

Chapter 7

Delinquent Life: Forensic Psychiatry and Neoliberal Biopolitics

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Introduction

In *Discipline and Punish*, Michel Foucault claims that a “curious substitution” takes place within the “penitentiary apparatus”: the convicted *offender* is substituted by the *delinquent*. While the “offender” was a product of a legal judgment corresponding to that individual’s criminal act(s), for the “delinquent” it is “not so much his act as his life that is relevant in characterizing him” (Foucault 1977: 251). Delinquency is in large part a product of a moral judgment that bears upon the person’s life or *bios*, less a matter of what one *does* and more a psychiatric question of who one *is*, “a whole bundle of complex threads (instincts, drives, tendencies, character)” (1977: 253). In treating the delinquent, correctional and psychiatric techniques represent a moral orthopedics that constellates around a vital norm, fixing on the precise manner in which that norm has been transgressed, and implementing new technologies of rectification. In this respect, as Foucault describes it, the prison becomes “a sort of artificial and coercive theatre in which his life will be examined from top to bottom” (1977: 251–252). At once—and often indistinguishably—both correctional and psychiatric, the prison is a theatre for the coercive production of a relatively new and emergent form of subjectivity—one produced through the regulation of an individual’s “disposition.”

This chapter examines the role of forensic psychiatry in the production and treatment of what we are calling *delinquent life*. We argue that forensic psychiatry has, wittingly or not, led the way toward a new form of power, evident in the place of expert psychiatric testimony in the legal arena and in the design and execution of treatment plans in prisons. Specifically, we develop the following claim from *Abnormal*, Foucault’s 1974–1975 lectures at the Collège de France: “a certain type of power—distinct from both medical and judicial power—has in fact colonized and forced back both medical knowledge and judicial power throughout modern society” (Foucault 2003b: 26). The “distinct” power that has “colonized” and “forced back” both medicine and law is the power of normalization—a normalization which we interpret specifically as the combined effect of biopolitics and neoliberalism, as discussed throughout Foucault’s 1978–1979 lectures at the Collège de France, *The Birth of Biopolitics* (2008). Forensic psychiatry is perhaps uniquely susceptible to such “colonization,” since it is situated at the nexus of the assiduous bureaucracy

of the biomedical and prison-industrial complexes, which produce regimes of truth and truth-effects in their own right. Forensic psychiatry is thus caught between conflicting and intersecting roles: an ethico-medical duty to care, a moral obligation to pass paralegal judgments in the form of expert testimony, and a professional responsibility to design and administer treatment plans in a correctional milieu—a total institution devised to carry out the punishment and legal judgment that his or her “expert opinion” may well have helped to determine in the first place.

Biopower and the Management of Life

Given what are arguably its incompatible allegiances, forensic psychiatry is a particularly rich site at which to investigate the ongoing historical shift taking place, from disciplinary forms of medical power-knowledge to biopolitical ones. These forms of biopower often intersect and overlap, although they are not mutually exclusive. Foucault writes: “Medicine is a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects” (Foucault 2003: 252). In the first form of biopower, the body is subject to a *disciplinary* power that takes the individual organism as its object of treatment. In the second, that body is understood primarily as a member of a population subject to *biopolitical* regulation and normalization. Effectively, the body is doubled along this axis, both a disciplinary body and a biopolitical body. This doubling is all the more salient when the body in question belongs to someone who has been diagnosed with a mental illness, and more complex still when that body belongs to an inmate in a correctional facility. As the convicted offender is gradually substituted by the delinquent, we see a shift from disciplinary power to the colonizing force of a specific form of biopolitics supported by and constituted in neoliberalism—a shift that marks not simply a distinction between corrections and psychiatry, but, increasingly, their indistinguishability, their colonization, and coerced collusion.

