other attributes in the structuring of clinical judgments about ***all*** subjects at METFORS and other forensic agencies. What the qualitative data reveal is that METFORS clinicians took for granted the "constructed normality" of a liberal democratic society based on capitalist, patriarchal relations, and the central role of "the family" in maintaining the status quo. Thus, far from being value neutral, their classification work for the courts was ideologically-charged. Women and men subjects were evaluated

according to class-related normative criteria and gender-based standards of femininity and masculinity simultaneously. In both areas, they were systematically found to be deficient with respect to the assumptions about normality that were embraced by their clinical judges.[1]

In establishing the deficiency of their clients, then, METFORS clinicians sometimes assessed women and men against the same norms, and other times against sex-specific norms, to produce similar outcomes. With regard to the former, both female and male forensic subjects were subject to a sweeping and multidimensional labelling enterprise. Regardless of gender, psycho-legal assessments at METFORS were primarily organized around the detection of deviance, disorder and disrepute. Indeed, the common adhesive that cemented the vast majority of all forensic assessments was the professional characterization of subjects as polymorphous failures. Women and men patients at METFORS were repeatedly stigmatized in the BAU for their inability to cope with the everyday demands of a "respectable" social existence.

The following two excerpts typify the biographies of disrepute which were scattered throughout the clinical records. Like other reports, they were used to establish that such generically deviant women and men were virtually beyond all means of social, psychiatric or legal redemption (see Menzies, 1989, c.3).

> We see in this young lady[2] a very disturbed, deprived woman of 26 who has led an extremely difficult life where she has abused her body, has abused other people, and has been abused by other people. She has spent a lot of time in and out of jail. ... She indicates that she has been in institutions off and on since she was about 10 years old. Her mother sent her to training school at age 10 as unmanageable. She has had 6 children, none of which are in her custody. ... It would not appear that she is particularly amenable to any kind of psychotherapeutic intervention. She in some ways is a rather pathetic figure. She impresses as perhaps not being very bright and it is difficult to know how much this is affected by [her] alcohol and drug abuse (SWR26)[3]...

> This 23 year old man ... has been in and out of trouble [since the age of 9] including having served time in Kingston Penitentiary. ... [When] he was out of prison, he had several jobs. He gave as the reason for losing many of these jobs as not turning up in the mornings or he did not like what the boss was doing. He readily acknowledges that he has had a marked tendency to overindulge in alcohol. He has also readily given a history of being involved in the abuse of street drugs from the age of 14. ... He is unrealistic in the sense that he believes he may get bail, or probation if he is found guilty of these charges. ... we felt that he had been given every chance to alter his lifestyle ... [but he] does not want to alter his lifestyle. ... We also felt unanimously that this man is quite dangerous (PL60).

As these examples demonstrate, the METFORS clinicians typically presented impoverished and institutionalized women and men as authors of their own unhappy fate, or as the victims of internal pathological processes more so than of social or financial misfortunes. Emotional disorder and criminality were thus effectively decontextualized (Lofland, 1969). In the construction of psychiatric explanations for their personal troubles, the class origins and socio-economic environment of these women and men were frequently ignored or discounted, as clinicians opted for accounts that stressed individual moral deficiency, mental defect and criminal character.

Accordingly, instead of being affirmed as a set of mitigating circumstances that might temper the severity of medico-legal response, the poverty and marginality of both women and men defendants simply converged with already-existing or emerging psychiatric formulations, as in the following

illustrative case. A 22 year-old woman was remanded to the Brief Assessment Unit on a charge of "Public Mischief" after she threw a brick through the window of a provincial government building. Her explanation of events appeared in the report of the arresting officer: "[the accused] broke the window as she had no place to stay, was down and out, and wanted to be arrested by the police" (PR37). In the BAU, however, clinicians sought a mental rather than social rationale for this woman's current crisis, and she was diagnosed to be suffering from "acute situational maladjustment".