In Foucault’s terms, disciplinary and biopolitical biopower have specific objects and objectives: where discipline “individualizes,” biopolitics “massifies,” the latter treating “populations” by regulating and regularizing them *en masse*. To be sure, both law and medicine will disavow their “massifying” role; if pressed, they would prefer to align themselves with disciplinary biopower in order to preserve and privilege the *individual* who is said to be free, rational, and autonomous—i.e., the foundation of personal rights, responsibility, consent, and dignity within the tradition of liberalism (and without which modern law and medicine become unrecognizable, inoperable). But consider Foucault’s description of biopolitics and we see how traditional liberalism is increasingly untenable, and how law and medicine have been colonized, perverted:

The mechanisms introduced by biopolitics include forecasts, statistical estimates, and overall measures. And their purpose is not to modify any

given phenomenon as such, or to modify a given individual insofar as he is an individual, but, essentially, to intervene at the level at which these general phenomena are determined ... [R]egulatory mechanisms must be established to establish an equilibrium, maintain an average, establish a sort of homeostasis, and compensate for variations within this general population and its aleatory field. In a word, security mechanisms have to be installed around the random element inherent in a population of living beings so as to optimize a state of life. (2003a: 246)

Management on this scale demands a vast network of experts, much in the ways that public health and epidemiology are mobilized as a form of population-based power-knowledge. We have left the “individual” of traditional liberalism far behind. While neoliberalism promotes hyper-individualism—one who is responsabilized to manage and assume various personal risks—this individuality is a ruse because individual “choices” have come increasingly to rely on a cadre of “experts,” whose expertise is managed and delivered through corporate structures which are increasingly privatized, deregulated, commodified. Expertise is purchased on the open market; the citizen is transformed into a consumer whose “freedom” is tied to his or her socioeconomic class, race, sexual orientation, etc.

There can be no doubt that medical knowledge and judicial power increasingly rely on statistical estimates and measures—to better understand risk, to regulate and mitigate it amongst “at-risk” populations. Indeed, we expect medicine and law to make use of advances in science and technology to “optimize” the lives of the living. At the same time, however, they have little choice: biopolitical “massification” is driven by the inexorable demand for economies of scale, the maximization of efficiencies, the minimization of costs, and the eradication of randomness. Under neoliberalism, market forces drive computerization and e-health, dictate permissible cost-benefit analyses, promote “affordable” and “reasonable” treatment plans (typically in line with multinational pharmaceutical and insurance industry profits and quarterly stock reports), and constellate around the statistically “average” patient of evidence-based medicine and its randomized controlled trials. Not just today, but in the future: hence, the rise of predictive rationalities, quantitative forecasts, epidemiological pattern recognition, vectors of infection, the analysis of past behaviors and trends, extrapolating them, in order to regulate and regularize, and to act pre-emptively, to thwart, to prevent, and when this is not possible, to prohibit and proscribe.

The result has less to do with treating illness or managing epidemics and more to do with the biopolitical regulation of living populations in their generality—their health, hygiene, productivity, and vitality. Epidemics have been substituted by “endemics”:

illnesses that were difficult to eradicate and that were not regarded as epidemics that caused more frequent deaths, but as permanent factors which ... sapped the population’s strength, shortened the working week, wasted energy, and cost

money, both because they led to a fall in production and because treating them was expensive. (Foucault 2003a: 244)

In brief, neoliberal biopolitics has as its object and its objective the (re)production and circulation of human capital. According to Henry A. Giroux, neoliberalism is “a form of terrorism because it abstracts economics from ethics and social costs, makes a mockery of democracy, works to dismantle the welfare state, thrives on militarization, undermines any public sphere not governed by market values, and transforms people into commodities” (Giroux and Letizia 2012). Thus, neoliberal biopolitics consists in this voracious, violent, near-totalizing economic ideology, together with the increasingly abstract “populations” it both constitutes and serves, in tandem with and further driven by the burgeoning technological capacities of the biomedical and military-industrial complexes.