This general assessment was supported with descriptions of the subject's multiple defects. The nurse reported that "she was inarticulate and she was difficult to understand due to her speech impediment. Clinically, she appeared to be of below average intelligence" (NR37). The social worker added: "She seems to be an inadequate, immature young lady who comes from a very deprived background with physical and emotional abuse. She also admits to misusing alcohol and states that she usually gets into trouble when she has been drinking" (SWR37). The psychologist wrote:

> Her presentation throughout the interview appeared to have some characteristics of those individuals who are seen as stuperous. She suffered from slurred speech, seldom, if ever, had eye contact and was rather slow in developing her thoughts. ... L. is a young lady who is in need of external support and, perhaps, control (POR37).

In this fashion, clinicians collaborated to simultaneously establish the subject's shortcomings as a social being, to hold her personally and psychiatrically accountable, and to furnish justifications for further intervention and control.

Moreover, despite the scientific, technical discourse, this was primarily a process of moral attribution. The classification of women and men at METFORS, and the content of official documents sent on to legal authorities, were dominated by the clinicians' search for moral culpability. Like the decision-making practices of officials elsewhere in the medico-legal system, psychiatric assessments of mental disorder, fitness to stand trial, dangerousness and other forensic concerns were secondary to more generic evaluations of character and virtue. During the course of their clinical remand at METFORS, few patients deemed deserving or salvageable were identified (see below). The vast majority of those who departed from acceptable standards of conduct were considered undeserving or incorrigible, and were subjected to an array of negative ascriptions that functioned to justify psychiatric interventions and to pave the way for further criminal sanctions.

This diagnostic emphasis on the flawed character of METFORS patients reflected the clinicians' own class-based standards. They clearly assumed that, in a liberal democratic society like Canada, all citizens are equally free to exercise rationality and choice, despite the existence of substantive inequalities among the populace. Thus, "normal" women and men achieve their goals and lead successful lives within the context of their particular social and economic circumstances because they choose to act responsibly; they work hard, defer gratification, impose self-discipline, and generally adhere to the Protestant Ethic. Therefore, if people eschew the behaviour which produces success, it is their own fault that they are failures. Through decisions guided by these assumptions, clinicians continually individualize and medicalize what is essentially a political issue: the social and material origins of their subjects' deviance.

However, while the women and men remanded to METFORS were assessed with respect to the same class-based standards, these standards were interwoven in forensic judgements with gender-related norms which reflected clinicians' assumptions about the normality of the nuclear family and the sexual division of labour. With few exceptions, the forensic assessors concluded that their patients were not meeting sex-role expectations and were unlikely to do so in the future. Clinicians routinely noted the absence of gender-appropriate (i.e. feminine, masculine) behaviour in three major areas: spousal and parental responsibilities, sexuality, and presentation of self.

Spousal and parental responsibilities:

The METFORS women and men were continuously being assessed not only as criminal defendants, dependants and pathological beings, but also according to conventional conceptions of spousal and maternal/paternal duty (Barrett and McIntosh, 1982; Donzelot, 1979; Thorne and Yalom, 1982; Zaretsky, 1976). Clinicians expected both female and male patients to be disciplined, hard working, and to reject hedonism in relation to their respective and complementary family roles. They assumed that a "good" wife/mother was a woman who managed the "private sphere" as the primary caregiver and housekeeper for other family members and that a "good" husband/father was a man who engaged in paid, steady employment as the primary provider for his dependants. Not surprisingly, the evaluation of METFORS subjects according to their degree of conformity to the bourgeois family pattern meant that most were found wanting. The very fact, then, that the overwhelming majority of METFORS women and men were not part of a "normal" family, or at least were disaffected from their existing relatives, virtually condemned them to a negative moral assessment.

We can see this clearly from an examination of specific cases processed at METFORS. Because clinicians viewed the family as the dominant institution in the evaluation of feminine achievement, a woman's expressed or inferred inability to sustain familial relationships, to find or keep a husband, to manage a home, and especially to perform as a competent and caring mother, was regularly collapsed together with psychiatric designations and presented as evidence of sickness and blame. In establishing such features of spoiled identity, clinicians were particularly alert to signs of nonperformance in discharging the duties of motherhood: "She tends to minimize the considerable difficulty legally and psychologically that her children are apparently in, and seems to have little regard for their well being" (SWR53). ... "She reports having three children [of whom two] are reported to be living with her sister in Florida. Little involvement with either child was reported by her on the advice of the Children's Aid Society who initiated their removal. The youngest child is reported to be in care with the Children's Aid Society somewhere in Ontario" (POR22). ... "The patient has 3 children who have been brought up by their grandmother, the patient's mother. Apparently the patient causes problems in several ways when she goes to their home. ... She tries to kiss the children, and they don't like it. She has had 8 babies altogether, but only kept three" (SWR01).

Similarly, METFORS clinicians viewed the ability of a man to earn a good living and support a family as the mark of masculine success. Therefore, whatever their marital status, male patients who fathered children and failed to maintain their dependants because they could not keep a job were invariably noted in clinical reports: "G. has a poor work record because of

his recurrent jail sentences but he has held numerous short-term jobs. ... he says that the longest job he has ever held was for a period of a year. He married at the age of 22 but the marriage lasted only a year. There is a small son by this union. G. states that he was never really close to his wife nor does he have any feelings for her or for the child" (PL64).

In the forensic assessment of METFORS subjects, the family was considered not only a site of gender role failures and general psychopathology, but also a valuable data source for developing official accounts of deviancy. The husbands, fathers, wives, mothers and other relatives of defendants were frequently recruited by clinicians as informants, who willingly provided clinicians with oral evidence of mental disorder, criminality and general miscreance. Such damaging testimony from intimate family members—eliciting information not usually available outside the home and family—was used to verify and to supplement the official depictions contained in medico-legal records (Menzies, 1989, c.4).

In one such case, the father of a 33 year-old "chronic schizophrenic" charged with common assault presented himself to the METFORS social worker and requested that his daughter be detained in a security hospital hospital: "He indicated ... that F. (the subject) has been hospitalized on 13 occasions [and] that she has lived a rather chaotic somewhat disruptive life. ... He felt that F. had been coming along fine [in psychiatric hospital] and seemed to be responding to the medication. He wants F. to be in a locked hospital, and if she is placed back in [general psychiatric facilities], will continue to run away from the hospital setting" (SWR51).

Alternatively, in the absence of a compliant close relation, the role of informant could sometimes be occupied by a strategically placed case worker or probation officer. Such evidence from a member of the helping professions could be equally revelatory about the reportedly deviant, disordered and disruptive conduct perpetrated by women subjects within the confines of the family unit. Like other official accounts that found their way into the METFORS documents, these depictions tended to concentrate on the apparent failure of defendants to conform with accepted gender norms, as with a woman charged with failing to comply with the terms of a probation order:

> I spoke to the patient's Children's Aid worker, Mrs. B., in order to gather more background information about G.'s personality and behaviour. Mrs. B. has seen the patient when she was behaving in a very bizarre way. She swears a great deal and much of her verbal abuse has a sexual connotation. ... The patient has also engaged in several spitting episodes, spitting at whoever happened to be nearby. She speaks of curses and has threatened that a witch will lay a curse on the staff of the Children's Aid Society. She often appears at the agency in inappropriate clothing such as pink hot pants and a blouse undone to the waist. Mrs. B. feels that she has the potential to be a loving mother but at least for the past year has been somewhat abusive with the children. She has seen her slap and pull the hair of her children. The Children's Aid Society is seriously thinking of going for a Crown wardship ... because they feel it would be better to get the children into a stable home environment (SWR25).

Sexuality:

Sexuality was an especially resilient feature of mental and moral apprehensions at METFORS. Clinicians clearly equated "normal" sex with heterosexual sex which, for women, is also confined to a legal, marriage relationship. Histories of licentious conduct were offered as evidence for current troubles and prospective problems and led to intensified scrutiny of

defendants by clinical team members. Moreover, once women and men were defined as mental patients, their sexual attitudes and comportment could become a central focus of investigation. Thus, defendants who departed from conventional sexual norms were consistently defined as moral risks and subjected to psychiatric sanctioning.