Under the aegis of neoliberal biopolitics, Foucault’s claim in *Abnormal* (2003b) takes on added significance. When read alongside *The Birth of Biopolitics* (2008), we get a better understanding of the “certain type of power—distinct from both medical and judicial power” that has “colonized and forced back both medical knowledge and judicial power” (2003b: 26). Somewhat paradoxically, medical knowledge and judicial power are “forced back” through what might be called the “advances” of science and technology, driven by the joint efficiencies of neoliberal economics and biopolitics. They must constitute as normative a juridico-biological field in which the (re)production and circulation of human capital will flourish; and as with any colonizing discourse, this “ground” is hegemonic, operating as originary and natural, fuelling false-consciousness. In *Abnormal*, Foucault traces a genealogy of the abnormal individual, a historical trajectory of three colonizing (his word again) “elements” or “figures” or “circles in which the problem of abnormality is gradually posed” (2003b: 55). The first in this trajectory is the “human monster,” followed by the “individual to be corrected,” and then the “masturbator” (particularly the child). The genealogy proceeds through increasingly circumscribed fields of application; while the frame of reference for the “human monster” was nature and society, for the “individual to be corrected” it is “the family and its entourage,” while for the “masturbator” it is “a much narrower space ... the bedroom, the bed, the body; it is the parents, immediate supervisors, brothers and sisters; it is the doctor: it is a kind of microcell around the individual and his body” (2003b: 59). In some respects, the trajectory traces for us the rise of disciplinary biopower, which “individualizes” in and through a meticulous technical infrastructure, a politico-medical micromanagement. But this history is incomplete.

Resurrection of Human Monstrosity

If, more recently, there has been a “colonization” and a “forcing back,” we are suggesting here that there has been a resurrection of human monstrosity—but a monstrosity that incorporates, that has itself been colonized by neoliberal economies

and biopolitical forces. Recall that the “human monster” is “not only a violation of the laws of society but also a violation of the laws of nature The field in which the monster appears can thus be called a ‘juridico-biological’ domain” (2003b: 55–56). Today, this juridico-biological field is occupied, we contend, by forensic (bio)psychiatry. And so we have passed from the “individual to be corrected,” which was the object of nineteenth-century penalty and psychiatry, to what we are calling *delinquent life*, which is at once monstrous in the classical sense, but whose monstrosity now secretes the hidden truth of the dangerous—or potentially dangerous—population it characterizes.

The high-profile American forensic psychiatrist Michael Welner prefers the term “depravity,” a term that captures very well our understanding of the role of forensic psychiatry in the production of delinquent life. Welner is a media darling, appearing on talk shows following particularly horrific violent crimes, such as the Sandy Hook school massacre, after which he propounded on the mental condition of the gunman, Adam Lanza, and others like him:

It starts with someone who is fundamentally resentful and alienated, and blames others. Alright? Then it progresses from there to someone who identifies with the idea of destruction as a matter of stature. And then, the person becomes increasingly withdrawn and they get a little older and they have social or sexual frustration and incompetence. (*Forensic Psychiatrist Dr. Michael Welner on the Newtown Shooting, Part 1*, 2012)

Of course, Welner cannot discuss the Lanza case with any authority, but he does not hesitate to provide a profile, a “type,” right down to the character’s sexual dysfunctions. He is resentful, he feels alienated, and so forth—hardly profound insights, but these alone are not crimes and the causal link to the criminal acts are tenuous at best. These dispositions are irregularities in his psychology, his relationships, his moral or spiritual life—irregularities characteristic of the profile but attached to Lanza seamlessly. In Foucault’s words: “Expert psychiatric opinion makes it possible to transfer the point of application of punishment from the offense defined by the law to criminality evaluated from a psychologico-moral point of view” (Foucault 2003b: 18). Welner’s status as forensic expert, his authority to pronounce a moral judgment on an individual he has never met, precedes him, part of the “CSI Effect” (Podlas 2005, Schweitzer and Saks 2007) in which the public exhibit an unrealistic faith in the capabilities and reliability of forensics, thanks to popular television shows like *CSI: Crime Scene Investigation*.