One woman, who was remanded to the BAU following a brawl with two police officers, received a clinical assessment that effectively merged her lesbian sexuality with attributions of criminality and drug dependency: "Miss J. presented as a petite, verbal and sometimes a seductive young lady. ... Her sexual orientation is one of lesbianism. She says she has had sexual relations with men only three times. ... The evidence indicates poor social anchoring, in conjunction with an ongoing addictive pattern. Internal and external resources are poor. There is little evidence of desire for change. ... [T]he pattern of alcohol abuse and lesbian activities seems well set" (POR24).

Similar clinical reasoning was apparent in the case of a woman arrested for stealing a car (about whom the arresting police officer, under "medical notes," reported: "lesbian—in good health"). Here, an apparent link was forged between the patient's sexual identity and her history of antisocial behaviour. She was described on the unit as "a short dark rather masculine looking young woman" (SWR33). The BAU social worker wrote: "She stated that she began drinking at age 15, was sent to training school when she was about 14 ... that she was involved in shoplifting and [that] she also set a fire on one occasion. ... She was also into the drug scene by age 14 and stated that glue sniffing was the major thing she was involved in. She stated that she has had sex only on one occasion with a boy and that really she prefers to be with girls" (SWR33). In the final psychiatric court letter this information was digested as follows: "She hinted that she had been involved in all sorts of activities which may be termed antisocial. In fact, she had no hesitation, cheerfully giving a long list of her various activities. ... We considered that she is possibly a dangerous young woman in that she can get herself involved in activities which can harm a lot of people" (PL33).

Men who engaged in homosexual behaviour were equally subject to moral condemnation and forensic sanctioning. In one case, a 33 year old mentally-retarded man charged with indecent assault on a seven year old boy was sent to the BAU for assessment. He had no prior charges and stated that "in the present charge ... he did not force the boy" (SWR112). While few people regard pedophilia as a "normal" or acceptable expression of sexuality, the METFORS psychologist proceeded to cast doubt on the patient's documented mental disability, thereby transforming him into a person who was accountable for his actions and deserving of a severe response:

> R. is a man of limited intellectual ability. However, he does not appear to be profoundly retarded. Some of the words that he used as well as the way he constructed his sentences indicate that his actual level of intelligence might be somewhat higher than one might assume. He does have a significant problem in the sexual area, but this is liable to be very resistive to any kind of therapeutic intervention of a psychotherapeutic nature. He might respond to some forms of chemotherapy (POR112).

In his court letter, the psychiatrist reiterated this recommendation for the control of the subject's sexuality: "R. may benefit from attendance at a psychiatric facility with the addition of medication to help lessen these impulses that at this time are perceived by R. as being uncomfortable" (PL112).

Although the forensic stigmatization of homosexuality was gender-blind, female patients at METFORS were also sanctioned for uninhibited sexuality. Clinicians clearly assumed that "normal" women confine their sexual activity to a monogamous marriage relationship. Therefore, women defendants whose documented sex lives revealed numerous pre-marital or extra-marital sexual relationships almost invariably elicited negative comments from clinicians.

Indeed, the METFORS records were replete with pronouncements about female patients which explicitly linked their sexual immorality to their marginality: "G. has lived a rather free and bouncing-around life. She has lived with young men on and off on many occasions. ... She says that she has been unable to find a job. ... [T]his young lady is a very inadequate, immature girl of borderline intelligence. She seems quite satisfied with her style of life" (SWR17). ... "She is somewhat of a maniacal character. Her social goals seem to be to have a man around and to enjoy herself thoroughly. Physical and social needs are quite important to her and she always manages to find ways to satisfy them. ... While not overtly anti-social in nature, values are largely of self-gratification and narcissistic varieties. She sees herself in a good light..." (POR21). ... "R. gave a story of having been involved in drugs, alcohol and promiscuity since she was about 16 years old" (PL49). "Miss G. is extremely troubled and emotionally needy ... with an anti-social flavour to her personality. She tends to approach the world from a manipulative and yet highly dependent stance, demanding almost constant attention and affection from others while giving little in return and changing little in the process. ... I believe she requires almost constant psychiatric supervision" (POR49).

When female defendants were detained at METFORS for extended observation, clinicians typically sexualized, and therefore challenged the appropriateness or authenticity of, their behaviour. One such woman, remanded to the Inpatient Unit on a minor arson charge, found her sexuality to be a constant theme in the ward progress notes that were charted by institutional staff: "Somewhat seductive to male co-patients. ... Patient has at this time misplaced her priorities. Presently being male companionship. ... Seeking and receiving much attention from male co-patients. ... She was almost constantly in the company of one male patient [and] a pseudo-romantic relationship grew from their mutual assessment periods" (IPN40). Another woman, who repeatedly voiced her discomfort at being the only female among 20 subjects on the METFORS ward, was the recipient of a generally negative assessment that concentrated on the "inappropriateness" of her social and sexual conduct during her confinement as an inpatient: "Keeps to herself. ... Was observed in suggestive poses. ... Seductive toward male co-patients. ... Appearance inappropriate, hair standing on end, makeup smeared. ... Out of touch with reality. ... Possibly onset of menses may be affecting her ... behaviour" (IPN25).

Presentation of self:

The METFORS clinicians assessed patients not only in relation to assumptions about the normality of the sexual division of labour and heterosexual marriage, but also with respect to assumptions about the appropriate presentation of self. In their reports, the "normal" or feminine woman is physically attractive and accommodating, while the masculine man is well-groomed and assertive but not violent. For different reasons, then,

both female and male defendants at METFORS were required to defer to the authority and expertise of medico-legal professionals during the conduct of their psychiatric examination, and to subscribe to the clinical theories being offered about the pathological origins of their present troubles.

To deny, discount or dispute the credibility of forensic practices was to invite questions about one's own authenticity as a "normal" woman or man. Hence, female patients who asserted themselves and failed to accept clinical authority were typically depicted as "masculine" and/or malicious troublemakers. Even when they were entirely unobservable, such inversions of the required gender role could sometimes be imputed by discerning professionals: "[She] plays the little girl role yet is capable of instigating trouble and seems to be a covert leader" (IPN44).

However, in most cases, clinicians had more than enough examples of "unfeminine" deportment to draw on. One woman who displayed considerable verbal aggressiveness during the BAU interview was described as "very controlling ... she appeared to have some mannish characteristics about her" (NR53). Another woman who verbalized hostility throughout the assessment, was described by the social worker as follows: "This 19 year-old girl I found to be quite hostile. She seemed to be lying and evading the truth. ... I found her to be quite hostile and sullen throughout the interview. She is somewhat masculine in her own approach and attitude" (SWR34).

Similarly, a 56 year-old woman, who was charged with the theft of $46.19 using a stolen credit card and refused to cooperate with the METFORS assessment, was described by the psychiatrist as "a cantankerous, demented, babbling old lady. ... She is also unfit to stand trial because she may be 'mute of malice' and she may be so uncooperative as to create quite a disturbance in the court scene" (PL02). Another woman was considered a recalcitrant subject because, in the words of the BAU social worker, "she would only tell her story in her own way and would not be interrupted" (SWR50). Yet another subject, described as "despondent, sullen, sarcastic, and resistant to questioning" in the nurse's report, received the following depiction in the psychiatrist court letter: "[S]he does not always listen to ... sound medical advice given to her by her family doctor and whichever specialists she has seen. We also felt that she does not have as much respect for authority as she may be able to use to help keep herself out of trouble" (PL34).