With the label “forensic,” it hardly matters that psychiatry cannot be considered analogous to blood spatter analysis and ballistic fingerprinting. Welner capitalizes on the perceived authority of forensics, offering us “The Depravity Scale,” which is proclaimed to be the latest in “evidence-based forensics.” The Depravity Scale is meant to *objectively* define evil in everyday human interactions, criminal or otherwise. The Depravity Scale boasts a website, <http://depravityscale.org/>, which also includes a depravity survey for those who are interested (and whose

participation, apparently, will contribute to this research). In response to the question, "What is the Standard helping to judge? The act, or the person?" the website tells us:

The Depravity Standard will measure the crime itself, and not the perpetrator—that is, it will judge the "what" of a crime, as opposed to the "who." This instrument will provide an objective, evidence-based standard by which to assess the intents, actions, and attitudes associated with a given crime that distinguish it as worse than other crimes. (<https://depravitiescale.org/depscale/faq.php#q6>)

"Depravity" and "evil" are patently subjective categories, and not absolute at that; a person's intents, actions, and attitudes cannot be abstracted from "who" he or she is. Some scholars are critical about whether categories such as these ought to be used as testimony (e.g., Simon 2003), noting that since the Supreme Court case of *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), courts must consider the admissibility of scientific evidence—whether it is testable, supported by peer review, and so forth. Certainly, "depravity" and "evil" can only fail the test of scientific objectivity. As Simon observes, "Some perpetrators of the worst atrocities do not have a diagnosable psychiatric disorder" (Simon 2003: 415). But this is all the more reason, Welner retorts, that his Standard is necessary: "Evil behavior bedevils the law and the behavioral sciences, and it will not go away. Defining evil is only the latest frontier where psychiatry, confronting the challenge of ambiguity, will bring light out of darkness" (Welner 2003: 421). In his view, psychiatry has an obligation to challenge "ambiguity," to expand its diagnostic arsenal to include tools that measure depravity and evil, and to operationalize this for judgment in a standardized fashion. According to Welner, the forensic psychiatrist is the person best equipped for this task:

What gives forensic psychiatrists the expertise to make judgments about what is normal or not, with any greater expertise than lay people? What gives psychiatrists the qualification to brand someone "psychotic" or as sexually "deviant" in a world of millions of particularized internet erotica consumers? Is there not a philosophical or theological point to be considered about mental infirmity? Is mental sickness not influenced by cultural and political orientation? But of course. (2003: 418)

Remarkably, in Welner's terms the role of the forensic psychiatrist is to judge "what is normal or not"—to judge, to pathologize, and by implication, to criminalize abnormality according to particular philosophical or theological values, according to cultural and political orientations—the failure to embody arbitrary norms. Should there be a philosophy or a (political) theology of evil, Welner claims their definitions of good and evil, friend and enemy, for forensic psychiatry, installing (or securing) evidence-based psychiatry as both the organizing principle and natural *telos* of such musings on evil.

While Welner presents a limit case, he demonstrates clearly the ways that both law and psychiatry have been "pushed back" and "colonized" by neoliberal biopolitics: in the name of normalization and standardization, at the altar of efficiency and operationalizability, we produce populations who are divided according to perceptions of normality, abnormality, and tolerable risk. It is a vague "public" or "society" that is constituted as the population "at risk" of harm from an endemically "risky" or "dangerous" population. In the province of Ontario, Canada, the forensic mental health system is aligned with the Ministry of Community Safety and Correctional Services. The name itself is telling: one ministry is in charge of public security and corrections, as if these were synonymous. Here, the forensic mental health system operates to protect the "public," to help judge when the security of the public is deemed to be at risk, and to act so as to prevent risk. "The public" is constituted rhetorically as a population whose lives and livelihood are perpetually at risk, while the offender is judged according to the prevailing norms of an existing population of mentally ill offenders who are judged to be at risk of re-offending and threatening public security.