When male patients resisted or rejected their assessment, particularly those who were charged with a violent offence, METFORS clinicians typically portrayed them as out-of-control and dangerous individuals. One 23 year old man arrived at the BAU charged with threatening (the husband of a woman who had left her spouse to live with the accused and subsequently returned to him) and with dangerous driving following a high speed police chase. Noting that the defendant had spent time in several mental hospitals, the police report then added: "The accused states he will NOT voluntarily seek psychiatric help or return to a psychiatric facility under any conditions, and the only treatment he wishes is Valium to help him cope" (PR 69). In their forensic reports, clinicians duly noted the subject's defiance and emphasized how unwarranted his lay diagnosis was. The social worker said that while M. "appeared to be within the average range of intelligence ... I did feel that he was hostile and anti-authority, impulsive and a very inadequate young man ... I feel that if he should get back into the drug scene he could be

dangerous in terms of physical acting out...." (SWR69). In his court letter, the psychiatrist stated: "[M.] does suffer from a personality disorder ... He is impulsive and emotionally unstable and in this respect shows some potential for dangerousness. I believe this would be enhanced on occasions when he was under the influence of drugs ... However, he is not motivated for treatment at this stage and would probably therefore be a poor candidate for any assistance at this time" (PL69).

Irrespective of gender, METFORS patients who did not adopt the appropriate masculine or feminine demeanour and behaviour almost invariably invoked a punitive response from their forensic assessors. Sometimes, clinicians interpreted a subject's resistance to official offers of assessment or treatment as grounds for intensified psychiatric intervention. For example, faced with the reticence of one woman diagnosed as a chronic schizophrenic, the BAU psychologist asserted that "[t]he refusal to cooperate may relate to a depression in which she feels helpless and unworthy of assistance" (POR28). In his letter to the presiding judge, the psychiatrist recommended a court-ordered inpatient remand, as "it would be difficult for her to remain uncooperative for a period of 30 days in a hospital setting such as exists on the Inpatient Unit" (PL28).

In other instances, METFORS women and men who did not demonstrate their deference to authority by accepting responsibility for their past misdeeds and future redemption, and particularly those who actively resisted, were the targets of seemingly interchangeable penal and/or therapeutic interventions. A 25 year-old woman on welfare was remanded to METFORS charged with shoplifting $22.69 worth of merchandise from a local drugstore. During the course of the one-day assessment, she was described by the nurse as "dishevelled, unkempt, obese, [and] circumstantial. Her insight appeared to be nil. [H]er judgment was poor. She appeared to be a very immature, dependent and manipulative young women" (NR49). The BAU social worker contacted the defendant's probation officer, who reported that "there is no way of helping this girl to change her behaviour" and that "it was probably best for [her] to go through the court system and that time in [prison] would not be detrimental to her" (SWR47). The psychiatrist's court letter echoed this theme:

> Ms. R. is not a good candidate for a psychiatric approach to her anti-social behaviour. In the examination she demonstrated considerable resistance and hostility to any attempt to clarify the triggering factors in her anti-social shop-lifting. ... Ms. R's immaturity surfaces in her failure to accept responsibility for her own behaviour. To date, she has failed to benefit from extensive probation assistance. ... It may be that a short period of incarceration will serve to advise her of her responsibility in her own behaviour (PL47).

In compliance with the psychiatrist's prescription, the judge sentenced the woman to jail for a week. A mere seven months later, she was remanded to METFORS again on another charge of shoplifting. Confronted with this continued malfeasance and with the apparent inefficacy of their earlier recommendation for carceral deterrence, the BAU clinicians returned to a psychiatric mode for managing this woman defendant. Rather than conceding the inappropriateness of such extreme control initiatives directed at a relatively minor criminal charge, clinicians opted instead to medicalize the subject's deviance, to invoke her "longstanding antisocial pattern of behaviour" (2PL49) as a rationale, and (even with certain expressed

reservations) to secure a long-term regimen of psychiatric assessment and treatment in a closed psychiatric facility:

> Ms. R. shows features of an immature personality disorder. ... [and her] history of ongoing repetitive shoplifting is significantly related to her psychological difficulties. It is my impression that her antisocial pattern relates to a desire for attention and a need to be taken care of by others in her environment...It may be that she could benefit from an inpatient psychiatric approach to her emotional difficulties. I had previously recommended a short period of incarceration as a deterrent to Ms. R. This would appear to have been unsuccessful in curbing her antisocial behaviour. Although I have doubts about the likelihood of success, I would recommend that Your Honour consider remanding Ms. R....for a 30 day inpatient assessment. This assessment would be directed towards Ms. R.'s capacity to respond to psychological treatment (2PL49).

When stereotypes fail:

The impact of class-gender assumptions on forensic decision-making becomes even clearer when we examine atypical cases. Forensic clinicians expect their subjects to be failures—to deviate from gender and class norms—and are thrown into diagnostic crisis if an individual sent for assessment contradicts their pre-conceived ideas about what kind of women and men are remanded to METFORS. In such cases, the production of favourable forensic assessments usually coincides with the occasional patient demonstration of gender-appropriate behaviour. For example, the rare METFORS subject who exhibited a stable matrimonial and maternal history, as well as a feminine demeanour, was a candidate for lenient treatment: "Mrs. V. is the mother of 2 preschool children, who presented in a pleasant cooperative way. During her admission she was very cooperative and seemed to be much relieved. ... She was found to have been a responsible mother and wife. Their marriage seems to function well. ... She does not suffer from a mental illness. She would be a candidate for bail and/or probation" (PL44).

Similarly, women who were seen to identify with the stereotypical gender role, and to embrace feminine ideals of attractiveness and deference, received a like response: "This attractive young single Caucasian female presented herself in an open manner. ... [S]he was on the verge of tears on several occasions" (NR38). ... "This 23 year old girl is a very bright gal. She is extremely attractive, and well groomed. ... I feel that she has a lot of potential and is probably well-motivated to change" (SWR38).

Finally, and of particular relevance for an understanding of gender and class relations at METFORS, there was one woman among the 57 whose social and material background struck a singularly discordant note against the nearly universal subject experience of poverty and marginality. This affluent, upper middle class teacher was charged with stabbing her estranged husband while he slept, for which she eventually received a sentence of 12 months probation. The atypicality of this case presented a serious classification problem for clinicians. This individual clearly did not fit into conventional categories.

In the end, unlike the majority of women at METFORS, she was cast into the more traditional role of a medical patient while in the agency. She was approached more as a victim of her husband's adultery and psychological oppression than as a perpetrator of his physical injuries; and she was ultimately recommended by clinicians for a relatively lenient disposition: "It seemed to us that Mrs. S. had stored up a lot of anger, hurt, frustration and

depressive feelings. She is a very intelligent woman with exceptional verbal skills. ... She was communicative and cooperative during her stay here, and presented no management problems. She has formulated realistic plans. ... She is a suitable candidate for bail. In her improved mental state she is not considered dangerous" (PL41).

CONCLUSIONS

In closing, we want to suggest that our analysis has implications which extend far beyond these 57 female criminal defendants and their male counterparts who underwent psychiatric assessment at the Metropolitan Toronto Forensic Service. The way in which forensic clinicians carry out their work is very relevant, both to the rest of the offender population and also to the people who do not receive deviant labels—the presumably conformist majority. Why is this so? First, although more uniformly marginal, the METFORS women (and men) had much in common with many accused persons who were not remanded for clinical assessment with respect to the kinds of charges against them and their personal histories of disrepute. In a more general sense, all criminal defendants stand accused, not just for breaking the law, but also for violating certain norms governing productivity, morality, sexuality and family life. Moreover, the decision-making of all criminal justice personnel reflects a concern with both types of transgression. Thus, the judgments about offenders by seemingly disparate groups of legal agents are strikingly similar (Eaton, 1986) and, to a certain degree, interchangeable.