Forensic Psychiatry as Switchpoint

Biopolitically, forensic psychiatry is the switchpoint between public security and corrections; it functions within an aleatory field—a field saturated by risk and uncertainty, informed by mental health statistics, probabilities, rates of recidivism, and so on. It intervenes in the lives of populations or sub-populations conceived in statistical or average terms, and its intervention is a form of actuarialism. But it is unclear which population forensic psychiatrists truly represent, or whose "risk" is being assessed and managed—whether they are motivated more by the care of one population or the security of the other. Arguably, "risk" has very little to do with either population: if there is risk, it is the risk to normality as such, a risk to "normal" philosophical or theological values, "normal" cultural and political orientations, here exalted as a "way of life." In other words, abnormality threatens our normative symbolic system; it serves the reproduction of an ideological form. The discourse on risk, then, shores up normality by performatively producing perpetual risks and dangers. While there may in some instances be a credible threat, highly mediatized events depicting mass murders succeed in terrorizing the public, who in turn become all the more willing to enlist the support security "experts," to approve if not call for "pre-emptive strikes" and a sort of counter-insurgent psychiatry. The legal concept of the "dangerous offender" provides the juridical sanction for psychiatry to act pre-emptively. However, by allowing for the designation of "dangerous offender," the *Criminal Code* of Canada (15, Part XXIV) seems to contradict Canada's *Charter of Rights and Freedoms* (Kaiser 2009). The *Criminal Code* allows courts to assign harsher (or indeterminate) sentences for those deemed by forensic psychiatrists to be "dangerous." These measures are justified according to the logic of "preventive detentions" or "protective sentences," which

are designed to protect the public from “likely harm” at some unspecified future moment. Responding to a challenge to such legislation, Canadian Supreme Court Justice La Forest clearly aligns risk and the need for security when discussing a criminal’s disposition: “His being in the wrong by virtue of the risk he represents is what entitles us to consider imposing on him the risk of unnecessary measures to save the risk of harm to innocent victims” (*R. v. Lyons*). The proliferation of “risk” is dizzying: who is at risk, or at risk of risk? “Innocent victims” in this case means *potential* victims, those at risk of victimization, and thus not victims at all. And all this justifies what La Forest does not hesitate to name a judicial “entitlement” to heap risk upon risk. In this case, the “dangerous offender” is punished not merely for what he has done, but for who he is, what he might do, and for what he represents; it is an ontological claim, he *is* “in the wrong” by virtue of the risk he represents. And this depends on the testimony of forensic psychiatrists, who wear the mantle of the scientific expert.

But here the forensic psychiatrist must leave his/her professional and deontological obligations behind to adopt the legal reasoning of the *Criminal Code*. In Alan Stone’s words, this amounts to a “legal assault on psychiatry” which has occurred over the last several decades (Stone 2008: 167). As forensic psychiatry has surrendered its “discretionary authority” to the courts, paradoxically, the courts have come to rely increasingly on expert testimony from forensic psychiatrists. Forensic psychiatry has been “juridicized,” that is, taken over by juridical forms of discourse concerned primarily with criminal justice, rather than mental health. This raises a basic boundary question for the profession. Stone asks: “Does psychiatry have anything true to say that the courts should listen to?” (2008: 167). There is a question here of what constitutes truth and how—or whether—truth can be told in such a context (Gutheil, Hauser, White, Spruiell, and Strasburger 2003). What authority must psychiatrists possess or presume in order to wield scientific knowledge, as the psychiatrist moves from the clinic to the courtroom? After all, these two domains have largely incommensurable conventions governing evidence. Stone suggests that “forensic psychiatrists are without any clear guidelines as to what is proper and ethical” (2008: 167–168). The ethical—and irresolvable—dilemma that faces the psychiatrist becomes exacerbated in the courtroom. The Hippocratic tension between helping and, first of all, doing no harm, makes little sense in a juridical context; help and harm become supplanted by the logics of evidence, justice, and public security. The ethic of the physician and the ethic of the jurist should not coincide; they take a different object, they have a different purpose.