In short, forensic clinicians utilize the same moral and legal criteria as police, prosecutors and judges in their evaluation of female offenders. It is clear that the clinicians at METFORS operate very much within a crime-responsibility-punishment framework and, contrary to what Allen (1987a,b) found, do not assess women more leniently than men. Rather, they presume the deficiency of all their clients and "try" each case at the assessment interview. Not surprisingly, most defendants are found both morally and legally culpable, and thus deserving of criminal sanctions.

Consequently, although METFORS clinicians frequently depict their patients as mentally and emotionally disordered individuals, very few men or women sent to the BAU are ultimately found unfit to stand trial and even fewer are judged to be insane (Menzies, 1989; Webster, Menzies, and Jackson, 1982). Despite the medical terminology which characterizes their reports, then, forensic psychiatrists play a role which is more akin to that of other legal actors within the criminal justice system than to that of the doctor. Like probation officers, they employ professional, technocratic language which incorporates the same concepts of responsibility and accountability as legal discourse.

Second, although the METFORS women (and men) belong to a marginal underclass, forensic decision-making about them contributes to the reinforcement and reproduction of capitalist, patriarchal relations across the entire population. By sanctioning those individuals who have consistently failed to conform to class and gender norms, clinicians convey a message to others, particularly members of the "respectable" working class, whose allegiance to the Protestant ethic and the nuclear family may be tenuous, that conformity pays. While not conspiratorial, or even necessarily conscious, such deeply held assumptions about class and gender profoundly affect the

work of forensic classifiers, and make them intolerant of those who do not meet expectations.

Thus, clinicians routinely punish non-compliance with "normal" standards, whether the deviant is actually able to conform or not. For example, they do not take into consideration that a woman with little education and few job skills, who is essentially unemployable, might find it impossible to embrace the Protestant work ethic. Similarly, forensic decision-makers expect women to be "good" mothers and wives and are apparently resistant to the reality that many of their patients have experienced the worst kinds of abuse within the nuclear family. Clinicians seemingly adhere to the "domino theory", that if some women are allowed off the conformity hook, many others are likely to follow.

Ultimately, then, forensic decision-makers individualize and thereby de-politicize deviance. In searching for causes, they recurrently ignore structural factors and locate the source of the deviance in the woman herself. Hedonism or promiscuity, to wit her personal failings, are ultimately responsible for her criminality. From this perspective, the solution to deviance is also an individual matter. She must change: give up drugs and alcohol, find a legitimate job, enter into a monogamous, heterosexual marriage relationship and take proper care of her children.

In this way, clinicians contribute to the maintenance of unequal gender and class relations. For if they were to identify their clients' material conditions of existence as the major source of their criminality, attention would be directed to the need for social rather than personal transformation. And such a revelation might well contribute to deconstruction movements in medicine and law, by challenging the very validity of the structured gender and class inequality which makes up the status quo in contemporary liberal democratic societies.

ENDNOTES

1. Interestingly, there were clear sexual divisions in the professional affiliations of METFORS Brief Assessment Unit team members. During the term of this study, from among those practitioners who participated in two or more evaluations of the 57 subjects, all four psychiatrists and all three psychologists were male, whereas the three social workers and four nurses were female. Only correctional officers demonstrated some gender variation, with a total of six men and two women involved in brief assessments.
2. Instead of pointing out every such example that appears throughout the remainder of this paper, we simply forewarn the reader that passages excerpted from the METFORS documents are riddled with gender-exclusive and sexist language. Men are always men but women are more likely to be referred to as "young ladies," as "gals," or by their first name only.
3. The 57 cases in the sample of METFORS women defendants are enumerated chronologically by order of appearance in the Brief Assessment Unit. In order to preserve confidentiality, all individuals are referenced by first and/or second initial only. The source materials from official reports are cited according to the following scheme:
   PR = Police report
   NR = Brief Assessment Unit nurse report
   SWR = Brief Assessment Unit social worker report
   POR = Brief Assessment Unit psychologist report
   PL = Brief Assessment Unit psychiatrist court report
   2PL = Brief Assessment Unit psychiatrist court report from first subsequent METFORS remand
   IPN = Inpatient Unit ward notes.

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