One way to close this gap involves reducing psychiatry, *grosso modo*, to jurisprudence. But what occurs when the language of law is imported into the psychiatric domain? Unsurprisingly, we find psychiatry adhering to increasingly rigid and refined diagnoses, adhering to the rhetoric of “evidence.” Increasingly, forensic psychiatrists align themselves with the rather narrow field of evidence-based medicine (Cole 2007), with its emphasis on randomized controlled trials and treatment plans informed by best-practice guidelines. For the evidence-based

practitioner, these guidelines function as quasi-legal precedents. But evidence-based medicine has many critics, within psychiatry and without, so it is troubling that this biomedical model has become the standard in courts of law. In the United States, evidence-based medicine has been endorsed by the Supreme Court in *Daubert* (1993), where the Court recognized trial judges as the gatekeepers of evidence, giving them the power to determine whether and which evidence is scientifically valid and relevant to the case at hand. In Canada, there are similar Supreme Court cases that treat the role of evidence and expert testimony, namely, *R. v. Mohan* (1994) and *R. v. J.-L.J.* (2000). Significantly, both involved cases of pedophilia, which provide additional leeway for expert testimony in light of judging the “disposition” of the accused: “the exception has been applied to abnormal behaviour usually connoting sexual deviance” (*R. v. Mohan* 1994). In *Mohan*, we read: “The trial judge should consider the opinion of the expert and whether the expert is merely expressing a personal opinion or whether the behavioral profile which the expert is putting forward is in common use as a reliable indicator of membership in a distinctive group” (*R. v. Mohan* 1994). Problematically, the decision to include expert testimony is made on the basis of the “common sense and experience” of the trial judge, but expert evidence is only deemed necessary to the trial if it is “outside the experience and knowledge of a judge or jury” (*R. v. Mohan* 1994), so psychiatric “expertise” and juridical “common sense” stand in some tension. Either way, the evidence does not speak to the crime, but seeks to establish “scientific” and “common sense” evidence for a “disposition,” and whether or not by virtue of said disposition the accused can be reliably profiled as a member of an abnormal population or group. In Foucault’s words, “penal sanction will not be brought to bear on a legal subject who is recognized as being responsible but on an element that is the correlate of a technique that consists in singling out dangerous individuals and of taking responsibility for those who are accessible to penal sanction in order to cure them or reform them” (Foucault 2003b: 25).

Conclusion

These “developments” in forensic psychiatry are perhaps merely symptomatic of a deeper illness afflicting the late modern psychiatric enterprise as a whole. If, as we have argued, forensic psychiatry is ripe for being “pushed back” and “colonized,” this is because psychiatry has largely abandoned a psychodynamic-psychotherapeutic approach to mental health care and has turned to a biopsychiatric one that treats the brain pharmacologically. The talk of “dispositions,” “attitudes,” “character” or “intent” no longer makes sense; these are not attributes of brains, and it is highly reductive to speak of them as neurochemical. The accused is a person, a life lived in complex relation with others and with the world. The person is subject to criminal law, not the brain. So psychiatry has nothing worthwhile to say; it speaks in another idiom.

While we have focused on forensic psychiatrists acting as expert witnesses in the courtroom, the courtroom scene is instructive because it provides a dramatization of the dilemma that faces the psychiatrist working in a prison setting—where the patient/inmate may be confused about the roles that the psychiatric healthcare provider plays. Does s/he practice psychiatry, taking up the role of a healer, to relieve suffering but first of all to do no harm? Does s/he practice forensics, using science to establish the facts in a criminal case, and to understand his/her patient's mental health in relation to the administration of criminal justice? Is s/he an agent of care or an agent of the correctional apparatus? Are his/her treatment plans informed by neoliberal biopolitics, as they are with "incentivizing" behaviour modification plans based on token economies? It matters little whether the token economy adopts a "rewards" or "punishments" model: it is a process of socialization that capitulates to market values, "where individuals are seduced into seeing themselves as 'human capital' within a system that calculates, quantifies and otherwise measures all manner of human relationships according to the terminology of the 'free' market" (Holmes and Murray 2011: 299). The answer, then, is that s/he has a dual role, s/he is a "double agent" (Austin, Goble, and Kelecevic 2009, Robertson and Walter 2008). And s/he lacks a meta-ethics that might help him/her to navigate between his/her two obligations. What happens to his/her ethical duty to "help" a patient if this results in a miscarriage of "justice"? Or, will s/he be forced to do "harm" in the name of "justice"? And how, according to what—and whose—logic will s/he decide?

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